curative

# Acthar Gel Prior Authorization Drug List A

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|---|---|
| **Drug(s) Applied:** | **Acthar gel** (repository corticotropin) |

**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