FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

H.P. Acthar® Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Ankylosing spondylitis
❑ Infantile spasms
❑ Inflammatory ophthalmic disease
❑ Juvenile rheumatoid arthritis
❑ Multiple sclerosis
❑ Nephrotic syndrome
❑ Psoriatic arthritis
❑ Rheumatoid arthritis (RA)
❑ Serum sickness
❑ Severe erythema multiforme
❑ Stevens-Johnson syndrome
❑ Symptomatic sarcoidosis
❑ Systemic dermatomyositis
❑ Systemic lupus erythematosus (SLE)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if H.P. Acthar is prescribed by one of the following specialists:

❑ Neonatologist
❑ Nephrologist
❑ Neurologist
❑ Ophthalmologist
❑ Pediatric neurologist
❑ Pulmonologist
❑ Rheumatologist

Select if there is documentation the patient has any of the following:

❑ Administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of H.P. Acthar Gel
❑ Adrenocortical hyperfunction
❑ Concurrent primary adrenocortical insufficiency or adrenocortical hyperfunction
❑ Congestive heart failure
❑ History of or the presence of peptic ulcer
❑ Ocular herpes simplex
❑ Osteoporosis
❑ Primary adrenocortical insufficiency
❑ Recent surgery
❑ Scleroderma
❑ Sensitivity to proteins or porcine origin, or where congenital infections are suspected in infants
❑ Systemic fungal infections
❑ Uncontrolled hypertension

H.P. Acthar® Coverage Determination Request Form (Page 2 of 2)

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For ankylosing spondylitis, juvenile rheumatoid arthritis, psoriatic arthritis, or rheumatoid arthritis, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate systemic steroids (e.g., prednisone, methylprednisolone)? ❑ **Yes** ❑ **No**

Is there documentation the patient has an acute exacerbation of disease while currently receiving a disease-modifying anti-rheumatic drug (DMARD)? ❑ **Yes** ❑ **No**

For inflammatory ophthalmic disease, serum sickness, severe erythema multiforme, Stevens-Johnson syndrome, symptomatic sarcoidosis, systemic dermatomyositis, or systemic lupus erythematosus, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate systemic steroids (e.g., prednisone, methylprednisolone)? ❑ **Yes** ❑ **No**

For multiple sclerosis, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate systemic steroids (e.g., prednisone, methylprednisolone)? ❑ **Yes** ❑ **No**

Is there documentation the patient has an acute exacerbation of multiple sclerosis while currently receiving maintenance treatment for MS (e.g., Avonex, Betaseron, Copaxone, Tecfidera, etc.)? ❑ **Yes** ❑ **No**

For nephrotic syndrome, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate systemic steroids (e.g., prednisone, methylprednisolone)? ❑ **Yes** ❑ **No**

Does the patient have proteinuria greater than 3.5 grams in 24 hours? ❑ **Yes** ❑ **No**

Does the patient have serum albumin less than 3 mg/dL? ❑ **Yes** ❑ **No**

Does the patient have peripheral edema? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.