



**BlueCross  
BlueShield**

Federal Employee Program.

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**5.30.080**

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| <b>Section:</b>    | Prescription Drugs            | <b>Effective Date:</b>       | April 1, 2025    |
| <b>Subsection:</b> | Endocrine and Metabolic Drugs | <b>Original Policy Date:</b> | January 21, 2022 |
| <b>Subject:</b>    | Cortrophin Gel                | <b>Page:</b>                 | 1 of 6           |

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**Last Review Date:** March 7, 2025

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## Cortrophin Gel

### Description

#### Cortrophin Gel (corticotropin injection; ACTH)

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#### Background

Purified Cortrophin Gel is a porcine derived purified corticotropin (ACTH) in a sterile solution of gelatin. It is made up of a complex mixture of ACTH, ACTH related peptides, and other porcine pituitary derived peptides. Purified Cortrophin Gel is the anterior pituitary hormone which stimulates the functioning adrenal cortex to produce and secrete adrenocortical hormones (1).

#### Regulatory Status

FDA-approved indications: Cortrophin Gel is indicated in the following disorders: (1)

1. Rheumatic disorders:
  - a. As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in:
    - i. Psoriatic arthritis
    - ii. Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy)
    - iii. Ankylosing spondylitis
    - iv. Acute gouty arthritis
2. Collagen diseases:
  - a. During an exacerbation or as maintenance therapy in selected cases of:
    - i. Systemic lupus erythematosus
    - ii. Systemic dermatomyositis (polymyositis)
3. Dermatologic diseases:
  - a. Severe erythema multiforme (Stevens-Johnson syndrome)

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| <b>Subject:</b>    | Cortrophin Gel                | <b>Page:</b>                 | 2 of 6           |

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- b. Severe psoriasis
- 4. Allergic states:
  - a. Atopic dermatitis
  - b. Serum sickness
- 5. Ophthalmic diseases:
  - a. Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as:
    - i. Allergic conjunctivitis
    - ii. Keratitis
    - iii. Iritis and iridocyclitis
    - iv. Diffuse posterior uveitis and choroiditis
    - v. Optic neuritis
    - vi. Chorioretinitis
    - vii. Anterior segment inflammation
- 6. Respiratory diseases:
  - a. Symptomatic sarcoidosis
- 7. Edematous states:
  - a. 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
- 8. Nervous system:
  - a. Acute exacerbations of multiple sclerosis

Cortrophin Gel is contraindicated for intravenous administration (1).

Cortrophin Gel is contraindicated in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, or sensitivity to proteins derived from porcine sources (1).

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## Related policies

Acthar Gel

## Policy

*This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.*

Cortrophin Gel may be considered **medically necessary** if the conditions indicated below are met.

|                    |                               |                              |                  |
|--------------------|-------------------------------|------------------------------|------------------|
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| <b>Subject:</b>    | Cortrophin Gel                | <b>Page:</b>                 | 3 of 6           |

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Cortrophin Gel may be considered **investigational** for all other indications.

## Prior-Approval Requirements

### Diagnoses

Patient must have **ONE** of the following:

1. Rheumatic disorder:
  - a. Psoriatic arthritis
  - b. Rheumatoid arthritis, including juvenile rheumatoid arthritis
  - c. Ankylosing spondylitis
  - d. Acute gouty arthritis
2. Collagen disease:
  - a. Systemic lupus erythematosus
  - b. Systemic dermatomyositis (polymyositis)
3. Dermatologic disease:
  - a. Severe erythema multiforme (Stevens-Johnson syndrome)
  - b. Severe psoriasis
4. Allergic state:
  - a. Atopic dermatitis
  - b. Serum sickness
5. Ophthalmic disease:
  - a. Allergic conjunctivitis
  - b. Keratitis
  - c. Iritis and iridocyclitis
  - d. Diffuse posterior uveitis and choroiditis
  - e. Optic neuritis
  - f. Chorioretinitis
  - g. Anterior segment inflammation
6. Respiratory disease:
  - a. Symptomatic sarcoidosis
7. Nephrotic syndrome
  - a. Prescribed by a nephrologist
  - b. Patient has had an inadequate treatment response or intolerance to a 1 month trial of **ONE** of the following:

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|                    |                               |                              |                  |
|--------------------|-------------------------------|------------------------------|------------------|
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| <b>Subsection:</b> | Endocrine and Metabolic Drugs | <b>Original Policy Date:</b> | January 21, 2022 |
| <b>Subject:</b>    | Cortrophin Gel                | <b>Page:</b>                 | 4 of 6           |

