

POTASSIUM BINDERS

MEDICATION(S)

VELTASSA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

Drug Class: Potassium Binders

Preferred Agents: No Prior Authorization required

Lokelma® powder packets
sodium polystyrene sulfonate oral powder
SPS Suspension
kionex suspension

Non-Preferred Agents: Prior Authorization Criteria below

Veltassa® oral powder packets

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure after a one-month trial of one preferred medication

?Duration of Approval: 1 year

Effective 11/1/24

TRYVIO/ APROCITENTAN

MEDICATION(S)

TRYVIO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

Drug Class: Endothelin Receptor Antagonist (ERA)

FDA-approved uses: Resistant Hypertension (RH)

Available dosage forms: 12.5 mg tablet

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Resistant Hypertension despite concurrent use of 3 or more antihypertensive drug classes

?Duration of approval:

oInitial authorization: 1 year

oContinuation of Therapy: 1 year

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oClinical documentation demonstrating failure to reach blood pressure goal despite concurrent use of 3 or more antihypertensive drug classes, AND

oClinical documentation demonstrating failure to reach blood pressure goal despite addition of a mineralocorticoid receptor antagonist (i.e., spironolactone OR eplerenone) to the current 3 drug regimen,

OR

oContraindication (i.e. hyperkalemia, renal impairment, etc.) or drug to drug interaction (i.e. CYP3A4 Inhibitors, potassium-sparing diuretics, etc.) preventing the use of both spironolactone and eplerenone,
AND

oFor patients who can become pregnant, the prescriber attests:

?patient is not pregnant or lactating

?patient has been counseled on the risk of major birth defects AND to use acceptable methods of contraception before treatment with TRYVIO, during treatment with TRYVIO, and for one month after treatment discontinuation, AND

oPrescriber is enrolled in TRYVIO REMS program

?Specialty: Prescribed by or in consultation with a specialist with experience in the treatment of RH such as a cardiologist, nephrologist or endocrinologist

?Quantity: 1 tablet per day

?Age: 18 years of age and older

Criteria for continuation of therapy:

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oFor patients who can become pregnant, prescriber attests patient is not pregnant or lactating

oClinical documentation demonstrates blood pressure improvement compared to baseline

oPrescriber attests that patient has not experienced unacceptable adverse effects from TRYVIO therapy (i.e. hepatotoxicity, clinically significant anemia, clinically significant edema)

Contraindications/Exclusions/Discontinuation:

•Pregnancy/lactation

UPHP MEDICAID - 2ND GEN ANTIHISTAMINES

MEDICATION(S)

ALLERGY RLF(CETRZN) 10 MG SFGL, CVS ALLERGY(CETRZN) 10 MG SFGL, CETIRIZINE HCL 10 MG CHEW TAB, CETIRIZINE HCL 5 MG CHEW TAB, CETIRIZINE HCL 5 MG/5 ML CUP, CHILD CETIRIZINE 10 MG CHEW TB, CHILD CETIRIZINE 5 MG CHEW TAB, CLARINEX, DESLORATADINE, LEVOCETIRIZINE 2.5 MG/5 ML SOL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIHISTAMINES – 2ND GENERATION

Drug Class: Antihistamines – 2nd Generation

Preferred Agents: No Prior Authorization required

cetirizine tablets

cetirizine 1mg/ml solution

fexofenadine suspension

fexofenadine tablets

levocetirizine tablets

loratadine

Non-Preferred Agents: Prior Authorization Criteria below

cetirizine chewable tabs

cetirizine 5mg/5ml solution cups

Clarinex®

desloratadine

levocetirizine solution

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Trial and failure on one preferred second-generation antihistamine or clinical rationale why they cannot be tried

Duration of Approval: 1 year

Effective 10/1/20, Updated 8/1/21

Updated 8/1/22

UPHP MEDICAID - 5-APLHA REDUCTASE INH

MEDICATION(S)

AVODART, DUTASTERIDE-TAMSULOSIN, PROSCAR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BPH AGENTS – 5-ALPHA REDUCTASE (5AR) INHIBITORS

Drug Class: BPH Agents – 5-Alpha Reductase (5AR) Inhibitors

Preferred Agents: No Prior Authorization required

Dutasteride capsule

finasteride 5mg tablet (generic for Proscar®)

Non-Preferred Agents: Prior Authorization Criteria below

Avodart® softgel

dutasteride/tamsulosin capsule

Proscar® tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects

- Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - ACE INHIBITORS

MEDICATION(S)

ACCUPRIL, ACCURETIC, ALTACE, CAPTOPRIL 100 MG TABLET, CAPTOPRIL 12.5 MG TABLET, CAPTOPRIL 25 MG TABLET, CAPTOPRIL 50 MG TABLET, CAPTOPRIL-HYDROCHLOROTHIAZIDE, ENALAPRIL 1 MG/ML ORAL SOLN, EPANED, FOSINOPRIL SODIUM, FOSINOPRIL-HYDROCHLOROTHIAZIDE, LOTENSIN, LOTENSIN HCT, MOEXIPRIL HCL, PERINDOPRIL ERBUMINE, QBRELIS, QUINAPRIL HCL, QUINAPRIL-HYDROCHLOROTHIAZIDE, TRANDOLAPRIL, VASERETIC, VASOTEC, ZESTORETIC, ZESTRIL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ACE INHIBITORS

Drug Class: ACE Inhibitors

Preferred Agents: No Prior Authorization required

benazepril/ benazepril HCT

enalapril/ enalapril HCT tablet

lisinopril/ lisinopril HCT

ramipril

Non-Preferred Agents: Prior Authorization Criteria below

Accupril® tablet

Accuretic® tablet
Altace® capsule
captopril/ captopril HCT tabs
enalapril solution (generic Epaned)
Epaned® solution
fosinopril/ fosinopril HCT tab
Lotensin®/ Lotensin HCT® tab
moexipril
Monopril® / Monopril HCT®
perindopril tablet
Qbrelis® solution
quinapril / quinapril HCT tab
trandolapril tablet
Vasotec® / Vaseretic® tablet
Zestril® / Zestoretic® tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Patient is clinically stable and switching would cause a deterioration in condition
- Therapeutic failure on one preferred medication
- See additional medication-specific criteria below:

EPANED® (enalapril solution)

- PDL criteria may be bypassed if patient is unable to swallow tablets.

QBRELIS®

- PDL criteria may be bypassed if patient is unable to swallow tablets.

Duration of Approval: 1 year

Effective 10/1/20

Updated 9/1/21

UPHP MEDICAID - ACEI COMBINATIONS

MEDICATION(S)

LOTREL, TRANDOLAPR-VERAPAM ER 2-180 MG, TRANDOLAPR-VERAPAM ER 2-240 MG,
TRANDOLAPR-VERAPAM ER 4-240 MG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIHYPERTENSIVE COMBINATIONS: ACEI

Drug Class: Antihypertensive Combinations: ACEI

Preferred Agents: No Prior Authorization required

amlodipine / benazepril capsule

Non-Preferred Agents: Prior Authorization Criteria below

Lotrel® capsule

Prestalia®

trandolapril / verapamil tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR

- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - ALPHA ADRENERGIC AGENTS

MEDICATION(S)

METHYLDOPA-HYDROCHLOROTHIAZIDE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ALPHA ADRENERGIC AGENTS

Drug Class: Alpha Adrenergic Agents

Preferred Agents: No Prior Authorization required

clonidine

clonidine ER

clonidine transdermal

guanfacine

methyldopa

Nexiclon XR

Non-Preferred Agents: Prior Authorization Criteria below

methyldopa / HCTZ

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications

- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure on one preferred medication

Duration of Approval: 1 year

Updated 7/1/2021

Updated 9/1/22

Updated 11/1/22

Updated 10/18/24

UPHP MEDICAID - ALPHA BLOCKERS

MEDICATION(S)

CARDURA, CARDURA XL, FLOMAX, MINIPRESS, RAPAFLO, SILODOSIN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BPH AGENTS – ALPHA BLOCKERS

Drug Class: BPH Agents – Alpha Blockers

Preferred Agents: No Prior Authorization required

Alfuzosin tablet

Doxazosin tablet

Prazosin capsule

Tamsulosin capsule

Terazosin capsule

Non-Preferred Agents: Prior Authorization Criteria below

Cardura® tablet

Cardura XR® tablet

Flomax® capsule

Minipress® capsule

Rapaflo® capsule

Silodosin (generic for Rapaflo) capsule

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year, unless otherwise noted in drug-specific criteria

Effective 10/1/20

UPHP MEDICAID - ALZHEIMER'S DEMENTIA

MEDICATION(S)

ADLARITY, ARICEPT, DONEPEZIL HCL 23 MG TABLET, GALANTAMINE ER, GALANTAMINE HYDROBROMIDE, MEMANTINE HCL ER, NAMENDA, NAMENDA XR, NAMZARIC, RIVASTIGMINE 13.3 MG/24HR PTCH, RIVASTIGMINE 4.6 MG/24HR PATCH, RIVASTIGMINE 9.5 MG/24HR PATCH

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ALZHEIMER'S DEMENTIA

Drug Class: Alzheimer's Dementia

Preferred Agents: No Prior Authorization required
donepezil tabs, ODT

Exelon® patch

galantamine immediate release tablet

memantine immediate release tabs, solution

rivastigmine capsules

Non-Preferred Agents: Prior Authorization Criteria below

Adlarity

Aricept® tablet

donepezil 23 mg® tablet

galantamine ER caps, solution

memantine ER capsule

Namenda® tablet

Namenda XR® capsule

Namzaric® capsule

rivastigmine patch

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - AMPYRA/DALFAMPRIDINE ER

MEDICATION(S)

DALFAMPRIDINE ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

AMPYRA® / DALFAMPRIDINE

Drug Class: Multiple Sclerosis Agent – Potassium Channel Blocker

FDA-approved uses: Indicated as a treatment to improve walking in patients with multiple sclerosis (MS).

Available dosage forms: 10 mg Extended-Release Tablet

Coverage Criteria/Limitations for initial authorization

Diagnoses: Documented diagnosis of multiple sclerosis with impaired walking ability

Duration of Approval:

Initial Authorization: 6 months

Continuation of Therapy: 1 year

Prescriber Specialty: Prescribed by a neurologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPatient must not be wheelchair-bound

oPatient must not have a history of seizures

oPatient must not have moderate to severe renal impairment (Crcl less than 50 ml/min)

- oPatient must be on disease modifying therapy for MS/confirmed diagnosis of MS
- oDocumentation of significant and continuous walking impairment that impairs ability to complete normal activities of daily living (such as meal preparation, household chores, etc.) attributable to ambulation or functional status despite optimal treatment for Multiple Sclerosis
- oAnd, Baseline 25-ft walking test between 8 and 45 seconds

OR

- oMember is ambulatory* AND has an Expanded Disability Status Scale (EDSS)** score greater than or equal to 4.5 but less than 7

*Does not require the use of a wheelchair (bilateral assistance is acceptable, such as a brace, cane, or crutch, as long as the patient can walk 20 meters without resting)

**The Expanded Disability Status Score (EDSS) quantifies disability in eight functional systems: pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, cerebral, and other. EDSS scores 1.0 to 4.5 refer to people with multiple sclerosis who are fully ambulatory. EDSS scores 5.0 to 9.5 are defined by increasing impairment to ambulation.

Quantity: 2 per day

Age: Patient is between 18 and 70 years old

Route of Administration: Oral

Criteria for continuation of therapy

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oMember currently meets ALL initial coverage criteria confirmed by documentation
- oAdherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history
- oFunctional impairment resolved as a result of increased speed of ambulation resulting in the member being able to complete instrumental activities of daily living (such as meal preparation, household chores, etc.)

AND

- oImprovement of at least 20% in timed walking speed as documented by the T25FW (timed 25-foot walk) from pre-treatment baseline:

Contraindications/Exclusions/Discontinuation:

- Patient does NOT have a diagnosis of spinal cord injury, myasthenia gravis, demyelinating peripheral neuropathies (such as Guillain-Barré syndrome), Alzheimer's disease, and Lambert Eaton myasthenic syndrome.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

UPHP MEDICAID - ANDROGENIC AGENTS

MEDICATION(S)

ANDROGEL, FORTESTA, NATESTO, TESTIM, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, VOGELXO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANDROGENIC AGENTS (TOPICAL)

Drug Class: Androgenic Agents (topical)

Preferred Agents: Clinical Prior Authorization below testosterone gel pump (generic for Androgel)

Clinical PA Criteria:

- Serum testosterone levels less than 300 ng/dL
- For requests submitted for gender dysphoria

oINITIAL REQUEST

Patient has had an initial evaluation completed by a health care provider experienced in gender dysphoria that specializes in treatment and evaluation of gender disorders (including health history, physical exam,

desired treatment goals and relevant lab testing), AND

Persistent well documented gender dysphoria, AND

Patient has the ability to make a fully informed decision and consent of treatment, AND

Prior consent for treatment including potential adverse health effects, expected benefits/effects including future body image changes and potential effects on fertility, AND

No significant medical or mental health concerns and, if so, they been addressed and been deemed to not be a contraindication to therapy

oRENEWAL REQUEST

Patient has had ongoing follow-up and monitoring following standard guidelines including addressing mental health concerns (for example, Version 7 WPATH Standards of Care or 2017 Clinical Practice Guideline, Endocrine Society <https://doi.org/10.1210/jc.2017-01658>)

•Contraindications:

Severe renal or cardiac diseases

Benign prostatic hyperplasia with obstruction

Prostate cancer

Undiagnosed genital bleeding

Breast cancer

Pregnancy

Non-Preferred Agents: Prior Authorization Criteria below

Androgel® packet and gel pump

Fortesta®

Natesto

Testim®

testosterone

Vogelxo®

Non-Preferred Agent PA Criteria:

•Trial and failure with one preferred medication is required

•Decreased testosterone levels

•Contraindications:

Severe renal or cardiac diseases

Benign prostatic hyperplasia with obstruction

Prostate cancer

Undiagnosed genital bleeding

Breast cancer

Pregnancy

Duration of Approval: 1 year

Effective 10/1/20

Updated 9/1/22

Updated 10/21/24

UPHP MEDICAID - ANGIOTENSIN II-RECEPTOR NEPRILYSIN INHIBITORS (ARNIS)

MEDICATION(S)

SACUBITRIL-VALSARTAN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANGIOTENSIN II-RECEPTOR NEPRILYSIN INHIBITORS (ARNIS)

Drug Class: Angiotensin II-Receptor Neprilysin Inhibitors (ARNIs)

Preferred Agents: No Prior Authorization required

Entresto®

Non-Preferred Agents: Prior Authorization Criteria below

sacubitril-valsartan

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications; OR
- Contraindication or drug to drug interaction with the preferred medications; OR
- History of unacceptable side effects; OR
- Therapeutic failure on one preferred medication

Quantity Limit:

Entresto®60 tablets per 30 days

sacubitril-valsartan60 tablets per 30 days

Effective 12/1/24

UPHP MEDICAID - ANTI-OBESITY AGENTS

MEDICATION(S)

ADIPEX-P, BENZPHETAMINE HCL, DIETHYLPROPION 25 MG TABLET, DIETHYLPROPION HCL ER, LOMAIRA, ORLISTAT 120 MG CAPSULE, PHENDIMETRAZINE TARTRATE, PHENDIMETRAZINE TARTRATE ER, PHENTERMINE 15 MG CAPSULE, PHENTERMINE 30 MG CAPSULE, PHENTERMINE 37.5 MG CAPSULE, PHENTERMINE 37.5 MG TABLET, SAXENDA, WEGOVY, XENICAL, ZEPBOUND 10 MG/0.5 ML PEN, ZEPBOUND 12.5 MG/0.5 ML PEN, ZEPBOUND 15 MG/0.5 ML PEN, ZEPBOUND 2.5 MG/0.5 ML PEN, ZEPBOUND 5 MG/0.5 ML PEN, ZEPBOUND 7.5 MG/0.5 ML PEN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTI-OBESITY AGENTS

Drug Class: Anti-Obesity Agents

Preferred Agents: Clinical Prior Authorization below

Adipex-P (phentermine), C-IV

benzphetamine (only available as generic), C-III

diethylpropion (only available as generic), C-IV

Lomaira (phentermine), C-IV

orlistat
phendimetrazine (only available as generic), C-III
phentermine, C-IV
Saxenda (liraglutide)
Wegovy (semaglutide)
Xenical (orlistat)
Zepbound®

Clinical Prior Authorization

Initial

- ?Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently, AND
- ?Patient age greater than or equal to 12 years (Wegovy, Xenical, Saxenda), OR
- ?Patient age greater than or equal to 17 years (phentermine), AND
- Patient age greater than or equal to 12 years to less than 18 years must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity), OR
- Patient age greater than or equal to 12 years to less than 18 years with BMI in the 85th – 94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions:
 - o diabetes, sleep apnea, hypertension, or dyslipidemia, OR
- ?Patient age greater than or equal to 18 years (benzphetamine, diethylpropion, phendimetrazine, Zepbound®), AND
- ?Patient age greater than or equal to 18 years must have an initial body mass index [BMI] greater than or equal to than 30 kg/m², OR
- ?Patient age greater than or equal to 18 years must have an initial body mass index [BMI] greater than or equal to than 27 kg/m² but less than 30 kg/m² and at least one of the following:
 - o hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea, OR
 - o This medication is being prescribed for cardiovascular risk reduction in members with prior myocardial infarction, prior stroke, or peripheral arterial disease (Wegovy), AND
- ?For patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatments, AND
- ?Prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.), AND

Clinical Prior Authorization Initial, Continued

- ?Prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II, AND

?Prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability, AND

?Prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted.

MDHHS recommends that prescribers consider the benefits of a diabetes prevention program for their patients.

Renewal

?For patient's age greater than or equal to 12 years to less than 18 years, prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy.

•For adults age greater than or equal to 18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of greater than or equal to 5% from baseline weight at initiation of therapy.

?Duration of Approval: Initial = 6 months, Renewal = 6 months

Updated 10/21/24

UPHP MEDICAID - ANTIBIOTIC - INHALED

MEDICATION(S)

TOBI, TOBRAMYCIN 300 MG/4 ML AMPULE, TOBRAMYCIN PAK 300 MG/5 ML

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIBIOTICS – INHALED

Drug Class: Antibiotics – Inhaled

Preferred Agents: No Prior Authorization required

Bethkis® ampule

Cayston® inhalation solution

Kitabis® pak

Tobi-Podhaler®

tobramycin solution (generic for Tobi inhalation solution)

Non-Preferred Agents: Prior Authorization Criteria below

tobramycin pak (generic for Kitabis pak)

TOBI inhalation solution

tobramycin ampule (generic for Bethkis ampule)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Trial and failure with one month with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - ANTICOAGULANTS

MEDICATION(S)

ARIXTRA, DABIGATRAN ETEXILATE 110 MG CP, FONDAPARINUX SODIUM, FRAGMIN 10,000 UNIT/ML SYRINGE, FRAGMIN 12,500 UNIT/0.5 ML SYR, FRAGMIN 15,000 UNIT/0.6 ML SYR, FRAGMIN 18,000 UNIT/0.72 ML, FRAGMIN 2,500 UNIT/0.2 ML SYR, FRAGMIN 5,000 UNIT/0.2 ML SYR, FRAGMIN 7,500 UNIT/0.3 ML SYR, FRAGMIN 95,000 UNIT/3.8 ML VL, LOVENOX, PRADAXA 110 MG PELLETT PACK, PRADAXA 150 MG PELLETT PACK, PRADAXA 20 MG PELLETT PACK, PRADAXA 30 MG PELLETT PACK, PRADAXA 40 MG PELLETT PACK, PRADAXA 50 MG PELLETT PACK, SAVAYSA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTICOAGULANTS

Drug Class: Anticoagulants

Preferred Agents: No Prior Authorization required

Eliquis® tablet

enoxaparin syringe, vial

Jantoven® tablet

Pradaxa® capsule

warfarin tablet

Xarelto®/ Xarelto® Dose Pack tablet

Non-Preferred Agents: Prior Authorization Criteria below

Arixtra® syringe

Bevyxxa® capsule

dabigatran etexilate

fondaparinux syringe

Fragmin® syringes and vials

Lovenox® syringe

Pradaxa oral pellets

Savaysa® tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure on one preferred medication
- See additional medication-specific criteria below:

Pradaxa Oral Pellets (dabigatran)

Patient must be less than or equal to 11 years old

When used for VTE prophylaxis, attestation that parenteral anticoagulation has been used for at least 5 days

BEVYXXA® (BETRIXABAN)

- Patient age: ≥18 years
- Patient has received Bevyxxa during hospitalization and will be continuing therapy following discharge from the hospital
- Patient at increased risk for VTE
- Quantity limit: 43 caps per 42 days
- Length of approval: 1 fill

SAVAYSA®

- Trial on Xarelto®, AND
- Patient must be 18 years or older

Duration of Approval: Current prescription up to 6 months

Effective 10/1/20

Update 8/1/22

UPHP MEDICAID - ANTIEMETICS

MEDICATION(S)

AKYNZEO 300-0.5 MG CAPSULE, APREPITANT 125-80-80 MG PACK, EMEND 125 MG POWDER PACKET, EMEND 80 MG CAPSULE, EMEND TRIPACK, ONDANSETRON ODT 16 MG TABLET, SANCUSO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIEMETICS

Drug Class: Antiemetics

Preferred Agents: No Prior Authorization required

aprepitant

granisetron

ondansetron

Non-Preferred Agents: Prior Authorization Criteria below

Akynzeo®

Emend® 80mg capsules

Emend Pack®

Sancuso®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with 48-hour trial with one preferred medication
- See additional medication-specific criteria below:

AKYNZEO

- May only be approved for highly emetogenic regimens or regimens including anthracyclines and cyclophosphamide that are not considered highly emetogenic and
- Therapeutic failure on a preferred 5-HT3 receptor antagonist (granisetron, ondansetron) and a preferred substance P receptor agonist (Emend)

QUANTITY LIMITS

Akynzeo® (netupitant/palonosetron) 1 per fill

Emend® (aprepitant) tab 125mg/80mg dose pack - 3 tablets per claim – billed by the tablet,
not by the pack

40mg, 125mg tablet - 1 tablet per claim 80mg tablet - 2 tablets per claim

granisetron (Kytril®) 1mg tab 60 per 30 days

granisetron (Kytril®) 1mg/5ml oral soln 150 mL per fill

ondansetron (Zofran®) ODT 4mg, 8mg Tablets – 60 per 30 days

ODT 16mg tablets – 30 per 30 days

4mg/5ml oral solution - 75mL per fill

Sancuso® (granisetron) transdermal patch 1 patch every 5 days

Duration of Approval: 1 year

Effective 10/1/20

Update 8/15/22, 7/29/24

UPHP MEDICAID - ANTIHYPERURICEMIC AGENTS

MEDICATION(S)

COLCHICINE 0.6 MG CAPSULE, COLCRYS, FEBUXOSTAT, GLOPERBA, MITIGARE, ULORIC, ZYLOPRIM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIHYPERURICEMIC AGENTS

Drug Class : Antihyperuricemic Agents

Preferred Agents: No Prior Authorization required

allopurinol tablet

colchicine tablets (generic for Colcrys)

probenecid/colchicine tablet

probenecid tablet

Non-Preferred Agents: Prior Authorization Criteria below

colchicine capsules (generic for Mitigare)

Colcrys (colchicine) tablet

febuxostat tablet

Mitigare® (colchicine capsules)

Uloric (febuxostat) tablet

Zyloprim (allopurinol) tablet
Gloperba (colchicine) Oral Solution

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure after one-month trial of one preferred agent
- See additional medication-specific criteria below:

COLCRYS® (COLCHICINE) TABLETS

- PDL criteria may be bypassed for diagnosis of treatment of an acute gout flare or Familial Mediterranean Fever prophylaxis.

