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
Dermatomyositis and Polymyositis

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

- **Acthar Gel single-dose pre-filled SelfJect injector is for subcutaneous administration by adults only.**

(Continued on next page)

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. Check box below for the Diagnosis that applies.

❑ **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**

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):**

❑ Methotrexate target dose 25 mg/wk	❑ Azathioprine 2 mg/kg IBW twice daily
❑ Mycophenolate mofetil, 500 mg twice daily, increased by 500 mg/wk until 1000 mg twice daily	❑ Cyclophosphamide, 0.6-1 g/m^2 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):**

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

Medication being provided by a 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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~11/17/2013~~; **9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~6/15/2016~~; ~~8/25/2016~~; ~~9/22/2016~~; ~~12/11/2016; 7/30/2017~~; ~~9/25/2017; 6/21/2018~~; ~~1/9/2020;~~ ~~6/16/2022;~~ ~~10/26/2023;~~ **10/15/2024**