OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Acthar® HP** (Corticotropin) - **INFANTILE SPASMS (IS)**

DRUG INFORMATION: ***Complete all information below or authorization process will be delayed.***

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

Note*: *(Neurology 2012;78:1974-1976) Class I study showed similar efficacy between low-dose (20-30 IU) and high dose (150 IU/m^2) natural ACTH. Low dose ACTH should be considered as an alternative to high dose ACTH for treatment of infantile spasms. (Level B).

CLINICAL CRITERIA: ***The criteria below must be met to qualify or authorization process will be delayed.***

- ❑ Prescriber **MUST** be a Neurologist

AND

- ❑ Patient **MUST** have a documented diagnosis of Infantile Spasms

AND

- ❑ Approval will only be granted for a **MAXIMUM** of **30 days only** due to similar adverse effect of corticosteroids. After 2 weeks of treatment, dosing should be gradually tapered and discontinued over a 2-week period. The following is one ***suggested*** tapering schedule:
  - 30 U/m2 in the morning for 3 days; 15 U/m2 in the morning for 3 days; 10 U/m2 in the morning for 3 days; and 10 U/m2 every other morning for 6 days.
- ❑ Complete the regimen below ***(HP Acthar gel is supplied as 5mL multidose vial containing 80 USP Units per mL):***

Approval will be a MAXIMUM of 30 days only *(combined inpatient and outpatient time period)*

Initial Dose Schedule	**Approval at Outpatient pharmacy will be based on volume needed at discharge from hospital**	
75 U/m^2 **BID** x _____ days	TOTAL _____mL x _____ # days (max 29 days)	
Taper Dose Schedule		**BODY SURFACE AREA BSA**
30 U/m^2 **QD** x _____ days	_____ mL x ____ days	**WEIGHT**: _____ kg
15 U/m^2 **QD** x _____ days	_____ mL x ____ days	Height/Length: _____ in.
10 U/m^2 **QD** x _____ days	_____ mL x ____ days	Calculated BSA: _____ m^2
10 U/m^2 **QOD** x _____ days	_____ mL x ____ days	

TOTAL Number of vials needed: _____/days (max 29 days)

(signature on next page)

Medication being provided by a Specialty Pharmacy - PropriumRx

*****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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***UPDATED/REVISED: 7/2/2018**