



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Cresemba<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>Continuation of therapy:</b>            Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No            If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b></p> <hr/>

<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Invasive Aspergillosis</p> <p><input type="checkbox"/> Invasive Mucormycosis</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
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<p><b>Clinical information:</b>            Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p><b>Medication history:</b></p> <p><b>Invasive Aspergillosis:</b>            Has the patient had a failure or intolerance to first and second line agents (voriconazole and amphotericin B)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Invasive Mucormycosis:</b>            Has the patient had a failure or intolerance to first and second line agents (amphotericin B and posaconazole)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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