

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.**

Topical Rosacea Drugs

Drug Requested: (check applicable box below)

<input type="checkbox"/> brimonidine (Mirvaso®)	<input type="checkbox"/> Rhofade ® (oxymetazoline)
<input type="checkbox"/> ivermectin (Soolantra®)	

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 brimonidine (Mirvaso®) and Rhofade® requests, ALL the following criteria must be met:

- Member is 18 years of age or older
- Member's quality of life has been impacted

(Continued on next page)

- Member has **ONE** of the following diagnosis:
 - Persistent (non-transient) facial erythema (subtype erythematotelangiectatic rosacea)
 - Papulopustular lesions with persistent (non-transient) facial erythema (subtype erythematotelangiectatic rosacea)
- Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following within the last 6 months (**submit chart notes documenting treatment failure**):

<input type="checkbox"/> azelaic acid gel 15%	<input type="checkbox"/> Oral doxycycline hyclate	<input type="checkbox"/> Oral minocycline	<input type="checkbox"/> Oral tetracycline
<input type="checkbox"/> metronidazole cream 0.75%, <input type="checkbox"/> metronidazole 0.75% gel <input type="checkbox"/> metronidazole 1% gel	<input type="checkbox"/> sodium sulfacetamide sulfur 10%/5%	<input type="checkbox"/> Topical retinoids (e.g., adapalene, tretinoin) (*requires prior authorization)	

For ivermectin (Soolantra®) requests, ALL the following criteria must be met:

- Member must have papulopustular rosacea and inflammatory lesions
- Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following within the last 6 months (**submit chart notes documenting treatment failure**):

<input type="checkbox"/> azelaic acid gel 15%	<input type="checkbox"/> Oral doxycycline hyclate	<input type="checkbox"/> Oral minocycline	<input type="checkbox"/> Oral tetracycline
<input type="checkbox"/> metronidazole cream 0.75%, <input type="checkbox"/> metronidazole 0.75% gel <input type="checkbox"/> metronidazole 1% gel	<input type="checkbox"/> sodium sulfacetamide sulfur 10%/5%	<input type="checkbox"/> Topical retinoids (e.g., adapalene, tretinoin) (*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.****