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 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 alternative 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
☐ Linezolid

Non-Preferred
☐ Zyvox

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

- ❑ **Vancomycin-resistant Enterococcus (VRE) and no alternative 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:**
  - o **Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration**
  - o **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 & Phone: _____

Pertinent Lab data:_____

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.*