HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Linezolid - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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. Does the patient have a gram-negative infection? Labs must be attached including sensitivities and cultures/blood culture results.

☐ Yes ☐ No

Q2. Does the patient have a vancomycin-resistant Enterococcus faecium infection, with or without concurrent bacteremia?

☐ Yes ☐ No

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

☐ Yes ☐ No

Q4. Does the patient have nosocomial pneumonia caused by Staphylococcus aureus (methicillin-susceptible and -resistant strains) or Streptococcus pneumoniae OR community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible strains only)?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q5. Have labs (sensitivities, sputum and/or blood culture results) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

☐ Yes ☐ No

Q6. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment with IV vancomycin? Please attach documentation.

☐ Yes ☐ No

Q7. Does the patient have an uncomplicated skin and skin structure infection caused by Staphylococcus aureus (methicillin-susceptible strains only) or Streptococcus pyogenes?

☐ Yes ☐ No

Q8. Have labs (sensitivities and cultures) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

☐ Yes ☐ No

Q9. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? Please attach documentation.

a. Clindamycin PO
b. Trimethoprim-sulfamethoxazole PO
c. Doxycycline PO or minocycline PO

☐ Yes ☐ No

Q10. Does the patient have a complicated skin and skin structure infection, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin-susceptible and -resistant strains), Streptococcus pyogenes, or Streptococcus agalactiae?

☐ Yes ☐ No

Q11. Have labs (sensitivities and cultures) and an Infectious Disease consult been completed? (Please attach documentation.)

☐ Yes ☐ No

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Q12. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment with clindamycin PO and IV vancomycin?

☐ Yes ☐ No

Q13. Does the patient have Staphylococcus aureus methicillin resistant (MRSA) osteomyelitis?

☐ Yes ☐ No

Q14. Have labs (MRI, cultures) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

☐ Yes ☐ No

Q15. Was surgical debridement and drainage of associated soft-tissue abscesses performed on the patient?

☐ Yes ☐ No

Q16. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? Please attach documentation.

a. Vancomycin IV
b. Clindamycin PO/IV
c. Trimethoprim-sulfamethoxazole PO/IV plus rifampin PO/IV

☐ Yes ☐ No

Q17. Does the patient have Staphylococcus aureus methicillin resistant (MRSA) septic arthritis?

☐ Yes ☐ No

Q18. Have labs (MRI, joint/blood cultures) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

☐ Yes ☐ No

Q19. Was drainage or debridement of the joint space performed on the patient?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q20. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? Please attach documentation.

a. Vancomycin IV
b. Clindamycin PO/IV
c. Trimethoprim-sulfamethoxazole PO/IV plus rifampin PO/IV

☐ Yes ☐ No

Q21. Additional Information:

Prescriber Signature

Date

v2025