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: Nereus™ (tradipitant)

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 Dosing: 85 mg or 170 mg as a single oral dose approximately 60 minutes before an event expected to cause vomiting induced by motion. The maximum dosage in a 24-hour period is a single dose of 85 mg or 170 mg. **NOTE:** The safety of NEREUS for the prevention of vomiting induced by motion in adults for more than 90 doses has not been established in clinical trials.

Quantity Limit: 14 capsules 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.

- ❑ Member is 18 years of age or older
- ❑ Medication is prescribed for the prevention of motion-induced vomiting
- ❑ Provider attests member has a planned event expected to cause vomiting induced by motion

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- ❑ Member has tried and failed transdermal scopolamine, unless contraindicated or clinically significant adverse effects are experienced **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Member has tried and failed at least **TWO (2)** generic antihistamines used for motion sickness (e.g., dimenhydrinate, meclizine, promethazine), unless clinically significant adverse effects are experienced or all are contraindicated **(verified by chart notes and/or pharmacy paid claims)**
- ❑ Request is for ≤ 7 days supply, unless medical justification is provided;
- ❑ Requested dose does **NOT** exceed 170 mg (2 capsules) per 24-hour period.

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.

***Approved by Pharmacy and Therapeutics Committee**: 7/23/2026
REVISED/UPDATED/REFORMATTED: 8/28/2026