



Request for Prior Authorization
REPOSITORY CORTICOTROPIN INJECTION
(H.P. ACTHAR GEL)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for repository corticotropin injection. Payment will be considered under the following conditions: 1) Patient is under two years of age, and 2) Patient has a diagnosis of infantile spasms.

Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection.

If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.

Non-Preferred

Acthar HP Cortrophin Inj Gel

Dosage instructions Quantity Days supply

Patient's current height and weight: height: weight:

Diagnosis:

Contraindication or intolerance to corticosteroids (for diagnosis other than infantile spasms):

Trial drug name & dose: Trial dates:

Reason for failure:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.