

**Neighborhood Health Plan of Rhode Island  
Prior Authorization Form  
Zyvox® (linezolid)**

Date of Request: \_\_\_\_\_

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Zyvox® (linezolid). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Fax Number **866-423-0945**.

Please complete the following information:

<b>Member Name:</b> (required)	<b>Member ID Number:</b> (required)								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 15px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
<b>Member Date of Birth:</b> (required) / /	<b>Member Sex:</b> M      F      (Circle One)								
<b>Prescriber Name:</b> (required)	<b>Contact Person at Office:</b>								
<b>Office Phone number:</b> (required) (    ) -	<b>Office Fax Number:</b> (required) (    ) -								

**ASSESSMENT OF BENEFIT NEED:**

	YES	NO
1. Antibiotic Resistance:		
a. Patient is using Zyvox® for the treatment of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) or multidrug resistant <i>Streptococcus pneumonia</i> (MDRSP) infection.	<input type="checkbox"/>	<input type="checkbox"/>
b. Patient is using Zyvox® for the treatment of vancomycin-resistant <i>Enterococcal faecium</i> infection.	<input type="checkbox"/>	<input type="checkbox"/>
c. Patient is using Zyvox® for the treatment of an infection which is resistant to other antibiotics.	<input type="checkbox"/>	<input type="checkbox"/>
2. Antibiotic resistance is demonstrated by culture and susceptibility.	<input type="checkbox"/>	<input type="checkbox"/>
3. Antibiotic resistance is demonstrated by history of antibiotic use. If yes, what trials of antibiotics has the patient completed?	<input type="checkbox"/>	<input type="checkbox"/>
Dicloxacillin <input type="checkbox"/>	Ciprofloxacin <input type="checkbox"/>	Cefdinir <input type="checkbox"/>
Amox/Clavulanate <input type="checkbox"/>	Gatifloxacin <input type="checkbox"/>	Cefprozil <input type="checkbox"/>
Vancomycin <input type="checkbox"/>	Doxycycline <input type="checkbox"/>	Cefuroxime <input type="checkbox"/>
Azithromycin <input type="checkbox"/>	Cephalexin <input type="checkbox"/>	Other: <input type="checkbox"/>
4. Antibiotic resistance is suspected due to local susceptibility patterns. If yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
5. The prescribing doctor is an infectious disease specialist OR the patient has received a consult from an infectious disease specialist.	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has received IV or oral Zyvox® as a hospital inpatient, and will be continuing Zyvox® therapy upon hospital discharge.	<input type="checkbox"/>	<input type="checkbox"/>
7. Indicate strength of medication being requested	20mg/mL suspension	<input type="checkbox"/>
	600mg tablet	<input type="checkbox"/>

**BENEFIT TERMS UPON APPROVAL:**

No further restrictions will be applied if the use of Zyvox is approved.
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**Information given on this form is accurate as of this date.**

\_\_\_\_\_  
Prescriber's signature and NPI

\_\_\_\_\_  
Date