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: Bronchitol® (mannitol) **inhalation powder**

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: 400 mg of Bronchitol (10 capsules) twice a day by oral inhalation, in the morning and evening, with the later dose taken 2-3 hours before bedtime. Maximum Quantity: 560 capsules/28 days. For the Bronchitol Tolerance Test Max dose: 400mg (10 capsules) once.

***Request for reauthorization of Bronchitol Tolerance Test is not permitted.**

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- 6 months

- ❑ Member must be 18 years of age and have a diagnosis of Cystic Fibrosis **(must submit chart notes)**

(Continued on next page)

AND

- ❑ Prescribing physician is a pulmonologist or has consulted with a pulmonologist who specializes in the treatment of Cystic Fibrosis

AND

- ❑ Provider attests that the member has passed the Bronchitol® (mannitol) Tolerance Test to confirm the member is a suitable candidate for Bronchitol® maintenance therapy

AND

- ❑ Provider submits documentation of an inadequate response, contraindication or clinically significant adverse event to hypertonic saline and Pulmozyme® (requires prior authorization) **(must attach chart notes)**

AND

- ❑ Bronchitol is prescribed concurrently with a short-acting bronchodilator (e.g. Proair, Ventolin)

Reauthorization- 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.

- ❑ Member has demonstrated disease response to therapy as indicated by improvement or stability of disease symptoms by **one or more** of the following **(must submit chart notes)**:
  - ❑ Decreased pulmonary exacerbations
  - ❑ Decrease in hospitalization rate
  - ❑ Stabilization of lung function as measured by FEV1
  - ❑ Improvement in quality of life

AND

- ❑ Bronchitol is prescribed concurrently with a short-acting bronchodilator

Medication being provided by a Specialty Pharmacy - PropriumRx

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:** 3/12/2021
REVISED/UPDATED: ~~6/30/2021~~;10/26/23