Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
CRESEMBA (Isavuconazonium) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage **CRESEMBA (Isavuconazonium).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete. KP-MAS Formulary can be found at:** **http://www.providers.kaiserpermanente.org/mas/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber an infectious disease specialist, hematologist/oncologist, or transplant specialist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Member is 18 years of age or older?
   □ No □ Yes

-AND-

4. Does the member have a diagnosis of invasive aspergillosis? **AND**
   □ No □ Yes
5. Has treatment failure/intolerance of voriconazole? **OR**
   □ No □ Yes
6. Did Voriconazole have a drug-drug interaction with the individual's current therapy which requires therapy modification?
   □ No □ Yes

-OR-

7. Does the member have diagnosis of invasive mucormycosis? **AND**
   □ No □ Yes
8. Has treatment failure/intolerance of Posaconazole? **OR**
   □ No □ Yes
9. Did Posaconazole have a drug-drug interaction with the individual's current therapy which requires therapy modification?
   □ No □ Yes

-OR-

10. Is there documentation supporting use of the requested agent for primary or secondary prophylaxis of invasive fungal infections in patients who have documented intolerance and/or drug-drug interactions which require therapy modification to posaconazole and voriconazole?
    □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Does the member continue to be followed by an infectious disease specialist, hematologist/oncologist, or transplant specialist; follow-up has occurred in the past 6 months?
   □ No □ Yes
2. Has the member demonstrated positive clinical and/or laboratory response to therapy?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**