

H.P. Acthar Gel (for Maryland only)
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. 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.

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

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*

Criteria Questions:

1. What is the patient's diagnosis?
 Infantile spasms
 Multiple sclerosis (MS)
 Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? Yes No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
 Yes No **ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)**
5. Is the medication effective in treating the member's condition? Yes No *Continue to #6 and complete this form in its entirety.*

Complete the following section based on the patient's diagnosis.

Section A: Infantile Spasms

6. Is the patient currently receiving treatment with H.P. Acthar Gel? *If Yes, skip to #8* Yes No
7. Is H.P. Acthar Gel being initiated for infantile spasms in a patient who is less than 2 years old?
 Yes No *No further questions*
8. Has the patient shown substantial clinical benefit from therapy? Yes No

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Section B: Multiple Sclerosis

9. Does the patient have an acute exacerbation of MS? Yes No
10. Did the patient have an inadequate response to a trial of 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. Yes No
11. Have chart notes been submitted detailing the trial with IV methylprednisolone? 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)