Noxafil (Posaconazole) Prior Authorization Form

Criteria*

Febrile neutropenia antifungal prophylaxis

And / Or

Serious fungal infection, and is intolerant or resistant to other therapy

Alternate antifungal therapy appropriate when Associated Diseases absent.

*These criteria are subject to change, and reflect the current NCCN guidelines “Prevention and Treatment of Cancer-Related Infections”

Diagnosis:

☐ Febrile neutropenia antifungal prophylaxis

☐ Other: ______________________________________

☐ Associated Disease (if febrile neutropenia prophylaxis)

☐ Acute Myeloid Leukemia

☐ Myelodysplastic syndromes

☐ Allogenic Hematopoietic Stem Cell Transplantation

☐ Significant Graft-Versus-Host Disease

☐ Other: ______________________________________

☐ Patient is intolerant or resistant to other therapy

☐ Fluconazole

☐ Itraconazole

☐ Voriconazole

☐ Other: ______________________________________

Other information supporting the need for Noxafil:

☐ Patient continuing Noxafil therapy?  ☐ Yes  ☐ No

If Yes, date initiated: ____________________

☐ Noxafil 200mg three times daily  ☐ Other: ____________________

☐ Expected duration of therapy: ____________________

Prescriber Signature: ____________________ Date: ____________

Mailing Address
Physicians Plus Insurance Corporation
Attn: Pharmacy Services
P.O. Box 2078
Madison WI 53701-2078

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