

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice[®] HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax back to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

*On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.
Caremark is an independent company that administers prescription drug benefits.*

1. Is the patient 12 years old or older? Y N
2. Does the patient have a diagnosis of invasive aspergillosis? Y N
3. Does the patient have a diagnosis of serious fungal infection caused by *Scedosporium apiospermum* or *Fusarium* species? Y N
4. Is the patient intolerant, or refractory to other antifungal therapy? Y N
5. Is Vfend oral a continuation of treatment started in the hospital? Y N
6. Is the patient currently taking any of the following drugs that are contraindicated with Vfend therapy: Propulsid, Orap, Qunidex/Quinaglute, Rapamune, Rifadin/Rimactine, Tegretol, Mycobutin, ergot alkaloids, phenobarbital/mephobarbital? Y N
7. Will the physician monitor the liver and renal function of the patient while on Vfend therapy? Y N

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FOR RENEWAL PRIOR AUTHORIZATION, PLEASE ANSWER THE FOLLOWING QUESTIONS:

8. Has the patient been taking oral Vfend therapy outside the hospital setting in the past 30 days? Y N
9. Has the infection shown improvement, but is unresolved? Y N
10. Has the physician monitored and will the physician continue to monitor hepatic and renal functions of the patient? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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