ANTIBIOTIC.16 Form # 30820 R: 07:24

State of Maine Department of Health & Human Services MaineCare/MEDEL Prior Authorization Form ANTIBACTERIAL ANTIBIOTICS

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

	Member ID #: _		Patient Name:		DOB:	
Provider Name: Provider Address: Fax: Pharmacy Name: Rx Address: Rx phone: Provider Maddress: Rx phone: Rx Address: Rx phone: Provider must fill all information above. It must be legible, correct and complete or form will be returned. Provider must fill all information above. It must be legible, correct and complete or form will be returned. NABP:						
Provider Address: Rx Address: Rx phone: Provider must fill all information above. It must be legible, correct and complete or form will be returned. Pharmacy use only): NPI: NPI: NABP: NABP: NDC: Circle Refills Vibativ*	Provider DEA: _ _	_ _ _	Provider NPI: _			
Pharmacy Name:	Provider Name:				Phone:	
Pharmacy use only): NPI: NABP: NABP: NDC: NDC: NBC: N	Provider Address:				Fax:	
Pharmacy use only): NPI: NABP: NABP: NDC: Drug Name Strength Dosage Instructions Quantity Days Supply Circle Refills	Pharmacy Name:		Rx Address:		Rx phone:	
Vibativ®	Provider m	ust fill all inforn	nation above. It must be le	gible, correct and complete or fo	rm will be returned.	
Vibativ* 1 Dalvance* 1 Other 1	Pharmacy use only):	NPI: _	_ NABP:	_ _ NDC: _		
AND Patient meets ONE of the following diagnostic criteria (please attach micro report): Vancomycin-resistant Enterococcus (VRE) Methicillin-resistant Staph. aureus (MRSA) Methicillin-resistant Staph. epidermidis (MRSE) Dalvance only- any susceptible gram positive bacteria (## in specified circumstances only-see below AND meets ONE of the following criteria (please attach relevant documentation): Patient intolerant to vancomycin, no alternative regimens (po or IV) with documented efficacy available* VRE in a part of body other than lower urinary tract** After attempting IV access the insertion of central or peripheral catheters is not possible (oral linezol an option) Patient discharged on (drug name) and requires additional quantity. (Up to 7 days available DALVANCE ONLY ## Unable to safely complete daily outpatient parenteral antimicrobial therapy reasons beyond convenience (home and daily at infusion center must both be considered first) (e.g. homeless, injection drug use) and must have transportation arranged to infusion center *Severe intolerance to vancomycin defined as: -severe rash, immune-complex mediated, determined to be directly related to vancomycin administra -Red-man's syndrome (histamine-mediated), refractory to traditional countermeasures (e.g., prolong IV infusion, premedication with diphenhydramine) **VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe ren insufficiency exists and/or patient is receiving hemodialysis or known hypersensitivity to nitrofurantoin exists Other: Other: Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of gare, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessar.	☐ Vibativ® ☐ Dalvance® ☐ Other Medical Necessity	Documentati		(34 retail / 90 mail order)	1 1 1	
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Provider Signature.	meets the MaineCare criter		zation, does not exceed the medic	al needs of the member and is supported		

*MUST MATCH PROVIDER LISTED ABOVE