# 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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

### Drug Requested: Repository Corticotropin Medications – Ocular Diseases

| PREFERRED | NON-PREFERRED |
|---|---|
| ❑ **Purified Cortrophin™ Gel** (repository corticotropin) | ❑ **Acthar® Gel** (repository corticotropin) 80 USP Units/mL 5 mL multi-dose vial<br>❑ **Acthar® Gel** (repository corticotropin) 40 USP Units/0.5 mL single-dose prefilled SelfJect injector<br>❑ **Acthar® Gel** (repository corticotropin) 80 USP Units/mL single-dose prefilled SelfJect injector<br>***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.

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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.

| **SECTION A:** | | |
|---|---|---|
| Slit lamp examination used to make diagnosis? | ❑ Yes | ❑ No |
| Intraocular pressure (IOP) measurement taken at baseline? | ❑ Yes | ❑ No |
| Baseline IOP results _____ | | |
| Visual Acuity Test results _____ | | |
| Labs and documentation to rule out infectious etiology | ❑ Yes | ❑ No |
| Anterior Chamber cells present? | ❑ Yes | ❑ No |

**SECTION B:**

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

| | | | |
|---|---|---|---|
| ❑ methotrexate | ❑ cyclosporine | ❑ mycophenolate | ❑ azathioprine |
| ❑ cyclophosphamide | ❑ tacrolimus | ❑ sirolimus | ❑ 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****

| | | | |
|---|---|---|---|
| ❑ Anterior Uveitis | ❑ Intermediate Uveitis | ❑ Posterior Uveitis | ❑ Pan Uveitis |

❑ Is this member positive for HLA-B27 antigen? ❑ Yes ❑ No

**(Continued on next page)**

- ❑ Please include other diagnosis that contributes to Anterior Uveitis **ONLY** diagnosis:

  _____

  _____

  _____

- ❑ Completed **SECTION A**

**AND**

- ❑ **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:

| | | |
|---|---|---|
| ❑ prednisolone acetate (Pred Forte®) | ❑ difluprednate (Durezol®) | ❑ loteprednol (Lotemax®) |
| ❑ Fluoromethalone (FML®) | ❑ Dexamethasone | ❑ 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:**

| | | | |
|---|---|---|---|
| ❑ adalimumab (Humira®) | ❑ etanercept (Enbrel®) | ❑ infliximab | ❑ rituximab |
| ❑ golimumab (Simponi®) | ❑ tocilizumab (Actemra®) | ❑ IVIG | ❑ 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

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❑ **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**

❑ 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:**

| | | |
|---|---|---|
| ❑ prednisolone acetate (Pred Forte®) | ❑ difluprednate (Durezol®) | ❑ loteprednol (Lotemax®) |
| ❑ Fluoromethalone (FML®) | ❑ Artificial tears | ❑ Cyclosporine (Restasis®) |
| ❑ Dexamethasone | ❑ 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**

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- ❑ 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*)***

- ❑ **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**

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- ❑ 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 – 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.****