

**Arkansas Medicaid Prior Authorization Request Form  
H.P. Acthar® gel (corticotropin injection)  
Infantile Spasm**

After completion of this form, please fax to the Arkansas Medicaid Pharmacy Unit. Fax: 1-800-424-5851  
For questions call: 1-501-683-4120.

<b>AR MEDICAID ENROLLED PRESCRIBER ID NUMBER:</b>	<b>AR MEDICAID BENEFICIARY ID NUMBER:</b>
<b>Prescriber Name:</b>	<b>Beneficiary Name:</b>
<b>Address:</b>	<b>Address:</b>
<b>City: State: Zip:</b>	<b>City: State: Zip:</b>
<b>Phone: ( ) Fax: ( )</b>	<b>Patient's Date of Birth: / /</b>
<b>Pharmacy name:</b>	<b>If recipient is hospitalized, approved prior authorizations will be entered at the time of discharge for the quantity needed to complete the taper.</b>
<b>Phone: ( )</b>	

Is recipient ≤ 2 years of age? YES  NO

Is this medication being prescribed by a neurologist? YES  NO

Does the recipient have the diagnosis of Infantile Spasms? YES  NO

**Initial request for Infantile Spasms**

- Should be made upon admission to the hospital to allow time for thorough review.
- Hospital use does not necessitate Medicaid approval of the PA request.
- Provider should submit the following for review:

- Admission clinical notes
- Documentation of previous therapies \_\_\_\_\_
- Current BSA (m<sup>2</sup>) OR current height (cm) AND weight (kg) to allow for calculation of BSA  
\_\_\_\_\_
- Expected taper plan with doses \_\_\_\_\_

**Discharge request for Infantile Spasms**

- Discharge clinical notes with documentation of number of doses received.
- Complete the following:

<b>Initial Dose Schedule (Doses remaining after hospitalization)</b>	<b><u>Approval at Outpatient pharmacy will be based on volume needed at discharge from hospital</u></b>	
75 U/m <sup>2</sup> BID x _____ days	TOTAL _____ mL x _____ # days (Total to complete initial dosing)	
<b>Dose Taper Schedule</b>	<b>Body Surface Area (BSA)</b>	
30 U/m <sup>2</sup> QD x _____ days	_____ mL x _____ days	Weight: _____ kg
15 U/m <sup>2</sup> QD x _____ days	_____ mL x _____ days	Height/Length: _____ cm
10 U/m <sup>2</sup> QD x _____ days	_____ mL x _____ days	Calculated BSA: _____ m <sup>2</sup>
10 U/m <sup>2</sup> QOD x _____ days	_____ mL x _____ days	Total number vials needed _____

**Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature the prescriber confirms the criteria information above is accurate and verifiable in recipient records.

**\*\*\*\*Please note that all information attested to herein is subject to Medicaid review and audit.\*\*\*\*\***