HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Corticotropin Injection Gel - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Please select the member's indication for treatment with Corticotropin:

☐ Allergic States (Serum Sickness). Initial Request - skip to 46. Renewal Request - skip to 70.

☐ Collagen Diseases. Initial Request - skip to 30. Renewal Request - skip to 70.

☐ Dermatologic Diseases. Initial Request - skip to 38. Renewal Request - skip to 70.

☐ Infantile spasms. Initial Request - skip to 3. Renewal Request - skip to 65.

☐ Multiple Sclerosis. Initial Request - skip to 9. Renewal Request - skip to 68.

☐ Nephrotic Syndrome. Initial Request - skip to 16. Renewal Request - skip to 70.

☐ Rheumatic Disorders. Initial Request - skip to 22. Renewal Request - skip to 70

☐ Ophthalmic Diseases. Initial Request - skip to 51. Renewal Request - skip to 70.

☐ Respiratory Diseases. Initial Request - skip to 60. Renewal Request - skip to 70.

Q2. Does the patient have any of the following contraindications: (scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, sensitivity to proteins of porcine origin, or administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of corticotropin injection gel)?

☐ Yes ☐ No

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Q3. For infantile spasms, does the patient have a diagnosis of infantile spasms? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q4. For infantile spasms, is the patient less than 2 years of age?

☐ Yes ☐ No

Q5. For infantile spasms, is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

Q6. For infantile spasms, does the patient have a suspected congenital infection?

☐ Yes ☐ No

Q7. For infantile spasms, is corticotropin injection gel going to be used as monotherapy?

☐ Yes ☐ No

Q8. For infantile spasms, is corticotropin injection gel going to be dosed in accordance with the recommended dosage regimen per the prescribing information as follows: Initial dose: 150 U/m2 (divided into twice daily intramuscular injections of 75 U/m2) for 2 weeks. Dosing should then be gradually tapered over a 2-week period to avoid adrenal insufficiency. The following is one suggested tapering schedule: 30 U/m2 intramuscularly in the morning for 3 days; 15 U/m2 intramuscularly in the morning for 3 days; 10 U/m2 intramuscularly in the morning for 3 days; and 10 U/m2 every other morning for 6 days? Skip to 77.

☐ Yes ☐ No

Q9. For acute exacerbation(s) of Multiple Sclerosis, does the patient demonstrate exacerbation symptoms of multiple sclerosis (including severe weakness, severe loss of vision, severe coordination problems, or severe walking impairment)? Please provide clinical documentation to support exacerbation symptoms of multiple sclerosis.

☐ Yes ☐ No

Q10. For acute exacerbation(s) of Multiple Sclerosis, is the patient 18 years or older?

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☐ Yes ☐ No

Q11. For acute exacerbation(s) of Multiple Sclerosis, is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

Q12. For acute exacerbation(s) of Multiple Sclerosis, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications?
A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone)
B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone)

☐ Yes ☐ No

Q13. For acute exacerbation(s) of Multiple Sclerosis, is documentation attached that the patient is currently being treated with a disease modifying drug for multiple sclerosis (such as Avonex, Betaseron, Dimethyl Fumarate DR, Fingolimod, Glatiramer Acetate, Kesimpta, Ocrevus, Rebif, Teriflunomide, Tysabri)? Please note these medications (Dimethyl Fumarate DR, Fingolimod, Kesimpta, Ocrevus, Teriflunomide, Tysabri) require prior authorization.

☐ Yes ☐ No

Q14. For acute exacerbation(s) of Multiple Sclerosis, is documentation attached that the patient is currently being treated with a disease modifying drug for multiple sclerosis (such as Avonex, Dimethyl Fumarate DR, Glatiramer Acetate, , Aubagio)? Please note these medications require prior authorization.

☐ Yes ☐ No

Q15. For acute exacerbation(s) of Multiple Sclerosis, is corticotropin injection gel being used to treat an acute exacerbation of Multiple Sclerosis and therefore is not being used as “pulse therapy” (defined as use on a once monthly or routine basis to prevent MS exacerbations)? Skip to 77.

☐ Yes ☐ No

Q16. For Nephrotic Syndrome, is corticotropin injection gel being used to induce diuresis or a remission of proteinuria in nephrotic syndrome without uremia of the idiopathic type or that is due to lupus erythematosus? Please provide clinical documentation to support this diagnosis.

