Acthar Gel

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:		Provider NPI #:
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐New medication ☐Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	☐Yes ☐No

Please indicate place of administration:	☐Physician's Office ☐Hospital/Clinic ☐Patient Home	Will the drug be: (select one) ☐ Billed directly by the provider via JCODE JCODE: ______________________________ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient
Please provide hospital/facility address:		

Please indicate the diagnosis on the left and complete the corresponding questions.

Diagnosis	Question	Response
☐Multiple Sclerosis	Is the member experiencing and acute exacerbation?	☐Yes ☐No
	Did the member try IV corticosteroids?	☐Yes ☐No
	If Yes, Please list reason for discontinuation:	
	Does the member have evidence of an active infection?	☐Yes ☐No
☐Infantile Spasms	Was the diagnosis confirmed by EEG?	☐Yes ☐No
	Does the member have evidence of an active infection?	☐Yes ☐No
☐Other	Please specify diagnosis:	
	Did the member try IV corticosteroids?	☐Yes ☐No

Please provide any additional information which should be considered in the space below: