

**ANTIFUNGAL AGENTS
(LAMISIL[®], SPORANOX[®])
PRIOR AUTHORIZATION
Physician Fax Form**



ONLY the prescriber may complete this form.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health System web site at www.primewest.org.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	Patient's telephone #:	DOB (mm/dd/yy):
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INSURANCE INFORMATION

Member's Insurance ID Number:	Member's Insurance Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PRIOR AUTHORIZATION INFORMATION

Patient's Diagnosis:
Medication Requested:
Dose and Duration of Medication requested:
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____
2. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____ _____
3. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please include approximate dates of any previous therapies.) _____ _____
4. If the diagnosis is onychomycosis: a. Are the infected nails on the fingers or toes? <input type="checkbox"/> Finger <input type="checkbox"/> Toe b. Is treatment of the patient's onychomycosis medically necessary (not for cosmetic reasons?) <input type="checkbox"/> Yes <input type="checkbox"/> No c. Has the fungal nail infection been confirmed by KOH, fungal culture, or nail biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please fax or mail this form to:
PrimeWest Health System
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 800.711.9866

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