Updated: 03/2024
DMMA Approved: 04/2024

Request for Prior Authorization for Corticotropin (H.P. Acthar, Purified Cortrophin Gel)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Corticotropin (H.P. Acthar, Purified Cortrophin Gel) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Corticotropin (H.P. Acthar, Purified Cortrophin Gel) Prior Authorization Criteria:

For all requests for Corticotropin (H.P. Acthar, Purified Cortrophin Gel) all of the following criteria must be met:

- Documentation of current height (cm) and weight (kg) are required.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines. If a requested dose is above these recommendations, medical rationale must be submitted.
- For infused products, must provide member's weight, dose, frequency and titration schedule.
- For H.P. Acthar Gel requests excluding diagnosis of infantile spasms, member must use Purified Cortrophin Gel, unless contraindicated or clinically significant adverse effects are experienced.

Coverage may be provided with a diagnosis of infantile spasms (West Syndrome) and the following criteria is met (H.P. Acthar ONLY):

- Member is less than 24 months of age
- Prescribed by a neurologist
- Medication is used as monotherapy
- 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)
- **Initial Duration of Approval:** 1 month
- **Reauthorization criteria**
  - Dosing does not exceed FDA labeled dosing
  - Requires documentation showing the member's EEG with continued hypsarrhythmia after 2 weeks of treatment **OR** the member is continuing to experience spasms.
- **Reauthorization Duration of Approval:** 1 month

Coverage may be provided with a diagnosis of acute exacerbation of multiple sclerosis and the following criteria is met:

- Member is 18 years of age or older
- Must be prescribed by a neurologist or physician that specializes in the treatment of multiple sclerosis
- Member has tried and failed oral methylprednisone 0.5g daily for 5 days and intravenous methylprednisolone 1g/day for 3 to 5 days within the last 45 days or has a contraindication to corticosteroid therapy
- There is documentation or claims verifying the member is on a medication for the treatment of multiple sclerosis. If not on a disease modifying therapy, refer to care management

- **Initial Duration of Approval:** 3 weeks
- **Reauthorization criteria**
  - Dosing does not exceed FDA labeled dosing
  - Documentation of disease response with treatment as indicated by resolution of symptoms
  - Absence of unacceptable toxicity from the drug (e.g. GI bleeding, gastric ulcer, hypertension, hypokalemia, severe depression, frank psychotic manifestations, posterior subcapsular cataracts, glaucoma)
- **Reauthorization Duration of Approval:** 3 weeks

Coverage is not provided for any of the following conditions based on the limited therapeutic value for Corticotropin:

- Rheumatic Disorders: Psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, ankylosing spondylitis
- Collagen Diseases: Systemic lupus erythematosus, systemic dermatomyositis (polymyositis)
- Dermatologic Diseases: Severe erythema multiforme, Stevens-Johnson syndrome
- Allergic States: Serum sickness
- Ophthalmic Diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation
- Respiratory Diseases: Symptomatic sarcoidosis
- Edematous State: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ **Infantile Spasms (West Syndrome)- Acthar ONLY**
- 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 (MS), acute exacerbation**
- Has the patient tried and failed or have a contraindication to corticosteroids? ☐ Yes ☐ No

☐ **Other:** _____

Is the prescribing physician a neurologist or MS Specialist? ☐ Yes ☐ No, provide specialty_____
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

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
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MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: _____pounds or _____kg

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe or provide documentation:_____
_____
_____

If used for Infantile Spasms (West Syndrome):
Is the member still experiencing spasms? ☐ Yes ☐ No
Does the member have continued hypsarrhythmia after 2 weeks of treatment? ☐ Yes ☐ No
If yes, please provide the member's EEG report.

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date