Updated: 08/2020
DMMA Approved: 08/2020

Request for Prior Authorization for Zyvox (linezolid) oral
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Zyvox (linezolid) oral require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Zyvox (linezolid) oral Prior Authorization Criteria:
For all requests for Zyvox (linezolid) oral all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) skin and soft tissue infections and the following criteria is met:

- Must provide documentation of one of the following:
  - Culture and sensitivity reports confirming purulent MRSA
  - Suspected MRSA due to:
    - Chart information describing infection is severe and purulent
    - Treatment failure with a previous trial of penicillin antibiotic
    - Member has risk factors for multi-drug resistant bacteria, which include:
      - Resident of a long-term care facility
      - Uncontrolled diabetes
      - History of recurrent infections to the same site as the current request
      - Cystic fibrosis with pulmonary manifestations
- Must provide documentation of the following:
  - Member has tried and failed (which will be verified via pharmacy claims if available), has an intolerance, has a contraindication, or has culture and sensitivity reports demonstrating resistance to all of the following:
    - Trimethoprim/sulfamethoxazole
    - Clindamycin
    - Minocycline
    - Doxycycline
  - If a culture and sensitivity report is provided, it must also show sensitivity to linezolid
- **Duration of Approval:** 14 days

Coverage may be provided with a diagnosis of Methicillin-Susceptible Staphylococcus Aureus (MSSA) skin and soft tissue infections and the following criteria is met:

- Must provide documentation of the following:
  - Member has tried and failed (which will be verified via pharmacy claims if available) has an intolerance, has a contraindication, or has culture and sensitivity reports demonstrating resistance to all of the following:
    - Penicillins
    - Clindamycin

        - Cephalexin
        - Doxycycline
        - Minocycline
        - Trimethoprim/sulfamethoxazole
    - If a culture and sensitivity report is provided, it must also show sensitivity to linezolid
- **Duration of Approval:** 14 days

Coverage may be provided with a diagnosis of Vancomycin-Resistant Enterococcus (VRE) infections and the following criteria is met:
- Must provide documentation of one of the following:
    - Confirmed VRE based on culture and sensitivity reports
    - Suspected VRE based on recent course of vancomycin and no clinical improvement with or without clinical improvement from intravenous linezolid
- **Duration of Approval:** 28 days

Coverage may be provided with a diagnosis of osteomyelitis and the following criteria is met:
- Must provide documentation of one of the following:
    - Member has tried and failed (which will be verified via pharmacy claims if available), has an intolerance, has a contraindication, or has culture and sensitivity reports demonstrating resistance to all of the following:
        - Trimethoprim/sulfamethoxazole
        - Clindamycin
    - If a culture and sensitivity report is provided, it must also show sensitivity to linezolid
- **Initial Duration of Approval:** Benefit approved for the requested duration. Treatment is generally a minimum of 8 weeks as per clinical guideline.
- **Reauthorization criteria**
    - Must provide chart documentation of clinical improvement
- **Reauthorization Duration of Approval:** Benefit approved for the requested duration.

Coverage may be provided with a diagnosis of pneumonia and the following criteria is met:
- Must provide culture and sensitivity report demonstrating sensitivity to linezolid
- **Duration of Approval:** 21 days

Coverage may be provided with a diagnosis of endocarditis and the following criteria is met:
- Must provide culture and sensitivity report demonstrating sensitivity to linezolid
- **Initial Duration of Approval:** Benefit approved for the requested duration. Treatment is generally a minimum of 6 weeks as per clinical guideline.
- **Reauthorization criteria**
    - Must provide chart documentation of clinical improvement
- **Reauthorization Duration of Approval:** Benefit approved for the requested duration.

Coverage may be provided with a diagnosis of septic arthritis and the following criteria is met:
- Must provide culture and sensitivity report demonstrating sensitivity to linezolid
- **Duration of Approval:** 28 days

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Updated: 08/2020
DMMA Approved: 08/2020

LINEZOLID (ZYVOX)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

1. Member's Diagnosis: _____
2. Has the infection been confirmed with culture and sensitivity reports? (If yes, please provide them).
   ☐ Yes ☐ No
3. If not confirmed, is MRSA skin and soft tissue infection suspected due to:
   a. Severity and purulence
   b. Treatment failure with a previous trial of penicillin antibiotic
   c. Risk of multi-drug resistant bacteria due to uncontrolled diabetes, residence at a long-term care facility, history of recurrent infections to the same site as the current request, or cystic fibrosis with pulmonary manifestations?
   ☐ Yes ☐ No
4. If not confirmed, is VRE suspected due to a recent course of vancomycin and no clinical improvement with or without clinical improvement from intravenous linezolid? ☐ Yes ☐ No
5. Please provide the intended duration of treatment: _____

MEDICATION ALLERGIES

Drug Name	Outcome

Updated: 08/2020
DMMA Approved: 08/2020

LINEZOLID (ZYVOX)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe: _____
_____
_____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date