AvMed

MEDICAL 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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Korsuva™ (difelikefalin) **Solution for IV Infusion (J0879) (Medical)**

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 #: _____

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:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limits: Max of 0.5 mcg/kg per hemodialysis (HD) session for max of 3 HD sessions per week

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. **(Trials will be verified using pharmacy claims and/or submitted chart notes.)**

Initial Authorization: 6 months

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- ❑ Member is 18 years of age or older, has a diagnosis of moderate-to-severe pruritus associated with chronic kidney disease (CKD-aP) and is undergoing hemodialysis (HD)
- ❑ Member's current dry weight must be noted: _____
- ❑ Baseline Worst Itching Intensity Numerical Rating Scale (WI-NRS) scale score documenting moderate-to-severe pruritus (score of at least 4) must be submitted
- ❑ Member has had trial and insufficient response to at least **TWO** of the following therapies **(verified by chart notes and/or pharmacy paid claims; check all that apply)**:

❑ antihistamines	❑ glucocorticoids	❑ skin emollients
❑ topical anesthetic agents	❑ opioids	❑ ultraviolet B phototherapy
❑ gabapentin	❑ pregabalin	❑ topical calcineurin inhibitors

- ❑ Other underlying causes of pruritis have been considered and addressed (e.g., sub-optimal dialysis Kt/V targets, hyperparathyroidism, hyperphosphatemia, and hypermagnesemia)
- ❑ Member does **NOT** have any of the following:
  - Severe hepatic impairment
  - Noncompliance with dialysis treatment
  - Scheduled to receive a kidney transplant
  - Requesting for use with peritoneal dialysis
- ❑ Member will be assessed for CNS effects of dizziness, somnolence, mental status changes, and gait disturbances, including falls, while using requested medication
- ❑ Member will **NOT** perform potentially hazardous activities, such as driving and operating machinery, immediately after receiving requested medication

Reauthorization: 6 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 continues to meet all initial authorization criteria
- ❑ Member's current dry weight must be noted: _____
- ❑ Member's Worst Itching Intensity Numerical Rating Scale (WI-NRS) scale score has decreased by at least 4 points from baseline **(submit current scale with score)**
- ❑ Member is **NOT** experiencing any significant adverse effects while using requested medication

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Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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**: 5/19/2022
REVISED/UPDATED: ~~5/13/2022;~~ ~~6/3/2022;~~ **6/17/2022**