



# PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

## Picato

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member/Subscriber Number:	<b>Supervising Physician:</b>	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

<p>Q1. For what diagnosis is the drug being prescribed (pick one)?</p> <p><input type="checkbox"/> Actinic Keratosis      <input type="checkbox"/> Other</p>
<p>Q2. Please provide the ICD diagnosis code for the above condition.</p>
<p>Q3. Is patient greater than or equal to 18 years of age?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>Q4. Is the patient a female with child-bearing potential?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>Q5. If the patient is female with child-bearing potential, is she using a form of birth control?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>Q6. Has the patient failed a fluorouracil product?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>Q7. Has the patient failed an imiquimod product?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>



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<p>Q8. Has the patient failed a diclofenac gel product?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No</p>
<p>Q9. Additional Comments:</p>

Prescriber Signature	Date
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Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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