

**State of Idaho, Division of Medicaid  
Prior Authorization Form**

**\* FOR THE EAR \***

**OTIC FLUOROQUINOLONES**

**\* FOR THE EAR \***

**\* 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 #: _____	Pharmacy Phone: _____	Pharmacy Fax: _____

*Floxin<sup>®</sup> otic, and Ciprodex<sup>®</sup> otic are preferred agents and will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.*

*Cipro<sup>®</sup> HC otic is non-preferred and will only be authorized if there is documented failure of 1 preferred agent in the past 180 days.*

**Medication Requested:**

<b>Floxin<sup>®</sup> otic</b>	<b>NO PA REQUIRED</b>
<b>Ciprodex<sup>®</sup> otic</b>	<b>NO PA REQUIRED</b>

<u>Drug</u>	<u>Strength</u>	<u>Instructions</u>
<input type="checkbox"/> Cipro <sup>®</sup> HC otic	_____	_____

**History of Preferred Agent:**

<u>Drug Name</u>	<u>Date(s) 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 diagnosis codes are submitted on professional office claims to 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: <http://www.medicaidpharmacy.idaho.gov> (PA Criteria & Forms)