

Request for Prior Authorization
BIOLOGICALS FOR
HIDRADENITIS SUPPURATIVA
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Topical Clindamycin Trial Name/Dose: _____ Trial dates: _____

Reason for failure: _____

Oral Clindamycin Plus Rifampin Trial:

Clindamycin: Dose: _____ Trial dates: _____

Reason for failure: _____

Rifampin: Dose: _____ Trial dates: _____

Reason for failure: _____

Maintenance Preferred Tetracycline Trial:

Name/Dose: _____ Trial dates: _____

Reason for failure: _____

Renewals

Document response to therapy:

Abscess/Nodule Count: Increase Decrease (provide count): _____ Date obtained: _____

Has patient had an increase in draining fistula count since initiation of therapy? No Yes

Other medical conditions to consider: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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 Health and Human Services, that the member continues to be eligible for Medicaid.*