



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:

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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:

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DRUG INFORMATION

All Non-Preferred Medications Require a SA

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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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:
Magellan Medicaid Administration/ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060