Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

H.P. Acthar Gel Renewal

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	Prescriber PA PROMISe ID:	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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. Has the patient been previously approved for H.P. Acthar Gel?

☐ Yes ☐ No

Q2. Has the patient been compliant with taking H.P Acthar Gel?

☐ Yes ☐ No

Q3. Has the patient been tolerating H.P Acthar Gel without any significant side effects?

☐ Yes ☐ No

Q4. Has the patient experienced resolution of symptoms/clinical improvement while receiving H.P. Acthar Gel treatment? (Please attach supporting documentation showing the response to prior treatment.)

☐ Yes ☐ No

Q5. 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 H.P. Acthar Gel)?

☐ Yes ☐ No

Q6. For infantile spasms, is the patient less than 2 years of age?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. For infantile spasms, does the patient have a suspected congenital infection?	
☐ Yes	☐ No
Q8. For infantile spasms, is H.P. Acthar Gel going to be used as monotherapy?	
☐ Yes	☐ No
Q9. 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 Copaxone,Tecfidera, Aubagio)? Please note these medications require prior authorization.	
☐ Yes	☐ No
Q10. For acute exacerbation(s) of Multiple Sclerosis, is H.P. Acthar 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
Q11. 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
Q12. 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
Q13. Requested Duration:	
☐ 3 months	
Q14. Additional Information:	

Prescriber Signature

Date

Updated 2018