Print Reset

Arkansas Medicaid Prior Authorization Request Form

H.P. Acthar® gel (corticotropin injection) Infantile Spasm

After completion of this form, please **fax** to Empower Healthcare Solutions.

Fax: 1-866-546-0484 For questions, call: 1-844-865-7829.

If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Please use one form per beneficiary. Information contained in this form is Protected Health Information under HIPAA.

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

AR Medicaid Beneficiary ID: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA #: _____

Specialty: _____ AR Medicaid Enrolled Prescriber ID: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

CRITERIA

If recipient is hospitalized, approved prior authorizations will be entered at the time of discharge for the quantity needed to complete the taper.

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

Beneficiary's Name: _____

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^2) **or** current height (cm) **and** weight (kg) to allow for calculation of BSA (provide below)
  - Expected taper plan with doses (provide below)

DISCHARGE REQUEST FOR INFANTILE SPASMS

- Must provide discharge clinical notes with documentation of number of doses received.

Complete the following:

Initial Dose Schedule (Doses remaining after hospitalization)

- 75 U/m^2 **BID** x _____ Days

Approval at Outpatient Pharmacy will be based on volume needed at discharge from hospital.

- Total: _____ mL x _____ **#** Days (Total to complete initial dosing)

Dose Taper Schedule

- 30 U/m^2 **QD** x _____ days _____ mL x _____ days
- 15 U/m^2 **QD** x _____ days _____ mL x _____ days
- 10 U/m^2 **QD** x _____ days _____ mL x _____ days
- 10 U/m^2 **QOD** x _____ days _____ mL x _____ days

Body Surface Area (BSA)

- Weight: _____ kg Height/Length: _____ cm
- Calculated BSA: _____ m^2 **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.

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