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 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: Sivextro® (tedizolid phosphate) **IV**
(J Codes J3090 200 mg solution reconstituted)

❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ________________

Diagnosis: ____________________________________ **ICD Code, if applicable:** ______________

Recommended Dosage: **Medical Benefit – 200 mg solution reconstituted (IV)**
Pharmacy Benefit – 200 mg tablets

CLINICAL CRITERIA: Check below **ALL** that apply**. ALL** criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

Authorization Approval Length – One (1) month

Does member meet the following criteria?

1) Acute bacterial skin or skin structure infections (ABSSSI) caused by susceptible isolates of: ❑ YES ❑ NO

- Staphylococcus aureus (**including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA]**)? ❑ YES ❑ NO
- Streptococcus pyogenes? ❑ YES ❑ NO
- Streptococcus agalactiae? ❑ YES ❑ NO
- Streptococcus anginosus Group (**including: S. anginosus, S. intermedius, and S. constellates**)? ❑ YES ❑ NO

OR

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

(Signature page MUST be included with this request)

- Enterococcus faecalis? ❑ YES ❑ NO

2) Member failed due to resistant organism infection or has contraindications to an alternative first-line antibiotic. **(Examples include, but are not limited to, beta-lactams, SMX/TMP, clindamycin, vancomycin.)** ❑ YES ❑ NO

3) Did prescriber submit the Culture and Sensitivity results indicating that the infecting organism is sensitive to oxazolidinones? ❑ YES ❑ NO

4) Is member 18 years of age or older? ❑ YES ❑ NO

Medication being provided by (check box below that applies)**:**

❑ **Location/site of drug administration:** ______________________________

NPI or DEA # of administering location: ______________________________

OR

❑ **Specialty Pharmacy - PropriumRx**

*****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: 4/11/2019; **(Reformatted) 7/18/019**