



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Acthar Gel

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

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

1. What drug is being prescribed? Acthar Gel Dose: _____ Frequency: _____
 Other _____
2. What is the diagnosis? Infantile spasms Multiple sclerosis (MS), acute exacerbation
 Other _____
3. Does the patient have any of the following contraindications to Acthar therapy? Yes No
 Scleroderma Ocular herpes simplex Hypersensitivity to porcine proteins
 Osteoporosis Peptic ulcer disease (PUD) Acute or uncontrolled psychosis
 Hypertension Congestive heart failure (CHF) Systemic fungal infection
 Recent surgery Primary adrenocortical insufficiency or hyperfunction
4. Has/Will the patient received/receive a live or live attenuated vaccine within 6 weeks of H.P. Acthar Gel administration? Yes No
5. Does the patient have known hypersensitivity to corticosteroids? **If no, skip to # 7* Yes No
6. Will the patient undergo appropriate skin testing prior to H.P. Acthar Gel use? Yes No
7. Does the patient have active thromboembolic disorder (e.g., DVT, PE) that has not been effectively managed? Yes No

If the diagnosis is Infantile Spasms:

8. Does the patient have a suspected congenital infection? Yes No
9. Is the dose of Acthar ranging from 0.2 IU/kg up to 150 IU/m²/day? Yes No
10. Is patient currently receiving treatment with Acthar Gel? *If yes, please skip to # 13* Yes No
11. What is the patient's age? _____ years

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

12. Please attach documentation of a tentative treatment plan/protocol that includes: **(please fax copy)**
- a. Daily dosages in IU
 - b. Member's surface area in m² as doses over 150 IU/m²/day will not be approved
 - c. Expected treatment course including dose tapering protocols
 - d. Informed consent obtained from parents or caregivers

Only answer below questions if patient is currently receiving Acthar.

13. How many consecutive weeks has the patient been on Acthar? _____ weeks
14. Within the first 14 days of therapy, has the patient had a decrease or elimination of seizures (spasms) AND hypsarrhythmia pattern on EEG? **If no, skip to # 16* Yes No
15. Attach documentation of EEG results and improvement in seizure frequency. **(please fax results)**
16. Is Acthar dose being increased as part of a low dose protocol? Yes No
17. Is the patient experiencing any serious side effects from Acthar? Yes No
18. Will a tentative dose tapering schedule be followed? Yes No
19. Please attach documentation of the details of the tentative tapering protocols. **(please fax copy)**

If the diagnosis is Multiple Sclerosis, Acute Exacerbation:

20. Has the patient previously received Acthar gel for MS exacerbation?
 Yes No *If no, skip to # 22*
21. Has the patient demonstrated an evidence of efficacy with prior therapy? Yes No
22. Has the patient failed a trial of parenteral corticosteroids or is patient contraindicated to such therapy?
 Yes No

****NOTE: We can NOT make a decision without documentation - Thank You****

Information given on this form is accurate as of this date:

X _____
Prescriber or Authorized Signature Date (mm/dd/yy)

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