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 1-800-319-5003**. 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) **- Nephrotic Syndrome (NS)**

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. If not completed, authorization process will be delayed. Send **ALL** progress notes and lab documentation with request form.

- ❑ Patient **MUST** have a documented diagnosis of Nephrotic Syndrome with **ONE** of the following:
  - ❑ Focal Segmental Glomerulosclerosis (FSGS) **OR** ❑ Membranous Nephropathy (MPGN)
  - ❑ Minimal Change Disease _____
- ❑ **The following MUST be noted**:
  1. Baseline current Kg: _____
  2. Baseline (prior to corticosteroid and calcineurin inhibitor***)*** urine protein/creatinine ratio with collection date: _____; __ _____ mg/mg (> 3-3.5mg/mg nephrotic range proteinuria)
- ❑ Member **MUST** have tried and failed both a corticosteroid **AND** a calcineurin inhibitor (CNI) taken concurrently within the year of request. Failure is defined as no change or an increase from baseline proteinuria levels after 90 consecutive days of concomitant corticosteroid and calcineurin therapy trial. Approval will be based on proteinurea increase from baseline after 90 consecutive days of concomitant corticosteroids and calcineurin inhibitor therapy.
  3. 90 days post concurrent corticosteroid and calcineurin inhibitor trial, urine protein/creatinine ratio; Date: _____ ; _____ (mg/mg nephrotic range proteinuria)
- ❑ Member **MUST** have had trial and failure of high dose corticosteroid for a minimum of 90 consecutive days within last 12 months. Note name of therapy tried and dose (**must** note therapy tried and trial **MUST** be noted in pharmacy or medical claims):
  - ❑ 1 mg/kg (max 80mg) **OR** ❑ 2mg/kg alternate day (max 120mg)

AND

(continued on next page)

- ❑ Member **MUST** have had concurrent trial and failure of calcineurin inhibitor for a minimum of 90 days consecutive days within last 12 months **(must** note therapy tried and trial **MUST** be noted in **pharmacy paid claims**)**:**

❑ Cyclosporine	❑ Tacrolimus	❑ Cyclophosphamide

OR

- ❑ If patient has a relative **contraindication or intolerance to high dose corticosteroids (e.g. uncontrolled diabetes BS > 200, or GI BLEED within the last 30 days):**
  - ❑ Member has had trial and failure of calcineurin inhibitor only **(therapy tried MUST be noted in pharmacy paid claims):**
    - ❑ Cyclosporine: _____ mg (4 to 5 mg/kg/day in 2 divided doses for at least 12 months **OR** 150 mg/m^2/day in 2 divided doses; adjust doses based on trough levels {(pediatrics): 80 to 100 ng/mL}
    - ❑ Tacrolimus: _____ mg
    - ❑ Cyclophosphamide: _____ mg
- ❑ Progress notes **MUST** be submitted with documentation of **ALL THREE (3)** of the following labs**:**

❑ Proteinuria	❑ Serum Albumin	❑ Cyclosporine levels

Dose Regimen: _____ Anticipated Length of therapy: _____

****NOTE*: Approval will be for a period of 6weeks with a follow up Proteinuria lab required to be submitted**. IF additional therapy is needed; the prescribing physician will need to submit a second request for continuation of therapy.****

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:** 2/21/2013
REVISED/UPDATED: ~~7/30/2017~~; ~~7/1/2018~~; **8/14/2018**