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 all information below or 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 or authorization process will be delayed. ALL HOSPITAL PROGRESS NOTES MUST BE ATTACHED TO REQUEST FORM.***

❑ ***Patient has diagnosis of DERMATOMYOSITIS OR POLYMYOSITIS with one of the following:***

❑ **Idiopathic Inflammatory Myopathy**	❑ **Refractory to conventional therapy or with severe organ-threatening manifestations**

1. **Diagnosis of Idiopathic Inflammatory Myopathy,** member ***must*** have tried and failed the therapies below **WITHIN THE PAST 6 MONTHS:**

   ❑ Prednisone 0.5-1mg/kg/day for 2-4 weeks, then taper for 2 weeks,

   AND

   ❑ Prednisone ***MUST*** have been taken CONCURRENTLY WITH AN IMMUNOSUPPRESSIVE DRUG FOR ***AT LEAST 90 DAYS*** **within the past 6 months** ***(must note therapy tried):***

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

2. **For diagnosis that is refractory to conventional therapy or with severe organ-threatening manifestations, member must have tried and failed the therapies below *WITHIN THE PAST 6 MONTHS*:**

   ❑ Methylprednisolone, 500-1000mg/day IV for 1-3 days for 3 months,

   AND

   ❑ **Member MUST have had trial and failure of ONE of the following therapies for at least 90 days *WITHIN THE PAST 6 MONTHS* *(MUST note therapy tried)*:**

❑ IVIG, 1grm once month for 1-6 months	❑ Cyclophosphamide, 0.6-1g/m^2 IV every 4weeks or 1-2mg/kg/day orally, >3months
❑ Rituximab, 1000mg repeat on day 15, or 375mg/m^2 once weekly for 4 weeks	❑ Cyclosporine A, 3.0-3.5 mg/kg per day

(signature on next page)

Medication being provided by a Specialty Pharmacy **- PropriumRx**

*****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;~~ **6/21/2018**