LAMISIL, PENLAC, SPORANOX
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM

BlueCross BlueShield of Illinois

ONLY the prescriber may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

Medication Requested:

Dosing Schedule: Length of Therapy:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No

   If yes, when was treatment with the requested medication started? _____

2. Please list all reasons for selecting the requested **medication** over alternatives (e.g. contraindications, allergies or history of adverse drug reactions.) _____

3. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please include approximate dates of any previous therapies.) _____

4. If the diagnosis is onychomycosis:
   a. Are the infected nails on the fingers or toes? ☐ Finger ☐ Toe
   b. Has the fungal nail infection been confirmed by KOH, fungal culture, or nail biopsy? ☐ Yes ☐ No
   c. Please check all comorbid conditions that apply:
      - ☐ Diabetes mellitus
      - ☐ Peripheral vascular insufficiency
      - ☐ Pain limiting normal activity
      - ☐ Impaired skin integrity (infection, dermatosis)
      - ☐ Immune deficiency due to medical condition or transplant (e.g. HIV/AIDS, cancer chemotherapy)

5. Is the fungal requested medication Penlac? ☐ Yes ☐ No

   If yes, does the treatment plan include removal of the unattached infected nails(s) by a health care professional? ☐ Yes ☐ No

Please fax or mail this form to:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 800.285.9426

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