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 #: |__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____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: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Circle Refills
❑ Vibativ®	_____	_____	_____	_____	1
❑ Dalvance®	_____	_____	_____	_____	1
❑ Other	_____	_____	_____	_____	1

Medical Necessity Documentation

❑ Prescriber is either an infectious disease provider or has consulted with one (_____)
ID consultant's name

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 linezolid is 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 for 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 administration
-Red-man's syndrome (histamine-mediated), refractory to traditional countermeasures (e.g., prolonged IV infusion, premedication with diphenhydramine)

**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or known hypersensitivity to nitrofurantoin exists

Other: _____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**