

AvMed

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 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Repository Corticotropin Medications - INFANTILE SPASMS (IS)

<u>PREFERRED</u>	<u>NON-PREFERRED</u>
<input type="checkbox"/> Purified Cortrophin™ Gel (repository corticotropin)	<input type="checkbox"/> HP Acthar® Gel (repository corticotropin) *Member must have tried and failed preferred Purified Cortrophin™ Gel and meet all applicable PA criteria below

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight: _____ Date: _____

Note: (Neurology 2012;78:1974-1976) Class I study showed similar efficacy between low-dose (20-30 IU) and high dose (150 IU/m²) natural ACTH. Low dose ACTH should be considered as an alternative to high dose ACTH for treatment of infantile spasms. (Level B).

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Prescriber **MUST** be a Neurologist

(Continued on next page)

- ❑ Member **MUST** have a documented diagnosis of Infantile Spasms
- ❑ Approval will only be granted for a **MAXIMUM** of **30 days only** due to similar adverse effects of corticosteroids. After 2 weeks of treatment, dosing should be gradually tapered and discontinued over a 2-week period. The following is one **suggested** tapering schedule:
 - 30 U/m² in the morning for 3 days; 15 U/m² in the morning for 3 days; 10 U/m² in the morning for 3 days; and 10 U/m² every other morning for 6 days.
- ❑ Complete the regimen below (**repository corticotropin is supplied as 5 mL multi-dose vial containing 80 USP Units per mL**):

Approval will be a **MAXIMUM** of **30 days only** (combined inpatient and outpatient time period)

<u>Initial Dose Schedule</u>	<u>Approval at Outpatient pharmacy will be based on volume needed at discharge from hospital</u>	
75 U/m ² BID x _____ days	TOTAL _____ mL x _____ # days (max 29 days)	
<u>Taper Dose Schedule</u>	<u>BODY SURFACE AREA BSA</u>	
30 U/m ² QD x _____ days	_____ mL x _____ days	Weight: _____ kg
15 U/m ² QD x _____ days	_____ mL x _____ days	Height/Length: _____ in.
10 U/m ² QD x _____ days	_____ mL x _____ days	Calculated BSA: _____ m ²
10 U/m ² QOD x _____ days	_____ mL x _____ days	

TOTAL Number of vials needed: _____/days (max 29 days)

Medication being provided by Specialty Pharmacy – PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****