

H.P. ACTHAR GEL
PRIOR AUTHORIZATION FORM

H.P. Acthar Gel requires a clinical prior authorization. To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – H.P. Acthar Gel (accessible at: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information

For Additional Information: Coordinator Name: _____ PA#: _____
Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone:(_____) _____ Fax:(_____) _____

MEDICAL INFORMATION

Dose: _____ **Route:** IM SQ

Weight: _____ kilograms **Quantity:** _____ vials (available as 400 units/5 mL vials) **Refills:** _____

Diagnosis: Infantile Spasms Multiple Sclerosis Other: _____

Diagnosis Code: _____ (Required)

Specialty Pharmacy Drug Program: Which Specialty pharmacy will be used? Diplomat Specialty Pharmacy
 Walgreens Specialty Pharmacy

Infantile Spasms: Please submit documentation of diagnosis

Multiple Sclerosis (MS): Check all that apply to the Recipient and submit documentation

Recipient is currently experiencing an MS exacerbation
 H.P. Acthar Gel has been effective in treating a previous exacerbation for this Recipient
 Recipient has tried & failed (or has a contraindication or intolerance to) both of the following for the treatment of an MS exacerbation: Oral corticosteroids Intravenous methylprednisolone
 Recipient is currently receiving chronic/maintenance medication for the treatment of MS

All Other Indications:

1. Is the Recipient's diagnosis and prescribed dosing listed in either the H.P. Acthar Gel package insert OR nationally recognized compendia for the determination of medically accepted indications for off-label uses?

Yes
 No – submit documentation of peer-reviewed medical literature supporting use of H.P. Acthar gel at the requested dose for the Recipient's diagnosis

2. Has the Recipient tried & failed (or have a contraindication or intolerance to) both of the following for the treatment of the requested indication (check all that apply and submit documentation)?

Oral corticosteroids Intravenous methylprednisolone

PLEASE SEND COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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