

**Prior Authorization Request Form
Kentucky Medicaid**

Zyvox®

Not to be used for requesting any other agent.

Fax this signed, completed form to: (800) 365-8835

Questions? Call Magellan Medicaid Administration at (800) 477-3071

Note: This fax form is required for all PA requests.

However, hospital discharge physicians can call **(800)-477-3071** with complete information below.

Reformatted 6/28/11

REQUESTOR	<input type="checkbox"/> Prescriber <input type="checkbox"/> Pharmacy	Requestor Name <i>(Print)</i>
RECIPIENT	Last Name, First Name, Middle I.:	
DOB:	Recipient ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
PRESCRIBER	Name:	NPI: - - - - -
Phone: ()		Fax: ()
Specialty:		
PHARMACY	Name:	NPI: - - - - -
Phone: ()		Fax: ()
REQUEST	Drug:	Strength: Dosage Form:
Primary Diagnosis: <i>see below</i>		Dosage schedule:
Other Diagnoses: <i>see below</i>		QTY: Day supply:
RATIONALE FOR PRIOR AUTHORIZATION		Requested start date:

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).

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