

Noxafil

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Is this an immunocompromised patient? Yes No

If yes, please explain: _____

ICD-9 Code: _____

2. Is the patient at increased risk for invasive systemic *Aspergillus* and/or *Candida* infections? Yes No

3. Does the patient have a diagnosis of oropharyngeal candidiasis? Yes No

4. For oropharyngeal candidiasis treatment, please list specific reasons why the patient is not a candidate for Diflucan/fluconazole or Sporanox/itraconazole for treatment of infection: _____

5. Quantity per Day: _____ units

Directions: _____

Printed Name

Signature

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.