STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
Office of Pharmacy Service
Prior Authorization Criteria

H.P. Acthar® Gel (Corticotropin)
Prior Authorization Request Form

H.P. Acthar Gel is an adrenocorticotropic hormone (ACTH) analogue that stimulates the release of endogenous cortisol. It is FDA-approved for a number of indications that are more generally treated with corticosteroids. Only indications that are supported by published clinical literature will be considered for prior authorization approval.

W.V Medicaid currently considers H.P. Acthar Gel to be medically necessary ONLY for the treatment of infantile seizures in children less than two (2) years of age. For all other indications, including the treatment of acute exacerbations of multiple sclerosis, there is currently no quality evidence that the medication is superior when compared to other much less costly medications.

Criteria for Approval

1) Medication is to be used as monotherapy for the treatment of infantile spasms (West syndrome) in infants and children less than two (2) years of age; AND
2) Must be prescribed by a pediatric neurologist or epilepsy specialist.

References

1) HP Acthar package insert revised 9/2012
2) Lexi-Comp Clinical Application 05/05/2015