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. 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

Q2. For infantile spasms, does the patient have a diagnosis of infantile spasms? (Please provide clinical documentation to support this diagnosis.) If YES, go to question 3. If NO, go to question 8.

☐ Yes ☐ No

Q3. For infantile spasms, is the patient less than 2 years of age?

☐ Yes ☐ No

Q4. For infantile spasms, is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

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Q5. For infantile spasms, does the patient have a suspected congenital infection?

☐ Yes ☐ No

Q6. For infantile spasms, is corticotropin injection gel going to be used as monotherapy?

☐ Yes ☐ No

Q7. 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?

☐ Yes ☐ No

Q8. 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.) If YES, go to question 9. If NO, go to question 15.

☐ Yes ☐ No

Q9. For acute exacerbation(s) of Multiple Sclerosis, is the patient 18 years or older?

☐ Yes ☐ No

Q10. For acute exacerbation(s) of Multiple Sclerosis, is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

Q11. 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?

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☐ A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone)

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

Q12. For acute exacerbation(s) of Multiple Sclerosis, 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)

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, Briumvi, Dimethyl Fumarate DR, Fingolimod, Glatiramer Acetate, Glatopa, Kesimpta, Ocrevus, Rebif, Teriflunomide, Tysabri)? Please note these medications (Briumvi, Dimethyl Fumarate DR, Fingolimod, Kesimpta, Ocrevus, Teriflunomide, Tysabri) require prior authorization.

☐ Yes ☐ No

Q14. 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

Q15. For all other FDA-approved approved indications, is documentation (such as clinical notes) attached that confirm the diagnosis?

☐ Yes ☐ No

Q16. For all other FDA-approved approved indications, is documentation attached that endorse an inadequate response, intolerance, or contraindication to a clinically appropriate intravenous corticosteroid AND a clinically appropriate oral corticosteroid to treat the patient's condition?

☐ Yes ☐ No

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Q17. For all other FDA-approved indications, is documentation attached that ALL other standard therapies have been trialed to treat the patient's condition based on compendia (Micromedex, AHFS, package insert) and treated in accordance with recognized standard of care guidelines and peer-reviewed literature OR there is a documented medical reason (inadequate response, intolerance, contraindication) for why other standard therapies cannot be used to treat the patient's condition.

☐ Yes ☐ No

Q18. For all other all other FDA-approved indications, is the drug being prescribed by the appropriate specialist or in consult with an appropriate specialist in the condition that is being treated?

☐ Yes ☐ No

Q19. *FOR RENEWALS* Has the patient been previously approved for corticotropin injection gel?

☐ Yes ☐ No

Q20. Has the patient been compliant with taking corticotropin injection gel?

☐ Yes ☐ No

Q21. Has the patient been tolerating corticotropin injection gel without any significant side effects?

☐ Yes ☐ No

Q22. 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

Q23. 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

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of corticotropin injection gel)? If NO, for infantile spasms go to question 24; for acute exacerbations of Multiple Sclerosis, go to question 27; for Rheumatic Disorders, go to question 11; for all other indications go to question 29.

☐ Yes ☐ No

Q24. For infantile spasms, is the patient less than 2 years of age?

☐ Yes ☐ No

Q25. For infantile spasms, does the patient have a suspected congenital infection?

☐ Yes ☐ No

Q26. For infantile spasms, is corticotropin injection gel going to be used as monotherapy?

☐ Yes ☐ No

Q27. 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, Briumvi, Dimethyl Fumarate DR, Fingolimod, Glatiramer Acetate, Glatopa, Kesimpta, Ocrevus, Rebif, Teriflunomide, Tysabri)? Please note these medications (Briumvi, Dimethyl Fumurate DR, Fingolimod, Kespimpta, Ocrevus, Teriflunomide, Tysabri) require prior authorization.

☐ Yes ☐ No

Q28. 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

Q29. For all other FDA-approved indications, is continued treatment or retreatment with corticotrophin injection gel clinically appropriate for the condition being treated based on standard of care guidelines or peer-reviewed literature to support use. (Please attach progress note and supportive documentation along with planned taper schedule).

☐ Yes ☐ No

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Q30. 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

Q31. Additional Information:

Prescriber Signature

Date

v2026