

## VFEND PRIOR AUTHORIZATION REQUEST FORM

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

Today's Date:			
<b>SECTION A - PATIENT INFORMATION</b>			
First Name:		Last Name:	
Address:		Member ID:	
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>SECTION B - PHYSICIAN INFORMATION</b>			
First Name:		Last Name: <span style="float: right;">M.D./D.O.</span>	
Address:		City:	State: <span style="float: right;">Zip:</span>
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
<b>SECTION C - MEDICAL INFORMATION</b>			
Medication:		Strength:	
Directions for use:		ICD-10 Code:	
<b>Diagnosis:</b> <i>(Please check appropriate box)</i> <input type="checkbox"/> Invasive Aspergillosis <input type="checkbox"/> Invasive Sinus Aspergillosis <input type="checkbox"/> Tracheobronchial aspergillosis <input type="checkbox"/> Chronic necrotizing pulmonary aspergillosis <input type="checkbox"/> Aspergillosis of the CNS Fungal infection caused by <i>Scedosporium apiospermum</i> <input type="checkbox"/> Fungal infection caused by <i>Fusarium</i> species, including <i>Fusarium solani</i> <input type="checkbox"/> Candidemia in non-neutropenic patients <input type="checkbox"/> Esophageal candidiasis <input type="checkbox"/> CNS blastomycosis <input type="checkbox"/> Allergic bronchopulmonary aspergillosis <input type="checkbox"/> 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 <u>2</u> other antifungal agents? <b>YES</b> or <b>NO</b> <i>(Circle Response)</i>			
Other Medications tried			
<b>Medication, Strength, and Directions</b>		<b>Dates of Therapy</b>	<b>Reason for Failure / Discontinuation</b>

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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