UnitedHealthcare Community Plan

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-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:** _____