

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Aldara™ (imiquimod) Cream**

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Aldara™ (imiquimod). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)								

Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

ASSESSMENT OF BENEFIT NEED	YES	NO
1. Is the patient being treated for cutaneous warts?	<input type="checkbox"/>	<input type="checkbox"/>
2. If yes, what previous therapy has the patient tried and failed? (for example: topical salicylic acid, bi- or trichloroacetic acid, cryotherapy) Please list other treatments attempted: _____ _____		
3. If no, what is Aldara being prescribed for? _____		

BENEFIT TERMS UPON APPROVAL:

Aldara will be approved for up to 16 weeks for the treatment of warts.
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All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI:** _____ **Date:** _____

**Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945**