



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

Sivextro® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Acute bacterial skin and skin structure infections (ABSSSI) caused by susceptible isolates of Gram-positive microorganisms <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Clinical information: Has the patient had an inadequate response to or inability to tolerate ALL antibiotics to which the organism is susceptible? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Sivextro the only antibiotic to which the organism is susceptible? <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescriber specialty: Was Sivextro prescribed by an infectious diseases specialist or upon consultation with an infectious disease specialist (telephone consultation is acceptable)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity Limit Requests: What is the quantity requested per DAY? _____ Is there documentation of the inability to reach the requested dose with higher strengths of commercially available dosage forms due to patient specific characteristics (i.e. inability to swallow larger pills, malabsorption, presence of a feeding tube, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested dose commercially available? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there documentation the dose requested is medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> 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?

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

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