AvMed

PHARMACY 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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: glycopyrrolate (Cuvposa®) oral solution

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

MAXIMUM APPROVED DOSE: 1.5 to 3 mg/dose based upon weight
Children ≥3 years and Adolescents ≤16 years: 0.02mg/kg/dose 3 times daily, titrate in increments of 0.02 mg/kg/dose every 5 to 7 days as tolerated to response up to a maximum dose of 0.1 mg/kg/dose 3 times daily.

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.

- ❑ Member must be 3 to 16 years of age and have a clinical diagnosis of a neurological condition (i.e., ALS, Parkinson's disease, cerebral palsy, multiple sclerosis) associated with chronic severe drooling (sialorrhea) **(must submit chart notes)**

AND

- ❑ Member has failed or has an intolerance to generic glycopyrrolate tablets **(verified by chart notes or pharmacy paid claims)**

OR

(Continued on next page)

- ❑ Member requires liquid formulation due to dosing or inability to take tablet formation

AND

- ❑ Member does not have any medical conditions that preclude anticholinergic therapy (i.e., glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis)

AND

- ❑ Member does not have concomitant use of solid oral dosage forms of potassium chloride

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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:** 2/18/2021
REVISED/UPDATED: ~~6/30/2021~~; **10/26/2023**