Effective Date **10/1/2023**
Next Review Date… **10/1/2024**
Coverage Policy Number **IP0374**

Purified Cortrophin Gel

Table of Contents

Related Coverage Resources

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This policy addresses the usage of repository corticotropin subcutaneous and intramuscular injection (**Purified Cortrophin™ Gel)**.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Conditions Not Covered

Repository corticotropin (Purified Cortrophin Gel) is considered to be experimental, investigational, or unproven due to insufficient data establishing safety, efficacy, and improved health outcomes for any condition.

Purified Cortrophin Gel is FDA approved for the treatment of allergic states, collagen diseases, dermatologic diseases, edematous state, acute exacerbations of multiple sclerosis, respiratory diseases, rheumatoid disorders and ophthalmic diseases; however, there is insufficient clinical efficacy data supporting these uses.

Background

OVERVIEW
Cortrophin Gel, a porcine derived purified corticotrophin (adrenocorticotropic hormone [ACTH] {1-39}) product, is indicated in the following disorders:[1]

- **Allergic states**, such as atopic dermatitis and serum sickness.
- **Collagen diseases**, during an exacerbation or as a maintenance therapy in selected cases of systemic lupus erythematosus and systemic dermatomyositis (polymyositis).
- **Dermatologic diseases**, such as severe erythema multiforme (Stevens-Johnson syndrome) and severe psoriasis.
- **Edematous state** including to induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.
- **Nervous system**, acute exacerbations of multiple sclerosis.
- **Respiratory diseases** such as symptomatic sarcoidosis.
- **Rheumatoid disorders**, as an adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in psoriatic arthritis, rheumatoid arthritis (including juvenile rheumatoid arthritis) [selected cases may require low-dose maintenance therapy], ankylosing spondylitis, and acute gouty arthritis.
- **Ophthalmic diseases** including severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as allergic conjunctivitis, keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, and anterior segment inflammation.

Clinical Efficacy
A recent review regarding repository corticotropin found few randomized controlled trials supporting the clinical benefit of repository corticotropin or ACTH for various conditions (e.g., use in rheumatoid arthritis, ankylosing spondylitis, optic neuritis, systemic lupus erythematosus, and nephrotic syndrome).[2] Most data suggest that repository corticotropin or ACTH was not superior to corticosteroids for treating relapses in patients with multiple sclerosis.

Guidelines
Several guidelines discuss repository corticotrophin or ACTH.

- **Kidney Disease Improving Global Outcomes (KDIGO) published clinical practice guidelines for the management of glomerular disease** (2021).[3] This includes diagnoses such as nephrotic syndrome, membranous nephropathy, immunoglobulin A nephropathy, minimal change disease, infection-related glomerulonephritis, focal segmental glomerulosclerosis, membranoproliferative glomerulonephritis, and lupus nephritis. ACTH is not prominent in the guidelines and there is a lack of quality evidence regarding ACTH.
- **National Multiple Sclerosis Society** has recommendations regarding corticosteroids in the management of multiple sclerosis relapses or exacerbations.[4] High-dose corticosteroids are the accepted standard of care short-term. The most common regimen is 500 to 1,000 mg of intravenous methylprednisolone given daily for 3 to 5 days, with or without an oral steroid tapering regimen (most often prednisone) for 1 to 3 weeks. ACTH and high-dose intravenous methylprednisolone have been shown to possess similar efficacy in the management of multiple sclerosis relapses.[5]
- The **American College of Rheumatology** has many guidelines regarding use in rheumatoid-type conditions.[6] ACTH does not have a prominent role and is generally not recommended for use in any of the related American College of Rheumatology guidelines.
- The **American College of Rheumatology has guidelines for the management of gout** (2020).[7] For gout flare management, using colchicine, non-steroidal anti-inflammatory drugs, or glucocorticoids (oral, intraarticular, or intramuscular) are appropriate first-line therapy for gout flare over interleukin-1 inhibitors or ACTH.
- **The European Respiratory Society published guidelines on the treatment of sarcoidosis (2021)**.[8] Repository corticotropin use should be reserved for patients who have failed prior treatments (e.g., steroids, antimetabolites). Only limited data are available. Repository corticotropin should be considered in a case by case basis only when other therapies are not effective or tolerated.

