UnitedHealthcare
Community Plan

# Zyvox
## Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328.** If you have questions, please call **800-310-6826.**
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**
**Allow at least 24 hours for review.**

**Section A – Member Information**

| First Name: | Last Name: | Member ID: |
|---|---|---|
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | DOB: | Allergies: |
| Primary Insurance Information (if any): | | |

**Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________**

**Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________**

**Section B - Provider Information**

| First Name: | | Last Name: M.D./D.O. | | |
|---|---|---|---|---|
| Address: | | City: | State: | ZIP code: |
| NPI #: | Phone: | Fax: | Specialty: | |
| Office Contact Name / Fax attention to: | | | | |

**Section C - Medical Information**

| **Medication:** | **Strength:** |
|---|---|
| **Directions for use:** | **Quantity:** |
| **Diagnosis** (Please be specific & provide as much information as possible): | **ICD-10 CODE:** |

**Is this member pregnant? □ Yes □ No** **If yes, what is this member's due date? ______________**

**Section D – Previous Medication Trials**

| Medication Name | Strength | Directions | Dates of Therapy | Reason for failure / discontinuation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives**

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| Member First name: | Member Last name: | Member DOB: |
|---|---|---|

| Clinical and Drug Specific Information | |
|---|---|
| **ALL REQUESTS** | |
| □ Yes □ No | **Does the patient have one of the following diagnoses?** *(If yes, check which applies)*<br>□ Invasive Vancomycin-Resistant Enterococcus Faecium (VRE) Infection<br>□ Nosocomial Pneumonia<br>□ Community-Acquired Pneumonia<br>□ Complicated Skin and Skin Structure Infection (including diabetic foot infections)<br>□ Uncomplicated Skin and Skin Structure Infection |
| □ Yes □ No | **Is this for continuation of therapy upon hospital discharge?**<br>*If yes, list discharge and start date:* |
| □ Yes □ No | **Is this for continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication?**<br>*If yes, list start date:* |
| □ Yes □ No | **Has Zyvox been recognized for treatment of the requested indication by the Infectious Disease Society of America (IDSA)?** |
| □ Yes □ No | **Is the infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Zyvox?** |
| □ Yes □ No | **Is the infection caused by methicillin-resistant Staphylococcus aureus (MRSA), documented by culture and sensitivity report?** |
| **NOSOCOMIAL PNEUMONIA** | |
| □ Yes □ No | **Does the patient have a history of failure, contraindication, or intolerance to any of the following antibiotics?** *(If yes, check which applies and complete Section D above)*<br>□ Levofloxacin<br>□ Ampicillin/sulbactam<br>□ A carbapenem (e.g. meropenem, doripenem, ertapenem, imipenem)<br>□ A cephalosporin (e.g. cefazolin, cefuroxime, cephalexin, cefepime, ceftriaxone, cefixime) |
| **COMMUNITY-ACQUIRED PNEUMONIA** | |
| □ Yes □ No | **Does the patient have a history of failure, contraindication, or intolerance to any of the following antibiotics?** *(If yes, check which applies and complete Section D above)*<br>□ Doxycycline<br>□ A macrolide (e.g. azithromycin, clarithromycin, erythromycin)<br>□ A cephalosporin (e.g. cefazolin, cefuroxime, cephalexin, cefepime, ceftriaxone, cefixime) |
| **SKIN AND SKIN STRUCTURE INFECTIONS** | |
| □ Yes □ No | **Does the patient have osteomyelitis?** |
| □ Yes □ No | **Does the patient have a history of failure, contraindication, or intolerance to any of the following antibiotics?** *(If yes, check which applies and complete Section D above)*<br>□ Sulfamethoxazole-trimethoprim (SMZ-TMP)<br>□ A tetracycline (e.g. doxycycline, tetracycline, minocycline, demeclocycline)<br>□ Clindamycin<br>□ Dicloxacillin<br>□ A cephalosporin (e.g. cefazolin, cefuroxime, cephalexin, cefepime, ceftriaxone)<br>□ Amoxicillin/clavulanate<br>□ A fluoroquinolone (e.g. ciprofloxacin, levofloxacin, moxifloxacin) |

**Provider Signature:** ______________________________ **Date:** ______________

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