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: Vecamyl® (mecamylamine HCl)

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:** __________

Recommended dosing: start with 50mg once daily at the same time; after two weeks may be increased to 100mg.

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.

- ❑ Member **MUST** have a diagnosis of hypertension
- ❑ Member **MUST** have a documented trial and failure of a combination of three (3) formulary antihypertensive agents from different drug classes, up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are expected
- ❑ Member may **NOT** receive concomitant therapy with antibiotics or sulfonamides

*****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**: 10/19/2017
REVISED/REFORMATTED/UPDATED: ~~12/18/2017; 3/31/2018;) 6/18/2019;~~ **10/27/2023**