UnitedHealthcare Community Plan

ZYVOX (linezolid)

PRIOR AUTHORIZATION REQUEST FORM

To Prescriber: Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:		
SECTION A - PATIENT INFORMATION		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:_____

Is this patient currently hospitalized? ☐ Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION	
Medication:	**Strength:**
Directions for use:	**Duration of Therapy:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Does the patient have one of the following infections documented by culture and sensitivity report? *(check appropriate response)*

- ☐ Vancomycin-Resistant Enterococcus faecium (VRE)
- ☐ Methicillin-Resistant Staphylococcus aureus (MRSA)
- ☐ Other: _____

Does the culture and sensitivity report support sensitivity of the organism to linezolid <u>and</u> resistance of the organism to all other appropriate therapies?

(circle answer) Yes or No

~ Please attach copy of culture and sensitivity report ~

Physician Signature: _____ **Date:** _____