Drug Coverage Policy

Effective Date.....7/15/2025
Coverage Policy Number.....IP0178
Policy Title..... Acthar Gel

Repository Corticotropin – Acthar Gel

- Acthar® Gel (repository corticotropin intramuscular and subcutaneous injection – Mallinckrodt)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Acthar, an adrenocorticotropic hormone (ACTH) analog, is indicated for the following uses:[1]

- **Infantile spasms**, treatment of, in infants and children < 2 years of age as monotherapy.
- **Multiple sclerosis, treatment of exacerbations** in adults.

Although data are limited, the prescribing information notes that Acthar may also be used for the following disorders and diseases:[1]

- **Allergic states**, such as serum sickness.
- **Collagen diseases**, during an exacerbation or as a maintenance therapy in selected cases of systemic lupus erythematosus and systemic dermatomyositis (polymyositis).
- **Dermatologic diseases**, such as severe erythema multiforme and Stevens-Johnson syndrome.
- **Edematous state** including to induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.
- **Respiratory diseases** such as symptomatic sarcoidosis.
- **Rheumatoid disorders**, as an adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in psoriatic arthritis, rheumatoid arthritis (including juvenile rheumatoid arthritis) [selected cases may require low-dose maintenance therapy], and ankylosing spondylitis.
- **Ophthalmic diseases** including severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, and anterior segment inflammation.

The Acthar gel vial is for either intramuscular or subcutaneous injection.[1] Acthar gel single-dose pre-filled SelfJect injector is for subcutaneous administration by adults only (used to administered single doses of 40 units or 80 units only). For infantile spasms, doses must be given intramuscularly using the Acthar gel vial. The recommended dose for this use is 150 units/m^2 divided twice daily into two injections of 75 units/m^2. After 2 weeks of treatment, dosing should be gradually tapered and discontinued over a 2-week period. Acthar gel single-dose prefilled SelfJect injector is not to be used for the treatment of infantile spasms.

Clinical Efficacy

A review regarding repository corticotropin found few randomized controlled trials supporting the clinical benefit of repository corticotropin or ACTH for various conditions (e.g., use in rheumatoid arthritis, ankylosing spondylitis, optic neuritis, systemic lupus erythematosus, and nephrotic syndrome).[2] Most data suggest that repository corticotropin or ACTH was not superior to corticosteroids for treating relapses in patients with multiple sclerosis.

Guidelines

Several guidelines discuss repository corticotropin or ACTH.

- The **American Academy of Neurology** and the **Child Neurology Society** published an evidence-based guideline for the medical treatment of infantile spasms (2012).[3] ACTH is a first-line agent for the short-term treatment of infantile spasms.
- **Infantile Spasms Working Group** published a US consensus report on infantile spasms in 2010.[4] Most patients with this condition (90%) present within the first year of life. ACTH is an effective first-line therapy for infantile spasms.
- **Kidney Disease Improving Global Outcomes** (KDIGO) published clinical practice guidelines for the management of glomerular disease (2021).[5] This includes diagnoses such as nephrotic syndrome, membranous nephropathy, immunoglobulin A nephropathy, minimal change disease, infection-related glomerulonephritis, focal segmental glomerulosclerosis, membranoproliferative glomerulonephritis, and lupus nephritis. ACTH is not prominent in the guidelines and there is a lack of quality evidence regarding ACTH. Updated KDIGO guidelines were published regarding the management of lupus nephritis (2024), as well as for the management of anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis (2024).[22,23] ACTH is not mentioned in the guidelines.

- The **American College of Rheumatology** has many guidelines regarding use in rheumatoid-type conditions.[8] ACTH does not have a prominent role and is generally not recommended for use in any of the related American College of Rheumatology guidelines.
- The **American College of Rheumatology** has guidelines for the management of gout (2020).[9] For gout flare management, using colchicine, non-steroidal anti-inflammatory drugs, or glucocorticoids (oral, intraarticular, or intramuscular) are appropriate first-line therapy for gout flare over interleukin-1 inhibitors or ACTH.
- The **European Respiratory Society** published guidelines on the treatment of sarcoidosis (2021).[10] Repository corticotropin use should be reserved for patients who have failed prior treatments (e.g., steroids, antimetabolites). Only limited data are available. Repository corticotropin should be considered in a case by case basis only when other therapies are not effective or tolerated.

