TEXAS MEDICAID
Clinical Edit Prior Authorization
corticotropin (HP ACTHAR)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Is the client less than (<) 2 years of age?

   ☐ Yes (Go to #2) ☐ No (Go to #3)

2. Does the client have a diagnosis of infantile spasms in the last 730 days?

   ☐ Yes (Go to #7) ☐ No (Deny)

   Dosing Instructions: _____

   Weight (kg): _____

   Height (cm): _____

   Body Surface Area (m^2): _____

3. Does the client have a diagnosis of multiple sclerosis in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

STEP 2: COMPLETE REQUIRED CRITERIA

4. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have one (1) claim for a corticosteroid in the last 60 days?

   Examples of corticosteroids include dexamethasone, hydrocortisone (CORTEF), methylprednisolone (MEDROL), prednisolone (MILLIPRED), and prednisone.

   ☐ Yes (Go to #7) ☐ No (Go to #6)

6. Does the client have a documented contraindication or intolerance to corticosteroid therapy? [Manual Step]

   ☐ Yes (Go to #7) ☐ No (Deny)

7. Does the client have a diagnosis of one or more of the following in the last 365 days?

   - heart failure
   - ocular herpes simplex
   - osteoporosis
   - peptic ulcer
   - scleroderma
   - systemic fungal infection

   ☐ Yes (Deny) ☐ No (Approve – 30 days)

STEP 3: SIGN AND FAX TO NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.