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☐ Yes ☐ No

Q17. For Nephrotic Syndrome, is the patient over 2 years of age? I

☐ Yes ☐ No

Q18. For Nephrotic Syndrome, is the prescriber a nephrologist or in consultation with a nephrologist?

☐ Yes ☐ No

Q19. For Nephrotic Syndrome, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? Treatment with the following agents should be dictated by the type of renal pathology causing nephrotic syndrome. A) Angiotensin-converting enzyme inhibitors (such as lisinopril, benazepril, captopril) ; B) Angiotensin receptor blockers (such as valsartan, irbesartan, losartan); C) Loop diuretics (such as furosemide, bumetanide) ; D) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); E) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); F) Alkylating agents (such as cyclophosphamide); G) Immunosuppressive Agents (such as cyclosporine, tacrolimus, mycophenolate).

☐ Yes ☐ No

Q20. For Nephrotic Syndrome, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records or sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Angiotensin-converting enzyme inhibitors (such as lisinopril, benazepril, captopril); B) Angiotensin receptor blockers (such as valsartan, irbesartan, losartan); C) Loop diuretics (such as furosemide, bumetanide); D) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); E) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); F) Alkylating agents (such as cyclophosphamide); G) Immunosuppressive Agents (such as cyclosporine, tacrolimus, mycophenolate)

☐ Yes ☐ No

Q21. For Nephrotic Syndrome, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached? Skip to 77.

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☐ Yes ☐ No

Q22. For Rheumatic Disorders, does the patient have a diagnosis of Psoriatic arthritis, Rheumatoid arthritis, Juvenile rheumatoid arthritis, or Ankylosing spondylitis? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q23. For Rheumatic Disorders, is the patient over 2 years of age?

☐ Yes ☐ No

Q24. For Rheumatic Disorders, is the prescriber a rheumatologist or in consultation with a rheumatologist?

☐ Yes ☐ No

Q25. For Rheumatic Disorders, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications?

A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone)

B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone)

☐ Yes ☐ No

Q26. For Rheumatic Disorders, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records or sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives.

A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone)

B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone)

☐ Yes ☐ No

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Q27. For Rheumatic Disorders, is the patient currently receiving maintenance treatment for the condition (such as non-biologic DMARDs, TNF inhibitor, or other biologic medication)? Please provide documentation.

☐ Yes ☐ No

Q28. For Rheumatic Disorders, is corticotropin injection gel being used as adjunctive therapy for short-term use (to tide the patient over an acute episode or exacerbation) in a rheumatic disorder?

☐ Yes ☐ No

Q29. For Rheumatic Disorders, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached? Skip to 77.

☐ Yes ☐ No

Q30. For Collagen Diseases, is the patient over 2 years of age?

☐ Yes ☐ No

Q31. For Collagen Diseases, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached? Skip to 77.

☐ Yes ☐ No

Q32. For systemic lupus erythematosus, does the patient have a diagnosis of systemic lupus erythematosus? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q33. For systemic dermatomyositis, does the patient have a diagnosis of systemic dermatomyositis (polymyositis)? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q34. For systemic lupus erythematosus, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as

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prednisone, methylprednisolone, dexamethasone); C) Non-steroidal anti-inflammatory drugs (such as naproxen, ibuprofen); D) Antimalarial agents (such as hydroxychloroquine, chloroquine); E) Immunosuppressive agents (such as azathioprine, methotrexate, mycophenolate, and cyclosporine); F) Alkylating agents (such as cyclophosphamide)

☐ Yes ☐ No

Q35. For systemic lupus erythematosus, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Non-steroidal anti-inflammatory drugs (such as naproxen, ibuprofen); D) Antimalarial agents (such as hydroxychloroquine, chloroquine); E) Immunosuppressive agents (such as azathioprine, methotrexate, mycophenolate, and cyclosporine); F) Alkylating agents (such as cyclophosphamide)

☐ Yes ☐ No

Q36. For systemic dermatomyositis, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Antimalarial agents (such as hydroxychloroquine); D) Immunosuppressive agents (such as azathioprine, methotrexate, mycophenolate, cyclosporine); E) Alkylating agents (such as cyclophosphamide)

☐ Yes ☐ No

Q37. For systemic dermatomyositis, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Antimalarial agents (such as hydroxychloroquine); D) Immunosuppressive agents (such as azathioprine, methotrexate, mycophenolate, cyclosporine); E) Alkylating agents (such as cyclophosphamide)
Skip to 77.

