OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-800-750-9692**. 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) **(Other conditions)**
(Multiple Sclerosis, Rheumatic disorders, Collagen diseases, Allergic /Ophthalmic /Respiratory/ Edematous states)

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: Boxes below **must** be checked to qualify or authorization process will be delayed. **ALL** hospital progress notes **MUST** be attached to this request form.

Use of repository corticotropin injection is considered **not medically necessary** as treatment of corticosteroid responsive conditions. **Please note patient's diagnosis:**

❑ Multiple Sclerosis	❑ Rheumatic disorders	❑ Collagen disease
❑ Allergic states	❑ Ophthalmic diseases	❑ Respiratory diseases
❑ Other: ____________________	❑ Edematous state	

AND

PAID CLAIMS MUST MATCH STATEMENT BELOW:

Member **MUST** have tried and failed the therapies below for at least 3 months consecutively within the last 12 months. Failure will be defined as no improvement in symptoms while on high dose corticosteroid and immunosuppressant agent concomitantly. Please note therapies tried:

- ❑ Prednisone 0.5-1mg/kg/day IV, PO, SOLUTION

AND

- ❑ PREDNISONE **MUST** HAVE BEEN TAKEN **CONCURRENTLY** WITH ONE OF THE FOLLOWING IMMUNOSUPPRESIVE DRUGS FOR **AT LEAST 90 DAYS CONSECUTIVELY WITHIN THE LAST 12 MONTHS**. Please note therapy tried **(paid claims will be verified through pharmacy records; chart notes documenting failure of prednisone plus concurrent immunosuppressive drug must be submitted):**

(continued on next page)

AND

❑ Methotrexate	❑ Azathioprine	❑ Mycophenolate mofetil
❑ IVIG	❑ Cyclophosphamide	❑ Rituximab
❑ Cyclosporine A		

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:** ~~8/26/2017; 7/2/2018;~~ **8/14/2018**