



**Repository Corticotropin (H.P. Acthar® Gel)  
Injectable Medication Precertification Request**

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

**Please indicate:**  Start of treatment  Continuation of therapy **Today's date:** \_\_\_\_\_ **Date needed:** \_\_\_\_\_

**Dispensing Provider:**  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ **TIN:** \_\_\_\_\_ **PIN:** \_\_\_\_\_

**Ship to:**  Doctor's office  Patient  Other: \_\_\_\_\_ Phone: \_\_\_\_\_

**Precertification Requested By:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**A. PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_ Email: \_\_\_\_\_  
Patient Current Weight: \_\_\_\_\_ lbs or \_\_\_\_\_ kgs Patient Height: \_\_\_\_\_ inches or \_\_\_\_\_ cms

**B. INSURANCE INFORMATION**

**Aetna Member ID #:** \_\_\_\_\_ **Does patient have other coverage?**  Yes  No  
**Group #:** \_\_\_\_\_ **If yes, provide ID#:** \_\_\_\_\_ **Carrier Name:** \_\_\_\_\_  
**Insured:** \_\_\_\_\_ **Insured:** \_\_\_\_\_  
**Medicare:**  Yes  No **If yes, provide ID #:** \_\_\_\_\_ **Medicaid:**  Yes  No **If yes, provide ID #:** \_\_\_\_\_

**C. PRESCRIBER INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ (Circle one): M.D. D.O. N.P. P.A.  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ St. Lic. #: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ UPIN: \_\_\_\_\_  
Provider Email: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Specialty (Circle one):** Neurologist Endocrinologist Pediatrician Podiatrist Rheumatologist Orthopedist Other: \_\_\_\_\_

**D. DIAGNOSIS INFORMATION – Indicate Primary ICD-9 below.**

<input type="checkbox"/> West syndrome - infantile spasms (345.60 - 345.61)	<input type="checkbox"/> Secondary thrombocytopenia (287.4)	<input type="checkbox"/> Diagnostic testing of adrenocortical function (V77.99)	<input type="checkbox"/> Allergic urticaria (708.0)
<input type="checkbox"/> Pulmonary tuberculosis (011.0-011.96)	<input type="checkbox"/> Multiple Sclerosis (340)	<input type="checkbox"/> Pneumonitis due to inhalation of food or vomitus (507.0)	<input type="checkbox"/> Diffuse diseases of connective tissue (710.0-710.9)
<input type="checkbox"/> Tuberculous meningitis (013.0)	<input type="checkbox"/> Sympathetic uveitis (360.11)	<input type="checkbox"/> Pulmonary eosinophilia (518.3)	<input type="checkbox"/> Rheumatoid arthritis (714.0-714.99)
<input type="checkbox"/> Herpes Zoster dermatitis of eyelid (053.20)	<input type="checkbox"/> Other endophthalmis (360.19)	<input type="checkbox"/> Other specified gastritis (535.4)	<input type="checkbox"/> Osteoarthritis (715.00-715.98)
<input type="checkbox"/> Trichinosis (124)	<input type="checkbox"/> Chorioretinal Inflammations (363.00-363.22)	<input type="checkbox"/> Regional enteritis (555.0-555.9)	<input type="checkbox"/> Traumatic arthropathy (716.10-716.19)
<input type="checkbox"/> Sarcoidosis (135)	<input type="checkbox"/> Iridocyclitis (364-364.3)	<input type="checkbox"/> Ulcerative colitis (556.0-556.9)	<input type="checkbox"/> Ankylosing spondylitis (720.00)
<input type="checkbox"/> Malignant neoplasm of lymphatic and hematopoietic tissue (200.00 - 208.91)	<input type="checkbox"/> Keratitis (370.00 - 370.9)	<input type="checkbox"/> Allergic gastroenteritis and colitis (558.3)	<input type="checkbox"/> Peripheral enesthopathies (726.0 - 727.9)
<input type="checkbox"/> Thyroiditis (245.0 - 245.9)	<input type="checkbox"/> Other chronic allergic conjunctivitis (372.14)	<input type="checkbox"/> Nephrotic syndrome (581.0-581.9)	<input type="checkbox"/> Angioneurotic edema (995.1)
<input type="checkbox"/> Gouty arthropathy (274.0)	<input type="checkbox"/> Optic neuritis (377.30 - 377.39)	<input type="checkbox"/> Seborrhic dermatosis (690.10-690.18)	<input type="checkbox"/> Other and unspecified adverse effect of drug, medicinal and biological substance (995.20 – 995.29)
<input type="checkbox"/> Hypercalcemia (275.42)	<input type="checkbox"/> Acute rheumatic fever (390 - 392.9)	<input type="checkbox"/> Contact dermatitis and other eczema (692.0-692.6)	<input type="checkbox"/> Allergy, unspecified (995.3)
<input type="checkbox"/> Autoimmune hemolytic anemias (283.0)	<input type="checkbox"/> Allergic rhinitis (477.0 - 477.9)	<input type="checkbox"/> Dermatitis due to substances taken internally (693.0-693.9)	<input type="checkbox"/> Anaphylactic shock due to serum (999.4)
<input type="checkbox"/> Constitutional red cell aplasia (284.01)	<input type="checkbox"/> Extrinsic asthma (493.00 - 493.02)	<input type="checkbox"/> Dermatitis herpetiformis (694.0)	<input type="checkbox"/> Other serum reaction (999.5)
<input type="checkbox"/> Other specified aplastic anemias (284.89)	<input type="checkbox"/> Pneumoconiosis due to other inorganic dust (503)	<input type="checkbox"/> Pemphigus (694.4)	
	<input type="checkbox"/> Bronchitis & pneumonitis due to fumes and vapors (506.0)	<input type="checkbox"/> Erythema multiforme (695.1)	
		<input type="checkbox"/> Psoriasis (696.0-696.1)	

Other \_\_\_\_\_

**Secondary ICD-9 Code (if applicable)** \_\_\_\_\_

**E. PRIOR TREATMENT**

Yes  No **Has the patient failed any corticosteroid therapy? If yes, please list below the failed corticosteroid and date attempted.**

**F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Acthar® Gel CPB # 0762	80units/ml 5ml vial			

**\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**  
**\*If the prescriber is providing the drug, the provider must verify benefits.**

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)  
**Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space:** \_\_\_\_\_