



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