Wellpoint

H.P. Acthar Gel
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
H.P. Acthar Gel	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

☐ Yes	☐ No	Is the patient less than two years of age?
☐ Yes	☐ No	Does the patient have a diagnosis of infantile spasms in the last 730 days?
☐ Yes	☐ No	Does the patient have a diagnosis of multiple sclerosis in the last 730 days?
☐ Yes	☐ No	Does the patient have a documented contraindication or intolerance to corticosteroid therapy?
☐ Yes	☐ No	Does the patient have a diagnosis of scleroderma, osteoporosis, systemic fungal infection, ocular herpes simplex, peptic ulcer and/or heart failure in the last 365 days?

For the *Texas Medicaid Preferred Drug List,* please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs**.

9. Physician signature

_____ _____ Prescriber or authorized signature Date
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.
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