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H.P. ACTHAR PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for MS exacerbations

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	Date of Birth:	Sex: M F
Last Name:		First Name:
GENERAL INFORMATION		
First Date of Service:		Last Date of Service:
Primary Diagnosis Code:		HCPC Code:
Drug Name:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<i>Note: The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.</i>		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	Taxonomy:	
Phone:	Fax:	

CRITERIA		
Medical records to support use of product are submitted		
Initial Therapy (check one)	Yes	No
	Individual is ≥18 years old	
	Individual has a diagnosis of multiple sclerosis (MS)	
	Documentation is provided indicating patient is having an acute MS exacerbation	
	Documentation is submitted indicating previous failure, contraindication, or intolerance to oral and injectable glucocorticoids	
	Documentation is provided indicating that individual is currently using disease modifying therapy for MS	
Continuation of Therapy (check one)	Yes	No
	Documentation is submitted indicating that there was a positive response to therapy	
	Documentation is provided indicating need for continuation of therapy beyond acute exacerbation stage	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form <u>must be</u> signed by a physician		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		Specialty:
Signature:		