

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Commercial Commercial Individual (PPACA)

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.

Linezolid (generic Zyvox®)

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 has consulted with an infectious disease specialist

Product and Billing Information

Drug product: Linezolid 600 mg tablet **Start date** (or date of next dose): _____
 Linezolid 100 mg/5 mL oral suspension **Date of last dose** (if applicable): _____
 Linezolid 600 mg/300 mL injection **Dosing frequency:** _____
 Zyvox 200 mg/100 mL injection

Place of administration: Self-administered
 Physician's office
 Outpatient infusion
 Facility: _____ NPI: _____ Fax: _____
 Home infusion
 Facility: _____ NPI: _____ Fax: _____

Billing: Patient to fill at community pharmacy
 Physician to buy and bill
 Facility to buy and bill
 Specialty Pharmacy
 Pharmacy: _____ NPI: _____ Fax: _____

ICD code(s): _____

Additional information

Note: If approved, authorization is for a maximum of 14 days. Authorization may be extended an additional 14 days if treating vancomycin-resistant *Enterococcus faecium* infection. **Longer courses of therapy may be approved if recommended by an infectious disease specialist.**

Review of precertification requests for indications and/or duration of therapy in the below criteria will be reviewed by a clinical pharmacist and/or medical director.

Precertification Requirements

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

1. Patient has one of the following conditions:

- a. Invasive vancomycin-resistant *enterococci* (VRE) infection
- b. Documented methicillin-resistant *Staphylococcus aureus* (MRSA) or other gram-positive bacterial infection including:
 - Pneumonia, complicated skin/skin structure infection including diabetic foot infections without osteomyelitis, and uncomplicated skin/skin structure infections.
- 2. Culture and sensitivity completed and faxed to Priority Health
- 3. Documented failure, contraindication, or allergy to all other susceptible oral antibiotics
- 4. Not using a medication that is contraindicated with linezolid (if provider is choosing to use in combination, please provide documentation that provider is aware of interaction)

Note: Authorization for indications 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 drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- Invasive vancomycin-resistant *enterococci* (VRE) infection
- MRSA infection, list diagnosis: _____
- Other gram-positive bacterial infection, list bacteria & diagnosis: _____
- Other – the patient's condition is: _____
Rationale for use: _____

B. Was a culture completed? Yes No

C. Was antibiotic susceptibility determined?

- Yes (fax results with this request) Note: results must show infection is not susceptible to alternative antibiotics
- No – rationale for use: _____

D. What antibiotics were previously used that were not successful in treating the patient's current infection?

- Antibiotics used include:

Drug: _____	Date: _____	Outcome: _____
Drug: _____	Date: _____	Outcome: _____
Drug: _____	Date: _____	Outcome: _____
- No other antibiotics have been used for the patient's current infection

E. Does the patient have an allergy or contraindication to alternative antibiotic therapies?

- No
- Yes:

Drug: _____	Reaction: _____
Drug: _____	Reaction: _____
Drug: _____	Reaction: _____

F. Is the patient taking any medications that interact with or are contraindicated when used with linezolid?

(examples: dopamine, bupropion, buspirone, MAOI (Nardil, tranylcypromine, Marplan), meperidine, SNRI (venlafaxine, duloxetine, Pristiq), SSRI (fluoxetine, paroxetine, citalopram, sertraline, escitalopram), pseudoephedrine, phenylephrine, tricyclic antidepressants (doxepin, amitriptyline, clomipramine, nortriptyline), triptans (sumatriptan, naratriptan, frovatriptan, rizatriptan, eletriptan, zolmitriptan)

- Yes, list medication and document if provider is aware of interaction: _____
- No

G. Provide any additional information you feel is necessary for review of this request: _____
