

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/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 1-800-750-9692. 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) (*Dermatomyositis and Polymyositis*)

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: _____

CLINICAL CRITERIA: ALL lines below **must** be checked to qualify or authorization process will be delayed. ALL HOSPITAL PROGRESS NOTES MUST BE ATTACHED TO REQUEST FORM.

Patient has diagnosis of DERMATOMYOSITIS OR POLYMYOSITIS with one of the following:

<input type="checkbox"/> Idiopathic Inflammatory Myopathy	<input type="checkbox"/> Refractory to conventional therapy or with severe organ-threatening manifestations
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1. **Diagnosis of Idiopathic Inflammatory Myopathy**, member **must** have tried and failed the therapies below **WITHIN THE PAST 6 MONTHS:**

Prednisone 0.5-1mg/kg/day for 2-4 weeks, then taper for 2 weeks,

AND

Prednisone **MUST** have been taken CONCURRENTLY WITH AN IMMUNOSUPPRESSIVE DRUG FOR **AT LEAST 90 DAYS** within the past 6 months (*must note therapy tried*):

<input type="checkbox"/> Methotrexate target dose 25mg/wk	<input type="checkbox"/> Azathioprine 2mg/kg IBW twice daily
<input type="checkbox"/> Mycophenolate mofetil, 500mg twice daily, increased by 500mg/wk until 1000mg twice daily	<input type="checkbox"/> Cyclophosphamide, 0.6-1g/m ² IV every 4weeks or 1-2mg/kg/day orally, >3months

2. **For diagnosis that is refractory to conventional therapy or with severe organ-threatening manifestations**, member **must** have tried and failed the therapies below **WITHIN THE PAST 6 MONTHS:**

Methylprednisolone, 500-1000mg/day IV for 1-3 days for 3 months,

AND

Member **MUST** have had trial and failure of **ONE** of the following therapies for at least 90 days **WITHIN THE PAST 6 MONTHS** (*MUST note therapy tried*):

<input type="checkbox"/> IVIG, 1grm once month for 1-6 months	<input type="checkbox"/> Cyclophosphamide, 0.6-1g/m ² IV every 4weeks or 1-2mg/kg/day orally, >3months
<input type="checkbox"/> Rituximab, 1000mg repeat on day 15, or 375mg/m ² once weekly for 4 weeks	<input type="checkbox"/> Cyclosporine A, 3.0-3.5 mg/kg per day

(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 #: _____

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