

Sivextro - 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

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 12 years of age or older?

 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? Labs and notes must be attached including sensitivities and cultures/blood culture results.

 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 includes the following:

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Member Name:

Prescriber Name:

- 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. Cetriaxone 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

v2025