



Prior Authorization Form
Anti-Infective Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Zmax® [] Zyvox® [] Noxafil® [] Oracea®
Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. PROVIDER SPECIALTY (specify all) _____
2. DIAGNOSIS FOR DRUG REQUESTED (request will not be processed without diagnosis)
[] Vancomycin-resistant Enterococcus faecium (VRE) infection
[] Methicillin-resistant Staphylococcus aureus (MRSA) infection
[] Prophylaxis of invasive Aspergillus and Candida infections
[] Treatment of invasive Aspergillus and Candida infections
[] Oropharyngeal candidiasis [] Rosacea
[] Other (specify) _____
3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)
[] N/A If none or not applicable to diagnosis, indicate "N/A."
Drug Name Date Duration

4. PATIENT HISTORY:
a. Is the patient severely immunocompromised? (Noxafil Only) [] Yes [] No
(Please state the underlying diagnosis) _____
b. Did the patient obtain an ID consultation? (Zyvox Only) [] Yes [] No
ID specialist's name _____ Date of the consultation _____
(must be within the last 60 days)

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only Coverage effective date / /
Document # _____ Processor Initials _____ Date _____
M F Rx coverage Y N STANDARD - SELECT LOB _____
Previous Auth Y N Approved Reviewer Initials _____ Date _____