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 the diagnosis on the left and complete the corresponding questions.

Diagnosis	Question	Answer
❑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: