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 1-877-535-1391**. 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: Aphexda™ (motixafortide) (J2277) (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.

Dosing Limits:

A. Quantity Limit – 62 mg single-dose vial: 2 vials per dose for two doses only

B. Maximum Units – 124 mg (2 vials) per dose for up to two doses

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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.

Authorization Criteria: One treatment of up to two doses per transplant.

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a hematologist/oncologist
- ❑ Requested medication will be used for autologous transplantation in multiple myeloma patients
- ❑ Planned date of transplantation must be provided: _____
- ❑ Requested medication will be used in combination with filgrastim (G-CSF) **(verified by chart notes and/or pharmacy/medical paid claims)**
- ❑ Prescriber attests requested medication, filgrastim, and apheresis will be administered once as a single dose 10 to 14 hours prior to the first apheresis. A second dose (1.25 mg/kg) may be administered 10 to 14 hours prior to a third apheresis **(must submit recent chart notes/progress notes detailing planned treatment regimen)**

Reauthorization: Coverage may NOT be renewed

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

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**: 11/16/2023
REVISED/UPDATED/REFORMATTED: ~~11/7/2023~~; 12/11/2023; **4/4/2024**