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 Muscarinic Antagonist (LAMA) Anticholinergic inhalers

Drug Requested: (Select one from below)

❑ **Lonhala Magnair®** (glycopyrrolate) **oral inhalation solution**	❑ **Tudorza® Pressair®** (aclidinium bromide inhalation powder)
❑ **Yupelri®** (revefenacin) **oral inhalation solution**	

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:** ____________

Quantity Limits:

- **Lonhala Magnair® - 60 vials per 30 days**
- **Tudorza® Pressair® - 1 inhaler per 30 days**
- **Yupelri® - 30 vials per 30 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.

(Continued on next page)

- ❑ Member must have tried and failed **at least** **30 days** of therapy with the following:
  - ❑ Spiriva® Handihaler®

    OR
  - ❑ Spiriva® Respimat®

    AND
  - ❑ Incruse® Ellipta®

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.****