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: Glaucoma Drugs (Select one from below)

❑ **Betimol®** (timolol)	❑ **Simbrinza®** (brinzolamide/brimonidine tartrate)
❑ **Betoptic-S®** (betaxolol hydrochloride)	❑ **tafluprost** (generic Zioptan)
❑ **brimonidine 0.1%** (generic Alphagan-P)	❑ **travoprost 0.004%** (generic Travatan Z)
❑ **Rhopressa®** (netarsudil)	❑ **Vyzulta®** (latanoprostene bunod)
❑ **Rocklatan®** (netarsudil/latanoprost)	

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.

(Continued on next page)

❑ **If requesting travoprost 0.004% (Travatan Z), Vyzulta®, or tafluprost (Zioptan):**

- ❑ Member must have tried and failed at least **30 days** of therapy with latanoprost **AND ONE** of the following:
  - ❑ bimatoprost
  - ❑ Lumigan 0.01%

❑ **If requesting Betoptic-S® or Betimol®:**

- ❑ Member must have tried and failed at least **30 days** of therapy with **TWO** of the following:
  - ❑ levobunolol
  - ❑ betaxolol
  - ❑ timolol
  - ❑ carteolol

❑ **If requesting brimonidine 0.1% (Alphagan-P):**

- ❑ Member must have tried and failed at least **30 days** of therapy with **BOTH** of the following:
  - ❑ brimonidine 0.15% or brimonidine 0.2%
  - ❑ apraclonidine

❑ **If requesting Rhopressa®, Rocklatan® and Simbrinza®:**

- ❑ Member must have tried and failed at least **30 days** of therapy with **ONE** of the following:
  - ❑ latanoprost
  - ❑ bimatoprost
  - ❑ Lumigan 0.01%
- ❑ Member must have tried and failed at least **30 days** of therapy with **ONE** of the following:
  - ❑ levobunolol or betaxolol or timolol or carteolol
  - ❑ brimonidine or apraclonidine
  - ❑ dorzolamide
  - ❑ timolol-dorzolamide

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.****

***Approved by Pharmacy and Therapeutics Committee:** ~~9/17/2020;~~ **11/16/2023**
REVISED/UPDATED: ~~12/7/2020; 5/6/2022; 6/13/2022; 6/17/2022;~~ **12/11/2023**