Jefferson Health Plans

***PRIOR AUTHORIZATION REQUEST FORM***
Individual and Family Plans

# Sivextro

**Fax back to: (833) 605-4407**
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is the patient at least 26 weeks gestational age and weighing at least 1 kg?

☐ Yes ☐ No

Q2. Does the patient have a proven diagnosis of a Gram-positive bacterial skin and/or subcutaneous tissue infection that is susceptible to Sivextro? Susceptible microorganisms include: Staphylococcus aureus (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus Group (including Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus), and Enterococcus faecalis. Documentation must be attached.

☐ Yes ☐ No

Q3. Have both labs (sensitivities and cultures/blood culture results) and an Infectious Disease consult been completed? Documentation must be attached.

☐ Yes ☐ No

Q4. Is the patient intolerant to, unable to take or tried and failed clinically appropriate pharmacological treatment based on lab results (sensitivities and cultures/blood culture results) and local resistance patterns? Documentation must be attached. Pharmacological treatment

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|---|---|

includes the following:

a. Clindamycin by mouth
b. Trimethoprim-sulfamethoxazole by mouth
c. Doxycycline by mouth or minocycline by mouth
d. Ciprofloxacin by mouth
e. Linezolid by mouth
f. Ceftriaxone intravenously
g. Vancomycin intravenously
h. Daptomycin intravenously

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of neutropenia defined as neutrophil counts <1000 cells/mm? Labs must be attached.

☐ Yes ☐ No

Q6. Additional Information:

_____ _____

Prescriber Signature Date

*v2026*