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: Cresemba® (isavuconazonium sulfate) **Capsules**

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:** _____

Recommended Dosage and Quantity Limit:

Cresemba 186mg Capsules

- **Loading Dose [Quantity 12]:**
  2 capsules (372mg) every 8 hours for 6 doses
- **Maintenance Dose [Quantity 60 per month]:**
  2 capsules once daily [started 12-24 hours after loading dose]

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 Approval: 12 weeks

- ❑ The member is ≥ 18 years old

AND

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- ❑ **For Invasive Aspergillosis,** the member has a documented trial and failure, or contraindication, to voriconazole therapy as first line therapy

OR

- ❑ **For Invasive Mucormycosis,** the member has a documented trial and failure, or contraindication, to liposomal amphotericin B as first line therapy

OR

- ❑ The member is completing a course of therapy that has been initiated in the hospital

Please provider date therapy was initiated (loading dose included) and how many days completed:

DATE: _____ **DAYS OF THERAPY COMPLETED:** _____

AND

- ❑ The provider confirms the member is not on concurrent use of strong CYP3A4 inducers such as rifampin, carbamazepine, or St. John's Wort

AND

- ❑ The provider confirms the member is not on concurrent use of strong CYP3A4 inhibitors such as ketoconazole or high-dose ritonavir

AND

- ❑ The provider confirms the member does not have medical history of familial short QT syndrome

Reauthorization Approval: 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.

- ❑ The member is ≥ 18 years old

AND

- ❑ The member will require secondary prophylaxis to prevent disease recurrence of invasive aspergillosis or mucormycosis

AND

- ❑ Liver function tests are being monitored, and the member is not experiencing clinical signs and symptoms of liver disease or hepatic failure

AND

- ❑ The provider confirms the member is not on concurrent use of strong CYP3A4 inducers such as rifampin, carbamazepine, or St. John's Wort

AND

- ❑ The provider confirms the member is not on concurrent use of strong CYP3A4 inhibitors such as ketoconazole or high-dose ritonavir

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AND

- ❑ The provider confirms the member does not have medical history of familial short QT syndrome

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.****

***Approved by Pharmacy and Therapeutics Committee:** 5/21/2020
REVISED/UPDATED/REFORMATTED: ~~9/9/2020~~ 10/27/2023