Independence Blue Cross

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_____

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