SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. 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)	❑ **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 Sentara #: _____ **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:** _____

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.

- ❑ 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: _____

(Continued on next page)

2. Baseline (prior to corticosteroid and calcineurin inhibitor*)* urine protein/creatinine ratio with collection date: _____; _____mg/mg (> 3-3.5mg/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 proteinurea 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 80mg) **OR** ❑ 2mg/kg alternate day (max 120mg)

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

❑ Proteinuria	❑ Serum Albumin	❑ Cyclosporine levels

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

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

Medication being provided by a Specialty Pharmacy - PropriumRx

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.