Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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: _____

Drug information

☐ New request ☐ Continuation request

Drug product: ☐ Sivextro 200 mg tablet

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

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

1. Must be used for a medically-accepted indication*
2. Must be age 18 or older
3. Prescriber must be an infectious disease specialist or have consulted with an infectious disease specialist
4. Must have culture and sensitivity results showing the patient's infection is not susceptible to alternative antibiotic treatments

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Additional information

Note: When authorized, coverage duration is 6 days. Sivextro oral tablets have a quantity limit of 6 tablets per 30 days

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2019
Last reviewed 01/2019

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Acute bacterial skin and skin structure infections caused by susceptible gram-positive microorganisms of Staphylococcus aureus, Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus group, and Enterococcus faecalis

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

Rationale for Other use: _____

B. Is the provider an infectious disease specialist or has an infectious disease specialist been consulted?

☐ Yes. *Check which one applies:*
- ☐ Provider is an infectious disease specialist
- ☐ Consulted an infectious disease specialist

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

C. Was a culture completed?

☐ Yes ***(results must be provided).*** **The result was:** _____

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

D. Was antibiotic susceptibility determined?

☐ Yes ***(results must be provided).*** *Note: susceptibility results must show infection is not susceptible to alternative antibiotics*

☐ No. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

E. Is the patient's infection susceptible to alternative antibiotic treatments?

☐ Yes, another alternative can be used.

☐ Yes, but another alternative can***not*** be used because the patient is unable to tolerate all other susceptible antibiotics*. Please explain*: _____

☐ No, the patient has tried all other susceptible antibiotics*. Tried antibiotics*:_____

☐ No, other. **Are you requesting an exception to the criteria?**
- ☐ Yes. ***Rationale for exception***: _____
- ☐ No

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Updated 01/2019
Last reviewed 01/2019

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Sivextro likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Sivextro, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

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Updated 01/2019
Last reviewed 01/2019