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- INFANTILE SPASMS (IS)

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:** _____

Note: (Neurology 2012;78:1974-1976) Class I study showed similar efficacy between low-dose (20-30 IU) and high dose (150 IU/m^2) natural ACTH. Low dose ACTH should be considered as an alternative to high dose ACTH for treatment of infantile spasms. (Level B).

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.

- ❑ Prescriber **MUST** be a Neurologist

(Continued on next page)

- ❑ Member **MUST** have a documented diagnosis of Infantile Spasms
- ❑ Approval will only be granted for a **MAXIMUM** of **30 days only** due to similar adverse effect of corticosteroids. After 2 weeks of treatment, dosing should be gradually tapered and discontinued over a 2-week period. The following is one **suggested** tapering schedule:
  - 30 U/m2 in the morning for 3 days; 15 U/m2 in the morning for 3 days; 10 U/m2 in the morning for 3 days; and 10 U/m2 every other morning for 6 days.
- ❑ Complete the regimen below **(repository corticotropin is supplied as 5 mL multi-dose vial containing 80 USP Units per mL):**
- ❑ Approval will be a **MAXIMUM** of **30 days only** (combined inpatient and outpatient time period)

Initial Dose Schedule		**Approval at Outpatient pharmacy will be based on volume needed at discharge from hospital**
75 U/m^2 **BID** x_____ days		TOTAL _____ml x _____# days (max 29 days)
Taper Dose Schedule		**Body Surface Area BSA**
30 U/m^2 **QD** x_____ days	_____ml x_____ days	Weight: _____kg
15 U/m^2 **QD** x_____ days	_____ml x_____ days	Height/Length: _____in.
10 U/m^2 **QD** x_____ days	_____ml x_____ days	Calculated BSA: _____m^2
10 U/m^2 **QOD** x_____ days	_____ml x_____ days	

TOTAL Number of vials needed**:** _____/days (max 29 days)

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate thferapy 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:** 2/21/2008
UPDATED: ~~6/2/2011; 8/11/2011; 10/1/2012; 8/19/2014; 10/31/2014; 4/3/2015; 5/23/2015; 6/8/2015; 12/22/2015; 6/15/2016; 8/25/2016; 9/22/2016; 12/11/2016; 5/25/2017; 7/30/2017; 7/2/2018; 8/14/2018; (Reformatted) 1/17/2020; 9/20/22;~~ **9/14/2023**