

2019 linezolid (generic Zyvox®) Prior Authorization Request

Page 1 of 2

(You must complete both pages.)

Fax completed form to: 1-800-408-2386

For urgent requests, please call: 1-800-414-2386

Patient information		Prescriber information	
Patient name	Today's date	Physician specialty	
Patient insurance ID number	Physician name	NPI/DEA number	
Patient address, city, state, ZIP	Physician address, city, state, ZIP		
Patient home telephone number	M.D. office telephone number		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number	
Diagnosis and medical information			
Medication requested		Strength and route of administration	Frequency
New prescription OR date therapy initiated	Quantity	Day supply	Expected length of therapy
Diagnosis (Please check all boxes that apply and include all office notes supporting diagnosis.)			
<input type="checkbox"/> Infection caused by vancomycin-resistant <i>Enterococcus faecium</i> (VRE) including cases with concurrent bacteremia <input type="checkbox"/> Nosocomial (hospital-acquired or healthcare-associated) pneumonia caused by <i>Staphylococcus aureus</i> methicillin-susceptible isolates (MSSA), <i>Staphylococcus aureus</i> methicillin-resistant isolates (MRSA), or <i>Streptococcus pneumoniae</i> <input type="checkbox"/> Community-acquired pneumonia caused by <i>Streptococcus pneumoniae</i> , including cases with concurrent bacteremia or <i>Staphylococcus aureus</i> methicillin-susceptible isolates only (MSSA) <input type="checkbox"/> Complicated skin and skin structure infection including diabetic foot infections, without concomitant osteomyelitis, caused by <i>Staphylococcus aureus</i> methicillin-susceptible isolates (MSSA), <i>Staphylococcus aureus</i> methicillin-resistant isolates (MRSA), <i>Streptococcus pyogenes</i> , or <i>Streptococcus agalactiae</i> <input type="checkbox"/> An uncomplicated skin and skin structure infection caused by <i>Staphylococcus aureus</i> methicillin-susceptible isolates only (MSSA) or <i>Streptococcus pyogenes</i> <input type="checkbox"/> Other diagnosis/(ICD 10): _____			
Please check all boxes that apply:			
1. <input type="checkbox"/> Patient is stable on current drug(s) and/or current quantity, and medication change would likely result in high risk of significant adverse clinical outcome.			
2. <input type="checkbox"/> All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.			
3. <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a confirmed diagnosis of vancomycin-resistant <i>Enterococcus faecium</i> infection?			
4. <input type="checkbox"/> Yes <input type="checkbox"/> No Patient was discharged from the hospital or medical facility due to a documented diagnosis/covered use AND there is documented initial treatment with intravenous (IV) vancomycin OR (IV) Zyvox® (linezolid) while in the hospital/medical facility?			

(continued on page 2)

Please check all boxes that apply (continued):

5. A trial of three days each of TWO preferred antibiotics (listed below) indicated for the member's condition would likely be less effective than linezolid or likely to cause the member adverse effects; therefore, this member needs an exception to the requirements for linezolid for the requested FDA approved indication. Skip this section if the diagnosis for use is confirmed to be vancomycin-resistant Enterococcus faecium infections.

▶ Preferred antibiotics:

- amoxicillin
- moxifloxacin (Avelox[®])
- azithromycin (Zithromax[®])
- cephalosporin (cephalexin (Keflex[®]), cefpodoxime, cefdinir etc.)
- clindamycin (Cleocin[®])
- dicloxacillin

6. Yes No **Linezolid is not covered with concomitant use of monoamine oxidase inhibitor (MAOI) therapy due to serotonin toxicity. Will the patient be taking a monoamine oxidase (MAO) inhibitor (such as Marplan[®]) (isocarboxazid), Nardil[®] (phenelzine), Emsam[®] (selegiline), Parnate[®] (tranylcypromine) concomitantly?**

7. Yes No **FOR INTRAVENOUS (IV) LINEZOLID ONLY: Is the member unable to take oral linezolid?**

8. Yes No **Quantity limits (QL) apply to linezolid tablets (QL 56 tablets/28 days) and oral suspension (QL 1800ml/28 days). Does the patient require higher dosage (quantity limit exception)?**

▶ If yes, indicate quantity requested: _____ per 30 days OR quantity _____ per day

The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.

The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

9. **Please list all medications the patient has tried specific to the diagnosis and specify below.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

10. **Other supporting information**

*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	Date
-----------------------------	-------------

Fax Confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the attached material is strictly prohibited and may subject you to criminal or civil penalties. **If you received this transmission in error, please notify us immediately by telephone at 1-800-414-2386.**