

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)

<input type="checkbox"/> Belsomra [®] (suvorexant)	<input type="checkbox"/> Dayvigo [®] (lemborexant)	<input type="checkbox"/> quazepam (Doral [®])
<input type="checkbox"/> Quviviq [™] (daridorexant)	<input type="checkbox"/> ramelteon (Rozerem [®])	

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.

For quazepam (Doral[®]) and ramelteon (Rozerem[®]) requests the following criteria must be met:

- Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following medications:
 - eszopiclone
 - temazepam
 - zaleplon
 - zolpidem or zolpidem CR

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□ For Belsomra[®], Dayvigo[®] and Quviviq[™] requests the following criteria must be met:

- Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following medications:
 - eszopiclone
 - temazepam
 - zaleplon
 - zolpidem or zolpidem CR
- Member has tried and failed **at least 30 days** of therapy with ramelteon (Rozerem[®]) 8 mg tablets (***requires prior authorization**)

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.