

ITRACONAZOLE

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- Has the patient taken Sporanox within the previous 3 months as a Caremark administered benefit?
[If the answer to this question is yes, skip to question 15.] Y N
- Does the patient have the diagnosis of blastomycosis?
[If the answer to this question is yes, skip to question 21.] Y N
- Does the patient have the diagnosis of histoplasmosis?
[If the answer to this question is yes, skip to question 21.] Y N
- Does the patient have the diagnosis of aspergillosis (pulmonary or extrapulmonary)?
[If the answer to this question is no, may skip to question 6.] Y N
- Is the patient tolerant to or the infection refractory to amphotericin B therapy?
[If the answer to this question is yes, skip to question 21.] Y N

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM

MedBlue RXSM and MedBlue RX PlusSM

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| 6. Does the patient have the diagnosis of onychomycosis due to dermatophytes (tinea unguium)?
[If the answer to this question is no, skip to question 20.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Has the diagnosis been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Does the patient have the diagnosis of diabetes mellitus?
[If the answer to this question is yes, may skip to question 11.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Does the patient have peripheral vascular disease?
[If the answer to this question is yes, may skip to question 11.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Does the patient have swelling and redness in the surrounding tissue? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 11. Has the patient received treatment with Sporanox within the past 12 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 12. Does the patient have evidence of left ventricular dysfunction, such as congestive heart failure, or have a history of congestive heart failure? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 13. Is the infection limited to the fingernails?
[If the answer to this question is yes, skip to question 21.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 14. Does the infection involve the toenails or toenails and fingernails?
[Skip to question 21.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 15. Does the patient have a susceptible, yet unresolved, infection and requires additional treatment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 16. Does the patient have the diagnosis of blastomycosis?
[If the answer to this question is yes, skip to question 21.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 17. Does the patient have a diagnosis of histoplasmosis?
[If the answer to this question is yes, skip to question 21.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 18. Does the patient have the diagnosis of aspergillosis (pulmonary or extrapulmonary)?
[If the answer to this question is no, then skip to question 20.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 19. Is the patient intolerant to or the infection refractory to amphotericin B therapy?
[Skip to question 21.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 20. Does the patient have a diagnosis of coccidioidomycosis infection? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 21. Will the LFTs of the patient be checked prior to initiation of therapy and as needed during Sporanox therapy? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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