SENTARA COMMUNITY PLAN
(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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Sivextro® (tedizolid phosphate) (**Tablets) (Pharmacy benefit)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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 may be denied.

Authorization Approval Length: One (1) month

(Continued on next page)

Does member meet the following criteria?

1. Acute bacterial skin or skin structure infections (ABSSSI) caused by susceptible isolates of:
   - 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

   - Enterococcus faecalis? ❑ Yes ❑ No
2. Member has 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 the member's weight 35kg or greater? ❑ Yes ❑ No

Medical necessity: Provide clinical evidence that the **PREFERRED** drug(s) will not provide adequate benefit.

_____

_____

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Medication being provided by 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.

REVISED/UPDATED/REFORMATTED: ~~12/23/2017; 8/30/2018; 4/11/2019; 11/8/2023;~~ **11/21/2025**