| Prescriber Criteria Form<br><br>Sporanox Capsules 2024 PA Fax 1432-A v1 010124.docx<br>Sporanox (itraconazole capsules)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.<br>Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.<br>When conditions are met, we will authorize the coverage of Sporanox (itraconazole capsules). |

| Drug Name:<br>Sporanox (itraconazole capsules) |
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| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
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| 1 | Will the requested drug be used orally?<br>[If no, then no further questions.] | Yes | No |
| 2 | Does the patient have a diagnosis of onychomycosis due to dermatophytes (Tinea unguium) which has been confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)?<br>[If yes, then no further questions.] | Yes | No |
| 3 | Is the requested drug being used for any of the following: A) Disseminated histoplasmosis, B) Central nervous system (CNS) histoplasmosis, C) Histoplasmosis prophylaxis in HIV infection, D) Coccidioidomycosis prophylaxis in HIV infection, E) Invasive fungal infection prophylaxis in chronic granulomatous disease, F) Primary treatment for chronic cavitary or subacute invasive (necrotizing) pulmonary aspergillosis?<br>[If yes, then no further questions.] | Yes | No |
| 4 | Is the requested drug being used for any of the following: A) Blastomycosis, B) Histoplasmosis, C) Aspergillosis in a patient intolerant of or refractory to amphotericin B therapy, D) Coccidioidomycosis, E) Cryptococcosis, F) Microsporidiosis, G) Talaromycosis (formerly Penicilliosis), H) Sporotrichosis, I) Pityriasis versicolor, J) Tinea versicolor, K) Tinea corporis, L) Tinea cruris, M) Tinea capitis, N) Tinea manuum, O) Tinea pedis, P) Invasive fungal infection prophylaxis in a liver transplant patient, Q) | Yes | No |

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| | Invasive fungal infection prophylaxis in hematologic malignancy?<br>[If yes, then no further questions.] | | |
| 5 | Is the requested drug being used as primary treatment for allergic bronchopulmonary aspergillosis?<br>[If no, then no further questions.] | Yes | No |
| 6 | Will the requested drug be initiated in combination with systemic corticosteroids? | Yes | No |

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| Comments: | _____ |

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| By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan. |
| **Prescriber (or Authorized) Signature:** _____ **Date:**_____ |