

Iowa Department of Human Services

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

Request for Prior Authorization MICONAZOLE-ZINC OXIDE-WHITE PETROLATUM (VUSION) OINTMENT

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address	,	Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC
will only be considered for cases in which there is documentation of previous trials and failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated. Non-Preferred		
☐ Miconazole-Zinc Oxide-Whi	te Petrolatum	
Strength	Dosage Instructions	Quantity Days Supply
Diagnosis: Treatment failure with over-the counter miconazole 2% cream (payable with a prescription): Trial start date: Trial end date: Reason for failure:		
That start date.	nai end date.	Reason for failure.
Treatment failure with nystatin cream or ointment: Trial start date: Trial end date: Reason for failure:		
Medical or contraindication reason to override trial requirements:		
Attach lab results and other docum	entation as necessary.	
Prescriber Signature:*MUST MATCH PRESCRIBER LISTED AB	OVE	_ Date of Submission:

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.