UnitedHealthcare Community Plan

Azole Antifungals
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? □ Yes □ No (Check which apply)

□ Systemic fungal infection
- □ Blastomycosis □ Histoplasmosis
- □ Aspergillosis □ Coccidioidomycosis

□ Esophageal candidiasis
□ Candidemia
□ Candida infection in the kidney
□ Candida infection in wounds
□ Esophageal candidiasis
□ *Fusarium spp.* infection including *Fusarium Solani*
□ *Exserohilum* species infection
□ Other, list diagnosis: _____

□ Fingernail onychomycosis
□ Toenail onychomycosis
- □ *Trichophyton rubrum* or *T. Mentagrophytes*

□ Oropharyngeal candidiasis
□ Invasive aspergillosis including *Aspergillus fumigatus*
□ Candida infection in the abdomen
□ Candida infection in the bladder wall
□ Disseminated candida infections in skin
□ *Scedosporium apiospermum* infection (asexual form of *Pseudallescheria boydii*) infection

- Is the medication being requested for a use recognized for treatment of the indication by The Infectious Diseases Society of America (IDSA)? □ Yes □ No
If yes, list recognized use: _____

- Does the patient have history of failure, contraindication, intolerance, or resistance to either of the following:
□ Yes □ No (check which applies) □ Fluconazole (generic Diflucan) □ Itraconazole (generic Sporanox)
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for FINGERNAIL/TOENAIL ONYCHOMYCOSIS:

- Is the diagnosis of fingernail/toenail onychomycosis confirmed by one of the following: □ Yes □ No (Check which apply)
□ KOH test □ Fungal culture □ Nail biopsy

- How many months have elapsed since completion of initial therapy for fingernail/toenail onychomycosis?
_____ Months List completion date: _____

- Is there documentation of positive clinical response to therapy? □ Yes □ No
If yes, list response: _____
_____

Requests for ONMEL:

- Does the patient have a history of failure to generic itraconazole (generic Sporanox)? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for VORICONAZOLE:

- Is the patient non-neutropenic? □ Yes □ No

Requests for NOXAFIL:

- Did the patient have a prior fungal infection requiring secondary prophylaxis? □ Yes □ No

- Is this used as prophylaxis of invasive fungal infections caused by one of the following? □ Yes □ No
(Check which apply) □ Aspergillus □ Candida □ Other, list infection: _____

- Is the patient at high risk of infections due to severe immunosuppression from one of the following conditions:
□ Yes □ No (Check which apply)
□ Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)
□ Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g. acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]
□ None of the above

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Requests for CRESEMBA:

- Does the patient have one of the following diagnoses: □ Yes □ No (check which applies)

□ Invasive aspergillosis

□ Invasive mucormycosis

□ Other, **List diagnosis:** _____

- Does the patient have a history of failure, contraindication, or intolerance to voriconazole (generic Vfend)?

□ **Yes** □ **No**

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Physician Signature: _____ **Date:** _____