

# 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:** select one drug below

**Furoscix<sup>®</sup>** (furosemide)

**Lasix<sup>®</sup> ONYU** (furosemide)

**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: \_\_\_\_\_

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

### **Quantity Limit:**

- Furoscix: 6 on-body infusors or 6 auto-injectors per 90 days
- Lasix Onyu: 6 infusors per 90 days

**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: 3 months**

- Medication is being prescribed by or in consultation with a cardiologist or nephrologist
- Member meets **ONE** of the following requirements:
  - For Furoscix<sup>®</sup> requests: Member is a pediatric patient or older and weighs at least 43 kg
  - For Lasix<sup>®</sup> Onyu requests: Member is 18 years of age or older

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- ❑ Member has a diagnosis of **ONE** of the following:
  - ❑ New York Heart Association (NYHA) Class II, III or IV chronic heart failure
  - ❑ Chronic Kidney Disease
- ❑ Member is experiencing congestion due to fluid overload that is **NOT** considered to be an emergency situation (**must submit documentation of symptoms such as rapid weight gain, jugular venous distension, pitting edema, pulmonary rales; etc.**)
- ❑ Member has a clinical reason for requiring subcutaneous furosemide (e.g., reduced responsiveness to oral diuretics such as bumetanide, furosemide, or torsemide)
- ❑ Prescriber agrees that member will use subcutaneous furosemide for short-term use only **AND** will replace with oral diuretics as soon as practical
- ❑ Member does **NOT** have any of the following: hypersensitivity to furosemide or medical adhesives; anuria; hepatic cirrhosis or ascites; or acute pulmonary edema
- ❑ Prescriber attests the member will be monitored outpatient for fluid, electrolyte, and metabolic abnormalities
- ❑ **For approval of Furoscix® for members 18 years of age or older:** Documentation of trial and intolerable life-endangering adverse event with Lasix® ONYU must be submitted

**Second Authorization for continued therapy after initial authorization approval: 3 months**

- ❑ Member meets **ALL** initial authorization criteria and requires re-treatment due to persistent reduced response to oral diuretics (**submit documentation**)

**Reauthorization: For use beyond 6 months, length of authorization is 12 months and will be reassessed annually.** 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.

- ❑ Member must have disease improvement and/or stabilization **OR** improvement in the slope of decline (e.g., improvement in signs/symptoms of fluid overload – edema, dyspnea, rapid weight gain)
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., fluid, electrolyte, or metabolic abnormalities, worsening renal function, ototoxicity, acute urinary retention)
- ❑ Member is considered to be refractory to oral diuretics, and continued use of subcutaneous furosemide is medically necessary for stabilization of their condition

*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.\****