

**REVIEW REQUEST****Rocephin® (ceftriaxone) for Lyme Disease - Medical Policy-Med-00013**

Complete form in its entirety and fax to:  
 Empire: 888-309-9672



Click on grey boxes to type

Request Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Initial Authorization Request       Re-Authorization Request; List Prior Auth Ref #: \_\_\_\_\_
- Buy and Bill
- Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800-824-2642)

**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 <b>Rocephin</b>		HCPCS or CPT Code(s) <b>J0696</b>		Strength / Dose	
Direction for Use (SIG)					
Date patient is scheduled to be treated (need by date) / /		Service From Date / /		Service Thru Date / /	
Number of Refills					

Place of Service  
 MD Office    Pt's Home    Other: (please specify)

**4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

NOTE: **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    No      Does 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**

	/ /
--	-----

**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.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify Empire Utilization Management. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.