



H.P. Acthar® Gel (repository corticotropin) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

Please indicate: Start of treatment: Start date: ____/____/____
 Continuation of therapy: ____/____/____

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Precertification Requested By: _____ **Phone:** _____ **Fax:** _____

A. PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

Medicare: Yes No If yes, provide ID #: _____ **Medicaid:** Yes No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:			Phone:

Specialty (Check one): Neurologist Pediatrician Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for Acthar Gel: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable

Primary ICD Code: _____ **Secondary ICD Code (If applicable)** _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests:
Please indicate patient's age (in months): _____
 Yes No Does the patient a documented diagnosis of West Syndrome (infantile spasms)?
 Yes No Is clinical documentation being submitted with the request to support the diagnosis of West Syndrome (infantile spasms)?

For Continuation of Therapy:
Please indicate the dates of the previous treatment: ____/____/____, ____/____/____

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.