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:	
Patient 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 the requested drug?

☐ Yes ☐ No

Q2. Has the patient been previously approved for the requested medication?
[If no, skip to question 17.]

☐ Yes ☐ No

Q3. Has the patient been compliant with taking the requested medication?

☐ Yes ☐ No

Q4. Has the patient been tolerating the requested medication without any significant side effects?

☐ Yes ☐ No

Q5. Has the patient experienced resolution of symptoms/clinical improvement while receiving the requested medication treatment? Note: Please attach supporting documentation showing the response to prior treatment.

☐ Yes ☐ No

Q6. Is the medication being requested for infantile spasms?
[If yes, skip to question 10.]

☐ Yes ☐ No

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Q7. Is the medication being requested for acute exacerbations of multiple sclerosis?
[If yes, skip to question 13.]

☐ Yes ☐ No

Q8. Is the medication being requested for a rheumatic disorder?
[If yes, skip to question 15.]

☐ Yes ☐ No

Q9. Is the medication being requested for nephrotic syndrome, collagen disease, dermatologic disease, serum sickness, ophthalmic disease or symptomatic sarcoidosis?
[If yes, skip to question 16.]

☐ Yes ☐ No

Q10. Is the patient less than 2 years of age?

☐ Yes ☐ No

Q11. Does the patient have a suspected congenital infection?

☐ Yes ☐ No

Q12. Is the requested medication going to be used as monotherapy?
[If yes, skip to question 16.]

☐ Yes ☐ No

Q13. Is documentation attached that the patient is currently being treated with a disease modifying drug for multiple sclerosis (such as glatiramer, Tecfidera, Aubagio)? Please note these medications may require prior authorization.

☐ Yes ☐ No

Q14. Is the requested medication being used to treat an acute exacerbation of multiple sclerosis (MS) 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. Is the patient currently receiving maintenance treatment for the condition (such as non-biologic disease modifying anti-rheumatic drugs [DMARDs], tumor necrosis factor [TNF] inhibitor, or other biologic medication)? Note: Please provide documentation.

☐ Yes ☐ No

Q16. Does the patient require treatment beyond the initial approved duration? Note: Please attach progress notes demonstrating the need for continued treatment along with the planned taper schedule.

☐ Yes ☐ No

Q17. Is the patient over 2 years of age?

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[If yes, skip to question 24.]

☐ Yes ☐ No

Q18. Does the patient have a diagnosis of infantile spasms? Note: Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q19. Is the patient less than 2 years of age?

☐ Yes ☐ No

Q20. Is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

Q21. Does the patient have a suspected congenital infection?

☐ Yes ☐ No

Q22. Is the requested drug going to be used as monotherapy?

☐ Yes ☐ No

Q23. s the requested drug going to be dosed in accordance with the recommended dosage regimen per the prescribing information as follows?
Initial dose: 150 Units/m2 (divided into twice daily intramuscular injections of 75 Units/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 Units/m2 intramuscularly in the morning for 3 days, 15 Units/m2 intramuscularly in the morning for 3 days, 10 Units/m2 intramuscularly in the morning for 3 days, and 10 Units/m2 every other morning for 6 days.

☐ Yes ☐ No

Q24. Does the patient demonstrate exacerbation symptoms of multiple sclerosis (including severe weakness, severe loss of vision, severe coordination problems, or severe walking impairment)? Note: Please provide clinical documentation to support exacerbation symptoms of multiple sclerosis.
[If no, skip to question 31.]

☐ Yes ☐ No

Q25. Is the patient 18 years or older?

☐ Yes ☐ No

Q26. Is the prescriber a neurologist or in consultation with a neurologist?

☐ Yes ☐ No

Q27. 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

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corticosteroids (such as prednisone, methylprednisolone, dexamethasone)?

☐ Yes ☐ No

Q28. 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? Note: 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

Q29. Is documentation attached that the patient is currently being treated with a disease modifying drug for multiple sclerosis (such as Avonex, glatiramer, , Tecfidera, Aubagio)? Please note these medications may require prior authorization.

