Prior Authorization Request Form for
Repository corticotropin injection (H.P. Acthar Gel)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Does the patient have a diagnosis of infantile spasms (West syndrome)?	☐ Yes Proceed to question **2**	☐ No Proceed to question **9**
2. Will the patient be less than 24 months of age?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for H.P. Acthar Gel*	☐ Yes (subject to verification) Proceed to question **7**	☐ No Proceed to question **4**
4. Does the patient have a diagnosis of infantile spasms with electroencephalogram (EEG)-confirmed hypsarrhythmia?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried a 2-week course of high-dose (40-60 mg/day) prednisone/prednisolone for any episode of infantile spasms and has failed therapy as evidenced by continued signs/symptoms of either spasms or hypsarrhythmia on EEG?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is H.P. Acthar Gel being prescribed by or in consultation with a pediatric neurologist with expertise in the management of infantile spasm?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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7. Has the patient demonstrated a clinical response to H.P. Acthar Gel as defined by cessation of both previous characteristic spasms AND hypsarrhythmia on EEG within 2 weeks of starting H.P. Acthar Gel?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient demonstrated intolerance to H.P. Acthar Gel, requiring discontinuation of therapy? Note that non-emergent hyperglycemia, weight gain, non-urgent/emergent hypertension, edema, parethesias, insomnia, constipation, diarrhea, hyperphagia, anorexia, nasal/sinus congestion, acne and menstrual irregularities do not meet the threshold for demonstrated intolerance to H.P. Acthar Gel.	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
9. Is the patient an adult older than 18 years of age diagnosed with multiple sclerosis?	☐ Yes Proceed to question **10**	☐ No Proceed to question **13**
10. Has the patient been diagnosed with an exacerbation of multiple sclerosis OR optic neuritis as a specific exacerbation of multiple sclerosis?	☐ Yes Proceed to question **11**	☐ No Proceed to question **13**
11. Has the patient failed or is intolerant to an adequate trial of IV/PO corticosteroids (e.g., 1000 mg methylprednisolone IV x 5-14 days OR oral equivalent) for the present exacerbation.	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is H.P. Acthar Gel being prescribed by or in consultation with a neurologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Is H.P. Acthar Gel being prescribed for one of the following uses: optic neuritis not related to MS exacerbation, Rheumatoid Arthritis, Systemic Lupus Erythematosus, Psoriatic Arthritis, Ankylosing Spondylitis, Dermatomyositis, Polymyositis, Juvenile Idiopathic Arthritis, Erythema Multiforme (any severity), Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis Syndrome, Serum Sickness, Keratitis, Iritis, Iridocyclitis, Uveitis, Choroiditis, Birdshot choroiditis, Chorioretinitis, anterior segment inflammation, Nephrotic Syndrome including focal segmental glomerulosclerosis (FSGS), idiopathic membranous nephropathy, IgA nephropathy, membranoproliferative glomerulonephritis (MPGN), and monoclonal diffuse proliferative glomerulonephritis, non-nephrotic edematous states, sarcoidosis, gout, scleritis, or conjunctivitis.	☐ Yes **STOP** **Coverage not approved**	☐ No See note below [1]

[1] Coverage is only allowed for infantile spasms, exacerbation of multiple sclerosis, or optic neuritis as a specific exacerbation of multiple sclerosis.

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[15 August 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: