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: Relyvrio™ (Sodium Phenylbutyrate and Taurursodiol)

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:** _____

Recommended Dosage:

- Initial: Oral: One packet (sodium phenylbutyrate 3 g/taurursodiol 1 g) once daily for 3 weeks, then increase dose to 1 packet twice daily, if tolerated

Quantity Limits:

- 2 packets per day

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

- ❑ Prescriber is a Neurologist
- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of amyotrophic lateral sclerosis (ALS) **(submit documentation)**

(Continued on next page)

- ❑ Member has tried and failed at least 60 days of therapy with **BOTH** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ **riluzole**
  - ❑ **Radicava**
- ❑ Provider has assessed member's baseline disease severity utilizing an objective measure/tool (e.g., ALS Functional Rating Scale-Revised (ALSFRS-R)) **(submit documentation)**
- ❑ Member does **NOT** require permanent assisted ventilation

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.

- ❑ Functionality retained for most activities of daily living (defined as total score from baseline did **NOT** decrease by more than 10 points on the ALS Functional Rating Scale-Revised (ALSFRS-R)
- ❑ Member has **NOT** experienced any unacceptable toxicity from treatment (e.g., worsening hypertension or heart failure)

Medication being provided by Specialty Pharmacy - PropriumRx

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.*