1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

H.P. Acthar Gel® Prior Authorization Request Form (Page 1 of 3)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Allergic states: Serum sickness
- ❑ Collagen diseases: Systemic lupus erythematosus, systemic dermatomyositis (polymyositis)
- ❑ Dermatologic diseases: Severe erythema multiforme, Stevens-Johnsons syndrome
- ❑ Edematous state: Proteinuria
- ❑ Infantile spasms (West Syndrome)
- ❑ Multiple sclerosis
- ❑ Ophthalmic diseases: Keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation
- ❑ Opsoclonus-myoclonus syndrome
- ❑ Respiratory diseases: Sarcoidosis
- ❑ Rheumatic disorders: Psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Prescriber's Specialty:

Select if H.P. Acthar is prescribed by or in consultation with one of the following specialists:

- ❑ Allergist
- ❑ Dermatologist
- ❑ Immunologist
- ❑ Nephrologist
- ❑ Neurologist
- ❑ Optometrist or ophthalmologist
- ❑ Pulmonologist
- ❑ Rheumatologist

For multiple sclerosis, answer the following:

Is H.P. Acthar being used for an acute exacerbation of multiple sclerosis? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to treatment with two corticosteroids (e.g., prednisone, methylprednisolone)? ❑ **Yes** ❑ **No**

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For other FDA-approved indications, answer the following:

Is treatment with the requested condition supported by two articles from major peer reviewed medical journals that present data from randomized controlled trials supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence present in a major peer-reviewed medical journal? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to two corticosteroids (e.g., prednisone, methylprednisolone), each given for a trial of at least two weeks? ❑ **Yes** ❑ **No**

For rheumatic disorders, also answer the following:

Select if the patient has one of the following diagnoses:
- ❑ Psoriatic arthritis
- ❑ Rheumatoid arthritis
- ❑ Juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy)
- ❑ Ankylosing spondylitis

Will H.P. Acthar be used as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation)? ❑ **Yes** ❑ **No**

For collagen diseases, also answer the following:

Select if the patient has one of the following diagnoses:
- ❑ Systemic lupus erythematosus
- ❑ Systemic dermatomyositis (polymyositis)

Will H.P. Acthar be used during an exacerbation or as maintenance therapy? ❑ **Yes** ❑ **No**

For dermatologic diseases, also answer the following:

Select if the patient has one of the following diagnoses:
- ❑ Severe erythema multiforme
- ❑ Stevens-Johnsons syndrome

For allergic states, also answer the following:

Does the patient have serum sickness? ❑ **Yes** ❑ **No**

For ophthalmic disease, also answer the following:

Select if the patient has one of the following diagnoses:
- ❑ Keratitis
- ❑ Iritis
- ❑ Iridocyclitis
- ❑ Diffuse posterior uveitis or choroiditis
- ❑ Optic neuritis
- ❑ Chorioretinitis
- ❑ Anterior segment inflammation

Will H.P. Acthar be used for severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa? ❑ **Yes** ❑ **No**

For respiratory diseases, also answer the following:

Does the patient have symptomatic sarcoidosis? ❑ **Yes** ❑ **No**

For edematous state, also answer the following:

Select if the patient has one of the following diagnoses:
- ❑ Proteinuria in nephrotic syndrome without uremia of the idiopathic type
- ❑ Proteinuria due to lupus erythematosus

Will H.P. Acthar be used to induce a diuresis or a remission? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician fe els is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	