Prior Authorization Conditions for Approval of Corticotropin, ACTH (Acthar H.P.®)
Website Form – www.highmarkhealthoptions.com
Submit request via Fax: 855-476-4158

All requests for Corticotropin, ACTH (Acthar H.P.) require prior authorization and will be screened for appropriateness using the criteria listed below.

**Corticotropin, ACTH (Acthar H.P.®):**
- Documentation of current height (cm) and weight (kg) are required
- **Coverage is provided for infantile spasms (West Syndrome) when:**
  - Patient is less than 24 months of age AND
  - Prescribed by a neurologist AND
  - Medication is used as monotherapy AND
  - Diagnosis is supported by documentation of epileptic spasms, arrest of psychomotor development, and EEG pattern of hypsarrhythmia (Hypsarrhythmia, which does not typically occur with other forms of epilepsy, can help to confirm a diagnosis of infantile spasms) AND
  - Dosing not exceeding more than 75 units/m2 intramuscularly twice daily for 14 days then tapered off (30 units/m2 intramuscularly in the morning x 3 days, 15 units/m2 intramuscularly in the morning x 3 days, 10 units/m2 intramuscularly every morning x 3 days, then 10 units/m2 intramuscularly every other morning x 6 days) will be approved for 2 cycles (2 months) before needing reauthorization AND
  - For reauthorization:
    - Dosing is not to exceed recommended dosing from above AND
    - Requires documentation showing the patient’s EEG having continued hypsarrhythmia after 2 weeks of treatment or the patient must continue to be experiencing spasms.
- **Coverage is provided for acute exacerbations of multiple sclerosis when:**
  - Patient is 18 years of age or older AND
  - Prescribed by a neurologist AND
  - There is documentation or claims verifying the patient is on a medication for the treatment of multiple sclerosis. If not on a disease modifying therapy, refer to care management.
  - Patient has tried and failed oral methylprednisone 0.5g daily for 5 days or intravenous methylprednisolone 1g/day for 3 to 5 days within the last 45 days or has a contraindication to corticosteroid therapy. AND
  - Dosing not exceeding 80-120 units intramuscularly or subcutaneously daily for 2-3 weeks will be approved up to a 3 week authorization.

- **Coverage is not provided for any of the following conditions based on the limited therapeutic value for Corticotropin in conditions that are responsive to corticosteroid therapy (corticosteroids are first line therapy) and/or antihistamines in allergic disorders:**
  - **Eye disorders:** allergic conjunctivitis, anterior segment inflammation, choroiditis, chorioretinitis, corneal ulcers, herpes zoster opthalmicus, iritis, iridocyclitis, keratitis, optic neuritis, sympathetic ophthalmia, and uveitis
  - **Inflammatory disorders:** nephrotic syndrome, regional enteritis, ulcerative colitis, sarcoidosis
  - **Rheumatologic/Inflammatory disorders:** ankylosing spondylitis, dermatomyositis, juvenile rheumatoid arthritis, psoriatic rheumatoid arthritis, systemic lupus erythematosus, polymyositis
  - **Skin/hypersensitivity disorder:** atopic dermatitis, bullous dermatitis herpetiformis, contact dermatitis, erythema multiforme, exfoliative dermatitis, psoriasis, seborrheic dermatitis, Stevens-Johnson syndrome
  - Transfusion reaction due to serum protein reaction (serum sickness)
• **All of the following are exclusions for coverage:**
  - Systemic fungal infection.
  - Uncontrolled hypertension or congestive heart failure
  - Osteoporosis
  - Scleroderma
  - Ocular Herpes Simplex
  - Recent surgery
  - History or presence of peptic ulcer
  - Sensitivity to proteins of porcine origin
  - Administration of live or live attenuated vaccines
  - Less than 2 years of age with suspected congenital infections
  - Primary adrenocortical insufficiency or adrenocortical hyperfunction

**References:**

1. H.P. Acthar Gel (repository corticotropin injection) [prescribing information]. Hazelwood, MO: Mallinckrodt; January 2015.
Acthar H.P. (corticotropin)

PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Health Options Pharmacy Services.

FAX: 1-855-476-4158

If needed, you may call to speak to a Pharmacy Services Representative.

PHONE: 1-844-325-6251

PROVIDER INFORMATION

Requesting Physician: ____________________________
NPI: ____________________________
Physician Specialty: ____________________________
Office Contact: ____________________________
Office Address: ____________________________
Office Phone: ____________________________
Office Fax: ____________________________

MEMBER INFORMATION

Patient Name: ____________________________
Health Options ID: ____________________________
DOB: ____________________________
Height: ____________________________
Weight: ____________________________

DRUG INFORMATION

Medication: ____________________________
Strength: ____________________________
Frequency: ____________________________
Duration: ____________________________

MEDICAL HISTORY

Diagnosis:

□ Infantile Spasms (West Syndrome)
  • Does the patient have epileptic spasms? Yes □ No □
  • Is treatment being used as monotherapy? Yes □ No □
  • Has an EEG pattern shown hypsarrhythmia? Yes □ No □
  • Is there an arrest of psychomotor development? Yes □ No □

□ Multiple Sclerosis, acute exacerbation
  • Has the patient tried and failed or have a contraindication to corticosteroids? Yes □ No □

□ Other: ________________________________________

Does the patient have any of the following conditions?

□ Systemic fungal infection □ Ocular Herpes Simplex □ History or presence of peptic ulcer
□ Uncontrolled hypertension □ Osteoporosis □ Scleroderma
□ Congestive heart failure □ Primary adrenocortical insufficiency or hyperfunction

Is the prescribing physician a neurologist? Yes □ No □

Will the patient be administered via intravenous route? Yes □ No □

Has the patient been administered or will be administered live or live attenuated vaccines?

Yes, Provide vaccine and date: ____________________________ □ No

If the patient is less than 2 years old, are they suspected to have any congenital infections?

Yes, Provide suspected congenital infection: ____________________________ □ No

Has the patient had surgery recently? Yes, Provide date: ____________________________ □ No

Does the patient have a sensitivity of porcine origin? Yes □ No □

PREVIOUS THERAPY

Drug Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why or Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature ____________________________
Date ____________________________

Revised 2/16/2017