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# 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

1. Has the patient had an adequate trial and failure within the last 60 days of any first-line drug (i.e., topical ciclopirox, clotrimazole, econazole, ketoconazole, miconazole, nystatin, terbinafine, or tolnaftate)? ☐ Yes ☐ No

   If yes, list treatment failures and provide dates or concurrent treatment:

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**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: _____
- Nystatin: _____
- Terbinafine: _____
- Tolnaftate: _____

Provide any additional information that would help in the decision-making process. **If additional space is needed, please use another page.**

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE**: _____ **DATE**: _____

**Phone**: 1-866-675-7755
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