HealthPAC
Health Program of Alameda County

Clinical Prior Authorization Request

Zyvox™ for Vancomycin resistant MRSA
OR
Zyvox™ for treatment of Extensively Drug Resistant Tuberculosis

TELEPHONE: 510-383-1790 FAX: 510-567-6850

The HealthPAC HIV Program reviews Clinical Prior Authorization requests on the basis of medical necessity only. The program will not be responsible for medications dispensed to patients prior to a written approval of coverage for the medication. Zyvox™ requires a prior authorization and is only covered for the treatment of Vancomycin resistant MRSA or Extensively Drug Resistant Tuberculosis.

PATIENT INFORMATION

Last name First name	Program ID or SS Number	Date of Birth	Sex (circle one) F M

PHARMACY INFORMATION

Name	NABP/NPI Number	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

PRESCRIBER INFORMATION

Last name First Name	NPI Number	DEA no.	
Address	City	State	Zip
E-mail address	Telephone ( )	Fax ( )	

Clinician Information: <u>Zyvox™ is ONLY covered by the HealthPAC HIV Program for the following indications</u>

- **If diagnosis is Extensively Drug Resistant Tuberculosis, Please fill Section 1**
- **If diagnosis is Vancomycin Resistant MRSA, Please fill Section 2**

<u>Section 1</u>

MEDICATION INFORMATION

For Extensively Drug Resistant Tuberculosis, please answer the following questions:

Is the infection resistant to isoniazid treatment? □Yes □No

Is the infection resistant to rifampin treatment? □Yes □No

Is the infection resistant to second-line medications: fluoroquinolones AND at least one of three injectable drugs? (i.e. amikacin, kanamycin or capreomycin) □Yes □No

Please provide any additional clinical information or medical justification. (e.g. drug allergies, history of IVDA)

Ramsell

HealthPAC
Health Program of Alameda County

Zyvox™ for Vancomycin resistant MRSA
OR
Zyvox™ for treatment of Extensively Drug Resistant Tuberculosis

TELEPHONE: 510-383-1790 FAX: 510-567-6850

The HealthPAC HIV Program reviews Clinical Prior Authorization requests on the basis of medical necessity only. The program will not be responsible for medications dispensed to patients prior to a written approval of coverage for the medication. Clinical Prior Authorization request is required for Zyvox™ for the treatment of Vancomycin resistant MRSA or Extensively Drug Resistant Tuberculosis

Section 2

MEDICATION INFORMATION

Please fax lab culture and sensitivities along with this form: • Vancomycin resistant MRSA
Please indicate the dose, frequency, and duration of Zyvox request:
For Vancomycin Resistant MRSA, please answer the following questions:
copy of the sensitivity results required with submission Was the culture positive for MRSA? □Yes □No Was the culture positive for Vancomycin-Resistant MRSA? □Yes □No Is the infection resistant or unresponsive to sulfamethoxazole/TMP? □Yes □No Is the infection resistant or unresponsive to clindamycin? □Yes □No Is the infection resistant or unresponsive to tetracycline-class drugs? □Yes □No Please provide any additional clinical information or medical justification. (e.g. allergies to β-lactams, history of IVDA)

PRESCRIBER'S SIGNATURE IS REQUIRED

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (stamp not accepted):_____Date:_____

Ramsell