Third Generation Cephalosporins and Fluoroquinolone Prior Authorization Request Form

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Member 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: ☐ Check if requesting brand ☐ Check if request is for continuation of therapy	Strength:	Dosage Form:
	Directions for Use:	

Exception Criteria

☐ Prescribed by an infectious disease specialist or an emergency department provider.

☐ Ceftriaxone prescribed as first line treatment for gonorrhea, pelvic inflammatory disease, epididymo-orchitis and an alternative to benzylpenicillin to treat meningitis for those with a severe penicillin allergy

The recipient resides in one of the following:

- ☐ Acute Care
- ☐ Long-term Acute Care (LTAC)
- ☐ Skilled Nursing Facility (SNF)

Clinical Information (required)

Diagnosis: **ICD-10 Code:**

Clinical Information:

Does a culture and sensitivity (C&S) suggests susceptibility to the requested agent? ☐ **Yes** ☐ **No**

If Yes to the above, list the date the C&S was performed: _____

Is resistance to first-line agents shown? ☐ **Yes** ☐ **No**

If Yes to the above, list agents: _____

Was treatment started with intravenous antibiotic(s) in the hospital and the recipient requires continued outpatient therapy? ☐ **Yes** ☐ **No**

Does the member have any contraindications to alternative antibiotics?

☐ **No** ☐ **Yes** - Describe (eg. allergy, drug interaction):

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the prescriber feels is important to this review?