PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 11/4/2024
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Will the requested drug be used in combination with another repository corticotropin? **Y** ☐ **N** ☐

2. What is the diagnosis?
   - Infantile spasms (If checked, go to 3) ☐
   - Multiple sclerosis (MS) (If checked, go to 7) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____

3. Please indicate which drug is being requested?
   - Acthar Gel (If checked, go to 4) ☐
   - Purified Cortrophin Gel (If checked, no further questions) ☐

4. Is the patient currently receiving treatment with Acthar Gel? **Y** ☐ **N** ☐

5. Is Acthar Gel being initiated for infantile spasms in a patient who is less than 2 years old? **Y** ☐ **N** ☐

6. Has the patient shown substantial clinical benefit from therapy? **Y** ☐ **N** ☐

7. Does the patient have an acute exacerbation of multiple sclerosis? **Y** ☐ **N** ☐

8. Did the patient have an inadequate response to a trial of intravenous (IV) methylprednisolone for this current exacerbation? ACTION REQUIRED: If Yes, attach chart notes detailing the outcomes of the most recent trial IV methylprednisolone, including the treatment dosage and duration. **Y** ☐ **N** ☐
   ACTION REQUIRED: Submit supporting documentation

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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