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.**

Ophthalmic Antihistamine/Ophthalmic Allergy

Drug Requested: (select one below)

❑ **Alocril®** (nedocromil sodium ophthalmic solution 2%)	❑ **Alomide®** (lodoxamide tromethamine ophthalmic solution 0.1%)	❑ **bepotastine besilate ophthalmic solution 1.5%** (Bepreve®)
❑ **Lastacaft®** (alcaftadine ophthalmic solution 0.25%)	❑ **Zerviate™** (cetirizine)	

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:** _____

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)

If requesting Alocril, bepotastine, Lastacaft or Zerviate:

- ❑ Patient must have documentation of trial and failure of **THREE (3)** of the following **(check each that has been tried; trials will be verified through paid pharmacy claims or chart notes)**:
  - ❑ ketotifen 0.025% ophthalmic solution
  - ❑ azelastine 0.05% ophthalmic solution
  - ❑ cromolyn sodium 4% ophthalmic solution
  - ❑ epinastine 0.05% ophthalmic solution
  - ❑ olopatadine 0.1% ophthalmic solution
  - ❑ olopatadine 0.2% ophthalmic solution

If requesting Alomide:

- ❑ Patient must have documentation of trial and failure of cromolyn sodium 4% ophthalmic solution **(trials will be verified through paid pharmacy claims or 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.*****