

Drug Coverage Review Request

Noxafil

35045



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder's ID# _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

mm_name1 Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

SECTION A Please answer the following question(s)

- For which indication is this drug being prescribed?
 - Prophylaxis or treatment of invasive aspergillus
 - Treatment of candida infection
 - Yes No Has the patient PREVIOUSLY RECEIVED fluconazole or itraconazole?
 - Yes No If **YES** to the previous question, has the patient FAILED drug therapy with fluconazole or itraconazole?
 - Other

SECTION B Physician signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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