PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Vfend - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Vfend - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Vfend (voriconazole) Voriconazole

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the patient receiving any of the following medications: A) Pimozide (Orap), B) Quinidine, C) Sirolimus (Rapamune), D) Rifampin, E) Carbamazepine, F) Long-acting barbiturates (Phenobarbital), G) Rifabutin, H) Ergot alkaloids (ergotamine and dihydroergotamine/DHE-45)? Y N

[If yes, then no further questions.]

2. Is this request for the primary treatment of pulmonary aspergillus? Y N

[Note: Documentation must be provided.]

	[If yes, then no further questions.]		
3.	Is this request for the primary treatment of amphotericin B and fluconazole resistant fungal infections (including Fusarium spp. and Scedosporium apiospermum - asexual form of Pseudoallescheria boydii)?	Y N	
	[Note: Documentation must be provided.]		
	[If yes, then no further questions.]		
4.	Is this request for the treatment of invasive fungal infections in patients who are intolerant of, or refractory to, other antifungal therapy?	Y N	
	[Note: Documentation must be provided.]		
	[If yes, then no further questions.]		
5.	Is this request for the empirical therapy of neutropenic fever in patients receiving concomitant nephrotoxins (cyclosporin, tacrolimus)?	Y N	
	[Note: Documentation must be provided.]		
	[If yes, then no further questions.]		
6.	Is this request for prophylaxis in high risk patients undergoing mini MUD transplants, mini allogeneic bone marrow transplants (BMTs), allogeneic bone marrow transplants (BMTs), or patients with severe graft versus host disease (GVHD)?	Y N	
	[Note: Documentation must be provided.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date