

# 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:** (Select ONE drug below)

<input type="checkbox"/> <b>Posaconazole</b> (generic Noxafil®) <b>delayed-release tablets 100 mg</b>	<input type="checkbox"/> <b>Posaconazole</b> (generic Noxafil®) <b>immediate-release oral suspension 40 mg/mL</b>	<input type="checkbox"/> <b>Noxafil® PowderMix Pak</b> (posaconazole) <b>delayed-release oral suspension 300 mg</b>
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**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, if applicable: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

### Quantity Limits:

- Delayed-release tablets, 100 mg: 8 tablets per day
- Immediate- release oral suspension, 40 mg/mL: 20 mL per day
- Delayed- release oral suspension, 300 mg packets: 1 packet 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.

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IF REQUESTING AN ORAL SUSPENSION FORMULATION, please provide clinical-based reasoning and attach applicable documentation why the member cannot swallow tablets:

☐ **Diagnosis: Aspergillosis**

**Approval Length: one time authorization, treatment period 6-12 weeks**

- ☐ Member is 13 years of age or older
- ☐ Member has a diagnosis of invasive aspergillosis
- ☐ Member has a documented trial and failure, contraindication, or documented resistance to itraconazole or voriconazole therapy as first line therapy

☐ **Diagnosis: Candidiasis Infection**

**Approval Length: one time authorization, treatment period up to 28 days**

- ☐ Member is 13 years of age or older
- ☐ Member has oropharyngeal candidiasis, **AND** has documented trial and failure, contraindication, or documented resistance to clotrimazole troches, nystatin suspension, **AND** fluconazole
- ☐ Member has esophageal candidiasis refractory to fluconazole infection, **AND** has documented trial and failure, contraindication, or documented resistance to itraconazole **AND** voriconazole

☐ **Diagnosis: Immunocompromised Patients, Prophylaxis against invasive fungal infections**

**Approval Length: 6 months**

- ☐ Member is severely immunocompromised and treatment is required for prophylaxis of invasive aspergillus and Candida infections:
  - ☐ Allogeneic hematopoietic stem cell transplant [HSCT] recipient
  - ☐ Hematologic malignancy (i.e. Leukemia, lymphoma, myelodysplastic syndrome)
  - ☐ Prolonged neutropenia from chemotherapy
  - ☐ High-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient
- ☐ Member meets ONE of the following age/formulation criteria:
  - ☐ Delayed-release tablets (members  $\geq 2$  years of age and  $> 40$  kg)
  - ☐ Immediate-release oral suspension (members  $\geq 13$  years of age)
  - ☐ Delayed-release oral suspension, powder mix (members  $\geq 2$  to  $< 18$  years of age and  $\leq 40$ kg)

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**❑ Diagnosis: Coccidioidomycosis**

**Approval Length: 6 months**

- ❑ Member has a diagnosis of chronic coccidioidal pneumonia and meets the following:
  - ❑ Is symptomatic [must provide progress notes, any laboratory documentation or imaging studies to convey debilitating illness and/or extensive pulmonary involvement with concurrent diabetes, and/or with age or comorbidity concern]
  - ❑ Member has a documented trial and failure, contraindication, or documented resistance to itraconazole or fluconazole as first line therapy
- ❑ For members with subsequent HIV infection and clinical evidence of coccidioidomycosis: laboratory documentation of peripheral blood CD4+ T-lymphocyte count <250cells/μL must be submitted

**NOTE: IDSA 2016 – for patients with peripheral CD4+ T-lymphocyte counts  $\geq 250$  cells/μL, clinical management of coccidioidomycosis should occur in the same manner as for patients without HIV infection, including discontinuing antifungal therapy in appropriate situations.**

**❑ Diagnosis: Mucormycosis**

**Approval Length: 6 month**

- ❑ Therapy is being used as salvage therapy for the treatment of mucormycosis
- ❑ Posaconazole is being used as step-down treatment from primary antifungal therapy

*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.***