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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

H.P. Acthar® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>																						
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 <small>(required)</small>																									
Medication Name:			Strength:		Dosage Form:																				
<input type="checkbox"/> Check if requesting brand			Directions for Use:																						
<input type="checkbox"/> Check if request is for continuation of therapy																									
Clinical Information <small>(required)</small>																									
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Acute exacerbations of multiple sclerosis</p> <p><input type="checkbox"/> Allergic states: Serum sickness</p> <p><input type="checkbox"/> Collagen diseases: For exacerbation or as maintenance therapy in selected cases of systemic lupus erythematosus, systemic dermatomyositis (polymyositis)</p> <p><input type="checkbox"/> Dermatologic disease: Severe erythema multiforme, Stevens-Johnson syndrome</p> <p><input type="checkbox"/> Edematous state: To induce a diuresis or remission of proteinuria in nephrotic syndrome without uremia of the idiopathic type or proteinuria due to lupus erythematosus</p> <p><input type="checkbox"/> Infantile spasms (West syndrome)</p> <p><input type="checkbox"/> Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation</p> <p><input type="checkbox"/> Respiratory diseases: Symptomatic sarcoidosis</p> <p><input type="checkbox"/> Rheumatic disorders: As adjunctive therapy for short-term administration in patients with psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>																									
<p>Clinical Information:</p> <p>Select the prescriber's specialty:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Allergist, immunologist</td> <td><input type="checkbox"/> Nephrologist</td> <td><input type="checkbox"/> Optometrist, ophthalmologist</td> <td><input type="checkbox"/> Rheumatologist</td> </tr> <tr> <td><input type="checkbox"/> Dermatologist</td> <td><input type="checkbox"/> Neurologist</td> <td><input type="checkbox"/> Pulmonologist</td> <td></td> </tr> </table> <p>Select if the prescriber confirms that the patient has any of the following conditions:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Scleroderma</td> <td><input type="checkbox"/> Recent surgery</td> <td><input type="checkbox"/> Primary adrenocortical insufficiency</td> </tr> <tr> <td><input type="checkbox"/> Osteoporosis</td> <td><input type="checkbox"/> History of or the presence of a peptic ulcer</td> <td><input type="checkbox"/> Adrenocortical hyperfunction</td> </tr> <tr> <td><input type="checkbox"/> Systemic fungal infection</td> <td><input type="checkbox"/> Congestive heart failure</td> <td><input type="checkbox"/> Sensitivity to proteins of porcine origin</td> </tr> <tr> <td><input type="checkbox"/> Ocular herpes simplex</td> <td><input type="checkbox"/> Uncontrolled hypertension</td> <td></td> </tr> </table>						<input type="checkbox"/> Allergist, immunologist	<input type="checkbox"/> Nephrologist	<input type="checkbox"/> Optometrist, ophthalmologist	<input type="checkbox"/> Rheumatologist	<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Neurologist	<input type="checkbox"/> Pulmonologist		<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Recent surgery	<input type="checkbox"/> Primary adrenocortical insufficiency	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> History of or the presence of a peptic ulcer	<input type="checkbox"/> Adrenocortical hyperfunction	<input type="checkbox"/> Systemic fungal infection	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Sensitivity to proteins of porcine origin	<input type="checkbox"/> Ocular herpes simplex	<input type="checkbox"/> Uncontrolled hypertension	
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<p>For infantile spasms (West syndrome), also answer the following:</p> <p>Is the dosing for infantile spasms (West syndrome) in accordance with the United States Food and Drug Administration (FDA) approved labeling (does not exceed 150 U/m² once daily)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have history of failure, contraindication, or intolerance to vigabatrin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																									
<p>For multiple sclerosis, also answer the following:</p> <p>Is the dosing for multiple sclerosis in accordance with the United States Food and Drug Administration (FDA) approved labeling (does not exceed 120 U/m² once daily)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																									

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 OptumRx. 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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For all other diagnoses, answer the following:

Has the patient had trial and failure, contraindication, or intolerance to **two** corticosteroids? Yes No

Is the dosing for infantile spasms (West syndrome) in accordance with the United States Food and Drug Administration (FDA) approved labeling (does not exceed 80 units once daily)? Yes No

Select if the patient has history of failure, contraindication, or intolerance to the following:

- Methylprednisolone tablets, methylprednisolone dose pack
- Prednisolone solution, prednisolone sodium phosphate solution
- Prednisone (tablets, tablet pack, solution), Prednisone Intensol concentrated solution

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.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.