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: Journavx™ (suzetrigine)

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: 30 tablets every 90 days

- **The use of Journavx™ for acute pain has not been studied for longer than 14 days. Journavx™ will not be approved for use beyond 14 days or for chronic pain.**

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.

Length of Authorization: 14 days

- ❑ Member 18 years of age or older
- ❑ Member has a confirmed diagnosis of moderate to severe acute pain

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- ❑ Member has tried and failed **ALL** the following:
  - ❑ Oral Non-steroidal Anti-inflammatory Drugs (NSAIDs)
  - ❑ Acetaminophen
  - ❑ Local anesthetics (if appropriate)
- ❑ Medication is **NOT** being used in combination with opioid products (e.g., oxycodone, hydrocodone)
- ❑ For female patients with reproductive potential, prescriber attests that member is not pregnant, planning to become pregnant or breastfeeding
- ❑ Please provide a patient-specific, clinically significant reason why the member cannot use other non-opioid pain relievers: _____

  _____

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.****