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United Healthcare Community Plan

FLORIDA MEDICAID

Prior Authorization

VFEND® (Voriconazole)

(Maximum of 90 Days Approval)

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

☐ Vfend® (voriconazole)
Initiation of therapy
Continuation of therapy

☐ 50 mg tab
☐ 200 mg tab

☐ 40 mg/ml susp.
☐ 200 mg vials (IV)

_____ **Directions**

_____ **Quantity/30 Days**

_____ lbs _____ kgs **Weight**

1. **Please check all that apply: (*Vfend not FDA approved for prophylactic therapy*).**

   ☐ Invasive Aspergillosis (***Only approved indication for primary treatment***)
   ☐ Candidemia in non-neutropenic patients
   ☐ Candidiasis of the esophagus
   ☐ Disseminated candidiasis of the skin and infections in the abdomen, kidney, bladder wall, and wounds
   ☐ Serious infections due to Scedosporium apiospermum and Fusarium spp., including Fusarium solani

2. **Has patient received transplant?** ☐ Yes ☐ No

   Type: _____ Date: _____

3. **What antifungal agent(s) has the patient received in the past 90 days?**

   Drug Name: _____ Dates of Use: _____

   Reason for Discontinuing: _____

   Drug Name: _____ Dates of Use: _____

   Reason for Discontinuing: _____

4. **Site(s) of Infection:** _____

5. **Diagnostic test(s) performed include: (check all that apply and submit copy of test results)**

   ☐ Platelia Aspergillus EIA test ☐ Thoracic CT ☐ Culture(s) ☐ Biopsy

6. **Vfend prescribed by:** ☐ Hematologist ☐ Oncologist, or ☐ Infectious Disease Specialist

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025

Approved Indications:

Invasive Aspergillosis:

a. The "Invasive Aspergillosis" diagnosis must be checked.
b. **Initial treatment** will be approved for **1 month** in patients suspected of having a life-threatening invasive Aspergillus infection that meet the following criteria:
   - Have a diagnosis indicating they are immunocompromised or are currently receiving immunosuppressive drugs; **AND**
   - Patient has clinical manifestations (symptoms, signs, and radiological features) compatible with the diagnosis of invasive aspergillosis. (**Supporting documentation must accompany request.**)
c. The **remaining 60 days of therapy** may be granted upon receipt of a positive **Platelia Aspergillus EIA test** (detects circulating galactomannam antigen), biopsy or culture. A copy of the original lab results is required.
d. New test results must accompany request for continuation of therapy after initial 90 days of therapy.

Treatment Failures:

Patient must have documented treatment failure with one or more of the following (except in the case of invasive aspergillosis):

- Amphotericin B (Abelcet®, Fungizone®)
- Flucanozole (Diflucan®)
- Ketoconazole (Nizoral®)

Indication	PDL Alternatives (Current December 2007)
Invasive Aspergillosis	Abelcet, amphotericin B, Fungizone
Candidemia in non-neutropenic patients	Abelcet, amphotericin B, fluconazole, Fungizone
Candidiasis of the Esophagus	Abelcet, amphotericin B, fluconazole, Fungizone, ketoconazole
Disseminated candidiasis of the skin, and infections in the bladder wall, abdomen, kidney, and wounds	Abelcet, amphotericin B, fluconazole, Fungizone
Scedosporium apiospermum and *Fusarium* species including *Fusarium solani*	Abelcet, amphotericin B, Fungizone