



Updated: 04/2019  
DMMA Approved: 04/2019

**Request for Prior Authorization for H.P. Acthar Gel (Corticotropin)**

**Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)**

**Submit request via: Fax - 1-855-476-4158**

All requests for H.P. Acthar Gel (Corticotropin) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

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

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

- Documentation of current height (cm) and weight (kg) are required
- Must be administered by intramuscular (IM) or subcutaneous (SQ) injection
- Cannot be administered in infants with suspected congenital infections or to members with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction or sensitivity to proteins of porcine origin
- Cannot be administered with live or live attenuated vaccines

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

- 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 (Hypsarrythmia, which does not typically occur with other forms of epilepsy, can help to confirm a diagnosis of infantile spasms)
- Dosing does not exceed more than 75 units/m<sup>2</sup> intramuscularly twice daily for 14 days then tapered off (30 units/m<sup>2</sup> intramuscularly in the morning x 3 days, 15 units/m<sup>2</sup> intramuscularly in the morning x 3 days, 10 units/m<sup>2</sup> intramuscularly every morning x 3 days, then 10 units/m<sup>2</sup> intramuscularly every other morning x 6 days)
- **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
- Dosing is consistent with the FDA labeling and does not exceed 80-120 units intramuscularly or subcutaneously daily for 2-3 weeks.
- **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.

**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 Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158  
If needed, you may call to speak to a Pharmacy Services Representative.  
**PHONE:** (844) 325-6253 Monday through Friday 8:30am to 5:00pm

**PROVIDER INFORMATION**

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

**MEMBER INFORMATION**

Member Name:	DOB:
Health Options ID:	Member weight: _____ pounds or _____ kg

**REQUESTED DRUG INFORMATION**

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)**

- 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:** \_\_\_\_\_

**Does the patient have any of the following conditions?**

<input type="checkbox"/> Systemic fungal infection	<input type="checkbox"/> Ocular Herpes Simplex	<input type="checkbox"/> History or presence of peptic ulcer
<input type="checkbox"/> Uncontrolled hypertension	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Primary adrenocortical insufficiency or hyperfunction	

**Is the prescribing physician a neurologist or MS Specialist?**  Yes  No, provide specialty \_\_\_\_\_

**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

**Acthar H.P. (corticotropin)**  
**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:
Health Options ID:	Member weight: _____ pounds or _____ kg

**CURRENT or PREVIOUS THERAPY**

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

**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