

ANTIFUNGAL PRIOR REVIEW FAX REQUEST FORM

PRESCRIBER INFORMATION		PATIENT INFORMATION
PRESCRIBER NAME	PROVIDER ID/TAX ID <i>(if out of state must have Tax ID)</i>	PATIENT NAME
CONTACT PERSON		PATIENT'S BCBSNC ID
PHONE	FAX	PATIENT'S DATE OF BIRTH

Medication Requested: Lamisil Sporanox

Dose and Duration Requested: _____

Indicate the diagnosis and answer any associated questions:

Onychomycosis

- a. Is the patient immunocompromised? Yes No
(e.g., diabetes, organ transplant, cancer, HIV+)
- b. Does this patient have peripheral vascular disease? Yes No
- c. Does the patient have peripheral neuropathy? Yes No
- d. Does this patient have extensive nail involvement which causes significant debilitation or secondary infection? Yes No
(Medical Record Documentation Required)
- e. **In addition to one of the above,** has the diagnosis of onychomycosis been confirmed by a KOH preparation, fungal culture, nail biopsy, or other assessment? ... Yes No

Tinea Infection

Diagnosis: _____ Treatments tried: _____

- If Tinea capitis or multicentric Tinea corporis, has it been confirmed by KOH preparation or fungal culture? Yes No
- If Tinea versicolor or other tinea infection, list treatments tried: _____

Systemic Fungal Infection (e.g., blastomycosis, histoplasmosis or aspergillosis)
(Medical Record Documentation Required)

I certify that the above information is accurate and **is documented in the medical record.**

Prescriber's Signature Required: _____ Date _____

Fax completed form to 1-800-795-9403

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