Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

H.P. Acthar Gel - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have a documented diagnosis of a Food and Drug Administration (FDA)-approved indication not otherwise excluded from Part D?

☐ Yes ☐ No

Q2. Is there evidence of scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, sensitivity to proteins of porcine origin, a congenital infection suspected in an infant, or administration of a live or live attenuated vaccine in a patient receiving immunosuppressive doses of H.P. Acthar Gel?

☐ Yes ☐ No

Q3. Does the patient have the diagnosis of infantile spasms?

☐ Yes ☐ No

Q4. Is the patient less than 2 years of age?

☐ Yes ☐ No

Q5. Does the patient have the diagnosis of multiple sclerosis?

☐ Yes ☐ No

Q6. Is the patient 18 years of age or older?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

H.P. Acthar Gel - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

Q7. For other Food and Drug Administration (FDA)-approved indications not otherwise excluded from Part D, is the patient older than 2 years of age?

☐ Yes ☐ No

Q8. Is the medication going to be furnished by the prescriber/office, administered in the prescriber's office or ambulatory setting, be billed by the prescriber/office, and covered under Medicare Part B?

☐ Yes ☐ No

Q9. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?

☐ Yes ☐ No

Q10. Does the patient have the diagnosis of infantile spasms?

☐ Yes ☐ No

Q11. Additional Information:

Q12. Duration:

☐ Infantile Spasms - 12 months
☐ Multiple Sclerosis - 1 month
☐ Other FDA Indications - 1 month

Prescriber Signature

Date

2021 Medicare Prior Authorization Request

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document