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) ***(Dermatomyositis and Polymyositis)***

***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.**

- Patient has diagnosis of **Dermatomyositis and Polymyositis:**

❑ 1. Idiopathic inflammatory myopathy

❑ 2. Refractory to conventional therapy or with severe organ-threatening manifestations

1. Diagnosis of Idiopathic inflammatory myopathy, *member failed the therapies below:*

❑ Prednisone 0.5-1mg/kg/day for 2-4 weeks, then taper for 2 weeks

AND

CONCURRENT WITH A IMMUNOSUPPRESSIVE DRUG FOR AT LEAST 3 MONTHS (90 DAYS)

❑ Methotrexate target dose 25mg/wk
❑ Mycophenolate mefetil, 500mg twice daily, increased by 500mg/wk until 1000mg twice daily
❑ Cyclophosphamide, 0.6-1g/m^2 IV every 4weeks or 1-2mg/kg/day orally, >3months
❑ Azathioprine 2mg/kg IBW twice daily

2. Diagnosis Refractory to conventional therapy or with severe organ-threatening manifestations, *member failed the therapies below:*

❑ Methylprednisolone, 500-1000mg/day IV for 1-3 days for 3 months

AND

A FAILURE OF ONE OF THE FOLLOWING THERAPIES FOR AT LEAST 3 MONTHS (90 DAYS)

❑ IVIG, 1grm once month for 1-6 months
❑ Cyclophosphamide, 0.6-1g/m^2 IV every 4weeks or 1-2mg/kg/day orally, >3months
❑ Rituximab, 1000mg repeat on day 15, or 375mg/m^2 once weekly for 4 week
❑ Cyclosporine A, 3.0-3.5 mg/kg per day

***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**