GLOPERBA® (COLCHICINE) ORAL SOLUTION

- Patient has difficulty swallowing tablets or has an enteral tube feeding

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/1/21

UPHP MEDICAID - ANTIPARKINSON'S - DOPAMINE AGONISTS

MEDICATION(S)

BROMOCRIPTINE 2.5 MG TABLET, BROMOCRIPTINE 5 MG CAPSULE, NEUPRO, PARLODEL 5 MG CAPSULE, PRAMIPEXOLE ER, ROPINIROLE ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIPARKINSON'S AGENTS – DOPAMINE AGONISTS

Drug Class: AntiParkinson's Agents – Dopamine Agonists

Preferred Agents: No Prior Authorization required

pramipexole

ropinirole

Non-Preferred Agents: Prior Authorization Criteria below

bromocriptine

Neupro®

pramipexole ER

ropinirole ER

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure of one month with one preferred medication
- Patients using bromocriptine for indications other than Parkinson's do not need to meet non-preferred agent criteria
- See additional medication-specific criteria below:

NEUPRO® (ROTIGOTINE)

- Quantity Limit (all strengths): 30 patches per 30 days

?Duration of Approval: 1 year

Duration of Approval: 1 year

Effective 10/1/2020

Updated 5/1/21

Updated 9/11/24

Updated 10/18/24

UPHP MEDICAID - ANTIPARKINSON'S AGENTS - OTHER

MEDICATION(S)

AMANTADINE 100 MG TABLET, AZILECT, CARBIDOPA 25 MG TABLET, CARBIDOPA-LEVO 10-100 MG ODT, CARBIDOPA-LEVO 25-100 MG ODT, CARBIDOPA-LEVO 25-250 MG ODT, CARBIDOPA-LEVODOPA-ENTACAPONE, COMTAN, DHIVY, DUOPA, ENTACAPONE, GOCOVRI, INBRIJA, LODOSYN, NOURIANZ, ONGENTYS, OSMOLEX ER 129 MG TABLET, OSMOLEX ER 258 MG TABLET, RASAGILINE MESYLATE 0.5 MG TAB, RASAGILINE MESYLATE 1 MG TAB, RYTARY, SELEGILINE HCL 5 MG CAPSULE, SELEGILINE HCL 5 MG TABLET, SINEMET 10-100, SINEMET 25-100, STALEVO 100, STALEVO 125, STALEVO 150, STALEVO 200, STALEVO 50, STALEVO 75, TASMAR, TOLCAPONE, XADAGO, ZELAPAR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIPARKINSON'S AGENTS – OTHER

Drug Class: AntiParkinson's Agents – Other

Preferred Agents: No Prior Authorization required (except rasagiline)

amantadine capsule, syrup

benztropine tablet (*Carve Out)

carbidopa/levodopa IR tablets

entacapone

rasagiline

trihexyphenidyl tablet (*Carve Out)

Rasagiline (AZILECT)

patient is 18 years or older

Non-Preferred Agents: Prior Authorization Criteria below

amantadine tablet

Azilect® tablet

carbidopa tablet

carbidopa tablet / levodopa ER, ODT

carbidopa/levodopa/entacapone tablet

Comtan® tablet

Dhivy®

Duopa® suspension

Gocovri® capsule

Inbrija® inhalation cap

Lodosyn® tablet

Nourianz® tablet

Ongentys

rasagiline tablet

Rytary® capsule

selegiline capsule, tablet

Sinemet®, Sinemet CR® tablet

Stalevo® tablet

Tasmar® tablet

tolcapone tablet

trihexyphenidyl elixir (*Carve Out)

Xadago® tablet

Zelapar® tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure of one month with one preferred medication
- See additional medication-specific criteria below:

AZILECT® (RASAGILINE)

- Patient is greater than 18 years of age

GOCOVRI® (AMANTADINE EXTENDED-RELEASE)

- Diagnosis of dyskinesia associated with Parkinson's disease, OR
- Experiencing Off-episodes of Parkinson's disease, AND
- The patient is receiving concomitant levodopa-based therapy, AND
- Patient has failure, contraindication or intolerance to immediate-release amantadine

INBRIJA® (LEVODOPA INHALATION)

- Prescribed by or in consultation with a neurologist, AND
- Medication will be used concomitantly with levodopa/carbidopa

ONGENTYS® (OPICAPONE)

- Patient has a diagnosis of Parkinson's Disease, AND
- Patient is experiencing 'off' time on levodopa/carbidopa therapy, AND
- Medication will be used concomitantly with levodopa/carbidopa and will not be used as monotherapy.

RYTARY® (CARBIDOPA/LEVODOPA)

- Patient is 18 years of age or older AND
- Prescribed by or in consultation with a neurologist

XADAGO® (SAFINAMIDE)

- Patient must be 18 years or older
- Patient is experiencing 'off' time on levodopa/carbidopa therapy, AND
- Medication will be used concomitantly with levodopa/carbidopa and will not be used as monotherapy.

Duration of Approval: Up to 1 year

Effective 10/1/20

Updated 2/1/22

Updated 10/18/24

UPHP MEDICAID - ANTIPSORIATIC - TOPICAL VITAMIN D ANALOGUES

MEDICATION(S)

CALCIPOTRIENE 0.005% CREAM, CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

DOVONEX® / CALCIPOTRIENE

Drug Class: Dermatological - Antipsoriatics

FDA-approved uses: The relief of Psoriasis

Available dosage forms: 0.005% Cream, Ointment and Solution

Coverage Criteria/Limitations for initial authorization

Diagnoses: Psoriasis

Duration of Approval

oInitial Authorization: 6 months

oContinuation of Therapy: 12 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPrescribed to treat an FDA approved indication for Topical Vitamin D analogs AND

oDocumented trial, failure or intolerance of at least one high potency or very high potency topical steroid

OR

Route of Administration: For Topical Use Only

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oRequires a positive response to therapy

Contraindications/Exclusions/Discontinuation:

Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy

Effective 10/1/20

UPHP MEDICAID - ANTIVIRALS - HERPES

MEDICATION(S)

VALTREX, ZOVIRAX 5% CREAM, ZOVIRAX 5% OINTMENT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIVIRALS – HERPES

Drug Class: Antivirals – Herpes

Preferred Agents: No Prior Authorization required

acyclovir tablets, capsules, suspension

famciclovir

valacyclovir

Non-Preferred Agents: Prior Authorization Criteria below

Valtrex®

Zovirax®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR

- Trial and failure on ten days of two preferred medications

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 10/18/24

UPHP MEDICAID - ANTIVIRALS - INFLUENZA

MEDICATION(S)

FLUMADINE, TAMIFLU

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIVIRALS – INFLUENZA

Drug Class: Antivirals – Influenza

Preferred Agents: No Prior Authorization required

Oseltamivir

Relenza®

Rimantadine

Xofluza®

Non-Preferred Agents: Prior Authorization Criteria below

Flumadine®

Tamiflu®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR

- History of unacceptable side effects, OR
- Therapeutic failure with a five-day trial with two preferred medications

QUANTITY LIMITS

Tamiflu® and solution (oseltamivir) – brand & generic Capsules – 14 per fill

12 mg/mL solution – 50 mL per fill

6 mg/mL – 120 mL per fill

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 5/1/21

Updated 8/1/22

Updated 8/15/22

UPHP MEDICAID - ARB COMBINATIONS

MEDICATION(S)

AZOR, EXFORGE, EXFORGE HCT, OLMESARTAN-AMLODIPINE-HCTZ, TELMISARTAN-AMLODIPINE, TRIBENZOR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIHYPERTENSIVE COMBINATIONS: ARB

Drug Class : Antihypertensive Combinations: ARB

Preferred Agents: No Prior Authorization required

amlodipine/olmesartan tablet

amlodipine/valsartan tablet

amlodipine/valsartan/HCTZ tablet

Non-Preferred Agents: Prior Authorization Criteria below

Azor® tablet

amlodipine/olmesartan/HCTZ tablet

Exforge® / Exforge HCT® tablet

telmisartan/amlodipine tablet

Tribenzor® tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/1/21

MEDICATION(S)

ATACAND, ATACAND HCT, AVALIDE, AVAPRO, BENICAR, BENICAR HCT, CANDESARTAN
CILEXETIL, CANDESARTAN-HYDROCHLOROTHIAZID, COZAAR, DIOVAN, DIOVAN HCT, EDARBI,
EDARBYCLOR, EPROSARTAN MESYLATE, HYZAAR, IRBESARTAN, IRBESARTAN-
HYDROCHLOROTHIAZIDE, MICARDIS, MICARDIS HCT, TELMISARTAN, TELMISARTAN-
HYDROCHLOROTHIAZID

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANGIOTENSIN RECEPTOR ANTAGONISTS

Drug Class: Angiotensin Receptor Antagonists

Preferred Agents: No Prior Authorization required

losartan/ losartan HCT tablet

olmesartan, olmesartan HCT tablet

valsartan/ valsartan HCT tablet

Non-Preferred Agents: Prior Authorization Criteria below

Atacand® / Atacand HCT® tablet

Avapro®/ Avalide® tablet

Benicar®/ Benicar HCT® tablet

candesartan/ candesartan HCT tablet
Cozaar® tablet
Diovan®/ Diovan HCT® tablet
Edarbi® tablet
Edarbyclor® tablet
eprosartan tablet
Hyzaar® tablet
irbesartan/ irbesartan HCT tablet
Micardis® / Micardis HCT® tablet
telmisartan/ telmisartan HCT tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Patient is clinically stable, and switching would cause a deterioration in condition
- Therapeutic failure on one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/1/21

UPHP MEDICAID - AUSTEDO (DEUTETRABENAZINE)

MEDICATION(S)

AUSTEDO, AUSTEDO XR, AUSTEDO XR TITR(12-18-24-30MG)

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

AUSTEDO/ DEUTETRABENAZINE

Drug Class Movement Disorder Therapy - Tardive Dyskinesia, Huntington's Disease

FDA-approved uses: Tardive Dyskinesia, Chorea associated with Huntington's

Available dosage forms: Tablets: 6mg, 9mg, 12mg, XR 6mg, Titration XR (12-18-24), XR 12mg, XR 18mg, XR 24mg, XR 30mg, XR 36mg, XR 42mg, XR 48mg

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Diagnosis of chorea associated with Huntington's disease, OR Tardive Dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)

Duration of approval:

oInitial authorization: 1 year

oContinuation of Therapy: 1 year

Prescriber Specialty: Prescribed by or in consultation with a neurologist or psychiatrist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

For tardive dyskinesia attestation that a baseline AIMS test has been completed

Age: Patient is 18 years of age or older

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

Attestation that a follow-up AIMS test has been completed and there has been a positive response to therapy

Effective 7/1/21

UPHP MEDICAID - BENZNIDAZOLE

MEDICATION(S)

BENZNIDAZOLE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BENZNIDAZOLE

Drug Class: Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents, TNF=alpha set

Background:

Benznidazole, a nitroimidazole antimicrobial, is indicated in pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis), caused by *Trypanosoma cruzi*.¹

Antiparasitic treatment is indicated for all cases of acute or reactivated Chagas disease and for chronic *Trypanosoma cruzi* (*T. cruzi*) infection in children up to 18 years old. Congenital infections are considered acute disease. Treatment is strongly recommended for adults up to 50 years old with chronic infection who do not already have advanced Chagas cardiomyopathy. For adults older than 50 years with chronic *T. cruzi* infection, the decision to treat with antiparasitic drugs should be individualized, weighing the potential benefits and risks for the patient. Physicians should consider factors such as the patient's age, clinical status, preference, and overall health.²

Authorization:

Diagnosis of Chagas disease (American trypanosomiasis) due to *Trypanosoma cruzi*

Authorization will be issued for 60 days.

References:

Benznidazole [prescribing information]. Laboratorios Liconsa S.A., Guadalajara, Spain. August 2017.

CDC Guidelines. Parasites – American Trypanosomiasis (also known as Chagas Disease).

<https://www.cdc.gov/parasites/chagas/>. December 2017.

Effective 10/1/20

UPHP MEDICAID - BETA BLOCKERS

MEDICATION(S)

ACEBUTOLOL 200 MG CAPSULE, ACEBUTOLOL 400 MG CAPSULE, BETAPACE 120 MG TABLET, BETAPACE 160 MG TABLET, BETAPACE 80 MG TABLET, BETAPACE AF, BETAXOLOL 10 MG TABLET, BETAXOLOL 20 MG TABLET, BISOPROLOL FUMARATE 10 MG TAB, BISOPROLOL FUMARATE 5 MG TAB, COREG, COREG CR, CORGARD, HEMANGEOL, INDERAL LA, INDERAL XL, INNOPRAN XL, KAPSPARGO SPRINKLE, LOPRESSOR, METOPROLOL-HYDROCHLOROTHIAZIDE, NADOLOL 20 MG TABLET, NADOLOL 40 MG TABLET, NADOLOL 80 MG TABLET, PINDOLOL, PROPRANOLOL-HYDROCHLOROTHIAZID, SOTYLIZE, TENORETIC 100, TENORETIC 50, TENORMIN, TIMOLOL MALEATE 10 MG TABLET, TIMOLOL MALEATE 20 MG TABLET, TIMOLOL MALEATE 5 MG TABLET, TOPROL XL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA BLOCKERS

Drug Class: Beta Blockers

Preferred Agents: No Prior Authorization required

atenolol

atenolol / chlorthalidone

bisoprolol fumarate HCT

Bystolic®

carvedilol / carvedilol ER
labetalol
metoprolol / metoprolol XL
metoprolol succinate
metoprolol tartrate
nebivolol
propranolol / propranolol LA
sotalol / sotalol AF

Non-Preferred Agents: Prior Authorization Criteria below

acebutolol
Betapace® / Betapace AF®
betaxolol
bisoprolol fumarate
Coreg® / Coreg CR®
Corgard®
Hemangeol oral solution®
Inderal LA®/ Inderal XL®
Innopran XL®
Kaspargo®
Lopressor®
metoprolol HCT
nadolol
pindolol
propranolol HCT
Sotylize®
Tenormin®/ Tenoretic®
timolol maleate
Toprol XL®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Patient is clinically stable, and switching would cause a deterioration in condition, OR
- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 9/15/21

Updated 9/11/24

Updated 10/18/24

UPHP MEDICAID - BILE SALTS

MEDICATION(S)

RELTONE, URSO, URSO FORTE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BILE SALTS

Drug Class: Bile Salts

Preferred Agents: No Prior Authorization required

ursodiol capsules (generic for Actigall)

ursodiol tablets

Non-Preferred Agents: Prior Authorization Criteria below

Actigall®

Reltone®

Urso®/Urso Forte®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR

- Therapeutic failure on a one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/1/21

Updated 9/1/22

UPHP MEDICAID - BPH AGENTS - ALPHA BLOCKERS

MEDICATION(S)

AVODART, DUTASTERIDE-TAMSULOSIN, PROSCAR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BPH AGENTS – 5-ALPHA REDUCTASE (5AR) INHIBITORS

Drug Class: BPH Agents – 5-Alpha Reductase (5AR) Inhibitors

Preferred Agents: No Prior Authorization required

dutasteride

finasteride 5mg (generic for Proscar®)

Non-Preferred Agents: Prior Authorization Criteria below

Avodart®

dutasteride/tamsulosin

Proscar®

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications, OR

- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with one preferred medication
- See additional medication-specific criteria below:

?Duration of Approval: 1 year (unless specified in drug specific criteria)

Effective 10/1/20

Updated 10/18/24

UPHP MEDICAID - BRONCHITOL/MANNITOL

MEDICATION(S)

BRONCHITOL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BRONCHITOL® / MANNITOL

Drug Class (ETC_Name): Mucolytic agent

FDA-approved uses: BRONCHITOL is a sugar alcohol indicated as add-on maintenance therapy to improve pulmonary function in adult patients 18 years of age and older with cystic fibrosis.

Available dosage forms: BRONCHITOL (mannitol) inhalation powder, 40mg of mannitol per capsule supplied in cartons containing 10, 140 or 560 capsules in blister packs co-packaged with 1, 1, and 4 inhalers respectively in a carton.

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Cystic fibrosis

Duration of approval:

oInitial authorization: 1 year

oContinuation of Therapy: for up to 1 year

Prescriber Specialty: pulmonologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- o Prescriber attestation that the Bronchitol Tolerance Test (BTT) has been performed to confirm the patient is suitable for Bronchitol therapy,
- o Trial and failure of hypertonic saline,
- o Bronchitol will be used as add-on maintenance therapy to improve pulmonary function

Quantity: Maximum 560 capsules per 28 days

Age: 18 years and older

Gender: Male and Female

Route of Administration: Oral

Place of Service: N/A

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- o Provider attestation that member has had positive response to treatment,
- o Patient did not experience event of hemoptysis (coughing up blood)

Contraindications/Exclusions/Discontinuation:

- Non-FDA-approved indications
- Hypersensitivity to mannitol or to any of the capsule components
- Failure to pass the BRONCHITOL Tolerance Test (BTT)

Other special considerations:

- Patient is also using bronchodilator (A short-acting bronchodilator should be administered 5-15 minutes before every dose of Bronchitol)

Effective 11/1/21

UPHP MEDICAID - CAMZYOS

MEDICATION(S)

CAMZYOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CAMZYOS/MAVACAMTEN

Drug Class: Cardiac Myosin Inhibitors

FDA-approved uses: CAMZYOS is a cardiac myosin inhibitor indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.

Available dosage forms: Tablets 2.5mg, 5mg, 10mg and 15mg

Coverage Criteria/Limitations for initial authorization:

?Diagnoses:

- oDiagnosis of symptomatic New York Heart Association (NYHA) class II or III obstructive hypertrophic cardiomyopathy (HCM)

?Duration of Approval:

- o Initial authorization: 6 months

- oContinuation of Therapy: 1 year

?Prescriber Specialty:

oPrescribed by a cardiologist, OR

oPrescribed in consultation with a cardiologist: Identify Cardiologist Name & NPI:_____

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oMember has a left ventricular ejection fraction (LVEF) of ? 55%, AND

oPrescriber attests that the member will not be prescribed disopyramide, ranolazine, or combination therapy of beta blocker and calcium channel blocker, while the member is receiving Camzyos, AND

oFor females of childbearing potential, a pregnancy test is performed and is negative before starting therapy. AND

oAttestation provided of patient, provider, and pharmacy enrollment in Camzyos Risk Evaluation and Mitigation Strategy (REMS) Program

?Quantity: 30 capsules per 30 days

?Age: ? 18 years of age

Criteria for continuation of therapy:

?Documentation Requirements (e.g., Labs, Medical Record, Special Studies):

oPrescribed by a cardiologist, OR

oPrescribed in consultation with a cardiologist: Identify Cardiologist Name & NPI:_____

•Prescriber attests to positive clinical response or stable disease, AND

•Prescriber attests that the member will not be prescribed disopyramide, ranolazine, or combination therapy of beta blocker and calcium channel blocker, while the member is receiving Camzyos, AND

•Prescriber attests that the member is not pregnant, AND

•LVEF is ? 50%

Contraindications/Exclusions/Discontinuation:

•Concomitant use of moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors,

•Concomitant use of moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers

•Pregnancy

Other special considerations:

•REMS program: Prescribers must be certified by enrolling in the REMS program. Patients must also enroll in the REMS program and comply with monitoring requirements. Pharmacies must be certified to dispense medication by enrolling in the REMS program.

•Verify pregnancy status prior to treatment initiation, pregnancy should be excluded prior to treatment initiation.

UPHP MEDICAID - CCB DIHYDROPYRIDINE

MEDICATION(S)

FELODIPINE ER, ISRADIPINE, KATERZIA, LEVAMLODIPINE MALEATE 5 MG TAB, NICARDIPINE 20 MG CAPSULE, NICARDIPINE 30 MG CAPSULE, NISOLDIPINE, NORLIQVA, NORVASC, SULAR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINE

Drug Class: Calcium Channel Blockers - Dihydropyridine

Preferred Agents: No Prior Authorization required

amlodipine besylate

nifedipine tablet / nifedipine SA

Non-Preferred Agents: Prior Authorization Criteria below

felodipine ER

isradipine

Katerzia®

Nicardipine

nisoldipine

Norvasc®

Procardia XL®

Sular®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Patient is clinically stable, and switching would cause a deterioration in condition OR
- Therapeutic failure with one-month trial of one preferred medication
- See additional medication-specific criteria below:

KATERZIA® SUSPENSION (AMLODIPINE)

- Patient age of 6 years or greater
- Allow if patient has swallowing difficulties

NORLIQVA® SUSPENSION (AMLODIPINE)

- Patient age of 6 years or greater
- Allow if patient has swallowing difficulties

Duration of Approval: 1 year

Effective 10/1/20

Update 11/1/22

UPHP MEDICAID - CCB NON-DIHYDROPYRIDINE

MEDICATION(S)

CALAN SR 240 MG TABLET, CARDIZEM, CARDIZEM CD, CARDIZEM LA, DILTIAZEM 24HR ER (LA), MATZIM LA, TIADYLT ER, TIAZAC, VERAPAMIL ER 120 MG CAPSULE, VERAPAMIL ER 180 MG CAPSULE, VERAPAMIL ER 240 MG CAPSULE, VERAPAMIL ER PM, VERAPAMIL SR 120 MG CAPSULE, VERAPAMIL SR 180 MG CAPSULE, VERAPAMIL SR 240 MG CAPSULE, VERELAN PM

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CALCIUM CHANNEL BLOCKERS – NON-DIHYDROPYRIDINE

Drug Class: Calcium Channel Blockers – Non-Dihydropyridine

Preferred Agents: No Prior Authorization required

Diltiazem tablet / diltiazem XR / diltiazem ER capsule

Taztia XT® capsule

verapamil / verapamil ER tablet

Non-Preferred Agents: Prior Authorization Criteria below

Calan® tablet/ Calan SR® caplet

Cardizem® tablet / Cardizem LA® tablet / Cardizem CD® capsule

diltiazem LA tablet

Matzim LA® tablet

Tiadylt ER® capsule

Tiazac® capsule

verapamil ER capsules

Verelan® / Verelan PM® pellet capsules

verapamil cap 24-hr pellet capsules

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Patient is clinically stable, and switching would cause a deterioration in condition
- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - CEPHALOSPORINS

MEDICATION(S)

CEFACTOR, CEFACTOR ER, CEFADROXIL 1 GM TABLET, CEFIXIME 100 MG/5 ML SUSP, CEFIXIME 200 MG/5 ML SUSP, CEFPODOXIME PROXETIL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CEPHALOSPORINS

Drug Class:

Cephalosporins - 1st Generation

Cephalosporins - 2nd Generation

Cephalosporins - 3rd Generation

CEPHALOSPORINS - 1ST GENERATION

Preferred Agents: No Prior Authorization required

cefadroxil capsules

cefadroxil suspension

cephalexin

Non-Preferred Agents: Prior Authorization Criteria below

cefadroxil tablets

Keflex®

CEPHALOSPORINS - 2ND GENERATION

Preferred Agents: No Prior Authorization required

Cefuroxime

cefprozil tablet

cefprozil suspension

Non-Preferred Agents: Prior Authorization Criteria below

Cefaclor

cefaclor ER

CEPHALOSPORINS - 3RD GENERATION

Preferred Agents: No Prior Authorization required

Cefdinir

cefixime capsules

CEPHALOSPORINS - 3RD GENERATION, continued

Non-Preferred Agents: Prior Authorization Criteria below

cefixime suspension

cefpodoxime tablets

cefpodoxime suspension

Suprax® chew tabs, suspension

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Infection caused by an organism resistant to the preferred cephalosporins
- Therapeutic failure (duration = 3 days) with any two preferred cephalosporins medications

QUANTITY LIMITS

cefaclor caps (Ceclor®)42 per fill

cefaclor ER tabs (Ceclor CD®)42 per fill

cefadroxil caps/tabs (Duricef®)28 per fill

cefdinir tabs (Omnicef®)28 per fill

cefpodoxime tabs (Vantin®)28 per fill

cefprozil tabs (Cefzil®)28 per fill

ceftibuten caps (Cedax®)14 per fill

cefuroxime tabs (Ceftin®)42 per fill

Duration of Approval: Date of service

Effective 10/1/20

Updated 8/1/21

Updated 5/1/22

UPHP MEDICAID - CGRP (AND OTHER) TREATMENT

MEDICATION(S)

ELYXYB, NURTEC ODT, REYVOW, UBRELVY, ZAVZPRET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIMIGRAINE AGENTS, ACUTE TREATMENT - OTHER

Drug Class: Antimigraine Agents, Acute Treatment - Other

Preferred Agents for Acute Migraines: Clinical Prior Authorization below
Nurtec ODT®

Clinical PA Criteria for Acute Migraines:

- Patient has a diagnosis of migraine with or without aura, AND
- Patient is greater than or equal to 18 years of age, AND
- Patient must have tried and failed, or have contraindication to one preferred triptan medication

NURTEC ODT® (RIMEGEPANT) – Quantity Limit: 54 tablets per 90 days

Non-Preferred Agents for Acute Migraines: Prior Authorization Criteria below
Elyxyb®
Reyvow

Ubrelvy
Zavzpret

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure after a one-month trial of the preferred medication

ELYXYB (CELECOXIB) - Quantity limit: 14 doses per 30 days

REYVOW® (LASMIDITAN) – Quantity Limit: 8 tablets per 30 days

UBRELVY® (UBROGEPANT) – Quantity Limit: 16 tablets per 30 days

ZAVZPRET® (ZAVEGEPANT) – Quantity Limit: 8 nasal spray devices per 30 days

Duration of Approval: 1 year

Effective 10/1/20

Updated 1/1/22

Updated 8/1/22

Updated 12/15/22

UPHP MEDICAID - CGRP PREVENTATIVE

MEDICATION(S)

AIMOVIG AUTOINJECTOR, AJOVY AUTOINJECTOR, AJOVY SYRINGE, EMGALITY PEN, EMGALITY 120 MG/ML SYRINGE, EMGALITY 300 MG (100 MG X3SYR), NURTEC ODT, QULIPTA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIMIGRAINE AGENTS, PREVENTIVE TREATMENT

Drug Class: Antimigraine Agents, Preventive Treatment

Preferred Agents for Migraine Prevention: Clinical Prior Authorization below

Aimovig®

Emgality®

Nurtec ODT®

Ajovy®

Clinical PA Criteria for Migraine Prevention:

•For initial requests:

oPatient has a diagnosis of migraine with or without aura, AND

o Patient is 18 years of age or older, AND

oPatient has greater than or equal to four migraine days per month for at least three months, AND

oPatient has tried and failed greater than or equal to one-month trial of any two of the following oral

medications:

?Antidepressants (e.g., amitriptyline, venlafaxine)

?Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)

?Anti-epileptics (e.g., valproate, topiramate)

?Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan),

OR

oDiagnosis of cluster headaches (Emgality only)

•For Renewal requests:

oPatient demonstrated significant decrease in the number, frequency, and/or intensity of headaches

Non-Preferred Agents for Migraine Prevention: Prior Authorization Criteria below

Qulipta®

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications, OR

•Contraindication or drug to drug interaction with the preferred medications, OR

•History of unacceptable side effects, OR

•Therapeutic failure after a one-month trial of one preferred medication

•See additional medication-specific criteria below:

QUANTITY LIMITS

Emgality® (galcanezumab-gnlm) 120 mg/mL Pen, Syringe 3 mL per 90 days

Emgality 300 mg Dose (3 x 100 mg/mL syringes) 9 mL per 90 days

Aimovig® (erenumab-aooe) 140 mg/mL Autoinjector 3 mL per 90 days

Aimovig® (erenumab-aooe) 70 mg/mL Autoinjector 6 mL per 90 days

Nurtec® ODT (rimegepant) 75mg Tablet 54 tablets per 90 days

Ajovy® (fremanezumab-vfrm) 225 mg/1.5 mL Autoinjector, Syringe 4.5 mL per 90 days

Qulipta® (atogepant) tablets 90 tablets per 90 days

An override will be approved for requests which demonstrate that prescribed loading dose will exceed the maintenance quantity limit in table above.

