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

***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:*** _____

- ***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:* *ALL of the following criteria MUST be met for approval or authorization process will be delayed. ALL chart notes/documentation MUST be attached with this request form.

- **Patient *MUST* have a documented diagnosis of sarcoidosis and ONE of the following:**
  - ❑ With active pulmonary symptoms **OR** ❑ Extra pulmonary symptoms only

AND

  - ❑ **Member must have tried and failed or has a contraindication to systemic corticosteroids as follows:**
    - ❑ Trial of dose equivalent to at least 20 mg prednisone daily for 3 months ***MUST*** be noted in pharmacy claims

OR

    - ❑ For contraindication: GI BLEED has occurred within the last 30 days ***(must submit chart note documentation)***

AND

  - ❑ **Member must have tried and failed or has a contraindication to at least *one* (1) of the following immunomodulators *(therapy tried must be noted in pharmacy claims)*:**

❑ methotrexate	❑ azathioprine	❑ leflunomide

AND

  - ❑ **Member must have tried and failed or has a contraindication to at least *one* (1) TNF Inhibitor *(therapy tried must be noted in pharmacy claims)*:**

❑ inFLIXimab (Remicade®)	❑ etanercept (Enbrel®)	❑ adalimumab (Humira®)

AND

(continued on next page)

- ❑ **Documentation that EITHER pulmonary imaging/pulmonary function tests OR noncaseating granulomas showed worsening of disease while on a steroid and immunomodulator and TNF-Inhibitor *(progress notes and diagnostics MUST be submitted)*:**
  - ❑ Pulmonary imaging **OR** ❑ Confirmation of noncaseating granulomas
  - ❑ Recent pulmonary function tests

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

❑ **Physician's office** **OR** ❑ **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:** 7/21/2016
REVISED/UPDATED: ~~9/22/2016; 12/11/2016; 7/31/2017;~~ **6/22/2018**