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: Zyvox® (linezolid)

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 **ONE (1) month approval** for this drug, ALL appropriate boxes below **must** be checked to qualify or authorization may 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**.**

_____

_____

_____

(Continued on next page; signature page MUST be included with request.)

(Signature page MUST be attached to 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;~~ **9/1/2018**