

**Physician's Prior Authorization Questionnaire  
Sporanox®**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

Sporanox® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* \_\_\_\_\_
2. What are the results of the fungal culture? \_\_\_\_\_
3. Site of treatment? \_\_\_\_\_
4. What tests were done to determine this medical diagnosis? \_\_\_\_\_
5. Has this patient had previous treatment for this diagnosis?  Yes  No

If Yes, what medication was prescribed and duration of therapy? \_\_\_\_\_  
\_\_\_\_\_

6. How long do you anticipate this treatment method to be prescribed? \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)