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 (Other conditions)

(Multiple Sclerosis, Rheumatic disorders, Collagen diseases, Allergic /Ophthalmic /Respiratory/ Edematous states)

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:** _____

Repository corticotropin is a form of adrenocorticotropic hormone (ACTH). It works by stimulating the adrenal cortex to secrete cortisol, corticosterone, aldosterone, and a few other weakly androgenic substances. Repository corticotropin has been compared in studies with other therapeutically equivalent alternatives such as cosyntropin and corticosteroids.

There is a lack of controlled studies for Nephrotic Syndrome that has hindered development of guidelines on treatment. The Kidney International Supplements (2012) and other clinical practice guidelines were used for this prior authorization form.

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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.

Use of repository corticotropin injection is considered **NOT** **medically necessary** as treatment of corticosteroid responsive conditions. **Please note member's diagnosis:** For "other diagnosis," literature to support repository corticotropin efficacy and documentation that primary study endpoints have been met for the requested diagnosis must be submitted:

❑ Multiple Sclerosis	❑ Rheumatic disorders	❑ Collagen disease
❑ Allergic states	❑ Ophthalmic diseases	❑ Respiratory diseases
❑ Other: _____	❑ Edematous state	

AND

❑ Medication is being prescribed by a specialist in treatment of the disease/condition (i.e. rheumatologist, neurologist, pulmonologist, ophthalmologist)

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:

❑ Prednisone 0.5-1mg/kg/day **AND** Prednisone 0.5-1 mg/kg/day oral (or an equivalent high dose steroid)

Name, dose and dates of the equivalent high does steroid trials: _____

_____

AND

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

AND

❑ Methotrexate	❑ Azathioprine	❑ Mycophenolate mofetil
❑ IVIG	❑ Cyclophosphamide	❑ Rituximab
❑ Cyclosporine A		

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Medication being provided by a Specialty Pharmacy - PropriumRx

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.*