PRIOR AUTHORIZATION REQUEST

Acthar Gel (corticotropin)

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

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

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 What is the indication or diagnosis?
[] Infantile spasms (If checked, go to 2)

[] Multiple Sclerosis (MS) as "Pulse Therapy" on a Monthly Basis (If checked, no further questions)

[] Treatment of Proteinuria in Diabetic Nephropathy (If checked, no further questions)

[] Treatment of Nephrotic Syndrome (If checked, no further questions)

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

[] Dermatomyositis or Polymyositis (If checked, no further questions)

[] Other (If checked, no further questions)

2 How old is the patient?
[] Greater than 0 years of age and Less than 2 years of age (If checked, go to 3)

[] Other (If checked, no further questions)

3	Does the requested dose exceed FDA approved label dosing for the requested indication? [If yes, no further questions.]	Yes	No
4	Is the requested medication being prescribed by or in consultation with a neurologist?	Yes	No

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: 1-833-896-0656

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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250