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 Insulins

Drug Requested: Select one from below

Rapid-acting Insulin Products		
❑ **Admelog®** (insulin lispro) **vial/SoloStar®**	❑ **Apidra®** (insulin glulisine) **vial/SoloStar®**	❑ **Fiasp®** (insulin aspart) **vial/FlexTouch®/PenFill®/ PumpCart®**
❑ **insulin aspart vial/cartridge/pen** (Novolog ABA)	❑ **insulin lispro vial/pen** (Humalog ABA)	❑ **insulin lispro Jr pen** (Humalog Jr ABA)
❑ **Novolog®** (insulin aspart) **vial/FlexPen®/PenFill®**	❑ **Lyumjev®** (insulin lispro-aabc) **vial/KwikPen®**	
Regular or short-acting Insulin Products		
❑ **Novolin® R** (Regular, Human Insulin) **vial/FlexPen®**		
Intermediate-acting Insulin Products		
❑ **Novolin® N** (NPH, Human Insulin) **vial/FlexPen®**		
Long-acting Insulin Products		
❑ **Basaglar®** (insulin glargine) **KwikPen®**	❑ **insulin degludec vial/pen** (Tresiba ABA)	❑ **insulin glargine vial/ SoloStar®** (Lantus ABA)
❑ **insulin glargine SoloStar®/Max SoloStar®** (Toujeo SoloStar® ABA)	❑ **Levemir® vial/FlexTouch®**	❑ **Semglee®** (insulin glargine-yfgn) **vial/pen**
Combination Insulin Products:		
❑ **insulin aspart protamine suspension/insulin aspart mix 70/30 vial/FlexPen®** (Novolog Mix ABA)	❑ **insulin lispro 75/25 mix KwikPen®** (Humalog Mix ABA)	❑ **Novolin® 70/30** (70% NPH, Human Insulin Isophane Suspension & 30% Regular, Human Insulin) **vial/FlexPen®**
❑ **Novolog® Mix 70/30** (70 % insulin aspart protamine suspension & 30% insulin aspart) **vial/FlexPen®**		

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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:** _____

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 Novolin® Brand, Mix or ABA products, the following criteria must be met:

- ❑ Member has tried and failed at least **30 days** of therapy with a Humulin® product

For Admelog®, Apidra®, Fiasp®, insulin aspart, insulin lispro, Lyumjev® and Novolog® Brand, Mix or ABA products, all the following criteria must be met:

- ❑ Member must have a **30-day trial** and failure or intolerance to brand Humalog®
- ❑ Provider must submit clinical chart notes or a completed MedWatch form documenting the experienced treatment failure or intolerance to brand Humalog®

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For Basaglar®, insulin degludec, insulin glargine, Levemir® and Semglee® Brand or ABA products, the following criteria must be met:

- ❑ Member has tried and failed at least **30 days** of therapy with **ONE** of the following
  - ❑ Lantus®
  - ❑ Toujeo®
  - ❑ Tresiba®

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.*