

UPMC HEALTH PLAN

Itraconazole (SPORANOX)

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	

MEDICAL HISTORY

Please Indicate The Diagnosis Pertaining To The Prescription For An Anti-Fungal:

Oral Thrush?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Esophageal Candidiasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Candida?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tinea Corporis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, list where:			
Onychomycosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, for patients who are NOT immunocompromised, transplant recipients, or diabetics, please fax related chart documentation showing evidence of symptomatic/painful onychomycosis			
Is patient immunocompromised?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, please specify: _____			
Has patient had a transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Is patient diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Patient Medical Chart Information Enclosed		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Other?	<input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, please list details:			

HISTORY OF FORMULARY MEDICATIONS USED TO TREAT THE ABOVE CONDITION:

Medication Trial/ Previous Therapy	Date of Therapy		Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing
	Start Date	End Date			

Please provide any additional information which should be considered in the space below:
