

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
LINEZOLID (ZYVOX®)
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
 Member ID #: _____ Patient Name: _____ DOB: _____
 Patient Address: _____
 Provider NPI: _____ Prescriber Name: _____ Phone: _____
 Prescriber Address: _____ Fax: _____
 Pharmacy Name: _____ Address: _____ Phone: _____
Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.
 Pharmacy
 NPI: _____ Pharmacy Fax: _____ NDC : _____

Prior authorization is required for Zyvox®. Payment for Zyvox® will be authorized when there is documentation that: Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable), AND Patient has an active infection and meets one of the following diagnostic criteria: Vancomycin-resistant Enterococcus (VRE) and no alternate regimens with documented efficacy, Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin, Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin.

Preferred

Zyvox

Strength _____

Dosage Instructions _____

Quantity _____

Days Supply _____

Diagnosis:

- Vancomycin-resistant Enterococcus (VRE) and no alternate regimens with documented efficacy**
 VRE is a body part other than lower urinary tract? Yes No If no,
 Patient has severe renal insufficiency? Yes No
 Is patient receiving hemodialysis? Yes No
 Does patient have known hypersensitivity to nitrofurantion? Yes No
- Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin****
- Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin****
****Patient has severe intolerance to vancomycin defined as:**
 - Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
 - Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)
- Other (specify):** _____

Is Prescriber Infectious Disease (ID) Specialist? Yes No If no, note consultation with ID Specialist: Consultation Date: _____ Physician Name: _____ Physician Phone: _____

Pertinent Lab data: _____

Additional relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

*MUST MATCH PRESCRIBER LISTED ABOVE

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.