OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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)

(continued on next page)

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)

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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 2/21/2008

UPDATED: ~~6/2/2011; 8/11/2011; 10/1/2012; 8/19/2014; 10/31/2014; 4/3/2015; 5/23/2015; 6/8/2015; 12/22/2015; 6/15/2016; 8/25/2016; 9/22/2016; 12/11/2016; 5/25/2017; 7/30/2017; 7/2/2018;~~ **8/14/2018**