Prior Authorization Form

Penlac

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Penlac.

Drug Name (select from list of drugs shown)
Penlac (ciclopirox)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Does the patient have a fungal infection of the nail due to dermatophytes?	Y N
2.	Has the diagnosis been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)?	Y N
3.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to an oral antifungal therapy (e.g., terbinafine, itraconazole)?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date