

ACTHAR (repository corticotropin) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **H.P. Acthar Gel** are available on the DHS Pharmacy Services website at
<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Product requested: <input type="checkbox"/> Acthar Gel 400 unit/5 ml vial <input type="checkbox"/> Acthar _____	Route: <input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> _____	
Directions:	Quantity:	Refills:
Diagnosis (<u>submit documentation</u>):	Diagnosis code (<u>required</u>):	

Complete section applicable to the beneficiary's diagnosis and SUBMIT DOCUMENTATION for each item.

- Infantile spasms:** Submit documentation of diagnosis.
- Multiple sclerosis (MS):**
- Currently experiencing an MS exacerbation
 - Acthar has been effective in treating a previous exacerbation
 - Tried and failed or has a contraindication or intolerance to oral corticosteroids for the treatment of an MS exacerbation
 - Tried and failed or has a contraindication or intolerance to IV methylprednisolone for the treatment of an MS exacerbation
 - Currently receiving chronic/maintenance medication for the treatment of MS
- All other indications:**
- Diagnosis and dose are listed in the Acthar package insert
 - Diagnosis and dose are supported by national recognized compendia for the determination of medically accepted indications for off-label uses
 - Tried and failed or has a contraindication or intolerance to oral corticosteroids
 - Tried and failed or has a contraindication or intolerance to IV methylprednisolone

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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