Arkansas Medicaid Prior Authorization Request Form
H.P. Acthar® Gel (Corticotropin Injection) Infantile Spasm

Fax completed form to CareSource PASSE™ Pharmacy benefit at **1-866-930-0019** or **1-888-399-0271** for CareSource PASSE Medical benefit.

Incomplete or illegible forms may delay the prior authorization (PA) process. Please use one form per member. Information contained in this form is Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Request Date: ☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

MEMBER INFORMATION

Member Last Name: ______

Member First Name: ______

CareSource PASSE Member ID: ______ Date of Birth: ______

Street Address: ______ City: ______ State: ______ ZIP: ______

PRESCRIBER INFORMATION

Prescriber Last Name: ______

Prescriber First Name: ______

Prescriber National Provider Identifier (NPI): ______ Specialty: ______

Prescriber Phone: ______ Prescriber Fax: ______

Street Address: ______ City: ______ State: ______ ZIP: ______

DRUG INFORMATION

Drug Name: ______ Drug Strength: ______

PHARMACY INFORMATION

Pharmacy Name: ______ Pharmacy Phone: ______

Diagnosis: ______ Diagnosis Code: ______

CRITERIA

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

Is recipient ≤ two 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

Member'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 body surface area (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)

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 signing, the prescriber confirms the criteria information above is accurate and verifiable in recipient records.

Approved PAs are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits. For questions, call **1-833-230-2100.**