OPTIMA HEALTH PLAN

PHARMACY 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) ***(Other conditions)***

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

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: Boxes below must be checked to qualify or authorization process will be delayed. ALL hospital progress notes MUST be attached to this request form.

Use of repository corticotropin injection is considered ***not*** **medically necessary** as treatment of corticosteroid responsive conditions. **Please note patient's diagnosis:**

❑ Multiple Sclerosis	❑ Rheumatic disorders	❑ Collagen disease
❑ Allergic states	❑ Ophthalmic diseases	❑ Respiratory diseases
❑ Other: _____	❑ Edematous state	

AND

PAID CLAIMS MUST MATCH STATEMENT BELOW:

Member MUST have tried and failed the therapies below for at least 3 months consecutively within the last 12 months. Failure will be defined as no improvement in symptoms while on high dose corticosteroid and immunosuppressant agent concomitantly. Please note therapies tried:

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

AND

❑ **PREDNISONE MUST HAVE BEEN TAKEN CONCURRENTLY WITH ONE OF THE FOLLOWING IMMUNOSUPPRESIVE DRUGS FOR AT LEAST 90 DAYS CONSECUTIVELY WITHIN THE LAST 12 MONTHS. Please note therapy tried (paid claims will be verified through pharmacy records; chart notes documenting failure of prednisone plus concurrent immunosuppressive drug must be submitted):**

AND

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

(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~~; ~~5/22~~/2015; ~~6/8/2015~~; ~~12/23/2015~~; ~~6/15/2016~~; ~~8/25/2016~~; ~~9/22/2016~~; ~~12/11/2016~~; ~~7/30/2017~~; **6/22/2018**;