

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: _____

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply



****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX