WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice

Pharmacy Prior Approval Request for Topical Antifungal Agents: Vusion

Beneficiary Information

1. Beneficiary Last Name: _____2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender:_____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____Ext.: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 days ☐ 60 Days

Clinical Information

1. Is the recipient at least 4 weeks of age? ☐ **Yes** ☐ **No**

2. Has the patient tried and failed on at least two different prescription products from this list within the past 60 days: nystatin cream, nystatin ointment, nystatin/triamcinolone cream, nystatin/triamcinolone ointment, or clotrimazole cream? ☐ **Yes** ☐ **No**

If YES, Please List Products failed:

_____

_____

Please note - a quantity limit of 50 gm per 60 days is in place

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

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.

Fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**

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