H.P. Acthar Gelacthar

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date: _____**
Patient's ID: _____ **Patient's Date of Birth: _____**
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#: _____**
Physician Office Telephone: _____ **Physician Office Fax: _____**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____kg

Patient Height: _____ft _____inches

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Criteria Questions:

1. ***Indicate where the drug is being dispensed:***
   ❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
   ❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
   ❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
   ❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
   ❑ Psychiatric Facility ❑ Pharmacy ❑ Other

2. ***Indicate where the drug is being administered:***
   ❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
   ❑ Office ❑ Outpatient Hospital ❑ Pharmacy

3. What is the patient's diagnosis? ❑ Infantile spasms ❑ Other _____

4. What is the ICD-10 code? _____

5. Please indicate which drug is being requested: ❑ H.P. Acthar Gel ❑ Purified Cortrophin Gel

6. Will H.P. Acthar Gel be used in combination with Purified Cortrophin Gel? ❑ Yes ❑ No

7. Is this request for a new start or continuation of therapy?
   ❑ New start
   ❑ Continuation, *Skip to #9*

8. Is H.P. Acthar Gel being initiated in a patient who is less than 2 years of age?
   ❑ Yes ❑ No *No further questions*

9. Has the patient shown substantial clinical benefit from therapy? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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