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: Select one below:

❑ **Aquoral®** (oxidized glycerol triesters)	❑ **Caphosol®** (supersaturated calcium phosphate rinse)	❑ **NeutraSal®** (supersaturated calcium phosphate rinse)
❑ **SalivaMax™** (supersaturated calcium phosphate rinse)	❑ **Salivate Rx** (supersaturated calcium phosphate rinse)	

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:** _____

Note: If approved, a maximum of 120 unit doses per 30 days for supersaturated calcium phosphate rinses or 1 unit (40mL) of Aquoral® per 30 days will be authorized

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.

❑ **For Mucositis Indication: Please check all that apply (two boxes must be checked)**

❑ Trial and failure of Magic Mouthwash for 30 days (must be verified by pharmacy paid claims)

AND

(Continued on next page)

- ❑ Trial and failure of lidocaine 2% viscous solution for 30 days (must be verified by pharmacy paid claims)

OR

- ❑ Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for 30 days

❑ **For Xerostomia or Hyposalivation Indications: Please check all that apply (one box must be checked)**

- ❑ Trial and failure of Mouth Kote® solution for 30 days (must be verified by pharmacy paid claims)

OR

- ❑ Trial and failure of Biotene Dry Mouth Moisturizing Spray, Biotene Dry Mouth Oral Rinse or Biotene Moisturizing Oral Rinse for 30 days

*****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**: 8/25/2016
REVISED/UPDATED: ~~11/14/2016; 12/12/2016; 8/17/2017;~~ **(Reformatted) 6/21/2019**