

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Aldara[®] (imiquimod cream)
Prior Authorization of Benefits (PAB) Form
 Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

<input type="checkbox"/> Aldara (imiquimod cream)	<input type="checkbox"/> 5%	_____	Specify: _____ (QL: 12 packets per 28 days)
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7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Please indicate the patient's diagnosis:	
<input type="checkbox"/> Basal cell cancer	<input type="checkbox"/> Nonmelanoma skin cancer
<input type="checkbox"/> Molluscum contagiosum	<input type="checkbox"/> Other: _____

8. PHYSICIAN SIGNATURE

_____	_____
Prescriber or Authorized Signature	Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</i> Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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