UnitedHealthcare Community Plan

Antifungals, Oral – Nebraska
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Antifungals, Oral – Nebraska
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check which applies)

- □ **Aspergillosis**
- □ **Candida Septicemia**
- □ **Candida UTIs**
- □ **Cryptococcus Pulmonary infections**
- □ **Neutropenia Myelodysplastic Syndrome**
- □ **Neutropenic hematologic malignancies**
- □ **Blastomycosis**
- □ **Onychomycosis**
- □ **S. apiospermum**
- □ **Esophageal Candidiasis**
- □ **Invasive Mucomycosis**
- □ **Candida Endocarditis**
- □ **Cryptococcus Meningitis**
- □ **Oropharyngeal/Esophageal Candidiasis**
- □ **Neutropenic Acute Myeloid Leukemia**
- □ **Graft vs. Host disease**
- □ **Histoplasmosis**
- □ **Candidemia**
- □ **Fusarium spp**
- □ **Immunosuppression secondary to hematopoietic stem cell transplant**

□ **Other, list diagnosis:** _____

Request for Noxafil Suspension:

- Is the patient's disease refractory to itraconazole and/or fluconazole? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Request for Onmel:

- Does the patient have a trial and failure or contraindication to terbinafine? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, date of trial, and reason for discontinuation)

Request for Sporanox Liquid:

- Is there a clinical reason why the oral (capsule) formulation cannot be used? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Request for Sporanox:

- Does the patient have a trial and failure with generic itraconazole? □ Yes □ No

Request for Sporanox/Itraconazole and VFend:

- Is the patient's onychomycosis due to terbinafine-resistant dermatophytes? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

- Is the patient's diagnosis refractory to fluconazole? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for Non-Preferred Medication: (please refer to www.uhccommunityplan.com)

- Has the patient failed TWO diagnosis-appropriate preferred medications? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Physician Signature: _____ **Date:** _____