

# 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 below)

<input type="checkbox"/> <b>Belsomra</b> <sup>®</sup> (suvorexant)	<input type="checkbox"/> <b>Dayvigo</b> <sup>®</sup> (lemborexant)	<input type="checkbox"/> <b>doxepin</b> (Silenor <sup>®</sup> )
<input type="checkbox"/> <b>quazepam</b> (Doral <sup>®</sup> )	<input type="checkbox"/> <b>Quviviq</b> <sup>™</sup> (daridorexant)	<input type="checkbox"/> <b>ramelteon</b> (Rozerem <sup>®</sup> )

**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: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

**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.

☐ **For doxepin (Silenor<sup>®</sup>), quazepam (Doral<sup>®</sup>) and ramelteon (Rozerem<sup>®</sup>) requests the following criteria must be met:**

- ☐ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following medications:
  - ☐ eszopiclone
  - ☐ temazepam
  - ☐ zaleplon
  - ☐ zolpidem or zolpidem CR

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☐ For Belsomra<sup>®</sup>, Dayvigo<sup>®</sup> and Quviviq<sup>™</sup> requests the following criteria must be met:

- ☐ Member has tried and failed at least 30 days of therapy with two (2) of the following medications:
  - ☐ eszopiclone
  - ☐ temazepam
  - ☐ zaleplon
  - ☐ zolpidem or zolpidem CR
- ☐ Member has tried and failed at least 30 days of therapy with ramelteon (Rozerem<sup>®</sup>)

*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.\****