Third Generation Cephalosporins and Fluoroquinolone Prior Authorization Request Form

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI #:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name: □ Check if requesting brand □ Check if request is for continuation of therapy	Strength:	Dosage Form: Directions for Use:

Exception Criteria

□ Prescribed by an infectious disease specialist or an emergency department provider.

□ Ceftriaxone prescribed as first line treatment for gonorrhea, pelvic inflammatory disease, epididymo-orchitis and an alternative to benzylpenicillin to treat meningitis for those with a severe penicillin allergy

The recipient resides in one of the following:

- □ Acute Care
- □ Long-term Acute Care (LTAC)
- □ Skilled Nursing Facility (SNF)

Clinical Information (required)

Diagnosis: **ICD-10 Code:**

Clinical Information:

Does a culture and sensitivity (C&S) suggests susceptibility to the requested agent? □ **Yes** □ **No**

If Yes to the above, list the date the C&S was performed:

Is resistance to first-line agents shown? □ **Yes** □ **No**

If Yes to the above, list agents:

Was treatment started with intravenous antibiotic(s) in the hospital and the recipient requires continued outpatient therapy? □ **Yes** □ **No**

Does the member have any contraindications to alternative antibiotics?

□ **No** □ **Yes** - Describe (eg. allergy, drug interaction):

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the prescriber feels is important to this review?