



Prescription Drug Coverage Determination Form
Antifungal
Sporanox® (itraconazole)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

Patient Information

Patient Name: Date of Birth:
Subscriber ID#:
Address City State Zip Code

Physician Information

Name: Specialty: Tax ID#:
Office Address City State Zip Code
Telephone: Fax: Contact Person

Physician Signature (REQUIRED): Date

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: J-code:
Dose: Directions:
Expected Duration of Therapy:

Prior Authorization Criteria:

- 1. Has the patient taken SporanoX® within the previous 3 months?
2. Does the patient have the diagnosis of blastomycosis, histoplasmosis, or aspergillosis (pulmonary or extrapulmonary)?
3. Does the patient have evidence of left ventricular dysfunction, such as congestive heart failure, or have a history of congestive heart failure?
4. Does the patient have the diagnosis of onychomycosis due to dermatophytes (tinea unguium)?

5. Is the infection limited to the fingernails?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the infection involve the toenails or toenails and fingernails?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the patient have the diagnosis of <i>pityriasis versicolor</i> , <i>tinea corporis</i> , or <i>tinea pedis</i> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Is the fungal infection a recalcitrant or very severe disfiguring or disabling infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the patient had a trial of griseofulvin or topical antifungals without response?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Will the liver function tests (LFTs) of the patient be checked prior to initiation of therapy and as needed during Sporanox® therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.