

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.**

Atypical Antipsychotics

Drug Requested: (select one below)

<input type="checkbox"/> asenapine (generic Saphris®)	<input type="checkbox"/> Caplyta ® (lumateperone)
<input type="checkbox"/> Cobenfy ™ (xanomeline/trospium chloride)	<input type="checkbox"/> Fanapt ® (iloperidone)
<input type="checkbox"/> lurasidone (generic Latuda®)	<input type="checkbox"/> paliperidone (generic Invega®)
<input type="checkbox"/> Rexulti ® (brexpiprazole)	<input type="checkbox"/> Vraylar ® (cariprazine)

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:** _____

If diagnosis is any type of depressive disorder, please list current antidepressant therapy:

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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.

For all antipsychotics used for the treatment of bipolar disorder or Schizophrenia

- Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following:

<input type="checkbox"/> risperidone	<input type="checkbox"/> quetiapine/ER
<input type="checkbox"/> ziprasidone	<input type="checkbox"/> olanzapine
<input type="checkbox"/> aripiprazole	

For Rexulti requests prescribed for Agitation Associated with Dementia due to Alzheimer’s Disease

Recommended Dosage: Initial: 0.5 mg once daily for 7 days, increase dose on days 8 to 14 to 1 mg once daily, then on day 15 to the target dose of 2 mg once daily. Based on response and tolerability, may increase dose after at least 14 days to the maximum dose of 3 mg once daily.

Quantity Limit: 1 tablet per day

- Prescribed by or in consultation with a neurologist or psychiatrist
- Member is 55 years of age or older
- Member has a confirmed diagnosis consistent with the findings of Alzheimer’s disease with magnetic resonance imaging (MRI) or computed tomography of the brain (**must submit documentation**)
- Member has/is experiencing signs and symptoms of agitation characterized by increased, often undirected, motor activity, restlessness, aggressiveness, or emotional distress (**must submit chart note documentation**)
- Provider continues to monitor member for the occurrence of any medical or neurological conditions (other than Alzheimer’s disease) that may be a contributing cause to the member’s agitation
- Provider attests the risk-benefit has been discussed with patients, surrogate decision-makers, families, and or caregivers before starting treatment
- Member has documented use of non-pharmacological interventions (i.e., music therapy, re-direction of behaviors) prior to starting treatment (**must submit chart note documentation**)
- Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following:

<input type="checkbox"/> risperidone	<input type="checkbox"/> quetiapine/ER
<input type="checkbox"/> ziprasidone	<input type="checkbox"/> olanzapine
<input type="checkbox"/> aripiprazole	

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❑ For Caplyta, Rexulti or Vraylar requests prescribed for Major Depressive Disorder

Quantity Limit: 1 capsule/tablet per day

- ❑ Member is 18 years of age or older
- ❑ Member has a confirmed diagnosis of Major Depressive Disorder
- ❑ Member must have experienced clinical failure or intolerance with at least **THREE (3)** antidepressant therapies from at least **TWO (2)** different drug classes (e.g. SSRI, SNRI, TCA, bupropion, mirtazapine), failures must be of adequate dose (maximally tolerated), adequate duration (at least 6 weeks), adherent fills required (**verified by pharmacy claims and/or chart notes**)
- ❑ Member must have experienced clinical failure or intolerance with at least **ONE (1)** preferred antipsychotic indicated for adjunctive therapy for major depressive disorder (e.g. aripiprazole, quetiapine ER) used concurrently with an antidepressant; failures must be of adequate dose (maximally tolerated), adequate duration (at least 6 weeks), adherent fills required (**verified by pharmacy claims and/or chart notes**)
- ❑ Member will use medication in combination with an antidepressant (**verified by pharmacy claims and/or chart notes**)

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.