

## Repository Corticotropin Injection

### Goal(s):

- Restrict use to patient populations in which corticotropin has demonstrated safety and effectiveness.

### Length of Authorization:

4 weeks

### Requires PA:

- Repository Corticotropin Injection (H.P. Acthar Gel for Injection)

### Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at [www.orpdl.org](http://www.orpdl.org)
- Searchable site for Oregon FFS Drug Class listed at [www.orpdl.org/drugs/](http://www.orpdl.org/drugs/)

### Approval Criteria

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code	
2. Is the diagnosis monotherapy for infantile spasms in infants and children under 2 years of age?	<b>Yes:</b> Approve up to 4 weeks (2 weeks of treatment and 2-week taper)	<b>No:</b> Go to #3
3. Is the diagnosis for acute exacerbation or relapse of multiple sclerosis?	<b>Yes:</b> Go to #4	<b>No:</b> Pass to RPh. Deny; medical appropriateness
4. Has the patient tried and been unable to tolerate intravenous methylprednisolone or high-dose oral methylprednisolone?	<b>Yes:</b> Approve up to 5 weeks (3 weeks of treatment, followed by 2-week taper).	<b>No:</b> Go to #5

## Approval Criteria

<p>5. Is the prescription for adjunctive therapy for short-term administration in corticosteroid-responsive conditions, including:</p> <ul style="list-style-type: none"> <li>• The following rheumatic disorders: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis or ankylosing spondylitis; <b>OR</b></li> <li>• The following collagen diseases: systemic lupus erythematosus or systemic dermatomyositis; <b>OR</b></li> <li>• Dermatologic diseases such as erythema multiforme or Stevens-Johnson syndrome; <b>OR</b></li> <li>• Ophthalmic diseases such as keratitis, iritis, uveitis, optic neuritis, or chorioretinitis; <b>OR</b></li> <li>• For the treatment of respiratory diseases, including symptomatic sarcoidosis or for treatment of an edematous state?</li> </ul>	<p><b>Yes:</b> Go to #6</p>	<p><b>No:</b> Pass to RPh. Deny; medical appropriateness</p>
<p>6. Is there a contraindication, intolerance, or therapeutic failure with at least one intravenous corticosteroid?</p>	<p><b>Yes:</b> Approve for 6 months.</p>	<p><b>No:</b> Pass to RPh. Deny; medical appropriateness.</p>

P&T Review: 11/16 (DM); 5/13  
 Implementation: 1/1/14