Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

Please provide the following information:

1. Is the patient under 2 years of age? ☐ Yes ☐ No
2. Will Acthar gel be used as a monotherapy? ☐ Yes ☐ No
3. What is the patient's diagnosis?
   - ☐Infantile spasm (West Syndrome)
   - ☐Acute exacerbations of MS in adult patients
   - ☐Nephrotic syndrome, without uremia of the idiopathic type (idiopathic membranous nephropathy) or that due to lupus erythematosus
   - ☐Ophthalmic conditions such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation
   - ☐Psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, and ankylosing spondylitis
   - ☐Sarcoidosis (symptomatic)
   - ☐Serum sickness
   - ☐Severe dermatologic conditions such as severe erythema multiforme, Stevens- Johnson syndrome, systemic dermatomyositis, and polymyositis
   - ☐Systemic lupus erythematosus (SLE), exacerbation
   - ☐Other, please indicate _____
4. If diagnosis is infantile spasm (West Syndrome), was it established by or in conjunction with a Pediatric neurologist or epilepsy specialist? ☐ Yes ☐ No
5. If renewing for infantile spasm use
   a. Is the patient having spasms? ☐ Yes ☐ No
   b. Does the patent have hypsarrhythmia on EEG? ☐ Yes ☐ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date