

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

Drug Name: Acthar® HP (Corticotropin) (Code-J0800)

- Acthar® HP is reserved to treat infantile spasms (IS), a rare form of epilepsy that affects infants.
- Prolonged use of corticotropin in children is associated with many complications including inhibition of skeletal growth, weight gain, hypertension, increased risk of infection, etc. If use is necessary, it is given over a short term (weeks to months) with careful observation of the child during treatment.
- Acthar® HP is contraindicated in persons with: hypersensitivity to Acthar® HP or any component of the formulation, Scleroderma; osteoporosis; systemic fungal infections; ocular herpes simplex; recent surgery; history of or presence of peptic ulcer; congestive heart failure (CHF); hypertension; sensitivity to porcine proteins; or in treatment of conditions accompanied by primary adrenocortical insufficiency or adrenocortical hyperfunction. It is administered IM, not IV.
- **Prescriptions will be approved for dispensing 6 weeks at a time. Each patient will be reviewed at the end of each period and evaluated for treatment failure.**

Please complete below: (check all boxes to qualify)

- Prescriber is a Neurologist
AND
 Patient has a documented diagnosis of Infantile Spasms

Dose Regimen: _____

Anticipated Length of therapy: _____

(Please Note: Approval will be for a period of 6weeks. If additional therapy is needed the prescribing physician is to make a second request)

Therapies Tried (may be none if infantile spasms are newly identified)

Patient Name: _____ Member Number: _____

Physician Signature _____ Date: _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____

(IF AVAILABLE)