



## 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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	What is the indication or diagnosis? <input type="checkbox"/> Acute bacterial skin and skin structure infections (ABSSSI) (If checked, go to 2)  <input type="checkbox"/> Community acquired bacterial pneumonia (CABP) (If checked, go to 2)  <input type="checkbox"/> 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

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

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3	Is this medication prescribed by or in consultation with an infectious disease specialist? [If no, no further questions.]	Yes	No
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

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

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**SECTION B:** Physician Signature

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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.

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