



**Independence
Blue Cross**

**Prior Authorization Form
Anti-Infective Agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* Zmax® Zyvox® Noxafil® Oracea® Nutridox®
 Avidoxy®

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)

c. Does the patient have a clinical need for an eye compress system? (**Nutridox only**) | Yes No

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 / /
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