



Prior Authorization Form
Anti-Infective Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Zmax [] Zyvox [] Noxafil [] Oracea [] Nutridox [] Avidoxy [] Avidoxy DK

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."

Table with 3 columns: 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.

Internal use only
Document #
M F Rx coverage Y N
Previous Auth Y N
Coverage effective date / /
Processor Initials Date
STANDARD - SELECT LOB
Approved Reviewer Initials Date