

# 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 may be delayed.**

**Drug Requested:** Repository Corticotropin Medications (Dermatomyositis and Polymyositis)

<u>PREFERRED</u>	<u>NON-PREFERRED</u>
<input type="checkbox"/> <b>Purified Cortrophin™ Gel</b> (repository corticotropin)	<input type="checkbox"/> <b>HP Acthar® Gel</b> (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 has diagnosis of DERMATOMYOSITIS OR POLYMYOSITIS with one of the following:

Idiopathic Inflammatory Myopathy

Refractory to conventional therapy or with severe organ-threatening manifestations

(Continued on next page)

1. **Diagnosis of Idiopathic Inflammatory Myopathy**, member **must** have tried and failed the therapies below **WITHIN THE PAST 6 MONTHS**:

- Prednisone 0.5-1 mg/kg/day for 2-4 weeks, then taper for 2 weeks
- Prednisone **MUST** have been taken **CONCURRENTLY WITH AN IMMUNOSUPPRESSIVE DRUG FOR AT LEAST 90 DAYS within the past 6 months (must note therapy tried):**

<input type="checkbox"/> Methotrexate target dose 25 mg/wk	<input type="checkbox"/> Azathioprine 2 mg/kg IBW twice daily
<input type="checkbox"/> Mycophenolate mofetil, 500 mg twice daily, increased by 500 mg/wk until 1000 mg twice daily	<input type="checkbox"/> Cyclophosphamide, 0.6-1 g/m <sup>2</sup> IV every 4 weeks or 1-2 mg/kg/day orally, > 3months

2. **For diagnosis that is refractory to conventional therapy or with severe organ-threatening manifestations, member must have tried and failed the therapies below WITHIN THE PAST 6 MONTHS:**

- Methylprednisolone, 500-1000 mg/day IV for 1-3 days for 3 months
- Member MUST have had trial and failure of ONE of the following therapies for at least 90 days WITHIN THE PAST 6 MONTHS (MUST note therapy tried):**

<input type="checkbox"/> IVIG, 1 g once month for 1-6 months	<input type="checkbox"/> Cyclophosphamide, 0.6-1g/m <sup>2</sup> IV every 4 weeks or 1-2 mg/kg/day orally, > 3months
<input type="checkbox"/> Rituximab, 1000 mg repeat on day 15, or 375 mg/m <sup>2</sup> once weekly for 4 weeks	<input type="checkbox"/> Cyclosporine A, 3.0-3.5 mg/kg per day

**Medication being provided by a 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.\****