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: Upneeq™ (oxymetazoline hydrochloride) **ophthalmic solution 0.1%**

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:** _____

Quantity Limit: 30 single-dose vials/30 days

Upneeq will NOT be approved for members with a diagnosis of dermatochalasis (excessive eyelid tissue)

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.

Initial Authorization Approval: 6 months

- ❑ Individual is 18 years of age or older

AND

- ❑ Diagnosis of acquired blepharoptosis confirmed by MRD1 measurement of ≤2 mm **(please provide chart notes)**

AND

(Continued on next page)

- ❑ Documentation of at least **ONE** of the following patient-reported features of functional impairment from acquired blephaorptosis **(please provide chart notes)**:
  - Interference with occupational duties and safety resulting from visual impairment
  - Decreased peripheral vision
  - Compensatory chin-up backward head tilt
  - Difficulty reading
  - Eye discomfort, fatigue or strain

Reauthorization Approval: 12 months. 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.

- ❑ Attestation that the member has not developed any negative side effects from the medication

AND

- ❑ Documentation of improvement in MRD1 measurement from baseline **(please provide chart notes)**

AND

- ❑ Documentation of improvement of patient-reported features of functional impairment from acquired blepharoptosis **(please provide chart notes)**

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.****