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 Rhode Island will authorize coverage of Sporanox® (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:	**YES**	**NO**
1) Systemic fungal infection (e.g., Blastomycosis, Histoplasmosis, Aspergillosis)	☐	☐
2) Recalcitrant superficial fungal skin infection	☐	☐
3) Onychomycosis of finger- or toenail confirmed by KOH preparation or fungal culture or nail biopsy **AND at least one of the following:**	☐	☐
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)	☐	☐
b) Patient has recurring ingrown toenails secondary to onychomycosis requiring surgical repair/removal	☐	☐
c) Patient has a history of cellulitis or soft tissue involvement secondary to onychomycosis	☐	☐
d) Patient has diabetes mellitus or other condition (i.e. PVD) predisposing patient to soft tissue infections in the extremities	☐	☐
e) Patient has an impaired immune system (i.e. HIV, receiving immunosuppressant medications, etc…)	☐	☐

REASON FOR BENEFIT DENIAL:		
1. Hypersensitivity to any component of the medication	☐	☐
2. Patient has CHF or chronic/active liver disease as listed in the prescribing information	☐	☐
3. Patient is would be undergoing coadministration of cisapride, pimozide, quinidine, or dofetilide	☐	☐
4. Patient does not meet above criteria	☐	☐

Onychomycosis Approval Quantities: Approval is for pulse therapy for onychomycosis

Specify fingernail or toenail *(circle one)*

1. Toenail: 200mg QD X12 weeks. Pulse therapy of 200mg BID for 1 week/month X 3-4 months is not supported by the manufacturer.
2. 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 Sporanox for the treatment of onychomycosis will be delayed if positive fungal results (ex. fungal culture, +KOH) are not submitted with this form.