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Prime THERAPEUTICS™

**NYRx the Medicaid Pharmacy Program**

# Oxazolidinone Antibiotics Prior Authorization Worksheet

**Fax Number: 1-800-268-2990**

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

## ENROLLEE INFORMATION

**Enrollee's Last Name:** _____

**Enrollee's First Name:** _____

**Date of Birth:** _____

**Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter):** _____

## PRESCRIBER INFORMATION

**Prescriber's Last Name:** _____

**Prescriber's First Name:** _____

**National Provider Identifier (NPI) Number:** _____

**Board Certified Specialty:** _____

**Prescriber's Phone Number:** _____

**Prescriber's Fax Number:** _____

## DRUG INFORMATION

**Drug Name:** _____ **Drug Strength:** _____

**Quantity[1]:** _____ **Refills[2]:** _____

**Directions:** _____

**New Prescription:** ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

**Expected length of therapy[3]:** _____

[1] Prescriptions for tedizolid (Sivextro®) are limited to a 6-day supply. Continuation of therapy will require a new prescription and PA number.

[2] Refills for linezolid (Zyvox®) are only allowed for diagnoses of extensively drug-resistant TB (XDR-TB) or treatment intolerant/non-responsive multidrug-resistant TB (MDR-TB).

[3] Diagnosis and length of therapy will be reviewed by a Clinical Pharmacist and/or Medical Director. Please submit progress notes for documentation of diagnosis with treatment plan.





Revision Date: 1/09/2023

**Enrollee's Last Name:** **Enrollee's First Name:**

## CLINICAL CRITERIA

1. What is the diagnosis[3] documented in the patient's chart that requires treatment with an oxazolidinone antibiotic?

   Diagnosis: _____

   Date of last evaluation for this diagnosis[3]: _____

2. If the diagnosis is extensively drug-resistant TB (XDR-TB) or treatment -intolerant/non-responsive multidrug-resistant TB (MDR-TB), is linezolid being used in combination with pretomanid and bedaquiline?

   ☐ Yes ☐ No

   If **NO**, please provide clinical rationale for not using the three drug regimen for this diagnosis:

3. Were cultures and sensitivities performed confirming the diagnosis?

   ☐ Yes ☐ No

   If **NO**, please provide the clinical rationale for prescribing this oxazolidinone antibiotic without performing culture and sensitivities?

4. Has treatment with this oxazolidinone antibiotic already been established?

   ☐ Yes ☐ No

5. Were other antibiotics used to treat this diagnosis?

   ☐ Yes ☐ No

## MEDICATION HISTORY

6. What is the patient's medication history for at least the last three months?

| Medication Trial/ Previous Therapies | Therapy Start Date | Therapy End Date | Strength | Frequency | Reason for Discontinuation |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**According to Sivextro® prescribing information, in an animal model of infection, the antibacterial activity of Sivextro® was reduced in the absence of granulocytes. Alternative therapies should be considered when treating patients with neutropenia (neutrophil counts < 1,000 cells/mm$^3$) and acute bacterial skin and skin structure infection.**

**Enrollee's Last Name:** **Enrollee's First Name:**

7. For tedizolid (Sivextro®), is the patient neutropenic?

   ☐ Yes ☐ No Neutrophil count: _____ cells/$mm^3$

   If **YES**, please provide the rationale for using tedizolid (Sivextro®) in a neutropenic patient?

8. Has the total duration of oxazolidinone therapy, including treatment in an inpatient setting, exceeded 14 days with linezolid (Zyvox®) or 6 days with tedizolid (Sivextro®)?

   ☐ Yes ☐ No

   If **YES**, please provide the rationale for exceeding 14 days of treatment with linezolid or 6 days with tedizolid:

9. For renewal requests, have you confirmed that the patient does not have myelosuppression?

   ☐ Yes ☐ No Please provide the date of laboratory testing: _____

According to Zyvox® prescribing information, myelosuppression (including anemia, leukopenia, pancytopenia, and thrombocytopenia) has been reported in patients receiving Zyvox®. Complete Blood Counts (CBCs) should be monitored weekly, particularly in patients receiving Zyvox® for longer than two weeks.

According to Sivextro® prescribing information, in Phase 3 trials, clinically significant changes in myelosuppression parameters were generally similar for both tedizolid and linezolid treatment arms, and Phase 1 studies in healthy adults exposed to tedizolid (Sivextro®) showed a possible dose and duration effect on hematologic parameters beyond 6 days of treatment.

Please be aware that the US Food and Drug Administration (FDA) has received reports of serious central nervous system (CNS) reactions when Zyvox® is given to patients taking serotonergic psychiatric medications. Some cases have been fatal. According to Zyvox® prescribing information under Serotonin Syndrome, "patients taking serotonergic antidepressants should receive Zyvox® only if no other therapies are available." In addition to complete FDA approved prescribing information, for more information and a list of the serotonergic psychiatric medications that can interact with Zyvox®, please also visit http://www.fda.gov/Drugs/DrugSafety/ucm265305.htm.

Also note that although both Zyvox® and Sivextro® are reversible monoamine oxidase inhibitors (MAOI), comparable information for Sivextro is limited as subjects taking MAOIs or serotonergic psychiatric medications were excluded from trials.

**Prescriber Signature (Required)** **Date**

*I attest that this oxazolidinone antibiotic is medically necessary for this patient and that all the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.*

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493 **Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Program Review questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.