Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Sivextro (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: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q2. Does the patient have a proven diagnosis of a Gram-positive bacterial skin and/or subcutaneous tissue infection that is susceptible to Sivextro? Susceptible microorganisms include: Staphylococcus aureus (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus Group (including Streptococcus anginosus, Streptococcus intermedius, and Streptococcus constellatus), and Enterococcus faecalis. Documentation must be attached.

☐ Yes ☐ No

Q3. Have both 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. Is the patient intolerant to, unable to take or tried and failed clinically appropriate pharmacological treatment based on lab results (sensitivities and cultures/blood culture results) and local resistance patterns? Documentation must be attached. Pharmacological treatment includes the following:

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Patient Name:	Prescriber Name:

a. Clindamycin by mouth
b. Trimethoprim-sulfamethoxazole by mouth
c. Doxycycline by mouth or minocycline by mouth
d. Ciprofloxacin by mouth
e. Linezolid by mouth
f. Cetriaxone intravenously
g. Vancomycin intravenously
h. Daptomycin intravenously

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of neutropenia defined as neutrophil counts <1000 cells/mm? Labs must be attached.

☐ Yes ☐ No

Q6. Additional Information:

Prescriber Signature

Date

Updated for 2024