

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**DIVISION OF HEALTH CARE FINANCING AND POLICY**  
NEVADA MEDICAID  
**DRUG USE REVIEW (DUR) BOARD**

**PROPOSED PRIOR AUTHORIZATION CRITERIA**

**Generic Name: Linezolid**

**Brand Name: Zyvox®**

**Medication Class: Oxazolidinone Antibiotics**

**1. Coverage and Limitations**

Criteria for Approval:

Patients who have been started and stabilized on linezolid (Zyvox®) or IV vancomycin while in the hospital for a documented MRSA infection

*-OR;*

Documented methicillin-resistant staphylococcus aureus (MRSA) infection with culture and documented sensitivity to linezolid that cannot be treated with these agents: doxycycline, minocycline, TMP/SMX, clindamycin, or other agents where sensitivity exists

QTY LIMIT = 14 days/2 tablets per day or 60 ml per day

*-OR;*

Documented vancomycin-resistant enterococcus (VRE) infection that cannot be treated with ampicillin or other agents where sensitivity exists

QTY LIMIT = 14 days; 1 refill/ 2 tablets per day or 60 ml per day

*ALSO:*

IV formulation is only approvable for members who are unable to take medications by mouth. QTY LIMIT = 600 ml per day