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)

(Multiple Sclerosis, Rheumatic disorders, Collagen diseases, Allergic states, Ophthalmic diseases, Respiratory diseases, or Edematous state)

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.

Use of repository corticotropin injection is considered ***not*** **medically necessary** as treatment of corticosteroid responsive conditions.

Patient has diagnosis of:

❑ Multiple Sclerosis	❑ Rheumatic disorders
❑ Collagen disease	❑ Allergic states
❑ Ophthalmic diseases	❑ Respiratory diseases
❑ other_____	❑ Edematous state

Tried and failed the therapies below for at least 3 months:

❑ Prednisone 0.5-1mg/kg/day IV, PO, SOLUTION

AND

CONCURRENT WITH A IMMUNOSUPPRESSIVE DRUG FOR AT LEAST 3 MONTHS (90 DAYS)

❑ Methotrexate	❑ Azathioprine
❑ Mycophenolate mefetil	❑ IVIG
❑ Cyclophosphamide	❑ Rituximab
❑ Cyclosporine A	

***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~~; ~~5/22~~/2015; ~~6/8/2015~~; ~~12/23/2015~~; ~~6/15/2016~~; ~~8/25/2016~~; ~~9/22/2016~~; ~~12/11/2016~~; **7/30/2017**;