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: 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.

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*****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**