

Acthar Support & Access Program (A.S.A.P.)
Phone: 1-888-435-2284 Fax: 1-877-937-2284

Please submit this referral form and outpatient prescription to initiate Acthar therapy. The Acthar Support & Access Program is available Monday – Friday from 8:00 am – 8:00 pm Eastern Time

Last Name		First Name		Today's Date		Date Needed	
Caregiver Name		Relationship		Cell Phone ()		MD Full Name	
Home Phone Number ()		Work Phone Number ()		Hospital/Clinic		Medicaid / Medicare Provider #	
Home Address		City		State		Zip	
Shipping Address (if different from home address)		<input type="checkbox"/> Physician <input type="checkbox"/> Home <input type="checkbox"/> Other		Primary Office Contact		Contact's Direct Phone Number: ()	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth		Back-Up Office Contact		Contact's Direct Phone Number: ()	
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish		<input type="checkbox"/> Other		Physician Specialty: <input type="checkbox"/> Neurology <input type="checkbox"/> Nephrology <input type="checkbox"/> Other:			
Allergies		Patient Weight		Office Main Phone Number ()		Office Fax Number: ()	

Special Instructions:

INSURANCE INFORMATION
(Fill out entirely or fax a copy of patient's insurance card, both sides)
 Uninsured

Primary Insurance: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

Secondary Insurance: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

Statement of Medical Necessity / Prior Authorization Info*

Primary Diagnosis: Infantile Spasms Multiple Sclerosis
 Nephrotic Syndrome Other (Specify) _____
ICD-9 Code (if known): _____
Has Patient Started Treatment? Yes No If yes, date started: _____
If applicable, other treatments tried and failed: _____

Medical History: _____
** Please be prepared to fax applicable chart notes, treatment history, Letter of Medical Necessity, etc if requested for supporting documentation for insurance Prior Authorization. Fax items to ASAP at 1-877-937-2284*

PRESCRIPTION FORM
(Please PRINT clearly and SIGN below.)

ACTHAR GEL 80 UNITS/ML 5ML MULTI DOSE VIAL

Sig: _____

Route of Administration: IM SC
Qty: _____ Refills x: _____

Supplies:
 1 cc syringe Quantity: _____
 3 cc syringe Quantity: _____
 23 g needle 1 inch Quantity: _____
 25 g needle 1 inch Quantity: _____
 25 g needle 5/8 inch Quantity: _____
 Other: _____

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS

Physicians Signature: _____ NPI#: _____ UPIN/DEA #: _____ State License#: _____