

Health New England
Medication Request Form (MRF)/Prescription Request

Vfend® (voriconazole)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Vfend®. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name:	
		Specialty:	
Patient Cell Phone #: () -		NPI #:	
Patient HNE ID#:		HNE Provider #:	
Patient Date of Birth:		DEA #:	
Allergies:		Telephone #: () -	
Diagnosis:		Fax # (required): () -	
Drug Information			
Requested Drug/Strength/Form: Vfend			
Dose, directions and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician Signature:		Date:	
Indication:			
<input type="checkbox"/> Treatment of invasive aspergillosis. <input type="checkbox"/> Treatment of fungal infections caused by Scedosporium apiospermum or Fusarium spp., in patients intolerant of, or refractory to, other therapy. <input type="checkbox"/> Treatment of esophageal Candidiasis in patients intolerant of, or refractory to, fluconazole.			
Documentation of Medical Necessity (check all that apply):			
Please note, culture must be attached			
<input type="checkbox"/> Patient on any of the following medications rifampin, rifabutin, ritonavir, carbamazepine, barbiturates, St. Johns's wort, or sirolimus <input type="checkbox"/> Vfend prescription is written by a hematologist, oncologist or infectious disease specialist. <input type="checkbox"/> Patient has failed, is intolerant of, or has contraindication to other antifungals, e.g., fluconazole, etc.			
Please list drug, dose and reason for discontinuation, e.g., failure, contraindication, side-effects (please list side effects)			

<input type="checkbox"/> Other pertinent history:			