PRIOR AUTHORIZATION REQUEST

ORLYNVAH

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
2	Is the patient female? [Note: Please indicate assigned sex at birth.] [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication?		

If you have any questions, call: 1-888-258-8250

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	[] Uncomplicated urinary tract infection caused by Escherichia coli, Klebsiella pneumoniae, or Proteus mirabilis (If checked, go to 4) [] Other (If checked, no further questions)		
4	Has a urine culture been obtained within the last 30 days to confirm the infection has been caused by ONE of the following: A) Escherichia coli, B) Klebsiella pneumoniae, C) Proteus mirabilia? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
5	Has documentation been provided confirming at least TWO of the following symptoms of uncomplicated UTI: A) Increased urinary frequency, B) Urinary urgency, C) Pain or burning during urination, D) Suprapubic pain? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has a urine culture been obtained within the last 30 days with a sensitivity report confirming lack of antibiotic resistance? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Has documentation been provided to show that the patient has experienced treatment failure with at least THREE of the following preferred alternatives: A) Nitrofurantoin, B) Trimethoprim-Sulfamethoxazole, C) Amoxicillin-Clavulanate, D) Cefpodoxime, E) Levofloxacin? ACTION REQUIRED: Submit supporting documentation. [Note: Treatment failure is defined as completing full course of therapy and continuing to have presence of bacterial infection confirmed via urine screening/culture.] [If no, no further questions.]	Yes	No
8	Does the provider attest that the requested medication is not being used for or as step-down treatment following IV antibacterial treatment for complicated UTI? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Does the provider attest that the requested medication is not being used for or as step-down treatment following IV antibacterial treatment for complicated intra-abdominal infections (cIAI)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been provided to show that the patient has adequate renal function (e.g., creatinine clearance [CrCl] greater than 15 mL/min)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient have ANY of the following: A) Known blood dyscrasias, B) Uric acid kidney stones, C) Concomitant use of ketorolac tromethamine? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Is the requested medication being prescribed by or in consultation with an infectious disease specialist? [If no, no further questions.]	Yes	No

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13	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication of uncomplicated urinary tract infections? [Note: Dosing is 1 tablet twice daily for 5 days.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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