P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Acthar® Gel
(repository corticotropin injection)

Therapeutic use: Treatment of infantile spasms
Quantity Limit:
- Determined by BSA

Authorization Period: 1 month

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescribing physician a neurologist?	❑ Yes	❑ No
2.	Has the patient been diagnosed with infantile spasms as confirmed by EEG?	❑ Yes	❑ No
2a.	Is the patient less than 24 months old?	❑ Yes	❑ No
2b.	Has the patient failed treatment with prednisone, prednisolone, hydrocortisone, or dexamethasone?	❑ Yes	❑ No
2c.	Has the patient failed treatment with vigabatrin and/or cosyntropin?	❑ Yes	❑ No
2d.	Please supply infant's body surface area (BSA): _____		
Acthar is only covered for a diagnosis of infantile spasms. Treatment of other conditions is not covered.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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