Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

HP Acthar (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of HP Acthar (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

HP Acthar (repository corticotropin injection)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Does the member have a diagnosis of infantile spasm (West syndrome)? Y N

   [If no, skip to question 6.]

2. Has the diagnosis been confirmed by an electroencephalogram (EEG)? Y N

   [If no, then no further questions.]

3. Is the member 2 years of age or younger? Y N

   [If no, then no further questions.]

4. Is the medication being prescribed by or in consultation with a neurologist or Y N

epileptologist?

[If no, then no further questions.]

5. Does the member have a documented body surface area (BSA)? Y N

   Please indicate the member's BSA: _____

   Note: Submission of appropriate medical records and clinical/chart notes supporting the criteria is required.

   [No further questions.]

6. Is the medication being requested for treatment of an acute exacerbation of multiple sclerosis? Y N

   [If no, then no further questions.]

7. Is the medication being prescribed by or in consultation with a neurologist? Y N

   [If no, then no further questions.]

8. Does the member continue to have functionally disabling symptoms despite a 7 day course of high dose intravenous (IV) corticosteroids (for example, methylprednisolone 1000 mg per day) for the CURRENT exacerbation? Y N

   [If yes, skip to question 10.]

9. Has the member had significant side effects with high dose intravenous (IV) corticosteroids? Y N

   [If no, then no further questions.]

10. Is the member at least 18 years of age? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**