

**NOXAFIL<sup>®</sup>, VFEND<sup>®</sup>**  
**PHYSICIAN FAX FORM**



**BlueCross BlueShield  
of Florida**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

**ONLY the prescriber may complete this form.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Florida web site at <http://www.bcbsfl.com>.

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):
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**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

DIAGNOSIS ICD-9 code plus description:	
MEDICATION REQUESTED:	Strength:
Dosing Schedule:	Quantity per Month:
1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment started? _____	
2. Please indicate the pathogen for the patient's infection: <input type="checkbox"/> Aspergillus sp. <input type="checkbox"/> Fusarium sp. <input type="checkbox"/> Candida sp. <input type="checkbox"/> Zygomycetes sp. <input type="checkbox"/> Scedosporium apiospermum <input type="checkbox"/> other _____	
3. Is the patient immunocompromised due to hematopoietic stem cell transplant (HSCT), ..... <input type="checkbox"/> Yes <input type="checkbox"/> No graft-vs-host disease (GVHD), hematologic malignancy or high risk solid organ transplant?	
4. Is the requested agent to be used for prophylaxis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Please list all medications the patient has <b>previously tried and failed for treatment of this diagnosis</b> . (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.) _____ _____	
6. Please list all reasons for selecting the requested <b>medication</b> over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.) _____ _____	

**Please fax or mail this form to:**  
Prime Therapeutics LLC  
Clinical Review Department  
1020 Discovery Road, No. 100  
Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130 Phone: 888.271.3183**

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