

Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

ITRACONAZOLE

Coverage Criteria / Required Medical Information

Patients with a diagnosis of blastomycosis, pulmonary and extrapulmonary **or** patients with a diagnosis of histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis **or** patients with a diagnosis of aspergillosis, pulmonary and extrapulmonary **or** patients with a diagnosis of onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (Tinea unguium) **or** patients with a diagnosis of onychomycosis of the fingernail due to dermatophytes (Tinea unguium).

Documentation is required showing a positive culture of aspergillosis, blastomycosis, histoplasmosis, or onychomycosis of the toenail or fingernail.

Exclusion Criteria

- A. Ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF) - do not use for onychomycosis
- B. Concomitant use with drugs metabolized by CYP3A4:
 e.g., dofetilide, oral midazolam, nisoldipine, pimozide, quinidine, HMG CoA-reductase inhibitors (lovastatin, simvastatin, etc.), triazolam, or ergot alkaloids (dihydroergotamine, ergometrine (ergonovine), ergotamine, methylergotamine (methylergonovine)).
- C. Pregnant women or women contemplating pregnancy - do not use for onychomycosis

Coverage Duration: 12 weeks

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			



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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 1-866-481-3704