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.**

Long-Acting Beta2 Agonist (LABA) and Inhaled Corticosteroid (ICS) Combination Products

Drug Requested: (select one from below)

❑ **Advair Diskus** (fluticasone and salmeterol)	❑ **AirDuo® Digihaler®** (fluticasone and salmeterol)
❑ **AirDuo RespiClick®** (fluticasone and salmeterol)	❑ **fluticasone furoate-vilanterol** (Breo Ellipta ABA)
❑ **Symbicort®** (budesonide and formoterol)	

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)

❑ All criteria must be met for approval of Advair Diskus, AirDuo® Digihaler®, or AirDuo RespiClick®:

- ❑ Member must have tried and failed **at least** **30 days** of therapy with **ALL** the following:
  - ❑ Breo Ellipta
  - ❑ Breyna™ (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)
  - ❑ Dulera®
  - ❑ Advair HFA
- ❑ If requesting Advair Diskus, Provider must submit clinical chart notes or a completed MedWatch form documenting the member is intolerant or has a contraindication to fluticasone-salmeterol or Wixela Inhub (generic Advair Diskus)

❑ All criteria must be met for approval of Brand Symbicort®:

- ❑ Member must have tried and failed **at least** **30 days** of therapy with **ALL** the following:
  - ❑ Breo Ellipta
  - ❑ Breyna™ (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)
  - ❑ Dulera®
  - ❑ Advair HFA
- ❑ Provider must submit clinical chart notes or a completed MedWatch form documenting the member is intolerant or has a contraindication to Breyna™ (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)

❑ All criteria must be met for approval of fluticasone furoate-vilanterol:

- ❑ Member must have tried and failed **at least** **30 days** of therapy with **ALL** the following:
  - ❑ Breo Ellipta
  - ❑ Breyna™ (AB-rated generic Symbicort) or budesonide-formoterol (ABA Symbicort)
  - ❑ Dulera®
  - ❑ Advair HFA
- ❑ Provider must submit clinical chart notes or a completed MedWatch form documenting the member is intolerant or has a contraindication to brand Breo Ellipta

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:** ~~10/19/2017; 2/21/2019;~~ **9/21/2023**
REVISED/UPDATED: ~~12/12/2017; 3/2/2019; 6/2/2020; 11/5/2020; 6/21/2022; 11/6/2023;~~ **1/12/2024**