SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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.**

Quinolones – Oral

Drug Requested (check applicable drug below):

PREFERRED (does not require Prior Authorization)		
❑ **ciprofloxacin susp/tab**	❑ **levofloxacin tab**	
Non-Preferred		
❑ Baxdela® IV	❑ Cipro® IR & XR & susp	❑ ciprofloxacin ER
❑ Noroxin®	❑ ofloxacin	❑ Levaquin® tab/susp
❑ levofloxacin susp	❑ moxifloxacin	

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

Length of Authorization: ONE TIME ONLY; no refills

(Continued on next page)

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.

- ❑ Infection caused by an organism resistant to ciprofloxacin and levofloxacin

OR

- ❑ Therapeutic failure to no less than a **three-day trial of ONE (1) Preferred quinolone**

OR

- ❑ Member is completing a course of therapy with a non-preferred drug which was initiated in the hospital

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.

REVISED/UPDATED/REFORMATTED: ~~6/29/2017; 8/31/2017; 8/29/2018; 3/13/2019; (Rev) 6/15/2019;~~ **11/09/2023**