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☐ Yes ☐ No

Q38. For Dermatologic Diseases, is the patient over 2 years of age?

☐ Yes ☐ No

Q39. For Dermatologic Diseases, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached?

☐ Yes ☐ No

Q40. For Severe erythema multiforme, does the patient have a diagnosis of severe erythema multiforme? Please provide clinical documentation to support the diagnosis.

☐ Yes ☐ No

Q41. For Stevens-Johnson syndrome, does the patient have a diagnosis of Stevens-Johnson syndrome? Please provide clinical documentation to support the diagnosis.

☐ Yes ☐ No

Q42. For Severe erythema multiforme, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Antiviral agents (such as acyclovir, valacyclovir, famciclovir); D) Immunosuppressive agents (such as azathioprine, mycophenolate, dapsone, cyclosporine); E) Antimalarial agents (such as hydroxychloroquine)

☐ Yes ☐ No

Q43. For Severe erythema multiforme, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Antiviral agents (such as acyclovir, valacyclovir, famciclovir); D) Immunosuppressive agents (such as azathioprine, mycophenolate, dapsone,

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cyclosporine); E) Antimalarial agents (such as hydroxychloroquine)
Skip to 77.

☐ Yes ☐ No

Q44. For Stevens-Johnson syndrome, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Immunosuppressive agents (such as cyclosporine)

☐ Yes ☐ No

Q45. For Stevens-Johnson syndrome, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Immunosuppressive agents (such as cyclosporine)

☐ Yes ☐ No

Q46. For serum sickness, does the patient have a diagnosis of serum sickness? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q47. For serum sickness, Is the patient over 2 years of age?

☐ Yes ☐ No

Q48. For serum sickness, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone)B) ; Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Antihistamines (such as hydroxyzine, cetirizine, loratadine, fexofenadine); D) Non-steroidal anti-inflammatory drugs (such as naproxen, ibuprofen)

☐ Yes ☐ No

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Q49. For serum sickness, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); C) Antihistamines (such as hydroxyzine, cetirizine, loratadine, fexofenadine); D) Non-steroidal anti-inflammatory drugs (such as naproxen, ibuprofen)

☐ Yes ☐ No

Q50. For serum sickness, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached? Skip to 77.

☐ Yes ☐ No

Q51. For Ophthalmic Diseases, is the patient over 2 years of age?

☐ Yes ☐ No

Q52. For Ophthalmic Diseases, is the prescriber an ophthalmologist or in consultation with an ophthalmologist?

☐ Yes ☐ No

Q53. For Ophthalmic Diseases, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached?

☐ Yes ☐ No

Q54. For optic neuritis, does the patient have a diagnosis of optic neuritis? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q55. For keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, chorioretinitis; or anterior segment inflammation, does the patient have a diagnosis of keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, chorioretinitis; or anterior segment inflammation? Please provide clinical documentation to support the diagnosis.

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☐ Yes ☐ No

Q56. For optic neuritis, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Intravenous corticosteroids (such as methylprednisolone); B) Oral corticosteroids (such as methylprednisolone); C) Immunomodulatory agents (such as Avonex, Glatiramer Acetate, Teriflunomide); [Please note Glatiramer Acetate, Teriflunomide require prior authorization.]

☐ Yes ☐ No

Q57. For optic neuritis, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? (Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives.) A) Intravenous corticosteroids (such as methylprednisolone); B) Oral corticosteroids (such as methylprednisolone); C) Immunomodulatory agents (such as Avonex, Glatiramer Acetate, Teriflunomide); [Please note Glatiramer Acetate and Teriflunomide require prior authorization.] **These agents are for patients with optic neuritis and abnormal brain MRIs considered to have a clinically isolated syndrome suggestive of Multiple Sclerosis. **

☐ Yes ☐ No

Q58. For keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, chorioretinitis; or anterior segment inflammation, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications? A) Ophthalmic corticosteroids (such as dexamethasone, prednisolone); B) Intravenous corticosteroids (such as methylprednisolone); C) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone); D) Calcineurin inhibitor (cyclosporine, tacrolimus); E) Immunosuppressive agents (such as azathioprine, methotrexate, mycophenolate) ; F) Alkylating agents (such as cyclophosphamide)

☐ Yes ☐ No

Q59. For keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, chorioretinitis; or anterior segment inflammation, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached?
Please attach documentation of why these formulary alternatives cannot be used and/or

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documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives. A) Ophthalmic corticosteroids (such as dexamethasone, prednisolone); B) Intravenous corticosteroids (such as methylprednisolone); C) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone);D) Calcineurin inhibitor (cyclosporine, tacrolimus); E) Immunosuppressive agents (such as azathioprine, methotrexate, mycophenolate) ; F) Alkylating agents (such as cyclophosphamide)
Skip to 77.

