



SPORANOX – itraconazole

Member Information

Relationship (Circle)

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

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**

- Primary Diagnosis:
- Pulmonary and extrapulmonary aspergillosis, blastomycosis, histoplasmosis (including chronic cavitary pulmonary disease and disseminated), and nonmeningeal histoplasmosis?
 - Oropharyngeal and esophageal candidiasis?
 - Empiric therapy of febrile neutropenic patients with suspected fungal infections
 - Other? _____
 - Onychomycosis? **Y / N** if yes:
 - o Please indicate severity: Moderate? Severe?
 - o If there documented pain on mobilization, please provide chart documentation.
 - o Please indicate which of the following lab tests have been conducted & the results to confirm the diagnosis of onychomycosis
 - o potassium hydroxide [KOH]: _____
 - o fungal culture: _____
 - o nail biopsy: _____

Dosage:
 Toenails with or without fingernail involvement: 200 mg (2 capsules) once daily for 12 consecutive weeks.
 Fingernails only: 2 treatment pulses, each consisting of 200 mg (2 capsules) twice daily (400 mg/day) for 1 week. The pulses are separated by a 3-week period without itraconazole.

Clinical Drug / Lab History Pertinent to Request

Strength / Dose

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**