



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Oral/Injectable Antifungal Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested

- Cresemba (isavuconazonium)* Oravig (miconazole buccal tablet) Other** _____
 Noxafil (posaconazole)* Tolsura (itraconazole 65 mg capsule)
 Onmel (itraconazole 200 mg tablet) voriconazole

*For Noxafil IV and Cresemba IV, Section VII is also required.

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).

Dose and frequency of medication requested _____

Indication (check all that apply)

*voriconazole requests only **Noxafil and Cresemba

- Aspergillus* endophthalmitis* *Scedosporium* infection* *Fusarium* infection*
 Aspergillus keratitis* *Aspergillus* infection *Zygomycosis* (mucormycosis)**

Please note: For Noxafil or voriconazole for the above indications, Sections I through VIII are not required.

For all indications checked below, please complete sections in parentheses

- Blastomycosis (Section V) Histoplasmosis (Section V) Other _____
 Candidemia (Section II) Onychomycosis (Section V) (Please attach a letter regarding medical necessity.)
 Disseminated candidiasis (Section II) Oropharyngeal candidiasis (Section IV or VIII)
 Esophageal candidiasis (Section III) Prevention of *Aspergillus* and *Candida* infections (Section I)

Section I. Please complete for Noxafil and voriconazole for prevention of Aspergillus and Candida infections.

1. For Noxafil requests, is the member's age within the FDA-approved range for use (Noxafil suspension \geq 13 years; Noxafil IV \geq 18 years)?
 Yes. No. Please provide clinical rationale for use in non-FDA approved age.

2. For both Noxafil and voriconazole requests, does the member have one of the following?
 Hematologic malignancy with neutropenia Graft-versus-host disease
 Hematopoietic stem cell transplantation
 No. Please describe why the member requires antifungal prophylaxis.

3. For Noxafil IV, please provide clinical rationale for use of IV formulation over oral formulations.

Section II. Please complete for voriconazole for candidemia and disseminated candidiasis.

Has the member had a trial of oral fluconazole?

- Yes. Dates/durations of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for oral fluconazole.

Section III. Please complete for Noxafil suspension and voriconazole for esophageal candidiasis.

1. For Noxafil requests, is the member 13 years of age or older?
 Yes. No. Please provide clinical rationale for use in non-FDA-approved age.

 2. For Noxafil requests, has the member had a trial of voriconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

 3. For both Noxafil and voriconazole requests, has the member had a trial of fluconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

 4. For both Noxafil and voriconazole requests, has the member had a trial of itraconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for itraconazole.

Section IV. Please complete for Noxafil suspension and voriconazole for oropharyngeal candidiasis.

1. For Noxafil requests, is the member 13 years of age or older?
 Yes. No. Please provide clinical rationale for use in non-FDA approved age.

2. For voriconazole requests, has the member had a trial of posaconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for posaconazole.

3. For both Noxafil and voriconazole requests, has the member had a trial of oral fluconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for oral fluconazole.

4. For both Noxafil and voriconazole requests, has the member had a trial of itraconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for itraconazole.

Section V. Please complete for Onmel and Tolsura.

Please provide medical necessity for the requested formulation instead of itraconazole 100 mg capsules.

Section VI. Please complete for Cresemba for the treatment of Aspergillus infection.

- Has the member had a trial of voriconazole?
 Yes. Dates/duration of use _____
Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

- No. Please describe why the member is not a candidate for voriconazole.

Section VII. Please complete for Cresemba IV and Noxafil IV.

Please provide clinical rationale for use of IV formulation over oral formulations.

Section VIII. Please complete for Oravig for oropharyngeal candidiasis.

1. Has the member had a trial of nystatin suspension?

Yes. Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

 No. Please describe why the member is not a candidate for nystatin suspension.

2. Has the member had a trial of clotrimazole troches?

Yes. Dates/duration of use _____

Did the member experience any of the following? Adverse reaction Inadequate response
Briefly describe details of adverse reaction or inadequate response.

 No. Please describe why the member is not a candidate for clotrimazole troches.

Section IX. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____