Prior Authorization Request Form for
flurandrenolide 4 mcg/sq.cm (**Cordran**) tape

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MEDICINE
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HEALTHCARE
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USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ____________________ Physician Name: ____________________
Address: ____________________ Address: ____________________
____________________ ____________________
Sponsor ID # ____________________ Phone #: ____________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Is the requested medication being prescribed by a dermatologist or plastic surgeon?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Provider acknowledges that this agent has been identified as having cost-effective alternatives, including clobetasol propionate 0.05% ointment and fluocinonide 0.05% cream and fluocinonide 0.05% solution. These agents do not require a PA.	Proceed to question **3**	
3. Provider acknowledges that barrier function can be accomplished by using an alternative agent (for example, fluocinonide 0.05% cream) with an occlusive dressing. Please note occlusion increases transmission (i.e., potency); a lower potency agent should be used as an alternative to flurandrenolide tape if used with a barrier.	Proceed to question **4**	
4. Has the patient tried for at least 2 weeks and failed, have a contraindication to, or has had an adverse reaction to clobetasol propionate 0.05% ointment OR halobetasol propionate 0.05% ointment OR betamethasone dipropionate 0.05% ointment?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

5. Please describe why Cordran tape is required as opposed to available alternatives.

Sign and date below

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature ____________________ Date __________

[4 March 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: