maryland physicians care
Medicaid with a Heart

# PRIOR AUTHORIZATION REQUEST

## Linezolid (Oral)

**Patient Information:**

| | |
|---|---|
| Name: | |
| Member ID: | |
| Address: | |
| City, State, Zip: | |
| Date of Birth: | |

**Prescriber Information:**

| | |
|---|---|
| Name: | |
| NPI: | |
| Phone Number: | |
| Fax Number | |
| Address: | |
| City, State, Zip: | |

**Requested Medication**

| | |
|---|---|
| Rx Name: | |
| Rx Strength | |
| Rx Quantity: | |
| Rx Frequency: | |
| Rx Route of Administration: | |
| Diagnosis and ICD Code: | |

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

| | | | |
|---|---|---|---|
| 1 | What is the diagnosis or indication?<br>[] Treatment of Vancomycin-Resistant Enterococcus (VRE) Species Infection (If checked, go to 3)<br><br>[] Treatment of Methicillin-Resistant Staphylococcus Species Infection (If checked, go to 3)<br><br>[] Treatment of another infection (If checked, go to 2)<br><br>[] Other (If checked, no further questions) | | |
| 2 | Is the requested medication being used to treat an infection that is resistant to other antibiotics, but the organism is sensitive to the requested medication? [If no, no further questions.] | Yes | No |

**If you have any questions, call: 1-888-258-8250**

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| | | | |
|---|---|---|---|
| 3 | Is this request for initial therapy or for a continuation of therapy?<br>[] Initial (If checked, no further questions)<br><br>[] Continuation (If checked, go to 4) | | |
| 4 | Is the patient transitioning from intravenous (IV) linezolid or IV vancomycin to oral linezolid therapy?<br>[If yes, no further questions.] | Yes | No |
| 5 | Has the patient been started on oral linezolid in an inpatient facility and is continuing therapy? | Yes | No |

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

## FAX COMPLETED FORM TO: 1-833-896-0656

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

**If you have any questions, call: 1-888-258-8250**