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 below):

❑ **candesartan** (Atacand®)	❑ **Edarbyclor®** (azilsartan-chlorthalidone)
❑ **candesartan-hydrochlorothiazide** (Atacand® HCT)	❑ **eprosartan**
❑ **Edarbi®** (azilsartan)	

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:** _____

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.

(Continued on next page)

For candesartan, candesartan-hydrochlorothiazide & eprosartan requests:

- ❑ Member has tried and failed 30 days of therapy with **at least TWO (2)** of the following **(select all that apply; verified by chart notes and/or pharmacy paid claims)**:

❑ amlodipine-olmesartan	❑ losartan	❑ telmisartan
❑ amlodipine-valsartan	❑ losartan-HCTZ	❑ valsartan
❑ irbesartan	❑ olmesartan	❑ valsartan-HCTZ
❑ irbesartan-HCTZ	❑ olmesartan-HCTZ	

If requesting candesartan tablets for migraine prevention:

- ❑ Provider must submit documentation to confirm indication for use

For Edarbi & Edarbyclor requests:

- ❑ Member has tried and failed 30 days of therapy with **at least THREE (3)** of the following **(select all that apply; verified by chart notes and/or pharmacy paid claims)**:

❑ amlodipine-olmesartan	❑ losartan	❑ telmisartan
❑ amlodipine-valsartan	❑ losartan-HCTZ	❑ valsartan
❑ irbesartan	❑ olmesartan	❑ valsartan-HCTZ
❑ irbesartan-HCTZ	❑ olmesartan-HCTZ	

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.*