References

1. Purified Cortrophin™ Gel subcutaneous and intramuscular injection [prescribing information]. Baudette, MN: ANI; November 2021.
2. Tran KA, Harrod C, Bourdette DN, et al. Characterization of the clinical evidence supporting repository corticotropin injection for FDA-approved indications. A scoping review. *JAMA Intern Med*. 2022;182(2):206-217.
3. KDIGO 2021 clinical practice guidelines for the management of glomerular diseases. *Kidney Int*. 2021;100:S1-S276.
4. National Multiple Sclerosis Society. Expert Opinion Paper. National Clinical Advisory Board of the National Multiple Sclerosis Society. Treatment Recommendations for Physicians. Recommendations Regarding Corticosteroids in the Management of Multiple Sclerosis. Available at: http://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/ExpOp_Steroids.pdf. Accessed on April 17, 2023.
5. Thompson AJ, Kennard C, Swash M, et al. Relative efficacy of intravenous methylprednisolone and ACTH in the treatment of acute relapses in MS. *Neurology*. 1989;39:969-971.
6. American College of Rheumatology. Clinical Practice Guidelines. Available at: https://rheumatology.org/clinical-practice-guidelines. Accessed on April 17, 2023.
7. Fitzgerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology guideline for the management of gout. *Arthritis Care Res (Hoboken)*. 2020;72(6):744-760.
8. Baughman RP, Valeyre D, Korsten P, et al. ERS clinical practice guidelines on treatment of sarcoidosis. *Eur Respir J*. 2021;58(6):2004079.
9. Ward MM, Deodhar A, Gensler LS, et al. 2019 update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019;71(10):1599-1613.
10. Ward MM, Deodhar A, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Care Res*. 2016;68:151-166.
11. Oldroyd AGS, Lilleker JB, Amin T, et al. British Society for Rheumatology guideline on management of paediatric, adolescent and adult patients with idiopathic inflammatory myopathy. *Rheumatology*. 2022;61(5):1760-1768.
12. American Diabetes Association Professional Practice Committee. Chronic Kidney Disease and Risk Management: Standards of Medical Care in Diabetes-2022. *Diabetes Care*. 2022;45(1):S175-S184.
13. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology Guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for oligoarthritis, temporomandibular joint arthritis, and systemic juvenile idiopathic arthritis. *Arthritis Rheumatol*. 2022;74(4):553-569.
14. Fanouriakis A, Kostopoulou M, Cheema K, et al. 2019 Update of the Joint European League Against Rheumatism and European Renal Association-European Dialysis and Transplant Association (EULAR/ERA-EDT) recommendations for the management of lupus nephritis. *Ann Rheum Dis*. 2020;79:713-732.
15. Crane AB, Sharon Y, Chu DS. Use of adrenocorticotropic hormone in ophthalmology. *J Ocul Pharmacol Ther*. 2020;36(9):661-667.
16. Wirta D, McLaurin E, Ousler G, et al. Repository corticotropin injection (Acthar® gel) for refractory severe noninfectious keratitis: efficacy and safety from a phase 4, multicenter, open-label study. *Ophthalmol Ther*. 2021;10:1077-1092.
17. Anesi SD, Chang PY, Maleki A, et al. Treatment of noninfectious retinal vasculitis using subcutaneous repository corticotropin injection. *J Ophthalmic Vis Res*. 2021;16:219-233.
18. Singh JA, Guyatt G, Ordie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheumatol*. 2019;71(1):5-32.
19. Fraenkiel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Care Res (Hoboken)*. 2021;73(7):924-939.