Duration of Approval: 6 months, Renewal = 12 months

Updated 1/1/22

Updated 5/1/22

UPHP MEDICAID - COLONY STIMULATING FACTORS

MEDICATION(S)

FULPHILA, FYLNETRA, GRANIX, LEUKINE, NEULASTA, NEULASTA ONPRO, NIVESTYM, RELEUKO, UDENYCA, ZARXIO, ZIEXTENZO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

COLONY STIMULATING FACTORS

Drug Class: Colony Stimulating Factors

Preferred Agents: No Prior Authorization required

Neupogen®

Nyvepria®

Non-Preferred Agents: Prior Authorization Criteria below

Fulphila®

Granix®

Leukine®

Neulasta® syringe, Neulasta® Onpro Kit

Nivestym®

Releuko

Stimufend

Udenyca®
Zarxio®
Ziextenzo®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with one preferred medication
- See additional medication-specific criteria below:

Quantity Limitations:

Fulphila 6mg/0.6mL syringe 0.6 mls per 14 days
Fynetra 6mg/0.6mL Syringe 0.6 mls per 14 days
Neulasta 6mg/0.6ml Syringe 0.6 mls per 14 days
Neulasta Onpro 6mg/0.6ml Kit 0.6 mls per 14 days
Nyvepria 6mg/0.6ml Syringe 0.6 mls per 14 days
Stimufend 6mg/0.6mL syringe 0.6 mls per 14 days
Fulphila 6mg/0.6ml Syringe 0.6 mls per 14 days
Udenyca 6mg/0.6ml Syringe 0.6 mls per 14 days
Ziextenzo 6mg/0.6ml Syringe 0.6 mls per 14 days
Zarxio 480mcg/0.8ml Syringe 45 mls per 30 days
Zarxio 300mcg/0.5ml Syringe 45 mls per 30 days

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/1/21

Updated 11/1/22

UPHP MEDICAID - COMBO BPO + CLINDAMYCIN

MEDICATION(S)

ACANYA, CABTREO, NEUAC, ONEXTON

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

COMBINATION BENZOYL PEROXIDE AND CLINDAMYCIN

Drug Class: Combination Benzoyl Peroxide and Clindamycin

Preferred Agents: No Prior Authorization Required
clindamycin / benzoyl peroxide

Non-Preferred Agents: Prior Authorization Criteria below

Acanya® gel and pump

Cabtreo®

clindamycin / benzoyl peroxide (generic Onexton)

Neuac 1.25% kit®

Onexton®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications

- History of unacceptable side effects
- Therapeutic failure with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 12/8/20 P&T

Updated 8/1/24

UPHP MEDICAID - CORLANOR

MEDICATION(S)

CORLANOR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CORLANOR/IVABRADINE

Drug Class (ETC_Name): Hyperpolarization-activated cycle nucleotide-gated channel blocker

FDA-approved uses: Heart failure, chronic, and heart failure, chronic, due to dilated cardiomyopathy

Available dosage forms:

-Oral solution 1mg/1ml

-Oral tablet: 5mg. 7.5mg

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Heart failure

?Duration of approval: 12 months

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDiagnosis of stable symptomatic chronic heart failure (NYHA class II, III or IV) AND

oLeft ejection fraction less than 35% AND

oThe patient is in sinus rhythm AND

oPatient has a resting heart rate greater than 70 beats per minute AND

oOne of the following:

?Patient is on maximum tolerated doses of beta-blockers (e.g. carvedilol, metoprolol, succinate, bisoprolol)

OR

?Patient has a contraindication to or intolerance to beta-blocker therapy

OR

oPediatric patients ages 6 months and older:

?Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM) AND

?Patient is in sinus rhythm AND

?Patient has an elevated heart rate for age

Criteria for continuation of therapy:

?Attestation to positive clinical response to therapy

Contraindications/Exclusions/Discontinuation:

Other special considerations:

Effective 8/1/22

UPHP MEDICAID - DARAPRIM/PYRIMETHAMINE

MEDICATION(S)

PYRIMETHAMINE 25 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

DARAPRIM® / PYRIMETHAMINE

Drug Class: Antimalarials

FDA-approved uses:

Treatment of toxoplasmosis: Daraprim is indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide.

Treatment of acute Malaria: Daraprim is indicated for the treatment of acute malaria. It should not be used alone to treat acute malaria. Fast-acting schizonticides such as chloroquine or quinine are indicated and preferable for the treatment of acute malaria. However, conjoint use of Daraprim with a sulfonamide will initiate transmission control and suppression of susceptible strains of plasmodia.

Malaria prophylaxis: Daraprim is indicated for the chemoprophylaxis of malaria due to susceptible strains of plasmodia. However, resistance to pyrimethamine is prevalent worldwide. It is not suitable as a prophylactic agent for travelers to most areas.

Available dosage forms: 25mg Tablet

Coverage Criteria/Limitations for initial authorization:

Diagnoses:

oTreatment of Toxoplasmosis

oSecondary prevention of Toxoplasmosis in patients with HIV

oPrevention of pneumocystis pneumonia in patients with HIV

Duration of Approval:

Initial Authorization:

Toxoplasmosis – 6 weeks

Pneumocystis prophylaxis – 3 months

oContinuation of Therapy:

Toxoplasmosis – 6 months

Pneumocystis – 3 months

Prescriber Specialty: infectious disease

Documentation Requirements: (e.g. Labs, Medical Record, Special Studies):

oFor Pneumocystis diagnosis ONLY: TMP/SMX, atovaquone, and dapsone

oFor Pneumocystis prophylaxis (ONE of the following):

CD4 count less than 200 cells/microL

Oropharyngeal candidiasis

CD4 count percentage less than 14 percent

CD4 cell count between 200 and 250 cells/microL IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

Quantity:

Toxoplasmosis (induction-dose): 90 tablets per 30 days

Toxoplasmosis (maintenance-dose): 60 tablets per 30 days

Pneumocystis prophylaxis: 12 tablets per 28 days

Gender: male and female

Route of Administration: oral

Place of Service: outpatient

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oFor Toxoplasmosis prophylaxis, after initial 6 weeks of induction treatment (ONE of the following):

Patient remains symptomatic

Patient is NOT receiving antiretroviral therapy (ART)

Patient has a detectable HIV viral load

Patient has maintained a CD4 count greater than 200 cells/microL for less than six months

oFor Pneumocystis prophylaxis (ONE of the following):

CD4 count less than 200 cells/microL

Oropharyngeal candidiasis

CD4 count percentage less than 14 percent

CD4 cell count between 200 and 250 cells/microL IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

Contraindications/Exclusions/Discontinuation:

- Megaloblastic anemia due to folate deficiency
- Secondary prophylaxis of Toxoplasmosis in patients with a CD4 count greater than 200 cells/microL for longer than 6 months and a sustained HIV viral load
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Daraprim is no longer recommended for malaria treatment or prophylaxis and treatment of malaria is very individualized.
- Refer to the CDC website for recommendations for treatment and prevention of malaria.

References

1.Gandhi RT. Toxoplasmosis in HIV-infected patients. Waltham, MA: UptoDate, Last modified September 21, 2015. http://www.uptodate.com/contents/toxoplasmosis-in-hiv-infected-patients?source=search_result&search=daraprim&selectedTitle=6%7E47. Accessed September 25, 2015. ?

References, continued

2.Thomas CF, Limper AH. Treatment and prevention of Pneumocystis pneumonia in non-HIV-infected patients. Waltham, MA: UptoDate, Last modified January 6, 2015. http://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-pneumonia-in-non-hiv-infected-patients?source=search_result&search=pneumocystis&selectedTitle=4%7E150. Accessed September 25, 2015.

3.Sax PE. Treatment and prevention of Pneumocystis infection in HIV-infected patients. Waltham, MA: UptoDate, Last modified August 27, 2015. http://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-infection-in-hiv-infected-patients?source=search_result&search=pneumocystis&selectedTitle=2%7E150#H2384560994. Accessed September 25, 2015.

Effective 10/1/20

UPHP MEDICAID - DESMOPRESSIN

MEDICATION(S)

DESMOPRESSIN 0.01% SOLUTION, DESMOPRESSIN 10 MCG/0.1 ML SPR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

DESMOPRESSIN NASAL SPRAY

Drug Class: Antidiuretic and vasopressor hormones

FDA-approved uses:

Diabetes Insipidus – Desmopressin Nasal Spray

Available dosage forms:

Desmopressin Nasal Spray – 0.1 mg/ml solution, 10 mcg/0.1 ml spray

Coverage Criteria/Limitations for initial authorization

Diagnoses:

o Diabetes Insipidus

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

o Documentation of Diabetes Insipidus

• Documented inadequate response to a 3-month trial of a maximum tolerated dose or clinical contraindication of Desmopressin tablets

Route of Administration: various

Contraindications/Exclusions/Discontinuation:

- Contraindicated in individuals with known hypersensitivity to desmopressin acetate or to any of its components.
- Contraindicated in patients with moderate to severe renal impairment (defined as a creatinine clearance below 50ml/min).
- Contraindicated in patients with hyponatremia or a history of hyponatremia.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- As of 2007, the intranasal formulation is no longer FDA-approved for the treatment of primary nocturnal enuresis.

Effective 10/1/20

Updated 11/1/21

UPHP MEDICAID - DIRECT RENIN INH

MEDICATION(S)

ALISKIREN, TEKTURNA, TEKTURNA HCT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

DIRECT RENIN INHIBITORS

Drug Class: Direct Renin Inhibitors

Preferred Agents: No Prior Authorization required

Non-Preferred Agents: Prior Authorization Criteria below
aliskiren

Tekturna® / Tekturna HCT®

Non-Preferred Agent PA Criteria:

- Trial/failure on an ACE inhibitor or an ARB or clinical rationale why neither is appropriate.

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - DOVONEX/CALCIPOTRIENE

MEDICATION(S)

CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

DOVONEX® / CALCIPOTRIENE

Drug Class: Dermatological - Antipsoriatics

FDA-approved uses: The relief of Psoriasis

Available dosage forms: 0.005% Cream, Ointment and Solution

Coverage Criteria/Limitations for initial authorization

Diagnoses: Psoriasis

Duration of Approval

oInitial Authorization: 3 months

oContinuation of Therapy: 6 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDiagnosis of Psoriasis

oFailure of two Topical Steroids, at least one of which must be high potency or very high potency

Route of Administration: For Topical Use Only

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oRequires a positive response to therapy

Contraindications/Exclusions/Discontinuation:

Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy

Effective 10/1/20

UPHP MEDICAID - ELECTROLYTE DEPLETERS

MEDICATION(S)

AURYXIA, CALCIUM ACETATE 667 MG CAPSULE, CALCIUM ACETATE 667 MG GELCAP, CALCIUM ACETATE 667 MG TABLET, FOSRENOL, LANTHANUM CARBONATE, PHOSLYRA, RENAGEL, RENVELA, SEVELAMER CARBONATE, SEVELAMER HCL, VELPHORO, XPHOZAH

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ELECTROLYTE DEPLETERS

Drug Class: Electrolyte Depleters

Preferred Agents: Clinical Prior Authorization below
calcium acetate capsules and tablets
sevelamer carbonate tablets (generic for Renvela)

Clinical PA Criteria:

- Diagnosis of chronic kidney disease

Non-Preferred Agents: Prior Authorization Criteria below
Auryxia®
Fosrenol® / Fosrenol® powder pak
lanthanum

Renvela powder pkts and tablets
sevelamer carbonate powder pkts (generic for Renvela)
sevelamer tablets (generic for Renagel)
Velphoro®
Xphozah®

Non-Preferred Agent PA Criteria:

- Diagnosis of chronic kidney disease
- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with one month with one preferred medication
- See additional medication-specific criteria below:

VELPHORO®

- Trial on two preferred medications.

XPHOZAH®

- Trial of two preferred medications
- Patient is currently receiving dialysis

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/24

MEDICATION(S)

ELMIRON

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ELMIRON® / PENTOSAN POLYSULFATE SODIUM

Drug Class: Urinary tract analgesic agents

FDA-approved uses: indicated for the relief of bladder pain or discomfort associated with interstitial cystitis.

Available dosage forms: 100mg Capsules

Coverage Criteria/Limitations for initial authorization

Diagnoses: interstitial cystitis

Duration of Therapy

oInitial Approval: 3 months

oContinuation of Therapy: 3 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDiagnosis of interstitial cystitis confirmed

Criteria for continuation of Therapy

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oIf pain has not improved after 3 months of therapy and if limiting adverse events have not occurred,

pentosan may be continued for an additional 3 months. The clinical benefit of treatment beyond 6 months

for patients whose pain has not improved is not known.

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

UPHP MEDICAID - ENDARI/L-GLUTAMINE

MEDICATION(S)

L-GLUTAMINE 5 GRAM POWDER PKT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ENDARI / L-GLUTAMINE

Drug Class: Sickle Cell Anemia Agents (N1H)

FDA-approved uses:

Endari is an amino acid indicated to reduce the acute complications of sickle cell disease in adult and pediatric patients 5 years of age and older.

Available dosage forms:

Oral Powder: 5 grams of L-glutamine powder per paper-foil-plastic laminate packet.

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Sickle Cell Disease

?Duration of approval:

oInitial authorization: 1-year duration upon approval

?Documented diagnosis of sickle cell disease AND

?Request is for an FDA approved dose AND

?Patient has had an inadequate response to a maximally tolerated dose of hydroxyurea OR

?Justification provided regarding intolerance, contraindication, or patient/family refusal to the use of hydroxyurea

oContinuation of Therapy: 1-year approval

?Prescriber attestation that member is tolerating current therapy AND

?Member continues on an FDA approved dose.

?Prescriber Specialty: Must be prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oMedical Record indicating

?Sickle Cell Disease

?Quantity: Maximum of 180 packets/30 days

?Age: 5 years of age and older

?Route of Administration: Oral

?Place of Service: Outpatient pharmacy

Contraindications/Exclusions/Discontinuation:

- No contraindications to report at this time.

- Warnings/Precautions: Use with caution in patients with hepatic and/or renal impairment. No specific dosage adjustments are documented.

- Safety has not been established in patients younger than 5 years old.

Effective 10/1/20

Updated 5/1/22

UPHP MEDICAID - ENSPRYNG

MEDICATION(S)

ENSPRYNG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ENSPRYNG/ SATRALIZUMAB-MWGE

Drug Class: Interleukin-6 (IL-6) Receptor Inhibitor

FDA-approved uses: Neuromyelitis optica spectrum disorder, Anti-aquaporin-4 (AQP4) antibody positive

Available dosage forms: Subcutaneous injection: 120mg/ml single-dose prefilled syringe

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Neuromyelitis optica spectrum disorder

?Duration of approval:

oInitial authorization: 12 months

oContinuation of Therapy: 12 months

?Prescriber Specialty: Prescribed by, or in consultation with, a neurologist or other provider who specializes in the treatment of NMOSD

?Documentation Requirements:

- oMember has a diagnosis of anti-aquaporin-4 (AQP4) antibody positive NMOSD, AND
- oClinical evidence of at least 1 documented relapse (including first attack) in last 12 months, AND
- oPrescriber attests that the member has been assessed for the following baseline values prior to first dose:
 - ?Hepatitis B virus
 - ?Tuberculosis
 - ?Liver transaminase levels
 - ?Neutrophil Count, AND
- oPrescriber attests that the member has or will avoid vaccinations within recommended time frames prior to initiation of Enspryng (see below), AND
- oDocumented trial and failure or medical contraindication to one of the following:
 - ?Rituximab
 - ?Azathioprine
 - ?Mycophenolate mofetil
- ?Quantity: 120 mg/mL by subcutaneous (SQ) injection at Weeks 0, 2, and 4, followed by a maintenance dosage of 120 mg every 4 weeks.
- ?Age: 18 years and older
- ?Route of Administration: Subcutaneous Injection
- ?Place of Service: Self-administered at home

Criteria for continuation of therapy:

- ?Documentation that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit)
- ?Request is for an FDA approved/medically accepted dose

Contraindications/Exclusions/Discontinuation:

- ?Prescriber attests that member has not received (or will not receive) live or attenuated-live virus vaccines within 4 weeks prior to initiation of Enspryng and non-live vaccines at least 2 weeks prior to initiation of Enspryng.

Other special considerations:

- ?Pregnancy Category: Fetal risk cannot be ruled out.
- ?Breast Feeding: Infant risk cannot be ruled out.

Effective 5/1/21

UPHP MEDICAID - ENTOCORT EC/BUDESONIDE EC

MEDICATION(S)

BUDESONIDE DR, BUDESONIDE EC

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ENTOCORT EC® / BUDESONIDE EC

Drug Class: Crohn disease - Oral

FDA-approved uses: Crohn disease (mild to moderate)

Available dosage forms: 3mg EC Capsule

Coverage Criteria/Limitations for initial authorization:

Diagnoses: active Crohn disease

Duration of approval:

oInitial authorization: 16 weeks of 9mg once daily

oContinuation of Therapy: 3 months of 6mg once daily, followed by a 3mg one daily for one month

Prescriber Specialty: Gastrointestinal (or in collaboration with GI)

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oIntolerance to or history of unacceptable side effects to prednisone (or other systemic steroids)

Quantity: 270 for 3 months, then 210 for 3 months

o16 weeks/4months – 9mg once daily (induction)

o3 months – 6mg once daily (maintenance)

o1 month – 3mg once daily (taper)

MEDICATION(S)

EOHILIA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

EOHILIA / BUDESONIDE

Drug Class : Corticosteroid

FDA-approved uses: Eohilia is a corticosteroid indicated for 12 weeks of treatment in adult and pediatric patients 11 years of age and older with eosinophilic esophagitis (EoE)

Available oral dosage forms: 2 mg/10 mL oral suspension 10 mL single-dose stick packs in a 60 count carton. Recommended dosage: 2 mg swallowed twice daily for 12 weeks

Coverage Criteria/Limitations for authorization:

?Diagnoses: Eosinophilic esophagitis

?Duration of approval:

o3 months

?Prescriber Specialty: Gastroenterologist or Allergist

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies, Provider attestation):

oPatient age 11 or older, AND

oTherapy is prescribed by or in consultation with a gastroenterologist or allergist AND

oThe patient has at least 15 eosinophils/high-power field (hpf) in the esophagus as confirmed by a biopsy AND

oPatient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor

?Age: 11 years of age and older

?Quantity Limit: 20mL/day for three months

Contraindications/Exclusions/Discontinuation:

Limitations of use: Eohilia has not been shown to be safe and effective for the treatment of EoE for longer than 12 weeks

UPHP MEDICAID - EPINEPHRINE INJ

MEDICATION(S)

AUVI-Q

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

EPINEPHRINE INJECTABLE

Drug Class: Epinephrine Injectable

Preferred Agents: No Prior Authorization required

Epi Pen®, Epi Pen Jr®

epinephrine (generic for Adrenaclick®)

epinephrine (generic for Epi Pen®)

Non-Preferred Agents: Prior Authorization Criteria below

Symjepi®

AUVI-Q

Non-Preferred Agent PA Criteria:

- Therapeutic failure with preferred medication

QUANTITY LIMITS

epinephrine (generic Adrenaclick®) 4 per fill

AUVI-Q 4 per fill

epinephrine (generics for EpiPen and EpiPen Jr)4 per fill

EpiPen® (epinephrine)4 per fill

EpiPen Jr® (epinephrine) 4 per fill

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/23/2024

MEDICATION(S)

EXSERVAN, TIGLUTIK

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

EXSERVAN FILM, TIGLUTIK SUSPENSION / RILUZOLE

Drug Class: ALS Agent - Benzathiazoles

FDA-approved uses: treatment of amyotrophic lateral sclerosis (ALS)

Available dosage forms: Exservan 50 mg Film, Tiglutik 50mg/10ml Suspension

Coverage Criteria/Limitations for initial authorization:

Diagnoses: ALS

Duration of approval:

oInitial authorization: 1 year

oContinuation of Therapy: 1 year

Prescriber Specialty: Prescribed by or in consultation with a neurologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPatient cannot swallow tablets,

Age: Greater than or equal to 18 years old

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oPatient is receiving clinical benefit from therapy

Effective 11/17/2021

UPHP MEDICAID - GASTROINTESTINAL ANTIBIOTICS

MEDICATION(S)

AEMCOLO, DIFICID 200 MG TABLET, FIRVANQ, FLAGYL, LIKMEZ, METRONIDAZOLE 375 MG CAPSULE, NITAZOXANIDE 500 MG TABLET, VANCOCIN HCL, XIFAXAN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

GASTROINTESTINAL ANTIBIOTICS

Drug Class: Gastrointestinal Antibiotics

Preferred Agents: No Prior Authorization required

Dificid

metronidazole tablets

neomycin tablet

tinidazole

vancomycin capsules

vancomycin solution

Non-Preferred Agents: Prior Authorization Criteria below

Aemcolo®

Firvanq®

Flagyl® tablet and capsule

Likmez®

metronidazole capsule

nitazoxanide tablet

Vancocin®

Xifaxan® 200mg

Xifaxan® 550mg

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure of one month with one preferred medication
- See additional medication-specific criteria below:

AEMCOLO® (RIFAMYCIN)

- Travelers' diarrhea caused by noninvasive strains of E. coli and age ≥18 years of age (PDL criteria do not apply), AND
- The patient has had an inadequate response, intolerance or contraindication to azithromycin or a fluoroquinolone
- Quantity Limit: 12 tablets
- Length of authorization: 3 days

DIDICID® (FIDAXOMICIN) 40 MG/ML ORAL SUSPENSION

- Maximum patient age = 17 years

LIKMEZ® (METRONIDAZOLE)

- PDL criteria may be bypassed if patient is less than 12 years of age or unable to swallow tablets
- Quantity Limit: 400 mL per 10 days
- Length of approval: Duration of the prescription

NITAZOXANIDE (ALINIA®) (PDL criteria do not apply)

- Tablets:
 - o For treatment of diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia* AND
 - o The patient has had a trial on metronidazole or a clinical reason why it cannot be tried
 - o length of authorization = 1 month
 - o Quantity limit = 6 tablets per rolling 30 days

XIFAXAN®

- 200 mg tabs:
 - oTravelers' diarrhea caused by noninvasive strains of E. coli and age greater than 12 years of age

oThe patient has had an inadequate response, intolerance, or contraindication to azithromycin or a fluoroquinolone.

