BlueCross BlueShield Federal Employee Program

ACTHAR GEL
(corticotropin (ACTH))

Pre - PA Allowance

None

Prior-Approval Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Infantile spasms (in children < 2 years of age)
    a. Prescribed by a neurologist
    b. **NO** dual therapy with Cortrophin Gel (corticotropin)

2. Exacerbations of multiple sclerosis (in adults ≥18 years of age)
    a. Prescribed by a neurologist
    b. Used in combination with a maintenance MS therapy
    c. Submission of medical records (e.g., chart notes, laboratory values) documenting **ONE** of the following:
        i. FDA labeled contraindication to oral or parenteral glucocorticoid therapy
        ii. An inadequate response or intolerance to a 1 month trial of oral or a 1 week trial of parenteral glucocorticoid therapy
    d. **NO** dual therapy with Cortrophin Gel (corticotropin)
    e. Patient **MUST** have tried the preferred product (Cortrophin Gel) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

3. Nephrotic syndrome
    a. Prescribed by a nephrologist
    b. Submission of medical records (e.g., chart notes, laboratory values) documenting an inadequate response or intolerance to a 1 month trial of **ONE** of the following:
        i. Oral glucocorticoid therapy
        ii. Immunosuppressant such as:
            1. Cyclophosphamide
            2. Cyclosporine
            3. Tacrolimus
            4. Mycophenolate mofetil

c. Submission of medical records (e.g., chart notes, laboratory values) documenting baseline levels of protein in urine indicative of proteinuria and low levels of albumin in blood indicative of hypoalbuminemia
d. **NO** dual therapy with Cortrophin Gel (corticotropin)
e. Patient **MUST** have tried the preferred product (Cortrophin Gel) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage

Prior - Approval Limits

Duration

Infantile spasms	1 month
Exacerbations of multiple sclerosis	1 month
Nephrotic syndrome	6 months

Prior – Approval *Renewal* Requirements

Diagnoses

Patient must have **ONE** of the following:

1. Infantile spasms (in children < 2 years of age)
    a. Prescribed by a neurologist
    b. **NO** dual therapy with Cortrophin Gel (corticotropin)

2. Exacerbations of multiple sclerosis (in adults ≥18 years of age)
    a. Prescribed by a neurologist
    b. Used in combination with a maintenance MS therapy
    c. Submission of medical records (e.g., chart notes, laboratory values) documenting 30 day lapse since previous exacerbation
    d. **NO** dual therapy with Cortrophin Gel (corticotropin)
    e. Patient **MUST** have tried the preferred product (Cortrophin Gel) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

3. Nephrotic syndrome

a. Prescribed by a nephrologist
b. Submission of medical records (e.g., chart notes, laboratory values) documenting a decrease in urine protein level and increase serum albumin level
c. **NO** dual therapy with Cortrophin Gel (corticotropin)
d. Patient **MUST** have tried the preferred product (Cortrophin Gel) unless the patient has a valid medical exception (e.g., inadequate treatment response, intolerance, contraindication)

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Prior – Approval *Renewal* Limits

Same as above