Adverse Reactions: Adverse reactions, when they occur, are usually reversible and disappear when corticotropin is discontinued. Abscess, sterile. *Activation and complication of peptic ulcer (including perforation and hemorrhage).* Aggravation or masking of infection. Alteration of Glucose Metabolism, with aggravation of diabetes mellitus, including hyperglycemia and glycosuria. Aseptic Necrosis of Hip and Humerus. Convulsions. Cushing's Syndrome (including moon facies, supraclavicular fat pads, hirsutism, striae, and acne). Electrolyte imbalance. Facial Erythema. Headache. Increased Blood Pressure. Increased Intracranial Pressure with Papilledema (pseudo-tumor cerebri). Increased Intraocular Tension. Insomnia. Menstrual Irregularities. Myopathy. Necrotizing Angiitis. Osteoporosis (reversible only with difficulty). *Pancreatitis.* Petechiae and Purpura. Posterior Subcapsular Cataracts (occasionally requiring extraction). Postinjection Flare. Protein Catabolism (with negative nitrogen balance). Psychic Disturbances (especially abnormal euphoria). Spontaneous Fractures. Suppression of Growth in Children. Sweating. Thromboembolism. Ulcerative Esophagitis. Vertigo. Weakness.

Dosage and Administration: Directions for Use of ACTHAR (Corticotropin) Preparations—Clinical response is the criterion of adequate dosage. Unusual laboratory studies are not necessary. Because the adrenals vary in their sensitivity to stimulation by ACTH there can be no specific, uniform dose effective for all individuals. The aim is to obtain a therapeutic effect with minimal dosage and with minimal or no metabolic alterations. A clinical response is secured within 2 weeks in the majority of conditions. *Once the disease is under control, decrease the total daily dose as rapidly as possible consistent with maintaining a remission—thus try to reduce the total dose to about 75% of that needed initially. If adequate, this dosage is continued for 3–7 days before making a further similar reduction. When the lowest daily maintenance dose is thus established, attempts should be made at lengthening the interval between doses. If symptoms are not suppressed after dosage reduction, return to the previous effective schedule. If the nature of the disease requires maintenance therapy, aim to employ the smallest effective dose with the longest possible interval between injections. If the doses needed for full relief produce significant "side effects", reduce the dose and be satisfied with less than full suppression of disease under management.*

Administration and Dosages of H.P. ACTHAR GEL (Repository Corticotropin Injection) and ACTHAR (Corticotropin Injection): Either H.P. ACTHAR GEL (Repository Corticotropin Injection) or ACTHAR (Corticotropin Injection) may be given subcutaneously, intramuscularly, or as an intravenous infusion. Since ACTHAR (Corticotropin Injection) is a lyophilized preparation, it must be reconstituted before administration by dissolving in a convenient amount of Water for Injecton or Sodium Chloride Injection in such a manner that an individual dose will be contained in 1–2 cc. of solution. Like all aqueous solutions of ACTH, ACTHAR (Corticotropin Injection) is usually given every 8–12 hours. When reconstituted, the solution should be refrigerated. *SUBCUTANEOUS OR INTRAMUSCULAR TREATMENT OF SPECIFIC DISEASES—Note:* The dosages expressed are for H.P. ACTHAR GEL (Repository Corticotropin Injection) only. For ACTHAR (Corticotropin Injection) give the same total daily dose stated for H.P. ACTHAR GEL (Depository Corticotropin Injection) but give this in 3 divided doses every 8 hours initially. Tapering and maintenance regimens should be carefully observed.

For children under 40 lbs. in weight, reduce by one-third the dose recommended below. The dosages stated below for specific diseases are suggestive only and not absolute. *ADRENAL INSUFFICIENCY—secondary to pituitary deficiency or to corticoid-induced adrenal atrophy. As a rule, 100 Units daily for 3 days will reactivate the corticoid-suppresed adrenal and 40 Units twice a week or 100 Units weekly will prevent adrenal atrophy induced by the administration of corticosteroids. ALCOHOLISM and D.T.'S—40–60 Units once daily; recovery usually within 36 hours. Injections may be continued 3 times a week for several weeks. ANGIONEUROTIC EDEMA—60–80 Units once daily or 40–50 Units b.i.d. if severe; maintenance treatment not required if cause removed. ANOGENITAL PRURITIS—60–80 Units once daily or 40–50 Units b.i.d. if severe. ARTHRITIS, RHEUMATOID including SPONDYLITIS, STILL'S DISEASE and PSORIATIC—60–80 Units once daily; 40–50 Units b.i.d. for severe cases. Maintenance therapy usually required. ASTHMA—60–80 Units daily or 40–50 Units b.i.d.; maintenance treatment may be necessary. BURNS—60–80 Units daily or 40–50 Units b.i.d. if severe; give for 5–10 days reducing dosage as patient's condition improves. BURSITIS—60–80 Units daily; results in hours especially in acute cases. COLITIS. Ulcerative—60–80 Units daily or 40–50 Units b.i.d. for severe*