Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Voriconazole

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the requested drug being prescribed for any of the following: A) treatment of invasive aspergillosis (including invasive pulmonary aspergillosis), B) serious fungal infection caused by Scedosporium apiospermum and Fusarium species, C) prophylaxis of invasive aspergillosis in a high-risk patient, D) chronic pulmonary aspergillosis, E) empiric antifungal therapy for febrile neutropenia in a high-risk patient, F) mycosis due to Scedosporium prolificans?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed for any of the following: A) candidemia in a non-neutropenic patient, B) disseminated Candida infection in the skin, C) Candida infection in the abdomen, kidney, bladder wall, or wounds, D) esophageal candidiasis, E) oropharyngeal candidiasis?

☐ Yes ☐ No

Q3. Had the patient experienced an inadequate treatment response or intolerance to an alternative antifungal therapy OR does the patient have a contraindication that would prohibit a trial of an alternative antifungal therapy?

☐ Yes ☐ No

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Q4. If the request is for voriconazole powder for oral suspension, does the patient meet one of the following: A) has difficulty swallowing solid oral dosage forms (e.g., tablets), B) requires a dose that cannot be obtained using the commercially available tablets?

☐ Yes ☐ No

Q5. Additional Information:

Prescriber Signature

Date

v2025