•550 mg tabs:

oReduction in risk of overt hepatic encephalopathy recurrence in patients greater than 18 years of age (PDL criteria do not apply)

oDiagnosis of irritable bowel syndrome with diarrhea (IBS-D) in patients greater than or equal to 18 years of age (PDL criteria do not apply)

Duration of Approval: 1 year, unless otherwise noted in drug-specific criteria

Effective 10/1/20

Updated 2/1/22

Updated 8/1/24

Updated 11/1/24

UPHP MEDICAID - GI MOTILITY, CHRONIC

MEDICATION(S)

ALOSETRON HCL, AMITIZA, IBSRELA, LOTRONEX, MOTTEGRITY, MOVANTIK, RELISTOR, SYMPROIC, TRULANCE, VIBERZI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

Drug Class:

?GI Motility, Chronic - Chronic idiopathic constipation (CIC)

?GI Motility, Chronic - Irritable bowel syndrome with constipation (IBS-C)

?GI Motility, Chronic - Irritable bowel syndrome with diarrhea (IBS-D)

?GI Motility, Chronic - Opioid-induced constipation (OIC)

?GI MOTILITY, CHRONIC - CHRONIC IDIOPATHIC CONSTIPATION (CIC)

Preferred Agents:

Linzess®

lubiprostone

Non-Preferred Agents: Prior Authorization Criteria below

Amitiza®
Motegrity®
Trulance®

?GI MOTILITY, CHRONIC - IRRITABLE BOWEL SYNDROME WITH CONSTIPATION (IBS-C)

Preferred Agents:

Linzess®
lubiprostone

Non-Preferred Agents: Prior Authorization Criteria below

Amitiza®
Ibsrela®
Trulance®

?GI MOTILITY, CHRONIC - IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)

Preferred Agents: Clinical Prior Authorization below

diphenoxylate/atropine (generic Lomotil®)
loperamide (generic Imodium®)

Non-Preferred Agents: Prior Authorization Criteria below

alosetron
Lotronex®
Viberzi®

?GI MOTILITY, CHRONIC - OPIOID-INDUCED CONSTIPATION (OIC)

Preferred Agents:

lubiprostone

Non-Preferred Agents: Prior Authorization Criteria below

Amitiza®
Relistor®
Symproic®
Movantik®

PA Criteria:

Non-Preferred Agents

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with one preferred medication within the same subclass
- See additional medication-specific criteria below:

Medication-Specific Criteria

AMITIZA® (LUBIPROSTONE)

- Patient is greater than or equal to 18 years of age, AND
- Quantity limit of 2 capsules per day

IBSRELA® (TENAPANOR)

- Diagnosis of irritable bowel syndrome with constipations (IBS-C): AND
- Patient is greater than or equal to 18 years of age AND
- Therapeutic failure after one-month trial of one preferred agent of IBS-C
- Quantity Limit = 2 tablets/day

LINZESS® (LINACLOTIDE)

- Patient is greater than or equal to 6 years of age, AND
- Quantity limit of 1 capsule per day

LOTROXEX® (ALOSETRON)

- Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND
- Therapeutic failure after one-month trial of diphenoxylate/atropine or loperamide
- Member is female

MOTEGRITY® (PRUCALOPRIDE)

- Diagnosis of chronic idiopathic constipation (CIC), AND
- Prescribed by or in consultation with a gastroenterologist, AND
- Therapeutic failure after one-month trial of one preferred agent for CIC

RELISTOR® (METHYLNALTREXONE)

- Diagnosis of opioid induced constipation (OIC), AND
- Therapeutic failure after one-month trial of one preferred agent for OIC

SYMPROIC® (NALDEMEDINE TOSYLATE)

- Diagnosis of opioid induced constipation (OIC), AND
- Therapeutic failure after one-month trial of one preferred agent for OIC

TRULANCE® (PLECANATIDE)

- Diagnosis of chronic idiopathic constipation (CIC) or irritable bowel syndrome with constipation (IBS-C), AND
- Therapeutic failure after one-month trial of one preferred agent for CIC or IBS-C

VIBERZI® (ELUXADOLINE)

- Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND
- Therapeutic failure after one-month trial of diphenoxylate/atropine or loperamide
- Quantity limit = 2 tablets/day

?Duration of Approval: Up to 1 year

Effective 10/1/20

Updated 11/1/21

Updated 2/24/22

Updated 11/1/22

Updated 10/22/24

UPHP MEDICAID - GLAUCOMA

MEDICATION(S)

ALPHAGAN P, APRACLONIDINE HCL, BETAXOLOL HCL 0.5% EYE DROP, BETIMOL, BIMATOPROST 0.03% EYE DROPS, BRIMONIDINE TARTRATE 0.1% DROP, BRIMONIDINE TARTRATE 0.15% DRP, BRIMONIDINE TARTRATE-TIMOLOL, COSOPT, COSOPT PF, DORZOLAMIDE-TIMOLOL 2%-0.5%, IOPIDINE, ISTALOL, LEVOBUNOLOL HCL, LUMIGAN, TAFLUPROST, TIMOLOL, TIMOLOL 0.5% EYE DROP, TIMOLOL MALEATE 0.5% EYE DROP, TIMOPTIC, TIMOPTIC OCUDOSE, TIMOPTIC-XE, TRAVATAN Z, TRAVOPROST, VYZULTA, XALATAN, XELPROS, ZIOPTAN 0.0015% EYE DROPS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

GLAUCOMA

Drug Class:

Glaucoma – Alpha-2 Adrenergics

Glaucoma – Beta Blockers

Glaucoma – Carbonic Anhydrase Inhibitors

Glaucoma – Combination Alpha-2 Adrenergic-Beta Blocker

Glaucoma – Prostaglandin Analogues

Glaucoma – Rho Kinase Inhibitors

GLAUCOMA – ALPHA-2 ADRENERGICS

Preferred Agents: No Prior Authorization required

Apraclonidine
brimonidine tartrate 0.2%

Non-Preferred Agents: Prior Authorization Criteria below

Alphagan P®
brimonidine tartrate 0.1%
brimonidine tartrate 0.15%
Ipidine®

GLAUCOMA – BETA BLOCKERS

Preferred Agents: No Prior Authorization required

Betoptic S®
Carteolol
timolol maleate (generic for Timoptic®)

Non-Preferred Agents: Prior Authorization Criteria below

Betaxolol
Betimol®
Istalol®
Levobunolol
timolol (generic for Betimol®)
timolol maleate (generic for Istalol®)
Timoptic®
Timoptic XE®

GLAUCOMA – CARBONIC ANHYDRASE INHIBITORS

Preferred Agents: No Prior Authorization required

Azopt®
dorzolamide
dorzolamide / timolol (generic Cosopt)
Simbrinza®

Non-Preferred Agents: Prior Authorization Criteria below

Brinzolamide
Cosopt®/ Cosopt PF®
dorzolamide/timolol PF (generic Cosopt PF)

GLAUCOMA – COMBINATION ALPHA-2 ADRENERGIC-BETA BLOCKER

Preferred Agents: No Prior Authorization required

Combigan®

Non-Preferred Agents: Prior Authorization Criteria below
brimonidine-timolol

GLAUCOMA – PROSTAGLANDIN ANALOGUES

Preferred Agents: No Prior Authorization required
latanoprost

Non-Preferred Agents: Prior Authorization Criteria below
bimatoprost (generic for Lumigan)

Lumigan®

tafluprost (generic for Zioptan)

Travatan Z®

travoprost (generic for Travatan®)

Vyzulta®

Xalatan®

Xelpros®

Zioptan®

GLAUCOMA – RHO KINASE INHIBITORS

Preferred Agents: No Prior Authorization required

Rhopressa®

Rocklatan®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with one preferred medication within the same subclass

Duration of Approval: 1 year

Effective 10/1/20

Updated 1/27/22

Updated 12/1/2024

UPHP MEDICAID - GLP1 AND COMBOS

MEDICATION(S)

BYDUREON BCISE, BYETTA, LIRAGLUTIDE 2-PAK 18 MG/3 ML, LIRAGLUTIDE 3-PAK 18 MG/3 ML, MOUNJARO, OZEMPIC, RYBELSUS, SOLIQUA 100-33, TRULICITY, VICTOZA 2-PAK, VICTOZA 3-PAK, XULTOPHY 100-3.6

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

INCRETIN MIMETICS AND COMBINATIONS

Drug Class:

?Incretin Mimetics

?Incretin Mimetics - Combinations

?INCRETIN MIMETICS

Preferred Agents: Clinical Prior Authorization below

Byetta®

Ozempic®

Trulicity®

Victoza®

Clinical Preferred Agent PA criteria:

- Patient has diagnosis of type 2 diabetes AND
- Discontinuation of other GLP-1 agonists

Non-Preferred Agents: Prior Authorization Criteria below

Bydureon Bcise®

Liraglutide

Mounjaro®

Rybelsus®

?INCRETIN MIMETICS – COMBINATIONS

Non-Preferred Agents: Prior Authorization Criteria below

Soliqua®

Xultophy®

Non-Preferred Agent PA Criteria:

- Diagnosis of type 2 diabetes AND
- Discontinuation of other GLP-1 agonists AND
- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Trial and failure with one preferred medication within same subgroup
- See additional medication-specific criteria below:

SOLIQUA® (INSULIN GLARGINE/LIXISENATIDE)

- One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist)

XULTOPHY® (INSULIN DEGLUDEC/LIRAGLUTIDE)

- One-month trial and failure with one of the preferred medications in each subgroup of the components (basal insulin and GLP-1 agonist)

QUANTITY LIMITS

Adlyxin 10-20mcg starter pack	6mL per 28 days
Adlyxin 20mcg maintenance pack	6mL per 28 days
Bydureon Bcise 2mg Auto Inject	3.4 mls per 28 days (4 doses per 28 days)
Byetta Dose Pen Injector	10mcg - 2.4 mls per 30 days
	5mcg - 1.2 mls per 30 days
Mounjaro Pens	2 mls per 28 days
Ozempic Pens	3 mls per 28 days
Rybelsus Tablets	1 per day
Soliqua 100 unit-33mcg/ml Pen	15 mls per 25 days
Trulicity Pens	2 mls per 28 days
Victoza Pens (brand and generic)	2-Pak 18mg/3ml - 6 mls per 30 days
	3-Pak 18mg/3ml - 9 mls per 30 days
Xultophy 100 unit-3.6mg/ml Pen	15 mls per 30 days

?Duration of Approval: Up to 1 year

UPHP MEDICAID - GLUCAGON AGENTS

MEDICATION(S)

GLUCAGON 1 MG EMERGENCY KIT, GVOKE, GVOKE PFS 1-PK 1 MG/0.2 ML SYR, GVOKE PFS 2-PK 1 MG/0.2 ML SYR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

GLUCAGON AGENTS

Drug Class: Glucagon Agents

Preferred Agents: No Prior Authorization required

Baqsimi®

Glucagen Hypokit

Gvoke Pen®

Zegalogue

Non-Preferred Agents: Prior Authorization Criteria below

Glucagon Emergency Kit (Lilly and Fresenius)

Gvoke® Syringe, Kit, Vial

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- History of trial and failure with one preferred medication

Quantity Limitations:

BAQSIMI 2 devices per 30 days

GVOKE HYPOPEN, SYRINGES2 syringes per 30 days

GVOKE VIALS2 vials per 30 days

Duration of Approval: 1 year

Updated 1/1/22

Updated 11/1/22

Updated 11/1/24

UPHP MEDICAID - GROWTH HORMONE

MEDICATION(S)

GENOTROPIN, HUMATROPE 12 MG CARTRIDGE, HUMATROPE 24 MG CARTRIDGE, HUMATROPE 6 MG CARTRIDGE, NORDITROPIN FLEXPOR, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SAIZEN-SAIZENPREP, SEROSTIM, SKYTROFA, SOGROYA, ZOMACTON

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

GROWTH HORMONES

Drug Class: Growth Hormones

Preferred Agents: Clinical Prior Authorization below

Genotropin®

Norditropin®

Norditropin Flexpro®

Clinical PA Criteria:

- Requests must be submitted by an endocrinologist or nephrologist.
- Panhypopituitarism – Cachexia, pituitary, Necrosis of pituitary (postpartum), Pituitary insufficiency NOS, Sheehan's syndrome, Simmond's disease.

- Pituitary dwarfism – Isolated deficiency of (human) growth hormone [HGH], Lorain-Levi dwarfism).
- Endocrine disorders – Other specified endocrine disorders: Pineal gland dysfunction, Progeria, Werner’s syndrome.
- Indeterminate sex and pseudohermaphroditism – Gynandrim, Hermaphroditism, Ovotestis, Pseudohermaphroditism (male, female), Pure gonadal dysgenesis
- Gonadal dysgenesis – Turner’s Syndrome (female only), XO syndrome, Ovarian dysgenesis
- Noonan Syndrome – Norditropin® is the only medication with this indication.
 - Prader-Willi Syndrome – Genotropin®, Norditropin FlexPro and Omnitrope are the only medications with this indication
- For Dx of Idiopathic Short Stature, individual medical record and necessity review will be required.
 - CKD – stage 1, 2 or 3 (CRI): Nutropin® is the only medication with this indication
- CKD – stage 4 or 5 (CRF or ESRD)
- SHOX: Humatrope® is the only medication with this indication

REQUIRED TESTING INFORMATION:

- Growth hormone stimulation testing:
 - oPituitary dwarfism: the patient must have failed two kinds of growth hormone stimulation tests for the diagnosis. Testing is required for pediatric, adolescent, and adult patients. For adolescent patients whose epiphyseal growth plates are closed and for adult patients, testing must be done after growth hormone therapy has been suspended for at least 3 months.
 - oRequester should document the kinds of stimulation tests performed, the result (lab value), reference range and date.
- Bone age x-rays (required regardless of diagnosis, x-ray does not have to be performed within a specific time frame):

Clinical PA criteria continued

- oPediatric patients - bone x-ray report is required unless the prescriber is a (pediatric) endocrinologist
- oAdolescent patients (13 to 19 years of age)– bone x-ray report is required UNLESS the prescriber is a (pediatric) endocrinologist, the requester must also note whether or not the epiphyseal growth plates have closed.
- oAdult patients – bone x-ray report is NOT required.

Papilledema

- oProvider is aware of the risk of intracranial hypertension and the role of fundoscopic examination to assess and monitor for papilledema.

oRequests that do not meet clinical criteria will require further review and must include the patient’s diagnosis including ICD-10, if available. Growth charts should be provided, if available, at time of review

(ensure that the correct chart is being submitted based on the patient's age – i.e., 0–3 vs 2–20) in addition to documentation of small for gestational age at birth, if appropriate.

Non-Preferred Agents: Prior Authorization Criteria below

Humatrope®

Ngenla®

Nutropin AQ®

Omnitrope®

Serostim®

Sogroya®

Skytrofa®

Zomacton®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with one preferred medication OR
- The patient's condition is clinically stable such that switching medications would cause deterioration in the condition
- See additional medication-specific criteria below

NGENLA® (SOMATROGON-GHLA)

- Maximum patient age = 16 years

Sogroya (somapacitanib-BECO)

Quantity limit: 8mg per week

SKYTROFA® (LONAPEGSOMATROPIN-TCGD)

- Maximum patient age = 16 years

Duration of Approval: 1 year

Effective 10/1/2020

Updated 5/1/22

Updated 9/1/22

Updated 9/11/24

Updated 11/1/24

MEDICATION(S)

BISMUTH-METRONIDAZOLE-TETRACYC, LANSOPRAZOL-AMOXICIL-CLARITHRO, OMECLAMOX-PAK, TALICIA, VOQUEZNA DUAL PAK, VOQUEZNA TRIPLE PAK

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

H. PYLORI TREATMENT

Drug Class: H. pylori Treatment

Preferred Agents: No Prior Authorization required

Pylera®

Non-Preferred Agents: Prior Authorization Criteria below

bismuth-metronidazole/tetracycline

lansoprazole/amoxicillin/clarithromycin

Omeclamox-PAK®

Talicia

Voquezna Dual Pak®

Voquezna Triple Pak®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure after one-course (e.g., 10-14 days) trial of the preferred agent

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/24

UPHP MEDICAID - HEMATOPOIETIC AGENTS

MEDICATION(S)

ARANESP, EPOGEN, PROCRIT, RETACRIT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

HEMATOPOIETIC AGENTS

Drug Class: Hematopoietic Agents

Preferred Agents: Clinical Prior Authorization below

Aranesp®

Epogen®

Retacrit®

Non-Preferred Agents: Prior Authorization Criteria below

Procrit®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure after one-month trial with one preferred medication

- See additional medication/diagnoses-specific criteria below:

CHRONIC KIDNEY DISEASE STAGE 3, STAGE 4 [CRF - CHRONIC RENAL FAILURE] AND STAGE 5 [ESRD END STAGE RENAL DISEASE] (EPOGEN®, PROCRI®T®, RETACRI®T® AND ARANESP®):

- Hemoglobin level less than 10 g/dL before treatment with Epogen®, Procrit®, Retacrit®, Aranesp® or transfusions
- RENEWAL: CURRENT hemoglobin level less than 12 g/Dl

KIDNEY TRANSPLANT PATIENTS - TRANSPLANTED KIDNEY IS NOTED AS NOT YET FUNCTIONING TO ANTICIPATED POTENTIAL (EPOGEN®, PROCRI®T®, RETACRI®T® AND ARANESP®):

- Less than 1-year post transplant
- CURRENT hemoglobin level less than 12 g/dL
- Length of Authorization: 6 months

CHEMOTHERAPY OR RADIATION THERAPY CONFIRMED AS CURRENT (EPOGEN®, PROCRI®T®, RETACRI®T® AND ARANESP® ONLY):

- Hemoglobin level less than 10 g/dL before beginning treatment with Epogen®, Procrit®, Retacrit®, Aranesp, or transfusions
- RENEWAL: CURRENT hemoglobin level less than 12 g/dL

ANEMIA IN AIDS PATIENTS: (EPOGEN®, PROCRI®T®, RETACRI®T® ONLY)

- Hemoglobin level less than 10 g/dL

ANEMIC PATIENTS SCHEDULED TO UNDERGO NON-CARDIAC, NON-VASCULAR SURGERY TO DECREASE NEED FOR TRANSFUSIONS: (EPOGEN®, PROCRI®T®, RETACRI®T® ONLY).

- Clinical rationale why alternative approaches such as donating own blood prior or transfusion is not an option.
- CURRENT hemoglobin level less than 10 g/dL

MYELOYDYSPLASIA AND MYELOYDYSPLASTIC SYNDROME (EPOGEN®, PROCRI®T®, RETACRI®T® ONLY):

- CURRENT hemoglobin level less than 10 g/dL

HEPATITIS C WITH CURRENT INTERFERON TREATMENT (EPOGEN®, PROCRI®T®, RETACRI®T® ONLY):

- Beginning hemoglobin level less than 10 g/dL
- RENEWAL: CURRENT hemoglobin level less than 12 g/dL

Duration of Approval: For the duration of the prescription up to 6 months, unless otherwise noted in Medication/Diagnoses-Specific Information

Effective 10/1/20

MEDICATION(S)

HYFTOR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

HYFTOR/SIROLIMUS

Drug Class: mTOR (mammalian target of rapamycin) inhibitor immunosuppressant

FDA-approved uses: Indicated for the treatment of facial angiofibroma associated with tuberous sclerosis in adults and pediatric patients ? 6 years old

Available dosage forms: Available in 10-gram tubes as 2 mg per gram (0.2%) topical gel.

Coverage Criteria/Limitations for initial authorization:

?Patient is ? 6 years old, AND

?Patient has a documented diagnosis of facial angiofibroma associated with tuberous sclerosis AND

?Prescribed by, or in consultation with, either a dermatologist or neurologist

?Length of approval:

oInitial Authorization: 3 months

oContinuation of therapy: 1 year

?Route of Administration: Topical

?Quantity:

oAges 6-11 years: Up to 2 tubes (20 grams) per 30 days

oAge 12 years and older: Up to 3 tubes (30 grams) per 30 days

Criteria for continuation of therapy

?Documentation Requirements (e.g., Labs, Medical Record, Special Studies):

oPrescriber attests to positive symptom improvement based on size and redness of facial angiofibroma

UPHP MEDICAID - ICS/LABA INHALER COMBINATIONS

MEDICATION(S)

AIRDUO DIGIHALER, AIRDUO RESPICLICK, AIRSUPRA, BREYNA, BUDESONIDE-FORMOTEROL FUMARATE, FLUTICASONE-SALMETEROL, FLUTICASONE-SALMETEROL HFA, FLUTICASONE-VILANTEROL, WIXELA INHUB

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA ADRENERGIC AND CORTICOSTEROID INHALER COMBINATIONS

Drug Class: Beta Adrenergic and Corticosteroid Inhaler Combinations

Preferred Agents: No Prior Authorization required

Advair Diskus® (DPI)

Advair HFA® (MDI)

Dulera® (MDI)

Symbicort® (MDI)

Non-Preferred Agents: Prior Authorization Criteria below

AirDuo Digihaler

AirDuo Respiclick® (DPI)

Airsupra®

Breo Ellipta® (DPI)
Breynd®
budesonide/formoterol (generic for Symbicort)
fluticasone/vilanterol (generic for Breo Ellipta)
fluticasone/salmeterol (generic for Advair Diskus)
fluticasone/salmeterol (generic for Advair HFA)
fluticasone/salmeterol (generic for AirDuo)
Wixela® (DPI) (generic for Advair Diskus)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure after a two-week trial with one preferred medication

QUANTITY LIMITS

Advair Diskus (fluticasone/salmeterol)3 inhalers per 90 days
Advair HFA (fluticasone/salmeterol)3 inhalers per 90 days
Airduo Resplick (fluticasone/salmeterol)3 inhalers per 90 days
Airduo Digihaler(fluticasone/salmeterol)3 inhalers per 90 days
Airsupra (albuterol/budesonide)6 inhalers per 90 days
Breo Ellipta (fluticasone/vilanterol)3 inhalers per 90 days
Breynd (budesonide/formoterol)6 inhalers per 90 days
Dulera (mometasone/formoterol)3 inhalers per 90 days
Symbicort (budesonide/formoterol)6 inhalers per 90 days
Wixela (fluticasone/salmeterol)3 inhalers per 90 days

MAXIMUM AGE LIMITS

Breo Ellipta (fluticasone/vilanterol) 50-25 mcg/11 years
Dulera (mometasone/formoterol) 50 mcg/5mcg/11 years

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/22

Updated 11/1/24

UPHP MEDICAID - ICS/LABA/LAMA COMBO

MEDICATION(S)

BREZTRI AEROSPHERE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA ADRENERGIC / ANTICHOLINERGIC / CORTICOSTEROID INHALER COMBINATIONS

Drug Class: Beta Adrenergic / Anticholinergic Combinations / Corticosteroid Inhalers Combinations

Preferred Agents: No Prior Authorization required

Trelegy Ellipta

Non-Preferred Agents: Prior Authorization Criteria below

Breztri Aerosphere

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medication, OR
- Contraindication or drug to drug interaction with the preferred medication, OR
- History of unacceptable side effects, OR
- The patient's condition is clinically stable such that switching medications would cause deterioration in the condition, OR
- Therapeutic failure after a two-week trial with the preferred medication

Duration of Approval: 1 year

Effective 8/1/21

UPHP MEDICAID - IMMUNOMODULATORS

MEDICATION(S)

ADBRY, ADBRY AUTOINJECTOR, CIBINQO, DUPIXENT PEN, DUPIXENT SYRINGE, ELIDEL, EUCRISA, FASENRA PEN, NUCALA 100 MG/ML AUTO-INJECTOR, NUCALA 100 MG/ML SYRINGE, NUCALA 40 MG/0.4 ML SYRINGE, OPZELURA, PIMECROLIMUS, RINVOQ, TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT, TEZSPIRE 210 MG/1.91 ML PEN, XOLAIR 150 MG/ML AUTOINJECTOR, XOLAIR 150 MG/ML SYRINGE, XOLAIR 300 MG/2 ML AUTOINJECT, XOLAIR 300 MG/2 ML SYRINGE, XOLAIR 75 MG/0.5 ML AUTOINJECT, XOLAIR 75 MG/0.5 ML SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

IMMUNOMODULATORS

Drug Class:

?Agents to Treat Asthma

?Agents to Treat Atopic Dermatitis

?Agents to Treat Chronic Idiopathic Urticaria

?Agents to Treat Chronic Obstructive Pulmonary Disease (COPD)

?Agents to Treat Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

?Agents to Treat Eosinophilic Esophagitis (EoE)

?Agents to Treat Eosinophilic Granulomatosis with Polyangiitis (EGPA)

?Agents to Treat Hypereosinophilic Syndrome (HES)

?Agents to Treat IgE-Mediated Food Allergy

?Agents to Treats Nonsegmental Vitiligo

?Agents to Treat Prurigo Nodularis (PN)

?AGENTS TO TREAT ASTHMA

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Fasenra® pen

Xolair® syringes, autoinjectors

Clinical PA Criteria for Asthma Indications:

- Patient's asthma symptoms have not been adequately controlled by at least three months of an asthma treatment regimen that must include an inhaled corticosteroid, AND
- Prescribed by or in consultation with an allergist, immunologist, or pulmonologist

DUPIXENT® (DUPILUMAB):

?Note:

- oA 56-day supply will be allowed for patients requiring dosing once every 28 days (every 4 weeks)
- oThe pre-filled PEN is for use in adult and pediatric patients aged 2 years and older.
- oThe pre-filled SYRINGE is for use in adult and pediatric patients aged 6 months and older.
- Patient must have moderate to severe asthma diagnosed as ONE of the following types:
 - oAsthma with eosinophilic phenotype with eosinophil count greater than or equal to 150 cells/mcL, OR
 - oOral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months, AND
- oPatient must be 6 years of age or older

FASENRA® (BENRALIZUMAB):

- Patient must have severe asthma, AND
 - oEosinophil blood count of greater than or equal to 150 cells/ μ L within last 6 weeks or greater than or equal to 300 cells/ μ L within the last 12 months, AND
- oPatient must be 6 years of age or older

XOLAIR® (OMALIZUMAB)

- Moderate to severe persistent asthma, AND
- oPatient is 6 years of age or older, AND
- oPatient has a positive skin test or in vitro testing (RAST, etc.) for allergen specific IgE antibodies for one or more seasonal aeroallergens, AND
- oBaseline IgE level is greater than or equal to 30 IU/ml

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector

Tezspire® pen

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure after a one-month trial of one preferred medication
- See additional medication-specific criteria below:

NUCALA® (MEPOLIZUMAB):

- Patient must have severe asthma, AND
- oEosinophil blood count of greater than or equal to 150 cells/ μ L within last 6 weeks or greater than or equal to 300 cells/ μ L within the last 12 months, AND
- oPatient must be 6 years of age or older, AND
- oFor Nucala 40mg/0.4 ml, patient age must be less than or equal to 11 years of age

TEZSPIRE® (TEZEPELUMAB-EKKO)

- Patient must have severe asthma, AND
- oPatient is 12 years of age or older, AND
- oPatient has been trained to self-administer this product, AND
- oMember will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Tezspire, AND

oBypass PDL criteria if patient does not meet specific criteria for Preferred agents (e.g. eosinophil blood count and/or IgE blood level requirements)

?Duration of Approval: 1 year

?AGENTS TO TREAT ATOPIC DERMATITIS

Preferred Agents: Clinical Prior Authorization below

Adbry®

Dupixent®

Elidel®

Eucrisa®

pimecrolimus (generic for Elidel)

tacrolimus

Clinical PA Criteria For Atopic Dermatitis Indications For Each Agent

•Diagnosis of atopic dermatitis

oDupixent®: moderate to severe for ages greater than or equal to 6 months

oElidel®: mild to moderate for ages greater than 2 years

oEucrisa®: mild to moderate for ages greater than or equal to 3 months

oTacrolimus 0.03%: moderate to severe for ages greater than 2 years

oTacrolimus 0.1%: moderate to severe for ages greater than 16 years

Non-Preferred Agents: Prior Authorization Criteria below

Cibinqo®

Opzelura®

Rinvoq®

?AGENTS TO TREAT ATOPIC DERMATITIS, continued

Non-Preferred Agent PA Criteria:

