

RYAN WHITE PROGRAM
Letter of Medical Necessity for Sporanox (Itraconazole)

Date: _____

As the primary care physician treating _____, I consider it medically necessary to prescribe Sporanox (Itraconazole). The medication will be utilized to treat **ONLY** one of the following two conditions (please check one box):

	Histoplasmosis
	Aspergillosis

The diagnosis above is fully documented in the patient's medical record.

Sincerely,

_____, M.D./D.O.

Print M.D./D.O. name

Florida medical license # (MEO#)

Patient's 10 digit Medicaid # (if applicable)

Patient's CIS # (assigned by the Ryan White Program
Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Assistant Director, Office of Grants Coordination, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to the most current Professional Service Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.