

Xepi[™] Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)				
Member Name:	Provider Name:						
Insurance ID#:			NPI#:		Specialty:		
Date of Birth:	Office Phone:						
Street Address:	Office Fax:						
City:	State:	Zip:	Office Street Address:				
Phone:			City:	State:		Zip:	
Medication Information (required)							
Medication Name:			Strength:		Dosage Form:		
Check if requesting brand			Directions for Use:				
Check if request is							
Clinical Information (required)							
Select the diagnosis below: Impetigo due to Staphylococcus aureus or Streptococcus pyogenes Other diagnosis:							
Medication history:							
Has the patient had a 10 day trial and failure of mupirocin ointment/cream within the past 6 months? D Yes D No							
Are there any other comments, diagnesses, symptome, mediactions triad or failed, and/or any other information the physician facts is important to							

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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