Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Posaconazole

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the requested drug age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Is the requested drug is being prescribed for the prevention of invasive Aspergillus and Candida infections in a patient who is at a high risk of developing these infections due to being severely immunocompromised?

☐ Yes ☐ No

Q3. Is Noxafil injection or Noxafil delayed-release tablets being prescribed for the treatment of invasive aspergillosis?

☐ Yes ☐ No

Q4. Is Noxafil oral suspension (immediate-release) being prescribed for the treatment of moderate to severe oropharyngeal candidiasis?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Additional Information:

Q6. Has the patient experienced an inadequate treatment response, intolerance or has a contraindication to fluconazole AND itraconazole oral solution?

☐ Yes ☐ No

_____ _____

Prescriber Signature Date

v2025