

US Family Health Plan

Prior Authorization Request Form for

Acthar (cortrophin) vial, Acthar selfject, purified corticotrophin gel

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

For MS, PA expires after 30 days. For infantile spasms, initial PA expires in 30 days and renewal expires in 1 year. For renewal of therapy an initial prior authorization approval is required.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
_____	_____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

<p>1. Does the patient have a diagnosis of infantile spasms (West syndrome)?</p>	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No Proceed to question 10
<p>2. What drug is being requested?</p>	<input type="checkbox"/> Acthar selfject STOP Coverage not approved	<input type="checkbox"/> Acthar vial, purified corticotrophin gel vials Proceed to question 3
<p>3. Will the patient be less than 24 months of age?</p>	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
<p>4. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for H.P. Acthar Gel</p>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 8	<input type="checkbox"/> No Proceed to question 5
<p>5. Does the patient have a diagnosis of infantile spasms with electroencephalogram (EEG)-confirmed hysarrhythmia?</p>	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
<p>6. Has the patient tried a 2-week course of high-dose (40-60 mg/day) prednisone/prednisolone for any episode of infantile spasms and has failed therapy as evidenced by continued signs/symptoms of either spasms or hysarrhythmia on EEG?</p>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
<p>7. Is the requested medication being prescribed by or in consultation with a pediatric neurologist with expertise in the management of infantile spasm?</p>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

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<p>8. Has the patient demonstrated a clinical response to the requested medication as defined by cessation of both previous characteristic spasms AND hypsarrhythmia on EEG within 2 weeks of starting the requested medication?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 9</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. Has the patient demonstrated intolerance to the medication, requiring discontinuation of therapy? Note that non-emergent hyperglycemia, weight gain, non-urgent/emergent hypertension, edema, paresthesias, insomnia, constipation, diarrhea, hyperphagia, anorexia, nasal/sinus congestion, acne and menstrual irregularities do not meet the threshold for demonstrated intolerance to the requested medication.</p>	<p align="center"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p align="center"><input type="checkbox"/> No Sign and date below</p>
<p>10. Is the patient an adult older than 18 years of age diagnosed with multiple sclerosis?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 11</p>	<p align="center"><input type="checkbox"/> No Proceed to question 14</p>
<p>11. Has the patient been diagnosed with an exacerbation of multiple sclerosis OR optic neuritis as a specific exacerbation of multiple sclerosis?</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 12</p>	<p align="center"><input type="checkbox"/> No Proceed to question 14</p>
<p>12. Has the patient failed or is intolerant to an adequate trial of IV/PO corticosteroids (e.g., 1000 mg methylprednisolone IV x 5-14 days OR oral equivalent) for the present exacerbation.</p>	<p align="center"><input type="checkbox"/> Yes Proceed to question 13</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>13. Is the requested medication being prescribed by or in consultation with a neurologist?</p>	<p align="center"><input type="checkbox"/> Yes Sign and date below</p>	<p align="center"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>14. Is the requested medication being prescribed for one of the following uses: optic neuritis not related to MS exacerbation, Rheumatoid Arthritis, Systemic Lupus Erythematosus, Psoriatic Arthritis, Ankylosing Spondylitis, Dermatomyositis, Polymyositis, Juvenile Idiopathic Arthritis, Erythema Multiforme (any severity), Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis Syndrome, Serum Sickness, Keratitis, Iritis, Iridocyclitis, Uveitis, Choroiditis, Birdshot choroiditis, Chorioretinitis, anterior segment inflammation, Nephrotic Syndrome including focal segmental glomerulosclerosis (FSGS), idiopathic membranous nephropathy, IgA nephropathy, membranoproliferative glomerulonephritis (MPGN), and monoclonal diffuse proliferative glomerulonephritis, non-nephrotic edematous states, sarcoidosis, gout, scleritis, or conjunctivitis.</p>	<p align="center"><input type="checkbox"/> Yes STOP Coverage not approved</p>	<p align="center"><input type="checkbox"/> No See note below ¹</p>

¹Coverage is only allowed for infantile spasms, exacerbation of multiple sclerosis, or optic neuritis as a specific exacerbation of multiple sclerosis.

**Step
3**

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date