

Health New England
Medication Request Form (MRF)/Prescription Request
Noxafil® (posaconazole)

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 Noxafil® (posaconazole). 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: <input type="checkbox"/> Noxafil		
Dose, Directions, and length of treatment (please be specific):	Quantity:	Refills:
Physician Signature:	Date:	

Indication:

- Prophylaxis of invasive Aspergillus or Candida in severely immunocompromised patient.
- Oropharyngeal candidiasis
- Other (please describe): _____

Documentation of Medical Necessity (check all that apply):

- Noxafil is being initiated or recommended by a hematologist, oncologist or infectious disease specialist.
- Patient has failed, is intolerant of or has contraindication to other antifungal agents (itraconazole, fluconazole, and voriconazole [also required Prior Authorization])
- Culture shows susceptible organism
- Patient is at least 13 years old
- Other medications tried and dates used _____
- Other pertinent history (please explain): _____