

# 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: Pharmacy Benefit Oncology Medications

**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.

### **Initial Authorization: 12 months**

- The requesting provider is an oncologist

**AND**

- Use of the requested oncology therapy is documented in literature and found in **ONE** of following (**please ensure diagnosis is documented above**):
- FDA labeling – in accordance with a specific indication

**OR**

**Accepted off-label indication found in the most recent edition of any of the following:**

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network's Drugs & Biologics Compendium
- Elsevier Gold Standard's Clinical Pharmacology

**(Continued on next page)**

**OR**

- For medical necessity (**Please provide clinical rationale and submit any chart notes/literature you feel would be pertinent in support of medical necessity. Note: experimental/investigational use as defined by the chemotherapy administration policy precludes medical necessity.**)

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**AND**

- If a biomarker/genetic component is required for the drug's site of action please ensure the following:**
  - Submit/attach all genetic mutation, receptor, biomarker, laboratory documentation using an FDA-approved test including both the results and which test was utilized

**NOTE: Experimental/investigational use as defined by the chemotherapy administration policy precludes medical necessity**

**AND**

- Member has tried and failed current treatment-guideline and FDA label-recommended first-line agents [or has a documented intolerance, FDA-labeled contraindication, or hypersensitivity to first line therapies]

**AND**

- Please list all previous chemotherapy regimens and dates (**please attach chart notes**)

<b>Chemotherapy Regimen</b>	<b>Dates/Cycles Completed</b>
1.	
2.	
3.	
4.	

(Continued on next page)

**AND**

- Requested dose must meet **ONE** of the following:
  - The quantity (dose) requested is in accordance with FDA approved labeling, and if applicable or necessary, age and weight conditions are met
    - What is the quantity requested per DAY? \_\_\_\_\_

**OR**

- The quantity (dose) requested is higher than the maximum dose recommendation found in FDA approved labeling (i.e., the package insert), and the prescriber has submitted clinical literature and medical documentation in support of the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature)

**\*\* Please note: Chart documentation of the above is required to be submitted along with this request \*\***

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**AND**

- If requesting Kisqali<sup>®</sup> (ribociclib) for advanced or metastatic hormone receptor-positive, HER2-negative breast cancer, member must have trial and failure of **ONE** of the following (**verified by chart notes or pharmacy paid claims**):
  - Ibrance<sup>®</sup> (palbociclib)
  - Verzenio<sup>®</sup> (abemaciclib)

**Reauthorization: 12 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 is currently receiving the requested agent (**please submit medical chart notes and documentation of therapy history**)

**AND**

- Member requires continuation of therapy and is **NOT** experiencing disease progression

**AND**

- Ongoing treatment is consistent with FDA-labeling or compendia support

**AND**

- Member is **NOT** experiencing an FDA-labeled limitation of use or toxicity

**(Continued on next page)**

**AND**

- The quantity (dose) requested is in accordance with FDA approved labeling
  - **IF** there is an adjustment in quantity (dose) requested, higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert), the prescriber must submit clinical literature and medical documentation in support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

**\*\* Please note: Chart documentation of the above is required to be submitted along with this request \*\***

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**Medication being provided by Specialty Pharmacy – Proprium Rx**

*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.\**