

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: Journavx™ (suzetrigine)

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 Limit: 30 tablets every 90 days

- The use of Journavx™ for acute pain has not been studied for longer than 14 days. Journavx™ will not be approved for use beyond 14 days or for chronic 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: 14 days

- ☐ Member 18 years of age or older
- ☐ Member has a confirmed diagnosis of moderate to severe acute pain, including post-operative pain

(Continued on next page)

- ☐ Member has tried and failed **ALL** the following:
 - ☐ Oral Non-steroidal Anti-inflammatory Drugs (NSAIDs)
 - ☐ Acetaminophen
 - ☐ Local anesthetics (if appropriate)
 - ☐ Medication is **NOT** being used in combination with opioid products (e.g., oxycodone, hydrocodone)
 - ☐ For female patients with reproductive potential, prescriber attests that member is not pregnant, planning to become pregnant or breastfeeding
 - ☐ Please provide a patient-specific, clinically significant reason why the member cannot use other non-opioid pain relievers: _____
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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.****