



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form**ITRACONAZOLE****Coverage Criteria**

All FDA-approved indications not otherwise excluded from Part D, recalcitrant or very severe disfiguring or disabling infections caused by pityriasis versicolor, tinea corporis, tinea cruris, or tinea pedis that is unresponsive to griseofulvin or topical antifungals, severe fungal infections caused by Blastomycosis, Histoplasmosis, Aspergillosis (prophylaxis), Basidiobolomycosis, Chromomycosis, Coccidioidomycosis, Cryptococcosis, Cryptococcal Meningitis (treatment or suppression), Chronic Mucocutaneous Candidiasis, Histoplasmosis suppression in immunocompromised patients, Leishmaniasis (cutaneous treatment), Paracoccidioidomycosis, Paronychia, Penicillium marneffei in adults, Fungal pneumonia and septicemia treatment, Sporotrichosis disseminated (treatment), Tinea manuum, Vulvovaginal Candidiasis coverage duration: Onychomycosis-2 months fingernails, 3 months toenails, all others uses 6 months

Required Medical Information

LFTs; fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)

Exclusion Criteria

Congestive heart failure, history of congestive heart failure, evidence of left ventricular dysfunction.

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

ITRACONAZOLE	Reason for Request				
Condition/Diagnosis Related					

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage			
Formulary Alternative(s) Attempted?	Yes:		No:	
Please List Alternative Formulary Drugs				
Comments				

Physicians Signature: _____

Fax Form to 1-877-847-9904