

# OPTIMA HEALTH COMMUNITY CARE

## 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 1-800-319-5003. 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 #: \_\_\_\_\_