

**Zyvox® (linezolid)**  
**Drug Authorization Request Form**

**FAX to 800-365-8835** (toll free)

*Not to be used for requesting any other agent*  
*Fax form must be filled out completely for consideration of request*  
SUBMITTED BY:  Prescriber  Pharmacy

For **URGENT** Requests Only, Fax to 800-421-9064  
For **NURSING FACILITY** Requests Only, Fax to 800-453-2273  
(MAP-82101, revised 1-11-10)

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

**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 \_\_\_\_\_)
- Sulfamethoxazole /trimethoprim (dates of therapy \_\_\_\_\_)
- Clindamycin (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 \_\_\_\_\_)
- Surgery (date of surgery \_\_\_\_\_)
- Participation in team sports (date of most recent participation \_\_\_\_\_)
- Jail/Prison (dates of stay \_\_\_\_\_)
- Military (dates of service \_\_\_\_\_)
- History of "spider bite" (date of bite \_\_\_\_\_)
- Pediatrics enrolled in daycare or school (dates of enrollment \_\_\_\_\_)
- Multiple areas of induration

- HIV
- Permanent indwelling catheters
- Percutaneous implanted device
- IV drug user
- Previously colonized with multi-drug resistant pathogens including MRSA
- Diabetic foot ulcer
- End stage renal disease

**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 First Health Services, on behalf of the Commonwealth, will retain this document and any attached materials for the purposes of possible future audit(s).