Prescriber Criteria Form

Cresemba PO 2026 PA Fax 4605-A v1 010126.docx
Cresemba oral (isavuconazonium sulfate)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cresemba oral (isavuconazonium sulfate).

Drug Name:
Cresemba oral (isavuconazonium sulfate)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being used orally? [If no, then no further questions.]	Yes	No
2	Is the patient 6 years of age or older? [If no, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for the treatment of invasive aspergillosis? [If no, then skip to question 5.]	Yes	No
4	Has the patient experienced inadequate treatment response, intolerance, or does the patient have a contraindication to voriconazole? [No further questions.]	Yes	No
5	Is the requested drug being prescribed for the treatment of invasive mucormycosis? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of both: A) fluconazole-refractory esophageal candidiasis, B) human immunodeficiency virus (HIV)? [If no, then skip to question 8.]	Yes	No
7	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to voriconazole? [No further questions.]	Yes	No

8	Is the requested drug being prescribed for the treatment of fungal peritoneal dialysis-associated peritonitis?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____