Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Acthar Gel™ (repository-corticotropin injection)

**Review Criteria:**
Approval will only be granted for a diagnosis of infantile spasms or acute exacerbations of Multiple Sclerosis.

Member must meet all of the following criteria specific to diagnosis:

- **Infantile Spasms:**
  - Provider must be a pediatric neurologist
  - Member must be under two years of age
  - Member must have a diagnosis of infantile spasms

- **Multiple Sclerosis:**
  - Member must have an intolerance to or inadequate response to IV steroids or muscle relaxant