

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)

☐ Posaconazole (generic Noxafil®) delayed-release tablets 100 mg	☐ Posaconazole (generic Noxafil®) immediate-release oral suspension 40 mg/mL	☐ Noxafil® PowderMix Pak (posaconazole) delayed-release oral suspension 300 mg
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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: _____

Quantity Limits:

- Delayed-release tablets, 100 mg: 8 tablets per day
- Immediate- release oral suspension, 40 mg/mL: 20 mL per day
- Delayed- release oral suspension, 300 mg packets: 1 packet 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.

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IF REQUESTING AN ORAL SUSPENSION FORMULATION, please provide clinical-based reasoning and attach applicable documentation why the member cannot swallow tablets:

☐ **Diagnosis: Aspergillosis**

Approval Length: one time authorization, treatment period 6-12 weeks

- ☐ Member meets ONE of the following age/formulation criteria:
 - ☐ Delayed-release tablets (members ≥ 2 to < 13 years of age and ≥ 40 kg)
 - ☐ Immediate-release oral suspension (members ≥ 13 years of age)
 - ☐ Noxafil® PowderMix Pak (posaconazole) delayed-release oral suspension (members ≥ 2 years of age and 10 to 40 kg)
- ☐ Member has a diagnosis of invasive aspergillosis
- ☐ Member has a documented trial and failure, contraindication, or documented resistance to itraconazole or voriconazole therapy as first line therapy

☐ **Diagnosis: Candidiasis Infection**

Approval Length: one time authorization, treatment period up to 28 days

- ☐ Member is 13 years of age or older
- ☐ Member has oropharyngeal candidiasis, **AND** has documented trial and failure, contraindication, or documented resistance to clotrimazole troches, nystatin suspension, **AND** fluconazole
- ☐ Member has esophageal candidiasis refractory to fluconazole infection, **AND** has documented trial and failure, contraindication, or documented resistance to itraconazole **AND** voriconazole

☐ **Diagnosis: Immunocompromised Patients, Prophylaxis against invasive fungal infections**

Approval Length: 6 months

- ☐ Member is severely immunocompromised and treatment is required for prophylaxis of invasive aspergillus and Candida infections:
 - ☐ Allogeneic hematopoietic stem cell transplant [HSCT] recipient
 - ☐ Hematologic malignancy (i.e., Leukemia, lymphoma, myelodysplastic syndrome)
 - ☐ Prolonged neutropenia from chemotherapy
 - ☐ High-risk solid organ (lung, heart-lung, liver, pancreas, small bowel) transplant patient

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- ☐ Member meets **ONE** of the following age/formulation criteria:
 - ☐ Delayed-release tablets (members ≥ 2 years of age and > 40 kg)
 - ☐ Immediate-release oral suspension (members ≥ 13 years of age)
 - ☐ Delayed-release oral suspension, powder mix (members ≥ 2 to <18 years of age and ≤ 40 kg)

☐ Diagnosis: Coccidioidomycosis

Approval Length: 6 months

- ☐ Member has a diagnosis of chronic coccidioidal pneumonia and meets the following:
 - ☐ Is symptomatic [**must provide progress notes, any laboratory documentation or imaging studies to convey debilitating illness and/or extensive pulmonary involvement with concurrent diabetes, and/or with age or comorbidity concern**]
 - ☐ Member has a documented trial and failure, contraindication, or documented resistance to itraconazole or fluconazole as first line therapy
 - ☐ For members with subsequent HIV infection and clinical evidence of coccidioidomycosis: laboratory documentation of peripheral blood CD4+ T-lymphocyte count <250 cells/ μ L must be submitted
- NOTE: IDSA 2016 – for patients with peripheral CD4+ T-lymphocyte counts ≥ 250 cells/ μ L, clinical management of coccidioidomycosis should occur in the same manner as for patients without HIV infection, including discontinuing antifungal therapy in appropriate situations.**

☐ Diagnosis: Mucormycosis

Approval Length: 6 months

- ☐ Therapy is being used as salvage therapy for the treatment of mucormycosis
- ☐ Posaconazole is being used as step-down treatment from primary antifungal therapy

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.****