

FLUOROQUINOLONES, ORAL PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Oral Fluoroquinolones, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Fluoroquinolones, Oral** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	# of pages in request: _____	Prescriber name:		
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Non-preferred medication requested:			
<input type="checkbox"/> Avelox tablet	<input type="checkbox"/> ciprofloxacin ER tablet	<input type="checkbox"/> Levaquin tablet	<input type="checkbox"/> levofloxacin oral solution
<input type="checkbox"/> Cipro tablet	<input type="checkbox"/> Factive tablet	<input type="checkbox"/> Levaquin oral solution	<input type="checkbox"/> moxifloxacin tablet
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (<i>required</i>):	
1. Has the Recipient tried and failed any of the preferred Oral Fluoroquinolones? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure</u>	
<input type="checkbox"/> Cipro 5% or 10% oral suspension	<input type="checkbox"/> ciprofloxacin tablet	<input type="checkbox"/> No	
<input type="checkbox"/> ciprofloxacin 5% or 10% oral suspension	<input type="checkbox"/> levofloxacin tablet		
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances and contraindications</u>	
		<input type="checkbox"/> No	
3. Does the Recipient have results of culture and sensitivity testing that indicates only the non-preferred Oral Fluoroquinolones will be effective?		<input type="checkbox"/> Yes – <u>submit results of culture and sensitivity testing</u>	
		<input type="checkbox"/> No	
4. Has the Recipient tried any alternative antibiotics (except those listed in question 1)? <u>List all other antibiotics tried. Submit documentation of each antibiotic drug regimen and treatment outcomes.</u>			
<input type="checkbox"/> Name/strength: _____ Directions: _____ Duration: _____			
<input type="checkbox"/> Name/strength: _____ Directions: _____ Duration: _____			
<input type="checkbox"/> Name/strength: _____ Directions: _____ Duration: _____			
5. Does the Recipient have a history of contraindication or intolerance to alternative antibiotics that are appropriate for the treatment of the infection based on culture and sensitivity testing?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances and contraindications</u>	
		<input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION.

Prescriber Signature:	Date:
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