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) - **INFANTILE SPASMS (IS)**

***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:*** _____

Note*: (*Neurology* 2012;78:1974-1976) *Class I study showed similar efficacy between low-dose (20-30 IU) and high dose (150IU/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:* *ALL* lines below *must* be completed to qualify. Authorization process will be delayed if incomplete.**

- ❑ Prescriber is a Neurologist

AND

- ❑ Patient has a documented diagnosis of Infantile Spasms

Approval is only granted for 30days 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)

Initial Dose Schedule	**Volume Needed/Day**	**Total Volume Needed**	
75 U/m^2 **BID** x 14 days	_____mL x 14 days	_____mL	
Taper Dose Schedule			**BODY SURFACE AREA BSA**
30 U/m^2 **QD** x 3 days	_____mL x 3 days	_____mL	**WEIGHT**: _____ kg
15 U/m^2 **QD** x 3 days	_____mL x 3 days	_____mL	Height/Length: _____ in.
10 U/m^2 **QD** x 3 days	_____mL x 3 days	_____mL	Calculated BSA:_____ m^2
10 U/m^2 **QOD** x 6 days	_____mL x 6 days	_____mL	
	TOTAL:	_____ mL	

TOTAL Number of vials needed: _____

(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: 8/26/2017**