AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions</u>: <u>The prescribing physician must sign and clearly print name (preprinted stamps not valid)</u> on this request. All other information may be filled in by office staff; <u>fax to 1-305-671-0200</u>. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. <u>If the information provided is not complete, correct, or legible, the authorization process can be delayed.</u>

NON-PREFERRED

Acthar® Gel (repository corticotropin) 80 USP

<u>Drug Requested</u>: Repository Corticotropin Medications Dermatomyositis and Polymyositis

PREFERRED

□ Purified Cortrophin[™] Gel

adults only.

(repository corticotropin)	Units/mL 5 mL multi-dose vial					
(1)y	□ 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 INFO	DRMATION: Authorization may be delayed if incomplete.					
Member Name:						
	Date of Birth:					
Prescriber Name:						
Prescriber Signature:	Date:					
Office Contact Name:						
Phone Number:	Number: Fax Number:					
NPI #:						
DRUG INFORMATION: Authoriza	tion 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					

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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 has diagnosis of <u>DERMATOMYOSITIS</u> OR <u>POLYMYOSITIS</u> with one of										
th	e fo	llo	wing:							
☐ Idiopathic Inflammatory Myopathy				☐ Refractory to conventional therapy or with severe organ-threatening manifestations						
1. Diagnosis of <u>Idiopathic Inflammatory Myopathy</u> , member must have tried and failed the therapies below <u>WITHIN THE PAST 6 MONTHS</u> :										
	u]	☐ Prednisone 0.5-1 mg/kg/day for 2-4 weeks, then taper for 2 weeks								
	□ Prednisone MUST have been taken CONCURRENTLY WITH AN IMMUNOSUPPRESSIVE									
	DRUG FOR AT LEAST 90 DAYS within the past 6 months (must note therapy tried):									
	Ī		Methotrexate target dose 25 mg/wk				Azathioprine 2 mg/kg IBW twice daily			
	-		• •	plate mofetil, 500 mg twice daily y 500 mg/wk until 1000 mg			Cyclophosphamide, 0.6-1 g/m ² IV every 4 weeks or 1-2 mg/kg/day orally, > 3months			
	. For diagnosis that is refractory to conventional therapy or with severe organ-threatening manifestations, member must have tried and failed the therapies below <u>WITHIN THE PAST 6</u> <u>MONTHS</u> :									
		Methylprednisolone, 500-1000 mg/day IV for 1-3 days for 3 months								
	□ Member MUST have had trial and failure of ONE of the following therapies for at least 90 day WITHIN THE PAST 6 MONTHS (MUST note therapy tried):									
			IVIG, 1 g once month for 1-6 mon	ths			Cyclophosphamide, 0.6-1g/m ² IV every 4 weeks or 1-2 mg/kg/day orally, > 3months			
					or		Cyclosporine A, 3.0-3.5 mg/kg per day			
	the Idi	the fo Idiopa 1. Diagonal belo 2. For mar MO	the follow Idiopathic 1. Diagnor below Vertical Prediction Predi	Idiopathic Inflammatory Myopathy 1. Diagnosis of Idiopathic Inflammatory M below WITHIN THE PAST 6 MONTHS □ Prednisone 0.5-1 mg/kg/day for 2-4 western CODRUG FOR AT LEAST 90 DAYS with Increased by 500 mg/wk until 1000 twice daily 2. For diagnosis that is refractory to convert manifestations, member must have tried MONTHS: □ Methylprednisolone, 500-1000 mg/day □ Member MUST have had trial and fath WITHIN THE PAST 6 MONTHS (Month) □ IVIG, 1 g once month for 1-6 month □ Rituximab, 1000 mg repeat on day	Idiopathic Inflammatory Myopathy 1. Diagnosis of Idiopathic Inflammatory Myopathy 2. Prednisone 0.5-1 mg/kg/day for 2-4 weeks, 2. Prednisone MUST have been taken CONCAT DRUG FOR AT LEAST 90 DAYS within 2. Methotrexate target dose 25 mg/wk 2. Mycophenolate mofetil, 500 mg twice increased by 500 mg/wk until 1000 mg twice daily 2. For diagnosis that is refractory to convention manifestations, member must have tried and MONTHS: 2. Methylprednisolone, 500-1000 mg/day IV in Member MUST have had trial and failure WITHIN THE PAST 6 MONTHS (MUS) 2. IVIG, 1 g once month for 1-6 months	Idiopathic Inflammatory Myopathy 1. Diagnosis of Idiopathic Inflammatory Myopathy, modelow WITHIN THE PAST 6 MONTHS: 1. Prednisone 0.5-1 mg/kg/day for 2-4 weeks, then tage of Prednisone MUST have been taken CONCURRENDRUG FOR AT LEAST 90 DAYS within the past of Methotrexate target dose 25 mg/wk 1. Methotrexate target dose 2-4 weeks, then tage of Methotrexate target dose 2-5 mg/wk 2. Methotrexate target dose 25 mg/wk until 1000 mg twice daily, increased by 500 mg/wk until 1000 mg twice daily 2. For diagnosis that is refractory to conventional them manifestations, member must have tried and failed MONTHS: 1. Methylprednisolone, 500-1000 mg/day IV for 1-3 of Member MUST have had trial and failure of ON WITHIN THE PAST 6 MONTHS (MUST note) 1. IVIG, 1 g once month for 1-6 months 1. Rituximab, 1000 mg repeat on day 15, or	Idiopathic Inflammatory Myopathy 1. Diagnosis of Idiopathic Inflammatory Myopathy, membelow WITHIN THE PAST 6 MONTHS: □ Prednisone 0.5-1 mg/kg/day for 2-4 weeks, then taper it Prednisone MUST have been taken CONCURRENTL DRUG FOR AT LEAST 90 DAYS within the past 6 □ Methotrexate target dose 25 mg/wk □ Mycophenolate mofetil, 500 mg twice daily, increased by 500 mg/wk until 1000 mg twice daily 2. For diagnosis that is refractory to conventional therapy manifestations, member must have tried and failed the MONTHS: □ Methylprednisolone, 500-1000 mg/day IV for 1-3 days □ Member MUST have had trial and failure of ONE of WITHIN THE PAST 6 MONTHS (MUST note there) □ IVIG, 1 g once month for 1-6 months □ Rituximab, 1000 mg repeat on day 15, or			

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.

^{*}Approved by Pharmacy and Therapeutics Committee: \(\frac{11/17/2013}{2016}\); \(\frac{9/26/2024}{9/22/2016}\); \(\frac{12/11/2016}{2016}\); \(\frac{12/11/2016}{