- Diagnosis of atopic dermatitis
- Allergy to the preferred medication, OR
- Contraindication or drug to drug interaction with the preferred medication, OR
- History of unacceptable side effects, OR
- Therapeutic failure after a one-month trial of one preferred medication
- Additional disease severity and age limits:
ORinvoq®: moderate to severe for ages greater than or equal to 12 years
- See additional medication-specific criteria below:

ADBRY® (TRALOKINUMAB-LDRM)

- Diagnosis of moderate to severe atopic dermatitis, AND
- oPatient age greater than or equal to 12 years old, AND
- oAdbry 150mg:
?Quantity limit: 4 syringes per 28 days (with special allowance for initial dose), OR
- oAdbry 300mg:
?Quantity limit: 2 Autoinjectors per 28 days (with special allowance for initial dose)

CIBINQO® (ABROCITINIB)

- Diagnosis of moderate to severe atopic dermatitis, AND
- oPatient age greater than or equal to 12 years old

DUPIXENT® (DUPILUMAB)

? Note:

- oA 56-day supply will be allowed for patients requiring dosing once every 28 days (every 4 weeks)
- oThe pre-filled PEN is for use in adult and pediatric patients aged 2 years and older.
- oThe pre-filled SYRINGE is for use in adult and pediatric patients aged 6 months and older.
- Diagnosis of moderate to severe atopic dermatitis AND
- oPatient greater than or equal to 6 months old

OPZELURA® (RUXOLITINIB PHOSPHATE)

- Diagnosis of mild to moderate atopic dermatitis, AND
- oPatient has atopic dermatitis estimated to affect less than or equal to 20% of the body surface area, AND
- oPatient age greater than or equal to 12 years old,

QUANTITY LIMITS

Adbry® (tralokinumab-ldrm) 150mg syringes 4 syringes per 28 days (with special allowance for initial dose)

Adbry® (tralokinumab-ldrm) 300mg Autoinjectors 2 autoinjectors per 28 days (with special allowance for initial dose)

Elidel® (pimecrolimus) 30gm per 30 days

Eucrisa® (crisaborole) 100 gm per 30 days

Opzelura® (ruxolitinib phosphate) 240gm (4 x 60gm) per 30 days

tacrolimus 30gm per 30 days

?Duration of Approval: 6 months for FDA approved diagnosis noted above, unless otherwise noted in Medication/Diagnosis-Specific Criteria

?AGENTS TO TREAT CHRONIC IDIOPATHIC URTICARIA

Preferred Agents: Clinical Prior Authorization below

Xolair® syringes, autoinjectors

Clinical PA Criteria for Chronic Idiopathic Urticaria Indications:

XOLAIR® (OMALIZUMAB)

•Diagnosis of Chronic Idiopathic Urticaria, AND

oPatient is 12 years of age or older, AND

oPrescribed by or in consultation with an allergist, immunologist, or dermatologist, AND

oPatient has had urticaria for at least 6 weeks with symptoms present despite an adherent trial of at least 2 weeks duration of an H1-antihistamine

?Duration of Approval: 1 year

?AGENTS TO TREAT CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

?AGENTS TO TREAT CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), continued

Clinical PA Criteria for Chronic Obstructive Pulmonary Disease (COPD):

DUPIXENT® (DUPILIMAB)

- Diagnosis of inadequately controlled chronic obstructive pulmonary disease (COPD), AND
- oPatient has an eosinophilic count greater than or equal to 300 cells/mcL, AND
- oPatient greater than or equal to 18 years old, AND
- oPatient is concurrently treated with triple therapy with inhaled corticosteroid [ICS], long-acting beta-2 agonist [LABA], and long-acting muscarinic antagonist [LAMA], OR
- oPatient is concurrently treated with a LABA and LAMA if ICS therapy is contraindicated.

?Duration of Approval: 1 year

?AGENTS TO TREAT CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Xolair® syringes, autoinjectors

Clinical PA Criteria for chronic rhinosinusitis with nasal polyposis (CRSwNP) Indications:

DUPIXENT® (DUPILUMAB):

- ?Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP), AND
- oPatient greater than or equal to 12 years old, AND
- oPatient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids, AND
- oPatient is concurrently treated with intranasal corticosteroids

XOLAIR® (OMALIZUMAB)

- ?Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP), AND
- oPatient is 18 years of age or older, AND
- oPrescribed by or in consultation with an allergist, immunologist or otolaryngologist, AND
- oPatient has not been adequately controlled by at least three months of treatment with an intranasal steroids or oral corticosteroids, AND
- oBaseline IgE level is greater than or equal to 30 IU/ml, AND

oPatient is concurrently treated with intranasal corticosteroids

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector

AGENTS TO TREAT CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP), continued

Non-Preferred Agent PA Criteria:

?Allergy to the preferred medication, OR

?Contraindication or drug to drug interaction with the preferred medication, OR

?History of unacceptable side effects, OR

?Therapeutic failure after a one-month trial with the preferred medication

?See additional medication-specific criteria below:

NUCALA (MEPOLIZUMAB)

•Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP), AND

oPatient greater than or equal to 18 years old AND

oPatient has inadequate response after 3 consistent months use of intranasal steroids or oral corticosteroids, AND

oPatient is concurrently treated with intranasal corticosteroids

?Duration of Approval: 1 year

?AGENTS TO TREAT EOSINOPHILIC ESOPHAGITIS (EOE)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Clinical PA Criteria for eosinophilic esophagitis (EoE):

DUPIXENT® (DUPILUMAB):

?Diagnosis of eosinophilic esophagitis (EoE), AND

oPatient greater than or equal to 1 years old, AND

oPatient weighs greater than or equal to 15 kg, AND

oPrescribed by or consultation with an allergist or gastroenterologist, AND

oPatient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor

?Duration of Approval: 1 year

?AGENTS TO TREAT EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)

Preferred Agents: Clinical Prior Authorization below

Fasenra®

?AGENTS TO TREAT EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA), continued
Clinical PA Criteria for Eosinophilic Granulomatosis with Polyangiitis (EGPA)

FASENRA® (BENRALIZUMAB)

- Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), AND
- Patient is 18 years of age or older

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medication, OR
- Contraindication or drug to drug interaction with the preferred medication, OR
- History of unacceptable side effects, OR
- Therapeutic failure after a one-month trial with the preferred medication
- See additional medication-specific criteria below:

NUCALA® (MEPOLIZUMAB):

- Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), AND
- oPatient is 18 years of age or older

?Duration of Approval: 1 year

?AGENTS TO TREAT HYPEREOSINOPHILIC SYNDROME (HES)

Non-Preferred Agents: Prior Authorization Criteria below

Nucala® syringe, auto-injector

Non-Preferred Agent PA Criteria:

NUCALA® (MEPOLIZUMAB):

- Diagnosis of hypereosinophilic syndrome (HES), AND

oPatient is 12 years of age or older

?Duration of Approval: 1 year

?AGENTS TO TREAT IGE-MEDIATED FOOD ALLERGY

Preferred Agents: Clinical Prior Authorization below

Xolair

Clinical PA Criteria for IgE-Mediated Food Allergy

XOLAIR® (OMALIZUMAB)

•Diagnosis of IgE-mediated food allergy, AND

oPatient is 1 year of age or older, AND

oPrescribed by or in consultation with an allergist or immunologist, AND

oPatient will follow food allergen avoidance in conjunction with Xolair, AND

oBaseline IgE level is greater than or equal to 30 IU/ml

?Duration of Approval: 1 year

?AGENTS TO TREAT NONSEGMENTAL VITILIGO

Non-Preferred Agents: Prior Authorization Criteria below

Opzelura®

Non-Preferred Agent PA Criteria:

OPZELURA® (RUXOLITINIB PHOSPHATE)

•Diagnosis of nonsegmental vitiligo, AND

oPatient has vitiligo involvement estimated to affect less than or equal to 10% of the body surface area,
AND

oPatient is greater than or equal to 12 years old, AND

oPrescribed by or in consultation with a dermatologist

?Duration of Approval: 1 year

?AGENTS TO TREAT PRURIGO NODULARIS (PN)

Preferred Agents: Clinical Prior Authorization below

Dupixent®

Clinical PA Criteria for Prurigo Nodularis (PN):

DUPIXENT® (DUPILUMAB):

?Diagnosis of prurigo nodularis (PN), AND

oPatient greater than or equal to 18 years old, AND

oPrescribed by or in consultation with a dermatologist, allergist, or immunologist

?Duration of Approval: 1 year

UPHP MEDICAID - INGREZZA (VALBENAZINE)

MEDICATION(S)

INGREZZA, INGREZZA INITIATION PK(TARDIV)

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

INGREZZA/ VALBENAZINE

Drug Class Movement Disorder Therapy - Tardive Dyskinesia, Huntington's Disease

FDA-approved uses: Tardive Dyskinesia, Chorea associated with Huntington's

Available dosage forms: Capsules: 40mg, 60mg, 80mg, Initiation Pack

Coverage Criteria/Limitations for initial authorization:

?Diagnoses:

oDiagnosis of chorea associated with Huntington's disease OR

oDiagnosis of tardive dyskinesia secondary to use of a dopamine antagonist (i.e., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)

?Duration of approval:

oInitial authorization: 1 year

oContinuation of Therapy: 1 year

?Prescriber Specialty: Prescribed by or in consultation with a neurologist or psychiatrist

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oFor tardive dyskinesia attestation that a baseline AIMS test has been completed

?Age: Patient is 18 years of age or older

Criteria for continuation of therapy:

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oAttestation of patient's improvement in symptoms associated with their condition AND

oFor tardive dyskinesia attestation that a follow-up AIMS test has been completed and there has been a positive response to therapy

Effective 7/1/21

UPHP MEDICAID - INHALED GLUCOCORTICIDS

MEDICATION(S)

ARMONAIR DIGIHALER, ASMANEX HFA, FLOVENT DISKUS, FLUTICASONE PROP 100MCG DISKUS, FLUTICASONE PROP 250 MCG DISK, FLUTICASONE PROP 50 MCG DISKUS, PULMICORT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

INHALED GLUCOCORTICIDS

Drug Class: Inhaled Glucocorticoids

Preferred Agents: No Prior Authorization required

Alvesco (MDI)

Arnuity Ellipta® (DPI)

Asmanex® Twisthaler (DPI)

budesonide 0.25 and 0.5mg nebulizer solution

budesonide 1mg nebulizer solution (generic for Pulmicort Respules)

Flovent HFA® (MDI)

Fluticasone Prop HFA (Generic Flovent HFA)

Pulmicort Flexihaler® (DPI)

QVAR Redihaler® (MDI)

Non-Preferred Agents: Prior Authorization Criteria below

Armonair Digihaler
Asmanex HFA® (DPI)
Flovent Diskus® (DPI)
fluticasone prop diskus (generic Flovent Diskus)
Pulmicort® 1mg Respules nebulizer solution
Pulmicort® 0.25mg and 0.5mg Respules

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with a two-week trial with one preferred medication
- For children less than 13 years of age or a patient with a significant disability: inability to use the inhaler on preferred medications, or non-compliance because of taste, dry mouth
- See additional medication-specific criteria below:

ASMANEX® HFA (MOMETASONE)

- Requests submitted referencing exception due to compatibility with spacer/chamber will require trial only on Flovent® HFA

ASMANEX® TwisThaler 110mcg (MOMETASONE) ONLY – Age Limit

- Requests submitted to exceed the age limit of 11 years may be approved if a lower dose is needed and the dose requested does not exceed 1 inhaler per 30 days

QUANTITY LIMITS

Asmanex (mometasone) HFA 3 inhaler per 90 days
Asmanex (mometasone) TwisThaler 1 inhaler per fill
Flovent (fluticasone) HFA 110mcg3 inhaler per 90 days
Flovent (fluticasone) HFA 2206 inhalers per 90 days
Flovent (fluticasone) HFA 44mcg3 inhaler per 90 days
Pulmicort 90mcg Flexhaler (budesonide)3 inhaler per 90 days
Pulmicort 180mcg Flexhaler (budesonide)6 inhalers per 90 days
Pulmicort Respules (budesonide)2 mL per day

MAXIMUM AGE LLIMITS

Arnuity Ellipta (fluticasone) 50 mcg11 years
Asmanex (mometasone) HFA 50 mcg12 years
Asmanex (mometasone) TwisThaler 110 mcg11 years
Pulmicort 0.25 mg/2 ml Respules (budesonide)8 years

Pulmicort 0.5 mg/2 ml Respules (budesonide)8 years

Pulmicort 1 mg/2 ml Respules (budesonide)8 years

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

Updated 7/1/22

Updated 9/7/22

Updated 12/10/24

Updated 8/1/24

Updated 11/1/24

UPHP MEDICAID - INSULIN SUPPRESSANTS

MEDICATION(S)

DIAZOXIDE 50 MG/ML ORAL SUSP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

INSULIN SUPPRESSANTS

Drug Class: Insulin Suppressants

Preferred Agents: No Prior Authorization required

Proglycem

Non-Preferred Agents: Prior Authorization Criteria below

diazoxide (generic for Proglycem)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- History of trial and failure with one preferred medication

?Duration of Approval: 1 year

Effective 11/1/22

UPHP MEDICAID - INSULINS

MEDICATION(S)

ADMELOG, ADMELOG SOLOSTAR, AFREZZA, BASAGLAR KWIKPEN U-100, FIASP, FIASP FLEXTOUCH, FIASP PENFILL, HUMALOG KWIKPEN U-200, HUMULIN N KWIKPEN, INSULIN ASPART PENFILL, INSULIN DEGLUDEC, INSULIN DEGLUDEC PEN (U-100), INSULIN DEGLUDEC PEN (U-200), INSULIN GLARGINE SOLOSTAR U100, INSULIN GLARGINE-YFGN, LYUMJEV, LYUMJEV KWIKPEN U-100, LYUMJEV KWIKPEN U-200, NOVOLIN 70-30 100 UNIT/ML VIAL, NOVOLIN 70-30 FLEXPEN, NOVOLOG 100 UNIT/ML VIAL, NOVOLOG 100 UNIT/ML FLEXPEN, NOVOLOG MIX 70-30 VIAL, NOVOLOG MIX 70-30 FLEXPEN, NOVOLOG PENFILL, REZVOGLAR KWIKPEN, SEMGLEE (YFGN), SEMGLEE (YFGN) PEN, TOUJEO MAX SOLOSTAR, TOUJEO SOLOSTAR, TRESIBA, TRESIBA FLEXTOUCH U-100, TRESIBA FLEXTOUCH U-200

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

INSULINS

Drug Class:

Insulins, Mixes

Insulins, Basal

Insulins, Rapid Acting

Insulins, Traditional

INSULINS, MIXES

Preferred Agents: No Prior Authorization required

Humalog® 50/50 Kwikpens

Humalog® 75/25 pens, vials

Humulin® 70/30 Kwikpens, vials

insulin aspart 70/30 pens, vials

Non-Preferred Agents: Prior Authorization Criteria below

insulin lispro mix 75-25 Kwikpen

Novolin® 70/30 pens, vials

Novolog® 70/30 pens vials

INSULINS, BASAL

Preferred Agents: No Prior Authorization required

Lantus® pens, vials

Levemir® pens, vials

Non-Preferred Agents: Prior Authorization Criteria below

Basaglar® pens

Semglee® pens , vials

insulin degludec pens, vials

insulin glargine-YFGN pens , vials (biosimilar for Semglee®)

insulin glargine Solostar U100 pens, vials (biosimilar for Lantus®)

Rezvoglar

Toujeo Solostar® pens

Tresiba Flextouch® pens, vials

INSULINS, RAPID ACTING

Preferred Agents: No Prior Authorization required

Apidra® pens, vials

Humalog® U-100 cartridges, pens, vials

insulin aspart pens, vials

insulin lispro U-100 Kwikpens, vials (gen for Humalog)

Novolog® cartridges

Non-Preferred Agents: Prior Authorization Criteria below

Admelog® vials, Admelog Solostar® pens

Afrezza® inhalation cartridges

Fiasp® pens, vials, pumpcart

Humalog® U-200 Kwikpens
insulin aspart cartridges
Lyumjev, Kwikpens, Tempo pens
Novolog pens, vials

INSULINS, TRADITIONAL

Preferred Agents: No Prior Authorization required

Humulin® R U-500 pens, vials

Humulin® N vials

Humulin® R vials

Novolin® N vials

Novolin® R vials

Non-Preferred Agents: Prior Authorization Criteria below

Humulin® N Kwikpens

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with one preferred medication within same subgroup
- See additional medication-specific criteria below:

LYUMJEV™ (INSULIN LISPRO-AABC)

- Quantity limit = 90 per fill

Rezvoglar (insulin glargine-AGLR)

- Quantity limit = 90 per fill

TOUJEO SOLOSTAR® (INSULIN GLARGINE)

- Trial and failure on both preferred medications in this class

Duration of Approval: 1 year

Effective 10/1/20

Updated 10/7/21

Updated 6/1/22

Updated 6/9/22

Updated 10/1/22

Updated 10/18/24

UPHP MEDICAID - ISOTRETINOIN

MEDICATION(S)

AMNESTEEM, CLARAVIS, ISOTRETINOIN 10 MG CAPSULE, ISOTRETINOIN 20 MG CAPSULE, ISOTRETINOIN 30 MG CAPSULE, ISOTRETINOIN 40 MG CAPSULE, MYORISAN, ZENATANE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

CLARAVIS® / ISOTRETINOIN

AMNESTEEM® / ISOTRETINOIN

MYORISAN™ / ISOTRETINOIN

ZENATANE™ / ISOTRETINOIN

Drug Class: Acne Therapy Systemic - Retinoids & Derivatives

FDA-approved uses: Treatment of severe (multiple locations) recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics

Available dosage forms: Claravis Capsule 10 mg, 20 mg, 30 mg, and 40 mg, Amnesteem Capsule 10mg, 20mg and 40mg, Myorisan Capsule 10mg, 20mg, 30mg and 40mg, Zenatane Capsule 10mg, 20mg, 30mg and 40mg

Coverage Criteria/Limitations for initial authorization:

Diagnoses: severe (multiple locations) recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics

Duration of Approval

oInitial Authorization: 5 months, with monthly office visits

oContinuation of Therapy: Reviewed for coverage after a period of 2 months or more off therapy, and if warranted by persistent or recurring severe nodular acne

Prescriber Specialty: Dermatologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oProper diagnosis of an FDA approved indication OR

oIf request is for a non-FDA Approved indication, the request must be for a “medically accepted indication” as noted in the following Compendia:

American Hospital Formulary Drug Service (AHFS-DI)

Micromedex DrugDex

Clinical Pharmacology

oMust be prescribed by a dermatologist

oCurrent chart notes detailing the diagnosis, including laboratory tests as appropriate for diagnosis

oDocumentation of dose, dates of therapy, and clinical outcomes as appropriate

oFailed/intolerant to at least 2 oral antibiotics (must have used consistently for 6 months)

oFailed/intolerant to topical retinoid product (must have used consistently for 6 months)

oFailed/intolerant to Benzoyl Peroxide wash (must have used consistently for 6 months)

oFailed/intolerant to Clindamycin and/or Erythromycin topical therapy (must have used consistently for 6 months)

oNegative pregnancy test

oMust select 2 forms of effective contraception simultaneously

oMust meet requirements of the iPledge Program

Not approved If:

oPatient has any contraindications to the use of isotretinoin

oPatient is not compliant with current therapy?

Dosing:

oAdult Acne, severe recalcitrant nodular:

Oral: 0.5-1 mg/kg/day in 2 divided doses for 15-20 weeks

May discontinue earlier if the total cyst count decreases by 70%

Adults with very severe disease/scarring or primarily involves the trunk may require dosage adjustment up to 2 mg/kg/day

A second course of therapy may be initiated after a period of ? 2 months off therapy

A dose of less than or equal to 0.5 mg/kg/day may be used to minimize initial flaring

oPediatric Acne, severe recalcitrant nodular:

Children 12-17 years:

•Oral: 0.5-1 mg/kg/day in 2 divided doses for 15-20 weeks

•May discontinue earlier if the total cyst count decreases by 70%

•A second course of therapy may be initiated after a period of greater than or equal to 2 months off therapy

- A dose of less than or equal to 0.5 mg/kg/day may be used to minimize initial flaring

Age: 12 years and older

Route of Administration: Oral

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oOffice visit every month with verified compliance and improvement or stability on drug

Contraindications/Exclusions/Discontinuation:

- Patient is noncompliant with medical or pharmacologic therapy

- No demonstrable of improvement in clinical condition has occurred after initiation of drug therapy

References:

a.American Academy of Pediatrics Committee on Drugs, "Retinoid Therapy for Severe Dermatological Disorders," Pediatrics, 1992, 90(1 Pt 1):119-20.

b.Claravis [package insert]. Sellersville PA: Teva Pharmaceuticals USA, January 2015.

c.Facts & Comparisons. (2012). Claravis. Retrieved from <http://0-online.factsandcomparisons.com.libcat.ferris.edu/MonoDisp.aspx?monoID=fandc-hcp1943&quick=159351%7c5&search=159351%7c5&isstemmed=True>.

d.Mitchell AA, Van Bennekom CM, Louik C, et al, "A Pregnancy-Prevention Program in Women of Childbearing Age Receiving Isotretinoin," N Engl J Med, 1995, 333(2):101-6.

e.iPledge. (2015). Claravis iPledge Program. www.ipledgeprogram.com

f.Graber E, et al "Treatment of Acne Vulgaris," UptoDate, November, 10, 2015.

Effective 10/1/20

MEDICATION(S)

JYNARQUE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

JYNARQUE (TOLVAPTAN)

CLINICAL CRITERIA FOR INITIAL APPROVAL

Diagnosis of Autosomal Dominant Polycystic Kidney Disease [ADPKD]

- Patient is at least 18 years of age, AND
- Confirmation the patient does not have liver disease (including cirrhosis), AND
- Patient will not be on concomitant therapy with strong CYP3A–inhibitors (e.g., ketoconazole, nefazodone, clarithromycin, etc.), AND
- Patient will not be on concomitant therapy with a V2-agonist (e.g., desmopressin (DDAVP)), AND
- Patient will not be on concomitant therapy with a strong CYP3A– inducers (e.g., carbamazepine, phenobarbital, phenytoin, rifampin, etc), AND
- Patient will not be on concomitant therapy with any of the following, or if therapy is unavoidable, the patient will be monitored closely for adverse reaction and/or dose modifications will be implemented:
 - Moderate CYP3A–inhibitors (e.g., atazanavir, ciprofloxacin, erythromycin, grapefruit juice, fluconazole, etc), AND
 - Patient is able to sense or respond to thirst, AND

- Patient does not have hypovolemia or hypovolemic hyponatremia, AND
- Patient does not have anuria, AND
- Patient has confirmed ADPKD as diagnosed using ultrasonography (patient meets the modified Ravine diagnostic criteria), or using CT-scanning or MRI, AND
- Used to slow kidney function decline in patients at risk of rapidly progressing disease, defined as one or more of the following:
 - Increase in total kidney volume of at least 5% per year
 - Decrease in eGFR of at least 5 mL/min in 1 year
 - Decrease in eGFR of at least 2.5 mL/min per year over 5 years, AND
 - Patient has a baseline total kidney volume measurement, AND
 - Patient does not have uncorrected urinary outflow obstructions, AND
 - Both patient AND prescriber are enrolled in the Jynarque REMS program

CLINICAL CRITERIA FOR RENEWAL

- Absence of unacceptable toxicity from the drug (e.g., osmotic demyelination, liver injury or ALT/AST ever exceeded 3 times the ULN during treatment, dehydration, hypovolemia), AND
- Patient has shown an improvement to therapy based on one or more of the following:
 - Stabilization or improvement from baseline in total kidney volume (TKV), OR
 - Stabilization or improvement in the rate of kidney function decline, OR
 - Improvement in signs and/or symptoms of disease (e.g., medically significant kidney pain, hypertension, albuminuria)

Length of Authorization: 6 months, may be renewed

Effective 5/1/22

MEDICATION(S)

KERENDIA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

MHP Common Formulary Prior Authorization Criteria

KERENDIA/FINERENONE

Drug Class: Mineralocorticoid (Aldosterone) Receptor Antagonists

FDA-approved uses: chronic kidney disease (CKD) with type 2 diabetes

Available dosage forms: 10mg, 20mg tablets

Coverage Criteria/Limitations for initial authorization:

Diagnoses: diagnosis of chronic kidney disease (CKD) with type 2 diabetes

Duration of approval:

- o Initial authorization: 1 year

- o Continuation of Therapy: 1 year

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- o Member is currently receiving a maximally tolerated dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) OR has a contraindication to ACE inhibitor or ARB therapy AND

- o Member is not taking any strong CYP3A4 inhibitors AND

- o Member at baseline member meets all of the following:

Estimated glomerular filtration rate (eGFR) greater than or equal to 25ml/min/1.73m² AND

Urine albumin-to-creatinine ratio greater than 30mg/g AND

Serum potassium level less than 5.0mEq/L

Quantity: 1 per day

Age: minimum 18 years

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- o Member has eGFR greater than 25ml/min/1.73m² AND

- o Member serum potassium level less than 5.0mEq/L

Contraindications/Exclusions/Discontinuation: concomitant strong CYP3A4 inhibitors, adrenal insufficiency

MEDICATION(S)

KRINTAFEL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

KRINTAFEL®/ TAFENOQUINE

Drug Class: Antimalarials

FDA-approved uses:

Indicated for the radical cure (prevention of relapse) of Plasmodium vivax malaria in patients aged 16 years and older who are receiving appropriate antimalarial therapy for acute P. vivax infection. It is not indicated for the treatment of acute P. vivax malaria

Available dosage forms: 150 mg tablet

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Prevention of Plasmodium vivax

Duration of approval:

oInitial authorization:

Plasmodium vivax – one-time single dose

oContinuation of Therapy:

A repeat dose should be given if vomiting occurs within 1 hour after dosing. Re-dosing should not be

attempted more than once.

