

Member's Last Name:

2. θ Yes

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Voriconazole Injection

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

 You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231

θ No Will voriconazole be used intravenously?

- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's First Name:

SCAN ID number:	Date of Birth:	
Prescriber's Name:	Contact Person:	
Office phone:	Office Fax:	
Office priorie.	Office Fax.	
Medication:	Diagnosis:	
What is the diagnosis or indica θ Invasive aspergillosis	ation?	
 θ Invasive aspergillosis θ Candidemia 		
θ Candidiasis of the esophagus θ Invasive candidiasis of the skin and infections in abdomen, kidney, bladder wall, and wounds		

Please document the symptoms and/or any other information important to this review:		
SECTION B Physician Signature		
	<u> </u>	
PHYSICIAN SIGNATURE	DATE	

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at http://www.villagehealthca.com