



Acthar Gel

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Referring Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office

Drug Information:

Strength/Measure _____ *Units* ml Gm mg ea Un

Directions(sig) _____ *Route of administration* _____

Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Acthar Gel RI SGM – 01/2022.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
 Infantile spasms
 Other _____
2. What is the ICD-10 code? _____
3. Please indicate which drug is being requested:
 Acthar Gel Purified Cortrophin Gel
4. Will Acthar Gel be used in combination with Purified Cortrophin Gel? Yes No
5. Is the patient currently receiving treatment with Acthar Gel? *If Yes, skip to #7* Yes No
6. Is Acthar Gel being initiated for infantile spasms in a patient who is less than 2 years old?
 Yes No *No further questions*
7. Has the patient shown substantial clinical benefit from therapy? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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