

# 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:** Qutenza<sup>®</sup> (capsaicin 8% topical system) (J7336) (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.

**Quantity Limit (max daily dose) [NDC Unit]:** 4 patches (1120 billable units) every 90 days

**NOTE:** Qutenza 8% Patch should only be applied by a health care provider in a well-ventilated area.

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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.

**Postherpetic Neuralgia (PHN)**

**Initial Authorization: 3 months**

- Requested medication will be used in the management of neuropathic pain associated with postherpetic neuralgia (PHN)
- Provider has documented the member's baseline Numerical Pain Rating Scale (NPRS) score: \_\_\_\_\_
- Member has postherpetic neuralgia that has persisted for at least 6 months following healing of herpes zoster rash (i.e., crusting of the skin vesicles)
- Painful areas to be treated are **NOT** located on the face, above the hairline of the scalp, and/or in proximity to mucous membranes
- Member has tried and had an inadequate response (or contraindication) to **BOTH** the following therapies:
  - Tricyclic antidepressants (e.g., amitriptyline, nortriptyline, maprotiline, desipramine)
  - Gabapentinoid (e.g., pregabalin, gabapentin)

**Diabetic peripheral Neuropathy (DPN)**

**Initial Authorization: 3 months**

- Provider has documented the member's baseline Numerical Pain Rating Scale (NPRS) score: \_\_\_\_\_
- Member has painful, distal, symmetrical, sensorimotor polyneuropathy due to diabetes that has persisted for at least 1 year prior to screening
- All other causes of pain in the feet have been ruled out
- Member has tried and had an inadequate response (or contraindication) to **BOTH** the following therapies:
  - Antidepressants (e.g., duloxetine, venlafaxine, amitriptyline, nortriptyline, maprotiline, desipramine)
  - Gabapentinoid (e.g., pregabalin, gabapentin)

**Reauthorization: 3 months.** 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.

**Postherpetic Neuralgia (PHN) or Diabetic peripheral Neuropathy (DPN)**

- Member continues to meet all initial authorization criteria

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