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: Zyvox® (linezolid)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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

Does member meet the following criteria?

1) **ONE** of the following infections caused by susceptible **Gram-positive** bacteria: ❑ 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

(Continued on next page)

2) 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

3) 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 and attach to this request**.**

_____

_____

_____

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~~; ~~9/1/2018; 4/8/2019~~; **11/10/2023**