

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Hoosier Healthwise**

**Onychomycosis**

**Prior Authorization of Benefits (PAB) Form**

**FAX TO PRIOR AUTHORIZATION OF BENEFITS CENTER AT (866) 408- 7103**



**1. PATIENT INFORMATION**

**2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____
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**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

<input type="checkbox"/> Sporanox <input type="checkbox"/> Lamisil <input type="checkbox"/> Penlac	_____ _____	_____ _____	Specify: _____
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**7. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<b>Patients with NO relevant comorbidity</b> (normal immune system, and no disorder which predisposes to infection in the extremities):		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	There is evidence of functional impairment present <b>AND</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has confirmed fungal infection (i.e., physical exam)
<b>Patients WITH relevant comorbidity</b> (abnormal immune system and/or disorder which predisposes to infection in the extremities):		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has confirmed fungal infection (i.e., physical exam)
<b>Sporanox Only:</b>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has one of the following indications:
<input type="checkbox"/>	<input type="checkbox"/> Blastomycosis	<input type="checkbox"/> Aspergillosis
<input type="checkbox"/>	<input type="checkbox"/> Stomatitis	<input type="checkbox"/> Esophagitis
<input type="checkbox"/>	<input type="checkbox"/> Histoplasmosis	<input type="checkbox"/> Paracoccidoidmycosis
<input type="checkbox"/>	<input type="checkbox"/> Cryptococcus	<input type="checkbox"/> Coccidioidomycosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Oral thrush
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fungal Vaginitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sporotrichosis
<b>Second-Line Non-Onychomycosis (Lamisil &amp; Sporanox only):</b>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has tinea infections which have failed topical therapy

**8. PHYSICIAN SIGNATURE**

_____ Prescriber or Authorized Signature	_____ Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.</i>	

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**FAX THIS FORM AND CERTIFICATE OF ENROLLMENT TO  
PRIOR AUTHORIZATION OF BENEFITS CENTER AT (866) 408-7103**

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