



**Repository Corticotropin (H.P. Acthar® Gel)
Injectable Medication Precertification Request**

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

Please indicate: Start of treatment Continuation of therapy **Today's date:** _____ **Date needed:** _____

Ship to: Doctor's office Patient Other: _____ **Phone:** _____

Dispensing Provider: Aetna Specialty Pharmacy® or Other: _____
Phone: _____ Fax: _____ **TIN:** _____ **PIN:** _____

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:
Patient Current Weight:	lbs or	kgs	Patient Height: inches or cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ **Does patient have other coverage?** Yes 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:		<i>(Circle one):</i> M.D. D.O. N.P. P.A.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St. Lic. #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty (Circle one): Neurologist Endocrinologist Pediatrician Podiatrist Rheumatologist Orthopedist Other: _____

D. DIAGNOSIS INFORMATION – Indicate Primary ICD-9 below.

<input type="checkbox"/> West syndrome - infantile spasms (345.60 - 345.61)	<input type="checkbox"/> Purulent & other endophthalmitis, sympathetic ophthalmia (360.0-360.19)	<input type="checkbox"/> Regional enteritis, Crohn's disease, ulcerative colitis (555.0-556.9)	<input type="checkbox"/> Diffuse diseases of connective tissue, Lupus erythematosus (710.0-710.9)
<input type="checkbox"/> Pulmonary tuberculosis (011.0-011.96)	<input type="checkbox"/> Chorioretinitis & retinochoroiditis (363.00-363.22)	<input type="checkbox"/> Allergic gastroenteritis and colitis (558.3)	<input type="checkbox"/> Rheumatoid arthritis & other inflammatory polyarthropthies (714.0-714.99)
<input type="checkbox"/> Tuberculous meningitis (013.00—013.06)	<input type="checkbox"/> Iridocyclitis (364-364.3)	<input type="checkbox"/> Nephrotic syndrome (581.0-581.9)	<input type="checkbox"/> Osteoarthritis [synovitis of] (715.00-715.98)
<input type="checkbox"/> Herpes Zoster with ophthalmic complications (053.20-053.29)	<input type="checkbox"/> Keratitis (370.00 - 370.9)	<input type="checkbox"/> Seborrhic dermatosis (690.10-690.18)	<input type="checkbox"/> Traumatic arthropathy (716.10-716.19)
<input type="checkbox"/> Trichinosis (124)	<input type="checkbox"/> Acute chronic conjunctivitis (372.00-372.15)	<input type="checkbox"/> Atopic Dermatitis and related conditions (691.0-691.8)	<input type="checkbox"/> Ankylosing spondylitis (720.00)
<input type="checkbox"/> Sarcoidosis (135)	<input type="checkbox"/> Optic neuritis (377.30 - 377.39)	<input type="checkbox"/> Contact dermatitis and other eczema (692.0-692.9)	<input type="checkbox"/> Peripheral enesthopathies (726.0 - 727.9)
<input type="checkbox"/> Malignant neoplasm of lymphatic and hematopoietic tissue (200.00 - 208.91)	<input type="checkbox"/> Rheumatic fever (390 - 392.9)	<input type="checkbox"/> Dermatitis due to substances taken internally (693.0-693.9)	<input type="checkbox"/> Proteinuria (791.0)
<input type="checkbox"/> Thyroiditis (245.0 - 245.9)	<input type="checkbox"/> Allergic rhinitis (477.0 - 477.9)	<input type="checkbox"/> Bullous dermatoses (694.0-694.9)	<input type="checkbox"/> Angioneurotic edema (995.1)
<input type="checkbox"/> Gouty arthropathy (274.0)	<input type="checkbox"/> Extrinsic asthma (493.00 - 493.9)	<input type="checkbox"/> Erythema multiforme [Stevens-Johnson syndrome] (695.1)	<input type="checkbox"/> Other and unspecified adverse effect of drug, medicinal and biological substance (995.20 – 995.29)
<input type="checkbox"/> Hypercalcemia (275.42)	<input type="checkbox"/> Pneumoconiosis due to other inorganic dust [berylliosis] (503)	<input type="checkbox"/> Other specified erythematous conditions (exfoliative dermatitis) (695.81-698.89)	<input type="checkbox"/> Allergy, unspecified (995.3)
<input type="checkbox"/> Autoimmune hemolytic anemias [acquired] (283.0-283.2)	<input type="checkbox"/> Bronchitis & pneumonitis due to fumes and vapors (506)	<input type="checkbox"/> Psoriasis [severe] (696.0-696.1)	<input type="checkbox"/> Anaphylactic shock due to serum (999.4)
<input type="checkbox"/> Constitutional red blood cell aplasia (284.10)	<input type="checkbox"/> Pneumonitis due to inhalation of food or vomitus (507.0)	<input type="checkbox"/> Allergic urticaria (708.0)	<input type="checkbox"/> Other serum reaction (999.5)
<input type="checkbox"/> Other specified aplastic anemias (284.8-284.89)	<input type="checkbox"/> Pulmonary eosinophilia [Loffler's syndrome] (518.3)		
<input type="checkbox"/> Secondary thrombocytopenia (287.4)	<input type="checkbox"/> Other specified gastritis [allergic gastritis] (535.4)		
<input type="checkbox"/> Multiple Sclerosis (340)			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Secondary ICD-9 Code (if applicable) _____			

E. PRIOR TREATMENT

Yes No **Has the patient failed any corticosteroid therapy? If yes, please list below the failed corticosteroid and date attempted.**

F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Acthar® Gel CPB # 0762	80units/ml 5ml vial			

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**
***If the prescriber is providing the drug, the provider must verify benefits.**

Prescriber's Signature: _____ **Date:** ____ / ____ / ____

(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)
Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: _____