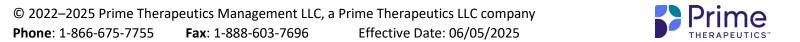


## New Hampshire Medicaid Fee-for-Service (FFS) Program Prior Authorization Drug Approval Form

Second-Line Antifungals

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED	
LAST NAME:	FIRST NAME:
MEDICAID ID NUMBER:	DATE OF BIRTH:
GENDER: Male Female	
Drug Name:	Strength:
Dosing Directions:	Length of Therapy:
SECTION II: PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
SPECIALTY:	NPI NUMBER:
PHONE NUMBER:	FAX NUMBER:
SECTION III: CLINICAL HISTORY	
<ol> <li>Has the patient had an adequate trial and failure with (i.e., topical ciclopirox, clotrimazole, econazole, ketoo terbinafine, or tolnaftate)?</li> <li>If yes, list treatment failures and provide dates or cor</li> </ol>	onazole, miconazole, nystatin,





## New Hampshire Medicaid Fee-for-Service (FFS) Program Prior Authorization

Second-Line Antifungals

DATE OF MEDICATION REQUEST: / /	
PATIENT LAST NAME:	PATIENT FIRST NAME:
2. Is there documented intolerance to a first-line drug?	? Yes No
If yes, describe the intolerance:	
Topical ciclopirox:	
Clotrimazole:	
Econazole:	
Ketoconazole:	
Miconazole:	_
	_
Tolnaftate:	
Provide any additional information that would help in the please use another page.	ne decision-making process. If additional space is needed,
	complete to the best of my knowledge and I understand
that any falsification, omission, or concealment of mat	erial fact may subject me to civil or criminal liability.
PRESCRIBER'S SIGNATURE:	DATE:

**Phone**: 1-866-675-7755 **Fax**: 1-888-603-7696

