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 may be delayed.**

Drug Requested: Xadago® (safinamide)

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 Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

Recommended Dosage: Start with 50 mg once daily at the same time; after two weeks, dose may be increased to 100 mg once daily.

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.

- ❑ Member must have tried and failed **at least 30 days** of therapy with **ONE** of the following **(verified by chart notes or pharmacy paid claims)**:
  - ❑ selegiline
  - ❑ rasagiline

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.

***Approved by Pharmacy and Therapeutics Committee**: 10/19/2017
Revised/Updated: ~~12/18/2017~~; ~~2/21/2018~~; ~~(Reformatted) 6/18/2019~~; **8/26/2022**