

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

 This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Acthar[®] (corticotropin) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

-
- H. P. Acthar Gel Injection 80 units/mL

Dose: _____ Start date: _____

Place of administration:

-
- Self-administered
-
-
- Provider's Office
-
-
- Outpatient Infusion Center Name of center: _____
-
-
- Home Infusion Name of agency: _____

Billing options:

-
- Physician buy and bill (J code: _____)
-
-
- Preferred Specialty Vendor
-
-
- Other: _____

Priority Health Precertification Requirements:

Authorization of Acthar requires:

- Diagnosis of infantile spasms
- Authorized at a dose of 20 to 30 units/day for two weeks

Continuation of Acthar¹:

- If after two weeks, spasms continue and/or the EEG continues to show hypsarrhythmia, Acthar will be authorized at a dose of 40 units/day for four additional weeks.
- If the spasms continue and/or the EEG continues to show a hypsarrhythmic pattern after six weeks, Acthar dose should be taper and discontinued. It is recommended that [prednisone](#) (2 mg/kg per day PO) be initiated.
- If the infant relapses after termination of therapy, a second course (four to six weeks) of Acthar will be authorized

Reference:

1. UpToDate. Management and prognosis of infantile spasms. Accessed October 15, 2007.

Diagnosis:

Infantile Spasms – ICD code: _____

Other: _____ – ICD code: _____

Please provide rationale for use:

New request or continuation of therapy:

New

Continuation (see section 2)

Requests for continuation of therapy:

Length of time patient has been on Acthar: _____

Patient is experiencing continued spasms:

Yes

No – Rationale for use: _____

EEG shows hypsarrhythmia:

Yes

No – Rationale for use: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX