Vitiligo Preauthorization Request Form

[Date]
[Insurer name]
Attn: [Name of individual]
[Address]

re: [Patient name]
[Policy number]

[Practice Name]

[Physician Name]

[Address 1]

[Address 2]

[City], [State] [Zipcode]

Diagnosis Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Area(s) of the body requiring treatment:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Left Arm   | \_\_\_ Right Arm   | \_\_\_ Axillary (Underarms)  | \_\_\_ Palmar (Hands) |
| \_\_\_ Right Leg | \_\_\_ Left Leg | \_\_\_ Plantar (Feet) |  |
| \_\_\_ Craniofacial (Face/Head) | \_\_\_ Upper thorax | \_\_\_ Lower abdomen | \_\_\_ Groin |
| \_\_\_ Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

# Impairment of Daily Activities, & Impact on Quality of Life:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Emotional state | \_\_\_ Relationships with  family & friends | \_\_\_ Work &  professional life | \_\_\_ Developing  personal relationships |
| \_\_\_ Shaking hands | \_\_\_ Education | \_\_\_ Sexual activities |  |

# Previous Treatments:

|  |  |
| --- | --- |
| \_\_\_ UVA Phototherapy | \_\_\_UVB Phototherapy |
| \_\_\_ Topical SteroidList: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Oral SteroidList: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| \_\_\_ Surgery (MKTP)List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ None |

Recommended Treatment for:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Left Arm   | \_\_\_ Right Arm   | \_\_\_ Axillary (Underarms)  | \_\_\_ Palmar (Hands) |
| \_\_\_ Right Leg | \_\_\_ Left Leg | \_\_\_ Plantar (Feet) |  |
| \_\_\_ Craniofacial (Face/Head) | \_\_\_ Upper thorax | \_\_\_ Lower abdomen | \_\_\_ Groin |
| \_\_\_ Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| \_\_\_ UVA Phototherapy | \_\_\_UVB Phototherapy |
| \_\_\_ Topical SteroidList: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Oral SteroidList: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| \_\_\_ Surgery (MKTP)List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ Other List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## The Treatment(s) IS/ARE

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| --- |
| Notes: |
|  |

Treating Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_