Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Voriconazole (Vfend) – Medical Necessity Request

Diagnosis Information (please indicate the diagnosis and answer the related questions):

1. What is the member's diagnosis? _____
2. Is the member neutropenic? **Yes or No**
3. Is the medication being used for prevention (prophylaxis) or treatment?

   □ Prevention (Prophylaxis) □ Treatment

4. What organism does the member have? _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**