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

H.P. Acthar Gel® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Infantile spasms (West Syndrome)
❑ Multiple sclerosis
❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Prescriber's Specialty:

Is H.P. Acthar prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

For multiple sclerosis, answer the following:

Is H.P. Acthar being used for an acute exacerbation of multiple sclerosis? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to treatment with two corticosteroids (e.g., prednisone, methylprednisolone)? ❑ **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?

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

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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