Prior Authorization Request Form for

sulopenem etzadroxil/probenecid (Orlynvah)

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

2

Please complete the clinical assessment:

1. All generic antibiotics for the treatment of Urinary Tract Infections (UTI) do not require prior authorization.	☐ **Acknowledged** Proceed to question **2**	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **Stop** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Uncomplicated urinary tract infection (such as, afebrile, infection that is limited to the bladder, and non-catheter associated infection) - Proceed to question **4** ☐ Other diagnosis – **STOP – Coverage not approved**	
4. Does the patient have a culture proven infection from the Enterobacterales family (for example, Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis)? Note: This drug does not cover Pseudomonas aeruginosa.	☐ Yes Proceed to question **5**	☐ No **Stop** **Coverage not approved**
5. Does the patient have a contraindication to or a culture proven resistance to ALL alternative oral antibacterial treatment options (such as, nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin, fluoroquinolone, or beta-lactam)?	☐ Yes **Sign and date below**	☐ No **Stop** **Coverage not approved**

3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[11 March 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: