PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function..

H.P. Acthar® (corticotropin)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ H.P. Acthar Gel 80 units/mL inj.

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dose and frequency: _____

Additional Information

H.P. Acthar Gel is covered for infantile spasms (West syndrome) when precertification requirements are met. H.P. Acthar Gel is not considered medically necessary for corticosteroid-responsive conditions because it has not been proven to be more effective than corticosteroids for these conditions.

***H.P. Acthar Gel is not considered medically necessary for all other indications including, but not limited to*:**

1. Acute exacerbations of multiple sclerosis
2. Rheumatic disorders (psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis)
3. Collagen diseases (systemic lupus erythematosus, systemic dermatomyositis)
4. Dermatologic diseases (severe erythema multiforme, Stevens-Johnson syndrome)
5. Allergic states (serum sickness)
6. Ophthalmic diseases (keratitis, iritis, iridocyclitis, uveitis, choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation)
7. Respiratory diseases (symptomatic sarcoidosis)
8. Edematous state

Precertification Requirements

Before this drug is covered, the patient must meet the requirements for one of the following conditions:

1. For a diagnosis of infantile spasms for patients under 2 years of age, H.P. Acthar Gel is authorized up to a dose of 75 units/m^2 twice daily for two weeks, followed by a tapering schedule for an additional two weeks

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 11/2017
Last reviewed 03/2019

New request
Priority Health Precertification Documentation

A. What is the patient's diagnosis?

- ☐ Infantile spasms
- ☐ Other – rationale for use: _____

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