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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ANTIFUNGALS, ORAL

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the member tried and failed any of the preferred Oral Antifungals?
   ☐ Yes ☐ No
   a. Check all that apply:
   ☐ fluconazole tab/susp ☐ Griseofulvin® susp ☐ nystatin tab/susp ☐ terbinafine
   Submit all supporting documentation of drug regimen and therapeutic failure.
2. Does the member have any contraindications or intolerances to any of the preferred agents listed in Question 1?
   ☐ Yes ☐ No
   a. If yes, document the specialty: _____
3. Does the member have a diagnosis for which none of the preferred Oral Antifungals are indicated or widely medically-accepted?
   ☐ Yes ☐ No
   a. Check all that apply or indicate diagnosis:
   ☐ aspergillosis ☐ blastomycosis ☐ cryptococcosis ☐ coccidioidomycosis
   ☐ febrile neutropenia ☐ histoplasmosis ☐ mucormycosis
   ☐ fungal infection caused by S. apiospermum or Fusarium species, including F. solani
   ☐ Other (specify): _____
4. Submit documentation of diagnosis and planned duration of treatment.

_____

_____

_____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC/Attn: GV – 4201
P.O. Box 64811, St. Paul, MN 55164-0811