



**Noxafil**  
(Posaconazole)  
**Prior Authorization Form**

**Express Scripts**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.)			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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- 1. Is the diagnosis or indication for the prevention of invasive Aspergillosis or Candida infections? If no continue to #3**
- 2. Is the patient 13 years of age and older, who is at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy?**
- 3. Is the diagnosis or indication for the treatment of oropharyngeal candidiasis?**
- 4. Has the patient tried and failed or intolerant to itraconazole and fluconazole for the current condition?**
- 5. Is the prescription recommended or initially written by an Infectious Disease specialist?**
- 6. Is the patient currently taking one of the following: Orap, Quinidine or Ergot alkaloids?**
- 7. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?**

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u>	
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Reviewer's Initials _____ Decision Date _____
Comments _____	