☐ Yes ☐ No

Q30. Is the requested drug being used to treat an acute exacerbation of multiple sclerosis (MS) 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

Q31. Is the requested drug 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? Note: Please provide clinical documentation to support this diagnosis.
[If no, skip to question 36.]

☐ Yes ☐ No

Q32. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q33. Is the prescriber a nephrologist or in consultation with a nephrologist?

☐ Yes ☐ No

Q34. Has the patient tried and failed, or has a contraindication or intolerance to the following formulary therapeutic classes or medications?
A)Angiotension-converting enzyme inhibitors (such as lisinopril, benazepril,), 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

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Q35. 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? Note: 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,), 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

Q36. Does the patient have a diagnosis of Psoriatic arthritis, Rheumatoid arthritis, Juvenile rheumatoid arthritis, or Ankylosing spondylitis? Note: Please provide clinical documentation to support this diagnosis.
[If no, skip to question 43.]

☐ Yes ☐ No

Q37. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q38. Is the prescriber a rheumatologist or in consultation with a rheumatologist?

☐ Yes ☐ No

Q39. 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

Q40. 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? Note: 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

Q41. Is the patient currently receiving maintenance treatment for the condition (such as non-biologic disease modifying anti-rheumatic drugs [DMARDs], tumor necrosis factor [TNF] inhibitor, or other biologic medication)? Note: Please provide documentation.

☐ Yes ☐ No

Q42. Is the requested drug being used as adjunctive therapy for short-term use (to tide the patient over an acute episode or exacerbation) in a rheumatic disorder?

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☐ Yes ☐ No

Q43. Does the patient have a diagnosis of systemic lupus erythematosus? Note: Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q44. Does the patient have a diagnosis of systemic dermatomyositis (polymyositis)? Note: Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q45. 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

Q46. 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? Note: 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)
[If yes, skip to question 49.]

☐ Yes ☐ No

Q47. 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

Q48. 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? Note: 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)

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☐ Yes ☐ No

Q49. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q50. Does the patient have a diagnosis of severe erythema multiforme? Note: Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q51. Does the patient have a diagnosis of Stevens-Johnson syndrome? Note: Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q52. 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

Q53. 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? Note: 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)
[If yes, skip to question 56.]

☐ Yes ☐ No

Q54. 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

Q55. 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? Note: 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

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prednisone, methylprednisolone, dexamethasone), C) Immunosuppressive agents (such as cyclosporine)

☐ Yes ☐ No

Q56. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q57. Does the patient have a diagnosis of serum sickness? Note: Please provide clinical documentation to support this diagnosis.
[If no, skip to question 61.]

☐ Yes ☐ No

Q58. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q59. 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

Q60. 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? Note: 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

Q61. Does the patient have a diagnosis of optic neuritis? Note: Please provide clinical documentation to support this diagnosis.

☐ Yes ☐ No

Q62. Does the patient have a diagnosis of keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, chorioretinitis, or anterior segment inflammation? Note: Please provide clinical documentation to support the diagnosis.

☐ Yes ☐ No

Q63. Is the prescriber an ophthalmologist or in consultation with an ophthalmologist?

☐ Yes ☐ No

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Q64. 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, glatiamer)? Please note Avonex, glatiramer may require prior authorization.

☐ Yes ☐ No

Q65. 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? Note: 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). Please note Avonex, glatiramer may require prior authorization. These agents are for patients with optic neuritis and abnormal brain magnetic resonance imaging (MRI) considered to have a clinically isolated syndrome suggestive of multiple sclerosis.
[If yes, skip to question 69.]

☐ Yes ☐ No

Q66. Is the prescriber an ophthalmologist or in consultation with an ophthalmologist?

☐ Yes ☐ No

Q67. 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

Q68. 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? Note: 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

Q69. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q70. Does the patient have a diagnosis of sarcoidosis? Note: Please provide clinical documentation to support this

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diagnosis.

☐ Yes ☐ No

Q71. Is documentation of evidence-based clinical literature supporting the use of the requested drug for this indication attached?

☐ Yes ☐ No

Q72. 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

Q73. 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? Note: 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

Q74. Additional Information:

Prescriber Signature

Date

Updated for 2020