

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.**

Non-Preferred Inhaled Corticosteroids (ICS)

Drug Requested: (select one from below)

<input type="checkbox"/> Alvesco [®] (ciclesonide)	<input type="checkbox"/> ArmonAir [®] Digihaler [®] (fluticasone propionate)
<input type="checkbox"/> Asmanex [®] HFA/Twisthaler (mometasone furoate)	<input type="checkbox"/> Flovent Diskus/HFA (fluticasone propionate)
<input type="checkbox"/> fluticasone propionate Diskus/HFA (Flovent Diskus/HFA ABA)	

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.

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For all non-preferred inhaled corticosteroids (Alvesco, ArmonAir Digihaler, Asmanex HFA/Twisthaler, Flovent Diskus/HFA, fluticasone propionate Diskus/HFA) the following criteria must be met:

- Member must have tried and failed at least **30 days** of therapy with **ONE (1)** of the following:
 - Arnuity Ellipta[®]
 - Pulmicort Flexhaler[®]
 - Qvar/Redihaler[®]

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.