

REQUEST FOR COVERAGE OF ZYVOX® (LINEZOLID)

PATIENT DATA

Patient Name: _____ GHI ID#: _____
DOB: _____ Weight(kg for pediatric pt): _____

****This request is NOT complete without a CULTURE/SENSITIVITY REPORT, CBC and this FORM (an updated CBC is required for > 14 days) ****

Is this a **hospital discharge** patient or an **out-patient**? (circle one)

Patient Diagnosis: (check ALL that apply)	Dose	Recommended duration treatment: (consecutive days)
<input type="checkbox"/> Vancomycin-resistant <i>E. faecium</i> (incl. cases with concurrent bacteremia)	<input type="checkbox"/> ***600mg po Q12H <input type="checkbox"/> (birth-11yrs 10mg/kg po Q8H)	14-28
<input type="checkbox"/> Nosocomial pneumonia: __ <i>S. aureus</i> (MSSA/MRSA) __ <i>S. pneumoniae</i> (PCN-suscept. strains only)	<input type="checkbox"/> 600mg po Q12H <input type="checkbox"/> (birth-11yrs 10mg/kg poQ8H)	10-14
<input type="checkbox"/> Community-acquired pneumonia __ <i>S.pneumoniae</i> (PCN-suscept strains only), including cases w/concurrent bacteremia __ <i>S.aureus</i> (MSSA only)	<input type="checkbox"/> 600mg po Q12H <input type="checkbox"/> (birth-11yrs 10mg/kg poQ8H)	10-14
<input type="checkbox"/> Complicated skin & skin structure infections __ <i>S.aureus</i> (MSSA/MRSA) __ <i>S.pyogenes</i> OR __ <i>S.agalactiae</i>	<input type="checkbox"/> 600mg po Q12H <input type="checkbox"/> (birth-11yrs 10mg/kg po Q8H)	10-14
<input type="checkbox"/> Uncomplicated skin/skin structure infections __ <i>S.aureus</i> (MSSA only) __ <i>S.pyogenes</i>	<input type="checkbox"/> 400mg po Q12H <input type="checkbox"/> (<5yrs: 10mg/kg po Q8H) <input type="checkbox"/> (5-11yrs: 10mg/kg Q12H) <input type="checkbox"/> (adolescents: 600mg po Q12H)	10-14
<input type="checkbox"/> **Other: _____		

**** Please submit Non-Formulary Request**

*****Last 2 weeks treatment given upon receipt of CBC**

Is the patient currently receiving an **SSRI, adrenergic agents (eg. pseudoephedrine)** or **foods/beverages containing high contents of tyramine**? Yes No

If YES, then the PHYSICIAN MUST MONITOR for potential INTERACTIONS (e.g. serotonin syndrome) & the PATIENT MUST be informed of possible side effects.

Has the patient been started on Zyvox® (IV or PO)? Yes No If yes, for how many days? _____

Culture/sensitivity done? Yes No Date: _____ Result: _____ (Attached)

Complete blood count done? Yes No Date: _____ Result: _____ (Attached)

CRITERIA WHICH MUST BE MET FOR COVERAGE OF UP TO A MAXIMUM OF 28 DAYS OF TREATMENT

- The culture/sensitivity and CBC results are provided to HIP Clinical Pharmacy Services that the patient has a diagnosis consistent with the FDA-approved diagnosis for use of Zyvox® (see above);
- For the patient requiring additional 2 weeks treatment (total 28 days) an updated CBC **MUST** be submitted.

- Physician Prior Approval (PPA) numbers will be issued for 2 weeks **ONLY** for patients meeting the above criteria.

PHYSICIAN DATA

Prescribing Physician Signature: _____ Date: _____

Prescribing Physician Name/Address/Phone #/Specialty: _____

Original Prescriber Name/Address/Phone # if different from above: _____

Please provide **appropriate medical documentation and all pertinent information along with this form** to: GHI Pharmacy Services, 55 Water Street, 12th Floor South, New York, NY 10041 or fax to (877) 300-9695 or email to clinicalpharmacy@hipusa.com.

Telephone No. 1-866-447-9717 (option #3 then option #2)