|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Adrenocorticotropic hormone (ACTH) analogue | | |
| **Criteria Subtitle** | Acthar | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ACTHAR | 006597 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 2 | 1001 |  | Select and Free Text | Is the medication being prescribed by an appropriate specialist?    If yes, please submit the provider’s specialty. | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response in the last 30 days to corticosteroid therapy for a multiple sclerosis diagnosis?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1003 |
| 4 | 1003 |  | Select and Free Text | Does the patient have a contraindication to corticosteroid therapy for a multiple sclerosis diagnosis?  If yes, please submit the medication name and reason for inability to use. | Y | END (Pending Manual Review) |
| N | 1235 |
| 5 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Up to 28 days

|  |  |
| --- | --- |
| **Last Approved** | 4/10/2023 |
| **Other** | INTERNAL NOTE: If member does not have a multiple sclerosis diagnosis, please review PA to label (if appropriate). As for length of authorization, 28 days for all indications and they can request another 28 days, if indicated, for up to 6 months duration in total. |