maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Cresemba

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions 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 plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Aspergillus Infection - Treatment (If checked, go to 3) [] Mucormycosis - Treatment (If checked, go to 6) [] Other (If checked, no further questions)		

If you have any questions, call: 1-888-258-8250

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3	Has documentation been provided to confirm that the patient has a diagnosis of invasive aspergillosis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
4	Is the requested medication prescribed by or in consultation with an infectious disease specialist, transplant specialist, or oncologist/hematologist? [If no, no further questions.]	Yes	No
5	Has documentation been provided to confirm that the patient has an intolerance, contraindication, or treatment failure with voriconazole? ACTION REQUIRED: Submit supporting documentation. [Reviewer Note: Clinical documentation and claims history review is required.] [If yes, skip to question 9.] [If no, no further questions.]	Yes	No
6	Has documentation been provided to confirm that the patient has a diagnosis of mucormycosis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Is the requested medication prescribed by or in consultation with an infectious disease specialist? [If no, no further questions.]	Yes	No
8	Has documentation been provided to confirm that the patient has an intolerance, contraindication, or treatment failure with posaconazole? ACTION REQUIRED: Submit supporting documentation. [Reviewer Note: Clinical documentation and claims history review is required.] [If no, no further questions.]	Yes	No
9	Does the patient have familial short QT syndrome? [If yes, no further questions.]	Yes	No
10	Does the loading and maintenance dosing exceed Food and Drug Administration (FDA) approved label dosing for the indication? [If yes, no further questions.]	Yes	No
11	Is the patient currently receiving the requested medication? [If no, no further questions.]	Yes	No
12	Has documentation been provided to confirm that according to the prescriber, the patient has a clinical benefit from the use of the requested medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been provided to confirm the number of months of treatment the patient has already received with the requested medication? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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[If no, no further questions.]

14 How many months of treatment has the patient already received with the requested medication?
[] 0 (If checked, no further questions)

[] 1 (If checked, no further questions)

[] 2 (If checked, no further questions)

[] 3 months or more (If checked, no further questions)

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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