



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

Form with fields for Patient Name, ID, DOB, Date of Rx, Phone, Email, Prescribing Physician, Address, Phone, Fax, Specialty, DEA, NPI, and Email Address.

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QTY PER 30 DAYS

Form with medication options (Lamisil, Sporanox), strength checkboxes, directions line, and quantity specification.

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

Form with multiple checkboxes and text questions regarding patient diagnosis and medical history.

9. PHYSICIAN SIGNATURE

Form with lines for Prescriber or Authorized Signature and 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.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law.