



### Prior Authorization Form Anti-Infective Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one)  Zmax®  Zyvox®  Noxafil®  Oracea®  
Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. PROVIDER SPECIALTY (specify all) \_\_\_\_\_

2. DIAGNOSIS FOR DRUG REQUESTED (request will not be processed without diagnosis)

- Vancomycin-resistant Enterococcus faecium (VRE) infection
- Methicillin-resistant Staphylococcus aureus (MRSA) infection
- Prophylaxis of invasive Aspergillus and Candida infections
- Treatment of invasive Aspergillus and Candida infections
- Oropharyngeal candidiasis  Rosacea
- Other (specify) \_\_\_\_\_

3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. PATIENT HISTORY:

a. Is the patient severely immunocompromised? (Noxafil Only)  Yes  No

(Please state the underlying diagnosis) \_\_\_\_\_

b. Did the patient obtain an ID consultation? (Zyvox Only)  Yes  No

ID specialist's name \_\_\_\_\_ Date of the consultation \_\_\_\_\_  
(must be within the last 60 days)

Please add any other supporting medical information that may be useful in the decision-making process:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

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