Iowa Department of Human Services

Request for Prior Authorization
LINEZOLID (ZYVOX®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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

Prior authorization (PA) is required for linezolid. Payment for linezolid will be authorized when there is documentation that:

1. **The patient has one of the following diagnostic criteria:**
   a. **Vancomycin-resistant Enterococcus (VRE); or**
   b. **Methicillin-resistant Staph aureus (MRSA); or**
   c. **Methicillin-resistant Staph epidermis (MRSE); or**
   d. **Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and**
2. **Patient meets ONE of the following criteria:**
   a. **Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or**
   b. **VRE in a part of the body other than lower urinary tract**, or**
   c. **Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed).**
3. **A current culture and sensitivity report is provided documenting sensitivity to linezolid.**

*** Severe intolerance to vancomycin is defined as:**

1. **Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration.**
2. **Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine).**

**** VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.**

Preferred	**Non-Preferred**
☐ Linezolid	☐ Zyvox

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:

- ❑ **VRE**
  VRE in 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 nitrofurantoin? ❑ Yes ❑ No
- ❑ **MRSA**
- ❑ **MRSE**
- ❑ **Other multiply resistant gram positive infection (specify):**_____

Does patient have a severe intolerance to vancomycin?

❑ Yes (select intolerance below)

- ○ **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)**

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❑ No

Was patient discharged on linezolid with additional quantity needed?
❑ Yes Discharge date: _____

❑ No

Attach a current culture and sensitivity report documenting sensitivity to linezolid.

Additional relevant information:
_____
_
_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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.*