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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Furoscix® (furosemide)

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:** _____

Weight: _____ **Date:** _____

Quantity Limit: 2 on-body infusors per fluid overload episode (max of 2 per fill)

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 is 18 years of age or older
- ❑ Member has a diagnosis of New York Heart Association (NYHA) Class II or III chronic heart failure
- ❑ Member is experiencing congestion due to fluid overload
- ❑ Member does **NOT** have anuria or hepatic cirrhosis or ascites
- ❑ Member does **NOT** have a hypersensitivity to furosemide or medical adhesives
- ❑ Member does **NOT** have acute pulmonary edema

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- ❑ Prescriber attests, Furoscix will **NOT** be prescribed for an emergency situation
- ❑ Prescriber attests the member requires a non-oral route of administration of a loop diuretic for congestion due to fluid overload in chronic heart failure
- ❑ Prescriber attests the member will be monitored outpatient for fluid, electrolyte, and metabolic abnormalities

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 must have disease improvement and/or stabilization **OR** improvement in the slope of decline (e.g., improvement in signs/symptoms of fluid overload – edema, dyspnea, rapid weight gain)
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., fluid, electrolyte, or metabolic abnormalities, worsening renal function, ototoxicity, acute urinary retention)

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.