pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Avelox tablet ☐ciprofloxacin ER tablet ☐levofloxacin oral solution ☐ofloxacin tablet
☐Baxdela tablet ☐Levaquin tablet ☐moxifloxacin tablet ☐_____
☐Cipro tablet

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Has the Beneficiary tried and failed any of the preferred Oral Fluoroquinolones? *Check all that apply.*
   ☐Cipro 5% or 10% oral suspension ☐ciprofloxacin tablet
   ☐ciprofloxacin 5% or 10% oral suspension ☐levofloxacin tablet

   ☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure.*
   ☐No

2. Does the Beneficiary have any contraindications or intolerances to any of the preferred agents listed in question (1)?

   ☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances and contraindications.*
   ☐No

3. Does the Beneficiary have results of culture and sensitivity testing that indicates only the non-preferred Oral Fluoroquinolones will be effective?

   ☐Yes – *Submit results of culture and sensitivity testing.*
   ☐No

4. Has the Beneficiary tried any alternative antibiotics (except those listed in question 1)? ***List all other antibiotics tried. Submit documentation of each antibiotic drug regimen and treatment outcomes.***

   ☐Name/strength: _____ Directions: _____ Duration: _____
   ☐Name/strength: _____ Directions: _____ Duration: _____
   ☐Name/strength: _____ Directions: _____ Duration: _____

5. Does the Beneficiary 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?

   ☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances and contraindications.*
   ☐No

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

Prescriber Signature:	**Date**: