

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: Anzupgo® (delgocitinib)

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 Name/Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

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

Quantity Limit: 1 tube (60 grams) per 28 days

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Humira, Opzelura, Rinvoq,) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
☐ Yes **OR** ☐ No
- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

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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: 6 months

- ☐ Member is 18 years of age or older
- ☐ Prescribed by or in consultation with a Dermatologist
- ☐ Member has a diagnosis of moderate to severe chronic hand eczema for ≥ 3 months
- ☐ Member has tried and failed 30 days of therapy with **TWO** high potency topical corticosteroids within the past 180 days (**chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes**):
- ☐ Member has tried and failed **TWO** of the following therapies within the past 180 days (**chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes**):
 - ☐ 30 days of therapy with tacrolimus (Protopic[®]) ointment
 - ☐ Oral prednisone 0.5 mg/kg daily
 - ☐ Oral immunosuppressants (e.g., azathioprine, cyclosporine, methotrexate)
 - ☐ 90 days of phototherapy (UVB or PUVA)
- ☐ Medication will **NOT** be used in combination with other biologic disease-modifying antirheumatic drugs (e.g., Humira, Enbrel, Taltz, Stelara), JAK inhibitors (e.g., Xeljanz, Rinvoq, Opzelura), or potent immunosuppressants (e.g., azathioprine, cyclosporine)

Reauthorization: 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.

- ☐ Member has experienced positive clinical response to therapy (**chart notes must be submitted**)
- ☐ Medication will **NOT** be used in combination with other biologic disease-modifying antirheumatic drugs (e.g., Humira, Enbrel, Taltz, Stelara), JAK inhibitors (e.g., Xeljanz, Rinvoq, Opzelura), or potent immunosuppressants (e.g., azathioprine, cyclosporine)

Medication being provided by Specialty Pharmacy – Proprium Rx

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.