AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid)</u> on this request. All other information may be filled in by office staff; <u>fax to 1-305-671-0200</u>. No additional phone calls will be necessary if all information (<u>including phone and fax #s</u>) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

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:	
Office Contact Name:	
Phone Number:	
DEA OR NPI #:	
DRUG INFORMATION: Authorization may be del	
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 load	ding dosel

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

 \Box The member is ≥ 18 years old

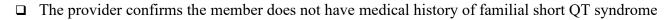
AND

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	For Invasive Aspergillosis, the member has a documented trial and failure, or contraindication, to voriconazole therapy as first line therapy
	<u>OR</u>
	For Invasive Mucormycosis, the member has a documented trial and failure, or contraindication, to liposomal amphotericin B as first line therapy
	<u>OR</u>
	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
ppro	uthorization Approval: 12 months. Check below all that apply. All criteria must be met for oval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart, 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
	<u>AND</u>
	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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A	N	D



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.