CMSP
COUNTY MEDICAL
SERVICES PROGRAM

MedImpact Healthcare Systems, Inc.

H.P. ACTHAR
Medication Request Form

Phone: 1-800-788-2949, Fax: 858-790-7100

Instructions:

Please complete this form and fax to Med**Impact** Healthcare Systems, Inc. at (858) 790-7100 or call (800) 788-2949 with this information. Please note that approval is based on medical necessity criteria approved by the County Medical Services Program Governing Board. If you have any questions regarding this process, please contact Med**Impact**'s Customer Service at (800) 788-2949.

Medication Request Information (please complete each section of this form prior to transmittal)

Patient Name (required):	Patient ID # (required):	Patient DOB (required):
Provider Name:		Provider Specialty:
Provider DEA Number:	Provider Phone Number (required): ( ) -	Provider Fax Number (required): ( ) -

H.P. Acthar Dose:	# of Vials Requested:	Length of Treatment:
Diagnosis:		

Initial Request (Patient has not been previously approved by CMSP for H.P. Acthar)

H.P. Acthar is medically necessary because:

☐ Patient has a history of a significant adverse reaction to injectable steroids

Submit copies of the medical record notes documenting the following:

- Details of the adverse reaction, including dates of the reaction and actions taken to treat the reaction.
- Whether injectable steroid therapy was effective despite the adverse reaction.
- Documentation indicating why reduction of the steroid dose and trial of a different steroid are not therapeutic options for the patient.
- Documentation indicating that a similar adverse reaction is not expected with H.P. Acthar use.

☐ Other: _____

Submit copies of the medical record notes documenting the following:

- Whether injectable steroids have been previously used to control the condition and, if applicable, the outcome of injectable steroid use.
- Explanation of why injectable steroids are not a therapeutic option for this patient.

Renewal Request

Submit copies of the medical record notes documenting the following:

- Measurable symptom improvement through use of H.P. Acthar.
- Planned duration of therapy.

Prescriber's Signature (**Required**): _____