Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

H.P. Acthar Gel

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. 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

Q2. For infantile spasms, does the patient have a diagnosis of infantile spasms? (Please provide clinical documentation to support this diagnosis)

☐ 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

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

☐ Yes ☐ No

Q6. For infantile spasms, Is H.P. Acthar Gel going to be used as monotherapy?

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☐ Yes	☐ No
Q7. For infantile spasms, Is H.P. Acthar 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)	
☐ 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? A) Intravenous corticosteroids (such as methylprednisolone, dexamethasone); B) Oral corticosteroids (such as prednisone, methylprednisolone, dexamethasone)	
☐ Yes	☐ No
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)	
☐ 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, Copaxone,Tecfidera, Aubagio)? Please note these medications require prior authorization.	
☐ Yes	☐ No

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Patient Name:	**Prescriber Name:**

Q14. 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

Q15. For Nephrotic Syndrome, is H.P. Acthar 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)

☐ Yes ☐ No

Q16. For Nephrotic Syndrome, Is the patient over 2 years of age?

☐ Yes ☐ No

Q17. For Nephrotic Syndrome, Is the prescriber a nephrologist or in consultation with a nephrologist?

☐ Yes ☐ No

Q18. 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) Angiotension-converting enzyme inhibitors (such as lisinopril, benazepril, captopril) , B) Angiotension 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

Q19. 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) Angiotension-converting enzyme inhibitors (such as lisinopril, benazepril, captopril) ;B) Angiotension 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 evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?

☐ Yes ☐ No

Q21. 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

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Patient Name:	**Prescriber Name:**

Q22. For Rheumatic Disorders, Is the patient over 2 years of age?

☐ Yes ☐ No

Q23. For Rheumatic Disorders, Is the prescriber a rheumatologist or in consultation with a rheumatologist?

☐ Yes ☐ No

Q24. 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

Q25. 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

Q26. 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

Q27. For Rheumatic Disorders, Is H.P. Acthar 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

Q28. For Rheumatic Disorders, Is documentation of evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?

☐ Yes ☐ No

Q29. For Collagen Diseases, is the patient over 2 years of age?

☐ Yes ☐ No

Q30. For Collagen Diseases, Is documentation of evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?

☐ Yes ☐ No

Q31. For systemic lupus erythematosus, does the patient have a diagnosis of systemic lupus erythematosus? (Please provide clinical documentation to support this diagnosis)

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q32. For systemic dermatomyositis, does the patient have a diagnosis of systemic dermatomyositis (polymyositis)? (Please provide clinical documentation to support this diagnosis)

☐ Yes ☐ No

Q33. 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 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

Q34. 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

Q35. 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

Q36. 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)

☐ Yes ☐ No

Q37. For Dermatologic Diseases, is the patient over 2 years of age?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q38. For Dermatologic Diseases, Is documentation of evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?

☐ Yes ☐ No

Q39. For Severe erythema multiforme, does the patient have a diagnosis of severe erythema multiforme? (Please provide clinical documentation to support the diagnosis).

☐ Yes ☐ No

Q40. For Stevens-Johnson syndrome, does the patient have a diagnosis of Stevens-Johnson syndrome? (Please provide clinical documentation to support the diagnosis)

☐ Yes ☐ No

Q41. 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

Q42. 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, cyclosporine)
; E) Antimalarial agents (such as hydroxychloroquine)

☐ Yes ☐ No

Q43. 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

Q44. 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)

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q45. For serum sickness, does the patient have a diagnosis of serum sickness? (Please provide clinical documentation to support this diagnosis)	
☐ Yes	☐ No
Q46. For serum sickness, Is the patient over 2 years of age?	
☐ Yes	☐ No
Q47. 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
Q48. 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
Q49. For serum sickness, Is documentation of evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?	
☐ Yes	☐ No
Q50. For Ophthalmic Diseases, is the patient over 2 years of age?	
☐ Yes	☐ No
Q51. For Ophthalmic Diseases, is the prescriber an ophthalmologist or in consultation with an ophthalmologist?	
☐ Yes	☐ No
Q52. For Ophthalmic Diseases, is documentation of evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?	
☐ Yes	☐ No
Q53. For optic neuritis, does the patient have a diagnosis of optic neuritis? (Please provide clinical documentation to support this diagnosis)	

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q54. 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)

☐ Yes ☐ No

Q55. 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, Copaxone); [Please note Avonex, Copaxone require prior authorization.]

☐ Yes ☐ No

Q56. 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, Copaxone); [Please note Avonex, Copaxone require prior authorization.]

☐ Yes ☐ No

Q57. 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

Q58. 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 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)

☐ Yes ☐ No

Q59. For sarcoidosis, does the patient have a diagnosis of sarcoidosis? (Please provide clinical documentation to support this diagnosis)

☐ Yes ☐ No

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Q60. For sacoidosis, Is the patient over 2 years of age?

☐ Yes ☐ No

Q61. 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, halobetasol); C)Inhaled corticosteroids (such as budesonide, Flovent Diskus, Flovent HFA); D) Immunosuppressive agents (such as azathioprine, methotrexate, leflunomide); E) Antimalarial agents (such as hydroxychloroquine, chloroquine)

☐ Yes ☐ No

Q62. 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, halobetasol); C) Inhaled corticosteroids (such as budesonide, Flovent Diskus, Flovent HFA); D)Immunosuppressive agents (such as azathioprine, methotrexate, leflunomide); E) Antimalarial agents (such as hydroxychloroquine, chloroquine)

☐ Yes ☐ No

Q63. For sarcoidosis, Is documentation of evidence-based clinical literature supporting the use of H.P. Acthar Gel for this indication attached?

☐ Yes ☐ No

Q64. Requested Duration:

☐ 21 days ☐ 1 month ☐ 3 months

Q65. Additional Information:

Prescriber Signature

Date

Updated 2018