



ITRACONAZOLE (SPORANOX®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW

Table with 2 main columns: PRESCRIBER INFORMATION and PATIENT INFORMATION. Rows include Physician Name, Provider ID/Tax ID, Patient Name, Contact Person/Practice Name, Patient's BCBSNC ID, Practice Phone, Practice Fax, Patient's Date of Birth, Practice Address, City, State, and ZIP.

Drug, Dose and Duration Requested:
Please answer the following questions: Dx code
Onychomycosis
1. Has the diagnosis of onychomycosis been confirmed by a KOH preparation, fungal culture, nail biopsy, or other assessment?
2. a. Is the patient immunocompromised? (e.g., diabetes, organ transplant, cancer, HIV+)
b. Does this patient have peripheral vascular disease?
c. Does the patient have peripheral neuropathy?
d. Does this patient have extensive nail involvement which causes significant debilitation or secondary infection? (Medical Record Documentation Required)
Tinea Infection
Diagnosis: Treatments Tried:
If Tinea capitis or multicentric Tinea corporis, has it been confirmed by KOH preparation or fungal culture?
If Tinea versicolor or other tinea infection, list treatments tried:
Systemic Fungal Infection (e.g., blastomycosis, histoplasmosis or aspergillosis)
Diagnosis: (Medical Record Documentation Required)

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required): Date:

For BCBSNC members, fax form to 1-800-795-9403