

Vusion PA FORM



Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Vusion must try other topical antifungal products as first line therapy.

***Note: Nystatin and clotrimazole do not require a prior authorization.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name					
Physician Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
Requested Drug and Dosage: <input type="checkbox"/> VUSION			Diagnosis for this request:		
Qualifications for coverage:					
<input type="checkbox"/> Failed antifungal therapy Name of medication failed: _____		Start Date	End Date	Dose	Frequency
<input type="checkbox"/> <i>I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</i>					
Prescriber Signature				Date	

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

Part III: FOR OFFICIAL USE ONLY

Date Received				Initials:	
Approved - Effective dates of PA: From: / / To: / /				Approved by:	
Denied: (Reasons)					