BlueChoice® HealthPlan of South Carolina

Medicaid

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Antifungal Oral Therapy

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: ______________________	Prescribing Physician: ______________________
Patient ID #: ______________________	Physician Address: ______________________
Patient DOB: ______________________	Physician Phone #: ______________________
Date of Rx: ______________________	Physician Fax #: ______________________
Patient Phone #: ______________________	Physician Specialty: ______________________
Patient Email Address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician Email Address: ______________________

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QTY PER 30 DAYS
Lamisil (terbinafine) Sporanox (itraconazole)	□ 250mg □ 125mg/packet □ 187.5mg/packet □100mg □ 10mg/mL solution	____________	Specify: ____________

7. DIAGNOSIS: ____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request

□ Yes □ No Does the patient have a diagnosis of onychomycosis

□ Yes □ No Does the patient have a confirmed fungal infection (i.e. physical exam, KOH, culture etc.)

□ Yes □ No Does the patient have evidence of functional impairment
Specify: □ Pain □ Swelling □ Loss of one or more toenails □ Other ______________

□ Yes □ No Does the patient have an abnormal immune system OR disorder which predisposes to infection of the extremities
Specify: □ HIV positive □ Chronic immunosuppressants □ Diabetes □ Other______________

□ Yes □ No Patient has a diagnosis of one of the following. **If yes,** please indicate below:
□ Blastomycosis □ Fungal Vaginitis □ Histoplasmosis □ Paracoccidioidomycosis
□ Sporotrichosis □Cryptococcus □ Other ______________________

□ Yes □ No Does the patient have Invasive Aspergillosis that is refractory to or contraindicated to treatment with amphotericin B

□ Yes □ No Does the patient have Oral thrush/stomatitis/esophagitis (oral solution)

□ Yes □ No Does the patient have a Tinea infection (other than tinea unguium/onychomycosis)

□ Yes □ No Has the patient failed topical antifungal therapy. **If yes,** please indicate below:
□ butenafine □ clotrimazole □ econazole □ ketoconazole □ miconazole
□ Nystatin □ terbinafine □ tolnaftate □ Other ______________________

CONTINUED ON PAGE 2

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Medicaid managed care administered by WellPoint Partnership Plan, LLC, an independent company.

SC SSB Antifungal Oral Therapy PAB Fax Form 06.01.08.doc

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9. PHYSICIAN SIGNATURE

____ ____________________________________
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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