AvMed

MEDICAL 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 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Recarbrio™ (imipenem, cilastatin, and relebactam) **(J0742) (Medical)**

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:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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 (7 days)

❑ **Diagnosis: Complicated Urinary Tract Infections (cUTI) or Pyelonephritis**

❑ **New Start**

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- ❑ Member is an adult or pediatric patient weighing at least 2 kg
- ❑ Member has a diagnosis of complicated urinary tract infection (cUTI) or pyelonephritis
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Recarbrio
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following oral antibiotics: nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following oral antibiotics: nitrofurantoin, cefdinir, cephalexin, amoxicillin, amoxicillin-clavulanate, ciprofloxacin, levofloxacin, trimethoprim-sulfamethoxazole, and fosfomycin
- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, cefazolin, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, cefazolin, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, gentamicin, tobramycin, amikacin, ertapenem, imipenem-cilastatin, and meropenem

Length of Authorization: Date of Service (7 days)

❑ **Diagnosis: Complicated intra-abdominal infections (cIAI)**

❑ **New Start**

- ❑ Member is an adult or pediatric patient weighing at least 2 kg
- ❑ Member has a diagnosis of complicated intra-abdominal infection (cIAI) with limited or no alternative treatment options
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days
- ❑ Lab cultures must show that bacteria is sensitive to Recarbrio

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- ❑ Member must meet **ONE** of the following:
  - ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, cefazolin, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, ertapenem, imipenem-cilastatin, and meropenem
  - ❑ Cultures (retrieved from most recent office visit or current inpatient admission collected within the last 7 days) shows resistance to **ALL** the following IV antibiotics: ciprofloxacin, levofloxacin, ceftriaxone, cefazolin, cefepime, piperacillin-tazobactam, trimethoprim-sulfamethoxazole, ertapenem, imipenem-cilastatin, and meropenem

Length of Authorization: Date of Service

❑ **Diagnosis: Complicated Urinary Tract Infections (cUTI) or Pyelonephritis or Complicated intra-abdominal infections (cIAI)**

❑ **Continuation of therapy following inpatient administration**

- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Complicated Urinary Tract Infections (cUTI) or Pyelonephritis
  - ❑ Complicated intra-abdominal infections (cIAI)
- ❑ Member is currently on Recarbrio for more than 72 hours inpatient **(progress notes must be submitted)**
- ❑ Provider has submitted lab culture sensitivity results retrieved during inpatient admission which shows resistance to **ALL** preferred antibiotics except for Recarbrio (sensitive)

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 (14 days total)

❑ **Diagnosis: Hospital-acquired bacterial pneumonia and ventilator-associated bacterial pneumonia (HABP/VABP)**

❑ **New Start**

- ❑ Member is an adult or pediatric patient weighing at least 2 kg
- ❑ Prescribed by an infectious disease specialist
- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Ventilator-associated bacterial pneumonia (VABP)
  - ❑ Hospital-acquired bacterial pneumonia (HABP)
- ❑ Provider must submit date that requested medication was started inpatient: _____
- ❑ Provider has submitted lab cultures from current hospital admission or office visit collected within the last 7 days

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- ❑ Lab cultures must show that bacteria is caused by the following susceptible gram-negative microorganisms: Acinetobacter calcoaceticus-baumannii complex, Enterobacter cloacae, Escherichia coli, Haemophilus influenzae, Klebsiella aerogenes, Klebsiella oxytoca, Klebsiella pneumoniae, Pseudomonas aeruginosa, and Serratia marcescens
- ❑ Provider must submit chart notes documenting trial and failure of **ALL** the following antibiotics unless intolerant or bacteria is drug resistant **(submit documentation)**:
  - ❑ vancomycin
  - ❑ cefepime
  - ❑ piperacillin-tazobactam
  - ❑ meropenem
  - ❑ tobramycin or amikacin

Length of Authorization: Date of Service
❑ **Diagnosis: Hospital-acquired bacterial pneumonia and ventilator-associated bacterial pneumonia (HABP/VABP)**
❑ **Continuation of therapy following inpatient administration**

- ❑ Member has **ONE** of the following diagnoses:
  - ❑ Ventilator-associated bacterial pneumonia (VABP)
  - ❑ Hospital-acquired bacterial pneumonia (HABP)
- ❑ Member is currently on Recarbrio for more than 72 hours inpatient **(progress notes must be submitted)**
- ❑ Provider has submitted lab culture sensitivity results retrieved during inpatient admission which shows resistance to **ALL** preferred antibiotics except for Recarbrio (sensitive)

Medication being provided by (check applicable box(es) below):

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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**: ~~3/27/2025;~~ **3/26/2026**
REVISED/UPDATED: ~~6/11/2025;~~ **4/16/2026**