REALRx

PRIOR AUTHORIZATION REQUEST FORM
POSACONAZOLE

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ posaconazole tablets, ☐ posaconazole solution

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
PROPHYLAXIS OF INVASIVE ASPERGILLUS OR CANDIDA INFECTION			
1. Is the request for prophylaxis of Invasive Aspergillus Infection or Candida infection?	☐	☐	
2. Is the member severely immunocompromised as defined by at least one of the following? • Member is status post hematopoietic stem cell transplant with current, significant graft-versus-host disease receiving immunosuppressive therapies • Member has a hematologic malignancy with neutropenia	☐	☐	**Please provide documentation**
FUNGAL INFECTION TREATMENT			
1. Is request made by, or in consultation with, an Infectious Disease Specialist?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of one of the following? • Refractory coccidioidomycosis, • Invasive mucormycosis, • Oropharyngeal candidiasis,	☐	☐	**Please provide documentation**

• Invasive *Aspergillus* infection (Aspergillosis)			

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

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Policy: PHARM-153
Origination Date: 05/04/2023
Reviewed/Revised Date: 05/19/2023
Next Review Date: 05/19/2024
Current Effective Date: 06/01/2023