

SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Repository Corticotropin Medications – Ocular Diseases

<u>PREFERRED</u>	<u>NON-PREFERRED</u>
<input type="checkbox"/> Purified Cortrophin™ Gel (repository corticotropin)	<input type="checkbox"/> 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: _____

- **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.**

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.

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<u>SECTION A:</u>		
Slit lamp examination used to make diagnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intraocular pressure (IOP) measurement taken at baseline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Baseline IOP results _____		
Visual Acuity Test results _____		
Labs and documentation to rule out infectious etiology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anterior Chamber cells present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SECTION B:

PREDNISONE MUST HAVE BEEN TAKEN CONCURRENTLY WITH ONE OF THE FOLLOWING IMMUNOSUPPRESSIVE 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:**

<input type="checkbox"/> methotrexate	<input type="checkbox"/> cyclosporine	<input type="checkbox"/> mycophenolate	<input type="checkbox"/> azathioprine
<input type="checkbox"/> cyclophosphamide	<input type="checkbox"/> tacrolimus	<input type="checkbox"/> sirolimus	<input type="checkbox"/> 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****

<input type="checkbox"/> Anterior Uveitis	<input type="checkbox"/> Intermediate Uveitis	<input type="checkbox"/> Posterior Uveitis	<input type="checkbox"/> Pan Uveitis
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- Is this member positive for HLA-B27 antigen? Yes No
- Please include other diagnosis that contributes to Anterior Uveitis **ONLY** diagnosis:

- Completed **SECTION A**
AND

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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:

<input type="checkbox"/> prednisolone acetate (Pred Forte®)	<input type="checkbox"/> difluprednate (Durezol®)	<input type="checkbox"/> loteprednol (Lotemax®)
<input type="checkbox"/> Fluoromethalone (FML®)	<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> 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:

<input type="checkbox"/> adalimumab (Humira®)	<input type="checkbox"/> etanercept (Enbrel®)	<input type="checkbox"/> infliximab	<input type="checkbox"/> rituximab
<input type="checkbox"/> golimumab (Simponi®)	<input type="checkbox"/> tocilizumab (Actemra®)	<input type="checkbox"/> IVIG	<input type="checkbox"/> 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

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

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- 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:**

<input type="checkbox"/> prednisolone acetate (Pred Forte [®])	<input type="checkbox"/> difluprednate (Durezol [®])	<input type="checkbox"/> loteprednol (Lotemax [®])
<input type="checkbox"/> Fluoromethalone (FML [®])	<input type="checkbox"/> Artificial tears	<input type="checkbox"/> Cyclosporine (Restasis [®])
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> 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

- 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)**

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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

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 - 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.*****