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 - Symptomatic Sarcoidosis

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.**

(Continued on next page)

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 sarcoidosis and ONE of the following:**
  - ❑ With active pulmonary symptoms
  - ❑ Extra pulmonary symptoms only
- ❑ **Member must meet ONE of the following:**
  - ❑ Trial of dose equivalent to at least 20 mg prednisone daily for 3 months **MUST** be noted in pharmacy claims
  - ❑ For contraindication: GI BLEED has occurred within the last 30 days **(must submit chart note documentation)**
- ❑ **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

- ❑ **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®)

- ❑ **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 a 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.****