PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Sivextro® (tedizolid)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

☐ Prescriber is an infectious disease specialist ☐ Prescriber consulted with an infectious disease specialist

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Sivextro® 200 mg oral tablet
☐ Sivextro® 200 mg intravenous injection

ICD-10 Diagnosis code(s): _____
Dose:_____ **Dose Frequency**:_____
Start Date: (if applicable): _____
Date of last dose: _____
Height: _____ **Weight**: _____ **Body Surface Area**:_____

Place of administration (IV Only): ☐ Physician's office
☐ Outpatient infusion
Facility: _____ NPI:_____ Fax:_____
☐ Home infusion
Agency: _____ NPI:_____ Fax:_____

Billing (IV only): ☐ Physician to buy and bill
☐ Facility to buy and bill
☐ Specialty Pharmacy
Pharmacy:_____ NPI:_____ Fax:_____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be age 18 or older
2. Fax a copy of culture and sensitivity results to Priority Health showing the patient's infection is not susceptible to alternative antibiotic treatments
3. Sivextro® must be started in the hospital or other health care facility and will be continued in outpatient facility (or self-administered if taken orally)

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018
Last reviewed 01/2021

4. Must have documented methicillin-resistant *Staphylococcus aureus* (MRSA) ABSSSI infection that is resistant to all other MRSA sensitive antibiotics or be unable to tolerate alternatives.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ ABSSSI
☐ Other – the patient's condition is: _____

B. Was a culture completed?

☐ Yes. **The result was**: _____
☐ No. **Rationale for use:** _____

C. Was antibiotic susceptibility determined?

☐ Yes (fax results with this prior authorization request)
Note: susceptibility results must show infection is not susceptible to alternative antibiotics

☐ No – rationale for use: _____

D. Was Sivextro started in the hospital (or other health care facility)?

☐ Yes – How many days of treatment did the patient receive? _____
☐ No

E. Were other antibiotics tried without success for the patient's *current* infection?

☐ Yes, other drugs tried include:
Drug: _____ Date: _____ Outcome: _____
Drug: _____ Date: _____ Outcome: _____
Drug: _____ Date: _____ Outcome: _____
☐ No other antibiotics have been used for the patient's current infection

F. Is the patient being treated for a MRSA infection?

☐ Yes, and
- ☐ All other susceptible antibiotics have already been tried
- ☐ Patient is unable to tolerate other susceptible antibiotics because:
  _____
  _____
- ☐ Patient has a documented allergy to susceptible antibiotics that have not been tried
- ☐ Other rationale: _____

☐ No – rationale for use: _____

Additional information

For requests that do not meet Priority Health's precertification requirements, prescribers are encouraged to include medical records, other supporting documents, or statements to establish medical necessity and rationale for an exception to the coverage requirements.

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