



Fax Referral To: 800-323-2445

Phone: 866-278-6634

**H.P. Acthar<sup>®</sup> Gel (corticotropin)**  
**Enrollment Form**  
**For Blue Cross Blue Shield of Rhode Island Members**

Date: \_\_\_\_\_ Needs by Date (Please Specify): \_\_\_\_\_

Ship to: ☐ Patient ☐ Office ☐ Other: \_\_\_\_\_

**PATIENT INFORMATION**

(Complete the following or send patient demographic sheet)

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

SS #: \_\_\_\_\_

Insurance ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Name: \_\_\_\_\_

State License #: \_\_\_\_\_ UPIN: \_\_\_\_\_

DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Group or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

**INSURANCE INFORMATION** (If available, please copy and attach the front and back of insurance and prescription drug card)

**Primary Insurance:** Subscriber: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_ Name of Insurer: **Blue Cross Blue Shield of RI**

**Secondary Insurance:** Subscriber: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members**

**Diagnosis (ICD-9 Code):** ☐ \_\_\_\_\_ • Date of Diagnosis: \_\_\_\_\_

**Approval Criteria: CHECK ALL BOXES THAT APPLY**

**Please note: Any areas that are not filled out will be considered not applicable to your patient and MAY AFFECT THE OUTCOME OF THIS REQUEST**

- Medication will be used for diagnostic testing of adrenocortical function ☐ Yes ☐ No
- Medication will be used as treatment of West syndrome (infantile spasms) ☐ Yes ☐ No
- Medication will be used as treatment of multiple sclerosis, acute exacerbations ☐ Yes ☐ No
- Patient has had a failure of corticosteroid therapy ☐ Yes ☐ No

**PRESCRIPTION INFORMATION**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> H.P. Acthar <sup>®</sup> Gel (corticotrophin)	<input type="checkbox"/> 80 units/mL			

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

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