

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Sporanox® (Itraconazole)**

Customer Service (401) 459-6020; Fax 866-423-0945

If approval criteria are met Neighborhood Health Plan of RI will authorize coverage of Sporanax® (itraconazole). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request ____/____/____ Patient Name: _____

Member ID#: _____ DOB: ____/____/____

Provider Name: _____ Number: _____

Provider Fax: _____ Contact Person in Office: _____

INDICATIONS FOR USE:

	<u>YES</u>	<u>NO</u>
1) Systemic fungal infection (e.g., Blastomycosis, Histoplasmosis, Aspergillosis)	<input type="checkbox"/>	<input type="checkbox"/>
2) Recalcitrant superficial fungal skin infection	<input type="checkbox"/>	<input type="checkbox"/>
3) Onychomycosis of finger- or toenail confirmed by KOH preparation or fungal culture or nail biopsy AND at least one of the following:	<input type="checkbox"/>	<input type="checkbox"/>
a) For toenail involvement: the infection is causing significant mechanically induced pain or functional impairment, which cannot be alleviated by appropriate mechanical debridement of the nail (non-cosmetic)	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient has recurring ingrown toenails secondary to onychomycosis requiring surgical repair/removal	<input type="checkbox"/>	<input type="checkbox"/>
c) Patient has a history of cellulitis or soft tissue involvement secondary to onychomycosis	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient has diabetes mellitus or other condition (i.e. PVD) predisposing patient to soft tissue infections in the extremities	<input type="checkbox"/>	<input type="checkbox"/>
e) Patient has an impaired immune system (i.e. HIV, receiving immunosuppressant medications, etc...)	<input type="checkbox"/>	<input type="checkbox"/>

REASON FOR BENEFIT DENIAL:

1. Hypersensitivity to any component of the medication	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient has CHF or chronic/active liver disease as listed in the prescribing information	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is would be undergoing coadministration of cisapride, pimozone, quinidine, or dofetilide	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient does not meet above criteria	<input type="checkbox"/>	<input type="checkbox"/>

Onychomycosis Approval Quantities: Approval is for pulse therapy for onychomycosis

Specify fingernail or toenail (*circle one*)

- Toenail: 200mg QD X12 weeks. Pulse therapy of 200mg BID for 1 week/month X 3-4 months is not supported by the manufacturer.
- Fingernail: Pulse therapy of 200mg(2 capsules) BID for 1 week then 3 weeks off; repeat for another pulse (2 month duration of therapy)

Approve for appropriate course of therapy for all other indications

Information given on this form is accurate as of this date.

Prescriber's Signature and NPI

Date

Request for Sporanax for the treatment of onychomycosis will be delayed if positive fungal results (ex. fungal culture, +KOH) are not submitted with this form.