



New Hampshire Medicaid Fee-for-Service (FFS) Program

Prior Authorization

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:

