MEDICAL MUTUAL®

Drug Policy

Policy:	**201010-MRx (04-24)**	**Initial Effective Date: 12/15/2010**
Code(s):	**HCPCS J0801, J0802**	**Annual Review Date: 08/21/2025**
SUBJECT:	**Corticotropin-ACTH:** • **Acthar® Gel (repository corticotropin injection)** • **Cortrophin ™ Gel (repository corticotropin injection)**	**Last Revised Date: 08/21/2025**

Subject to: ☒Site of Care
☐Medication Sourcing

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

Initial and renewal requests for the medication(s) listed in this policy are subject to site of care management. When billed under the medical benefit, administration of the medication will be restricted to a non-hospital facility-based location (i.e., home infusion provider, provider's office, free-standing ambulatory infusion center) unless the member meets the site of care exception criteria. To view the exception criteria and a list of medications subject to site of care management please click here.

Submission of supporting clinical documentation (including but not limited to medical records, chart notes, lab results, and confirmatory diagnostics) related to the medical necessity criteria is REQUIRED on all requests for authorizations. Records will be reviewed at the time of submission as part of the evaluation of this request. Please provide documentation related to diagnosis, step therapy, and clinical markers (i.e., genetic, and mutational testing) supporting initiation when applicable. Please provide documentation via direct upload through the PA web portal or by fax. Failure to submit the medical records may result in the denial of the request due to inability to establish medical necessity in accordance with policy guidelines.

I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 1 month.
- Renewal: Prior authorization validity may be renewed monthly thereafter.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

B. Max Units (per dose and over time) [HCPCS Unit]:

- 35 billable units (1377 USP units) every 28 days

III. Initial Approval Criteria [1,2,5-18,47-52]

Infantile Spasms (West Syndrome) (Acthar † Φ; Cortrophin ‡)

- Patient is under 2 years of age; **AND**
- Clinical documentation indicating patient has a diagnosis of infantile spasms (West Syndrome); **AND**
- Must be used as monotherapy; **AND**
- Patient does not have a suspected congenital infection

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); **Φ** Orphan Drug

Use of repository corticotropin injection for indications including, but not limited to, those additionally listed in the product labeling are not supported by substantial clinical evidence.
Repository Corticotropin Injection was originally approved by the U.S. Food and Drug Administration (FDA) in 1952 as HP ACTH and in 1954 as Cortrophin, for a variety of disorders and diseases that at the time were thought to benefit from steroid mediated immunosuppression. The initial approval of H.P. ACTH and CORTROPHIN gels occurred prior to the Kefauver-Harris amendment to the Federal Food, Drug and Cosmetic Act of 1962, which introduced the requirement of "substantial evidence" of two adequate and well controlled trials. At the time of the original approval drug manufacturers only had to show the drug was safe for use in humans. The original data included case reports from a few physicians describing patients with conditions originally treated with adrenocorticotropic hormone powder that were transferred to treatment with the approved product and gave dosing guidance for treatment of these individual conditions. These data would be grossly inadequate to support approval of a new drug or new indications by the Agency under current standards requiring evidence from adequate and well-controlled clinical trials. A Drug Efficacy Study Implementation (DESI) review of corticotrophin injection (Acthar NDA 022432) was initiated in 1971 and finalized in 1977.[4] Cortrophin was approved via sNDA November 2021.

IV. Renewal Criteria [1,2]

Authorizations can be renewed based on the following criteria:

- Patient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Disease response with treatment as indicated by resolution of symptoms and/or normalization of laboratory tests; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infections, elevated blood pressure, salt and water retention, gastrointestinal perforation and bleeding, gastric ulcer,

behavioral and mood disturbances (e.g., euphoria, insomnia, irritability, mood swings, personality changes, severe depression, frank psychotic manifestations, etc.), posterior subcapsular cataracts, glaucoma, anaphylaxis, etc.

V. Dosage/Administration [1,4,48-50]

Indication	Dose
Infantile Spasms	Administer 75 units/m^2 intramuscularly given twice daily for 2 weeks, then taper the dose over a 2 week period (e.g., 30 units/m^2 in the morning for 3 days; 15 units/m^2 in the morning for 3 days; 10 units/m^2 in the morning for 3 days; and 10 units/m^2 every other morning for 6 days).

VI. Billing Code/Availability Information

HCPCS Code(s):

- J0801 – Injection, corticotropin (acthar gel), up to 40 units; 1 billable unit = up to 40 units *(applicable to Acthar ONLY)*
- J0802 – Injection, corticotropin (ani), up to 40 units; 1 billable unit = up to 40 units *(applicable to Cortrophin ONLY)*

NDC(s):

- Acthar Gel 80 units/mL (5 mL multi-dose vial): 63004-8710-xx
- Purified Cortrophin Gel 80 USP units/mL (1 mL multi-dose vial): 62559-0860-xx
- Purified Cortrophin Gel 400 USP units/5 mL (5 mL multi-dose vial): 62559-0860-xx

VII. References

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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
G40.821	Epileptic spasms, not intractable, with status epilepticus
G40.822	Epileptic spasms, not intractable, without status epilepticus
G40.823	Epileptic spasms, intractable, with status epilepticus
G40.824	Epileptic spasms, intractable, without status epilepticus

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdictio	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT,	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

MEDICAL MUTUAL®

Drug Policy

FOR MEDICAL BENEFIT COVERAGE REQUESTS:

Prior approval is required for HCPCS Codes J0800

Edits and Denials:

Prior approval: Prior approval is required for repository corticotropin injection **(HCPCS Code J0800)**. Requests for prior approval will be authorized by a nurse reviewer if submitted documentation meets criteria outlined within the Corporate Medical Policy.

Requests for prior approval will be forwarded to a qualified physician reviewer if submitted documentation does not meet criteria outlined within the Corporate Medical Policy.

TOPPS: Claims received with **HCPCS Code J0800** will edit with **Remark Code M3M or M4M** and will be adjudicated in accordance with Corporate Medical Policy.

Liability: A participating provider will be required to write off charges denied as not medically necessary.