

**SOUTH DAKOTA MEDICAID
PRIOR AUTHORIZATION CRITERIA**

Physician Administered Drugs, Vaccines, and Immunizations

Corticotropin (H.P. Acthar) – PA Criteria

HCPC: J0801

H.P. Acthar is an adrenocorticotropin stimulating hormone indicated for treatment of infantile spasms in children less than 2 years of age and for exacerbations of multiple sclerosis in adults. It is covered by South Dakota Medicaid following prior authorization when the patient meets the following criteria:

- **Initial Therapy (must meet all):**
 - Therapy is requested by or in consultation with a neurologist
 - Therapy meets the following criteria as specified per indication
 - For Infantile Spasms (must meet all):
 - Individual has a diagnosis of infantile spasms (West Syndrome)
 - Individual is <2 years old
 - Approval duration: 3 months
 - For Multiple Sclerosis Exacerbations (must meet all):
 - Individual is ≥18 years old
 - Individual has a diagnosis of multiple sclerosis (MS)
 - Documentation is provided indicating patient is having an acute MS exacerbation
 - Documentation is submitted indicating previous failure, contraindication, or intolerance to oral and injectable glucocorticoids
 - Documentation is provided indicating that individual is currently using disease modifying therapy for MS
 - Approval duration: 1 month
- **Continuation of Therapy (must meet all):**
 - Documentation is submitted indicating that there was a positive response to therapy
 - Approval duration meets the following as specified per indication
 - Infantile spasms
 - Approval duration: 4 weeks only - 2 weeks of regular use followed by approximately 2 weeks of tapering
 - Reauthorization can be considered for an additional 4 weeks if there is a relapse in spasm symptoms after H.P. Acthar is discontinued
 - Multiple Sclerosis Exacerbations
 - Documentation is provided indicating need for continuation of therapy beyond acute exacerbation stage
 - Approval duration: 3 weeks