

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?			
<input type="checkbox"/> Invasive and noninvasive pulmonary aspergillosis (Go to # 5)	<input type="checkbox"/> Blastomycosis (Go to # 5)		
<input type="checkbox"/> Onychomycosis (Go to # 3)	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> 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
<input type="checkbox"/> Pimozide (Orap®)	<input type="checkbox"/> Midazolam	<input type="checkbox"/> Simvastatin	
<input type="checkbox"/> Dofetilide (Tikosyn®)	<input type="checkbox"/> Lovastatin	<input type="checkbox"/> Triazolam	
<input type="checkbox"/> Quinidine			
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

MC-Rx 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.

Prior authorization forms are reviewed at least annually and are available at www.MC-Rx.com. Medical Review Criteria are reviewed at least annually. Revised 5/2019