OPTIMA HEALTH PLAN

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 may be delayed.**

Drug Requested: Tarpeyo™ (budesonide delayed release)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Quantity Limit: 120 capsules per 30 days

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.

Length of Authorization: 9 months - Request is NOT eligible for renewal

- ❒ Member is 18 years of age or older
- ❒ Provider is a nephrologist
- ❒ Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN), confirmed by biopsy **(submit results or chart notes confirming diagnosis)**
- ❒ Member is currently established on a stable and maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (angiotensin converting enzyme [ACE] inhibitor or angiotensin receptor blocker [ARB]) and has been for ≥ 3 months **(verified by chart notes or pharmacy paid claims)**
- ❒ Member has a current proteinuria level ≥ 1 g/24 hour **(submit current lab test results)**
- ❒ Member is at risk of rapid disease progression as confirmed by physician assessment using the Oxford classification of IgAN or other assessment
- ❒ Member has an estimated glomerular filtration filter (eGFR) ≥ 35 mL/min/1.73 m^2 **(submit lab results)**
- ❒ Member does **NOT** have any of the following: severe hepatic impairment (Child-Pugh class C), history of kidney transplant, diagnosis of other glomerulopathies or nephrotic syndrome, diagnosis of a systemic disease that may cause mesangial IgA deposition, diabetes mellitus which is poorly controlled, history of unstable angina, class III or IV congestive heart failure, clinically significant arrhythmia, or uncontrolled hypertension
- ❒ Prescriber attests that risks due to immunosuppression will be monitored and appropriate prophylaxis will be initiated

(Continued on next page; signature page must be attached to this request form)

(Please ensure signature page is attached to form.)

Medication being provided by Specialty Pharmacy - PropriumRx

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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by the Pharmacy and Therapeutics Committee:** 3/17/2022
REVISED/UPDATED: ~~10/6/2014; 10/8/2014; 11/6/2014; 11/20/2014; 1/26/2015; 5/22/2015; 12/29/2015; 11/17/2016; 12/31/2016; 2/8/2017; 3/28/2017; 8/20/2017; 3/7/2018;(Reformatted) 6/18/2019; 9/10/2020; 12/31/2020; 4/2/2021; 9/9/2021; 10/11/2021; 12/14/2021; 12/23/2021; 4/26/2022;~~ **6/16/2022**