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: Zyvox® (linezolid)

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 ONE (1) 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?

- One of the following infections caused by susceptible **Gram-positive** bacteria: ❑ Yes ❑ No
- Does member have ***one (1)*** of the following diagnoses? ❑ Yes ❑ No
  - Nosocomial pneumonia
  - Community-acquired pneumonia
  - Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis
  - Uncomplicated skin and skin structure infections
  - Vancomycin-resistant Enterococcus faecium infections
- 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: 7/1/2018