

**State of Idaho, Division of Medicaid
MACROLIDES/KETOLIDES (Oral Agents)
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#: _____	Date of Birth: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#: _____	Phone: _____	Fax: _____

Azithromycin, Biaxin[®] XL, clarithromycin, erythromycin, Zithromax[®] powder/suspension, and Zmax[™] are preferred agents and will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.

Ketek[®] is a non-preferred agent and will only be authorized if there is documentation of another antibiotic within the past 28 days.

Brand name drugs (i.e. Biaxin[®] or Zithromax[®]) will be considered for payment by submission of FDA MedWatch form and documentation of failure of two different manufacturers' generic equivalent formulations of that brand name drug.

Preferred Agents:

<u>Drug</u>	<u>Strength</u>	<u>Dosing Instructions</u>
<input type="checkbox"/> azithromycin	_____	_____
<input type="checkbox"/> Biaxin [®] XL	_____	_____
<input type="checkbox"/> clarithromycin	_____	_____
<input type="checkbox"/> erythromycin	_____	_____
<input type="checkbox"/> Zithromax [®] suspension	_____	_____
<input type="checkbox"/> Zmax [™]	_____	_____

Non-preferred Agent:

<input type="checkbox"/> Ketek [®]	_____	_____
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History of other antibiotics used within past 28 days:

<u>Drug</u>	<u>Date of trial</u>	<u>Reason for failure</u>
_____	_____	_____
_____	_____	_____

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:	