

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: Topical Corticosteroids (select drug below)

Low Potency Steroids		
<input type="checkbox"/> Capex[®] (fluocinolone) 0.01% shampoo	<input type="checkbox"/> Texacort[®] (hydrocortisone) 2.5% solution	
Medium Potency Steroids		
<input type="checkbox"/> betamethasone valerate 0.12% foam (generic Luxiq)	<input type="checkbox"/> clocortolone pivalate 0.1% cream (generic Cloderm)	<input type="checkbox"/> Cordran[®] (flurandrenolide) 4 mcg/sqcm tape
<input type="checkbox"/> flurandrenolide 0.05% cream (generic Cordran)	<input type="checkbox"/> fluticasone 0.05% lotion (generic Cutivate)	
High Potency Steroids		
<input type="checkbox"/> amcinonide 0.1% cream, lotion or ointment	<input type="checkbox"/> desoximetasone 0.05% cream/gel/ointment (generic Topicort)	<input type="checkbox"/> calcipotriene 0.005%-betamethasone 0.064% ointment or suspension (generic Taclonex)
<input type="checkbox"/> diflorasone 0.05% cream or ointment	<input type="checkbox"/> fluocinonide 0.1% cream (generic Vanos)	<input type="checkbox"/> triamcinolone spray (generic Kenalog)
Very High Potency Steroids		
<input type="checkbox"/> clobetasol propionate 0.05% foam (generic Olux)	<input type="checkbox"/> clobetasol propionate emulsion 0.05% foam (generic Olux-E)	<input type="checkbox"/> clobetasol propionate 0.05% shampoo (generic Clodan)
<input type="checkbox"/> Impoiz[®] (clobetasol) 0.025% cream		

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 #: _____

(Continued on next page)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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 30 days of therapy with at least **THREE** of the following therapies (**Check all that apply; verified by chart notes or pharmacy paid claims**):

Low Potency Steroids	
<input type="checkbox"/> alclometasone dipropionate 0.05% cream/ointment	<input type="checkbox"/> desonide 0.05% cream/lotion/ointment
<input type="checkbox"/> fluocinolone acetonide 0.01% body oil/scalp oil	<input type="checkbox"/> hydrocortisone 2.5% cream/lotion/ointment
Medium Potency Steroids	
<input type="checkbox"/> fluocinolone acetonide 0.01% solution or 0.025% cream/ointment	<input type="checkbox"/> fluticasone 0.05% cream or 0.005% ointment
<input type="checkbox"/> hydrocortisone valerate 0.2% cream	<input type="checkbox"/> hydrocortisone butyrate 0.1% cream/cream (lipo)/ointment/solution
<input type="checkbox"/> mometasone 0.1% cream/ointment/solution	<input type="checkbox"/> prednicarbate 0.1% ointment
High Potency Steroids	
<input type="checkbox"/> augmented betamethasone 0.05% cream/ointment	<input type="checkbox"/> betamethasone dipropionate 0.05% cream/lotion/ointment
<input type="checkbox"/> betamethasone valerate 0.1% cream/lotion/ointment	<input type="checkbox"/> desoximetasone 0.25% cream/ointment
<input type="checkbox"/> fluocinonide 0.05% cream/ointment solution or 0.05% emulsified base cream	<input type="checkbox"/> triamcinolone 0.025% cream/lotion/ointment, 0.1% cream/lotion/ointment, or 0.5% cream/ointment
Very High Potency Steroids	
<input type="checkbox"/> clobetasol propionate 0.05% cream/gel/ointment/solution/spray or 0.05% emollient cream	<input type="checkbox"/> halobetasol 0.05% cream

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: 2/20/2014; 7/21/2022

REVISED/UPDATED: 5/8/2014; 7/22/2014; 9/26/2014; 9/29/2014; 11/5/2014; 5/22/2015; 11/20/2015; 12/22/2015; 6/16/2016; 8/15/2016; 9/28/2016; 12/20/2016; 8/19/2017; 6/14/2018; 5/13/2019; 2/03/2020; 3/17/2022; 4/25/2022; 6/3/2022; 6/17/2022; 8/5/2022; 10/27/2023; 01/02/2025