maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Nuzyra

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the indication or diagnosis? [] Acute bacterial skin and skin structure infections (ABSSSI) (If checked, go to 2) [] Community acquired bacterial pneumonia (CABP) (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
3	Is this medication prescribed by or in consultation with an infectious disease specialist?	Yes	No

If you have any questions, call:
1-888-258-8250

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
4	Has documentation been provided to confirm that the patient has bacterial culture and susceptibility to doxycycline/minocycline/tetracyclines? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
5	Has the patient had a previous trial and failure of either doxycycline or minocycline? [If no, no further questions.]	Yes	No
6	Has the patient had a previous trial and failure with Linezolid? [If yes, skip to question 8.]	Yes	No
7	Has documentation been provided to confirm that the patient has an intolerance or contraindication to Linezolid? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has the patient had a previous trial and failure with two additional drug classes listed below other than doxycycline/minocycline/tetracyclines? Examples for community acquired bacterial pneumonia (CABP) are penicillins, cephalosporins, macrolides, fluoroquinolones. Examples for acute bacterial skin and skin structure infections (ABSSSI) are penicillins, cephalosporins, sulfonamides, lincosamides, oxazolidinones. [If yes, skip to question 10.]	Yes	No
9	Has documentation been provided to confirm that the patient has an intolerance or contraindication to at least two additional drug classes listed below? Examples for community acquired bacterial pneumonia (CABP) are penicillins, cephalosporins, macrolides, fluoroquinolones. Examples for acute bacterial skin and skin structure infections (ABSSSI) are penicillins, cephalosporins, sulfonamides, lincosamides, oxazolidinones. ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Is the requested dose within the Food and Drug Administration (FDA) approved labeling?	Yes	No

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

If you have any questions, call: 1-888-258-8250

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250