



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, etc.

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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<p>Q7. Is the medication being requested for acute exacerbations of multiple sclerosis? [If yes, skip to question 13.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Is the medication being requested for a rheumatic disorder? [If yes, skip to question 15.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is the patient less than 2 years of age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Does the patient have a suspected congenital infection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. Is the requested medication going to be used as monotherapy? [If yes, skip to question 16.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q17. Is the patient over 2 years of age?</p>

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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. Is 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, glatiramer)? 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 2022