

Linezolid (Non-PDL)

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:		Prescriber Name:	
HPP HPP Member Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Patient Primary Phone:		NPI:	PA PROMISe ID:
Address:		Address:	
City, State ZIP:		City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP		Specialty Pharmacy (if applicable):	
Drug Name:		Strength:	
Quantity:		Refills:	
Directions:			
Diagnosis Code:		Diagnosis:	
<i>HPP's maximum approval time is 12 months but may be less depending on the drug.</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a gram-negative infection? Labs must be attached including sensitivities and cultures/blood culture results.

Yes

No

Q2. Does the patient have a vancomycin-resistant Enterococcus faecium infection, with or without concurrent bacteremia?

Yes

No

Q3. Have labs (sensitivities and cultures/blood culture results) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

Yes

No

Q4. Does the patient have nosocomial pneumonia caused by Staphylococcus aureus (methicillin-susceptible and -resistant strains) or Streptococcus pneumoniae OR community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible strains only)?

Yes

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Q5. Have labs (sensitivities, sputum and/or blood culture results) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

Yes

No

Q6. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment with IV vancomycin? Please attach documentation.

Yes

No

Q7. Does the patient have an uncomplicated skin and skin structure infection caused by Staphylococcus aureus (methicillin-susceptible strains only) or Streptococcus pyogenes?

Yes

No

Q8. Have labs (sensitivities and cultures) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

Yes

No

Q9. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? Please attach documentation.

- a. Clindamycin PO
- b. Trimethoprim-sulfamethoxazole PO
- c. Doxycycline PO or minocycline PO

Yes

No

Q10. Does the patient have a complicated skin and skin structure infection, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus (methicillin-susceptible and -resistant strains), Streptococcus pyogenes, or Streptococcus agalactiae?

Yes

No

Q11. Have labs (sensitivities and cultures) and an Infectious Disease consult been completed? (Please attach documentation.)

Yes

No

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Q12. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment with clindamycin PO and IV vancomycin?

Yes

No

Q13. Does the patient have Staphylococcus aureus methicillin resistant (MRSA) osteomyelitis?

Yes

No

Q14. Have labs (MRI, cultures) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

Yes

No

Q15. Was surgical debridement and drainage of associated soft-tissue abscesses performed on the patient?

Yes

No

Q16. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? Please attach documentation.

- a. Vancomycin IV
- b. Clindamycin PO/IV
- c. Trimethoprim-sulfamethoxazole PO/IV plus rifampin PO/IV

Yes

No

Q17. Does the patient have Staphylococcus aureus methicillin resistant (MRSA) septic arthritis?

Yes

No

Q18. Have labs (MRI, joint/blood cultures) and an Infectious Disease consult been completed? Labs and notes must be attached including sensitivities and cultures/blood culture results.

Yes

No

Q19. Was drainage or debridement of the joint space performed on the patient?

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Yes

No

Q20. Is the patient intolerant to, unable to take or tried and failed pharmacological treatment from the following formulary therapeutic classes or medications? Please attach documentation.

- a. Vancomycin IV
- b. Clindamycin PO/IV
- c. Trimethoprim-sulfamethoxazole PO/IV plus rifampin PO/IV

Yes

No

Q21. Additional Information:

Prescriber Signature

Date

Updated for 2024