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- i. Oral glucocorticoid therapy
  - ii. Immunosuppressant such as:
    - 1. Cyclophosphamide
    - 2. Cyclosporine
    - 3. Tacrolimus
    - 4. Mycophenolate mofetil
  - c. Patient has baseline levels of protein in urine indicative of proteinuria and low levels of albumin in blood indicative of hypoalbuminemia
- 8. Exacerbations of multiple sclerosis (MS)
  - a. Prescribed by a neurologist
  - b. Used in combination with a maintenance MS therapy
  - c. Patient has **ONE** of the following:
    - i. FDA labeled contraindication to oral or parenteral glucocorticoid therapy
    - ii. An inadequate response or intolerance to a 1 month trial of oral or a 1 week trial of parenteral glucocorticoid therapy

**AND** the following for **ALL** indications:

- 1. **NO** dual therapy with Acthar Gel (corticotropin)

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## Prior – Approval *Renewal* Requirements

### Diagnoses

Patient must have **ONE** of the following:

- 1. Rheumatic disorder:
  - a. Psoriatic arthritis
  - b. Rheumatoid arthritis, including juvenile rheumatoid arthritis
  - c. Ankylosing spondylitis
  - d. Acute gouty arthritis
- 2. Collagen disease:
  - a. Systemic lupus erythematosus
  - b. Systemic dermatomyositis (polymyositis)
- 3. Dermatologic disease:
  - a. Severe erythema multiforme (Stevens-Johnson syndrome)
  - b. Severe psoriasis
- 4. Allergic state:

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|--------------------|-------------------------------|------------------------------|------------------|
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| <b>Subject:</b>    | Cortrophin Gel                | <b>Page:</b>                 | 5 of 6           |

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- a. Atopic dermatitis
- b. Serum sickness
- 5. Ophthalmic disease:
  - a. Allergic conjunctivitis
  - b. Keratitis
  - c. Iritis and iridocyclitis
  - d. Diffuse posterior uveitis and choroiditis
  - e. Optic neuritis
  - f. Chorioretinitis
  - g. Anterior segment inflammation
- 6. Respiratory disease:
  - a. Symptomatic sarcoidosis
- 7. Nephrotic syndrome
  - a. Prescribed by a nephrologist
  - b. Patient has had a decrease in urine protein level and an increase in serum albumin level
- 8. Exacerbations of multiple sclerosis (MS)
  - a. Prescribed by a neurologist
  - b. Used in combination with a maintenance MS therapy
  - c. Patient has had a 30 day lapse since previous exacerbation

**AND** the following for **ALL** indications:

- 1. **NO** dual therapy with Acthar Gel (corticotropin)

## Policy Guidelines

### Pre - PA Allowance

None

### Prior - Approval Limits

|                 |                                     |           |
|-----------------|-------------------------------------|-----------|
| <b>Duration</b> | Exacerbations of multiple sclerosis | 1 month   |
|                 | Nephrotic syndrome                  | 6 months  |
|                 | All other indications               | 12 months |

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### Prior – Approval *Renewal* Limits

Same as above

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|--------------------|-------------------------------|------------------------------|------------------|
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| <b>Subject:</b>    | Cortrophin Gel                | <b>Page:</b>                 | 6 of 6           |

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## Rationale

### Summary

Cortrophin Gel stimulates the release of adrenocortical hormones. It is approved for several indications that are more generally treated with corticosteroids, such as rheumatoid arthritis, systemic lupus erythematosus, severe psoriasis, etc. (1).

Prior authorization is required to ensure the safe, clinically appropriate, and cost-effective use of Cortrophin Gel while maintaining optimal therapeutic outcomes.

### References

1. Cortrophin Gel [package insert]. Baudette, MN: ANI Pharmaceuticals, Inc.; October 2023.

## Policy History

| Date           | Action  |
|----------------|---|
| January 2022   | Addition to PA  |
| March 2022     | Annual review   |
| April 2022     | Per FEP, addition of no dual therapy with Acthar Gel and removed Cortrophin Gel from managed PA |
| June 2022      | Annual review   |
| March 2023     | Annual review and reference update. Changed policy number to 5.30.080                           |
| September 2023 | Annual review and reference update  |
| March 2024     | Annual review and reference update  |
| September 2024 | Annual review   |
| March 2025     | Annual review   |

## Keywords

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**This policy was approved by the FEP® Pharmacy and Medical Policy Committee on March 7, 2025 and is effective on April 1, 2025.**