FUTURE SCRIPTS

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

Xofluza™ 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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acute uncomplicated influenza in patients who have been symptomatic for no more than 48 hours

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

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.)? ❑ **Yes** ❑ **No**

Is the requested dose commercially available? ❑ **Yes** ❑ **No**

Is there documentation the dose requested is medically necessary? ❑ **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?

_____

_____

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