A Public Entity
Inland Empire Health Plan

Drug Prior Authorization Criteria
H.P. Acthar Gel

Line of Business: Medicaid
P & T Approval Date: February 20, 2019 **Effective Date:** April 1, 2019

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutics Subcommittee.

Drugs Requiring Prior Authorization Review: H.P. Acthar Gel (repository corticotropin injection)

Formulary Alternative: None

CRITERIA:

H.P. ACTHAR GEL (REPOSITORY CORTICOTROPIN INJECTION)

Covered Uses:	*Infantile Spasms (West Syndrome) (*Subject to review by Clinical Pharmacist)
Exclusion Criteria:	N/A
Required Medical Information:	Must meet the following requirement: a. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.
Age Restriction:	Must be less than 24 months old
Prescriber Restrictions:	Neurologist or Pediatrician
Other Criteria:	N/A

Covered Uses:	*Multiple Sclerosis with acute exacerbation (*Subject to review by Clinical Pharmacist)
Exclusion Criteria:	N/A
Required Medical Information:	Must meet all of the following requirements: a. Failure or clinically significant adverse effects to corticosteroid therapy (i.e. prednisone, intravenous methylprednisolone, etc.). b. Documentation of concurrent multiple sclerosis agents (i.e. **Avonex**, **Betaseron**, **Glatiramer**, etc.). c. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.
Age Restriction:	N/A
Prescriber Restrictions:	Neurologist
Other Criteria:	N/A

Change Control		
Date	**Change**	**RPH**
02/20/2019	• Changed Format	ND
06/29/2018	• Changed Format	IK
02/21/2018	• Renewed with no new updates/changes.	CT