OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: **Sivextro®** (tedizolid phosphate)

***DRUG INFORMATION:* Complete information below. If incomplete, authorization process will be delayed.**

Drug Form/Strength/Quantity per Day: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

***CLINICAL CRITERIA*: To receive a THREE (3) month approval for this drug, ALL appropriate boxes below must be checked to qualify or authorization process will be delayed.**

Does member meet the following criteria?

- Is member 18 years of age or older? ❑ Yes ❑ No
- Acute bacterial skin or skin structure infections (ABSSSI) caused by susceptible isolates? ❑ Yes ❑ No
  - ***Staphylococcus aureus (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA]***
  - ***Streptococcus pyogenes***
  - ***Streptococcus agalactiae***
  - ***Streptococcus anginosus Group (including: S. anginosus, S. intermedius, and S. constellatus)***

  OR
  - ***Enterococcus faecalis***
- Member has failed due to resistant organism infection or has contraindication to an alternative first-line antibiotic? ***(Examples include but not limited to beta-lactams, SMX/TMP, clindamycin, vancomycin)*** ❑ Yes ❑ No
- Did prescriber submit Culture and Sensitivity results indicating that the organism is sensitive to oxazolidinones? ❑ Yes ❑ No

***MEDICAL NECESSITY*: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.**

_____

_____

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 71/2018