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: (Check applicable drug below)

❑ **tiopronin** (Thiola®)	❑ **tiopronin delayed-release tablets** (Thiola® EC)

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: 6 months

❑ Provider requesting this medication is a nephrologist or has experience in treating/monitoring members with homozygous cystinuria

AND

❑ Member has a confirmed diagnosis of homozygous cystinuria **(documentation recording family history, history of nephrolithiasis, kidney stone collection analysis, and metabolic testing/24-hour urinalysis MUST accompany request)**

AND

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- ❑ Before any treatment for cystinuria, the urine cystine levels have been measured to be greater than 500mg/day **(laboratory results MUST be attached to request)**

  Laboratory Results: _____ Date of test: _____

AND

- ❑ Prevention of recurrent cystine stones in this member has not been achieved with increased fluid intake, restriction of sodium/protein intake, and urinary alkalinization **(ALL OF THESE THERAPY TRIALS/FAILURES MUST BE RECORDED, DOCUMENTED AND SUBMITTED WITH THIS REQUEST)**

AND

- ❑ A baseline urinary protein level has been measured, and there are **NOT** signs of proteinuria

  Laboratory Results: _____ Date of test: _____

AND

- ❑ A lower dose will be initiated for members who have experienced severe toxicity with D-Penicillamine

AND

- ❑ **FOR PEDIATRIC PATIENTS:** Current weight is ≥ 20kg

  Current weight measurement: _____ Date of measurement: _____

  (NOTE: tiopronin (Thiola) or tiopronin DR (Thiola EC) will NOT be approved for members less than 20kg, or for doses greater than 50mg/kg)

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.

NOTE: Renal function, 24-hour urinary protein and urinalysis should have been measured at baseline and then every 3 to 6 months, and urinary cystine level measured 1 month after initiating treatment and then every 3 months thereafter

- ❑ Member does **NOT** have signs of proteinuria **(Provide the last interval of urinalysis measuring urinary protein – laboratory results MUST be attached to request)**

  Laboratory Results: _____ Date of test: _____

AND

- ❑ Provide the last interval of urinalysis measuring urinary cystine levels **(laboratory results MUST be attached to request)**

  Laboratory Results: _____ Date of test: _____

  NOTE: Maintenance dose should be adjusted to reduce urinary cystine concentration < 250 mg/L

AND

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- ❑ Improvement/reduction in cystine crystalluria observed and documented **(follow up chart notes MUST be attached to request)**

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 pha rmacy paid claims or submitted chart notes.*