**Louisiana Medicaid**
**Repository Corticotropin (Acthar® Gel)**

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for repository corticotropin (Acthar® Gel).

## Approval Criteria (Initial and reauthorization)

- Recipient has a diagnosis of infantile spasms; **AND**
- Recipient is less than 2 years of age on the date of the request**; AND**
- Repository corticotropin (Acthar® Gel) is being prescribed by, or the request states that the medication is being prescribed in consultation with, a neurologist; **AND**

**OR**

- Recipient is 18 years of age or older on the date of the request: **AND**
- Recipient is being treated for an acute exacerbation of multiple sclerosis; **AND**
- Recipient has tried and failed an IV corticosteroid for this exacerbation occurrence; **OR**
- Recipient has a contraindication or intolerance to corticosteroid therapy; **AND**
- Repository corticotropin (Acthar® Gel) is being prescribed by, or the request states that the medication is being prescribed in consultation with, a neurologist; **AND**

**AND**

- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of repository corticotropin (Acthar® Gel); **AND**
    - The recipient will not be receiving repository corticotropin (Acthar® Gel) in combination with any medication that is contraindicated or not recommended per FDA labeling.

## Duration of approval:

For infantile spasms: 12 months **OR** until the child's second birthday, whichever is less
For multiple sclerosis: 1 month

*Additional edits may apply at Point-of-Sale (POS). Override options may be available. For more information, refer to the Louisiana Department of Health Pharmacy Benefits Management Services Manual at www.lamedicaid.com/provweb1/Providermanuals/manuals/PHARMACY/PHARMACY.pdf*

## References


Acthar® Gel (repository corticotropin) [package insert]. Bedminster, NJ: Mallinckrodt™ Pharmaceuticals; March 2019. https://www.acthar.com/pdf/Acthar-PI.pdf

Olek, M. Howard, J. Treatment of acute exacerbations of multiple sclerosis in adults. In: UpToDate, Post, TW (Ed), UpToDate, Waltham, MA, 2019.


| Revision | Date |
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