



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

Visit 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

Vfend® (voriconazole) Prior Authorization Request Form

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

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

Select the diagnosis below:					
<input type="checkbox"/> <i>Candida</i> infection in abdomen, kidney, bladder wall, or wound					
<input type="checkbox"/> Candidemia in non-neutropenic patient					
<input type="checkbox"/> Disseminated <i>Candida</i> skin infection					
<input type="checkbox"/> Esophageal candidiasis					
<input type="checkbox"/> Invasive aspergillosis					
<input type="checkbox"/> Serious fungal infection caused by <i>Scedosporium apiospermum</i> or fungal infection caused by <i>Fusarium</i> species					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Medication history:					
Has the patient had prior use of fluconazole or is fluconazole contraindicated, inappropriate, or ineffective for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-855-297-2870.
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.