PA Request Criteria

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**CAREFIRST ASO**
**Noxafil**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Noxafil.

**Patient Name:** _____ **Date:** 11/27/2023
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** _____ **Patient Phone:** _____ **Physician Name:**
**NPI#:** **Specialty:**
**Physician Office Address:** _____ **Physician Office Telephone:**

**Drug Name (select from list of drugs shown)**
Noxafil (posaconazole) Posaconazole

**Quantity:** _____ **Frequency:** _____ **Strength:** _____
**Route of Administration:** _____ **Expected Length of Therapy:** _____
**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____
_____
_____

**Please check the appropriate answer for each applicable question.**

1. Is the requested drug being prescribed for the prevention of invasive aspergillus and candida infections in a patient who is at a high risk of developing these infections due to being severely immunocompromised? **Y** ☐ **N** ☐

2. Which drug is being requested?
   - Noxafil Injection (If checked, go to 3) ☐
   - Noxafil delayed-release tablets (If checked, go to 3) ☐
   - Noxafil oral suspension (immediate-release) (If checked, go to 4) ☐
   - Noxafil PowderMix for delayed-release oral suspension (If checked, no further questions) ☐

   [Note: Please check the drug being requested.]

3. Is the requested drug being prescribed for the treatment of invasive aspergillosis? **Y** ☐ **N** ☐

4. Is the requested drug being prescribed for the treatment of moderate to severe oropharyngeal candidiasis? **Y** ☐ **N** ☐

5. Has the patient experienced an inadequate treatment response, intolerance or does the patient have a contraindication to fluconazole AND itraconazole oral solution? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

**Prescriber (Or Authorized) Signature and Date**

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