☐ Yes ☐ No

Q60. For sarcoidosis, does the patient have a diagnosis of sarcoidosis? Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q61. For sarcoidosis, is the patient over 2 years of age?

☐ Yes ☐ No

Q62. For sarcoidosis, has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications?
A) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone)
B) Topical corticosteroids (such as clobetasol and fluocinonide cream)
C) Inhaled corticosteroids
D) Immunosuppressive agents (such as azathioprine, methotrexate, leflunomide)
E) Antimalarial agents (such as hydroxychloroquine, chloroquine)

☐ Yes ☐ No

Q63. For sarcoidosis, is documentation of trial(s) with the following formulary therapeutic classes or medications, dates, and outcomes, such as medical or pharmacy records and sample logs, attached? (Please attach documentation of why these formulary alternatives cannot be used and/or documentation (including dose, dates/duration of use, and specific outcomes) showing previous use of these formulary alternatives.)
A) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone)
B) Topical corticosteroids (such as clobetasol and fluocinonide cream)
C) Inhaled corticosteroids
D) Immunosuppressive agents (such as azathioprine, methotrexate, leflunomide)
E) Antimalarial agents (such as hydroxychloroquine, chloroquine)

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☐ Yes ☐ No

Q64. For sarcoidosis, is documentation of evidence-based clinical literature supporting the use of corticotropin injection gel for this indication attached? Skip to 77.

☐ Yes ☐ No

Q65. Renewal: For infantile spasms, is the patient less than 2 years of age?

☐ Yes ☐ No

Q66. Renewal: For infantile spasms, does the patient have a suspected congenital infection?

☐ Yes ☐ No

Q67. Renewal: For infantile spasms, is corticotropin injection gel going to be used as monotherapy?

☐ Yes ☐ No

Q68. For acute exacerbation(s) of Multiple Sclerosis, is documentation attached that the patient is currently being treated with a disease modifying drug for multiple sclerosis (such as Avonex, Betaseron, Dimethyl Fumarate DR, Fingolimod, Glatiramer Acetate, Kesimpta, Ocrevus, Rebif, Teriflunomide, Tysabri)? Please note these medications (Dimethyl Fumurate DR, Fingolimod, Kespimpta, Ocrevus, Teriflunomide, Tysabri) require prior authorization.

☐ Yes ☐ No

Q69. Renewal: For acute exacerbation(s) of Multiple Sclerosis, is corticotropin injection gel being used to treat an acute exacerbation of Multiple Sclerosis and therefore is not being used as “pulse therapy” (defined as use on a once monthly or routine basis to prevent MS exacerbations)?

☐ Yes ☐ No

Q70. Renewal: For Rheumatic Disorders, is the patient currently receiving maintenance treatment for the condition (such as non-biologic DMARDs, TNF inhibitor, or other biologic medication)? Please provide documentation.

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☐ Yes ☐ No

Q71. Renewal: Has the patient been previously approved for corticotropin injection gel? If NO, start with question 2.

☐ Yes ☐ No

Q72. Renewal: Has the patient been compliant with taking corticotropin injection gel?

☐ Yes ☐ No

Q73. Renewal: Has the patient been tolerating corticotropin injection gel without any significant side effects?

☐ Yes ☐ No

Q74. Renewal: Has the patient experienced resolution of symptoms/clinical improvement while receiving corticotropin injection gel treatment? Please attach supporting documentation showing the response to prior treatment.

☐ Yes ☐ No

Q75. Renewal: Does the patient have any of the following contraindications: (scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, sensitivity to proteins of porcine origin, or administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of corticotropin injection gel)?

☐ Yes ☐ No

Q76. Renewal: Does the patient require treatment beyond the initial approved duration? Please attach progress notes demonstrating the need for continued treatment along with the planned taper schedule.

☐ Yes ☐ No

Q77. Additional Information:

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Corticotropin Injection Gel - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

Prescriber Signature

Date

v2025