Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Posaconazole - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 documentation attached showing use for prophylaxis of invasive Aspergillus and Candida infections in severely immunocompromised patients (hematopoietic stem cell transplant (HSCT) recipients with graft-versus host-disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy)? If YES, go to 7. If NO, go to 2.

☐ Yes ☐ No

Q2. Is the request for posaconazole delayed release tablet? If YES, go to 4. If NO, go to 3.

☐ Yes ☐ No

Q3. Is the request for posaconazole suspension? If YES, go to 5.

☐ Yes ☐ No

Q4. Is documentation attached showing use for the treatment of invasive aspergillus? If YES, go to 8.

☐ Yes ☐ No

Q5. Is the medication being used for treatment of oropharyngeal candidiasis (OC)? If YES, go to 6.

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Member Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. For OC, is documentation attached showing inadequate response, intolerance, or contraindication to itraconazole or fluconazole? If YES, go to 8.

☐ Yes ☐ No

Q7. Is the patient 2 years of age or older? If YES, go to 9.

☐ Yes ☐ No

Q8. Is the patient 13 years of age or older? If YES, go to 9.

☐ Yes ☐ No

Q9. Does the patient have a known hypersensitivity to posaconazole or other azole antifungal agents?

☐ Yes ☐ No

Q10. Will posaconazole be used with sirolimus, CYP3A4 substrates (pimozide, quinidine), HMG-CoA reductase inhibitors primarily metabolized through cyp3a4 (e.g., atorvastatin, lovastatin, and simvastatin), ergot alkaloids (ergotamine and dihydroergotamine), or venetoclax?

☐ Yes ☐ No

Q11. Requested Duration:

☐ 12 Months ☐ Other:

Q12. Additional Information:

Prescriber Signature Date

v2026