

Repository Corticotropin Injection (H.P. Acthar Gel, Purified Cortrophin Gel)

Override(s)	Approval Duration
Prior Authorization	3 months

Medications
H.P. Acthar Gel (repository corticotropin injection)
Purified Cortrophin Gel (repository corticotropin injection)

APPROVAL CRITERIA

Requests for repository corticotropin injection (H.P. Acthar Gel or Purified Cortrophin Gel) may be approved if the following criterion is met:

- I. Individual is an infant or child less than 2 years of age and is using as monotherapy for the treatment of infantile spasms (West syndrome).

Repository corticotropin injection (H.P. Acthar Gel, Purified Cortrophin Gel) may not be approved when the above criteria are not met and for all other indications.

Key References:

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18. Thompson AJ, Kennard C, Swash M, et al. Relative efficacy of intravenous methylprednisolone and ACTH in the treatment of acute relapse in MS. *Neurology*. 1989; 39(7):969-971.
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Federal and state laws or requirements, contract language, and Plan utilization management programs or policies may take precedence over the application of this clinical criteria.

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