blue of california

corticotropin (ACTHAR, CORTROPHIN)

Diagnoses Considered for Coverage:

- Infantile spasms (West Syndrome)
- Acute exacerbation of Multiple Sclerosis (MS)
- Nephrotic Syndrome (idiopathic or lupus erythematosus associated)
- Other FDA approved indications

Coverage Criteria

1. **For diagnosis of infantile spasms, approve if:**

Initial Authorization
• Home self-injectables are under the pharmacy benefit, **and** • Diagnosed by a pediatric neurologist or neonatologist, **and** • Infant is less than 2 years of age, **and** • Dose does not exceed 150 units/m^2/day for 2 weeks, followed by a 2-week taper. ***Coverage Duration:*** One time
Reauthorization
• Home self-injectables are under the pharmacy benefit, **and** • Confirmed continued diagnosis (by EEG) of infantile spasm, **and** • Infant is less than 2 years of age, **and** • Dose does not exceed 150 units/m^2/day for 2 weeks, followed by a 2-week taper. ***Coverage Duration:*** One time

2. **For diagnosis of acute exacerbation of Multiple Sclerosis (MS), approve if:**

• Home self-injectables are under the Pharmacy Benefit, **and** • Dose does not exceed 120 units/day for 3 weeks maximum per exacerbation episode, **and** • Prescribed by a neurologist or MS specialist, **and** • Patient is currently receiving maintenance treatment for MS (e.g., Avonex, Betaseron, Copaxone, Gilenya, Rebif, Novantrone, Tysabri, etc.), **and** • Intolerable side effect or contraindication to systemic corticosteroids that is not also expected with the use of Acthar/Cortrophin. ***Coverage Duration:*** 3 weeks

3. **For idiopathic or systemic lupus erythematosus (SLE) associated nephrotic syndrome, approve if:**

Initial Authorization
• Home self-injectables are under the pharmacy benefit, **and** • Dose does not exceed 80 units per day, **and** • Being prescribed by a nephrologist, **and** • Inadequate response to all standard therapies other than systemic corticosteroids (e.g. cyclophosphamide, cyclosporine, mycophenolate), **and** • Intolerable side effect or contraindication to systemic corticosteroids that is not also expected with the use of Acthar/Cortrophin, **and** • Patient does not have corticosteroid-resistant disease (i.e., patient failed to response to corticosteroid therapy). ***Coverage Duration:*** 1 month
Reauthorization
• Home self-injectables are under the pharmacy benefit, **and** • Being prescribed by a nephrologist, **and** • Patient is responding to therapy, **and** • Dose does not exceed 80 units per day. ***Coverage Duration:*** Based on documented response to therapy

4. **For other FDA approved indications for inflammatory conditions, approve if:**

Initial Authorization
• Home self-injectables are under the pharmacy benefit, **and** • Being prescribed by a specialist for the given condition, **and** • Inadequate response to all standard therapies other than systemic corticosteroids, **and** • Intolerable side effect or contraindication to systemic corticosteroids that is not also expected with the use of Acthar/Cortrophin, **and** • Dose does not exceed 80 units per day. ***Coverage Duration:*** 1 month
Reauthorization
• Home self-injectables are under the Pharmacy Benefit, **and** • Being prescribed by a specialist for the given condition, **and**

- Patient is responding to therapy, **and**
- Dose does not exceed 80 units per day.

Coverage Duration: Based on documented response to therapy

Coverage Duration: *see specific coverage criteria*

Effective Date: 09/27/2023