

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.

Patient Name:	Prescriber Name:		
HPP HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Patient 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 mg	onths hut may he less denendin	a on the drug	
The Tomasimam approval allocity 12 ms	onano sat may so loco acponam	g on the drag.	
Please attach any pertinent medical history including lab	s and information for this me	mber that may support approval.	
Please answer the fol	llowing questions and sign.		
O1 Does the nationt have a gram negative infe	otion? Labo must be atte	school including	
Q1. Does the patient have a gram-negative infe	clion? Labs must be alla	ached 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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Patient 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 (methicillinsusceptible 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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Patient Name:	Prescriber Name:	
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	famnin BO/IV	
c. Trimethoprim-sulfamethoxazole PO/IV plus ri	ampin PO/IV	
☐ Yes	□ No	
Q17. Does the patient have Staphylococcus aurarthritis?	eus methicillin resistant (MRSA) septic	
☐ 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 s	space performed on the patient?	

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Patient 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	

Updated for 2023