

Prior Authorization Request Form for  
itraconazole 65 mg capsules (Tolsura)



**JOHNS HOPKINS**  
MEDICINE

JOHNS HOPKINS  
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

# USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

1. What is the indication or diagnosis?	<input type="checkbox"/> Histoplasmosis - Proceed to question 2 <input type="checkbox"/> Pulmonary or Extrapulmonary Blastomycosis - Proceed to question 2 <input type="checkbox"/> Pulmonary or Extrapulmonary Aspergillosis - Proceed to question 4 <input type="checkbox"/> Other – <b>STOP</b> Coverage not approved		
	2. Has the patient had serious side effects with generic itraconazole 100 mg tablets/capsules?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No Proceed to question 3
	3. Has the patient failed drug treatment with generic itraconazole 100 mg tablets/capsules?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
	4. Has the patient had serious side effects with generic itraconazole 100 mg tablets/capsules and amphotericin B?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No Proceed to question 5
5. Has the patient failed drug treatment with generic itraconazole 100 mg tablets/capsules and amphotericin B?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved	

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

_____	_____
Prescriber Signature	Date

[29 May 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: