Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Corticotropin Gel

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health 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: □ Exchange - PA	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 the 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. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the product being requested?

☐ Acthar Gel ☐ Corticotropin ☐ Other

Q3. If other, please specify:

Q4. What is the diagnosis?

☐ Infantile Spasms
☐ Multiple Sclerosis
☐ Other FDA-approved and Medically Accepted Indications
☐ Other

Q5. If other, please specify:

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Q6. What is the member's age?

☐ 0 - 2 years
☐ 18 years or older
☐ Age consistent with FDA labeling, compendia, recognized standards of care, guidelines, or peer-reviewed literature
☐ Other

Q7. If other, please specify:

Q8. For the diagnosis Infantile Spasms, does the member have a suspected congenital infection?

☐ Yes ☐ No

Q9. Will corticotropin be used as monotherapy?

☐ Yes ☐ No

Q10. Is the dose in accordance with prescribing information (Initial dose: 150 units/m2 daily, divided as 75 units/m2 intramuscularly twice daily for 2 weeks, followed by a gradual 2-week taper)?

☐ Yes ☐ No

Q11. For the diagnosis Infantile Spasms, is the medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q12. For the diagnosis Infantile Spasms, does the member have a suspected congenital infection?

☐ Yes ☐ No

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Q13. Will corticotropin be used as monotherapy?

☐ Yes ☐ No

Q14. For the diagnosis Infantile Spasms, is treatment required beyond the initial approved duration (progress notes demonstrating the need for continued treatment along with the planned taper schedule must be attached)?

☐ Yes ☐ No

Q15. Does the member demonstrate exacerbation symptoms of MS with severe weakness, severe vision loss, severe coordination problems, or severe walking impairment?

☐ Yes ☐ No

Q16. Has the member had an inadequate response, intolerance, or contraindication to both IV and oral corticosteroids?

☐ Yes ☐ No

Q17. Is the member currently being treated with MS disease-modifying therapy (such as Avonex, Betaseron, Briumvi, Dimethyl Fumarate DR, Fingolimod, Glatiramer Acetate, Glatopa, Kesimpta, Ocrevus, Rebif, Teriflunomide, Tysabri)?

☐ Yes ☐ No

Q18. Is the requested drug being used to treat an acute episode and NOT being used as routine monthly or pulse therapy to prevent exacerbations?

☐ Yes ☐ No

Q19. Is the dose in accordance with the prescribing information (daily intramuscular or subcutaneous doses of 80 to 120 units for 2-3 weeks for acute exacerbations or less if appropriate)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q20. For the diagnosis Multiple Sclerosis, is the medication prescribed by or in consultation with a neurologist?

☐ Yes ☐ No

Q21. Is the member currently being treated with MS disease-modifying therapy?

☐ Yes ☐ No

Q22. Is the requested drug being used to treat an acute episode and NOT being used as routine monthly or pulse therapy to prevent exacerbations?

☐ Yes ☐ No

Q23. For the diagnosis Multiple Sclerosis, is treatment required beyond the initial approved duration (progress notes demonstrating the need for continued treatment along with the planned taper schedule must be attached)?

☐ Yes ☐ No

Q24. Does the member have a diagnosis for which the requested drug is FDA-approved or medically accepted?

☐ Yes ☐ No

Q25. Has the member had an inadequate response, intolerance, or contraindication to clinically appropriate IV and oral corticosteroids?

☐ Yes ☐ No

Q26. Have all other standard therapies been trialed to treat the condition based on compendia and treated in accordance with recognized standard of care guidelines and peer-reviewed literature OR is there a documented medical reason (inadequate response, intolerance, contraindication) for why other standard therapies cannot be used to treat the member's condition?

☐ Yes ☐ No

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Q27. Is the dose in accordance with the prescribing information (40 to 80 units given intramuscularly or subcutaneously every 24 to 72 hours)?

☐ Yes ☐ No

Q28. Is the medication prescribed by or in consultation with an appropriate specialist for the condition being treated?

☐ Yes ☐ No

Q29. Is continued treatment or retreatment with corticotropin injection clinically appropriate for the condition being treated based on standard of care guidelines or peer-reviewed literature to support use (progress note and supportive documentation along with planned taper schedule must be attached)?

☐ Yes ☐ No

Q30. Is the member compliant with corticotropin therapy?

☐ Yes ☐ No

Q31. Is the member tolerating therapy without significant side effects?

☐ Yes ☐ No

Q32. Has the member experienced resolution of symptoms or clinical improvement while on therapy (supporting documentation attached)?

☐ Yes ☐ No

Q33. Does the member have any contraindications per exclusion criteria? (i.e., Scleroderma, osteoporosis, systemic fungal infection, ocular herpes simplex, recent surgery, history or presence of peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, porcine protein sensitivity, or is receiving live or live attenuated vaccines while on immunosuppressive doses).

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q34. For Acthar gel, has the member had an inadequate response, intolerance, or contraindication to Corticotropin gel that is not expected to occur with the requested drug?

☐ Yes ☐ No

Q35. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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