AmeriHealth Caritas Iowa
Request for Prior Authorization

Linezolid (Zyvox®)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred	**Non-Preferred**
☐ Linezolid (authorized generic)	☐ 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:

- Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
- 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:

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Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
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.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.