Trillium Health Resources
Pharmacy Prior Approval Request for

Topical Antifungal: Vusion

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **__Vusion__** 2. Strength:_____ 3. Quantity Per 30 Days:_____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days

Clinical Information

1. The member is at least four weeks of age ☐ **Yes** ☐ **No**
2. The member has tried and failed on at least 2 different prescription products from this list within the past 60 days: nystatin cream, nystatin ointment, nystatin/triamcinolone cream, nystatin/triamcinolone ointment, or clotrimazole cream ☐ **Yes** ☐ **No** **If YES, Please List Products failed:** _____
   _____

Please note - a quantity limit of 50 gm per 60 days is in place

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277