CAREFIRST
Zyvox (REG)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zyvox (REG).

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Zyvox (linezolid) Linezolid

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Will the patient be using the requested drug orally or intravenously?	**Y** ☐	**N** ☐
2.	Is the patient being converted from intravenous (IV) linezolid (Zyvox) as prescribed or directed by an Infectious Disease specialist for a NON-Tuberculosis (TB) bacterial infection?	**Y** ☐	**N** ☐
3.	Does the patient have any of the following: A) an infection caused by vancomycin-resistant Enterococcus faecium including cases with concurrent bacteremia, B) a nosocomial (institution-acquired) pneumonia caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates) or Streptococcus pneumoniae, C) community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible isolates only), D) a complicated skin and skin structure infection including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin-susceptible and -resistant isolates), Streptococcus pyogenes, or Streptococcus agalactiae, E) an uncomplicated skin and skin structure infection caused by Staphylococcus aureus (methicillin-susceptible isolates only) or Streptococcus pyogenes?	**Y** ☐	**N** ☐
4.	Is the infection proven or strongly suspected to be caused by susceptible bacteria?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed for pulmonary extensively drug resistant (XDR) or treatment-intolerant/nonresponsive multidrug-resistant (MDR) tuberculosis?	**Y** ☐	**N** ☐
6.	Is the requested drug being prescribed as part of a combination regimen with Pretomanid and Sirturo (bedaquiline)?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date