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.**

Long-Acting Antimuscarinic (LAMA) and Long-Acting Beta2 Agonist (LABA) Combination Products

Drug Requested: (Select one from below)

❑ **Bevespi Aerosphere®** (glycopyrrolate and formoterol)	❑ **Breztri®** (budesonide, glycopyrrolate and formoterol)
❑ **Duaklir Pressair®** (aclidinium and formoterol)	

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.

Diagnosis: Chronic Obstructive Pulmonary Disease (COPD)

(Continued on next page)

- ❑ Patient must be ≥ 18 years of age
- ❑ Patient must have tried and failed **at least 30 days** of **TWO** of the following:

❑ Anoro Ellipta®	**OR**	❑ Trelegy Ellipta®	**AND**	❑ Stiolto Respimat®

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.****