Sporanox[®] (itraconazole) capsule Prior Authorization Request Form (Page 1 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

| Member Information (required) | | | Provider Information (required) | | | | |
|--|--------|------|--|---------|--------------|--------------|--|
| Member Name: | | | Provider Name: | | | | |
| Insurance ID#: | | | NPI#: Specialty: | | | | |
| Date of Birth: | | | Office Phone: | | | | |
| Street Address: | | | Office Fax: | | | | |
| City: | State: | ZIP: | Office Street Address: | | | | |
| Phone: | | | City: | State: | State: ZIP | | |
| Medication Information (required) | | | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: | | |
| | | | Directions for | or Use: | • | | |
| Clinical Information (required) | | | | | | | |
| Does the patient have a diagnosis of a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis)? | | | | | 🗆 Yes 🗖 No | | |
| 2. Does the patient have one of the following diagnoses? | | | | | 🛛 Yes 🖾 No | | |
| Pityriasis versicolor | | | | | | | |
| Tinea capitis (scalp ringworm) Tinea corporis (ring worm) | | | | | | | |
| Tinea cruris (jock itch) | | | | | | | |
| Tinea pedis (athlete's foot) | | | | | | | |
| 3. Is the tinea infection resistant to topical antifungal treatment? | | | | | | 🗆 Yes 🗅 No | |
| 4. Does the patient have a diagnosis of fingernail onychomycosis? | | | | | | 🛛 Yes 🖾 No | |
| 5. Does the patient have a diagnosis of toenail onychomycosis? | | | | | | 🛛 Yes 🖾 No | |
| 6. Was the diagnosis of fingernail/toenail onychomycosis confirmed by one of the following: positive potassium hydroxide (KOH) preparation, fungal culture or nail biopsy? | | | | | | 🗆 Yes 🗖 No | |
| 7. Is the patient's condition causing debility or a disruption in his/her activities of daily living (e.g., limitations to manual dexterity, walking, standing, wearing shoes, or appropriately manicuring nails)? | | | | | | s 🗆 Yes 🗆 No | |
| 8. Has the patient had a trial and failure, contraindication or intolerance to oral terbinafine? | | | | | | 🗆 Yes 🗖 No | |

Information on this form is accurate as of this date.

| Prescriber's Signature: | Date: |
|-------------------------|-------|
| | |
| | |

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Sporanox[®] (itraconazole) capsule Prior Authorization Request Form (Page 2 of 2)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

<u>Please note</u>: **This request may be denied unless all required information is received.** For more information about the prior authorization process, please contact us at 855-811-2218. Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

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