Pharmacy Transition of Medications

Effective 4/1/2015. This list is subject to change prior to the effective date.

Welcome to AvMed

This form is to help newly enrolled members transition from their previous insurance carrier to AvMed Health Plans. Some prescription medications on AvMed's formulary have certain requirements for coverage. Completion of this transition form provides AvMed the information needed to facilitate refills of these medications to assure continued care.

Please complete and submit both pages of this form.

AvMed's formulary is updated monthly. The Pharmacy Transition of Medications is reviewed and revised quarterly and therefore may not exactly mirror the formulary. Before completing this form, please check the updated electronic version of the formulary at www.avmed.org.

Complete this form ONLY if you are taking a medication listed below.
Please fill out one form per family member, if needed. Fax: 855-748-8742

Si usted necesita ayuda para completar este documento, por favor llame a nuestro Departamento de Servicios a los Afiliados utilizando el número de su tarjeta de identificación. Un representante que habla español le ayudará.

Today's Date: _____ Employer Group: _____

Member Name: _____ Date of Birth: _____

Member ID or SS: _____ Daytime Contact Phone Number: _____

Please ask your pharmacy for a list of your Mediction History and fax it with this form to AvMed.
This will expidite the processing of this request

Progressive Medication Program (PMP) List

The Progressive Medication Program (PMP) encourages the use of generic medications. This program requires the trial of alternative medications first in order to be approved for one of the medications listed below. However, if you have been taking one of these medications within the last 90-days, an authorization will be entered that will allow you to continue the use of this medication. Circle the medication you are taking and fax to AvMed for authorization. Please allow 10-14 days for processing. Call your pharmacy before going to ensure your prescription is ready. If you do not pick up your prescription within the first 90 days of your effective date with AvMed, a new authorization will be required.

Aciphex	Cymbalta	Glumetza	Micardis	Prevacid solutab	Tribenzor	All brand oral Contraceptives (listed as Tier 3)
Actonel	Daytrana	ibandronate (Boniva)	Micardis HCT	Qnasl	Triglide	
Atelvia	Dexilant		Nesina	Relpax	Vascepa	
Axert	Dymista	Intuniv	Nexium	Rhinocort Aqua	Veramyst	
Azor	Edarbi	Kazano	Niaspan	Ritalin LA	Victoza	
Beconase AQ	Edarbyclor	Lescol XL	Omnaris	Rozerem	Vytorin	
Benicar	eprosartan	Lipofen	Oseni	Strattera	Vyvanse	
Benicar HCT	Focalin XR	Liptruzet	Oxycontin	SymlinPen	Zetonna	
methylphenidate (Concerta	Fosamax D	Lovaza	Pristiq	Teveten	zolpidem ER	
	Frova	Lunesta	Procentra	Teveten HCT		

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Medications That Need Prior Authorization (PA)

Prior Authorization (PA) Needed: This program is designed to require close monitoring of medications with potentially serious adverse effects, prevent medication misuse/abuse, and ensure the appropriate utilization of high cost agents. The PA program requires approval before the medication is covered by AvMed. **We will initiate the PA with your doctor on your behalf if you provide your doctor's information below. Allow two weeks from receipt of all required documentation from your physician. Contact your physician for the status.**

Abilify	Botulinum Toxins	Enbrel	Humira	Mekinist	Peg-Intron	sildenafil citrate (Revatio)	tretinoin (Retin-A)	Diabetic Test Strips with Insulin Pump**
Abstral	Brovana	Endometrin	Iclusig	metformin ER (Glumetza)	Perforomist			
Actemra	budesonide susp (Pulmicort Respules)	Entyvio	Imbruvica		Plegridy	Simponi	Tysabri	
Adcetris		Episil	Impavido	Methitest	Pomalyst	Simponi Aria	Tyvaso	
Adcirca	Buphenyl	Epogen		modafinil (Provigil)	Potiga	Sirturo	Uloric	
Adempas	butorphanol tartrate	Erivedge	Inlyta		Procrit	Soliris	Valchlor	
adapalene (Differin)		Erwinaze	Intron-A	morphine sulfate er (Kadian)	Procysbi	Somatuline Depot	vancomycin (Vancocin)	
	Butrans	Esbriet	itraconazole (Sporanox)		Promacta			
ADHD Medication (Only if >18)	Caphosol	fentanyl citrate (Actiq)		Mozobil	Provenge	Solvaldi	Ventavis	
	celecoxib (Celebrex)		IVIG	Mugard	Quillivant	Stelara	Vimpat	
	Cerdelga	Fentora	Jakafi	Nesina	quinine sulfate (Qualaquin)	Stimate	Virazole	
Afinitor	Cerezyme	Ferriprox	Jentadueto	Neulasta		Stivarga	Votrient	
Akynzeo	Cimzia	Firazyr	Jevtana	Neumega	Ravicti	sumatriptan inj (Imitrex)	Vpriv	
Alferon N	Cinryze	flouride	Juxtapid	Neupogen	Regranex		Xalkori	
Androderm	Cometriq	folic acid	Kadcyla	Noxafil	Remicade	Supprelin La	Xeljanz	
Androgel	Crinone	Forteo	Kadian	Nplate	Restasis	Sylatron	Xenazine	
Androxy	Cyramza	Fortesta	Kalydeco	Nuedexta	Revlimid	Sylvant	Xifaxan	
Aranesp	Cystaran	Fulyzaq	Kazano	Nuvigil	ribavirin	Synagis	Xiaflex	
Aubagio	Daliresp	Fycompa	Kineret	Olysio	Rituxan	Tafinlar	Xolair	
Avita	Dificid	Gammagard	Korlym	Omnitrope	Ruconest	Tarceva	Xtandi	
Avonex	dihydroergotamine (D.H.E. 45)	Gamunex-C	Krystexxa	Opsumit	Sabril	Tecfidera	Xyrem	
Axiron		Gattex	Kynamro	Orencia	Samsca	Testim	Yervoy	
Benlysta	dronabinol (Marinol)	Gazyva	Lazanda	Oseni	Sancuso	Testosterone injection	Zelboraf	
Betaseron	Elelyso	Gilenya	Letaris	oxandrolone (Oxandrin)	Seroquel XR		Zydelig	
Blincyto	Eloctate	Gilotrif	Leukine		Serostim	Tracleer	Zytiga	
Bosulif	Emend	Granix	Lotronex	Oxycontin	Signifor	Tradjenta	Zyvox	
	Emsam	Harvoni	Lupron	Pegasys				

Prescribing physician name, phone & fax number:

This field is required

Other brand medications you are taking not identified on this form:

Additional Information

Your pharmacy phone number:

I AUTHORIZE any licensed physician, hospital, clinic or other related facility or provider to release for review my or my enrolled dependent children's (under age 18) medical records to AvMed. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. By signing this form, you consent to our use and disclosure of protected health information about you or your dependent children for treatment, payment and health care operations.

Member Signature: _____ **Date:** _____

If you have any questions regarding this form, please call Member Services at the number listed on the back of your AvMed ID card.

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