AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Baxdela® (delafloxacin) **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

Quantity Limit: 28 tablets per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Acute bacterial skin and skin structure infections (ABSSSI)**

Recommended Dosage: Oral: 450 mg every 12 hours for 5 to 14 days

Length of Authorization: Date of Service (14 days)

❑ **New Start**

- ❑ Member is 18 years of age or older

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- ❑ Must be prescribed or consulted with by an Infectious Disease Specialist
- ❑ Member has a diagnosis of acute bacterial skin and skin structure infection (ABSSSI)
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Baxdela
- ❑ If member is receiving IV antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
- ❑ If member is receiving oral antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: penicillin VK, amoxicillin, amoxicillin-clavulanate, dicloxacillin, cephalexin, clindamycin, doxycycline, trimethoprim-sulfamethoxazole, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: penicillin VK, amoxicillin, amoxicillin-clavulanate, dicloxacillin, cephalexin, clindamycin, doxycycline, trimethoprim-sulfamethoxazole, and linezolid

❑ **Diagnosis: Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms**
Recommended Dosage: Oral: 450 mg every 12 hours
Length of Authorization: Date of Service (14 days)
❑ **New Start**

- ❑ Member is 18 years of age or older
- ❑ Must be prescribed or consulted with by an Infectious Disease Specialist
- ❑ Member has a diagnosis of Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Baxdela

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- ❑ If member is receiving IV antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
- ❑ If member is receiving oral antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: amoxicillin, amoxicillin-clavulanate, dicloxacillin, doxycycline, azithromycin, cefdinir, cefpodoxime, levofloxacin, linezolid and moxifloxacin
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: amoxicillin, amoxicillin-clavulanate, dicloxacillin, doxycycline, azithromycin, cefdinir, cefpodoxime, levofloxacin, linezolid and moxifloxacin

❑ **Diagnosis: Acute Bacterial Skin and Skin Structure Infections (ABSSSI) or Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms**
Length of Authorization: Date of Service
❑ **Continuation of therapy following inpatient administration**

- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Acute Bacterial Skin and Skin Structure Infections (ABSSSI)
  - ❑ Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms
- ❑ Member is currently on Baxdela for more than 72 hours inpatient **(progress notes must be submitted)**
- ❑ Must be prescribed or consulted with by an Infectious Disease Specialist
- ❑ Provider has submitted lab culture sensitivity results retrieved during inpatient admission which shows resistance to **ALL** preferred antibiotics except for Baxdela (sensitive) or documentation of severe allergic reactions preventing the administration and use of an alternative agent(s)

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 9/24/2026
REVISED/UPDATED/REFORMATTED: 10/15/2026