BlueCross BlueShield Federal Employee Program

ACTHAR GEL
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

For Standard and Basic Option patients Cortrophin Gel is a preferred product. Please consider prescribing the preferred product. Standard/Basic Option patients who switch to the preferred product will be eligible for 2 copays at no cost in the benefit year.

Acthar Gel (corticotropin; ACTH)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. **Multiple Sclerosis or Nephrotic Syndrome Diagnosis (Standard/Basic Option Patient):** Would you like to switch the patient to the preferred product, Cortrophin Gel? ❑Yes ❑No*

   If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Cortrophin Gel? ***Please select answer below:***

   ❑**Yes**, specify result: _____

   ❑**No**: Is there a clinical reason for not trying Cortrophin Gel? ❑Yes* ❑No

   If YES, please specify: _____

2. Will Acthar Gel be used in combination with Cortrophin Gel (corticotropin)? ❑Yes ❑No

3. What is the patient's diagnosis?

   ❑Infantile spasms

   a. Has Acthar Gel been prescribed by a neurologist? ❑Yes ❑No

   ❑Exacerbation of Multiple Sclerosis (MS)

   a. Has Acthar Gel been prescribed by a neurologist? ❑Yes ❑No

   b. Will Acthar Gel be used in combination with maintenance multiple sclerosis therapy? ❑Yes ❑No

   c. Is this request for **INITIATION** of therapy? ***Please select answer below:***

   ❑**Yes**: Please answer the following questions:

   i. Is there documentation the patient has a FDA labeled contraindication to oral or parenteral glucocorticoid therapy? ❑Yes ❑No*

   If NO, is there documentation the patient experienced an intolerance or inadequate response to a one month trial of oral glucocorticoid therapy? ❑Yes ❑No

   ii. Is there documentation the patient experienced an intolerance or inadequate response to a one week trial of parenteral glucocorticoid therapy? ❑Yes ❑No

   ❑**No**: Is there documentation that at least 30 days have passed since the patient had their last exacerbation? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Nephrotic syndrome

a. Has Acthar Gel been prescribed by a nephrologist? ❑Yes ❑No

b. Is this request for **INITIATION** of therapy? ***Please select answer below:***

❑**Yes**: Please answer the following questions:

i. Is there documentation the patient experienced an intolerance or an inadequate response to a one month trial of oral glucocorticoid therapy? ❑Yes ❑No*****

****If NO***, is there documentation the patient experienced an inadequate response to a one month trial of an immunosuppressant such as: cyclophosphamide, cyclosporine, tacrolimus, or mycophenolate mofetil? ❑Yes ❑No

ii. Is there documentation of the patient's baseline level of protein in the urine indicative of proteinuria? ❑Yes ❑No

iii. Is there documentation of low levels of albumin in the blood indicative of hypoalbuminemia? ❑Yes ❑No

❑**No:** Is there documentation that the patient's urine protein level has decreased and the serum albumin level has increased? ❑Yes ❑No

❑Other diagnosis ***(please specify):*** _____

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To ensure a quick and accurate response to your approval request, please **submit medical records (e.g., chart notes, laboratory values)** and use of claims history pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a guideline of what documentation is required to process the prior authorization request.

❑Exacerbations of multiple sclerosis

- **Documentation required for <u>INITIATION</u> of therapy:**
  - Submission of medical records documenting **ONE** of the following: **PAGE _____ of _____**
    - FDA labeled contraindication to oral or parenteral glucocorticoid therapy
    - An inadequate response or intolerance to a 1 month trial of oral or a 1 week trial of parenteral glucocorticoid therapy
- **Documentation required for <u>CONTINUATION</u> of therapy:**
  - 30 day lapse since previous exacerbation **PAGE _____ of _____**

❑Nephrotic syndrome

- **Documentation required for <u>INITIATION</u> of therapy: PAGE _____ of _____**
  - Inadequate response or intolerance to a 1 month trial of **ONE** of the following:
    - Oral glucocorticoid therapy
    - Immunosuppressant such as:
      - ✓ Cyclophosphamide
      - ✓ Cyclosporine
      - ✓ Mycophenolate mofetil
      - ✓ Tacrolimus
  - Baseline levels of protein in urine indicative of proteinuria and low levels of albumin in blood indicative of hypoalbuminemia
- **Documentation required for <u>CONTINUATION</u> of therapy:**
  - Decrease in urine protein level and increase serum albumin level **PAGE _____ of _____**