Prescriber Specialty: infectious disease

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oMedical record

oMust be tested negative for glucose-6-phosphate dehydrogenase (G6PD) deficiency prior to prescribing

oNegative pregnancy test result in all women of reproductive potential

oBreastfeeding an infant found to be G6PD deficient or unknown status is contraindicated

Quantity: Two (2), 150 mg tablets per 365 days

Age: 16 years of age and older

Gender: males and non-pregnant and non-lactating females

Route of Administration: Oral

Place of Service: Outpatient

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oUpdated medical record

Contraindications/Exclusions/Discontinuation:

•Glucose-6-phosphate dehydrogenase (G6PD) deficiency or unknown G6PD status

•May cause hemolytic anemia for patients when administered to pregnant woman with a G6PD-deficient fetus. A G6PD-deficient infant may be at risk for hemolytic anemia from exposure through breast milk.

Check infant's G6PD status before breastfeeding begins

•Patients with known hypersensitivity to tafenoquine, other 8-aminoquinolines, or any component of Krintafel

Other special considerations:

• Refer to the CDC website for recommendations for treatment and prevention of Plasmodium vivax malaria.

Effective 10/1/20

MEDICATION(S)

BROVANA, FORMOTEROL 20 MCG/2 ML NEB VL, PERFOROMIST, STRIVERDI RESPIMAT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA ADRENERGICS – LONG ACTING

Drug Class: Beta Adrenergics – Long Acting

Preferred Agents: No Prior Authorization required

Serevent® (DPI)

Non-Preferred Agents: Prior Authorization Criteria below

Arcapta® (DPI)

Brovana® nebulizer solution

formoterol nebulizer solution

Perforomist® nebulizer solution

Striverdi Respimat® (ISI)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications

- History of unacceptable side effects
- Therapeutic failure after a two-week trial with one preferred medication
- See additional medication-specific criteria below:

BROVANA® (ARFORMOTEROL) NEBULIZER SOLUTION

- Bypass PDL criteria if patient requires long-acting beta-adrenergic medication and cannot use a dry powder dose inhaler

PERFOROMIST® (FORMOTEROL) NEBULIZER SOLUTION

- Bypass PDL criteria if patient requires long-acting beta-adrenergic medication and cannot use a dry powder inhaler

STRIVERDI RESPIMAT® (OLODATEROL) INHALER

- Diagnosis of COPD (must not be used for asthma or acute exacerbations) inhaler

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/1/21

MEDICATION(S)

DUAKLIR PRESSAIR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS

Drug Class: Beta Adrenergic and Anticholinergic Combinations

Preferred Agents: No Prior Authorization required

Anoro Ellipta® (DPI)

Bevespi Aerosphere® (MDI)

Combivent RESPIMAT® (ISI)

ipratropium/albuterol nebulizer solution

Stiolto Respimat® (ISI)

Non-Preferred Agents: Prior Authorization Criteria below

Duaklir Pressair® (DPI)

Utibron Neohaler® (DPI)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications

- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- The patient's condition is clinically stable such that switching medications would cause deterioration in the condition
- Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

MEDICATION(S)

LONHALA MAGNAIR REFILL, LONHALA MAGNAIR STARTER, TIOTROPIUM BROMIDE, TUDORZA PRESSAIR, YUPELRI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTICHOLINERGIC AGENTS – LONG ACTING

Drug Class: Anticholinergic Agents – Long Acting

Preferred Agents: No Prior Authorization required

Incruse Ellipta® (DPI)

Spiriva® (DPI)

Spiriva Respimat® (ISI)

Non-Preferred Agents: Prior Authorization Criteria below

Lonhala Magnair nebulizer solution

tiotropium (DPI)

Seebri Neohaler® (DPI)

Tudorza Pressair® (DPI)

Yupelri® nebulizer solution

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- The patient's condition is clinically stable such that switching medications would cause deterioration in the condition OR
- Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

Updated 8/15/22

UPHP MEDICAID - LARIAM/MEFLOQUINE

MEDICATION(S)

MEFLOQUINE HCL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LARIAM® / MEFLOQUINE

Drug Class: Antimalarial

FDA-approved uses:

Treatment of Acute Malaria Infections: Mefloquine is indicated for the treatment of mild to moderate acute malaria caused by mefloquine-susceptible strains of *P. falciparum* (both chloroquine-susceptible and resistant strains) or by *P. vivax*.

Prevention of Malaria: Mefloquine is indicated for the prophylaxis of *P. falciparum* and *P. vivax* malaria infections, including prophylaxis of chloroquine-resistant strains of *P. falciparum*.

Available dosage forms: 250mg Tablets

Coverage Criteria/Limitations for initial authorization [30 days for acute treatment, 3 months for prophylaxis]:

Diagnoses: treatment or prevention of malaria

Duration of Approval:

oInitial Authorization:

Acute Treatment: 30 days

Prophylaxis: 3 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oCountry/region where the patient will be traveling

oFor Acute Treatment:

cultures and sensitivities to support malaria diagnosis

For Malaria Prophylaxis:

date and duration of travel

Use of doxycycline

Quantity: 5 tablets per 30 days

Gender: male or female

Route of Administration: oral

Place of Service: outpatient

Contraindications/Exclusions/Discontinuation:

- Mefloquine should not be prescribed for prophylaxis in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions.

- Mefloquine is contraindicated with the use of ketoconazole.

- Mefloquine should be used with caution with potent CYP3A4 inhibitors and medications that prolong the QTc interval.

- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

UPHP MEDICAID - LEUKOTRIENE INH

MEDICATION(S)

ACCOLATE, MONTELUKAST SOD 4 MG GRANULES, SINGULAIR, ZAFIRLUKAST, ZILEUTON ER, ZYFLO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LEUKOTRIENE INHIBITORS

Drug Class: Leukotriene Inhibitors

Preferred Agents: See Age Criteria for chew tablets below
montelukast tablets, 4mg chew tabs, 5mg chew tabs

Non-Preferred Agents: Prior Authorization Criteria below

Accolate®

montelukast granules

Singulair® tablets, 4mg chew tabs, 5mg chew tabs, granules

zafirlukast

Zileuton ER®

Zyflo®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Trial and failure with one month with one preferred medication

MONTELUKAST (SINGULAIR®)

- clinical rationale why the (swallow) tablet dosage form inappropriate for the following age limits:
 - o4mg chew tabs – prior authorization (PA) required for patients greater than 5
 - o5mg chew tabs – PA required for patients greater than 14
 - oGranules – PA required for patients greater than 5

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - LIDOCAINE 5% PATCH

MEDICATION(S)

LIDOCAINE 5% PATCH

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIDOCAINE 5% PATCH

Drug Class: Dermatological - Topical Local Anesthetic Amides

FDA-approved uses: Post-herpetic neuralgia (PHN)

Available dosage forms: Lidocaine 5% patch

Coverage Criteria/Limitations for initial authorization:

Diagnoses: (any of the following)

Post-herpetic neuralgia (PHN) or

Diabetic neuropathic pain or

Peripheral polyneuropathy not due to post-herpetic neuralgia, diabetes, or cancer with history of substance abuse disorder SUD or

SUD related concerns

Duration of Approval:

o Initial Authorization:

PHN: Up to 90 days

Neuropathic pain: initially 2 months

Pain with SUD related concerns: Up to 6 months

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

o For diabetic neuropathic pain only: Trial of at least 2 of the following or contraindication to all of the following: gabapentin, tricyclic antidepressant, nerve block, trigger point injection, SNRIs, TENS unit

Quantity: Max 3 patches per day (may be cut to cover areas of most severe pain)

Criteria for continuation of therapy:

Requires positive response to use of the patch

Duration of approval: Up to 12 months

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 5/1/2021

Updated 8/1/2021

UPHP MEDICAID - LIPOTROPICS - BILE ACID SEQUESTRANTS

MEDICATION(S)

COLESEVELAM HCL, COLESTID, COLESTIPOL HCL GRANULES, COLESTIPOL HCL GRANULES PACKET, QUESTRAN, QUESTRAN LIGHT, WELCHOL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: NON-STATINS - BILE ACID SEQUESTRANTS

Drug Class: Lipotropics: Non-Statins - Bile Acid Sequestrants

Preferred Agents: No Prior Authorization required

cholestyramine/ cholestyramine light

colestipol tablets, packets

Prevalite powder, packets

Non-Preferred Agents: Prior Authorization Criteria below

Colestid® tablet

colestipol granules

colesevelam tablet, packet

Questran®/ Questran Light®

Welchol® powder and tablets

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Patient is clinically stable, and switching would cause a deterioration in condition
- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - LIPOTROPICS - FIBRIC ACID DERIVATIVES

MEDICATION(S)

FENOFIBRATE 120 MG TABLET, FENOFIBRATE 130 MG CAPSULE, FENOFIBRATE 150 MG CAPSULE, FENOFIBRATE 40 MG TABLET, FENOFIBRATE 43 MG CAPSULE, FENOFIBRATE 50 MG CAPSULE, FENOFIBRATE 90 MG CAPSULE, FENOFIBRIC ACID 105 MG TABLET, FENOFIBRIC ACID DR 135 MG CAP, FENOFIBRIC ACID DR 45 MG CAP, FENOGLIDE, LIPOFEN, LOPID, TRICOR, TRILIPIX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: FIBRIC ACID DERIVATIVES

Drug Class: Lipotropics: Fibric Acid Derivatives

Preferred Agents: No Prior Authorization required
fenofibrate, nanocrystallized (generic for Tricor®)
fenofibric acid capsules (generic for Lofibra® caps)
fenofibrate tablets (generic for Lofibra tablets)
gemfibrozil tablet

Non-Preferred Agents: Prior Authorization Criteria below
Antara® capsule
fenofibrate, micronized capsules (generic for Antara)

fenofibrate, nanocrystallized (generic for Triglide®)

fenofibric acid (generic for Fibracor)

fenofibric acid (generic for Trilipix®)

Fenoglide® tablet

Fibracor

Fibracor® tablet

Lopid® tablet

Lipofen® capsule

Tricor® tablet

Triglide® tablet

Trilipix® capsule

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Patient is clinically stable, and switching would cause a deterioration in condition OR
- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/5/21

UPHP MEDICAID - LIPOTROPICS - NIACIN DERIVATIVES

MEDICATION(S)

NIACIN ER 500 MG TABLET, NIACIN ER, SLO-NIACIN 750 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: NIACIN DERIVATIVES

Drug Class: Lipotropics: Niacin Derivatives

Preferred Agents: No Prior Authorization required

niacin tablet (OTC)

niacin ER tablets (OTC)

niacin ER capsules (OTC)

Non-Preferred Agents: Prior Authorization Criteria below

Niacin ER (generic for Niaspan)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Patient is clinically stable, and switching would cause a deterioration in condition OR

- Therapeutic failure with one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/22

UPHP MEDICAID - LIPOTROPICS - OTHERS

MEDICATION(S)

ICOSAPENT ETHYL 1 GRAM CAPSULE, LOVAZA, NEXLETOL, NEXLIZET, OMEGA-3 ACID ETHYL ESTERS, ZETIA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: OTHERS

Drug Class: Lipotropics: Others

Preferred Agents: No Prior Authorization required

ezetimibe

Non-Preferred Agents: Prior Authorization Criteria below

icosapent ethyl 1 gm capsule

Lovaza®

Nexletol®

Nexlizet®

omega-3 acid ethyl esters capsule (generic for Lovaza)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Patient is clinically stable, and switching would cause a deterioration in condition, OR
- Therapeutic failure with one-month trial of one preferred medication
- See additional medication-specific criteria below:

LOVAZA® (OMEGA-3 ACID ETHYL ESTERS) – PDL CRITERIA DO NOT APPLY

- Adjunct to diet to reduce severe triglyceride (TG) levels (hypertriglyceridemia) in adult patients.
- Triglyceride levels greater than or equal to 500 mg/Dl

NEXLETOL® (BEMPEDOIC ACID) – PDL CRITERIA DO NOT APPLY

- Patient is greater than or equal to 18 years of age, AND
- Established atherosclerotic cardiovascular disease (ASCVD), OR
- Heterozygous familial hypercholesterolemia, AND
- Failure to achieve target LDL-C on maximally tolerated doses of statins, AND
- Therapy will be used in conjunction with maximally tolerated doses of a statin

NEXLIZET® (BEMPEDOIC ACID/EZETIMIBE) – PDL CRITERIA DO NOT APPLY

- Patient is greater than or equal to 18 years of age, AND
- Established atherosclerotic cardiovascular disease (ASCVD), OR
- Heterozygous familial hypercholesterolemia, AND
- Failure to achieve target LDL-C on maximally tolerated doses of statins, AND
- Therapy will be used in conjunction with maximally tolerated doses of a statin

(ICOSAPENT ETHYL) – PDL CRITERIA DO NOT APPLY

- Adjunct to diet to reduce severe triglyceride (TG) levels (hypertriglyceridemia) in adult patients, AND
- Triglyceride levels greater than or equal to 500 mg/dL, OR
- Adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated triglyceride (TG) levels greater than 150 mg/dL, AND
 - oEstablished cardiovascular disease, OR
 - oDiabetes mellitus and 2 or more additional risk factors for cardiovascular disease (i.e., men greater than 55 years and women greater than 65 years, cigarette smoker or stopped smoking within the past 3 months, hypertension (pretreatment blood pressure greater than 140mmHg systolic or greater than 90mmHg diastolic)

?Duration of Approval: 1 year

Effective 10/1/20

Updated 12/8/20 P&T

Updated 11/1/22

Updated 10/18/24

UPHP MEDICAID - LIPOTROPICS - PCSK9 INH

MEDICATION(S)

REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: PCSK9 INHIBITORS

Drug Class: Lipotropics: PCSK9 Inhibitors

Preferred Agents: Clinical Prior Authorization below

Praluent®

Repatha®

REPATHA® (EVOLOCUMAB) AND PRALUENT® (ALIROCUMAB)

Initial Request

- Diagnosis of atherosclerotic cardiovascular disease (ASCVD), heterozygous familial hypercholesterolemia (HeFH) or homozygous familial hypercholesterolemia (HoFH)
- Treatment failure with the highest available dose or maximally tolerated dose of high intensity statin

(atorvastatin or rosuvastatin) for at least 8 weeks.

- If intolerant to statins, this must be supported by submitted chart notes/labs.

- Patient has failed to reach target LDL-C levels (document lab values):

 - ASCVD: LDL-C is less than 70 mg/dL

 - HeFH or HoFH: LDL-C is less than 100 mg/dL

Length of Authorization: Initial – 12 months, Renewal – 12 months

Renewal Criteria: Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating medication

Quantity Limits:

PRALUENT®: 2 pens/syringes per 28 days

REPATHA®: 140 mg/mL pen/syringe – 2 pens/syringes per 28 days, 420 mg/3.5 mL Pushtonex® – 3.5 mL per 28 days, (for diagnosis of HoFH, Quantity Limit of 7mls per 28 days)

Duration of Approval: 1 year

Updated 4/1/21

Updated 5/1/22

UPHP MEDICAID - LIPOTROPICS - STATINS

MEDICATION(S)

ALTOPREV, AMLODIPINE-ATORVASTATIN, ATORVALIQ, CADUET, EZALLOR SPRINKLE, EZETIMIBE-SIMVASTATIN, FLUVASTATIN ER, FLUVASTATIN SODIUM, LESCOL XL, LIPITOR, LIVALO, VYTORIN, ZOCOR, ZYPITAMAG

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: STATINS

Drug Class: Lipotropics: Statins

Preferred Agents: No Prior Authorization required

Atorvastatin tablet

Lovastatin tablet

Pravastatin tablet

Rosuvastatin tablet

Simvastatin tablet

Non-Preferred Agents: Prior Authorization Criteria below

amlodipine / atorvastatin tablet

Altoprev® tablet

Atorvaliq

Caduet® tablet
Ezallor® Sprinkle capsule
ezetimibe/simvastatin tablet
fluvastatin capsule / fluvastatin ER tablet
Lescol XL® tablet
Lipitor® tablet
Livalo® tablet
pitavastatin
Pravachol® tablet
Vytorin® tablet
Zocor® tablet
Zypitamag® tablet

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Patient is clinically stable, and switching would cause a deterioration in condition
- Therapeutic failure with one-month trial of one preferred medication
- Quantity limit (all products) = one per day
- See additional medication-specific criteria below:

Atorvaliq (atorvastatin)

- Patient cannot swallow whole tablets
- Quantity limit: 20 mL per day

EZALLOR® SPRINKLE (rosuvastatin)

Patient cannot swallow whole tablets

Duration of Approval: 1 year

Effective 10/1/20

MEDICATION(S)

LITFULO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LITFULO/ RITLECITINIB

Drug Class: Janus Kinase (JAK) Inhibitors / TEC family kinase inhibitor

FDA-approved uses: Indicated for the treatment of severe alopecia areata in adults and adolescents 12 years and older.

Available dosage forms: 50mg Capsule

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Severe alopecia areata

?Duration of approval:

oInitial authorization: 6 months

oContinuation of Therapy: for up to 1 year

?Prescriber Specialty: Prescribed by or in consultation with a dermatologist

?Documentation Requirements (e.g., Labs, Medical Record, Special Studies):

- oSeverity of Alopecia Tool (SALT) score of ≥50 (range: 0 to 100, with 0 representing no scalp hair loss and 100 complete scalp hair loss) AND
- oCurrent AA episode lasting at least 6 months without spontaneous regrowth AND
- oDocumentation of inadequate response to a 3-month trial of at least one of the following:
 - ?intralesional corticosteroid therapy OR
 - ?prescription topical corticosteroid therapy (e.g., betamethasone dipropionate) OR
 - ?systemic immunomodulator therapy (e.g., corticosteroids, methotrexate, cyclosporine)
- ?Quantity: 1 capsule per day
- ?Age: 12 years of age or older

Criteria for continuation of therapy:

- ?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
 - o Provider documentation of clinical improvement in hair regrowth as indicated by improvement in post-treatment SALT score

Contraindications/Exclusions/Discontinuation:

- Not covered for patients with a diffuse hair loss pattern or other forms of alopecia such as androgenetic alopecia (Hamilton-Norwood classification system grade IV or greater) or chemotherapy-induced hair loss
- Cannot be used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine, or other potent immunosuppressants (e.g., methotrexate, azathioprine)

UPHP MEDICAID - MACROLIDES

MEDICATION(S)

CLARITHROMYCIN ER, E.E.S. 200, E.E.S. 400, ERY-TAB, ERYPED 200, ERYPED 400, ERYTHROMYCIN 250 MG TABLET, ERYTHROMYCIN 500 MG TABLET, ERYTHROMYCIN DR 250 MG CAP, ERYTHROMYCIN DR 250 MG TABLET, ERYTHROMYCIN DR 333 MG TABLET, ERYTHROMYCIN DR 500 MG TABLET, ERYTHROMYCIN 400 MG/5 ML SUSP, ZITHROMAX 1 GM POWDER PACKET, ZITHROMAX 100 MG/5 ML SUSP, ZITHROMAX 200 MG/5 ML SUSP, ZITHROMAX 250 MG TABLET, ZITHROMAX 250 MG Z-PAK TABLET, ZITHROMAX 500 MG TABLET, ZITHROMAX TRI-PAK

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

MACROLIDES

Drug Class: Macrolides

Preferred Agents: No Prior Authorization required

Azithromycin

Clarithromycin

erythromycin ethylsuccinate tablets

erythromycin ethylsuccinate 200mg suspension

Erythrocin®

Non-Preferred Agents: Prior Authorization Criteria below

clarithromycin ER
E.E.S.® tablet, suspension
EryPed®
Ery-Tab®
Erythromycin base
erythromycin ethylsuccinate 400mg suspension
Zithromax® tablets, suspension

Non-Preferred Agent PA Criteria

Allergy to the preferred medications
Contraindication or drug to drug interaction with the preferred medications
History of unacceptable side effects
Infection caused by an organism resistant to the preferred macrolide medications
Therapeutic failure (duration = 3 days) with two preferred medications

Quantity Limitations:

azithromycin (Zithromax®)
500mg – 3 per fill
600mg – 12 per fill
1g packet - 2 per fill
clarithromycin tabs (Biaxin®)28 per fill
Zithromax® (azithromycin)
500mg – 3 per fill
600mg – 12 per fill
1g packet - 2 per fill

Duration of Approval: Date of service

Effective 10/1/20

Update 8/1/21

UPHP MEDICAID - MARINOL/DRONABINOL

MEDICATION(S)

DRONABINOL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

MARINOL ®/DRONABINOL

Drug Class: Antiemetic - Cannabinoids

FDA-approved uses:

Appetite stimulation in AIDS patients

Chemotherapy-induced nausea and vomiting

Available dosage forms: Capsules: 2.5 mg, 5 mg, 10 mg,

Coverage Criteria/Limitations for initial authorization:

Diagnosis: chemotherapy induced nausea and vomiting

Duration of Approval:

oInitial Authorization: duration of the chemotherapy treatment

oContinuation of Therapy: limited time -- determined based on the plan of care developed utilizing the chemotherapeutic agents

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPatient must be receiving chemotherapy and meet the following criteria:

Intolerant or refractory to first line agents such as Zofran

Patient must be under close supervision during the initial use and during dose adjustments due to its potential for altered mental status

The number of pills approved will be limited to the amount necessary for a single cycle of chemotherapy.

oFor antiemetic purposed: trial and failure, intolerance, or contraindication to an emetic regimen that includes a serotonin antagonist (ondansetron, granisetron), dexamethasone, promethazine, or prochlorperazine

oFor cancer: trial and failure, intolerance, or contraindication to an emetic regimen consistent with NCCN guidelines

Age restrictions: adults and pediatrics

Prescriber Specialty: Oncologist

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDecreased episodes of nausea and vomiting.

Effective 10/1/20

UPHP MEDICAID - MEPRON/ATOVAQUONE

MEDICATION(S)

ATOVAQUONE 750 MG/5 ML SUSP, ATOVAQUONE 750 MG/5ML SUSP CUP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

MEPRON® / ATOVAQUONE

Drug Class: Antiprotozoal Agents - Other

FDA-approved uses: Pneumocystis jiroveci pneumonia:

Prophylaxis: Prevention of P. jiroveci pneumonia (PCP) in adults and adolescents 13 years and older who are intolerant to trimethoprim-sulfamethoxazole (TMP-SMZ).

Treatment:

Acute oral treatment of mild to moderate PCP in adults and adolescents 13 years and older who are intolerant to trimethoprim-sulfamethoxazole.

Available dosage forms: 750mg/5ml Oral Suspension

Coverage Criteria/Limitations for initial authorization:

Diagnoses: FDA approved uses as listed above

Prescriber Specialty: Infectious Disease

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

Failure or contraindication to TMP-SMZ

Quantity: 21 day supply

Age: 13 years or older

Route of Administration: Oral

Contraindications/Exclusions/Discontinuation:

- Patient is noncompliant with medical or pharmacologic therapy.
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- Hypersensitivity to atovaquone or any component of the formulation.

Effective 10/1/20

UPHP MEDICAID - MULTIPLE SCLEROSIS AGENTS

MEDICATION(S)

AUBAGIO, BAFIERTAM, COPAXONE 40 MG/ML SYRINGE, GILENYA, GLATIRAMER ACETATE, GLATOPA, KESIMPTA PEN, MAVENCLAD, MAYZENT, PLEGRIDY, PLEGRIDY PEN, PONVORY, REBIF, REBIF REBIDOSE, TASCENSO ODT, TECFIDERA, TERIFLUNOMIDE, VUMERITY, ZEPOSIA 0.92 MG CAPSULE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

MULTIPLE SCLEROSIS AGENTS

Drug Class: Multiple Sclerosis Agents

Preferred Agents: No Prior Authorization required

Avonex®

Betaseron® vial / Betaseron® Kit

Copaxone 20 mg

dimethyl fumarate (generic for Tecfidera)

fingolimod (generic for Gilenya)

teriflunomide (generic for Aubagio)

Non-Preferred Agents: Prior Authorization Criteria below

Aubagio® tablet

Bafiertam

Copaxone® 40 mg syringe

glatiramer 20 mg/ml and 40 mg/ml

Gilenya®

Glatopa®

Kesimpta®

Mavenclad®

Mayzent®

Plegridy®

Ponvory®

Rebif®/ Rebif Rebidose®

Tascenso ODT®

Tecfidera®

Vumerity®

Zeposia®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure of one month with one preferred medication
- See additional medication-specific criteria below:

BAFIERTAM™ (MONOMETHYL FUMARATE)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
- Prescribed by or in consultation with a neurologist, AND
- Attestation that Bafiertam will be used as single agent monotherapy
- Quantity limit: 120 per 30 days

Initial length of authorization: 6 months

- Renewal criteria:

Attestation of tolerance to maintenance dose.

