

Health New England
Medication Request Form (MRF)
Zyvox[®] (linezolid)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Zyvox[®]. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA # :
Allergies:	Area Code and Telephone #: () -
Diagnosis:	Area Code and Fax #: () -

Drug Information		
Requested Drug/Strength:	Zyvox [®]	
Dose, directions and length of treatment (please be specific):	Quantity:	Refills:
Physician signature:	Date:	
What is your area of specialty? (<i>required</i>) _____		
Reason for prescribing Zyvox (please circle appropriate response):		
<input type="radio"/> The patient has an infection caused by Vancomycin-Resistant Enterococcus faecium or faecalis (VRE). <input type="radio"/> The patient has an infection caused by methicillin-resistant Staphylococcus aureus (MRSA). <input type="radio"/> The patient has bacteriemia or endocarditis <input type="radio"/> The culture and sensitivity reports indicate that organism is susceptible to minocycline, doxycycline, clindamycin or TMP/sulfamethoxazole DS? <i>Copy of culture and sensitivity is required to be submitted along with this form.</i> <input type="radio"/> The patient has a contraindication to minocycline or doxycycline; and clindamycin and TMP/sulfamethoxazole DS. <input type="radio"/> The patient is being transitioned to oral therapy from intravenous vancomycin, Zyvox [®] , Synercid [®] , or Daptomycin [®] . <input type="radio"/> The physician is aware of the potential risk of myelosuppression and plans to monitor the patient's CBC. <input type="radio"/> The patients medication regimen has been evaluated for interactions (MAOI's) <input type="radio"/> The patient has been counseled about diet		
Other Pertinent History (relative or pertaining to this request): _____		