H.P. Acthar Gel

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Rendering Provider Info: ❑ Same as Requesting Provider **HPHC Provider ID:**_____
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____ **Provider Tax ID:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882

 Acthar Gel IS SGM – 10/2018.

Criteria Questions:

1. What is the patient's diagnosis?
   - ❑ Infantile spasms
   - ❑ Multiple sclerosis (MS)
   - ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Infantile Spasms

3. Is the patient currently receiving treatment with H.P. Acthar Gel? *If Yes, skip to #5* ❑ Yes ❑ No
4. Is H.P. Acthar Gel being initiated for infantile spasms in a patient who is less than 2 years old?
   ❑ Yes ❑ No *No further questions*
5. Has the patient shown substantial clinical benefit from therapy? ❑ Yes ❑ No

Section B: Multiple Sclerosis

6. Does the patient have an acute exacerbation of MS? ❑ Yes ❑ No
7. Did the patient have an inadequate response to a trial of IV methylprednisolone for this current exacerbation? ***ACTION REQUIRED: If Yes, attach chart notes detailing the outcomes of the most recent trial of IV methylprednisolone, including the treatment dosage and duration.*** ❑ Yes ❑ No
8. Have chart notes been submitted detailing the trial with IV methylprednisolone? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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