



# 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 request an INITIAL or CONTINUATION of therapy?	
	<input type="checkbox"/> Initial (If checked, go to 6)	
	<input type="checkbox"/> Continuation (If checked, go to 2)	
2	Is the patient currently receiving the requested medication? [If no, go to question 6.]	Yes      No

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3	<p>Has the patient been receiving medication samples of Cresemba? [If yes, go to question 6.]</p>	Yes	No
4	<p>Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]</p>	Yes	No
5	<p>Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]</p>	Yes	No
6	<p>What is the indication or diagnosis?  <input type="checkbox"/> Aspergillus, Invasive Infection - Treatment (If checked, go to 7)   <input type="checkbox"/> Mucormycosis, Invasive Infection - Treatment (If checked, go to 13)   <input type="checkbox"/> Other (If checked, no further questions)</p>		
7	<p>Is the patient greater than or equal to 6 years of age? [If no, no further questions.]</p>	Yes	No
8	<p>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.]</p>	Yes	No
9	<p>Is the requested medication prescribed by or in consultation with an infectious disease specialist, transplant specialist, or oncologist/hematologist? [If no, no further questions.]</p>	Yes	No
10	<p>Does the patient have familial short QT syndrome? [If yes, no further questions.]</p>	Yes	No
11	<p>Has documentation been submitted to confirm that the patient has had a treatment failure with voriconazole for AT LEAST 1 month unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]</p>	Yes	No
12	<p>Does the dose of the requested medication exceed FDA approved label dosing for the indication? [Note: Dosing for adults: 372 mg every 8 hours for 6 doses; Maintenance: 372 mg once daily. Dosing for pediatrics: weight based dosing.] [No further questions.]</p>	Yes	No

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13	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
14	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
15	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
16	Has documentation been submitted to confirm that the patient has had a treatment failure with posaconazole for AT LEAST 1 month unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Does the patient have familial short QT syndrome? [If yes, no further questions.]	Yes	No
18	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing for adults: 372 mg every 8 hours for 6 doses; Maintenance: 372 mg once daily. Dosing for pediatrics: weight based dosing.]	Yes	No

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

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**SECTION B: Physician Signature**

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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

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immediately and destroy this document.

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