



Please complete ALL information below and fax your request to 1-888-671-5285

Onmel®, Sporanox® (itraconazole), & Tolsura™ Prior Authorization Request Form
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required) and Provider Information (required) form with fields for Member Name, Insurance ID#, Date of Birth, Street Address, City, State, Zip, Phone, Provider Name, NPI#, Specialty, Office Phone, Office Fax, Office Street Address, City, State, Zip.

Medication Information (required) form with fields for Medication Name, Strength, Dosage Form, and checkboxes for generic substitution and continuation of therapy.

Clinical Information (required) form with sections for diagnosis selection (Aspergillosis, Blastomycosis, Histoplasmosis, etc.), Aspergillosis/Blastomycosis/Histoplasmosis, Esophageal/oropharyngeal candidiasis, Onychomycosis, and Pityriasis versicolor/Tinea infection.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.