

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
CANCIDAS (caspofungin acetate)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext.and options _____ Fax# _____
Pharmacy _____ Pharmacy phone# _____
Diagnosis _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA FOR:

- ▶ Age 18 and older
- ▶ **Diagnosis of Invasive Aspergillosis Infection**
- ▶ Failure on Amphotericin B ***OR***
- ▶ Have documented lab culture showing aspergillosis is not sensitive to amphotericin B or itraconazole

CRITERIA FOR:

- ▶ **Diagnosis of Esophageal Candidiasis, intra-abdominal abscess, peritonitis or pleural space infections**
- ▶ Age 18 and older
- ▶ Cultures identifying Candida.

ALSO APPROVED FOR:

- ▶ Prophylaxis for severely immuno-compromised bone marrow transplant patients with severe graft vs. host disease.
- ▶ Child with cancer or bone marrow transplant post-hospital

AUTHORIZATION:

- ▶ 3 months for Invasive Aspergillosis, Esophageal Candidiasis, intra-abdominal abscess, peritonitis, or pleural space effusions.
- ▶ Child with cancer or bone marrow transplant post-hospital receives as needed.
- ▶ Adult with bone marrow transplant, post-hospital receives as needed.

RE-AUTHORIZATION:

3 months with current lab culture and continuing symptoms for Invasive Aspergillosis, Esophageal Candidiasis, intra-abdominal abscess, peritonitis, or pleural space effusions.