HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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: ☐ 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. Is the member age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q2. Does the patient have a 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

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Member Name:	Prescriber Name:

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 or intravenously
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

v2026