

# 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) (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 AN IMMUNOSUPPRESSIVE DRUG FOR AT LEAST 3 MONTHS (90 DAYS)**

Methotrexate target dose 25mg/wk

Azathioprine 2mg/kg IBW twice daily

Mycophenolate mofetil, 500mg twice daily, increased by 500mg/wk until 1000mg twice daily

Cyclophosphamide, 0.6-1g/m<sup>2</sup> IV every 4weeks or 1-2mg/kg/day orally, >3months

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<sup>2</sup> IV every 4weeks or 1-2mg/kg/day orally, >3months

Rituximab, 1000mg repeat on day 15, or 375mg/m<sup>2</sup> once weekly for 4 weeks

Cyclosporine A, 3.0-3.5 mg/kg per day

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

OhioHealth 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: 1/7/2014; 8/19/2014; 10/31/2014; 4/3/2015; 5/23/2015; 6/8/2015; 12/23/2015; 6/15/2016; 8/25/2016; 9/22/2016; 12/11/2016; 7/30/2017; 9/25/2017.