BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES	
SECTION: DRUGS	
ORIGINAL EFFECTIVE DATE:	**4/01/2019**
LAST REVIEW DATE:	**2/17/2022**
LAST CRITERIA REVISION DATE:	**2/17/2022**
ARCHIVE DATE:	

ACTHAR® GEL (repository corticotropin) injection
PURIFIED CORTROPHIN™ GEL (repository corticotropin) injection

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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ACTHAR® GEL (repository corticotropin) injection
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Criteria:

ACTHAR GEL (repository corticotropin)

- **Criteria for initial therapy:** Acthar Gel (repository corticotropin) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist

  2. A confirmed diagnosis of **ONE** of the following:
     a. Individual under 2 years of age with infantile spasms (West Syndrome)

     b. Individual 18 years of age or older with acute exacerbation of multiple sclerosis (MS) who is adherent with maintenance immune suppressing agent for MS **AND** has a contraindication per FDA label or is intolerant to corticosteroids that are not also expected to occur with use of Acthar Gel **AND** will not be using Acthar Gel on a monthly basis for prophylaxis of acute exacerbations of MS

     c. Individual 18 years of age or older with a corticosteroid responsive condition who has a contraindication per FDA label or is intolerant to corticosteroids that are not also expected to occur with use of Acthar Gel

  3. There are **NO** FDA-label contraindications, such as:
     a. Intravenous administration
     b. Congenital infection suspected in an infant
     c. Administration of live or attenuated vaccines in an individual on immunosuppressive doses of Acthar Gel
     d. Scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, or sensitivity to proteins of porcine origin

  Initial approval duration: 4 weeks
  Requests beyond 4 weeks requires a Medical Director review
  Maximum of 35 mL (7 vials) will be authorized, requests for more vials requires a Medical Director review

- **Criteria for continuation of coverage (renewal request):** Acthar Gel (repository corticotropin) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist

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2. All requests for renewal or continuation will be reviewed using initial criteria and if approved the same duration will apply

3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
    a. Contraindications as listed in the criteria for initial therapy section
    b. Significant adverse effect such as:
        i. Infection
        ii. Adrenal insufficiency
        iii. Cushing's syndrome
        iv. Gastrointestinal perforation and bleeding

Renewal duration: 4 weeks

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

    1. **Off-Label Use of Non-cancer Medications**

    2. **Off-Label Use of Cancer Medications**

PURIFIED CORTROPHIN GEL (repository corticotropin)

- **Criteria for initial therapy:** Purified Cortrophin Gel (repository corticotropin) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

    1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Neurologist

    2. Individual 18 years of age or older

    3. A confirmed diagnosis of **ONE** of the following:
        a. Acute exacerbation of multiple sclerosis (MS) who is adherent with maintenance immune suppressing agent for MS **AND** has a contraindication per FDA label or is intolerant to corticosteroids that are not also expected to occur with use of Purified Cortrophin Gel **AND** will not be using Purified Cortrophin Gel on a monthly basis for prophylaxis of acute exacerbations of multiple sclerosis

        b. Corticosteroid responsive condition who has a contraindication per FDA label or is intolerant to corticosteroids that are not also expected to occur with use of Purified Cortrophin Gel

4. There are **NO** FDA-label contraindications, such as:
    a. Intravenous administration
    b. Congenital infection suspected in an infant
    c. Administration of live or attenuated vaccines in an individual on immunosuppressive doses of Purified Cortrophin Gel
    d. Scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, or sensitivity to proteins of porcine origin

Initial approval duration: 4 weeks
Requests beyond 4 weeks requires a Medical Director review
Maximum of 35 mL (7 vials) will be authorized, requests for more vials requires a Medical Director review

- **Criteria for continuation of coverage (renewal request):** Purified Cortrophin Gel (repository corticotropin) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Neurologist

2. All requests for renewal or continuation will be reviewed using initial criteria and if approved the same duration will apply

3. Individual has been adherent with the medication

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use
    a. Contraindications as listed in the criteria for initial therapy section
    b. Significant adverse effect such as:
        i. Infection
        ii. Adrenal insufficiency
        iii. Cushing's syndrome
        iv. Gastrointestinal perforation and bleeding

Renewal duration: 4 weeks

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-cancer Medications**

2. **Off-Label Use of Cancer Medications**

ACTHAR® GEL (repository corticotropin) injection
PURIFIED CORTROPHIN™ GEL (repository corticotropin) injection

Description:

Repository corticotropin (Acthar Gel, Purified Cortrophin Gel) injection is a preparation of the natural form of adrenocorticotropic hormone (ACTH) in gelatin to provide a prolonged release after intramuscular or subcutaneous injection. ACTH works by stimulating the adrenal cortex to produce cortisol, corticosterone and a number of other hormones. Repository corticotropin is primarily used for treating infantile spasms (West syndrome), it has been investigated for diagnostic testing of adrenocortical function, and it has been used in the treatment of a variety of other conditions.

