

Noxafil (posaconazole) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

				U	JRGENT
MEMBER INFORMATION					
LAST NAME:			FIRST NAME:		
PHONE NUMBER:			DATE OF BIRTH:	:	
STREET ADDRESS:					
CITY:			STATE:	ZIP CODE:	
PATIENT INSURANCE ID N	IUMBER:		l		
MALE FEMALE H	EIGHT (IN/CM):	WEIGH	НТ (LB/KG):	ALLERGIES:	
IF YOU ARE NOT THE PATIENT OR THE PRE FOLLOWING LINK: <u>HTTPS://MAGELLANRX</u>				RM WITH THIS REQUEST WHICH CAN BE FOUND AT THE OSURE AUTHORIZATION.PDF	į
PATIENT'S AUTHORIZED RI AUTHORIZED REPRESENTA	-	-			
PRESCRIBER INFORMATION	ON				
LAST NAME:		FIRST NAME:			
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:			
NPI NUMBER:		DEA NUMBER:			
PHONE NUMBER:		FAX NUMBER:			
STREET ADDRESS:					
CITY:		STATE: ZIP CODE:			
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:			
MEDICATION OR MEDICA	AL DISPENSING INFOR	RMATION			
MEDICATION NAME:					
DOSE/STRENGTH:	FREQUENCY:		LENGTH OF THERAPY/REFILL	QUANTITY: LS:	
NEW THERAPY DURATION OF THERAPY (S	RENEW SPECIFIC DATES):	/AL	IF RENEWAL: DA	ATE THERAPY INITIATED:	
Continued on next page.					

© 2018 – 2023 by Magellan Rx Management, LLC. All Rights Reserved.

Revision Date: 02/1/2023

CAT0164







Noxafil (posaconazole) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTH	ER MEDICATIONS FOR THIS CONDITION	? YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
☐ Invasive Aspergillus prophylaxis		100 20.	
☐ Invasive Aspergillus treatment			
☐ Candida Infection prophylaxis			
□ Oropharyngeal candidiasis			
☐ Invasive Mucormycosis			
3. REQUIRED CLINICAL INFORMATIO	N: PLEASE PROVIDE ALL RELEVANT CLINI	CALINFORMATION TO SUPPORT A	
PRIOR AUTHORIZATION.			
Clinical Information:			
Does the noticet verying outifuncely	wowhydovic? = Voc = No		
Does the patient require antifungal p	oropnylaxis? 🗆 Yes 🗆 No		
Does the patient have one of the following	lowing associated diseases? Yes No		
If yes, please select:	0		
☐ Acute myeloid leukemia			
☐ Allogeneic hematopoietic stem cel	l transplant		
☐ Aplastic anemia receiving immuno	suppressive therapy		
☐ Myelodysplastic syndrome (MDS)			
☐ Significant graft-versus-host disea	se		
Does the patient have a serious fung	al infection? □ Yes □ No		
Has the patient tried and was intoler voriconazole? □ Yes □ No	ant or resistant to at least one of the fo	llowing: fluconazole, itraconazole, or	
Does the patient have mucomycosis	(i.e. zygomycetes)? □ Yes □ No		
Are there any other comments, diag physician feels is important to this re		failed, and/or any other information the	
Please note: Not all drugs/diagnosis a information is received.	are covered on all plans. This request ma	y be denied unless all required	
	on provided is true and accurate to the b	est of my knowledge. I understand that	
	up or its designees may perform a routin	•	
information necessary to verify the ac	ccuracy of the information reported on t	his form.	

 $\hbox{@ 2018-2023}$ by Magellan Rx Management, LLC. All Rights Reserved.

Revision Date: 02/1/2023

CAT0164







Noxafil (posaconazole) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Prescriber Signature or Electronic I.D. Verification:

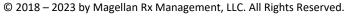
Date:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811



Revision Date: 02/1/2023

CAT0164



