



Federal Employee Program.

ORLYNVAH
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 cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Form with sections: Patient Information (required), Provider Information (required), and PHYSICIAN COMPLETES. Includes fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, NPI, Office Phone, Office Fax, Office Street Address, City, State, Zip, and Physician Signature.

Orlynvah

(unopened estuarial and probenecid)

**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. Will the patient need more than 10 tablets for 30 days? [] Yes* [] No

*If YES, please specify the requested quantity: _____ tablets for 30 days

2. Is this medication being used to treat an uncomplicated urinary tract infection (uUTI)? [] Yes [] No

3. Is the infection caused by Escherichia coli, Klebsiella pneumoniae, or Proteus mirabilis? [] Yes [] No

4. Is the infection caused by or strongly suspected to be caused by susceptible bacteria based on culture and susceptibility, local epidemiology, or susceptibility patterns? [] Yes [] No

5. Does the patient have alternative oral antibacterial treatment options? [] Yes* [] No

*If YES, are the alternative oral antibacterial treatment options limited? [] Yes [] No