# PRIOR AUTHORIZATION REQUEST

## ACTHAR GEL

**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 Is the request an INITIAL or CONTINUATION of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

Version 05.2026

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| | | | |
|---|---|---|---|
| 3 | Has the patient been receiving medication samples for Acthar Gel?<br>[If yes, skip to question 7.] | Yes | No |
| 4 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?<br>[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]<br>[If no, skip to question 7.] | Yes | No |
| 5 | Does the patient have a diagnosis of infantile spasms?<br>[If no, no further questions.] | Yes | No |
| 6 | Has documentation been submitted to confirm that the patient has experienced a clinical response to therapy as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation.<br>[No further questions.] | Yes | No |
| 7 | What is the indication or diagnosis?<br><br>[] Infantile spasms (If checked, go to 8)<br><br>[] Multiple Sclerosis (MS) as "Pulse Therapy" on a Monthly Basis (If checked, no further questions)<br><br>[] Treatment of Proteinuria in Diabetic Nephropathy (If checked, no further questions)<br><br>[] Treatment of Nephrotic Syndrome (If checked, no further questions)<br><br>[] Dermatomyositis or Polymyositis (If checked, no further questions)<br><br>[] Gout (If checked, no further questions)<br><br>[] Other (If checked, no further questions) | | |
| 8 | How old is the patient?<br><br>[] Greater than 0 years of age and less than 2 years of age (If checked, go to 9)<br><br>[] Other (If checked, no further questions) | | |
| 9 | Is the requested medication being prescribed by or in consultation with a neurologist?<br>[If no, no further questions.] | Yes | No |
| 10 | Does the requested dose exceed FDA approved label dosing for the requested indication? | Yes | No |

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***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**