



Please complete ALL information below and fax your request to 1-888-671-5285

Noxafil® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

- Prophylaxis of invasive Aspergillus and Candida infections due to a severe immunocompromised state
- Treatment of invasive Aspergillus and Candida infections due to a severe immunocompromised state
- Treatment of oropharyngeal candidiasis
- Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has had an inadequate response to:

- Fluconazole
- Itraconazole
- Voriconazole (Vfend)

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Is there documentation of the inability to reach the requested dose with higher strengths of commercially available dosage forms due to patient specific characteristics (i.e. inability to swallow larger pills, malabsorption, presence of a feeding tube, etc.)? Yes No

Is the requested dose commercially available? Yes No

Is there documentation the dose requested is medically necessary? Yes No

If YES, please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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