

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		Tax ID#	
Home Address		City		State		Zip	
Shipping Address (if different from home address)		<input type="checkbox"/> Physician <input type="checkbox"/> Home <input type="checkbox"/> Other		Phone Number ( )		Fax Number ( )	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth		Office Contact:			
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				Communication Preference: <input type="checkbox"/> Fax <input type="checkbox"/> Phone Physician Specialty: <input type="checkbox"/> Neurology <input type="checkbox"/> Other:			
Allergies		Patient Weight		Special Instructions:			

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

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

Uninsured

**Statement of Medical Necessity**

Primary Diagnosis: \_\_\_\_\_  
 ICD9 Code (if known): \_\_\_\_\_  
 Has Patient Started Treatment?  Yes  No  
 If yes, date of first treatment? \_\_\_\_\_  
 Other current treatments: \_\_\_\_\_  
 Medical History: \_\_\_\_\_

**TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:**

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