Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Repository Corticotropin (Acthar Gel) – Medical Necessity Request

1. Please indicate if member has any of the following contraindications to therapy:

□ Administration via intravenous route
□ Children younger than 2 years of age with suspected congenital infections
□ Administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of Acthar Gel.
□ Scleroderma
□ Osteoporosis
□ Systemic fungal infections
□ Ocular herpes simplex
□ Recent surgery
□ History of or the presence of a peptic ulcer
□ Congestive heart failure
□ Uncontrolled hypertension
□ Primary adrenal insufficiency
□ Adrenocortical hyperfunction
□ Sensitivity to proteins of porcine origin
□ NONE

2. Diagnosis Information (please select diagnosis and provide requested information):

□ Infantile Spasms/West Syndrome

- Is Acthar Gel being used as monotherapy? **Yes or No**

- Is the member's diagnosis confirmed by electroencephalogram (EEG) displaying hypsarrhythmia? **Yes or No**

- What is the member's current weight? _____ lbs Date Taken: _____
_____ kg

- What is the member's current height? _____ feet _____inches Date Taken: _____
_____ cm

**** Please note, height and weight must be from within the past 60 days.***

□ Multiple Sclerosis

- Is the member having an acute exacerbation? **Yes or No**

- Has the member tried a systemic corticosteroid for the current exacerbation?
  - □ **Yes**
  - □ **No** - Would the MD consider trying corticosteroid therapy for this member instead? **Yes or No**
    - If not, please provide the clinical reason why a systemic corticosteroid cannot be tried:

_____

_____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**.