

# 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) - 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<sup>2</sup>) 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/m<sup>2</sup> in the morning for 3 days; 15 U/m<sup>2</sup> in the morning for 3 days; 10 U/m<sup>2</sup> in the morning for 3 days; and 10 U/m<sup>2</sup> 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)*

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

**TOTAL Number of vials needed:** \_\_\_\_\_

*(continued on next page)*

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: 2/21/2008**

**UPDATED:** 6/2/2011; 8/11/2011; 10/1/2012; 8/19/2014; 10/31/2014; 4/3/2015; 5/23/2015; 6/8/2015; 12/22/2015; 6/15/2016; 8/25/2016; 9/22/2016; 12/11/2016; 5/25/2017; 9/11/2017; 10/6/2017.