BlueChoice®
HealthPlan of South Carolina

Medicaid

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Ciprodex® (ciprofloxacin/dexamethasone)

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: ______________________	Prescribing Physician: ______________________
Patient ID #: ______________________	Physician Address: ______________________
Patient DOB: ______________________	Physician Phone #: ______________________
Date of Rx: ______________________	Physician Fax #: ______________________
Patient Phone #: ______________________	Physician Specialty: ______________________
Patient Email Address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician Email Address: ______________________

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Ciprodex (ciprofloxacin/dexamethasone)	☐ 0.1/0.3 %	______________________	______________________

7. DIAGNOSIS: ____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Does the patient have a diagnosis of granulation tissue around tympanostomy tubes?

☐ Yes ☐ No Does the patient have a diagnosis of chronic otomastoiditis with perforation?

☐ Yes ☐ No Has the patient previously used Ciprodex otic solution for six (6) months or more?

☐ Yes ☐ No Has the patient tried, failed, has a documented drug interaction with or had an adverse drug experience with a formulary product?

9. PHYSICIAN SIGNATURE

______________________________________ ______________________
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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