AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Nuzyra® (omadacycline) **IV (J0121) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – provide therapy start date: _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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❑ **Diagnosis: Acute bacterial skin and skin structure infections (ABSSSI)**

Length of Authorization: Date of Service (14 days)

❑ **New Start**

- ❑ Member is 18 years of age or older
- ❑ Must be prescribed or consulted with by an Infectious Disease Specialist
- ❑ Member has a diagnosis of acute bacterial skin and skin structure infection (ABSSSI)
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Nuzyra
- ❑ If member is receiving IV antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
- ❑ If member is receiving oral antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: penicillin VK, amoxicillin, amoxicillin-clavulanate, dicloxacillin, cephalexin, clindamycin, doxycycline, trimethoprim-sulfamethoxazole, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: penicillin VK, amoxicillin, amoxicillin-clavulanate, dicloxacillin, cephalexin, clindamycin, doxycycline, trimethoprim-sulfamethoxazole, and linezolid

❑ **Diagnosis: Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms**

Length of Authorization: Date of Service (14 days)

❑ **New Start**

- ❑ Member is 18 years of age or older
- ❑ Must be prescribed or consulted with by an Infectious Disease Specialist
- ❑ Member has a diagnosis of Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Nuzyra

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- ❑ If member is receiving IV antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: penicillin G, nafcillin, ampicillin, ampicillin-sulbactam, cefazolin, ceftriaxone, vancomycin, daptomycin, clindamycin, and linezolid
- ❑ If member is receiving oral antibiotics, **ONE** of the following must be met:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: amoxicillin, amoxicillin-clavulanate, dicloxacillin, doxycycline, azithromycin, cefdinir, cefpodoxime, levofloxacin, linezolid and moxifloxacin
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: amoxicillin, amoxicillin-clavulanate, dicloxacillin, doxycycline, azithromycin, cefdinir, cefpodoxime, levofloxacin, linezolid and moxifloxacin

❑ **Diagnosis: Acute Bacterial Skin and Skin Structure Infections (ABSSSI) or Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms**

Length of Authorization: Date of Service

❑ **Continuation of therapy following inpatient administration**

- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Acute Bacterial Skin and Skin Structure Infections (ABSSSI)
  - ❑ Community-acquired bacterial pneumonia (CABP) without Multidrug-resistant organisms
- ❑ Member is currently on Nuzyra for more than 72 hours inpatient **(progress notes must be submitted)**
- ❑ Must be prescribed or consulted with by an Infectious Disease Specialist
- ❑ Provider has submitted lab culture sensitivity results retrieved during inpatient admission which shows resistance to **ALL** preferred antibiotics except for Baxdela (sensitive) or documentation of severe allergic reactions preventing the administration and use of an alternative agent(s)

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee**: 3/27/2025
REVISED/UPDATED/REFORMATTED: ~~6/11/2025;~~ **10/16/2026**