

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: Orlynvah™ (sulopenem etzadroxil and probenecid)

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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Recommended Dosage: One tablet twice daily for 5 days

Quantity Limit: 10 tablets 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.

Length of Authorization: **Date of Service**

- ☐ Member is 18 years of age or older
- ☐ Member has a diagnosis uncomplicated urinary tract infections (uUTI) caused by the designated microorganisms Escherichia coli, Klebsiella pneumoniae or Proteus mirabilis in adults
- ☐ Lab cultures must show that bacteria is sensitive to Orlynvah (**submit documentation**)

(Continued on next page)

- ☐ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics unless intolerant or bacteria is drug resistant (**submit documentation**):
- ☐ sulfamethoxazole-trimethoprim
 - ☐ nitrofurantoin
 - ☐ ciprofloxacin or levofloxacin
 - ☐ amoxicillin-clavulanate
 - ☐ cephalexin
 - ☐ cefdinir

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.****