PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cresemba

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Which formulation of Cresemba is requested?

☐ Oral capsules ☐ IV solution

Q2. Is the patient a NEW start to therapy?

☐ Yes ☐ No (please provide start date)

Q3. Specify the prescriber's specialty.

☐ Infectious Disease ☐ Other (please specify)

Q4. What diagnosis is this drug being prescribed for?

☐ Invasive aspergillosis
☐ Mucormycosis
☐ Other (Please Specify)

Q5. If for invasive aspergillosis, does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to voriconazole?

☐ Yes ☐ No

Q6. If for mucormycosis, does the patient have failure of an adequate trial of, clinically significant intolerance, or

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contraindication to amphotericin B?

☐ Yes ☐ No

Q7. Were the causative organisms isolated and identified through fungal culture and other relevant laboratory studies (including histopathology)?

☐ Yes ☐ No

Q8. Does the patient have any of the following? Please select all that apply.

☐ Familial short QT syndrome
☐ Concurrent use of drugs that are strong inducers of CYP3A4 (e.g. phenytoin, carbamazepine, rifampin, St. John's wort)
☐ Concurrent use of drugs that are strong inhibitors of CYP3A4 (e.g. ketoconazole, high-dose ritonavir)
☐ None of the above

Q9. Does the patient have culture and sensitivity showing susceptibility to Cresemba?

☐ Yes ☐ No

Q10. If not a new start, does the patient show need for continuation of therapy through any of the following? Please select all that apply.

☐ Radiographic abnormalities have not stabilized
☐ Signs of active infection are still present
☐ Persistent immune defects present
☐ Other (please specify)

Q11. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q12. Provide name and NPI of the billing entity

Q13. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

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☐ Medical	☐ Pharmacy
Q14. Additional Comments	

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.