

ACTHAR GEL (repository corticotropin injection)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Acthar Gel
2. What is the diagnosis? Infantile spasms Multiple Sclerosis, acute exacerbations
 Diagnostic testing of adrenocortical function Other (specify): _____
3. Please check which of the following apply to the patient. Scleroderma Osteoporosis
 Systemic fungal infection Ocular herpes simplex Recent surgery Hypertension
 History of peptic ulcer disease (PUD) Congestive heart failure (CHF) Sensitivity to porcine proteins
 Primary adrenocortical insufficiency or hyperfunction
 None of the above
4. Has/Will the patient received/receive a live vaccine within 6 weeks of H.P. Acthar Gel administration? Y N

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| 5. Does the patient have known hypersensitivity to corticosteroid? | Y | N |
| 6. Will the patient undergo appropriate skin testing prior to H.P. Acthar Gel use? | Y | N |
| 7. Does the patient have acute or uncontrolled psychosis? | Y | N |
| 8. Does the patient have active thromboembolic disorder? | Y | N |

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::