Attestation of a CBC, including lymphocyte count, serum aminotransferase, ALP, and total bilirubin levels

Length of authorization: 1 year

KESIMPTA® (OFATUMUMAB)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
- Prescribed by or in consultation with a neurologist, AND
- Attestation that Kesimpta will be used as single agent monotherapy
- Attestation that the first injection will be monitored by a healthcare professional
- Length of authorization: 1 year

PLEGRIDY® (PEGINTERFERON BETA-1A)

- Therapeutic failure on two preferred medications required.

PONVORY® (PONESIMOD)

- Patient age between 18 years and 55 years, AND
- Patient has a diagnosis of a relapsing form of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) or active secondary progressive disease (SPMS), AND
- Prescribed by or in consultation with a neurologist, AND
- Patient has obtained a baseline electrocardiogram (ECG), AND
- Prescriber attestation that first-dose monitoring, as clinically indicated, will occur, AND
- Patient does NOT have an active infection, including clinically important localized infections, AND
- Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy, AND
- For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment, AND
- Prescriber attestation that ponesimod will NOT be used in combination with anti-neoplastic, immunosuppressive, or immune-modulating therapies, or, if therapy is unavoidable, the patient will be monitored closely for adverse reactions and/or dose modifications, AND
- Therapeutic failure of one month trial of at least two preferred medications

MAVENCLAD® (CLADRIBINE)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include relapsing-remitting disease and active secondary progressive disease, AND
- Prescribed by or in consultation with a neurologist
- Therapeutic failure of one month trial of at least two preferred medications

MAYZENT® (SIPONIMOD)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
- Prescribed by or in consultation with a neurologist, AND
- Patient CYP2C9 variant status has been tested to determine genotyping (required for dosing), AND
- Patient has obtained a baseline electrocardiogram (ECG), AND
- Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed immunization

series for VZV prior to beginning therapy, AND

- For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment, AND
- Therapeutic failure of one month trial of at least two preferred medications

TASCENSO ODT® (FINGOLIMOD)

- oDiagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS) AND
- oPatient age is 11 and up
- oPrescribed by or in consultation with a neurologist AND
- oPatient is unable to use generic fingolimod capsules or brand Gilenya capsules due to swallowing difficulties.
- oLength of approval: 1 year

VUMERITY® (DIROXIMEL FUMARATE)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS), AND
- Prescribed by or in consultation with a neurologist, AND
- Therapeutic failure of one month trial of at least two preferred medications

ZEPOSIA®(OZANIMOD)

- Diagnosis of relapsing forms of multiple sclerosis (MS) to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS) and active secondary progressive disease (SPMS)AND
- Prescribed by or in consultation with a neurologist, OR
- Diagnosis of moderately or severely active ulcerative colitis (UC), AND
- Prescribed by or in consultation with a gastroenterologist, AND
- Patient has obtained a baseline electrocardiogram (ECG) AND
- Patient does NOT have an active infection, including clinically important localized infections AND
- Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy AND
- For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment AND
- Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months, AND
- For MS, therapeutic failure of one month trial of at least two preferred MS medications.
- For UC, may bypass PDL criteria.

Quantity Limitations:

AVONEX®4 per 34 days

BAFIERTAM®120 per 30 days

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/1/21

Updated 6/1/22

Updated 10/18/24

UPHP MEDICAID - NARCOLEPSY

MEDICATION(S)

XYWAV

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NARCOLEPSY AGENTS

SODIUM OXYBATE

XYWAV/ CALCIUM, MAGNESIUM, POTASSIUM, SODIUM OXYBATE

Drug Class: Narcolepsy Agents

Agents: Prior Authorization Criteria below

Xywav® - Rationale for lower sodium needed for approval of Xywav except when the indication is for idiopathic hypersomnia in adults.

Sodium Oxybate

FDA-approved uses: Excessive daytime sleepiness/cataplexy: Treatment of excessive daytime sleepiness and cataplexy in patients with narcolepsy: Idiopathic hypersomnia in adults.

Available dosage forms: Oral solution, 500 mg per mL

Coverage Criteria/Limitations for initial authorization:

?Diagnoses:

oType 1 Narcolepsy (cataplexy in narcolepsy)

oType 2 Narcolepsy [narcolepsy without cataplexy, excessive daytime sleepiness (EDS) in narcolepsy]

oIdiopathic hypersomnia (Xywav only)

?Duration of approval:

oInitial authorization: 3 months

oContinuation of Therapy: for up to 6 months

?Prescriber Specialty: Board-certified Sleep Medicine Specialist, neurologist, pulmonologist, or psychiatrist.

Submit consultation notes if applicable.

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies, Pharmacy claims, Physician attestation):

oDaily excessive daytime sleepiness for at least 3 months (AASM ICSD-3 Criteria)

oNocturnal polysomnography (PSG) confirmation

?Overnight polysomnography to rule out other conditions and confirm adequate sleep before first Multiple Sleep Latency Test (MSLT)

oPositive MSLT* including:

?Mean Sleep Latency ? 8 minutes

?2 or more sleep onset rapid eye movement (REM) periods less than 15 minutes

EXCEPTION to positive MSLT test for Type 1 Narcolepsy (cataplexy in narcolepsy): Hypocretin-1 less than or equal to 110 pg/mL (or less than 1/3 of mean normal control values) may be alternative to MSLT sleep study

EXCEPTION 2 For Idiopathic Hypersomnia, the number of sleep-onset rapid eye movement sleep periods (SOREMPs) is less than two

oMember is not currently on a sedative hypnotic agent (examples include but are not limited to: Lunesta (eszopiclone), Ambien (zolpidem), Sonata (zaleplon), Restoril (temazepam), Halcion (triazolam), or Belsomra (suvorexant))?

oMember is not currently on other prescription or non-prescription sedatives, including but not limited to excessive alcohol or marijuana use.

oMetabolic and psychiatric causes have been evaluated and ruled out, if present, attestation that treatment has been optimized. Provider attests that patient is enrolled in the Xywav/sodium oxybate REMS program.

oType 1 Narcolepsy (cataplexy in narcolepsy)

?Member has cataplexy defined as more than one episode of generally brief (less than 2 minutes) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness.

oType 1 Narcolepsy (cataplexy in narcolepsy), continued

?Member did not achieve treatment goals or experienced inadequate clinical response after an adherent trial at maximum therapeutic dose, persistent intolerable adverse effects or contraindication to at least ONE (1) medication from BOTH of the following: [BOTH: 1 AND 2]

•Non-amphetamine stimulant OR Amphetamine-based stimulant or a methylphenidate-based stimulant:

?Non-amphetamine stimulant: modafanil (Provigil) or armodafanil (Nuvigil)

?Amphetamine-based products: amphetamine/dextroamphetamine mixed salts,

amphetamine/dextroamphetamine mixed salts extended-release, dextroamphetamine extended-release

?Methylphenidate-based products: methylphenidate, methylphenidate extended-release, dexamethylphenidate

•Tricyclic Antidepressants (TCA) OR Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotonin-norepinephrine Reuptake Inhibitor (SNRI):

?TCA: imipramine, nortriptyline, protriptyline, clomipramine, etc.

?SSRI/SNRI: fluoxetine, venlafaxine, atomoxetine, etc.

oType 2 Narcolepsy [narcolepsy without cataplexy]

?Other conditions that cause EDS have been ruled out or treated, including (but not limited to): shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, effects of sedating medications, idiopathic hypersomnolence, insufficient sleep at night (sleep deprivation), obstructive sleep apnea, central sleep apnea, periodic limb movement disorder (including restless legs syndrome), depression, Circadian rhythm disorders (including delayed sleep phase syndrome), and sedating medications.

?Member did not achieve treatment goals or experienced inadequate clinical response after a documented adherent trial at maximum therapeutic dose, persistent intolerable adverse effects or contraindication to at least ONE (1) medication from ALL of the following: [1,2, 3, 4, AND 5]

•Non-amphetamine stimulant:

?Modafanil (Provigil)

?Armodafanil (Nuvigil)

•Amphetamine-Based Products: amphetamine/dextroamphetamine mixed salts, amphetamine/dextroamphetamine mixed salts extended-release, dextroamphetamine extended-release

•Methylphenidate based products: methylphenidate, methylphenidate extended-release, dexamethylphenidate

•Dopamine and norepinephrine reuptake inhibitor (DNRI): Sunosi (solriamfetol)

•Histamine-3 (H3) receptor antagonist/inverse agonist: Wakix (pitolisant)

oldiopathic Hypersomnia (must meet all):

oDiagnosis of Idiopathic Hypersomnia

oRequest for Xywav

oPrescribed by or in consultation with a neurologist or sleep medicine specialist

oAge greater than 18 years

oExclusion of all of the following:

?Narcolepsy of cataplexy

?Narcolepsy of EDS

?Insufficient sleep syndrome

?Quantity: Maximum Dose: 9 grams per day, 18 mL per day OR 540 mL per 30 days

?Age: greater than or equal to 7 years old and greater than 20 kg

oFor idiopathic hypersomnia must be greater than 18 years of age

?Gender: Male and Female

?Route of Administration: Oral

Criteria for continuation of therapy:

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oConsultation notes must be submitted for initial request and for continuation of treatment requests at least ONCE annually

oAdherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history (review Rx history for compliance), including:

?Adherent to the prescribed medication regimen

?Tolerance to therapy

?No severe adverse reactions or drug toxicity

oDocumentation of efficacy and positive response to therapy as evidenced by response of decreasing cataplexy events and improvement in score for appropriate test (e.g. Epworth Sleepiness Scale, Clinical Global Impression of Change, etc.) for EDS [ALL APPLICABLE]

?Decrease or reduction in the frequency of cataplexy events/attacks associated with therapy for Type 1 Narcolepsy

?Decrease or reduction in symptoms of excessive daytime sleepiness associated with therapy

?For excessive daytime sleepiness (EDS): Improvement in the Epworth Sleepiness Scale (ESS), Clinical Global Impression of Change or Maintenance of Wakefulness Test (MWT) for Type 1 and 2 Narcolepsy

oA documented attempt to decrease dose or step down to alternative drugs

Contraindications/Exclusions/Discontinuation:

•Non-FDA approved indications

•Hypersensitivity to Xyrem (sodium oxybate) or any ingredient in the formulation

•Co-administration with CNS depressant anxiolytics, sedatives, and hypnotics or other sedative CNS depressant drugs

oAdministration with alcohol or other psychoactive drugs can potentiate the effects of sodium oxybate.

•Co-administration with alcohol (ethanol)

oEthanol is contraindicated in patients using sodium oxybate. The combined use of alcohol (ethanol) with sodium oxybate may result in potentiation of the CNS-depressant effects of sodium oxybate and alcohol.

•Succinic Semialdehyde Dehydrogenase Deficiency

oThis rare disorder is an in?born error of metabolism and variably characterized by mental retardation, hypotonia, and ataxia.

•History of drug abuse

oSodium oxybate is a CNS depressant with potential for misdirection and abuse and patients should be evaluated for a history of drug abuse.

•Uncontrolled hypertension (due to sodium content)

Other special considerations:

- Patients with Hepatic Impairment Dosing

- oReduce the initial dosage by 50%

References

- 1.Xyrem (sodium oxybate) [prescribing information]. Palo Alto, CA: Jazz Pharmaceuticals, Decemeber 2018.
- 2.Micromedex Healthcare Series. DrugDex. [Micromedex Web site]. Available at: <http://www.thomsonhc.com/micromedex2/librarian> [via subscription only].
- 3.Drug Facts and Comparisons. Drug Facts and Comparisons 4.0 [online]. 2018. Available from Wolters Kluwer Health, Inc. [via subscription only]
- 4.Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc., 2018. URL: <http://www.clinicalpharmacology.com>. [via subscription only]

Effective 10/1/20

Updated 5/1/21

Updated 5/1/22

Updated 8/1/22

UPHP MEDICAID - NARCOTICS - LONG-ACTING

MEDICATION(S)

BELBUCA, CONZIP, DISKETS, HYDROCODONE ER 10 MG CAPSULE, HYDROCODONE ER 15 MG CAPSULE, HYDROCODONE ER 20 MG CAPSULE, HYDROCODONE ER 30 MG CAPSULE, HYDROCODONE ER 40 MG CAPSULE, HYDROCODONE ER 50 MG CAPSULE, HYDROMORPHONE ER, HYSINGLA ER, METHADONE 10 MG/5 ML SOLUTION, METHADONE 10 MG/ML ORAL CONC, METHADONE 40 MG TABLET DISPR, METHADONE 5 MG/5 ML SOLUTION, METHADONE HCL 10 MG TABLET, METHADONE HCL 5 MG TABLET, METHADONE INTENSOL, METHADOSE, MORPHINE SULFATE ER 10 MG CAP, MORPHINE SULFATE ER 100 MG CAP, MORPHINE SULFATE ER 120 MG CAP, MORPHINE SULFATE ER 20 MG CAP, MORPHINE SULFATE ER 30 MG CAP, MORPHINE SULFATE ER 45 MG CAP, MORPHINE SULFATE ER 50 MG CAP, MORPHINE SULFATE ER 60 MG CAP, MORPHINE SULFATE ER 75 MG CAP, MORPHINE SULFATE ER 80 MG CAP, MORPHINE SULFATE ER 90 MG CAP, MS CONTIN, NUCYNTA ER, OXYCODONE HCL ER, OXYCONTIN, OXYMORPHONE HCL ER, TRAMADOL HCL ER 100 MG CAPSULE, TRAMADOL HCL ER 200 MG CAPSULE, TRAMADOL HCL ER 300 MG CAPSULE, XTAMPZA ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPIOIDS – LONG ACTING

Drug Class: OPIOIDS – Long Acting

Preferred Agents: Clinical Prior Authorization for codeine and tramadol containing products only

morphine sulfate ER tablets
tramadol ER tablets

Preferred Agent PA Criteria:

Greater than or equal to 12 years of age (for codeine and tramadol containing products only)

Non-Preferred Agents: Prior Authorization Criteria below

Belbuca®
Conzip ER®
Diskets
hydrocodone ER capsules (generic Zohydro ER®)
hydrocodone ER tablets (generic Hysingla ER®)
hydromorphone ER®
Hysingla ER®
Kadian®
Methadone
Methadose tablet dispersible, oral concentrate
morphine sulfate ER caps (generic Avinza®)
morphine sulfate ER caps (generic Kadian®)
MS Contin®
Nucynta ER®
Oramorph SR®
Oxycontin®
oxycodone ER
oxymorphone ER
Ultram ER®
Xtampza ER®
Zohydro ER®

Non-Preferred Agent PA Criteria:

- Greater than or equal to 12 years of age (for codeine and tramadol containing products only) AND
- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure of one week with one preferred medication
- See additional medication-specific criteria below:

BELBUCA® (BUPRENORPHINE BUCCAL FILM)

- Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia, AND

- Patient greater than 18 years old

XTAMPZA ER® (OXYCODONE)

- Diagnosis of severe chronic pain requiring around the clock opioid analgesia, AND
- Patient greater than 18 years old, AND
- Alternative treatment options have been ineffective, not tolerated or inadequate for controlling pain

Quantity Limitations:

Belbuca® (buprenorphine)60 per 30 days

buprenorphine film 60 per 30 days

Oxycontin® ER 10mg (oxycodone-controlled release tab)180 per 30 days

Oxycontin® ER 15mg (oxycodone-controlled release tab)120 per 30 days

Oxycontin® ER 20 mg (oxycodone-controlled release tab)90 per 30 days

Oxycontin® ER 30mg (oxycodone-controlled release tab)60 per 30 days

Oxycontin® ER 40mg (oxycodone-controlled release tab)45 per 30 days

Oxycontin® ER 60 mg (oxycodone-controlled release tab)30 per 30 days

Oxycontin® ER 80mg (oxycodone-controlled release tab)22 per 30 days

Duration of Approval: 6 months for Zohydro® ER, 1 year for all other medications

Chronic Opioid Management with High Morphine Milligram Equivalent (MME)

*Note: High MME applies to all opioids (i.e. short acting, long, acting, transdermal)

Initial High MME Exceptions: If any are “True”, no further information is required and member meets the requirements for this section. If all are “False” then proceed to the remaining requirements under Additional High MME Criteria.

- 1.Does the patient have documented “current” cancer-related pain?
- 2.Does the patient have pain related to sickle cell disease?
- 3.Is the patient in hospice or palliative care?
- 4.Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).

Additional High MME Criteria:

- Provider must attest to all of the following:

- oRisk assessment has been performed

- oPain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient

- oMAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber’s assessment the drugs and doses are safe for the member.

- oConcurrently prescribed drugs have been reconciled and reviewed for safety

oThe following Non-opioid pain interventions have been recommended and/or utilized:

Non-opioid medications

Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss

oA toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.

oPatient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.

oIf applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).

•Additional documentation:

oCurrent documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME

oRecent non-opioid medications utilized for pain management or rationale these cannot be used

oDocumentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.

oDuration of current opioid therapy and current daily Morphine Milligram Equivalent

Opioid Oral MME conversion factor table can be found under the following resources:

If differences exist in language, the more current MME guidelines will be followed:

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR

•<https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0>

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oIf patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:

oMust continue to meet high MME criteria and provide all required documentation

oDocumentation of taper plan or rationale why taper is not appropriate

Effective 10/1/20

Updated 8/1/21

Updated 11/1/22

UPHP MEDICAID - NARCOTICS - SHORT AND INTERMEDIATEACTING

MEDICATION(S)

ACETAMIN-CAFF-DIHYDROCODEINE, ASA-BUTALB-CAFFEINE-CODEINE, ASCOMP WITH CODEINE, BUTALB-ACETAMINOPH-CAFF-CODEIN, BUTALBITAL COMPOUND-CODEINE, BUTORPHANOL 10 MG/ML SPRAY, DILAUDID 2 MG TABLET, DILAUDID 4 MG TABLET, DILAUDID 5 MG/5 ML ORAL LIQUID, DILAUDID 8 MG TABLET, FENTANYL CIT 100 MCG BUCCAL TB, FENTANYL CIT 200 MCG BUCCAL TB, FENTANYL CIT 400 MCG BUCCAL TB, FENTANYL CIT 600 MCG BUCCAL TB, FENTANYL CIT 800 MCG BUCCAL TB, FENTORA, FIORICET WITH CODEINE, HYDROCODONE-IBUPROFEN, HYDROMORPHONE 3 MG SUPPOS, LEVORPHANOL 2 MG TABLET, LEVORPHANOL 3 MG TABLET, MEPERIDINE 50 MG TABLET, MEPERIDINE 50 MG/5 ML SOLUTION, NALOCET, NUCYNTA, OXAYDO, OXYCODONE HCL (IR) 20 MG TAB, OXYCODONE HCL (IR) 30 MG TAB, OXYCODONE HCL (IR) 5 MG CAP, OXYCODONE HCL 100 MG/5 ML CONC, OXYMORPHONE HCL, PENTAZOCINE-NALOXONE HCL, PERCOCET, PROLATE, ROXICODONE, ROXYBOND 15 MG TABLET, ROXYBOND 30 MG TABLET, ROXYBOND 5 MG TABLET, SEGLENTIS, TRAMADOL HCL 25 MG/5 ML CUP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPIOIDS – SHORT AND INTERMEDIATE ACTING

Drug Class: OPIOID – Short and Intermediate Acting

Preferred Agents: Clinical Prior Authorization for codeine and tramadol containing products only.

codeine
codeine / acetaminophen
Endocet
hydrocodone / acetaminophen
hydromorphone oral tablets
morphine sulfate tablets, solution, suppository
oxycodone tabs (5mg, 10mg, 15mg)
oxycodone oral solution
oxycodone / acetaminophen
tramadol / acetaminophen
tramadol

Non-Preferred Agents: Prior Authorization Criteria below

butorphanol
codeine / acetaminophen /caffeine /butalbital
codeine / aspirin /caffeine /butalbital
Demerol® tablets, solution
Dilaudid® all forms
fentanyl citrate buccal
Fentora®
Fioricet w/ Codeine®
Fiorinal w/ Codeine®
hydrocodone/ ibuprofen
hydromorphone suppository
levorphanol
Lorcet®, Lorcet HD®, Lorcet Plus®
Lortab®
meperidine tablets, solution
Nalocet
Nucynta®
Oxaydo®
oxycodone / aspirin
oxycodone capsule
oxycodone tabs (20mg, 30mg)
oxycodone oral conc soln
oxycodone oral syringe

oxycodone/ibuprofen
oxymorphone
pentazocine/naloxone
Percocet®
Prolate
Qdolo
Roxicodone®
Seglentis®
Tramadol Oral Solution (generic Qdolo Soln)

Preferred Agent PA Criteria:

- greater than or equal to 12 years of age (for codeine and tramadol containing products only) AND

SHORT ACTING OPIOID 7-DAY LIMIT

Claims submitted for short acting opioids for more than a 7-day supply for opioid naïve patients (i.e., those with no claim for an opioid medication within the past 180 days) will deny for prior authorization.

Non-Preferred Agent PA Criteria:

- greater than or equal to 12 years of age (for codeine and tramadol containing products only) AND
- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure of one week each with two preferred medications
- See additional medication-specific criteria below:

SHORT ACTING OPIOID 7-DAY LIMIT

Claims submitted for short acting opioids for more than a 7-day supply for opioid naïve patients (i.e., those with no claim for an opioid medication within the past 180 days) will deny for prior authorization.

FENTANYL – ORAL (ABSTRAL®, FENTORA®)

- Management of breakthrough cancer pain in patients established on immediate release and long-acting opioid therapy.
- Requests for controlled substances must be under the name and ID of the prescribing physician.
- greater than 18 years of age
- Medication must be prescribed by a physician who is experienced in the use of Schedule II opioids
- Current dosage regimen of the long acting and regularly prescribed immediate release narcotics must be maximally optimized.

- No concomitant use of other inducers of cytochrome P450
- No concomitant use of other inhibitors of cytochrome P450

SEGLENTIS (CELECOXIB/TRAMADOL)

- Patient age is 12 years and older, AND
 - Prescriber attests that Seglentis will not be used for postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy, AND
- Quantity Limit=120 tablets per 30 days

TRAMADOL (QDOLO®) ORAL SOLUTION

- Patient age is 12 years and older, AND
- Allow if patient has difficulty swallowing tablets
- Quantity limit = 80 ml per day (400mg/day)

Quantity Limitations:

- FENTANYL CITRATE 120 units/30 days for each strength
- BUTORPHANOL 10MG/ML NASAL SPRAY15 mL per 30 days
- CODEINE SULFATE 15 MG TAB180 per 30 days
- CODEINE SULFATE 30MG TAB180 per 30 days
- CODEINE SULFATE 60 MG TAB180 per 30 days
- FENTORA – all strengths120 every 24 days
- HYDROMORPHONE HCL 1 MG/ML ORAL CONC120ml per 30 days
- HYDROMORPHONE HCL 2MG TAB180 per 30 days
- HYDROMORPHONE HCL 4MG TAB135 per 30 days
- HYDROMORPHONE HCL 8MG TAB67 per 30 days
- MEPERIDINE HCL 50MG TAB120 per 30 days
- MEPERIDINE HCL 50 MG/5ML SOLN240ml per 30 days
- MORPHINE SULFATE 10 MG /5ML SOLN240ml per 30 days
- MORPHINE SULFATE 100 MG/5ML SOLN120 per 30 days

Quantity Limitations, continued

- MORPHINE SULFATE 15 MG TAB180 per 30 days
- MORPHINE SULFATE 20 MG/5ML SOLN240ml per 30 days
- MORPHINE SULFATE 30 MG TAB90 per 30 days
- OXYCODONE HCL 5 MG CAP90 per 30 days
- OXYCODONE HCL 5MG TAB90 per 30 days
- OXYCODONE HCL 5MG/5ML SOLN240ml per 30 days
- OXYCODONE HCL 20MG/ML SOLN90ml per 30 days
- OXYCODONE HCL 10MG TAB90 per 30 days
- OXYCODONE HCL 15 MG TAB90 per 30 days

OXYCODONE HCL 20 MG TAB90 per 30 days
OXYCODONE HCL 30 MG TAB60 per 30 days
OXYMORPHONE HCL 5MG TAB120 per 30 days
OXYMORPHONE HCL 10MG TAB90 per 30 days
ROXYBOND 5MG TAB 90 PE R30 DAYS
ROXYBOND 15MG TAB 90 PER 30 DAYS
ROXYBOND 30MG TAB 60 PER 30 DAYS
SEGLENTIS 56 MG - 44 MG TAB120 per 30 days
TRAMADOL SOLUTION 25MG/5ML (QDOLO)80 per day (400mg)

Duration of Approval: 14 days for Adapaz®, 1 year for all other medications

Chronic Opioid Management with High Morphine Milligram Equivalents (MME)

*Note: High MME applies to all opioids (i.e. short acting, long, acting, transdermal)

Initial High MME Exceptions: If any are “True”, no further information is required and member meets the requirements for this section. If all are “False” then proceed to the remaining requirements under Additional High MME Criteria.

- 1.Does the patient have documented “current” cancer-related pain?
- 2.Does the patient have pain related to sickle cell disease?
- 3.Is the patient in hospice or palliative care?
- 4.Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).

Additional High MME Criteria:

•Provider must attest to all of the following:

oRisk assessment has been performed

oPain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient

oMAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber’s assessment the drugs and doses are safe for the member.

oConcurrently prescribed drugs have been reconciled and reviewed for safety

oThe following Non-opioid pain interventions have been recommended and/or utilized:

?Non-opioid medications

?Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss

oA toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.

oPatient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.

oIf applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).

