Medical Policy:
Acthar Gel

Last review date: 7/1/2026

Applicable Products:
Acthar Gel (repository corticotropin injection) corticotropin injection

Initial Approval Criteria:
Coverage may be approved if all of the following are met:

- Must be used one of the following FDA-approved indications:
  - Infantile spasms in patients under 2 years of age; **OR**
  - Acute exacerbations of multiple sclerosis; **OR**
  - Acute exacerbations of a rheumatic disorder (i.e., Psoriatic arthritis, Rheumatoid arthritis [including juvenile rheumatoid arthritis], ankylosing spondylitis); **OR**
  - Exacerbation or maintenance therapy for systemic lupus erythematosus or systemic dermatomyositis; **OR**
  - Severe erythema multiforme, Stevens-Johnson syndrome; **OR**
  - Serum sickness; **OR**
  - 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; anterior segment inflammation; **OR**
  - Symptomatic sarcoidosis; **OR**
  - To induce diuresis or remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus; **AND**
- If applicable: Trial and failure, intolerance, or a contraindication to the preferred products as listed in the medical drug list

Renewal Criteria:
Coverage may be renewed if all of the following are met:

- Patient continues to meet Initial Approval Criteria; **AND**
- Absence of unacceptable toxicity

Length of Authorization:
1 month