

Sporanox® (itraconazole) oral solution Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
			Directions for Use:		
Clinical Information (required)					
1. Does the patient have one of these diagnoses? <ul style="list-style-type: none">• Esophageal candidiasis• Oropharyngeal candidiasis					<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the candidiasis refractory to treatment with fluconazole?					<input type="checkbox"/> Yes <input type="checkbox"/> No

Information on this form is accurate as of this date.

Prescriber's Signature:		Date:

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern