

**Physician's Prior Authorization
Questionnaire for Noxafil®**

PATIENT'S NAME: _____ **ID#:** _____ **DOB:** _____
Patient Address: _____

Noxafil® is covered under certain clinical conditions. Please furnish the information below to assist us in making a determination of this patient's eligibility for coverage for treatment with this drug. Failure to answer all questions may result in a denial.

1. What is the age of the patient? _____
2. Is the patient able to eat a whole meal or tolerate an oral nutrition supplement?
YES____ NO____
3. Is this medication being prescribed as prophylaxis? YES____ NO____
If YES, is the patient neutropenic? YES____ NO____
If YES, why is the patient neutropenic? _____

4. Is this medication being prescribed to treat an existing infection? YES____ NO____
If YES, what is the infection? _____
If YES, what other medications have been tried and failed? _____

5. Are other medications being used in combination with Noxafil®? YES____ NO____
If yes, list the medications. _____

6. What is the exact dose and dosing regimen for the prescribed medication? _____

***Please provide all the information asked for above and below.
There is a maximum limit of 20mL per day.***

_____ Physician's Signature	_____ Date
_____ Please Print Name	_____ Fax Number
_____ Please Print Physician's Specialty	_____ Phone Number

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

Sincerely,
Pharmacy Programs

7/3/2007

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>