



**Nuzyra(omadacycline tosylate)  
Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640



**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.  **URGENT**

MEMBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**MALE**    **FEMALE**   **HEIGHT (IN/CM):** \_\_\_\_\_ **WEIGHT (LB/KG):** \_\_\_\_\_ **ALLERGIES:** \_\_\_\_\_

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI\\_DISCLOSURE\\_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_

**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

PRESCRIBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PRESCRIBER SPECIALTY:</b>	<b>EMAIL ADDRESS:</b>
<b>NPI NUMBER:</b>	<b>DEA NUMBER:</b>
<b>PHONE NUMBER:</b>	<b>FAX NUMBER:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>REQUESTOR (if different than prescriber):</b>	<b>OFFICE CONTACT PERSON:</b>

MEDICATION OR MEDICAL DISPENSING INFORMATION			
<b>MEDICATION NAME:</b>			
<b>DOSE/STRENGTH:</b>	<b>FREQUENCY:</b>	<b>LENGTH OF THERAPY/REFILLS:</b>	<b>QUANTITY:</b>
<input type="checkbox"/> <b>NEW THERAPY</b>		<input type="checkbox"/> <b>RENEWAL</b>	
<b>DURATION OF THERAPY (SPECIFIC DATES):</b>		<b>IF RENEWAL: DATE THERAPY INITIATED:</b>	





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*Continued on next page.*

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> community-acquired bacterial pneumonia (CABP) <input type="checkbox"/> acute bacterial skin and skin structure infections (ABSSSI) <input type="checkbox"/> <i>Mycobacterium abscessus</i> (Mab) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>Clinical Information:</b> <b>Is prescriber an infectious disease specialist, pulmonologist, or cystic fibrosis specialist?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Does patient have positive cultures for <i>Mycobacterium abscessus</i>?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab results &amp; subspecies, if available.</i>  <b>Does patient have <i>in vitro</i> sensitivities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab results.</i>  <b>Does patient have "erm gene" results available?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit lab results.</i>  <b>Has patient tried and failed a course of antibiotics, which include at least one macrolide antibiotic such as azithromycin, clarithromycin, in combination with two other antibiotics such as amikacin, imipenem, clofazimine, cefoxitin, linezolid, tigecycline, eravacycline, or bedaquiline?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit a list of trial dates.</i>  <b>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</b>  <hr/> <hr/>		
<b>Please note:</b> Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		
<b>ATTESTATION:</b> I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.		
<b>Prescriber Signature or Electronic I.D. Verification:</b> _____ <b>Date:</b> _____		
<b>CONFIDENTIALITY NOTICE:</b> The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents		





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of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

