# OPTIMA HEALTH COMMUNITY CARE

## 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 1-800-319-5003. 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)

***(Multiple Sclerosis, Rheumatic disorders, Collagen diseases, Allergic states, Ophthalmic diseases, Respiratory diseases, or Edematous state)***

***DRUG INFORMATION: Complete information below. If incomplete, 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. ALL HOSPITAL PROGRESS NOTES MUST BE ATTACHED TO REQUEST FORM.***

| Use of repository corticotropin injection is considered ***not*** **medically necessary** as treatment of corticosteroid responsive conditions. **Patient has diagnosis of:** | |
|---|---|
| ❑ Multiple Sclerosis | ❑ Rheumatic disorders |
| ❑ Collagen disease | ❑ Allergic states |
| ❑ Ophthalmic diseases | ❑ Respiratory diseases |
| ❑ other_____ | ❑ Edematous state |
| **Tried and failed the therapies below for at least 3 months:** | |
| ❑ Prednisone 0.5-1mg/kg/day IV, PO, SOLUTION | |
| **AND CONCURRENT WITH A IMMUNOSUPPRESSIVE DRUG FOR AT LEAST 3 MONTHS (90 DAYS)** | |
| ❑ Methotrexate | ❑ Azathioprine |
| ❑ Mycophenolate mefetil | ❑ 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**