First Health Services Corporation

Zyvox® (linezolid)
Drug Authorization Request Form

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

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

Not to be used for requesting any other agent

Fax form must be filled out completely for consideration of request

SUBMITTED BY: [ ] Prescriber [ ] Pharmacy)

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _ _	
First Health is directed to FAX a response to the following fax number (s): ----------→	**Prescriber Fax # (Print Clearly)** and / or	**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_____)

[ ] 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).