

June 17, 2014

Dear SoonerCare Prescriber,

The Oklahoma Health Care Authority is engaged in an effort to improve cost effective utilization of cephalosporin antibiotics by our members. The purpose of this letter is to provide updates regarding cephalosporin antibiotic coverage.

Beginning July 1st 2014, cefixime (Suprax®), ceftibuten (Cedax®), and cefditoren (Spectracef®) will require prior authorization. A list of the preferred cephalosporin antibiotics is attached to this letter in the form of a prescription change request. You may receive this form from pharmacies. The preferred products included on the prescription change request do not require prior authorization.

Antibiotics on the preferred list generally cost \$8 - \$15 per 10 day supply and provide similar spectrum coverage as the non-preferred products, which range in cost from \$200 to \$650 per 10 day supply.

Your discretion in appropriate use of cephalosporin antibiotics can result in a significant cost savings.

If no available products on the preferred list meet the specific needs of your patient, a prior authorization may be submitted for consideration, along with patient-specific, clinically significant, supporting information for use of the non-preferred medication.

Updated versions of prior authorization criteria for cephalosporin antibiotics can be downloaded from www.okhca.org/rx, by clicking on "Prior Authorizations," then clicking "Antibiotics."

Thank you for the services you provide to Oklahomans insured by SoonerCare!

Oral Cephalosporin Antibiotics Available without Prior Authorization

Patient's Name: _____
 SoonerCare ID: _____

Patient's DOB: _____

Please send this prescription change to the patient's pharmacy.

This patient's prescription for _____ has been changed to the following:

PRODUCT NAME	INDICATIONS ⁺	STRENGTH	DOSING REGIMEN	QUANTITY [∞]
1st Generation				
<i>(Please fill in)</i>				
Cefadroxil (Duricef®)	D, G, I	250mg/5 mL susp*		QS
		500mg/5mL susp*		Other:
		500mg caps		
		1 gram tabs		
Cephalexin (Keflex®)	D, G, I	125mg/5mL susp*		QS
		250mg/5mL susp*		Other:
		250mg caps		
		500mg caps		
2nd Generation				
Cefaclor (Ceclor®)	B, D, E, G, H, I	125mg/5mL susp*		QS
		250mg/5mL susp*		Other:
		375mg/5mL susp*		
		250mg caps		
		500mg caps		
Cefprozil (Cefzil®)	B, C, D, H, I	125mg/5mL susp*		QS
		250mg/5mL susp*		Other:
		250mg tabs		
		500mg tabs		
3rd Generation				
Cefdinir (Omnicef®)	A, B, C, D, H, I	125mg/5mL susp*		QS
		250mg/5mL susp*		Other:
		300mg caps		
Cefpodoxime (Vantin®)	A, B, C, D, F, G, H, I	50mg/5mL susp*		QS
		100mg/5mL susp*		Other:
		100mg tabs		
		200mg tabs		

*Oral powder for suspension

[∞] Prescription will be filled with the quantity sufficient (QS) based on the dosing regimen, unless indicated otherwise.

Prescriber's Signature: _____
 Date: _____
 Prescriber's Name: _____
 Prescriber's NPI: _____

***Indications:**

- A = Pneumonia
- B = Acute Exacerbation of Chronic Bronchitis
- C = Acute Maxillary Sinusitis
- D = Pharyngitis/Tonsillitis/Upper Respiratory Tract Infections
- E = Lower Respiratory Tract Infections
- F = Acute, Uncomplicated Urethral/Cervical Gonorrhea
- G = Uncomplicated Urinary Tract Infections
- H = Acute Otitis Media
- I = Skin and Skin Structure Infections

Please Send to Patient's Pharmacy:

Pharmacy Name: _____
 Pharmacy Fax: _____