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) - ***Nephrotic Syndrome (NS)***

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. Send ALL progress notes and lab documentation with request form.***

- **Patient has a documented diagnosis of Nephrotic Syndrome:**
  - ❑ Focal Segmental Glomerulosclerosis (FSGS)
  - ❑ Membranous Nephropathy (MPGN)
  - ❑ Minimal Change Disease
  - ❑ OTHER _____
- **Has the member tried and failed both Corticosteroid and Calcineurin Inhibitor (CNI)?** ❑ Yes ❑ No
  - ❑ High dose corticosteroids for a minimum of 4weeks-up to max 16 weeks as tolerated:
    - ❑ 1 mg/kg (max 80mg) **OR** ❑ 2mg/kg alternate day (max 120mg)

AND

  - ❑ **Tried and Failed Calcineurin Inhibitor:**
    - ❑ Cyclosporine ❑ Tacrolimus ❑ Cyclophosphamide

OR

If patient has a relative contraindication or intolerance to high dose corticosteroids (e.g. uncontrolled diabetes, psychiatric conditions, severe osteoporosis), send Progress Notes and Labs of Protein Urea.

  - ❑ **Tried and Failed Calcineurin Inhibitors:**
    - ❑ Cyclosporine ❑ Tacrolimus ❑ Cyclophosphamide

Please send progress notes along with documentation of ALL THREE (3) **labs:**

- ❑ Proteinuria ❑ Serum Albumin ❑ Cyclosporine levels

Dose Regimen: _____ **Anticipated Length of therapy:** _____

(Note: Approval will be for a period of 6weeks with a follow up Proteinuria lab.
IF additional therapy is needed; the prescribing physician will need to submit a second request.)

(signature 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:** 2/21/2013
REVISED/UPDATED: ~~6/18/2013~~; ~~4/8/2014~~; ~~8/21/2014~~; ~~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~~; ~~9/11/2017~~; **10/6/2017**