

# 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:** Vabomere<sup>®</sup> (meropenem and vaborbactam) **J2186 (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 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.

**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.

**Length of Authorization: Date of Service (14 days)**

New Start

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- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of complicated urinary tract infection (cUTI) or pyelonephritis
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Vabomere
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, ceftazidime, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, ceftazidime, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem

<b>Length of Authorization: Date of Service</b>
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<b>❑ Continuation of therapy following inpatient administration</b>
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- ❑ Member is currently on Vabomere for more than 72 hours inpatient (**progress notes must be submitted**)
- ❑ Provider has submitted lab culture sensitivity results retrieved during admission which shows resistance to **ALL** preferred antibiotics except for Vabomere (sensitive)

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**Medication being provided by: Please check applicable box below.**

- Location/site of drug administration: \_\_\_\_\_  
NPI or DEA # of administering location: \_\_\_\_\_

**OR**

- Specialty Pharmacy

For urgent reviews: Practitioner should call AvMed Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed Health'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.\****