Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

Repository corticotropin injection (H.P. Acthar Gel)

Initial approval 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 -AND-
- Diagnosis of infantile spasms (West Syndrome) -AND-
- Patient is less than 2 years of age

* May be covered for 1 additional month on the prescription drug benefit if deemed clinically appropriate by neurologist and patient continues to meet initial approval criteria.

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.