



PRIOR AUTHORIZATION REQUEST
H.P. Acthar Gel

PATIENT: Name, Address, City, State, Zip, D.O.B., Member ID

Prescriber: Name, Address, City, State, Zip, Phone, Fax, NPI

Medication Requested: Qty Requested:

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided.

SECTION A: Please answer the following questions

- 1. What is the indication or diagnosis?
Treatment of Infantile Spasms
Multiple sclerosis as "pulse therapy" on a monthly basis
Treatment of proteinuria in diabetic nephropathy
Treatment of nephrotic syndrome
Dermatomyositis or polymyositis
Other indications (please specify):
2. Yes No Is Acthar prescribed by, or in consultation with, a neurologist?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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If you have any questions, call: 800-753-2851



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