

Clinical Policy: Cosyntropin (Cortrosyn)

Reference Number: CP.PHAR.203

Effective Date: 04.01.16

Last Review Date: 02.22

Line of Business: HIM, Medicaid

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Cosyntropin (Cortrosyn[®]) is a synthetic subunit of adrenocorticotrophic hormone (ACTH).

FDA Approved Indication(s)

Cortrosyn is indicated for use as a diagnostic agent in the screening of patients presumed to have adrenocortical insufficiency.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Cortrosyn is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Presumed Adrenocortical Insufficiency (must meet all):**

1. Prescribed for diagnostic testing of adrenocortical insufficiency;
2. If Cortrosyn is requested, member must use generic cosyntropin, unless contraindicated or clinically significant adverse effects are experienced;
3. Dose does not exceed one of the following (a or b):
 - a. If age $\leq$ 2 years: 0.25 mg per dose (1 vial);
 - b. If age $>$ 2 years: 0.75 mg per dose (3 vials).

Approval duration: 1 dose

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy**A. Presumed Adrenocortical Insufficiency**

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 3 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ACTH: adrenocorticotrophic hormone

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to Cosyntropin injection, synthetic ACTH, or to any of the excipients.
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Diagnostic testing of adrenal insufficiency	0.25-0.75 mg IV or IM; in pediatric patients ≤ 2 years, 0.125 mg will often suffice	0.75 mg/dose

VI. Product Availability

Vial for injection: 0.25 mg

VII. References

1. Cosyntropin Prescribing Information. Princeton, NJ: Sandoz Inc. May 2018. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/022028s005lbl.pdf Accessed September 20, 2021.
2. Cortrosyn Prescribing Information. Rancho Cucamonga, CA. Amphastar Pharmaceuticals, Inc.; September 2010. Available at <http://www.cortrosyn.com>. Accessed September 20, 2021.
3. Cosyntropin Drug Monograph. Clinical Pharmacology. Tampa, FL: Gold Standard Inc.; 2020. Available at: <http://www.clinicalpharmacology-ip.com>. Accessed September 20, 2021.

4. Bornstein, S, Allolio B, Arlt, Wiebke, et al. Diagnosis and Treatment of Primary Adrenal Insufficiency: An Endocrine Society Clinical Practice Guideline. The Journal of Clinical Endocrinology and Metabolism. Feb 2016; 101(2): 364-389.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0833	Injection, cosyntropin, not otherwise specified, 0.25 mg
J0834	Injection, cosyntropin (Cortrosyn), 0.25 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: - Modified max dose criteria from 0.125 mg to 0.25 mg for age ≤ 2 years since 0.125 is not a true max per labeling, plus partial vials cannot be dispensed so a dose of 0.125 is unenforceable post-approval. - References reviewed and updated.	10.30.17	02.18
1Q 2019 annual review: no significant changes; references reviewed and updated	10.12.18	02.19
1Q 2020 annual review: no significant changes; references reviewed and updated; added HIM line of business	11.04.19	02.20
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.03.20	02.21
1Q 2022 annual review: added generic redirection for Cortrosyn requests; references reviewed and updated	09.20.21	02.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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