

CORTICOTROPIN PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
 Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Infantile spasms <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient’s body surface area (BSA)? _____ (m ²) 2. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication: _____ _____ _____ 4. Is the requested quantity (dose) within FDA labeled dosing for the requested indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for therapy with a higher dose for the requested indication: _____ _____ _____ 5. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For Purified Cortrophin Gel requests:

6. Is the patient currently being treated with the requested agent AND currently stable on the requested agent? Yes No
7. Has the patient tried and had an inadequate response to ONE preferred agent for the requested indication? The preferred agent is Acthar Gel..... Yes No
 If no, was ONE preferred agent for the requested indication discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event. The preferred agent is Acthar Gel. Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE preferred agent for the requested indication that is NOT expected to occur with the requested agent? The preferred agent is Acthar Gel. Yes No
 If no, does the patient have an FDA labeled contraindication to ALL preferred agents for the requested indication that is NOT expected to occur with the requested agent? The preferred agent is Acthar Gel..... Yes No
8. Is ONE of the following expected of ONE preferred agent for the requested indication: 1) to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug, 2) cause a significant barrier to the patient's adherence of care, 3) worsen a comorbid condition, 4) decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities, OR 5) cause an adverse reaction or cause physical or mental harm? The preferred agent is Acthar Gel..... Yes No
9. Is ONE preferred agent for the requested indication NOT in the best interest of the patient based on medical necessity? The preferred agent is Acthar Gel. Yes No
10. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE preferred agent for the requested indication, AND that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? The preferred agent is Acthar Gel. Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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