



Prescription Drug Coverage Determination Form
Antifungal
Sporanox® (itraconazole)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

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. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Does the patient have evidence of left ventricular dysfunction, such as congestive heart failure, or have a history of congestive heart failure?
3. Has the diagnosis been confirmed with a fungal diagnostic test (KOH preparation, fungal culture, or nail biopsy)?
4. Is the infection limited to the fingernails?
5. Does the infection involve the toenails or toenails and fingernails?
6. Will the liver function tests (LFTs) of the patient be checked prior to initiation of therapy and as needed during Sporanox® therapy?

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.