OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

H.P. Acthar® Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Continuation of therapy:

Is this a continuation of prior therapy? ❑ **Yes** ❑ **No**

If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (**REQUIRED)**

_____

_____

Select the diagnosis below:

- ❑ Allergic states: Serum sickness
- ❑ Collagen disease: Exacerbation or maintenance therapy in selected cases of systemic lupus erythematosus, systemic dermatomyositis (polymyositis)
- ❑ Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome
- ❑ Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus
- ❑ Infantile spasms
- ❑ Multiple sclerosis, acute exacerbations
- ❑ Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: Keratitis; Iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis; Anterior segment inflammation
- ❑ Respiratory diseases: Symptomatic sarcoidosis
- ❑ Rheumatic disorders: As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: Psoriatic arthritis; Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), Ankylosing spondylitis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication History:

Has the patient had prior use of injectable corticosteroids or are injectable corticosteroids contraindicated, inappropriate, or ineffective for this patient? ❑ **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.
For urgent or expedited requests please call 1-855-297-2870.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.