PA Request Criteria

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237374

CAREFIRST COMMUNITY HEALTH PLAN MARYLAND (CHPMD) (MEDICAID)
Itraconazole Capsules (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 855-762-5205. Please contact CVS/Caremark at 877-418-4133 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Itraconazole Capsules (Medicaid).

Patient Name: _____ **Date:** 8/25/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)

Itraconazole Capsules Sporanox Oral Capsules (itraconazole)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being used in a footbath?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed for any of the following: A) Pityriasis versicolor, B) Tinea versicolor, C) Onychomycosis due to dermatophytes (Tinea unguium) confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy)?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed for any of the following: A) Tinea corporis, B) Tinea cruris, C) Tinea capitis, D) Tinea manuum, E) Tinea pedis?	**Y** ☐	**N** ☐
4.	Has the patient experienced an inadequate treatment response, intolerance or does the patient have a contraindication to any of the following: A) fluconazole, B) griseofulvin, C) terbinafine?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed for any of the following: A) Histoplasmosis, B) Histoplasmosis prophylaxis in HIV infection, C) Coccidioidomycosis prophylaxis in HIV infection, D) Invasive fungal infection prophylaxis in a patient with chronic granulomatous disease, E) Primary therapy for chronic cavitary pulmonary aspergillosis?	**Y** ☐	**N** ☐
6.	Is the requested drug being prescribed for any of the following: A) Blastomycosis, B) Primary therapy for allergic bronchopulmonary aspergillosis, in combination with systemic corticosteroids, C) Aspergillosis in a patient intolerant of or refractory to amphotericin B therapy, D) Coccidioidomycosis, E) Cryptococcosis, F) Sporotrichosis, G) Talaromycosis (formerly Penicilliosis), H) Microsporidiosis, I) Invasive fungal infection prophylaxis in a liver transplant patient, J) Invasive fungal infection prophylaxis in a patient with a hematologic malignancy?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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