



**BlueCross
BlueShield**

**Federal Employee Program. BAXDELA
PRIOR APPROVAL REQUEST**

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: **1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R <input type="text"/>			Physician Signature:		
PHYSICIAN COMPLETES						

Baxdela (delafloxacin)

*Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

☐ Acute Bacterial Skin and Skin Structure Infections (ABSSSI)

a. What is the name of the organism causing, or strongly suspected to be causing, the infection? *Please select organism below:*

- | | | |
|--|---|--|
| <input type="checkbox"/> <i>Enterobacter cloacae</i> | <input type="checkbox"/> <i>Pseudomonas aeruginosa</i> | <input type="checkbox"/> <i>Staphylococcus lugdunensis</i> |
| <input type="checkbox"/> <i>Enterococcus faecalis</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> (methicillin-resistant) | <input type="checkbox"/> <i>Streptococcus agalactiae</i> |
| <input type="checkbox"/> <i>Escherichia coli</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> (methicillin-susceptible) | <input type="checkbox"/> <i>Streptococcus anginosus</i> (entire group) |
| <input type="checkbox"/> <i>Klebsiella pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus haemolyticus</i> | <input type="checkbox"/> <i>Streptococcus pyogenes</i> |
| <input type="checkbox"/> Other organism (<i>please specify</i>): _____ | | |

☐ Community-Acquired Bacterial Pneumonia (CABP)

a. What is the name of the organism causing, or strongly suspected to be causing, the infection? *Please select organism below:*

- | | | |
|--|--|---|
| <input type="checkbox"/> <i>Chlamydia pneumoniae</i> | <input type="checkbox"/> <i>Klebsiella pneumoniae</i> | <input type="checkbox"/> <i>Staphylococcus aureus</i> (methicillin susceptible isolates only) |
| <input type="checkbox"/> <i>Escherichia coli</i> | <input type="checkbox"/> <i>Legionella pneumophila</i> | <input type="checkbox"/> <i>Streptococcus pneumoniae</i> |
| <input type="checkbox"/> <i>Haemophilus influenza</i> | <input type="checkbox"/> <i>Mycoplasma pneumoniae</i> | |
| <input type="checkbox"/> <i>Haemophilus parainfluenzae</i> | <input type="checkbox"/> <i>Pseudomonas aeruginosa</i> | |
| <input type="checkbox"/> Other organism (<i>please specify</i>): _____ | | |

☐ Other diagnosis (*please specify*): _____

2. Has the patient had inadequate treatment response, intolerance, or contraindication to a first-line antibiotic such as macrolide, fluoroquinolone, beta-lactam, or tetracycline? ☐ Yes ☐ No



**BlueCross
BlueShield**

Federal Employee Program.

BAXDELA

PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: **1-877-378-4727**

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug Prior Authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA .
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 . Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

**faster...
easier...
better...**

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark 