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.**

Long-Acting Muscarinic Antagonist (LAMA) Anticholinergic inhalers

Drug Requested: (Select one from below)

❏ **Tudorza® Pressair®** (aclidinium bromide inhalation powder)	❏ **Yupelri®** (revefenacin) **oral inhalation solution**

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:** _____

Quantity Limits:

- **Tudorza® Pressair®** - 1 inhaler per 30 days
- **Yupelri®** - 30 vials per 30 days

> **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 must have tried and failed **at least <u>30 days</u>** of therapy with <u>**BOTH**</u> of the following medications:
    - ❑ Spiriva® Respimat®

    > **AND**

    - ❑ Incruse® Ellipta®

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.

*<u>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>*