

VFEND PRIOR AUTHORIZATION REQUEST FORM

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

	Complete Living and Lax to: 000-940-7320				
Today's Date:					
SECTION A - PATIENT INF	ORMATION				
First Name: Last N		ame:	Member ID:	Member ID:	
Address:					
City: State:			Zip:	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:	P	
Office Contact Name / Fax Attention to:					
SECTION C - MEDICAL INFORMATION					
Medication: Strength:				th:	
Directions for use:			ICD-10 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:					

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Phone: 800-310-6826 Fax: 866-940-7328