



VUSION PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a prescription for Vusion must use nystatin or OTC miconazole first line.

- Nystatin or miconazole OTC may be prescribed **WITHOUT** a prior authorization
- Patients must use nystatin or OTC miconazole for a minimum of 14 days for the trial to be considered a failure.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN PROVIDER NUMBER:		
City:	State:	PHONE: ()	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)	Diagnosis for this request:
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Qualifications for coverage:

<input type="checkbox"/> Failed trial of nystatin or OTC miconazole in the last 30 days	Was trial for at least 14 days? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Adverse Reaction (attach FDA Medwatch form) or contraindication: (provide description below):

Medical Justification for use of Vusion without trial of miconazole or nystatin:

Physician Signature:

Date:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ():	FAX: ()
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

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