SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Sivextro® (tedizolid phosphate) **(J3090) (Medical)**

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 Form/Strength: _____

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

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

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

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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.

Length of Authorization: Date of Service (6 days)

❑ **New Start**

(Continued on next page)

- ❑ Member has a diagnosis of acute bacterial skin and skin structure infection (ABSSSI)
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Sivextro or linezolid
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: penicillin VK, amoxicillin, amoxicillin-clavulanate, dicloxacillin, cephalexin, clindamycin, doxycycline, trimethoprim-sulfamethoxazole, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: penicillin VK, amoxicillin, amoxicillin-clavulanate, dicloxacillin, cephalexin, clindamycin, doxycycline, trimethoprim-sulfamethoxazole, and linezolid
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid

Length of Authorization: Date of Service

❑ Continuation of therapy following inpatient administration

- ❑ Member is currently on Sivextro for more than 72 hours inpatient **(progress notes must be submitted)**
- ❑ Provider has submitted lab culture sensitivity results retrieved during inpatient admission which shows resistance to **ALL** preferred antibiotics except for Sivextro (sensitive)

(Continued on next page)

Medication being provided by (check applicable box(es) below):

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.*

***Approved by Pharmacy and Therapeutics Committee**: ~~3/27/2025;~~ **5/22/2025**
REVISED/UPDATED: 6/9/2025