



## Acthar Gel Prior Authorization

<b>Drug(s) Applied:</b>	<b>Acthar gel (repository corticotropin)</b>
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### Criteria:

Drug(s) Applied will be approved when the requested medication is being used for an FDA approved indication and all of the following criteria are met:

#### I. Initial Therapy Criteria

##### A. **Infantile spasms** as indicated by chart notes within past 90 days

1. Patient is less than 24 months of age **and**
2. Chart notes and/or prescriber do not provide documentation of any FDA labeled contraindications to the requested drug, or prescriber has documented that the benefits outweigh the risk despite having a contraindication. Contraindications include but are not limited to:
  - a) Suspected congenital infections
  - b) Systemic fungal infections
  - c) Recent surgery **and**
3. Patient has tried and had an inadequate response or intolerance to glucocorticoids (e.g. prednisolone) or has a contraindication to glucocorticoids

**Approval Duration:** 2 months

##### B. **All other indications**

1. Not considered medically necessary

**Approval Duration:** n/a

The effectiveness of repository corticotropin has not been demonstrated as clinically superior to conventional corticosteroids and/or immunosuppressive therapy for uses other than infantile spasms.

**Policy Owned by:** Curative PBM team