



Sporanox® (itraconazole) Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8282 or 800-647-2240.

Patient Name: _____

Today's Date: ____/____/____

Patient Pharmacy ID: _____
(located on bottom right of insurance card)

Date of Birth: ____/____/____

Requesting Physician: _____
(Please print)

Specialty: _____

Office Contact Person: _____

Phone #: __ (____) ____ - _____

Medication/dose Requested: _____

Fax #: __ (____) ____ - _____

Expected Duration of Therapy: _____

ICD-9 _____

INITIAL AUTHORIZATION REQUEST

- | | | |
|--|-----|----|
| 1. Does the patient have a diagnosis of Blastomycosis? | YES | NO |
| 2. Does the patient have a diagnosis of Histoplasmosis? | YES | NO |
| 3. Does the patient have a diagnosis of Aspergillosis? | YES | NO |
| 4. Does the patient have a diagnosis of Onychomycosis? | YES | NO |
| 5. Does the patient have a different diagnosis than those listed above? | YES | NO |
| 6. Is the patient intolerant to or refractory to amphotericin B therapy? | YES | NO |
| 7. Has the diagnosis been confirmed with a fungal diagnostic test (KOH or fungal culture)? | YES | NO |
| Results: _____ | | |
| 8. Is the patient immunocompromised? | YES | NO |
| 9. Does the patient have any of the following? (mark all that apply) | YES | NO |
| Diabetes mellitus | | |
| Peripheral vascular disease | | |
| 10. Does the patient have congestive heart failure? | YES | NO |
| 11. Does the patient have swelling and redness in the surrounding tissue? | YES | NO |
| 12. Is the infection located on the fingernails? | YES | NO |
| 13. Is the infection located on the toenails? | YES | NO |

RENEWAL AUTHORIZATION REQUEST

- | | | |
|--|-----|----|
| 1. Does the patient have a diagnosis of Blastomycosis? | YES | NO |
| 2. Does the patient have a diagnosis of Histoplasmosis? | YES | NO |
| 3. Does the patient have a diagnosis of Aspergillosis? | YES | NO |
| 4. Does the patient have a diagnosis of Onychomycosis? | YES | NO |
| 5. Does the patient have a different diagnosis than those listed above? | YES | NO |
| 6. Is the patient intolerant to or refractory to amphotericin B therapy? | YES | NO |
| 7. Has the patient received at least 2 months of therapy for a fingernail infection or 3 months for a toenail infection? | YES | NO |
| 8. Has the patient had a documented response to therapy? | YES | NO |
| 9. Has the patient received the maximum duration of therapy within the previous year? | YES | NO |
- (The maximum for fingernails is 3 months; toenails is 4 months; and if both affected 4 months.)

Physician's Signature: _____

Date: ____/____/____

For Mercy Health Plans use only: Approved Length of Approval _____

Denied Reason for Denial _____

Reviewer's Signature: _____ Date Reviewed: ____/____/____

Override Entered in Caremark CCMS for _____ - _____ by _____

Office Notified on _____ at _____ am/pm by _____