Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Zyvox

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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 Vancomyclin-Resistant Enterococcus faecium infection with concurrent bacteremia?

☐ Yes ☐ No

Q2. Have labs (sensitivities and cultures/blood culture results) and an Infectious Disease consult been completed? (Please attach documentation.)

☐ Yes ☐ No

Q3. 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

Q4. Have labs (sensitivities, sputum and/or blood culture results) and an Infectious Disease consult been completed? (Please attach documentation.)

☐ Yes ☐ No

Q5. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications: a. Vancomycin IV; b. Clindamycin PO/IV?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Does the patient have an uncomplicated skin and skin structure infection caused by Staphylococcus aureus (methicillin-susceptible strains only) or Streptococcus pyogenes?

☐ Yes ☐ No

Q7. Are labs (sensitivities and cultures) and an Infectious Disease consult attached?

☐ Yes ☐ No

Q8. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications: a. Clindamycin PO; b. Trimethoprim-sulfamethoxazole PO; c. Doxycycline PO or minocycline PO?

☐ Yes ☐ No

Q9. 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

Q10. Have labs (sensitivities and cultures) and an Infectious Disease consult been completed? (Please attach documentation.)

☐ Yes ☐ No

Q11. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications: a. Vancomycin IV;
b. Clindamycin PO/IV?

☐ Yes ☐ No

Q12. Does the patient have Staphylococcus aureus methicillin resistant (MRSA) osteomyelitis?

☐ Yes ☐ No

Q13. Have labs (MRI, cultures) and an Infectious Disease consult been completed? (Please attach documentation.)

☐ Yes ☐ No

Q14. Was surgical debridement and drainage of associated soft-tissue abscesses performed on the patient?

☐ Yes ☐ No

Q15. Does the patient have Staphylococcus aureus methicillin resistant (MRSA) septic arthritis?

☐ Yes ☐ No

Q16. Are labs (MRI, joint/blood cultures) and an Infectious Disease consult attached?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q17. Was drainage or debridement of the joint space performed on the patient?

☐ Yes ☐ No

Q18. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? a. Vancomycin IV; b. Clindamycin PO/IV; c. Trimethoprim-sulfamethoxazole and rifampin PO/IV?

☐ Yes ☐ No

Q19. Requested duration:

☐ 10-14 days
☐ 14-28 days
☐ 8 weeks
☐ 3-4 weeks

Q20. Additional Information:

Prescriber Signature

Date

Updated 2018