

# Pharmacy

## PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

# Vibativ (*telavancin*)

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

### PRODUCT INFORMATION

Vibativ 250mg IV solution

Vibativ 750mg IV solution

**Dose:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

### BILLING INFORMATION

#### Place of administration:

Provider's Office

Other: \_\_\_\_\_

#### Billing Options:

Physician buy and bill

Preferred Specialty Vendor

Other: \_\_\_\_\_

**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT**

Authorization for *Vibativ* requires the following information to certify:

**Patient must have one of the following diagnoses** (step therapy and additional requirements listed below individual indication):

1.  Complicated skin and skin structure infections, including MRSA  
ICD code \_\_\_\_\_

One of the following is required:

- Patient has a documented therapeutic trial and clinical failure with vancomycin IV. The recommended effective trough level with vancomycin is 15-20 mcg/mL. *Note: IV vancomycin is covered as a medical benefit and no prior authorization is required. If home healthcare is needed, please contact the Priority Health medical department for authorization.*
- Patient has history of severe intolerance to vancomycin, as defined by ONE of the following:
- Hypersensitivity rash determined to be directly related to vancomycin administration.
  - Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g. prolonged IV infusion, premedicated with diphenhydramine).

2.  OTHER ICD code \_\_\_\_\_

Rationale for use: \_\_\_\_\_

*note: authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, Clinical Pharmacology) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.*

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## DURATION OF THERAPY

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If approved, Vibativ will be authorized for up to 14 days.

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## PRIORITY MEDICARE PLANS

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**Note:** Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**