Prior Authorization (PA) Form
Antifungals, Oral

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per Anthem HealthKeepers Plus member.

MEMBER INFORMATION

Last Name: | **First Name:**

Medicaid ID Number: | **Date of Birth:** – –

Gender: ☐ **Male** ☐ **Female** | **Weight in Kilograms**: ______________________________

PRESCRIBER INFORMATION

Last Name: | **First Name:**

NPI Number:

Phone Number: – – | **Fax Number:** – –

DRUG INFORMATION

Non-Preferred Medications Require a PA:

- ☐ Ancobon®
- ☐ clotrimazole (mucous mem)
- ☐ Cresemba®
- ☐ Diflucan® tab/susp
- ☐ flucytosine
- ☐ Gris-Peg®
- ☐ griseofulvin tab
- ☐ griseofulvin ultramicrosize
- ☐ itraconazole
- ☐ ketoconazole
- ☐ Lamisil® tab
- ☐ Lamisil® granules
- ☐ Noxafil®
- ☐ Onmel®
- ☐ Sporanox® cap/sol
- ☐ Tolsura™
- ☐ Vfend® tab/susp
- ☐ voriconazole tab
- ☐ voriconazole powder for susp

Drug Name/Form: ______________________________

Strength: ______________________________

Dosing Frequency: ______________________________

Length of Therapy: ______________________________

Quantity per Day: ______________________________

(Form continued on next page.)

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AVAPEC-2108-19 [rdate]

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

1. Has the member tried and failed any of the preferred Oral Antifungals?

   ☐ Yes ☐ No

   a. Check all that apply:

      ☐ fluconazole tab/susp ☐ Griseofulvin® susp ☐ nystatin tab/susp ☐ terbinafine

      Submit all supporting documentation of drug regimen and therapeutic failure.

2. Does the member have any contraindications or intolerances to any of the preferred agents listed in Question 1?

   ☐ Yes ☐ No

   a. If yes, document the specialty: ____

3. Does the member have a diagnosis for which none of the preferred Oral Antifungals are indicated or widely medically-accepted?

   ☐ Yes ☐ No

   a. Check all that apply or indicate diagnosis:

      ☐ aspergillosis ☐ blastomycosis ☐ cryptococcosis ☐ coccidioidomycosis
      ☐ febrile neutropenia ☐ histoplasmosis ☐ mucormycosis
      ☐ fungal infection caused by S. apiospermum or Fusarium species, including F. solani
      ☐ Other (specify): ____

4. Submit documentation of diagnosis and planned duration of treatment.

   ____

   ____

   ____

____ ___________________________

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.