Tedizolid (Sivextro®) Prior Authorization Request Form

Member Information (required)			Provider Information (required)
Member Name:			Provider Name:
Member ID#:			NPI #: Specialty:
Date of Birth:			Office Phone:
Street Address:			Office Fax:
City:	State:	Zip:	Office Street Address:
Phone:			City: State: Zip:

Medication Information (required)		
Medication Name: ☐ Check if requesting brand ☐ Check if request is for continuation of therapy	Strength:	Dosage Form: Directions for Use:

Exception Criteria

☐ Prescribed by an infectious disease specialist or an emergency department provider.
The recipient resides in one of the following:
- ☐ Acute Care
- ☐ Long-term Acute Care (LTAC)
- ☐ Skilled Nursing Facility (SNF)

Clinical Information (required)

Diagnosis: **ICD-10 Code:**

Clinical Information: (mark all that apply)

☐ Infection is caused by methicillin-resistant Staphylococcus aureus (MRSA).

☐ Recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: TMP/SMX, doxycycline, vancomycin, daptomycin, telavancin, clindamycin).

☐ Treatment started with intravenous antibiotic(s) in the hospital and the recipient requires continued outpatient therapy.

Does the member have any contraindications to alternative antibiotics?

☐ **No** ☐ **Yes** - Describe (eg. allergy, drug interaction):

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the prescriber feels is important to this review?