



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**Linezolid (Zyvox®)
Prior Authorization Request Form**

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ **Date Of Birth:** ____/____/____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ **Pharmacy NPI#:** _____

Phone number: (____) _____ **Fax number:** (____) _____

NDC Requesting: _____

Prescribing Physician's Name: _____

Physician Medicaid ID#: _____ **Physician NPI#:** _____

Phone number: (____) _____ **Fax number:** (____) _____

The following must be provided and should be signed/initialed and dated by the prescriber:

A copy of the culture and sensitivity for the organism being treated

A copy of the beneficiary's most recent complete blood count (CBC)

If an Infectious Disease (ID) consult was done, that may be forwarded also.

Seven (7) days of therapy is approved at a time. A repeat CBC is required every 7 days before processing another week of Zyvox®.

Signature of Physician or Designee: _____ **Date:** ____/____/____

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**