

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:	
Address:		Member ID:	
City:	State:	Zip:	
Phone:	DOB:	Allergies:	
Primary Insurance:	Policy #:	Group #:	
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
<p>Does the patient have one of the following infections documented by culture and sensitivity report? <i>(check appropriate response)</i></p> <p><input type="checkbox"/> Vancomycin-Resistant Enterococcus faecium (VRE)</p> <p><input type="checkbox"/> Methicillin-Resistant Staphylococcus aureus (MRSA)</p> <p><input type="checkbox"/> Other: _____</p>			
<p>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?</p> <p><i>(circle answer)</i> Yes or No</p> <p style="text-align: center;">~ Please attach copy of culture and sensitivity report ~</p>			

Physician Signature: _____ **Date:** _____

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