FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Zyvox® (linezolid) Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

- ❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.
- ❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.
- ❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.
  Quantity per DAY requested? _____

Select the diagnosis AND causative organism below:

❑ Community-acquired pneumonia	❑ *Staphylococcus aureus*-methicillin susceptible (only) ❑ *Streptococcus Pneumonia*
❑ Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis	❑ *Staphylococcus aureus*-methicillin resistant ❑ *Staphylococcus aureus*-methicillin susceptible (only) ❑ *Streptococcus agalactiae* ❑ *Streptococcus pyogenes*
❑ Nosocomial pneumonia	❑ *Staphylococcus aureus*-methicillin resistant ❑ *Staphylococcus aureus*-methicillin susceptible (only) ❑ *Streptococcus Pneumonia*
❑ Uncomplicated skin and skin structure infections	❑ *Staphylococcus aureus*-methicillin susceptible (only) ❑ *Streptococcus pyogenes*
❑ Vancomycin-resistant Enterococcus faecium (VRE) infection	❑ *Vancomycin-resistant Enterococcus faecium* (VRE)
❑ Other diagnosis: _____	ICD-10 Code(s): _____

Clinical information:

Is there documentation of a current bacterial infection? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to or inability to tolerate TWO antibiotics to which the organism is susceptible? ❑ **Yes** ❑ **No**

If **yes,** please document all antibiotics tried: _____

Is the requested medication the only antibiotic to which the organism is susceptible? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by an infectious disease (ID) specialist? ❑ **Yes** ❑ **No**

Was the requested medication prescribed with ID consultation (telephone consultation is acceptable) within the last 60 days? ❑ **Yes** ❑ **No**

If **yes**, please specify the name of the ID specialist and the date of consultation: _____

_____

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Select the medication(s) the patient has a history of trial and failure, or intolerance to:

- ❑ Linezolid
- ❑ Other drugs in the same class. Please specify: _____
- ❑ Other therapeutic equivalent alternatives. Please specify: _____

Reauthorization:

If this is a reauthorization request, answer the following:

Was the requested medication prescribed by an infectious disease (ID) specialist? ❑ **Yes** ❑ **No**

Was the requested medication prescribed with ID consultation (telephone consultation is acceptable) within the last 60 days? ❑ **Yes** ❑ **No**

If **yes**, please specify the name of the ID specialist and the date of consultation: _____

_____

Is there documentation that an infectious disease consult determined that a longer duration of therapy is required? ❑ **Yes** ❑ **No**

Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.