

REVIEW REQUEST**Rocephin® (ceftriaxone) for Lyme Disease - Medical Policy-Med-00013**Complete form in its entirety and fax to:
Empire: 888-309-9672**Anthem UM Services, Inc.**

Click on grey boxes to type

Request Date: _____ / _____ / _____

 Initial Request Subsequent Request; List Ref #: _____ Buy and Bill**1. PATIENT INFORMATION**

Member Last Name		Member First Name		Member's Empire ID Number		Member DOB / /	
Address			City		State / Zip Code /		Contact Phone Number () -
Date of Diagnosis / /	Primary Diagnosis			ICD-9 Code(s)		Member's Current Weight	

2. PHYSICIAN INFORMATION

Physician Last Name		Physician First Name		Physician DEA or NPI Number		Physician Tax ID	
Address			City		State		Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name and ext.			Physician Specialty		

3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.

Drug Name Rocephin		HCPCS or CPT Code(s) J0696		Strength / Dose	
Direction for Use (SIG)					
Date patient is scheduled to be treated (need by date) / /		Service From Date / /		Service Thru Date / /	
Place of Service <input type="checkbox"/> MD Office <input type="checkbox"/> Pt's Home <input type="checkbox"/> Other: (please specify)					

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLYNOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended.
If indicated, please provide **ALL** supporting lab results, progress notes, etc.**(1) Lyme Disease** Yes NoDoes the patient have Lyme disease? **If yes**, please check off any of the following Yes No Does the patient have myocarditis associated with second or third degree atrioventricular block, or with first-degree heart block when the PR interval is prolonged to 30 milliseconds or greater; **or?** Yes No Does the patient have persistent or recurrent joint swelling after an initial 1 month trial of oral

antibiotics or?

- Yes No Does the patient have acute or chronic neurological disease affecting the central or peripheral nervous system **(check all that apply)**?
- Meningitis
- Any neurological syndrome with cerebrospinal fluid (CSF) pleiocytosis
- Severe peripheral neurological syndromes with normal CSF or following treatment failure with oral antibiotic therapy
- Encephalomyelitis
- Encephalopathy

(2) **Other Use(s)** (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

5. PHYSICIAN SIGNATURE

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

	/ /
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Prescriber's Signature

Date

Pre-determination 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.

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