FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Non-Oral Antibiotics Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.
Quantity per DAY requested? _________

Provide the diagnosis: _______________________________________ ICD-10 Code(s): ______________________________

End-Stage Renal Disease:

For Cubicin or daptomycin, answer the following:

Does the patient have end-stage renal disease (ESRD)? ❑ **Yes** ❑ **No**

Is the patient on dialysis? ❑ **Yes** ❑ **No**

Is the requested medication being used for an FDA-approved or medically–accepted diagnosis related to dialysis? ❑ **Yes** ❑ **No**

Was the prescription written by any of the following: dentist, chiropractor, gynecologist, ophthalmologist, podiatrist, hospital emergency room prescriber? ❑ **Yes** ❑ **No**

Medication History:

For Cubicin, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Generic daptomycin injection
- ❑ Other drugs in the same class. Please specify: ____
- ❑ Other therapeutic equivalent alternatives. Please specify: ____

For Zerbaxa, list the medication(s) (in the **same class**) the patient has a history of trial and failure, or intolerance to: _________________

____

List the medication(s) (that are **therapeutic equivalent alternatives**) the patient has a history of trial and failure, or intolerance to: ______

____

For Zyvox, select if the patient has had a history of trial and failure, or intolerance to the following:

- ❑ Generic linezolid
- ❑ Other drugs in the same class. Please specify: ____
- ❑ Other therapeutic equivalent alternatives. Please specify: ____

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Clinical Information:

Is there documentation the patient has a current bacterial infection? ❑ **Yes** ❑ **No**

Is there documentation the patient has had an inadequate response or inability to tolerate at least TWO drugs to which the organism is susceptible? ❑ **Yes** ❑ **No**

Is the requested medication the only antibiotic to which the organism is susceptible? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by an infectious disease (ID) specialist? ❑ **Yes** ❑ **No**

Is the requested medication prescribed with ID consultation (telephone consultation is acceptable) including name of the ID specialist and date of the consultation within the last 60 days? ❑ **Yes** ❑ **No**

If **yes**, please specify the name of the ID specialist and the date of consultation:____

____

Reauthorization:
If this is a reauthorization request, answer the following:

Is the requested medication prescribed by an infectious disease (ID) specialist? ❑ **Yes** ❑ **No**

Is the requested medication prescribed with ID consultation (telephone consultation is acceptable) including name of the ID specialist and date of the consultation within the last 60 days? ❑ **Yes** ❑ **No**

If **yes**, please specify the name of the ID specialist and the date of consultation:____

____

Is there documentation that an infectious disease consult determined that a longer duration of therapy is required? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

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Please note: This request may be denied unless all required information is received.

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