|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Oxazolidinone Antibacterial | | |
| **Criteria Subtitle** | Sivextro (tedizolid) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| SIVEXTRO | 072477 | GCNSeqNo |
| SIVEXTRO | 072478 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 2 | 1001 |  | Select and Free Text | Has the provider submitted documentation of the patient’s diagnosis and any culture and sensitivity reports showing the infection is caused by an organism resistant to preferred drugs?  If yes, please submit documentation. | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response to linezolid or has the provider submitted documentation of reasoning for why the patient cannot be changed to linezolid?  If yes, please submit documentation. | Y | END (Approve x 6 days) |
| N | 1235 |
| 4 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 6 days

|  |  |
| --- | --- |
| **Last Approved** | 4/11/2023 |
| **Other** |  |