Sporanox® (itraconazole) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information call 800-647-2240.

Patient Name: ____ Today's Date: _____/_______/_____

Patient Pharmacy ID: __________________________________ Date of Birth: _____/_______/_____
(located on bottom right of insurance card)

Requesting Physician: _________________________________ Specialty: ______________________
(Please print)

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 ______________ spoke to _______________________

Created: 05/31/2005; Updated: 05/01/2011