ProCare Rx

Sporanox® itraconazole

Ticket #: ____________ Request Date: ____________ Request Time: ____________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Sporanox® itraconazole. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Is patient at least 18 years of age? YES NO
2. What is the patient's current diagnosis?
   - ☐ Invasive and noninvasive pulmonary aspergillosis (Go to # 5)
   - ☐ Blastomycosis (Go to # 5)
   - ☐ Onychomycosis (Go to # 3)
   - ☐ Other: ____________
   - ☐ Chronic pulmonary histoplasmosis (Go to # 5)
3. Was the diagnosis confirmed by obtaining nail specimens for laboratory testing (KOH preparation, fungal culture or nail biopsy)? (continue on question #4) YES NO
4. Has the patient tried and failed terbinafine (Lamisil®) therapy? YES NO
5. Does the patient have a history of evidence of cardiac dysfunction, such as CHF or a history of CHF? YES NO
6. Has a baseline liver function test profile been obtained for this patient? YES NO
7. Is patient currently on any of the following medications? (check all that apply) YES NO
   - ☐ Pimozide (Orap®)
   - ☐ Midazolam
   - ☐ Simvastatin
   - ☐ Dofetilide (Tikosyn®)
   - ☐ Lovastatin
   - ☐ Triazolam
   - ☐ Quinidine

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.