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: Lodoco® (colchicine)

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 Limit: 1 tablet 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: 12 months

- ❑ Member is 35 years of age or older
- ❑ Requested medication will be used to reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular disease
- ❑ Prescribed by or in consultation with a provider specializing in heart disease (i.e., cardiology, lipidology)

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- ❑ Member has Atherosclerotic Cardiovascular Disease (ASCVD) confirmed by at least **ONE** of the following:
  - ❑ History of myocardial infarction or a history of an acute coronary syndrome
  - ❑ Stable or unstable angina
  - ❑ History of Stroke
  - ❑ History of Transient ischemic attack
  - ❑ Peripheral arterial disease presumed to be of atherosclerotic origin
  - ❑ Member has undergone coronary or other arterial revascularization procedure in the past (e.g., coronary artery bypass graft surgery, percutaneous coronary intervention, angioplasty, and coronary stent procedures
- ❑ Member must meet **ONE** of the following **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member will continue background therapy with maximally tolerated statin therapy (e.g., atorvastatin, rosuvastatin, simvastatin)
  - ❑ If member is statin intolerant, member will continue background therapy with maximally tolerated non-statin lipid-lowering agents (e.g., ezetimibe, Repatha, fenofibric acid) unless contraindicated or not tolerated
- ❑ Requested medication is being added onto other background regimens of other ASCVD disease medications according to the prescriber **(verified by chart notes and/or pharmacy paid claims) Note: Examples of medications recommended in guideline-directed therapy for patients with atherosclerotic disease can include aspirin, antiplatelet agents (e.g., clopidogrel, Brilinta [ticagrelor tablets]), anticoagulants, beta blockers, angiotensin-converting enzyme inhibitors, and/or angiotensin receptor blockers.**
- ❑ Member's blood pressure is controlled and stable on current antihypertensive therapy
- ❑ Provider attests member does **NOT** have any of the following comorbidities:
  - Renal failure (i.e., CrCl < 15 mL/min)
  - Severe liver impairment
  - Pre-existing blood dyscrasias
  - Concurrent use of strong CYP3A4 or P-gp inhibitors

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.

- ❑ Member continues to meet all initial authorization criteria
- ❑ Provider must submit documentation indicating improvement in member's condition and attests member continues to benefit from therapy with requested medication

*****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: 11/16/2023**
REVISED/UPDATED/REFORMATTED: 12/11/2023