

Medical Policy:
Acthar Gel



Last review date: 6/17/2024

Applicable Products:
Acthar Gel (repository corticotropin injection) corticotropin injection

Initial Approval Criteria:

Coverage may be approved if all of the following are met:

- Must be prescribed by a pediatric neurologist; **AND**
- Must have a diagnosis of infantile spasms confirmed by EEG; **AND**
- Must be under the age of 2 years; **AND**
- Must have no evidence of infection; **AND**
- If applicable: Trial and failure, intolerance, or a contraindication to the preferred products as listed in the medical drug list

Renewal Criteria:

Coverage may be renewed if all of the following are met:

- Patient continues to meet Initial Approval Criteria; **AND**
- Absence of unacceptable toxicity

Length of Authorization:

1 month

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical or other circumstances may warrant individual consideration, based on review of applicable medical records, as well as other regulatory, contractual and/or legal requirements.

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.