UnitedHealthcare Community Plan

ITRACONAZOLE
PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐**?** If so, start date:_____

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:** **Dosing frequency:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-9 CODE:**

Is itraconazole being prescribed for disseminated histoplasmosis in a HIV infected patient? Yes___ No____

For Allergic Bronchopulmonary Aspergillosis (ABPA): Does the patient have an associated diagnosis of asthma or cystic fibrosis? Yes___ No____

For Aspergillosis, Blastomycosis, or Empiric therapy for febrile neutropenia: Has the patient previously received treatment with Amphotericin B? Yes___ No____ If yes, dates of therapy_____ ____ _____ _____ _____

_____

Has treatment with amphotericin B failed to treat the patient's condition or was the patient unable to tolerate treatment wit amphotericin B? Yes___ No____ If yes, describe intolerance: _____

_____

For all other diagnoses please list previous medication trials below:

Medication (Include Strength and Directions)	Dates of Therapy	Reason for Discontinuation

Did the patient experience an <u>intolerance/ adverse reactions</u>, or has a <u>documented contraindication</u> to treatment with at least two other agents used to treat their condition? Yes___ No____ If yes, please provide details: _____

_____

Physician Signature: _____ **Date:** _____