Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone - -	**Fax** - -

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:** - -

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Itraconazole Capsules/Powder
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. What is the patient's diagnosis? **(Please circle)** • Tinea unguium (Onychomycosis) • Other tinea infections • Blastomycosis • Invasive aspergillosis • Allergic bronchopulmonary aspergillosis • Fungal vaginitis • Histoplasmosis • Paracoccidioidomycosis • Sporotrichosis • Cryptococcus • Coccidioidomycosis • Other: _____		
2. Has the patient had a trial and inadequate response to one prior topical therapy, including miconazole, tolnaftate, clotrimazole, ketoconazole, econazole, nystatin, butenafine, or terbinafine?	Y	N
3. Has the patient had an intolerance to, or had a confirmed adverse event with at least one prior topical therapy?	Y	N

4. Does the patient have a confirmed fungal infection (such as through physical exam)?	Y	N
5. Does the patient have any of the following relevant comorbidities? **(Please circle)** • Abnormal immune system [e.g., HIV positive, on immunosuppressant drugs) • Diabetes • Other disorder which predisposes the patient to infection in the extremities	Y	N
6. Does the patient have evidence of functional impairment (such as loss of one or more toenails, pain, or swelling)?	Y	N
7. Has the patient had inadequate response to amphotericin B?	Y	N
8. Has the patient had an intolerance to, or a confirmed adverse event to treatment with amphotericin?	Y	N

Itraconazole Solution
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient
1. What is the patient's diagnosis? **(Please circle)** • Oropharyngeal candidiasis • Esophageal candidiasis • Other: _____

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Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. What is the patient's diagnosis? **(Please circle)** • Tinea unguium (Onychomycosis) • Other: _____		
2. Does the patient have a confirmed fungal infection (such as through physical exam)?	Y	N
3. Does the patient have any of the following relevant comorbidities? **(Please circle)** • Abnormal immune system [e.g., HIV positive, on immunosuppressant drugs) • Diabetes • Other disorder which predisposes the patient to infection in the extremities	Y	N
4. Does the patient have evidence of functional impairment (such as loss of one or more toenails, pain, or swelling)?	Y	N
5. Has the patient had a trial of itraconazole 100mg capsules?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).