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 from below)

❑ **Cequa™** (cyclosporine ophthalmic solution) **0.09%**	❑ **Lacrisert®** (hydroxypropyl cellulose ophthalmic insert)
❑ **Tyrvaya®** (varenicline solution nasal spray) **0.03 mg**	

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 Limits: Cequa™** and **Lacrisert®:** 60-unit doses or single-use vials per 30 days
- **Quantity Limit: Tyrvaya™:** 2 bottles (1 package of 8.4 mL) per 30 days

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.

(Continued on next page)

- ❑ Member has tried and failed **at least 30 days** of therapy with **BOTH** of the following medications:
  - ❑ Brand Restasis®
  - ❑ Xiidra® (lifitegrast ophthalmic solution) 5%

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:** 9/17/2020
REVISED/UPDATED: ~~11/5/2020; 3/8/2021; 12/29/2021; 2/24/2022; 3/23/2022; 6/24/2022; 11/7/2022;~~ **10/26/2023**