Prior Authorization Request Form for
ozenoxacin 1% cream (**Xepi**)

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Sponsor ID # ______________________ Phone #: ______________________
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question		
1. Is the patient 2 months of age or older?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of impetigo?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient failed a trial of mupirocin 2% ointment or cream (unless contraindicated or clinically significant adverse effects have been experienced)?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to or has failed a trial of an oral antibiotic (for example cephalexin, dicloxacillin, clindamycin)?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Will the dose for Xepi exceed twice daily topical application for 5 days?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ______________
Prescriber Signature Date

[6 March 2019]

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