OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 or 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 to ensure authorization will **NOT** 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**.**

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(Continued on next page; signature page MUST be attached to this request.)

(Signature page MUST be included with 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: 12/23/2017; **8/30/2018**