

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: Glucagon Analogs (select drug below)

<input type="checkbox"/> GlucaGen[®] HypoKit[®] (glucagon)	<input type="checkbox"/> Zegalogue[®] (dasiglucagon)
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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.

Member has tried and failed therapy with at least **two (2)** of the following (check each that has been tried; trials will be verified through paid pharmacy claims or chart notes):

<input type="checkbox"/> Baqsimi [®]	<input type="checkbox"/> Gvoke [™]
<input type="checkbox"/> Glucagon HypoKit (Fresenius)	

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.