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: **HP Acthar® Gel (repository corticotropin) - *Symptomatic Sarcoidosis***

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:*** _____

- ***Adverse effects that may occur with Acthar® are related primarily to its steroidogenic effects and are similar to corticosteroids. There may be increased susceptibility to new infection and increased risk of reactivation of latent infections. Adrenal insufficiency may occur after abrupt withdrawal of the drug following prolonged therapy.***

CLINICAL CRITERIA: Check applicable box (es) below. At least ONE (1) box MUST be checked to qualify. Incomplete information will delay authorization process.

- **Patient has a documented diagnosis of sarcoidosis**
  - ❑ With active pulmonary symptoms
  - ❑ Extrapulmonary symptoms only
- **Has the member tried and failed or has a contraindication to systemic corticosteroids?** ❑ Yes ❑ No
  - ❑ Dose equivalent to at least 20 mg prednisone daily
  - ❑ contraindication: _____
- **Has the member tried and failed or has a contraindication to immunomodulators?** ❑ Yes ❑ No
  - ❑ methotrexate
  - ❑ azathioprine
  - ❑ leflunomide
  - ❑ contraindication: _____
- **Has the member tried and failed or has a contraindication to TNF alpha inhibitors?** ❑ Yes ❑No
  - ❑ inFLIXimab (Remicade®)
  - ❑ etanercept (Enbrel®)
  - ❑ adalimumab (Humira®)
  - ❑ contraindication: _____

***Please send progress notes along with documentation of ALL of the following*:**

- ❑ Pulmonary imaging
- ❑ Confirmation of noncaseating granulomas
- ❑ Recent pulmonary function tests

Please Note: Approval will be for a period of 4 weeks

If additional therapy is needed, the prescriber will need to submit a second request.

(signature on next page)

***Medication being provided by** (check box below that applies)**:**

- ❑ **Physician's office**

  OR

- ❑ **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:** 7/21/2016
REVISED/UPDATED: ~~9/22/2016~~; ~~12/11/2016~~; ~~9/11/2017~~; **10/6/2017**;