

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Antifungal Oral Therapy
Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QTY PER 30 DAYS

<input type="checkbox"/> Lamisil (terbinafine) <input type="checkbox"/> Sporanox (itraconazole) <input type="checkbox"/> Terbinex (terbinafine HCl) <input type="checkbox"/> Fluconazole <input type="checkbox"/> Griseofulvin	<input type="checkbox"/> 250mg <input type="checkbox"/> 125mg/packet <input type="checkbox"/> 187.5mg/packet <input type="checkbox"/> 100mg <input type="checkbox"/> 10mg/mL solution <input type="checkbox"/> 250mg <input type="checkbox"/> _____ (please indicate)	_____ _____	Specify: _____
--	--	----------------	-------------------

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a diagnosis of onychomycosis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have a confirmed fungal infection (e.g. potassium hydroxide [KOH] preparation, fungal culture, nail biopsy or physical exam)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have evidence of functional impairment? Specify: <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Loss of one or more toenails <input type="checkbox"/> Other _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have an abnormal immune system OR disorder which predisposes to infection of the extremities? Specify: <input type="checkbox"/> HIV positive <input type="checkbox"/> Chronic immunosuppressants <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have one of the following diagnosis? If yes , please indicate below: <input type="checkbox"/> Blastomycosis <input type="checkbox"/> Fungal Vaginitis <input type="checkbox"/> Histoplasmosis <input type="checkbox"/> Paracoccidioidomycosis <input type="checkbox"/> Sporotrichosis <input type="checkbox"/> Cryptococcus <input type="checkbox"/> Basidiobolomycosis <input type="checkbox"/> Other _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have Invasive Aspergillosis that is refractory to or contraindicated to treatment with amphotericin B?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the patient have oral thrush/stomatitis/esophagitis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the medication being used as an alternative to fluconazole for long-term suppressive or maintenance therapy (second prophylaxis) to prevent recurrence or relapse of mucocutaneous candidiasis (esophageal, oropharyngeal, vaginal) in HIV-infected infants?

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Antifungal Oral Therapy
Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at (800) 601- 4829

Patient Name: _____

Patient ID#: _____

Yes No Does the patient have a Tinea infection (other than tinea unguium/onychomycosis)?

Yes No Has the patient failed topical antifungal therapy? **If yes**, please indicate below:

butenafine

clotrimazole

econazole

ketoconazole

miconazole

Nystatin

terbinafine

tolnaftate

Other _____

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature

Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.