pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CORTICOTROPIN (REPOSITORY) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Corticotropin** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Route: ☐IM ☐SQ ☐_____	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Diagnosis code (*required*):	

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of infantile spasms: Submit documentation of diagnosis.
2. For treatment of all other indications:
   - ☐Diagnosis and dose are included in the FDA-approved package labeling
   - ☐Diagnosis and dose are supported by national recognized compendia for the determination of medically accepted indications for off-label uses
   - ☐Tried and failed or has a contraindication or an intolerance to oral corticosteroids
   - ☐Tried and failed or has a contraindication or an intolerance to IV methylprednisolone

RENEWAL requests

1. For all indications:
   - ☐Continues to experience clinical benefit from and tolerability of corticotropin

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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