# 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 - Nephrotic Syndrome (NS)

| PREFERRED | NON-PREFERRED |
|---|---|
| ❑ **Purified Cortrophin™ Gel** (repository corticotropin) | ❑ **Acthar® Gel** (repository corticotropin) 80 USP Units/mL 5 mL multi-dose vial<br>❑ **Acthar® Gel** (repository corticotropin) 40 USP Units/0.5 mL single-dose prefilled SelfJect injector<br>❑ **Acthar® Gel** (repository corticotropin) 80 USP Units/mL single-dose prefilled SelfJect injector<br>***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 Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

- **Acthar Gel single-dose pre-filled SelfJect injector is for subcutaneous administration by adults only.**

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**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. Check box below for the Diagnosis that applies.

- ❑ **Member MUST have a documented diagnosis of Nephrotic Syndrome with ONE of the following:**
  - ❑ Focal Segmental Glomerulosclerosis (FSGS) **OR** ❑ Membranous Nephropathy (MPGN)
  - ❑ Minimal Change Disease _____
- ❑ **The following MUST be noted**:
  1. Baseline current kg: _____
  2. Baseline (prior to corticosteroid and calcineurin inhibitor**)** urine protein/creatinine ratio with collection date: _____; _____ mg/mg (> 3-3.5 mg/mg nephrotic range proteinuria)
- ❑ **Member MUST have tried and failed both a corticosteroid AND a calcineurin inhibitor (CNI) taken concurrently within the year of request. Failure is defined as no change or an increase from baseline proteinuria levels after 90 consecutive days of concomitant corticosteroid and calcineurin therapy trial. Approval will be based on proteinuria increase from baseline after 90 consecutive days of concomitant corticosteroids and calcineurin inhibitor therapy.**
  3. 90 days post concurrent corticosteroid and calcineurin inhibitor trial, urine protein/creatinine ratio; Date: _____ ; _____ (mg/mg nephrotic range proteinuria)
- ❑ **Member MUST have had trial and failure of high dose corticosteroid for a minimum of 90 consecutive days within last 12 months. Note name of therapy tried and dose (must note therapy tried and trial MUST be noted in pharmacy or medical claims):**
  - ❑ 1 mg/kg (max 80 mg) **OR** ❑ 2mg/kg alternate day (max 120 mg)

**AND**

- ❑ **Member MUST have had concurrent trial and failure of calcineurin inhibitor for a minimum of 90 days consecutive days within last 12 months (must note therapy tried and trial MUST be noted in pharmacy paid claims):**

| | | |
|---|---|---|
| ❑ Cyclosporine | ❑ Tacrolimus | ❑ Cyclophosphamide |

**OR**

- ❑ **If member has a relative contraindication or intolerance to high dose corticosteroids (e.g., uncontrolled diabetes BS > 200, or GI BLEED within the last 30 days)**:
- ❑ Member has had trial and failure of calcineurin inhibitor only **(therapy tried MUST be noted in pharmacy paid claims):**
  - ❑ Cyclosporine: _____ mg (4 to 5 mg/kg/day in 2 divided doses for at least 12 months **OR** 150 mg/m$^2$/day in 2 divided doses; adjust doses based on trough levels {(pediatrics): 80 to 100 ng/mL}
  - ❑ Tacrolimus: _____ mg
  - ❑ Cyclophosphamide: _____ mg

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- ❑ **Progress notes <u>MUST</u> be submitted with documentation of <u>ALL THREE (3)</u> of the following labs:**

| | | |
|---|---|---|
| ❑ Proteinuria | ❑ Serum Albumin | ❑ Cyclosporine levels |

**Dose Regimen: _____ Anticipated Length of therapy: _____**

**<u>NOTE</u>: <u>Approval will be for a period of 6 weeks with a follow up Proteinuria lab required to be submitted</u>. IF additional therapy is needed; the prescribing physician will need to submit a second request for continuation of therapy.**

## Medication being provided by Specialty Pharmacy – Proprium Rx

***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.****

*<u>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</u>*