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2018 linezolid (generic Zyvox®) Prior Authorization Request

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(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 ☐ Male ☐ 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.)*

- ☐ Infection caused by vancomycin-resistant Enterococcus faecium (VRE) including cases with concurrent bacteremia
- ☐ Nosocomial (hospital-acquired or healthcare-associated) pneumonia caused by Staphylococcus aureus methicillin-susceptible isolates (MSSA), Staphylococcus aureus methicillin-resistant isolates (MRSA), or Streptococcus pneumonia
- ☐ Community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia or Staphylococcus aureus methicillin-susceptible isolates only (MSSA)
- ☐ Complicated skin and skin structure infection including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus methicillin-susceptible isolates (MSSA), Staphylococcus aureus methicillin-resistant isolates (MRSA), Streptococcus pyogenes, or Streptococcus agalactiae
- ☐ An uncomplicated skin and skin structure infection caused by Staphylococcus aureus methicillin-susceptible isolates only (MSSA) or Streptococcus pyogenes
- ☐ 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 **Does the patient have a confirmed diagnosis of vancomycin-resistant Enterococcus faecium infection?**
4. ☐ Yes ☐ 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?**

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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®)
- dicloxicillin

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**