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2020 linezolid (generic Zyvox®) Prior Authorization Request

(You must complete all pages.)

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Coverage Criteria:

- Medication is covered on plan when being prescribed for treatment of:
  - Nosocomial (hospital-acquired or healthcare-associated) pneumonia caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates) or Streptococcus pneumoniae
  - Community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible isolates only)
  - Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates), Streptococcus pyogenes, or Streptococcus agalactiae.
  - Uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes
  - Vancomycin-resistant Enterococcus faecium infections, including cases with concurrent bacteremia

AND

- Patient is not taking concomitant MAOI (monoamine oxidase inhibitor) therapy

AND

- Patient must meet ONE (1) of the following (1,2 OR 3):
  1. Confirmed diagnosis of Vancomycin-resistant Enterococcus faecium infections
  2. A trial of THREE (3) days each of TWO (2) preferred antibiotics indicated for the patient's condition such as: amoxicillin, moxifloxacin, azithromycin, cephalosporin, clindamycin, dicloxacillin
  3. If discharged from hospital or medical facility due to a documented diagnosis/covered use, patient must meet one (1) of the following (a OR b):
     a. Documented initial treatment with vancomycin
     b. Documented intravenous (IV) linezolid (Zyvox) while in the hospital/medical facility

- For all IV linezolid (Zyvox) requests, confirmation that patient is unable to take oral linezolid (Zyvox) is required

Authorization duration: 28 days

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 ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information			
Medication requested ☐ linezolid (generic Zyvox) tablet ☐ linezolid (generic Zyvox) powder for oral suspension 100 mg/5ml ☐ linezolid (generic Zyvox) intravenous solution 600 mg/300 ml	**Strength and route of administration**		**Frequency**
New prescription OR date therapy initiated	**Quantity**	**Day supply**	**Expected length of therapy**

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Diagnosis and medical information (continued)

Diagnosis (*Please check all boxes that apply and include all office notes supporting diagnosis.)*

☐ Nosocomial (hospital-acquired or healthcare-associated) pneumonia caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates) or Streptococcus pneumoniae

☐ Community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible isolates only)

☐ Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates), Streptococcus pyogenes, or Streptococcus agalactiae

☐ Uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes

☐ Vancomycin-resistant Enterococcus faecium infections, including cases with concurrent bacteremia

☐ Other diagnosis/(ICD10): _____

Please check all boxes that apply:

1. ☐ **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. ☐ **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. ☐ Yes ☐ No **Is this request for IV (intravenous) linezolid (Zyvox)?**
   ☐ Yes ☐ No **Is the member able to take oral linezolid (Zyvox)?**

4. ☐ Yes ☐ No **Will the requested medication be taken concomitantly with a monoamine oxidase inhibitor (MAOI)?**

5. For **vancomycin-resistant Enterococcus faecium (VRE) infection**, including cases with concurrent bacteremia:
   ☐ Yes ☐ No **Has the diagnosis of vancomycin-resistant Enterococcus faecium infection been confirmed?**

6. ☐ Yes ☐ No **Has the patient had a trial of THREE days each of TWO (2) preferred antibiotics indicated for the patient's condition such as the following?**
   - amoxicillin
   - moxifloxacin
   - azithromycin
   - cephalosporin
   - clindamycin
   - dicloxacillin

7. ☐ Yes ☐ No **Has the patient been discharged from a hospital or medical facility due to a documented diagnosis/covered use?**
   ☐ Yes ☐ No **Did the patient receive intravenous (IV) linezolid (Zyvox) while in the hospital/medical facility?**

8. ☐ Yes ☐ No **Does the patient have a documented initial treatment with vancomycin?**

9. ☐ Yes ☐ No **The quantity limit for linezolid tablets is 56 tablets per 28 days and linezolid powder for oral suspension is 1800 ml per 28 days.**
   Does the patient require higher dosage (quantity limit exception)?
   ►If yes, indicate quantity requested: _____ per 28 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.

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

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

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Please check all boxes that apply (continued):

11. ☐ **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**