

Generic Name: Repository corticotropin injection gel

Therapeutic Class or Brand Name: H.P. Acthar

Applicable Drugs (if Therapeutic Class): N/A

Preferred: N/A

Non-preferred: N/A

Date of Origin: 1/2/2019

Date Last Reviewed / Revised: 12/22/2022

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I or II is met)

- I. Documented diagnosis of infantile spasms (West Syndrome) and all of criteria A through D are met:
 - A. Confirmation of diagnosis by an electroencephalogram (EEG).
 - B. Documented body surface area (BSA), dosing schedule, and dose and quantity are appropriate for patient's treatment regimen including tapering schedule.
 - C. Treatment must be prescribed by or in consultation with a pediatric neurologist or an epilepsy physician specialist.
 - D. Patient must be under 2 years of age.
- II. Documented diagnosis of multiple sclerosis with evidence of acute exacerbation and all of criteria A through D are met:
 - A. Documentation of concurrent multiple sclerosis agents
 - B. Documented failure, intolerance, or contraindication to 1 month trial of oral and 7 days trial of parenteral glucocorticoid therapy
 - C. Patient is at least 18 years of age or older
 - D. Treatment must be prescribed by or in consultation with a neurologist

EXCLUSION CRITERIA

- The plan does not cover HP Acthar for the treatment of rheumatic disorders, collagen diseases, dermatologic disease, serum sickness, ophthalmic disease, symptomatic sarcoidosis, or edematous state. Although it is approved for these indications, available data to support use in this conditions are limited and use has been replaced by other agents.
- Patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, or sensitivity to proteins of porcine origin.
- Concurrent administration of live or live attenuated vaccines.
- Congenital infections.

- Primary adrenocortical insufficiency or adrenocortical hyperfunction.

OTHER CRITERIA

- Repository corticotropin is not considered medically necessary for conditions including but not limited to: multiple sclerosis, rheumatic disorders, dermatologic diseases, nephrotic syndrome, ophthalmic diseases, respiratory diseases, serum sickness, or collagen diseases.

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Infantile spasms (West Syndrome): Up to the quantity and duration required for patient's documented dosing regimen and tapering schedule.
- Exacerbation of multiple sclerosis: 80 to 120 units IM or SUBQ daily for 2 to 3 weeks for acute exacerbations

APPROVAL LENGTH

- **Authorization:** One time for a single treatment duration.
- **Re-Authorization:** One time for a single treatment duration
 - Initial approval criteria are met
 - An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and the medication was effective during previous exacerbation.
 - It is not used as "Pulse Therapy" on a Monthly Basis.

APPENDIX

N/A

REFERENCES

1. Wilmshurst JM, Gaillard WD, Vinayan KP, et al. Summary of recommendations for the management of infantile seizures: Task Force Report for the ILAE Commission of Pediatrics. *Epilepsia*. 2015;56(8):1185-1197. Accessed December 22, 2022. doi:10.1111/epi.13057
2. Go CY, Mackay MT, Weiss SK, et al. Evidence-based guideline update: medical treatment of infantile spasms. Report of the Guideline Development Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society. *Neurology*. 2012;78(24):1974-1980. Accessed December 22, 2022. doi:10.1212/WNL.0b013e318259e2cf
3. Thompson AJ, Kennard C, Swash M, et al. Relative efficacy of intravenous methylprednisolone and ACTH in the treatment of acute relapse in MS. *Neurology*. 1989;39(7):969-971. Accessed December 22, 2022. doi:10.1212/wnl.39.7.969

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4. H.P. Acthar.· Package Insert. Mallinckrodt. October 2021. Accessed December 22, 2022.
<https://www.acthar.com/pdf/Acthar-PI.pdf>.

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.