

US Family Health Plan Prior Authorization Request Form for Topical Antifungals

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan pharmacy program (USFHP).

- Formulary topical antifungals available at a \$3 copay (generics) or \$9 copay (formulary brands) include butenafine (Mentax), clotrimazole, ketoconazole, miconazole, naftifine (Naftin), and nystatin. Topical formulations of ciclopirox (Loprox), econazole (Spectazole), oxiconazole (Oxistat), sertaconazole (Ertaczo), sulconazole (Exelderm), and miconazole 0.25% / zinc oxide 15% (Vusion) are non-formulary, but available to most beneficiaries at a \$22 cost share. The non-formulary designation applies to both the brand name and generic versions of these medications.
- You do NOT need to complete this form in order for non-active duty beneficiaries (spouses, dependents, and retirees) to obtain non-formulary medications at the non-formulary cost share. The purpose of this form is to provide information that will be used to determine if the use of a non-formulary medication instead of a formulary medication is medically necessary. If a non-formulary medication is determined to be medically necessary, non-active duty beneficiaries may obtain it at the \$9 formulary cost share.

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 OR The completed form may be faxed to 1-617-562-5296

Step 1 Please complete patient and physician information (Please Print)

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID: _____	Phone #: _____
	Date of Birth: _____	Secure Fax: _____

Step 2 1. Please indicate which medication is being prescribed:

- | | | |
|----------|---|-------------------------|
| 2 | <input type="checkbox"/> ciclopirox (Loprox) | Please go to Question 2 |
| | <input type="checkbox"/> econazole (Spectazole) | |
| | <input type="checkbox"/> oxiconazole (Oxistat) | |
| | <input type="checkbox"/> sertaconazole (Ertaczo) | |
| | <input type="checkbox"/> sulconazole (Exelderm) | |
| | <input type="checkbox"/> miconazole 0.25% / zinc oxide 15% (Vusion) | Please go to Question 3 |

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Topical Antifungals**

Ciclopirox (Loprox), econazole (Spectazole), oxiconazole (Oxistat), sertaconazole (Ertaczo), sulconazole (Exelderm)

2. Please indicate which of the reasons below (1-5) applies to each of the formulary alternatives listed in the table. You MUST circle a reason AND supply a specific written clinical explanation for EACH formulary alternative.

Formulary Alternative	Reason	Clinical Explanation
Butenafine (Mentax)	1 2 3 4 5	
Clotrimazole	1 2 3 4 5	
Ketoconazole	1 2 3 4 5	
Miconazole	1 2 3 4 5	
Naftifine (Naftin)	1 2 3 4 5	
Nystatin	1 2 3 4 5	

Acceptable clinical reasons for not using each of the formulary alternatives are:

1. The formulary agent is contraindicated (e.g., due to hypersensitivity).
2. The formulary agent is not available in the desired formulation.
3. The formulary agent caused significant burning, itching, redness or other significant adverse effects.
4. An adequate treatment course with the formulary agent resulted in therapeutic failure.
5. The formulary agent is not effective for the treatment of the specific condition. For example, nystatin is not effective for the treatment of tinea pedis, corporis, cruris, or versicolor.

Miconazole 0.25% / Zinc Oxide 15% Ointment (Vusion)

3. Please indicate which of the reasons below (1-2) applies to each of the formulary alternatives listed in the table. You MUST circle a reason AND supply a specific written clinical explanation for EACH formulary alternative.

Formulary Alternative	Reason	Clinical Explanation
Clotrimazole 1% (cream)	1 2 3	
Miconazole 2% (ointment or cream)	1 2 3	
Nystatin (ointment, powder, or cream)	1 2 3	

Note: Vusion is FDA-indicated for the adjunctive treatment of diaper dermatitis (diaper rash) only when complicated by documented candidiasis (microscopic evidence of pseudohyphae and/or budding yeast) in immunocompetent children 4 weeks of age and older. Other topical antifungals commonly used for diaper rash include higher concentrations of miconazole (2%), clotrimazole, and nystatin, often used in conjunction with zinc oxide ointment, a skin protectant.

Acceptable clinical reasons for not using each of the formulary alternatives are:

1. The formulary agent is contraindicated (e.g., due to hypersensitivity).
2. The patient has experienced or is likely to experience significant adverse effects from the formulary agent.
3. The formulary agent is not available in the desired formulation (clotrimazole only).

Step 3 I certify the above is correct and accurate to the best of my knowledge. By completing and signing this

3 document you are confirming that the patient has either tried ALL of the formulary alternatives or has a clinical reason(s) for not trying ALL of the alternatives. Please sign and date:

Prescriber Signature

Date