Effective Date:9/01/2018
Reviewed: 4/2019, 1/2020, 3/2021, 6/2022, 4/2023, 11/2023, 5/2024, 4/2025 Scope: Medicaid

Corticotropin-ACTH:
Acthar Gel (repository corticotropin injection), Cortrophin Gel (repository corticotropin injection)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 1 month may be granted when all the following criteria are met:

A. Patient is less than 24 months old and has a diagnosis of infantile spasms (West Syndrome);
B. Must be used as monotherapy;
C. Documentation that patient does not have a suspected congenital infection;
D. If the request is for Acthar Gel, the patient must have a documented contraindication, inadequate response or intolerance to Cortrophin Gel;
E. Dose does not exceed 75 units/m^2 intramuscularly given twice daily for 2 weeks, then taper the dose over a 2-week period (e.g., 30 units/m^2 in the morning for 3 days; 15 units/m^2 in the morning for 3 days; 10 units/m^2 in the morning for 3 days; and 10 units/m^2 every other morning for 6 days).

II. COVERAGE DURATION

1 month

III. REFERENCES:

1. H.P. Acthar Gel [package insert]. Hazelwood, MO; Mallinckrodt Pharmaceuticals Inc; December 2024. Accessed April 2025.
2. Purified Cortrophin Gel [package insert].Baudette, MN; ANI Pharmaceuticals, Inc.; March 2025. Accessed April 2025.

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