USAble Administrators

Physician's Prior Authorization Questionnaire
VFend®

Patient: **ID#:** **DOB:**

Patient Address:

VFend® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? ______________________________

2. Has a WBC differential count been obtained? ☐ Yes ☐ No

   If Yes, what is the patient's neutrophil percentage?________________%

3. If female, is the patient pregnant? ☐ Yes ☐ No

4. What dose is requested (mg/day)? ______________________________

5. What is the expected duration of therapy? ______________________________

6. Have specimens been obtained for fungal culture? ☐ Yes ☐ No

   If Yes, have you received culture results? ☐ Yes ☐ No

   If Yes, please list results: ______________________________

   ____

______________________________ ______________________________

Physician's Signature Date

______________________________ ______________ / ______________

Please **Print** Physician's Name & Specialty Phone Number Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx