AscellaHealth

Medical Policy

Acthar Gel

Last review date: **1/1/2026**

Prior review date: **10/1/2025**

Applicable Products
Acthar Gel (repository corticotropin injection) corticotropin injection

Initial Approval Criteria

Coverage may be approved if all of the following are met:

- Must be used for an FDA-approved indication and dosage; AND
- If applicable: Trial and failure, intolerance, or a contraindication to the preferred products as listed in the medical drug list.

Renewal Criteria

Coverage may be renewed if all of the following are met:

- Patient continues to meet Initial Approval Criteria; AND
- Absence of unacceptable toxicity.

Length of Authorization

1 Month

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical or other circumstances may warrant individual consideration, based on review of applicable medical records, as well as other regulatory, contractual and/or legal requirements.

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.