Arkansas Medicaid Prior Authorization Request Form
H.P. Acthar® gel (corticotropin injection)
Infantile Spasm

After completion of this form, please **fax** to the Arkansas Medicaid Pharmacy Unit. **Fax: 1-800-424-5851**
For questions call: 1-501-683-4120.

AR MEDICAID ENROLLED PRESCRIBER ID NUMBER:	**AR MEDICAID BENEFICIARY ID NUMBER:**
Prescriber Name:	**Beneficiary Name:**
Address:	**Address:**
City: State: Zip:	**City: State: Zip:**
Phone: ( ) Fax: ( )	**Patient's Date of Birth: / /**
Pharmacy name:	**If recipient is hospitalized, approved prior authorizations will be entered at the time of discharge for the quantity needed to complete the taper.**
Phone: ( )	

Is recipient ≤ 2 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 ☐

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 BSA (m^2) OR current height (cm) AND weight (kg) to allow for calculation of BSA**

_____

☐ **Expected taper plan with doses**_____

_____

Discharge request for Infantile Spasms

☐ **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**	
75 U/m^2 **BID** x _____ days	TOTAL _____mL x _____ # days (Total to complete initial dosing)	
Dose Taper Schedule		**Body Surface Area (BSA)**
30 U/m^2 **QD** x _____ days	_____ mL x ____ days	Weight: _____ kg
15 U/m^2 **QD** x _____ days	_____ mL x ____ days	Height/Length: _____ cm
10 U/m^2 **QD** x _____ days	_____ mL x ____ days	Calculated BSA: _____ m^2
10 U/m^2 **QOD** x _____ days	_____ mL x ____ days	Total number vials needed_____

Prescriber Signature: _____ **Date:** _____

Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature the prescriber confirms the criteria information above is accurate and verifiable in recipient records.

******Please note that all information attested to herein is subject to Medicaid review and audit.********