



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Itraconazole capsules (Medicare Prior Auth)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Itraconazole capsules (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Itraconazole capsule

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Will the LFT's of the patient be checked prior to initiation of therapy and as needed during Sporanox therapy? | Y | N |
| 2. Does the patient have the diagnosis of onychomycosis due to dermatophytes (tinea unguium)?
[If the answer to this question is no, then skip to question 10.] | Y | N |
| 3. Does the patient have evidence of left ventricular dysfunction, such as congestive heart failure, or have a history of congestive heart failure?
[If the answer to this question is yes, then no further questions required.] | Y | N |
| 4. Has the diagnosis been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)? | Y | N |
| 5. Does the patient have the diagnosis of diabetes mellitus?
[If the answer to this question is yes, then skip to question 8.] | Y | N |
| 6. Does the patient have peripheral vascular disease?
[If the answer to this question is yes, then skip to question 8.] | Y | N |
| 7. Does the patient have swelling and redness in the surrounding tissue? | Y | N |
| 8. Is the infection limited to the fingernails? | Y | N |



Arkansas BlueCross BlueShield

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[If the answer to this question is yes, skip to question 16.]

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|-----|--|---|---|
| 9. | Does the infection involve the toenails or toenails and fingernails?
[Skip to question 16.] | Y | N |
| 10. | Does the patient have a diagnosis of Pityriasis versicolor?
[If the answer to this question is yes, then skip to question 14.] | Y | N |
| 11. | Does the patient have a diagnosis of Tinea corporis?
[If the answer to this question is yes, then skip to question 14.] | Y | N |
| 12. | Does the patient have a diagnosis of Tinea cruris?
[If the answer to this question is yes, then skip to question 14.] | Y | N |
| 13. | Does the patient have a diagnosis of Tinea pedis?
[If the answer to this question is no, then skip to question 17.] | Y | N |
| 14. | Is the fungal infection a recalcitrant or very severe, disfiguring or disabling infection?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 15. | Has the patient had a trial of griseofulvin or topical antifungals and the fungal infection was unresponsive?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 16. | Has the patient received treatment with Sporanox within the past 12 months?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 17. | Does the patient have a susceptible, yet unresolved fungal infection and require additional treatment? | Y | N |

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date