

Prescriber Criteria Form

Vfend 2026 PA Fax 2877-A v1 010126.docx

Vfend, Vfend IV (voriconazole)

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 Vfend.

Drug Name (select from list of drugs shown):

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 prescribed for a Food and Drug Administration (FDA) approved indication? [If no, then no further questions.]	Yes	No
2	Will the patient be using the requested drug orally or intravenously?	Yes	No

Comments:	_____
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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:** _____