Criteria-Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

Repository Corticotropin (H.P. Acthar Gel)

Notes:

- Use of H.P. Acthar Gel for the treatment of infantile spasms for more than 4 weeks is generally not recommended.
- Kaiser Permanente Northwest has determined that use of H.P. Acthar Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

Initiation (new start) criteria: Non-formulary **repository corticotropin injection (H.P. Acthar Gel)** will be covered for 1 month on the prescription drug benefit when the following criteria are met:

- Prescriber is a neurologist
- Diagnosis of infantile spasms (West Syndrome)
- Patient is less than 2 years of age

Continued use criteria (1 month after initiation): Non-formulary **pository corticotropin injection (H.P. Acthar Gel)** will continue to be covered on the prescription drug benefit for 1 month when the following criteria are met:

- If deemed clinically appropriate by neurologist
- Patient continues to meet initial approval criteria.

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