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 – Ocular Diseases

PREFERRED	NON-PREFERRED
❑ **Purified Cortrophin™ Gel** (repository corticotropin)	❑ **Acthar® Gel** (repository corticotropin) 80 USP Units/mL 5 mL multi-dose vial ❑ **Acthar® Gel** (repository corticotropin) 40 USP Units/0.5 mL single-dose prefilled SelfJect injector ❑ **Acthar® Gel** (repository corticotropin) 80 USP Units/mL single-dose prefilled SelfJect injector ***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:** _____

- Adverse effects that may occur with repository corticotropin 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.
- 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.

SECTION A:		
Slit lamp examination used to make diagnosis?	❑ Yes	❑ No
Intraocular pressure (IOP) measurement taken at baseline?	❑ Yes	❑ No
Baseline IOP results _____		
Visual Acuity Test results _____		
Labs and documentation to rule out infectious etiology	❑ Yes	❑ No
Anterior Chamber cells present?	❑ Yes	❑ No

SECTION B:

PREDNISONE MUST HAVE BEEN TAKEN CONCURRENTLY WITH ONE OF THE FOLLOWING IMMUNOSUPPRESIVE DRUGS/NON-BIOLOGICS 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): **Check ALL that apply**:

❑ methotrexate	❑ cyclosporine	❑ mycophenolate	❑ azathioprine
❑ cyclophosphamide	❑ tacrolimus	❑ sirolimus	❑ Other: _____

❑ **NON-INFECTIOUS UVEITIS (NIU).** 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.

Initial Authorization: 3 months

❑ Use of repository corticotropin injection is considered **NOT medically necessary** as treatment of corticosteroid responsive conditions. **Please note member's diagnosis**. ****NOTE if member is only diagnosed with Anterior Uveitis additional comorbidities including etiology will be required for approval****

❑ Anterior Uveitis	❑ Intermediate Uveitis	❑ Posterior Uveitis	❑ Pan Uveitis

❑ Is this member positive for HLA-B27 antigen? ❑ Yes ❑ No

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- ❑ Please include other diagnosis that contributes to Anterior Uveitis **ONLY** diagnosis:

  _____

  _____

  _____

- ❑ Completed **SECTION A**

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**:**

- ❑ Member tried and maximized topical steroid treatment for at least 4 weeks resulting in ineffective therapy:

❑ prednisolone acetate (Pred Forte®)	❑ difluprednate (Durezol®)	❑ loteprednol (Lotemax®)
❑ Fluoromethalone (FML®)	❑ Dexamethasone	❑ Other: _____

AND

- ❑ Prednisone 1 mg/kg/day oral (or an equivalent high dose steroid)

  Name, dose and dates of the equivalent high does steroid trials: _____

  _____

AND

- ❑ Completed **SECTION B**

AND

- ❑ **Member tried and failed at least 2 different BIOLOGICS for a minimum of 3 months due to toxicity OR failure to stabilize disease. Submit supporting document on toxicities and progression. (Include labs - CBC, BUN, SCr, AST, ALT and albumin). Check ALL that apply:**

❑ adalimumab (Humira®)	❑ etanercept (Enbrel®)	❑ infliximab	❑ rituximab
❑ golimumab (Simponi®)	❑ tocilizumab (Actemra®)	❑ IVIG	❑ Other: _____

AND

- ❑ CBC, CMP, HbA1C, TB, Hepatitis B and C labs collected prior to initiation of repository corticotropin therapy have been submitted

AND

- ❑ Medication is prescribed by an ophthalmologist or rheumatologist

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❑ **NON-INFECTIOUS KERATITIS.** 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.
****Note approval will not exceed 16 weeks for this indication****

❑ Complete **SECTION A**

AND

❑ Provider attests all infectious etiologies have been ruled out (e.g., bacterial, fungal or viral eye infection) **(Attach labs and culture and sensitivity reports to support)**

AND

❑ Positive fluorescein stain has been obtained

AND

❑ Corneal Scraping used to stain and culture specimen has been completed to rule out infectious etiologies

AND

❑ Member tried and maximized topical lubricant and/or steroid treatment for at least 4 weeks resulting in ineffective therapy. **Check ALL that apply:**

❑ prednisolone acetate (Pred Forte®)	❑ difluprednate (Durezol®)	❑ loteprednol (Lotemax®)
❑ Fluoromethalone (FML®)	❑ Artificial tears	❑ Cyclosporine (Restasis®)
❑ Dexamethasone	❑ Other:_____	

AND

❑ Medication is prescribed by an ophthalmologist

❑ **OPTIC NEURITIS.** 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.
****Note approval will not exceed 14 days for this indication****

❑ MRI of brain and orbital region has been completed for lesions consistent with MS and visualizing the optic chiasm for negative pituitary tumors **(submit imaging results)**

AND

❑ Provider attests all other primary etiologies have been ruled out (e.g., infectious, neuromyelitis optica)

AND

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- ❑ Member is contraindicated or has failed methylprednisolone IV use for 3-5 days

AND

- ❑ Member is contraindicated or has failed oral prednisone (1 mg/kg) use for 2 weeks after IV methylprednisolone

AND

- ❑ Member tried and failed IVIG for a minimum of 3 months
- ❑ **Proof of inability to improve vision with treatments above has been submitted (submit documentation)**

Visual Acuity Baseline: _____ Current Vision Acuity: _____

Contrast Sensitivity: _____ Current Contrast Sensitivity: _____

❑ **OTHER OPHTHALMIC DISEASES.** 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. **(Please submit supporting document to questions below including literature to support therapeutic decision making)**

- ❑ **Diagnosis:** _____

AND

- ❑ Completed **SECTION A**

AND

- ❑ Completed **SECTION B**
- ❑ Other previously failed therapies along with dates tried have been documented below:

_____

_____

_____

❑ **REAUTHORIZATION FOR NON-INFECTIOUS UVEITIS.** 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.

If member is in remission for 2 years reduced dose is indicated until discontinuation

- ❑ Completed **SECTION A**

AND

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- ❑ Signs and symptoms have improved within 3 months of use (Submit supporting labs and documentation)

  Current IOP results: _____

  Current acuity: _____

  Anterior Chamber cells present? ❑ Yes ❑ No

AND

- ❑ No toxicities or severe adverse reactions have developed

AND

- ❑ Medication is prescribed by a specialist in treatment of the disease/condition (rheumatologist or ophthalmologist)

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.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****