GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
CORTICOTROPIN PA SUMMARY

Preferred	Non-Preferred
Acthar Gel (repository corticotropin injection) Purified Cortrophin Gel (repository corticotropin injection)	n/a

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Acthar Gel and Purified Cortrophin Gel do not require a PA for members under 2 years of age with a diagnosis of infantile spasms.
- If medication is being administered in a physician's office or clinic, then the medication must be billed through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program can be located at www.mmis.georgia.gov.

PA CRITERIA:

Acthar and Cortrophin

- Approvable for members less than 2 years of age with a diagnosis of infantile spasms (West Syndrome).
- Approvable for members 18 years of age or older with a diagnosis of exacerbations of multiple sclerosis (MS) who are experiencing neurologic symptoms and increased disability or impairment (such as impaired vision, severe weakness, poor balance or gait and/or other cerebellar symptoms that impair function) and have experienced an inadequate response within the last 30 days, contraindication or intolerance to high-dose intravenous (IV) methylprednisolone or high-does oral corticosteroid. In addition, members with relapsing-remitting MS must be currently receiving an immunomodulator agent to treat MS for at least the last 3 months.
- Approvable for members 2 years of age or older with a diagnosis of psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis or ankylosing spondylitis who have experienced an inadequate response after 3 months, allergies, contraindications, drug-drug interactions or intolerable side effects to Enbrel and Humira AND have experienced an inadequate response within the last 30 days, contraindication or intolerance to high-dose oral or IV corticosteroid.
- Approvable for members 2 years of age or older with a diagnosis of systemic lupus erythematosus who have experienced an inadequate response, allergies contraindications, drug-drug interactions or intolerable side effects to hydroxychloroquine or chloroquine AND have experienced an inadequate response within the last 30 days, contraindication or intolerance to high-dose oral or IV corticosteroid.

- Approvable for members 2 years of age or older with a diagnosis of systemic dermatomyositis (polymyositis), severe erythema multiforme, Stevens-Johnson syndrome, serum sickness, keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, symptomatic sarcoidosis or nephrotic syndrome who have experienced an inadequate response within the last 30 days, contraindication or intolerance to high-dose oral or IV corticosteroid.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.