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: Brexafemme® (ibrexafungerp)

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:** _____

Weight: _____ **Date:** _____

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.

Diagnosis: Vulvovaginal Candidiasis (VVC), acute infection

Recommended Dosing: 300 mg every 12 hours for 1 day (2 doses)

Length of Authorization: Date of Service, one-time fill

- ❑ Member is post-menarchal
- ❑ Provider has confirmed that the member is not pregnant
- ❑ Member has a current diagnosis for acute, uncomplicated vulvovaginal candidiasis (VVC) **(please include laboratory documentation or medical chart notes to confirm diagnosis i.e., urinalysis, microscopic examination via 10% KOH)**
- ❑ Trial and failure of oral fluconazole at the recommended dosage of 150 mg as a single dose for the treatment of VVC **(pharmacy claims history and chart notes must confirm failure)**

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- ❑ Trial and failure of two topical agents (suppository inserts/ovules/creams) for the treatment of VVC **(pharmacy claims history and chart notes must confirm failure)**
  - ❑ Gynazole-1 vaginal cream 2 %
  - ❑ Terconazole vaginal cream 0.4 %, 0.8 %
  - ❑ Terconazole vaginal suppository 80 mg
  - ❑ OTC products: tioconazole ointment 6.5%, miconazole suppository 100 mg/200 mg, clotrimazole cream 1%, 2% /100 mg suppository

Diagnosis: Recurring Vulvovaginal Candidiasis (RVVC)
Recommended Dosing: 300 mg every 12 hours for 1 (2 doses); repeat monthly for a total of 6 months
Length of Authorization: 6 months

- ❑ Member is post-menarchal
- ❑ Provider has confirmed that the member is not pregnant
- ❑ Member is currently experiencing signs and symptoms consistent with an acute episode of VVC (e.g., vulvovaginal pain, pruritis or irritation, abnormal vaginal discharge), **AND** it is a laboratory confirmed VVC episode **(please include laboratory documentation or medical chart notes to confirm diagnosis i.e., urinalysis, microscopic examination via 10% KOH, culture)**
- ❑ Member has a history of recurring VVC (RVVC) **(please include past medical history notes recording RVVC, defined as ≥ 3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period)**
- ❑ Member remains symptomatic and culture positive after therapy with fluconazole, completing a 6-month dosing regimen as follows unless intolerant or contraindicated **(please include medical chart/progress notes and laboratory results; pharmacy claims history and chart notes must confirm failure, intolerance or contraindication to therapy)**:
  - ❑ 100, 150 or 200 mg oral dose of fluconazole every third day for a total of 3 doses (days 1, 4 and 7)
  - ❑ Followed by oral fluconazole (100, 150 or 200 mg oral dose) weekly for 6 months as the maintenance regimen

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.****