Coverage Policy

Coverage of repository corticotropin may depend on the applicable health benefit plan definition of medical necessity. Where that definition limits coverage to the most cost-effective equivalent treatment, repository corticotropin is not considered medically necessary.

POLICY STATEMENT

Prior Authorization is required for benefit coverage of Acthar Gel. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients with these conditions, as well as monitoring required for adverse events and efficacy, approval requires Acthar Gel to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Acthar Gel is considered medically necessary when the following criteria are met:

FDA-Approved Indication

1. **Infantile Spasms, Treatment.** Approve Acthar Gel multidose vial for 1 month if the patient meets ALL of the following (A, B, and C):
   Note: Acthar Gel single-dose pre-filled SelfJect Injector for subcutaneous use should not be approved.
   - **A)** Child is less than 2 years of age; AND
   - **B)** Acthar is being administered as an intramuscular injection; AND
   - **C)** Medication is prescribed by a physician who has consulted with or specializes in neurology.

   Dosing. Approve up to 150 units/m^2 by intramuscular injection per day for up to 1 month.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Acthar Gel for any other use is considered not medically necessary, including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Ankylosing Spondylitis.** The American College of Rheumatology guidelines for the treatment of ankylosing spondylitis do not convey a role for ACTH in this condition.[11,12]

2. **Dermatomyositis or Polymyositis.** British Society for Rheumatology guidelines on the management of pediatric, adolescent, and adult patients with idiopathic inflammatory myopathy (2022) do not cite ACTH as an agent to utilize in patients with such conditions.[13]

3. **Diabetic Nephropathy.** ACTH is not a cited therapy or the standard of care for the management of chronic kidney disease in patients with diabetes.[5,14]

4. **Glomerular Kidney Diseases.**
   Note: Diagnoses can include nephrotic syndrome, membranous nephropathy, immunoglobulin A nephropathy, minimal change disease, infection-related glomerulonephritis, focal segmental glomerulosclerosis, and membranoproliferative glomerulonephritis. ACTH is not prominent in related guidelines from KDIGO (2021) and there is a lack of quality evidence regarding ACTH to support its use.[5] KDIGO guidelines for the management of anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis (2024) do not mention ACTH.[23]

5. **Gout.** American College of Rheumatology guidelines for gout (2020) recommend other therapies beside ACTH for gout flare management (e.g., colchicine, non-steroidal anti-inflammatory drugs, or glucocorticoids).[9]

6. **Juvenile Idiopathic Arthritis.** Related guidelines from the American College of Rheumatology regarding the treatment of juvenile idiopathic arthritis (2021) do not mention ACTH as having a role for this disease.[15]

7. **Lupus Nephritis.** The KDIGO guidelines for the management of glomerular disease (2021) cite many other agents besides ACTH for the management of this condition.[5] The European League Against Rheumatism-European Renal Association-European Dialysis and Transplantation Association joint recommendations on the management of lupus nephritis do not cite ACTH as a therapy to use in this condition.[16] Updated KDIGO guidelines were published regarding the management of lupus nephritis (2024) and do not mention ACTH.[22]

8. **Multiple Sclerosis, Acute Exacerbations.** High-dose corticosteroids, usually intravenous methylprednisolone, are the accepted standard of care short-term for acute relapses or exacerbations.[6] **ACTH and high-dose intravenous methylprednisolone have been shown to possess similar efficacy in the management of multiple sclerosis relapses.[7]**

9. **Ophthalmic Conditions.** Only limited data describe the use of ACTH in ophthalmic-related conditions (e.g., acute optic neuritis, keratitis, retinal vasculitis).[2,17-19] Prospective data are needed to more rigorously define the efficacy and safety of ACTH in ocular disease.

10. **Psoriatic Arthritis.** The American College of Rheumatology/National Psoriasis Foundation guidelines for the treatment of psoriatic arthritis (2018) do not mention a role for ACTH in this condition.[20]

11. **Rheumatoid Arthritis.** The American College of Rheumatology guidelines for the treatment of rheumatoid arthritis (2021) do not mention a role for ACTH in this disease state.[21]

12. **Sarcoidosis.** The European Respiratory Society published guidelines on the treatment of sarcoidosis (2021).[10] Repository corticotropin use should be reserved for patients who have failed prior treatments (e.g., steroids, antimetabolites). Only limited data are available. Repository corticotropin should be considered in a case by case basis only when other therapies are not effective or tolerated.

