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: Jesduvroq (daprodustat)

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:** _____

Quantity Limits:

Strength	Maximum number of tablets per day
1 mg	1 tablet per day
2 mg	1 tablet per day
4 mg	1 tablet per day
6 mg	2 tablets per day
8 mg	3 tablets per day

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

(Continued on next page)

- ❑ Member is 18 years of age or older
- ❑ Medication is prescribed by or in consultation with a nephrologist
- ❑ Member has a diagnosis of anemia due to chronic kidney disease (CKD) and has been receiving dialysis for at least 4 months
- ❑ Provider attests other causes of anemia have been ruled out (e.g., vitamin deficiency, metabolic or chronic inflammatory conditions, bleeding)
- ❑ Member's hemoglobin level is less than 10g/dL **(must submit lab test results from within the last 30 days)**
- ❑ Member's labs show adequate iron stores with **BOTH** of the following **(must submit lab test results from within the last 30 days)**:
  - ❑ Transferrin saturation is at least 20%
  - ❑ Ferritin is at least 100 mcg/L
- ❑ Member has tried and failed an erythropoiesis stimulating agent (ESA) for at least 4 weeks **(must submit chart notes and/or lab test results documenting therapy failure)**
- ❑ Member will **NOT** be using the requested medication in combination with an ESA (e.g., Aranesp®, Epogen®, Mircera®, Procrit®, Retacrit®)
- ❑ Member does **NOT** have uncontrolled hypertension
- ❑ Member does **NOT** have severe hepatic impairment (Child-Pugh Class C)
- ❑ Member does **NOT** have active malignancy
- ❑ Member has **NOT** experienced a myocardial infarction, cerebrovascular event, or acute coronary syndrome within the last 3 months
- ❑ Member is **NOT** taking a strong cytochrome P450 (CYP) 2C8 inhibitor (e.g., gemfibrozil)

Reauthorization: 6 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's hemoglobin has increased compared to baseline **(must submit lab test results from within the last 30 days)**
- ❑ Member's current hemoglobin level does **NOT** exceed 12 g/dL
- ❑ Member will **NOT** be using the requested medication in combination with an ESA (e.g., Aranesp®, Epogen®, Mircera®, Procrit®, Retacrit®)

Medication being provided by Specialty Pharmacy – Proprium Rx

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.*