



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

Xofluza™ Prior Authorization Request Form

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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:		
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 uncomplicated influenza in patients who have been symptomatic for no more than 48 hours	
<input type="checkbox"/> 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.)? <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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