Repository corticotropin was approved by the U.S. Food and Drug Administration (FDA) in 1952, before there was a requirement that innovator companies provide clinical evidence of efficacy of their product.

Prescription products have a package label that covers important information such as product description, use, available dosage forms, dosing information, administration, contraindications, warnings/precautions, adverse effects, and other data that guides prescribers on the proper use of the product. The Clinical Studies section of the product label contains a brief review of the clinical study or studies that were presented to the FDA to obtain formal FDA approval.

Acthar Gel product label says that it is **indicated** for *infantile spasms* and **indicated** for the treatment of *acute exacerbations of multiple sclerosis*. The product label states that controlled clinical trials have shown it to be effective in speeding the resolution of acute exacerbations of multiple sclerosis but there is no evidence that it affects the ultimate outcome or natural history of the disease. The product label also includes several conditions where it says Acthar Gel **may be used.** Clinical efficacy and safety data for most of the other uses are lacking. There is little data available for the general uses for rheumatic, collagen, dermatologic, allergic states, ophthalmic, respiratory, and edematous disorders/diseases, and these uses were grandfathered in by the FDA. Based on the lack of both efficacy and safety data for the above referenced grandfathered uses, these additional disorders will be considered unsupported. The clinical studies section of the product labeling of Acthar Gel describes efficacy data **only for** infantile spasms. The product label provides specific dosing and administration for infantile spasms and acute exacerbations of multiple sclerosis and a usual dosage range and frequency for the other uses.

Purified Cortrophin Gel product label says it is indicated for conditions where Acthar Gel stated it may be used. The product label also lists other conditions that are not included in Acthar Gel labelling. Purified Cortrophin Gel product label does not have a Clinical Studies section that would provide a review of the data supporting use in these conditions. The label does not list Infantile Spasms as a use for the product. The product label provides specific dosing for acute exacerbations of multiple sclerosis. Given the lack of both efficacy and safety data, use of Purified Cortrophin for these disorders will be considered unsupported except for acute exacerbations of multiple sclerosis.

Although repository corticotropin (Acthar Gel, Purified Cortrophin Gel) can be used to treat various other medical conditions responsive to corticosteroid therapy, it has not been proven to be superior to corticosteroids for these uses. Corticosteroid therapy is generally considered the treatment of choice. Also, Acthar Gel and Purified Cortrophin have limited therapeutic value since they cannot be administered orally and their effectiveness is dependent on adrenocortical responsiveness. There is a lack of controlled studies on repository corticotropin for treatment of non-corticosteroid-responsive conditions who have received repository corticotropin.

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The adverse effects of both Acthar Gel and Purified Cortrophin Gel are related primarily to steroid-like effects.

Acthar Gel is a naturally sourced complex mixture of adrenocorticotropic hormone analogs and other pituitary peptides. The manufacturing process converts the initial porcine pituitary extract with low ACTH content into a mixture having modified porcine ACTH and other related peptide analogs solubilized in gelatin. A major component in the formulated complex mixture is N-25 deamidated porcine ACTH (1-39). Acthar Gel is available as a 5 mL vial (80 units/mL, total of 400 units).

Purified Cortrophin Gel is a porcine derived purified corticotropin (ACTH) in a sterile solution of gelatin. It is made up of a complex mixture of ACTH, ACTH related peptides and other porcine pituitary derived peptides. It contains the porcine derived ACTH (1-39). Purified Cortrophin Gel is supplied sterile in 5 mL multiple-dose vials containing 80 USP units/mL.

Definitions:

Infantile spasms:

Evidence of specific abnormal pattern detected by a video EEG with hypsarrhythmia

Response is defined as achieved and maintains complete cessation of spasms and elimination of hypsarrhythmia on a full sleep video EEG

MS exacerbation:

Evidence of an attack with neurologic disturbances consistent with MS that have lasted for at least 24 hours and is separated from the previous attack by at least 30 days

Response is defined as **THREE** of the following:

- Mild/minimal to no functional neurologic (pyramidal, cerebellar, brainstem, sensory) disabilities
- Ambulatory without need for assistance
- Reduction in number of exacerbations or relapses of MS
- Prolonged time to exacerbation or relapses of MS
- Reduction in hospitalizations for MS

Resources:

Acthar Gel (repository corticotropin) product information, revised by Mallinckrodt ARD, LLC. 10-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed January 13, 2022.

Purified Cortrophin Gel (repository corticotropin) product information, revised by ANI Pharmaceuticals, Inc. 11-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed January 13, 2022.

5.01.17 Blue Cross Blue Shield Association Medical: Repository Corticotropin Injection. Review date November 2021. Accessed January 15, 2022.

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Glaze DG. Management and prognosis of infantile spasms. In: UpToDate, Nordli DR, Dashe JF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated December 22, 2021. Accessed January 16, 2022.

Olek MJ, Howard J. Treatment of acute exacerbations of multiple sclerosis in adults. In: UpToDate, Gonzalez-Scarano F, Dashe JF (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated January 10, 2022. Accessed January 16, 2022.