



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

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

Expedited/Urgent checkbox

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 Vancomycin-Resistant Enterococcus faecium infection with concurrent bacteremia?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox



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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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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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*