AvMed

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 1-305-671-0200**. 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)	❑ **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 AvMed #: _____ **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.

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❑ **Member has diagnosis of <u>DERMATOMYOSITIS</u> OR <u>POLYMYOSITIS</u> with one of the following:**	
❑ **Idiopathic Inflammatory Myopathy**	❑ **Refractory to conventional therapy or with severe organ-threatening manifestations**

1. **Diagnosis of <u>Idiopathic Inflammatory Myopathy</u>,** member **must** have tried and failed the therapies below **<u>WITHIN THE PAST 6 MONTHS:</u>**
   - ❑ 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 **<u>AT LEAST 90 DAYS</u> 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 <u>WITHIN THE PAST 6 MONTHS</u>:**
   - ❑ 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 <u>WITHIN THE PAST 6 MONTHS</u> (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 - 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.*****

****<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>****

***Approved by Pharmacy and Therapeutics Committee**: 11/17/2013
REVISED/UPDATED/REFORMATTED: 9/20/2023;