

Iowa Department of Human Services

Request for Prior Authorization REPOSITORY CORTICOTROPIN INJECTION (H.P. ACTHAR GEL)

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name				DOB		
Patient address							
Provider NPI		Phone					
Prescriber address			Fax				
Pharmacy name Address				Phone			
Procesiber must complete all inform	n correct and	nomplote or f	orm will b	ao roturnod			
Prescriber must complete all informations in the Pharmacy NPI	Pharmacy fax	e, correct, and c	NDC	orm will t	oe returnea.		
Prior authorization is required for repository corticotropin injection. Payment will be considered under the following conditions: 1) Patient is under two years of age, and 2) Patient has a diagnosis of infantile spasms.							
Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection.							
If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.							
Acthar HP							
Dosage instructions	Quantity	Da	ays supply				
Patient's current height and weight: height:		v	weight:				
Diagnosis:							
Contraindication or intolerance to corticosteroids (for diagnosis other than infantile spasms):							
Trial drug name & dose: Trial dates:							
Reason for failure:							
Possible drug interactions/conflicting drug therapies:							
Attach lab results and other documentation as necessary.							
Prescriber signature (Must match pre		Date of sub	Date of submission				
			1				

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.