Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

HP Acthar (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of HP Acthar (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

HP Acthar (repository corticotropin injection)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of infantile spasm (West syndrome)? Y N

   [If no, skip to question 5.]

2. Has the diagnosis been confirmed by an electroencephalogram (EEG)? Y N

   [If no, then no further questions.]

3. Is the patient 2 years of age or younger? Y N

   [If no, then no further questions.]

4. Is the medication being prescribed by or in consultation with a neurologist or epileptologist? Y N

   [No further questions.]

5. Is the medication being requested for treatment of an acute exacerbation of multiple sclerosis? Y N

   [If no, then no further questions.]

6. Does the patient continue to have functionally disabling symptoms despite a 7 day course of high dose IV corticosteroids (i.e., methylprednisolone 1000mg per day) for the CURRENT exacerbation? Y N

   [If yes, then no further questions.]

7. Has the patient had significant side effects with high dose IV corticosteroids? Y N

   [No further questions.]

Comments:

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

Prescriber (Or Authorized) Signature Date