

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: 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: 2/21/2013

REVISED/UPDATED: 6/4/2013; 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; 7/30/2017.