

State of Idaho, Division of Medicaid
CEPHALOSPORINS (ORAL) AND RELATED ANTIBIOTICS
PRIOR AUTHORIZATION FORM

CONFIDENTIAL INFORMATION

Phone: 1-208-364-1829 *One drug per form ONLY – Use black or blue ink* **Fax: 1-208-364-1864**

Patient Name: _____	Medicaid ID#: _____	D.O.B.: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#: _____	Phone: _____	Fax: _____

Preferred agents will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.

Non-preferred agents will be approved for payment only after documented failure of 1 preferred agent.

Medication Requested:

Preferred Agents (NO PA REQUIRED):

- amoxicillin/clavulanic acid (tablets and suspension)
- Augmentin XR[®]
- Cedax[®]
- cefaclor
- cefadroxil
- cefpodoxime
- cefuroxime
- Cefzil[®]
- cefprozil
- cephalixin
- Omnicef[®]
- Spectracef[®]
- Suprax[®]

Non-Preferred Agents:

<u>Drug</u>	<u>Strength</u>	<u>Dosing Instructions</u>
<input type="checkbox"/> Panixine [®]	_____	_____
<input type="checkbox"/> Raniclor [®]	_____	_____
<input type="checkbox"/> Lorabid [®]	_____	_____

History of preferred agent:

<u>Drug</u>	<u>Dates of Trial</u>	<u>Reason(s) for Failure</u>
_____	_____	_____

Other pertinent information for review:

To ensure continuity of care, please make sure corresponding ICD-9 codes are submitted on professional office claims to Idaho Medicaid on a routine basis.

Prescriber Signature: _____ **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only

Date: _____	RPh: _____	Tech: _____	PA#: _____
Approved _____	Denied _____	Comments: _____	

All current PA forms and criteria for use are available at: www.medicaidpharmacy.idaho.gov (PA Criteria & Forms)