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 – Ocular Diseases

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:** _____

- **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.

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SECTION A:		
Slit lamp examination used to make diagnosis?	❑ Yes	❑ No
Intraocular pressure (IOP) measurement taken at baseline?	❑ Yes	❑ No
Baseline IOP results _____		
Visual Acuity Test results _____		
Labs and documentation to rule out infectious etiology	❑ Yes	❑ No
Anterior Chamber cells present?	❑ Yes	❑ No

SECTION B:

PREDNISONE MUST HAVE BEEN TAKEN CONCURRENTLY WITH ONE OF THE FOLLOWING IMMUNOSUPPRESIVE DRUGS/NON-BIOLOGICS 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): **Check ALL that apply**:

❑ methotrexate	❑ cyclosporine	❑ mycophenolate	❑ azathioprine
❑ cyclophosphamide	❑ tacrolimus	❑ sirolimus	❑ Other: _____

❑ **NON-INFECTIOUS UVEITIS (NIU).** 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.

Initial Authorization: 3 months

❑ Use of repository corticotropin injection is considered **NOT medically necessary** as treatment of corticosteroid responsive conditions. **Please note member's diagnosis**. ****NOTE if member is only diagnosed with Anterior Uveitis additional comorbidities including etiology will be required for approval****

❑ Anterior Uveitis	❑ Intermediate Uveitis	❑ Posterior Uveitis	❑ Pan Uveitis

❑ Is this member positive for HLA-B27 antigen? ❑ Yes ❑ No

❑ Please include other diagnosis that contributes to Anterior Uveitis **ONLY** diagnosis:

_____

_____

_____

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❑ Completed **SECTION A**

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**:**

❑ Member tried and maximized topical steroid treatment for at least 4 weeks resulting in ineffective therapy:

❑ prednisolone acetate (Pred Forte®)	❑ difluprednate (Durezol®)	❑ loteprednol (Lotemax®)
❑ Fluoromethalone (FML®)	❑ Dexamethasone	❑ Other: _____

AND

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

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

_____

AND

❑ Completed **SECTION B**

AND

❑ **Member tried and failed at least 2 different BIOLOGICS for a minimum of 3 months due to toxicity OR failure to stabilize disease. Submit supporting document on toxicities and progression. (Include labs - CBC, BUN, SCr, AST, ALT and albumin). Check ALL that apply:**

❑ adalimumab (Humira®)	❑ etanercept (Enbrel®)	❑ infliximab	❑ rituximab
❑ golimumab (Simponi®)	❑ tocilizumab (Actemra®)	❑ IVIG	❑ Other: _____

AND

❑ CBC, CMP, HbA1C, TB, Hepatitis B and C labs collected prior to initiation of repository corticotropin therapy have been submitted

AND

❑ Medication is prescribed by an ophthalmologist or rheumatologist

❑ **NON-INFECTIOUS KERATITIS.** 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.

****Note approval will not exceed 16 weeks for this indication****

❑ Complete **SECTION A**

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AND

- ❑ Provider attests all infectious etiologies have been ruled out (e.g., bacterial, fungal or viral eye infection) **(Attach labs and culture and sensitivity reports to support)**

AND

- ❑ Positive fluorescein stain has been obtained

AND

- ❑ Corneal Scraping used to stain and culture specimen has been completed to rule out infectious etiologies

AND

- ❑ Member tried and maximized topical lubricant and/or steroid treatment for at least 4 weeks resulting in ineffective therapy. **Check ALL that apply:**

❑ prednisolone acetate (Pred Forte®)	❑ difluprednate (Durezol®)	❑ loteprednol (Lotemax®)
❑ Fluoromethalone (FML®)	❑ Artificial tears	❑ Cyclosporine (Restasis®)
❑ Dexamethasone	❑ Other:_____	

AND

- ❑ Medication is prescribed by an ophthalmologist

❑ **OPTIC NEURITS.** 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.

****Note approval will not exceed 14 days for this indication****

- ❑ MRI of brain and orbital region has been completed for lesions consistent with MS and visualizing the optic chiasm for negative pituitary tumors **(submit imaging results)**

AND

- ❑ Provider attests all other primary etiologies have been ruled out (e.g., infectious, neuromyelitis optica)

AND

- ❑ Member is contraindicated or has failed methylprednisolone IV use for 3-5 days

AND

- ❑ Member is contraindicated or has failed oral prednisone (1 mg/kg) use for 2 weeks after IV methylprednisolone

AND

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- ❑ Member tried and failed IVIG for a minimum of 3 months
- ❑ **Proof of inability to improve vision with treatments above has been submitted (submit documentation)**

Visual Acuity Baseline: _____ Current Vision Acuity: _____

Contrast Sensitivity: _____ Current Contrast Sensitivity: _____

❑ **OTHER OPHTHALMIC DISEASES.** 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. **(Please submit supporting document to questions below including literature to support therapeutic decision making)**

- ❑ **Diagnosis:** _____

AND

- ❑ Completed **SECTION A**

AND

- ❑ Completed **SECTION B**
- ❑ Other previously failed therapies along with dates tried have been documented below:

_____

_____

_____

❑ **REAUTHORIZATION FOR NON-INFECTIOUS UVEITIS.** 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.

If member is in remission for 2 years reduced dose is indicated until discontinuation

- ❑ Completed **SECTION A**

AND

- ❑ Signs and symptoms have improved within 3 months of use (Submit supporting labs and documentation)

Current IOP results: _____

Current acuity: _____

Anterior Chamber cells present? ❑ Yes ❑ No

AND

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- ❑ No toxicities or severe adverse reactions have developed

AND

- ❑ Medication is prescribed by a specialist in treatment of the disease/condition (rheumatologist or ophthalmologist)

Medication being provided by 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.****

***Approved by Pharmacy and Therapeutics Committee**: 3/17/2022
REVISED/UPDATED: ~~5/2/2022;~~ **6/16/2022**