Coding Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J0801	Injection, corticotropin (acthar gel), up to 40 units

References

1. Acthar® Gel injection for subcutaneous and intramuscular use [prescribing information]. Bridgewater, NJ: Mallinckrodt; February 2024.
2. Tran KA, Harrod C, Bourdette DN, et al. Characterization of the clinical evidence supporting repository corticotropin injection for FDA-approved indications. A scoping review. *JAMA Intern Med*. 2022;182(2):206-217.
3. Go CY, Mackay MT, Weiss SK, et al. Evidence-based guideline update: medical treatment of infantile spasms: Report of the guideline development subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society. *Neurology*. 2012;78:1974-1980.
4. Pellock JM, Hrachovy R, Shinnar S, et al. Infantile spasms: a US consensus report. *Epilepsia*. 2010;51(10):2175-2189.
5. KDIGO 2021 clinical practice guidelines for the management of glomerular diseases. *Kidney Int.* 2021;100:S1-S276.
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7. Thompson AJ, Kennard C, Swash M, et al. Relative efficacy of intravenous methylprednisolone and ACTH in the treatment of acute relapses in MS. *Neurology*. 1989;39:969-971.
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9. Fitzgerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology guideline for the management of gout. *Arthritis Care Res (Hoboken)*. 2020;72(6):744-760.
10. Baughman RP, Valeyre D, Korsten P, et al. ERS clinical practice guidelines on treatment of sarcoidosis. *Eur Respir J*. 2021;58(6):2004079.
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13. Oldroyd AGS, Lilleker JB, Amin T, et al. British Society for Rheumatology guideline on management of paediatric, adolescent and adult patients with idiopathic inflammatory myopathy. *Rheumatology*. 2022;61(5):1760-1768.
14. American Diabetes Association Professional Practice Committee. Chronic Kidney Disease and Risk Management: Standards of Medical Care in Diabetes-2024. *Diabetes Care*. 2025;48(Suppl 1):S239-S251.
15. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology Guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for oligoarthritis, temporomandibular joint arthritis, and systemic juvenile idiopathic arthritis. *Arthritis Rheumatol*. 2022;74(4):553-569.
16. Fanouriakis A, Kostopoulou M, Cheema K, et al. 2019 Update of the Joint European League Against Rheumatism and European Renal Association-European Dialysis and Transplant Association (EULAR/ERA-EDT) recommendations for the management of lupus nephritis. *Ann Rheum Dis*. 2020;79:713-732.
17. Crane AB, Sharon Y, Chu DS. Use of adrenocorticotropic hormone in ophthalmology. *J Ocul Pharmacol Ther*. 2020;36(9):661-667.
18. Wirta D, McLaurin E, Ousler G, et al. Repository corticotropin injection (Acthar® gel) for refractory severe noninfectious keratitis: efficacy and safety from a phase 4, multicenter, open-label study. *Ophthalmol Ther*. 2021;10:1077-1092.
19. Anesi SD, Chang PY, Maleki A, et al. Treatment of noninfectious retinal vasculitis using subcutaneous repository corticotropin injection. *J Ophthalmic Vis Res*. 2021;16:219-233.
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21. Fraenkiel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Care Res (Hoboken)*. 2021;73(7):924-939.
22. Kidney Disease Improving Global Outcomes lupus nephritis work group. KDIGO 2024 clinical practice guidelines for the management of lupus nephritis. *Kidney Int*. 2024;105(Suppl 1S):S1-S69.
23. Kidney Disease Improving Global Outcomes ANCA Vasculitis Work Group. KDIGO 2024 clinical practice guideline for the management of antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis. *Kidney Int*. 2024;105(Suppl 3S):S71-S116.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	**Policy Name Change: Updated** Policy Name from "Repository Corticotropin" to "Repository Corticotropin – Acthar Gel." **Infantile Spasms, Treatment:** It was added to specify that the formulation of Acthar Gel to be approved for this use is the multidose vial. A Note was added that Acthar Gel single-dose pre-filled SelfJect Injector for subcutaneous use should not be approved. A criterion was added that Acthar is being administered as an intramuscular injection. **Added** dosing information.	08/15/2024

	Conditions Not Covered: Removed the statement regarding the effectiveness of repository corticotropin (Acthar Gel) not being demonstrated as clinically superior to conventional corticosteroids and/or immunosuppressive therapy for uses other than infantile spasms.	
Annual Revision	No criteria changes. **Updated HCPCS Coding:** **Removed**: J0800 (Code deleted 9/30/2023)	7/15/2025

The policy effective date is in force until updated or retired.