

# 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:** Xdemvy™ (lotilaner ophthalmic solution) 0.25%

**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:** 10 mL per 365 days

**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.

**Length of Authorization: 6 weeks**

- Member is 18 years of age or older
- Prescribed by or in consultation with an eye specialist (e.g., ophthalmologist, optometrist)
- Member has a diagnosis of blepharitis due to Demodex infestation confirmed by the presence of **ALL** the following in **at least one (1) eye:**
  - Demodex infestations with >10 lashes with collarettes present on the upper lid (collarette scale grade 2 or worse)
  - Mild erythema of the upper eyelid margin
  - Average mite density of > 1.5 mites per lash (upper and lower eyelids combined)

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**Reauthorization: Coverage may NOT be renewed. Reauthorization will not be granted as Xdemvy has NOT been studied beyond 6 weeks of therapy or for re-treatment.**

**Medication being provided by Specialty Pharmacy – Proprium Rx**

***\*\*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.\****