



DIFLUCAN - fluconazole

Member Information

Name \_\_\_\_\_
Enrollment / Cardholder ID \_\_\_\_\_
Group / Plan \_\_\_\_\_
Birth Date \_\_\_\_\_
Address \_\_\_\_\_
City State Zip \_\_\_\_\_

Relationship (Circle)

Subscriber Spouse Dependent
Gender (Circle)
Male Female
AGE: \_\_\_\_\_

Practitioner Information

Name \_\_\_\_\_
Agent / Contact Name \_\_\_\_\_
Specialty \_\_\_\_\_
Office / Clinic Name \_\_\_\_\_
Address \_\_\_\_\_
City State Zip \_\_\_\_\_
Phone ( ) - \_\_\_\_\_
Fax ( ) - \_\_\_\_\_
Email \_\_\_\_\_ @ \_\_\_\_\_

Primary Diagnosis Condition /
Diagnosis Related – Reason for Request

Please provide diagnosis:
[ ] Vaginal yeast infections due to Candida
[ ] Oropharyngeal and esophageal candidiasis
[ ] Cryptococcal meningitis
[ ] Prophylactic treatment in patients undergoing bone marrow transplantation who receive cytotoxic chemotherapy or radiation therapy to decrease the incidence of candidiasis.
[ ] Other: (please define) \_\_\_\_\_

Strength / Dose

\_\_\_\_\_

Duration of Therapy (Expected)

\_\_\_\_\_

Formulary Alternatives
Attempted/Outcome

\_\_\_\_\_

Clinical Drug / Lab History Pertinent to Request

\_\_\_\_\_

Contact Pharmacy? Y N
Pharmacy Phone Number

\_\_\_\_\_

Practitioner Signature

Date Received: \_\_\_\_\_
Reviewed By: \_\_\_\_\_
Forwarded To: \_\_\_\_\_

FAX Form to
877-800-5633