

# OPTIMA HEALTH PLAN

## 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 1-800-750-9692. 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)  
(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:

- |  |   |
|--|---|
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Rheumatic disorders  |
| <input type="checkbox"/> Collagen disease    | <input type="checkbox"/> Allergic states      |
| <input type="checkbox"/> Ophthalmic diseases | <input type="checkbox"/> Respiratory diseases |
| <input type="checkbox"/> other _____         | <input type="checkbox"/> 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)**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Methotrexate          | <input type="checkbox"/> Azathioprine |
| <input type="checkbox"/> Mycophenolate mofetil | <input type="checkbox"/> IVIG         |
| <input type="checkbox"/> Cyclophosphamide      | <input type="checkbox"/> Rituximab    |
| <input type="checkbox"/> Cyclosporine A        |                                       |

**Medication being provided by a Specialty Pharmacy:**  Briova SpecialtyRx

**\*\*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: 11/17/2013

REVISED/UPDATED: 4/7/2014; 8/49/2014; 10/31/2014; 4/3/2015; 5/22/2015; 6/8/2015; 12/23/2015; 6/45/2016; 8/25/2016; 9/20/2016; 11/16/2016; 12/7/2016; 9/11/2017; 10/6/2017