

Pharmacy Services

(800) 522-0114, option 4

October 5, 2016

Dear SoonerCare Provider,

You are receiving this fax because you recently prescribed or dispensed H.P. Acthar® Gel for SoonerCare member(s). **Effective November 3, 2016, H.P. Acthar® Gel will require a prior authorization for members older than 3 years of age.** This notice will provide information regarding an update in coverage of H.P. Acthar® Gel (corticotropin injection). Members currently receiving H.P. Acthar® Gel for a diagnosis of infantile spasms will be grandfathered. All others must submit a manual prior authorization on form PHARM-4 which can be found on the SoonerCare website at www.okhca.org/forms. The authorization criteria for reimbursement is as follows:

H.P. Acthar® Gel (Corticotropin Injection) Approval Criteria:

1. An FDA approved diagnosis of infantile spasms; and
 - a. Member must be three years of age or younger; and
 - b. Must be prescribed by, or in consultation with, a neurologist or an advanced care practitioner with a supervising prescriber that is a neurologist; or
2. An FDA approved diagnosis of multiple sclerosis (MS); and
 - a. Member is experiencing an acute exacerbation; and
 - b. Must be prescribed by, or in consultation with, a neurologist or an advanced care practitioner with a supervising prescriber that is a neurologist or a physician that specializes in MS; and
 - c. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g. IV methylprednisolone).
 - d. Therapy will be limited to five weeks per approval (three weeks of treatment, followed by taper). Additional approval, beyond the initial five weeks, will require prescriber documentation of response to initial treatment and need for continued treatment; or
3. An FDA approved diagnosis of nephrotic syndrome without uremia of the idiopathic type or that is due to lupus erythematosus to induce a diuresis or a remission; and
 - a. Must be prescribed by, or in consultation with, a nephrologist or an advanced care practitioner with a supervising prescriber that is a nephrologist; and
 - b. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g., prednisone); or
4. An FDA approved diagnosis of the following disorders and diseases: rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous states; and
 - a. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy.

Thank you for the services you provide to Oklahomans insured by SoonerCare!