Prescriber Criteria Form

Noxafil Tab 2025 PA Fax 4504-A v1 010125.docx
Noxafil (posaconazole tablet)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Noxafil (posaconazole tablet).

Drug Name:
Noxafil (posaconazole tablet)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being used orally? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the prophylaxis of invasive Aspergillus or Candida infections in a patient who is at a high risk of developing these infections due to being severely immunocompromised? [If no, then skip to question 5.]	Yes ◯	No ◯
3	Is the patient 2 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
4	Does the patient weigh greater than 40 kilograms? [No further questions.]	Yes ◯	No ◯
5	Is the requested drug being prescribed for the treatment of invasive aspergillosis? [If no, then no further questions.]	Yes ◯	No ◯
6	Is the patient 13 years of age or older?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____