AvMed

PHARMACY/MEDICAL DRUG NECESSITY 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 information provided is not complete, correct, or legible, authorization may be delayed.**

This form is intended for use when a medication being requested is:
Non-Formulary and/or a specific preauthorization form is not available.

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:** _____

Weight: _____ **Date:** _____

PREVIOUS THERAPIES FAILED: Complete information below to ensure authorization will **NOT** be delayed.

Medication Name	Dose	Length of Trial
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

(Continued on next page)

Has the member failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives? ❑ Yes ❑ No

If Yes, please describe AND attach chart notes. If incomplete, authorization process will be delayed.

_____

_____

_____

_____

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:** 7/16/1998
REVISED/UPDATED: ~~02/14/2013; 3/7/2013; 4/24/2013; 11/6/2014; 5/22/2015; 12/29/2015; 12/6/2016; 9/12/2017; 11/1/2017; 10/8/2018; ;3/2/2023~~**;10/26/2023**