

VFEND
PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW or a CONTINUATION of THERAPY ? If so, start date: _____
 Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:		City: State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		

SECTION C - MEDICAL INFORMATION

Medication: _____ **Strength:** _____

Directions for use: _____ **ICD-9 Code:** _____

- Diagnosis:** *(Please check appropriate box)*
- Invasive Aspergillosis
 - Invasive Sinus Aspergillosis
 - Tracheobronchial aspergillosis
 - Chronic necrotizing pulmonary aspergillosis
 - Aspergillosis of the CNS Fungal infection caused by *Scedosporium apiospermum*
 - Fungal infection caused by *Fusarium* species, including *Fusarium solani*
 - Candidemia in non-neutropenic patients
 - Esophageal candidiasis
 - CNS blastomycosis
 - Allergic bronchopulmonary aspergillosis
 - Other (please explain): _____

Explanation of why the preferred medication(s) would not meet your patient's needs: _____

Did the patient exhibit an inadequate response to treatment OR an intolerance/adverse reaction or has a documented contraindication with 2 other antifungal agents? YES or NO (Circle Response)

Other Medications tried		
Medication, Strength, and Directions	Dates of Therapy	Reason for Failure / Discontinuation

Physician Signature: _____ **Date:** _____