New Hampshire AIDS Drug Assistance 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:

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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**: _____

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