

H.P. Acthar® Coverage Determination Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		Office Contact:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)		Strength:
<input type="checkbox"/> Check if request is for continuation of therapy		Dosage Form:
		Directions for Use:

Clinical Information <small>(required)</small>	
Select the Type of Coverage Determination Requested: <input type="checkbox"/> Prior Authorization - Request is for a drug that requires prior authorization under the plan.	
Select the diagnosis below:	
<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Infantile spasms <input type="checkbox"/> Inflammatory ophthalmic disease <input type="checkbox"/> Juvenile rheumatoid arthritis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Other diagnosis: _____	<input type="checkbox"/> Rheumatoid arthritis (RA) <input type="checkbox"/> Serum sickness <input type="checkbox"/> Severe erythema multiforme <input type="checkbox"/> Stevens-Johnson syndrome <input type="checkbox"/> Symptomatic sarcoidosis <input type="checkbox"/> Systemic dermatomyositis <input type="checkbox"/> Systemic lupus erythematosus (SLE) <input type="checkbox"/> ICD-10 Code(s): _____
Clinical information:	
Select if H.P. Acthar is prescribed by one of the following specialists:	
<input type="checkbox"/> Allergist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Immunologist <input type="checkbox"/> Neonatologist <input type="checkbox"/> Nephrologist	<input type="checkbox"/> Neurologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Pediatric neurologist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Rheumatologist
Select if there is documentation the patient has any of the following:	
<input type="checkbox"/> Administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of H.P. Acthar Gel <input type="checkbox"/> Adrenocortical hyperfunction <input type="checkbox"/> Concurrent primary adrenocortical insufficiency or adrenocortical hyperfunction <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> History of or the presence of peptic ulcer <input type="checkbox"/> Ocular herpes simplex	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Primary adrenocortical insufficiency <input type="checkbox"/> Recent surgery <input type="checkbox"/> Scleroderma <input type="checkbox"/> Sensitivity to proteins or porcine origin, or where congenital infections are suspected in infants <input type="checkbox"/> Systemic fungal infections <input type="checkbox"/> Uncontrolled hypertension

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of the Pharmacy Benefit Manager. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: HPActhar_FSPartD_2020May

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For ankylosing spondylitis, juvenile rheumatoid arthritis, psoriatic arthritis, or rheumatoid arthritis, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate two systemic steroids (e.g., prednisone, methylprednisolone)? Yes No

Is there documentation the patient has an acute exacerbation of disease while currently receiving a disease-modifying anti-rheumatic drug (DMARD)? Yes No

For inflammatory ophthalmic disease, serum sickness, severe erythema multiforme, Stevens-Johnson syndrome, symptomatic sarcoidosis, systemic dermatomyositis, or systemic lupus erythematosus, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate two systemic steroids (e.g., prednisone, methylprednisolone)? Yes No

For multiple sclerosis, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate two systemic steroids (e.g., prednisone, methylprednisolone)? Yes No

Is there documentation the patient has an acute exacerbation of multiple sclerosis while currently receiving maintenance treatment for MS (e.g., Avonex, Betaseron, Copaxone, Tecfidera, etc.)? Yes No

For nephrotic syndrome, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate two systemic steroids (e.g., prednisone, methylprednisolone)? Yes No

Does the patient have proteinuria greater than 3.5 grams in 24 hours? Yes No

Does the patient have serum albumin less than 3 mg/dL? Yes No

Does the patient have peripheral edema? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-275-2583 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-275-2583 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-800-275-2583 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-800-275-2583 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-275-2583 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-275-2583 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-275-2583 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-275-2583 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري, ليس سيقوم (TTY: 711) 1-800-275-2583 عليك سوى الاتصال بنا على . بمساعدتك. هذه خدمة مجانية شخص ما يتحدث العربية.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-275-2583 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-275-2583 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-275-2583 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-275-2583 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-275-2583 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-275-2583 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-275-2583 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-275-2583 (TTY: 711)にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

You can file a grievance in the following ways:

- In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103
- By phone: 1-888-377-3933 (TTY: 711)
- By fax: 215-761-0245
- By email: civilrightscordinator@1901market.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.