CORTICOTROPIN

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>HICL</th>
<th>GCN</th>
<th>Exception/Other</th>
</tr>
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<tbody>
<tr>
<td>CORTICOTROPIN</td>
<td>ACTHAR HP GEL</td>
<td>02830</td>
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</tbody>
</table>

This PA should only be reviewed by a pharmacist.

GUIDELINES FOR USE

1. Is the product being ordered for diagnostic purposes?
   
   If yes, do not approve.
   
   DENIAL TEXT: See the denial text at the end of the guideline.
   
   If no, continue to #2.

2. Is the patient less than two years old and diagnosed with infantile spasms?
   
   If yes, approve for 28 days by HICL.
   
   If no, continue to #3.

3. Is the patient being treated for acute exacerbation of multiple sclerosis?
   
   If yes, continue to #4.
   
   If no, continue to #5.

4. Has the patient tried or does the patient have a contraindication to IV corticosteroids?
   
   If yes, approve up to 21 days by HICL with a maximum of 35mL in 28 days (each 5mL vial contains 400 units).
   
   If no, do not approve.
   
   DENIAL TEXT: See the denial text at the end of the guideline.

5. Is the patient diagnosed with ONE of the following FDA indications:
   
   • a rheumatic disorder
     o psoriatic arthritis
     o rheumatoid arthritis, including juvenile rheumatoid arthritis
     o ankylosing spondylitis
   
   • a collagen disease
     o systemic lupus erythematosus
     o systemic dermatomyositis (polymyositis)
     o severe erythema multiforme (Stevens-Johnson syndrome)
   
   • an allergic disease
     o serum sickness
   
   • an ophthalmic disease
     o severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa (such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, or anterior segment inflammation)
   
   • a respiratory disease
     o symptomatic sarcoidosis
   
   • an edematous state
     o to induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type
     o due to lupus erythematosus?

DENIAL TEXT: See the denial text at the end of the guideline.
If yes, continue to #6.
If no, do not approve.

DENIAL TEXT:  See the denial text at the end of the guideline.

6. Has the patient tried or have a contraindication to IV corticosteroids?

If yes, approve for 12 months by HICL.
If no, do not approve.

DENIAL TEXT:  See the denial text at the end of the guideline.

DENIAL TEXT:  Our guideline for CORTICOTROPIN requires an FDA diagnosis. Additional guideline requirements apply.

- For the diagnosis of infantile spasms, approval is granted for patients less than 2 years of age.
- For all other FDA indications (except infantile spasm), approval requires a trial of IV corticosteroids. Our guideline does not approve CORTICOTROPIN for diagnostic purposes (please consider cosyntropin (Cortrosyn®)).
- FDA approved indications include infantile spasms, acute multiple sclerosis, psoriatic arthritis, rheumatoid arthritis (including juvenile rheumatoid arthritis), ankylosing spondylitis, systemic lupus erythematosus, systemic dermatomyositis (polymyositis), severe erythema multiforme (Stevens-Johnson syndrome), serum sickness, severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa (such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, or anterior segment inflammation), symptomatic sarcoidosis, to induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type, and due to lupus erythematosus.

REFERENCES


| Commercial | HIEx |
| Medical Benefit | Medical Benefit |