

# Drug Coverage Review Request

## ANTIFUNGAL AGENTS

35045



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PRESCRIBER

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder's ID# \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

### SECTION A Answer the following questions

1. Specify the NAME and STRENGTH of the prescribed medication: \_\_\_\_\_
2. Indicate the diagnosis and answer any associated questions

**Onychomycosis** (nail fungus)

- ↳  Yes  No Has the diagnosis of onychomycosis been confirmed by a KOH preparation, fungal culture, nail biopsy, or other assessment?
- Yes  No In addition to nail fungus (onychomycosis), does the patient have any one of the following conditions: an immunocompromised state, diabetes mellitus, peripheral vascular disease, swelling and/or redness in the surrounding nail tissue, or pain in the affected nail(s)?

**Tinea infection**

**Intertrigo Infection** (body fold area) -OR- **Vulvo-vaginal candidiasis**

- ↳  Yes  No Has the use of topical antifungal therapy and fluconazole (*Diflucan*®) failed to treat the patient's infection?
- Yes  No IF NO to the previous question, is the patient UNABLE to receive treatment with topical antifungal therapy and fluconazole (*Diflucan*®)?

**Other FUNGAL INFECTIONS** (for example, blastomycosis, histoplasmosis, aspergillosis)

### SECTION B Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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