

**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:

<b>Member Name:</b> (required) _____	<b>Member ID Number:</b> (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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<b>Member Date of Birth:</b> (required)    /    /	<b>Member Sex:</b> M      F      (Circle One)										
<b>Prescriber Name:</b> (required) _____	<b>Contact Person at Office:</b> _____										
<b>Office Phone number:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -										

<b>ASSESSMENT OF BENEFIT NEED</b>	<u>YES</u>	<u>NO</u>
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:  
Neighborhood Customer Service  
866-423-0945**