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: Furoscix® (furosemide)

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 Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

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

Quantity Limit: 6 on-body infusors per 90 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.

Initial Authorization: 3 months

- ❑ Medication is being prescribed by or in consultation with a cardiologist
- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of New York Heart Association (NYHA) Class II, III or IV chronic heart failure
- ❑ Member is experiencing congestion due to fluid overload that is **NOT** considered to be an emergency situation
- ❑ Member has a clinical reason for requiring Furoscix (e.g., reduced responsiveness to oral diuretics such as bumetanide, furosemide, or torsemide)

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- ❑ Prescriber agrees that member will use Furoscix for short-term use only **AND** will replace with oral diuretics as soon as practical
- ❑ Member does **NOT** have any of the following: hypersensitivity to furosemide or medical adhesives; anuria; hepatic cirrhosis or ascites; or acute pulmonary edema
- ❑ Prescriber attests the member will be monitored outpatient for fluid, electrolyte, and metabolic abnormalities

Second Authorization for continued therapy after initial authorization approval: 3 months

- ❑ Member meets **ALL** initial authorization criteria and requires re-treatment due to persistent reduced response to oral diuretics (**submit documentation**)

Reauthorization: For use beyond 6 months. Length of authorization is 12 months and will be reassessed annually. 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 disease improvement and/or stabilization **OR** improvement in the slope of decline (e.g., improvement in signs/symptoms of fluid overload – edema, dyspnea, rapid weight gain)
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., fluid, electrolyte, or metabolic abnormalities, worsening renal function, ototoxicity, acute urinary retention)
- ❑ Member is considered to be refractory to oral diuretics, and continued use of Furoscix is medically necessary for stabilization of their condition

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.****