PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Sporanox® and itraconazole oral suspension

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Sporanox 10mg/mL oral suspension ☐ itraconazole 10mg/mL oral suspension

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following criteria:

1. Patient has one of the following conditions:
   - Invasive Aspergillosis
   - Blastomycosis
   - Histoplasmosis
   - Oropharyngeal and esophageal candidiasis
2. Inadequate response, intolerable side effect, or contraindication to clotrimazole troches, nystatin suspension, fluconazole and itraconazole oral capsules (oropharyngeal/esophageal candidiasis); or itraconazole oral capsules (all other approved indications).
3. Prescribed or recommended by an infectious disease specialist.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Invasive Aspergillosis
☐ Blastomycosis
☐ Histoplasmosis
☐ Oropharyngeal and esophageal candidiasis
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 05/2018
Last reviewed 05/2020

B. Was a culture completed?

☐ Yes
☐ No

C. Was antifungal susceptibility determined?

☐ Yes (fax results with this request)
☐ No – rationale for use: _____

D. What antifungals were previously used that were not successful in treating the patient's current infection?

☐ Antifungals used include:
Drug: _____ Date: _____ Outcome: _____
Drug: _____ Date: _____ Outcome: _____
Drug: _____ Date: _____ Outcome: _____
☐ No other antifungals have been used for the patient's current infection.

Note: If adequate blood levels while on itraconazole oral capsules could not be achieved, please provide laboratory value(s) with this request.

E. Does the patient have an allergy or contraindication to alternative antifungal therapies?

☐ No
☐ Yes
Drug: _____ Date: _____ Reaction: _____
Drug: _____ Date: _____ Reaction: _____
Drug: _____ Date: _____ Reaction: _____

Additional information
Notes:

If approved, initial authorization is for a maximum of 3 months (Invasive Aspergillosis, Blastomycosis, Histoplasmosis); oropharyngeal candidiasis (4 weeks); esophageal candidiasis (6 weeks).

Review of precertification requests for indications and/or duration of therapy in the above criteria will be reviewed by a clinical pharmacist and/or medical director.

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 05/2018
Last reviewed 05/2020