PRIOR AUTHORIZATION REQUEST
Nuzyra

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the indication or diagnosis?
   ☐ Acute bacterial skin and skin structure infections (ABSSSI)
   ☐ Community acquired bacterial pneumonia (CABP)
   →please proceed to question 2

2. θ Yes θ No Is the member 18 years or older?
   →If yes, please proceed to question 3

3. θ Yes θ No Is this medication prescribed by or in consultation with an infectious disease specialist?
   →If yes, please proceed to question 4

4. θ Yes θ No Does the member have documentation of bacterial culture and susceptibility to doxycycline/minocycline/tetracyclines?
   →If Yes, please proceed to question 5 [documentation required]

5. θ Yes θ No Has the member had a previous trial and failure of either doxycycline or minocycline?
   →If Yes, please proceed to question 6

6. θ Yes θ No Has the member had a previous trial and failure with Linezolid? If member has not tried linezolid, must provide documentation of intolerance/contraindication. [documentation required]
   →If Yes, please proceed to question 7

7. θ Yes θ No Has the member had a trial and failure with two additional drug classes other than doxycycline/minocycline/tetracyclines? If member has not tried two additional drug classes, must provide documentation of intolerance/contraindications to at least two additional drug classes listed below. [documentation required]
   Examples for CABP are penicillins, cephalosporins, macrolides, fluoroquinolones

If you have any questions, call: 800-753-2851

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Examples for ABSSSI are penicillins, cephalosporins, sulfonamides, lincosamides, oxazolidinones
→If yes, please proceed to question 8

8. θ Yes θ No Is the requested dose within the FDA approved labeling?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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