Policy Title:	**Corticotropin-ACTH :** **Acthar Gel (repository corticotropin injection), Cortrophin Gel (repository corticotropin injection)**		
		Department:	PHA
Effective Date:	01/01/2020		
Review Date:	9/18/2019, 12/18/19, 1/22/20, 3/4/2021, 6/16/2022, 4/13/2023, 09/21/2023, 01/10/2024		

Purpose: To support safe, effective, and appropriate use of repository corticotropin injection.

Scope: Medicaid and Commercial

(Effective 10/01/2023: NOT COVERED for Part B Medical Benefit for Medicare-Medicaid Plan (MMP) members)

Policy Statement:

Repository corticotropin injection is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:

Coverage of Repository corticotropin injection will be reviewed prospectively via the prior authorization process based on criteria below.

Summary of Evidence:

Acthar (repository corticotropin injection) is indicated for the treatment of infantile spasms in children under the age of 2, multiple sclerosis (MS) exacerbations in adults, and used in the treatment of various other conditions. Acthar carries several warnings including increased risk for infections, adrenal insufficiency, hypertension, gastrointestinal perforation, masking of symptoms of other underlying disorders, Cushing's syndrome, mood disorders, worsening of comorbid diseases, ophthalmic effects, negative effects on growth and physical development, and decrease in bone density. The most common adverse events reported with Acthar include injection site reaction, asthenic conditions, fluid retention, insomnia, headache, and blood glucose elevation. Common adverse reactions for the treatment of infantile spasms are increased risk of infections, convulsions, hypertension, irritability, and pyrexia. The effectiveness of Acthar Gel for the treatment of infantile spasms was demonstrated in a single-blinded clinical trial in which patients were randomized to receive either a 2-week course of treatment with Acthar Gel twice daily or prednisone 1mg/kg twice daily. The primary outcome was a comparison of the number of patients in each group who were treatment responders, defined as a patient having complete suppression of both clinical spasms and hypsarrhythmias on a full sleep cycle video EEG performed 2 weeks following treatment initiation. The results demonstrated 86.7% (N = 13) participants responded to Acthar Gel as compared to 26.8% (N = 4) given prednisone ($p < 0.002$) after 2 weeks following treatment initiation.

Initial Criteria:

Infantile Spasms (Acthar † Φ; Cortrophin ‡)*:*

- Clinical documentation indicating patient has a diagnosis of Infantile Spasms (West Syndrome); AND
- Patient is less than 24 months old; AND
- Must be used as monotherapy; AND
- Documentation that patient does not have a suspected congenital infection; AND
- If the request is for Acthar Gel, the patient must have a documented contraindication, inadequate response or intolerance to Cortrophin Gel; AND
- 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)

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

Dosing:

Indication	Maximum units (1 billable unit = 40 units)
Infantile Spasms	35 billable units every 28 days

Coverage durations:

- Initial coverage: 1 month

Per §§ 42 CFR 422.101, this clinical medical policy only applies to INTEGRITY in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD)

Policy Rationale:
Acthar Gel and Cortrophin Gel were reviewed by the Neighborhood Health Plan of Rhode Island Pharmacy & Therapeutics (P&T) Committee. Neighborhood adopted the following clinical coverage criteria to ensure that its members use Acthar Gel and Cortrophin Gel according to Food and Drug Administration (FDA) approved labeling and/or relevant clinical literature. Neighborhood worked with network prescribers and pharmacists to draft these criteria. These criteria will help ensure its members are using this drug for a medically accepted indication, while minimizing the risk for adverse effects and ensuring more cost-effective options are used first, if applicable and appropriate. For INTEGRITY (Medicare-Medicaid Plan) members, these coverage criteria will only apply in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Neighborhood will give individual consideration to each request it reviews based on the information submitted by the prescriber and other information available to the plan.

Investigational use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

Applicable Codes:
Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.

The following HCPCS/CPT code is:

HCPCS/CPT Code	Description
J0801	Injection, corticotropin (acthar gel), up to 40 units
J0802	Injection, corticotropin(ani), up to 40 units

References:

1. Acthar Gel [package insert]. Hazelwood, MO; Mallinckrodt Pharmaceuticals Inc; March 2023. Accessed September 2023.
2. Purified Cortrophin Gel [package insert].Baudette, MN; ANI Pharmaceuticals, Inc.; June 2023. Accessed September 2023.
3. Go, C.Y., Mackay, M.T., Weiss, S.K. et al. Evidence-based guideline update: Medical treatment of infantile spasms: Report of the Guideline Development Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society. Neurology 2012;78;1974-1980.
4. Hussain SA, Shinnar S, Kwong G, et al. Treatment of infantile spasms with very high dose prednisolone before high dose adrenocorticotropic hormone. Epilepsia. 2014 Jan;55(1):103- 7. doi: 10.1111/epi.12460. Epub 2013 Nov 8.
5. Hrachovy RA, Frost JD, Glaze DG et al. High-dose, long-duration versus low-dose, short duration corticotropin therapy for infantile spasms. J Pediatr 1994;124:803-806.

6. Kivity S, Lerman P, Ariel R, et al. Long-term cognitive outcomes of a cohort of children with cryptogenic infantile spasms treated with high-dose adrenocorticotropic hormone. Epilepsia. 2004 Mar;45(3):255-62.
7. Pellock JM, Hrachovy R, Shinnar S, et al. Infantile spasms: a U.S. consensus report. Epilepsia. 2010 Oct;51(10):2175-89.
8. M. T. Mackay, S. K. Weiss, T. Adams-Webber, et al. Practice parameter: medical treatment of infantile spasms: report of the American Academy of Neurology and the Child Neurology Society. Neurology 2004;62;1668-81
9. Lexicomp. Corticotropin (pituitary) (AHFS DI (adult and pediatric)). Accessed October 12, 2021. [Database]. https://online.lexi.com
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13. Knupp KG, Coryell J, Nickels KC, et al. Response to treatment in a prospective national infantile spasms cohort. Ann Neurol. 2016;79(3):475-484.
14. Wilmshurst JM, Gaillard WD, Vinayan KP, et al. Summary of recommendations for the management of infantile seizures: Task Force Report for the ILAE Commission of Pediatrics. Epilepsia. 2015;56(8):1185-1197.