

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: Pivya™ (pivmecillinam)

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: _____

Recommended Dosage: One tablet three times daily for 3 to 7 days as clinically indicated

Quantity Limit: 9 tablets per 30 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.

Length of Authorization: Date of Service

- Member is 18 years of age or older
- Member has a diagnosis uncomplicated urinary tract infections (uUTI) caused by susceptible isolates of *Escherichia coli*, *Proteus mirabilis* and *Staphylococcus saprophyticus*
- Lab cultures must show that bacteria is sensitive to Pivya (**submit documentation**)

(Continued on next page)

- ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics unless intolerant or bacteria is drug resistant (**submit documentation**):
 - ❑ sulfamethoxazole-trimethoprim
 - ❑ nitrofurantoin
 - ❑ ciprofloxacin or levofloxacin
 - ❑ amoxicillin-clavulanate
 - ❑ cephalexin
 - ❑ cefdinir

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.