



Zyvox Prior Authorization Request Form

(KY -MAP-82101, revised 6/1/10)

**Not to be used for requesting any other agent.
Must be filled out completely for consideration of request**

FAX to 800-365-8835

OR MAIL to Pharmacy Department, 1st floor South, 14100 Magellan Plaza, Maryland Heights, MO 63043

For **URGENT** Requests Only, FAX to **800-421-9064**

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273**

RECIPIENT NAME			MEDICAID # (10 digits)			DATE OF BIRTH			
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Magellan is directed to FAX a response to the following fax number (s): ----->			Prescriber Fax # (Print Clearly)			Pharmacy Fax # (Print Clearly)			
			PRESCRIBER Information			PHARMACY Information			
Name									
Specialty									
Phone #									
NPI # (no DEA #)						NPI # (no DEA#)			
	Drug Requested	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)		

PERTINENT DIAGNOSIS:

Vancomycin-Resistant Gram Positive Infections (VRE)

Enterococcus faecium (please attach C & S results)

Enterococcus faecalis (please attach C & S results)

Methacillin-Resistant Staph Aureus Infections (MRSA) (please attach C & S results)

Empiric Treatment for MRSA (Check all that apply)

- Previously documented MRSA infection,
- Previous cellulitis caused by documented MRSA,
- Skin and soft tissue infection with abscess,
- Patient tried any of the following antibiotics:

Tetracycline (dates of therapy _____) Clindamycin (dates of therapy _____)

Sulfamethoxazole /trimethoprim (dates of therapy _____) Any fluoroquinolone (dates of therapy _____)

Patient with any the following risk factor (s) (check all that apply):

- Health facility stay/visit (dates of stay _____) HIV
- Surgery (date of surgery _____) Permanent indwelling catheters
- Participation in team sports (date of most recent participation _____) Percutaneous implanted device
- Jail/Prison (dates of stay _____) IV drug user
- Military (dates of service _____) Diabetic foot ulcer
- History of "spider bite" (date of bite _____) End stage renal disease
- Pediatrics enrolled in daycare or school (dates of enrollment _____) Previously colonized with multi-drug resistant pathogens including MRSA
- Multiple areas of induration

IS THIS AN UNINTERRUPTED CONTINUATION OF ZYVOX THERAPY INITIATED IN A HOSPITAL?

No Yes, therapy began _____ (date).

IF LENGTH OF THERAPY IS GREATER THAN 28 DAYS, PLEASE EXPLAIN: _____

Signature of submitter ** _____ Date: _____ On behalf of the Prescriber or Pharmacy Provider, I **certify that the information stated above is a true statement, made for the purposes of inducing Kentucky Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that Magellan Medicaid Administration, on behalf of the Commonwealth, will retain this document and any attached materials for the purposes of possible future audit(s). **SUBMITTED BY :** Prescriber Pharmacy

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.