

# AvMed

## PHARMACY/MEDICAL DRUG NECESSITY 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 information provided is not complete, correct, or legible, authorization may be delayed.**

**This form is intended for use when a medication being requested is:  
Non-Formulary and/or a specific preauthorization form is not available.**

**BENEFIT SELECTION:** Authorization may be delayed if incomplete.

Pharmacy Benefits (for self-administration only)

Medical Benefits (please specify below):

In-office (MD to supply and deliver)

Home Health Provider

Outpatient Hospital

Ambulatory Surgical Center

Specialty Pharmacy (delivery to MD office)

**Service Provider Information:**

Outpatient facility

Infusion Suite

Name of Facility/Suite: \_\_\_\_\_

Facility/Suite Provider Number: \_\_\_\_\_

**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 Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Height/Weight (if applicable): \_\_\_\_\_ Date obtained: \_\_\_\_\_

(Continued on next page)

<b>PREVIOUS THERAPIES FAILED:</b> Complete information below to ensure authorization will <b><u>NOT</u></b> be delayed.		
Medication Name	Dose	Length of Trial
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Has the member failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives?  Yes  No

If **Yes**, please describe **AND** attach chart notes. If incomplete, authorization process will be delayed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***\*\*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.\****