RxAmerica
221 N. Charles Lindbergh Dr.
Salt Lake City, UT 84122-9902
Phone (866) 453-1999 Fax: (866) 514-1715

Minnesota Health Care Programs Prior Authorization Request Form
Zyvox® (linezolid)

● ● ●Only one medication request per form ●●● All fields must be complete and legible for review ●●●

☐ STANDARD REVIEW	☐ EXPEDITED REVIEW
By selecting the expedited review and signing this form below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.	

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name and Specialty:
Member ID#:	DEA #:
Sex (circle): Male Female	Office Phone:
Date of Birth:	Office Fax:
Patient Phone:	Contact Person:

PHARMACY INFORMATION			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:

DIAGNOSIS AND MEDICAL INFORMATION		
Medication:	Strength and Route of Administration:	Frequency:
☐ New Prescription – OR – Date Therapy Initiated: / /	Expected Length of Therapy:	Quantity:
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:

Rationale for Prior Authorization Request

Medical Justification for Zyvox:

1. Was Zyvox initiated in an institutional setting and additional medication is required to complete the course of therapy? ☐ YES ☐ NO
2. Has culture and sensitivity testing revealed susceptibility to Zyvox? ☐ YES ☐ NO
3. Has the patient failed treatment with alternative antimicrobial agents? ☐ YES ☐ NO
4. Are alternative antimicrobial agents contraindicated for this patient due to allergy, interactions or adverse effects? ☐ YES ☐ NO

Prescriber's Signature:	Date:

Effective Date:1/1/06
Revised:7/17/06