

Bravo Health

Coverage Review / Prior Authorization Request Form
Zyvox® (linezolid)



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	

Diagnosis and Medication Requested		
Medication Requested (dosage, frequency):		Qty:
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:

Clinical Criteria	
Please answer the following questions:	
1. Does CULTURE AND SENSITIVITY REPORT** data indicate a diagnosis of VRE? <input type="checkbox"/> Yes <input type="checkbox"/> No*	
2. Does CULTURE AND SENSITIVITY REPORT** data indicate a diagnosis of MRSA? <input type="checkbox"/> Yes <input type="checkbox"/> No*	
3. If MRSA, is there resistant to Vancomycin** or inability for patient to use Vancomycin IV (Please submit clinical documentation)? <input type="checkbox"/> Yes <input type="checkbox"/> No*	
*Request will be denied if above diagnosis criteria is not met.	
**<u>Culture and Sensitivity Report must be provided.</u> Failure to provide adequate data could result in denial of this request. Culture and Sensitivity Report must be dated less than 30 days.	
Additional Comments/Explanation:	

Request for Expedited Review	
<input type="checkbox"/>	REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Prescriber's Signature: _____ Date: _____

Fax back to: 866-464-0709 For info call: 877-813-5595
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>