State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
ANTIFUNGALS

Phone: 1-888-445-0497 www.mainecarepdl.org Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__|__| Patient Name: ___________________________________ DOB: ____________________
(NOT MEDICARE NUMBER)
Patient Address:____

Provider DEA: |__|__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:____ Phone:____________________

Provider Address:____ Fax:____________________

Pharmacy Name:_____________________________Rx Address:_______________________________Rx phone:_________________

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

(Topical Antifungals NOT requiring PA: Nystatin, Nystatin/Triamcinolone, Clotrimazole, Clotrimazole/Betamethasone)

Topical Antifungals Requiring a PA:

Drug	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ PENLAC	___________________________	____________	_________________	1 2 3 4 5
❑ OTHER	___________________________	____________	_________________	1 2 3 4 5

Medical Necessity Documentation

❑ MUST provide evidence that at least one other topical antifungal failed (describe): ______________________________

❑ Must include KOH or Fungal culture lab results

(Oral Antifungals NOT requiring PA: FLUCONAZOLE, NYSTATIN and TERBINAFINE)

Oral Antifungals requiring a PA:

Drug (Step Order)	Strength	Dosage Instructions	Quantity	Days Supply (34 day max)	Circle Refills
❑ ITRACONAZOLE TABS® (6)	_______	______________________________	________	__________	1 2 3 4 5
❑ LAMISIL TABS® (6)	_______	______________________________	________	__________	1 2 3 4 5
❑ SPORANOX PULSEPAK CAPS ® (8)	_______	______________________________	________	__________	1 2 3 4 5
❑ SPORANOX SOLN® (8)	_______	______________________________	________	__________	1 2 3 4 5
❑ SPORANOX® (7)	_______	______________________________	________	__________	1 2 3 4 5
❑ NOXAFIL® (8)	_______	______________________________	________	__________	1 2 3 4 5
❑ OTHER__________	_______	______________________________	________	__________	1 2 3 4 5

Medical Necessity Documentation

❑ No cosmetic indications

❑ Symptomatic onychomycosis with pain around nail; or

❑ Soft tissue involvement by infection;

❑ And any one of the following conditions:

- ❑ Diabetes
- ❑ Peripheral vascular disease
- ❑ Immunosuppression; or
- ❑ Other (describe): ____

Location and Length of Therapy

❑ Fingernails – Max 6 weeks

❑ Toenails – Max of 12 weeks

MUST include Documentation for approval process:

☐ KOH or Fungal culture – copy of lab attached

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: ___________________________________ **Date of Submission:** ____________________________________

***MUST MATCH PROVIDER LISTED ABOVE**