HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM **HYFTOR**®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

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If	you have prior authorization questions, please call for assistance:	385-425	5-5094	
Dis	sclaimer: Prior Authorization request forms are subject to change in acco	ordance	with Fede	eral and State notice requirements.
Da	ite: Member Name:		ID#:	
DC	DB: Gender:		Dhy	cicion.
DC	DB: Gender:		Phy	sician:
Of	fice Phone: Office Fax:		Office Contact:	
He	eight/Weight:		<u> </u>	
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: Hyftor® (topical sirolimus) Dosing/Frequency:				
	If the request is for reauthorization, proceed	to reau	ıthorizat	ion section.
	Questions	Yes	No	Comments/Notes
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What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy: PHARM-CHIP- 145 Origination Date: 07/01/2024 Reviewed/Revised Date: 01/29/2025 Next Review Date: 01/29/2026 Current Effective Date: 02/01/2025

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