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.**

Drug Requested: Rhapsido® (remibrutinib)

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:** _____

Recommended Dosage: 25 mg orally twice daily

Quantity Limit: 2 tablets per day

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.

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with an allergist or pulmonologist
- ❑ Member is ≥ 18 years of age
- ❑ Member has had a confirmed diagnosis of chronic spontaneous urticaria for at least 6 weeks with or without angioedema

(Continued on next page)

- ❑ Member has failed **ONE (1)** of the following H1 antihistamines at 4 times the initial dose for at least 4 weeks:

❑ levocetirizine 10 mg – 20 mg QD	❑ desloratadine 10 – 20 mg QD	❑ fexofenadine 120 mg – 240 mg BID
❑ cetirizine 20 mg – 40 mg QD	❑ loratadine 20 mg – 40 mg QD	

- ❑ Member has remained symptomatic despite treatment with **ALL** the following therapies **(verified by pharmacy paid claims)**:
  - ❑ Hydroxyzine 10 mg – 25 mg taken daily
  - ❑ Leukotriene Antagonist for at least 4 weeks (e.g., montelukast, zafirlukast)
  - ❑ H2 antihistamine, for treatment of acute exacerbations, for at least 5 days (e.g., famotidine, cimetidine)

❑ Diagnosis: Chronic Spontaneous Urticaria

Reauthorization: 12 months

- ❑ Members disease status has been re-evaluated since the last authorization to confirm the members condition warrants continued treatment **(chart notes must be submitted for documentation)**
- ❑ Provider has submitted chart notes documenting the members symptoms have improved (e.g., a decrease in the number of hives, a decrease in the size of hives, and improvement of itching)

Medication being provided by Specialty Pharmacy – Proprium Rx

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: 11/20/2025
REVISED/UPDATED/REFORMATTED: 12/12/2025