Prescriber Criteria Form Ketoconazole PO 2024 PA Fax 1440-A v1 010124.docx Ketoconazole tablets Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ketoconazole tablets.

Drug Name: Ketoconazole tablets

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have acute or chronic liver disease? [If yes, then no further questions.]	Yes	No
2	Will the requested drug be used concurrently with ANY of the following: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for treatment of ANY of the following systemic fungal infections: A) blastomycosis, B) coccidioidomycosis, C) histoplasmosis, D) chromomycosis, E) paracoccidioidomycosis? [If yes, then skip to question 5.]	Yes	No
4	Is the requested drug being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or where surgery has not been curative? [If no, then no further questions.]	Yes	No
5	Do the potential benefits outweigh the risks of treatment with oral ketoconazole?	Yes	No

Comments:	

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____