•Additional documentation:

oCurrent documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME

oRecent non-opioid medications utilized for pain management or rationale these cannot be used

oDocumentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.

oDuration of current opioid therapy and current daily Morphine Milligram Equivalent

?Opioid Oral MME conversion factor table can be found under the following resources:

•If differences exist in language, the more current MME guidelines will be followed:

•CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR

•<https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0>

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oIf patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:

oMust continue to meet high MME criteria and provide all required documentation

oDocumentation of taper plan or rationale why taper is not appropriate

Effective 10/1/20

Updated 1/1/22

Updated 2/22/22

Updated 5/1/22

Updated 11/1/22

Updated 10/18/24

UPHP MEDICAID - NARCOTICS - TRANSDERMAL

MEDICATION(S)

BUPRENORPHINE, FENTANYL 37.5 MCG/HR PATCH, FENTANYL 62.5 MCG/HR PATCH, FENTANYL 87.5 MCG/HR PATCH

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPIOIDS – TRANSDERMAL

Drug Class: Opioids – Transdermal

Preferred Agents: No Prior Authorization required

Butrans® patches

fentanyl patches 12, 25, 50, 75, and 100 mcg only (generic only)

Non-Preferred Agents: Prior Authorization Criteria below

buprenorphine patches

fentanyl generic patches 37.5 mcg, 62.5 mcg and 87.5 mcg only

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medication
- History of unacceptable side effects

- Therapeutic failure of one week with the preferred medication

Quantity Limitations:

Butrans® (buprenorphine patch)6 per 28 days

fentanyl patch (Duragesic®)10 per fill

Duration of Approval: 1 year

Chronic Opioid Management with High Morphine Milligram Equivalents (MME)

*Note: High MME applies to all opioids (i.e. short acting, long, acting, transdermal)

Initial High MME Exceptions: If any are “True”, no further information is required and member meets the requirements for this section. If all are “False” then proceed to the remaining requirements under Additional High MME Criteria.

- 1.Does the patient have documented “current” cancer-related pain?
- 2.Does the patient have pain related to sickle cell disease?
- 3.Is the patient in hospice or palliative care?
- 4.Patient resides in a long-term care or other facility that is exempt from reporting to or checking the State Prescription Drug Monitoring Program (i.e. MAPS) (NOTE: upon discharge from long-term care member must meet the additional high MME Criteria below).

Additional High MME Criteria:

- Provider must attest to all of the following:

- oRisk assessment has been performed

- oPain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient

- oMAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber’s assessment the drugs and doses are safe for the member.

- oConcurrently prescribed drugs have been reconciled and reviewed for safety

- oThe following Non-opioid pain interventions have been recommended and/or utilized:

Non-opioid medications

Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss

- oA toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.

- oPatient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit.

- oIf applicable, the patient has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers).

- Additional documentation:

- oCurrent documentation provided outlining pain related history and physical(s) including clinical justification supporting need for exceeding high MME

- oRecent non-opioid medications utilized for pain management or rationale these cannot be used

- oDocumentation includes list of all current opioid medications (long and short-acting) and when the regimen was initiated.

- oDuration of current opioid therapy and current daily Morphine Milligram Equivalent

- Opioid Oral MME conversion factor table can be found under the following resources:

- If differences exist in language, the more current MME guidelines will be followed:

- CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR

- <https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0>

- o

- oIf patient is currently pregnant, must provide the name and location of the OB/GYN following this high-risk pregnancy

Criteria for Continuation of Therapy:

- oMust continue to meet high MME criteria and provide all required documentation

- oDocumentation of taper plan or rationale why taper is not appropriate

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

Updated 11/28/23

UPHP MEDICAID - NASAL ANTIHISTAMINES

MEDICATION(S)

OLOPATADINE 665 MCG NASAL SPRY, PATANASE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NASAL ANTIHISTAMINES

Drug Class: Nasal Antihistamines

Preferred Agents: No Prior Authorization required

Azelastine spray

Non-Preferred Agents: Prior Authorization Criteria below

Olopatadine spray

Patanase Nasal® spray

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Trial and failure on one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - NASAL CORTICOSTEROIDS

MEDICATION(S)

24 HOUR NASAL ALLERGY, ALLERGY RELIEF 50 MCG SPRAY, EQ ALLERGY RELIEF 50 MCG SPRAY, FT ALLERGY RELIEF 50 MCG SPRAY, HM ALLERGY RELIEF 50 MCG SPRAY, QC ALLERGY RELIEF 50 MCG SPRAY, SM ALLERGY RELIEF 50 MCG SPRAY, BECONASE AQ, BUDESONIDE 32 MCG NASAL SPRAY, CVS BUDESONIDE 32 MCG SPRAY, GNP BUDESONIDE 32 MCG SPRAY, RA BUDESONIDE 32 MCG SPRAY, CHILDREN'S FLONASE ALLERGY RLF, FLUNISOLIDE 0.025% SPRAY, MOMETASONE FUROATE 50 MCG SPRY, NASAL ALLERGY, OMNARIS, QNASL, QNASL CHILDREN, TRIAMCINOLONE 55 MCG NASAL SPR, XHANCE, ZETONNA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NASAL CORTICOSTEROIDS

Drug Class: NASAL CORTICOSTEROIDS

Preferred Agents: No Prior Authorization required
fluticasone (Rx)

Non-Preferred Agents: Prior Authorization Criteria below
Beconase AQ®
budesonide
flunisolide

fluticasone (OTC)
mometasone spray (RX)
mometasone 24hr (OTC)
Nasonex 24hr (OTC)
Omnaris®
Qnasl®
triamcinolone
Xhance®
Zetonna®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with a one-month trial with a preferred medication
- See additional medication-specific criteria below:

XHANCE® (FLUTICASONE)

- Diagnosis of chronic rhinosinusitis with or without nasal polyps in adults
- Therapeutic failure with a three-month trial with a preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/24

MEDICATION(S)

CELEBREX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS

Drug Class: NON-STEROIDAL ANTI-INFLAMMATORY – COX II INHIBITORS

Preferred Agents: No Prior Authorization required (ST is required)

celecoxib

Non-Preferred Agents: Prior Authorization Criteria below

Celebrex®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure of one month each with two preferred NSAIDS

See additional medication-specific criteria below:

CELEBREX®(CELECOXIB)•

Therapeutic failure of one month each with two preferred NSAIDs (unless specifically contraindicated), including generic celecoxib

Quantity Limitations:

Celebrex 50mg, 100mg, 200mg caps 2 per day

Celebrex 400mg 1 per day

celecoxib 50mg, 100mg, 200mg caps 2 per day

celecoxib 400mg 1 per day

Duration of Approval: For the duration of the prescription up to 1 year

Effective 10/1/20

Update 5/1/21

UPHP MEDICAID - NSAIDS

MEDICATION(S)

ARTHROTEC 50, ARTHROTEC 75, DAYPRO, DICLOFENAC EPOLAMINE, DICLOFENAC POT 50 MG TABLET, DICLOFENAC 2% SOLUTION PUMP, DICLOFENAC SODIUM ER, DIFLUNISAL 500 MG TABLET, DOLOBID, DUEXIS, EC-NAPROXEN, ETODOLAC, ETODOLAC ER, FELDENE, FENOPROFEN 400 MG CAPSULE, FENOPROFEN 600 MG TABLET, FLURBIPROFEN 100 MG TABLET, IBUPROFEN-FAMOTIDINE, INDOCIN 25 MG/5 ML SUSPENSION, INDOMETHACIN 25 MG/5 ML SUSP, INDOMETHACIN ER, KETOPROFEN 50 MG CAPSULE, KETOPROFEN 75 MG CAPSULE, KETOPROFEN ER 200 MG CAPSULE, KETOROLAC 15.75 MG NASAL SPRAY, LOFENA, MECLOFENAMATE 100 MG CAPSULE, MECLOFENAMATE 50 MG CAPSULE, MEFENAMIC ACID 250 MG CAPSULE, MELOXICAM 10 MG CAPSULE, MELOXICAM 5 MG CAPSULE, NALFON, NAPRELAN, NAPROXEN DR 375 MG TABLET, NAPROXEN DR 500 MG TABLET, NAPROXEN SODIUM 550 MG TAB, NAPROXEN-ESOMEPRAZOLE MAG, OXAPROZIN 600 MG CAPLET, OXAPROZIN 600 MG TABLET, PENNSAID, PIROXICAM 10 MG CAPSULE, PIROXICAM 20 MG CAPSULE, RELAFEN DS, SPRIX, TOLECTIN 600, VIMOVO, ZIPSOR, ZORVOLEX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

Drug Class: NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)

Preferred Agents: No Prior Authorization required

diclofenac
diclofenac topical gel 1% (generic Voltaren Gel®)
diclofenac topical gel 1% (OTC)
diclofenac topical solution 1.5%
ibuprofen
indomethacin
ketorolac tablets
meloxicam tablets
nabumetone
naproxen OTC
naproxen (generic for Naprosyn®)
sulindac

Non-Preferred Agents: Prior Authorization Criteria below

Arthrotec®
Daypro®
diclofenac 2% pump (generic Pennsaid)
diclofenac epolamine 1.3% patch
diclofenac ER
diclofenac-misoprostol
diclofenac potassium
diflunisal
Dolobid®
dual action pain (OTC ibuprofen/apap)
Duexis®
EC-Naprosyn®
EC-naproxen
etodolac / etodolac ER
Feldene®
fenoprofen
flurbiprofen
ibuprofen-famotidine
Indocin® oral suspension
indomethacin ext release, oral suspension
ketoprofen ext release
ketoprofen immediate release
Lofena®
meclofenamate sodium
mefenamic acid
meloxicam capsule

Nalfon®
Naprelan CR®
Naprosyn Suspension
naproxen (generic for Anaprox)
naproxen delayed release
naproxen/esomeprazole (generic for Vimovo)
oxaprozin
Pennsaid®
piroxicam
Qmiiz ODT®
Relafen DS®
Sprix®
Tivorbex®
Tolectin
tolmetin sodium
Vimovo®
Vivlodex®
Voltaren® gel
Zipsor®
Zorvolex®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR
Contraindication or drug to drug interaction with the preferred medications OR
History of unacceptable side effects OR
Therapeutic failure of one month each with two preferred medications
See additional medication-specific criteria below:

SPRIX®

Contraindication to oral dosage forms (i.e., inability to swallow)
Length of authorization – 30 days.

VIMOVO® (NAPROXEN/ESOMEPRAZOLE) AND DUEXIS®(IBUPROFEN/FAMOTIDINE)

History of or active GI bleed/ulcer OR
Risk for bleed/ulcer –
Therapeutic failure with one preferred medication

ZORVOLEX®(diclofenac submicronized)

•Trial on a preferred diclofenac product and one other preferred NSAID.

Quantity Limitations:

Toradol® (ketorolac) tablets 21 per fill

Duration of Approval: For the duration of the prescription up to 1 year, unless otherwise noted in

Medication-Specific Information

Effective 10/1/20

Updated 6/15/22

Updated 11/18/21

Updated 9/7/22

Updated 10/21/24

UPHP MEDICAID - OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATOR

MEDICATION(S)

CEQUA, CYCLOSPORINE 0.05% EYE EMULS, EYSUVIS, MIEBO, TYRVAYA, VERKAZIA, VEVYE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC ANTI-INFLAMMATORY/IMMUNOMODULATOR

Drug Class: Ophthalmic Anti-Inflammatory/Immunomodulator

Preferred Agents: No Prior Authorization required

Restasis®

Xiidra®

Non-Preferred Agents: Prior Authorization Criteria below

Cequa®

cyclosporine (generic Restasis®)

Eysuvis®

Miebo

Tyrvaya®

Verkazia®

Vevye®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a six-week trial with one preferred medication
- See additional medication-specific criteria below:

EYSUVIS® (LOTEPREDNOL):

- For Renewal: Patient has had an examination under magnification (e.g., slit lamp) and evaluation of the intraocular pressure (IOP)
- Renewal length of approval: 2 weeks

MIEBO® (PERFLUOROHEXYLOCTANE/PF)

- Patient is 18 years of age or older AND
- Quantity Limit: 3.0 mls per 30 days

VERKAZIA (CYCLOSPORINE): PDL criteria do not apply

- Patient is 4 years of age or older AND
- Diagnosis of moderate to severe vernal keratoconjunctivitis AND
- Trial and failure, contraindication, or intolerance to one of the following:
 - oTopical ophthalmic “dual-action” mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine) OR
 - oTopical ophthalmic mast cell stabilizers (e.g., cromolyn), AND
- Prescribed by or in consultation with an ophthalmologist or optometrist

VEVYE® (CYCLOSPORINE)

- Patient is 18 years of age or older, AND
- Quantity Limit: 2 ml per 30 days

QUANTITY LIMITS

Restasis (cyclosporine) single-use containers 60 per 30 days

Restasis multi-dose vial 5.5ml (1 vial) per 30 days

Xiidra 60 single-use containers per 30 days

Cequa 60 single-use containers per 30 days

Eysuvis 8.3ml (1 bottle) per 14 days

Miebo 3ml per 30 days

Verkazia 120 single dose vials per 30 days

Tyrvaya 8.4ml (2 bottles) per 30 days

Vevye 2 ml per 30 days

Duration of Approval: 1 year (except Eysuvis – 2 weeks)

Effective 8/1/21

Updated 5/1/22 (criteria name change to Ophthalmic Anti-Inflammatory/Immunomodulator per 3/8/22 P&T)

Updated 8/1/24

UPHP MEDICAID - OPHTHALMIC ANTIHISTAMINES

MEDICATION(S)

ALCAFTADINE, ALREX, BEPOTASTINE BESILATE, BEPREVE, EPINASTINE HCL, LOTE Prednol ETABONATE 0.2% DRP, OLOPATADINE HCL 0.1% EYE DROP, OLOPATADINE HCL 0.1% EYE DROPS, OLOPATADINE HCL 0.2% EYE DROP, PATADAY ONCE DAILY RELIEF, PATADAY TWICE DAILY RELIEF, ZADITOR, ZERViate

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC ANTIHISTAMINES

Drug Class: OPHTHALMIC ANTIHISTAMINES

Preferred Agents: No Prior Authorization required

azelastine

ketotifen fumarate (OTC Only)

olopatadine (OTC Only)

Non-Preferred Agents: Prior Authorization Criteria below

alcaftadine

Alrex®

bepotastine

Bepreve®
epinastine
Lastacaft®
loteprednol (generic for Alrex)
olopatadine RX
Pataday®
Zaditor®
Zerviate®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR

Contraindication or drug to drug interaction with the preferred medications OR

History of unacceptable side effects OR

Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/1/21

Updated 10/21/2024

UPHP MEDICAID - OPHTHALMIC FLUOROQUINOLONES

MEDICATION(S)

BESIVANCE, CILOXAN, GATIFLOXACIN, OCUFLOX, VIGAMOX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC FLUOROQUINOLONES

Drug Class: Ophthalmic Fluoroquinolones

Preferred Agents: No Prior Authorization required

ciprofloxacin

moxifloxacin (generic for Vigamox®)

ofloxacin

Non-Preferred Agents: Prior Authorization Criteria below

Besivance®

Ciloxan®

gatifloxacin

moxifloxacin (generic for Moxeza®)

Ocuflox®

Vigamox®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/22

Updated 8/9/24

Updated 10/18/24

UPHP MEDICAID - OPHTHALMIC MACROLIDES

MEDICATION(S)

AZASITE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC MACROLIDES

Drug Class: Ophthalmic Macrolides

Preferred Agents: No Prior Authorization required
erythromycin 0.5% eye ointment

Non-Preferred Agents: Prior Authorization Criteria below
Azasite® eye drops

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with one preferred medication

Duration of Approval: 1 year

UPHP MEDICAID - OPHTHALMIC MAST CELL STABILIZERS

MEDICATION(S)

ALOCRIIL, ALOMIDE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC MAST CELL STABILIZERS

Drug Class: OPHTHALMIC MAST CELL STABILIZERS

Preferred Agents: No Prior Authorization required
cromolyn sodium drops

Non-Preferred Agents: Prior Authorization Criteria below
Alocril® drops
Alomide® drops

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - OPHTHALMIC NSAIDS

MEDICATION(S)

ACULAR, ACULAR LS, ACUVAIL, BROMFENAC SODIUM 0.09% EYE DRP, BROMSITE, ILEVRO, KETOROLAC 0.4% OPHTH SOLUTION, NEVANAC 0.1% DROPTAINER, PROLENSA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OPHTHALMIC NSAIDS

Drug Class: Ophthalmic NSAIDS

Preferred Agents: No Prior Authorization required

diclofenac

flurbiprofen

ketorolac

Non-Preferred Agents: Prior Authorization Criteria below

Acular®

Acular LS®

Acuvail®

bromfenac

Bromsite®

Ilevro®

ketorolac LS

Nevanac®

Prolensa®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Medical necessity of lower strength dosages for post-operative pain relief
- Therapeutic failure with a trial with one preferred medication

Duration of Approval: 1 year

Updated 5/1/21

UPHP MEDICAID - ORAL ANTIFUNGALS

MEDICATION(S)

ANCOBON, BREXAFEMME, CRESEMBA 186 MG CAPSULE, CRESEMBA 74.5 MG CAPSULE, DIFLUCAN 100 MG TABLET, DIFLUCAN 150 MG TABLET, DIFLUCAN 200 MG TABLET, DIFLUCAN 40 MG/ML SUSPENSION, FLUCYTOSINE 250 MG CAPSULE, FLUCYTOSINE 500 MG CAPSULE, GRISEOFULVIN MICRO 500 MG TAB, GRISEOFULVIN ULTRAMICROSIZE, ITRACONAZOLE 10 MG/ML SOLUTION, ITRACONAZOLE 100 MG CAPSULE, NOXAFIL 300 MG POWDERMIX SUSP, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, ORAVIG, POSACONAZOLE 200 MG/5 ML SUSP, POSACONAZOLE DR 100 MG TABLET, SPORANOX 10 MG/ML SOLUTION, TOLSURA, VFEND, VIVJOA, VORICONAZOLE 200 MG TABLET, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIFUNGALS – ORAL

Drug Class : Antifungals – Oral

Preferred Agents: No Prior Authorization required

clotrimazole troches

fluconazole

griseofulvin oral suspension

ketoconazole

nystatin oral susp, tablets
terbinafine

Non-Preferred Agents: Prior Authorization Criteria below

Ancobon®
Brexafemme®
Cresemba®
Diflucan®
flucytosine
griseofulvin tablet
griseofulvin microsize tablets
griseofulvin ultramicrosize tab
itraconazole
Noxafil®
Noxafil DR®
Noxafil PowderMix Suspension
Oravig®
posaconazole
Sporanox®
Tolsura®
Vfend®
Vivjoa®
voriconazole

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Trial and failure with one month with one preferred medication, OR
- Serious illness resulting immunocompromised status
- See additional medication-specific criteria below:

BREXAFEMME®

- Diagnosis of vulvovaginal candidiasis OR
 - Patient has diagnosis of recurrent vulvovaginal candidiasis with 3 or more episodes of vulvovaginal candidiasis (VVC) in a 12 month period AND
 - attestation that the provider has confirmed a negative pregnancy test or that the patient is not of childbearing potential

- Quantity Limit: Treatment = 4 tablets, Maintenance = 24 tablets
- Length of approval: Treatment: one time, Maintenance = 6 months

CRESEMBA®

- Diagnosis of aspergillosis, AND
- Patient is 18 years or older, AND
- Trial on voriconazole/Vfend or amphotericin B - approve without trials if intolerant to prerequisite meds or renal dysfunction

NOXAFIL® (POSACONAZOLE) 300 MG SUSPENSION PACKETS

- Maximum patient age = 17 years

VFEND®

- Aspergillosis – no trial/failure required

SPORANOX®

- Onychomycosis with previous failure on or contraindication to terbinafine: length of approval - toenails 12 weeks, fingernails - 6 weeks.
- Below diagnoses without previous trial:
 - Aspergillosis
 - Blastomycosis
 - Febrile neutropenia
 - Histoplasmosis

VIVJOA

- Patient has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period AND
- Patient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy) AND
- Patient has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole.
- Quantity limit: 18 tablets per treatment course
- Length of approval: one time

QUANTITY LIMITS

Brefemfe Tablets	Treatment = 4 tablets, Maintenance = 24 tablets
Diflucan® 150 mg tab (fluconazole)	2 per fill
fluconazole 150 mg tabs (Diflucan®)	2 per fill

Lamisil® tabs (terbinafine)	84 per fill
Sporanox® (itraconazole) – brand & generic	100 mg – 120 per 30 days
250 mg kit –	34 per fill
Solution –	840 per fill
terbinafine tabs (Lamisil®)	84 per fill
Vivjoa -	18 per treatment course

Duration of Approval: For the duration of the prescription up to 6 months, unless otherwise noted in Medication specific information

Updated 11/1/24

UPHP MEDICAID - ORAL HYPOGLYCEMICS - 2ND GEN SU

MEDICATION(S)

GLUCOTROL XL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – 2ND GENERATION SULFONYLUREAS

Drug Class: Oral Hypoglycemics – 2nd Generation Sulfonylureas

Preferred Agents: No Prior Authorization required

glimepiride

glipizide / glipizide ER

glyburide

glyburide micronized

Non-Preferred Agents: Prior Authorization Criteria below

Glucotrol XL®

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications, OR

- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with two preferred medications within the same class

?Duration of Approval: 1 year

Duration of Approval: 1 year

Effective 10/1/20

Updated 9/1/22

Updated 9/11/24

Updated 10/21/24

MEDICATION(S)

PRECOSE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – ALPHA-GLUCOSIDASE INHIBITORS

Drug Class: Oral Hypoglycemics – Alpha-Glucosidase Inhibitors

Preferred Agents: No Prior Authorization required

Acarbose tablets

Miglitol tablets

Non-Preferred Agents: Prior Authorization Criteria below

Precose® tablets

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year

Effective 10/1/20

Update 9/1/22

UPHP MEDICAID - ORAL HYPOGLYCEMICS - BIGUANIDES

MEDICATION(S)

GLUMETZA, METFORMIN ER GASTRIC, METFORMIN ER OSMOTIC, METFORMIN HCL 500 MG/5 ML SOLN, METFORMIN HCL 625 MG TABLET, RIOMET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – BIGUANIDES

Drug Class: Oral Hypoglycemics – Biguanides

Preferred Agents: No Prior Authorization required
metformin / metformin XR tablets

Non-Preferred Agents: Prior Authorization Criteria below

Glumetza®

metformin 625mg tablets

metformin ER (generic for Fortamet)

metformin (generic for Glumetza)

metformin solution (generic for Riomet)

Riomet®

Riomet ER®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with a preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 6/1/22

Updated 9/1/22

Updated 11/1/24

UPHP MEDICAID - ORAL HYPOGLYCEMICS - COMBINATIONS

MEDICATION(S)

ACTOPLUS MET, ALOGLIPTIN-METFORMIN, ALOGLIPTIN-PIOGLITAZONE, DUETACT, GLIPIZIDE-METFORMIN, GLYXAMBI, INVOKAMET, INVOKAMET XR, JENTADUETO XR, KAZANO, KOMBIGLYZE XR, OSENI, PIOGLITAZONE-GLIMEPIRIDE, PIOGLITAZONE-METFORMIN, QTERN, SAXAGLIPTIN-METFORMIN ER 5-500, SAXAGLIPTIN-METFORMIN ER 5-1000, SEGLUROMET, STEGLUJAN, TRIJARDY XR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – COMBINATIONS

Drug Class: Oral Hypoglycemics – Combinations

Preferred Agents: No Prior Authorization required

glyburide / metformin

Janumet®/Janumet XR®

Jentaduetto®

Synjardy®/ Synjardy XR®

Xigduo XR®

QUANTITY LIMITS

Janumet® (sitagliptin / metformin) 2 tabs per day

Non-Preferred Agents: Prior Authorization Criteria below

Actoplus Met®

alogliptin/metformin

alogliptin/pioglitazone

dapagliflozin/metformin ER

Duetact®

glipizide / metformin

Glyxambi®

Invokamet®/Invokamet XR®

Jentadueto XR®

Kazano®

Kombiglyze XR®

Oseni®

pioglitazone/glimepiride

pioglitazone/metformin

Qtern®

saxagliptin/metformin ER

Segluromet®

Steglujan®

Trijardy XR

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/1/21

Updated 9/1/22

Updated 11/1/22

Updated 11/1/24

UPHP MEDICAID - ORAL HYPOGLYCEMICS - DPP4 INH

MEDICATION(S)

ALOGLIPTIN, NESINA, ONGLYZA, SAXAGLIPTIN HCL, SITAGLIPTIN, ZITUVIO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – DPP4 INHIBITORS

Drug Class: Oral Hypoglycemics – DPP4 Inhibitors

Preferred Agents: No Prior Authorization required

Januvia®

Tradjenta®

QUANTITY LIMITS

Januvia® (sitagliptin phosphate) 100mg/day max daily dose limit, qty limit of 1 tab - any strength - per day]

Non-Preferred Agents: Prior Authorization Criteria below

alogliptin

Nesina®

Onglyza®

saxagliptin

sitagliptin (generic for Zituvio®)

Zituvio®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/24

UPHP MEDICAID - ORAL HYPOGLYCEMICS - SGLT2 INHIBITORS

MEDICATION(S)

DAPAGLIFLOZIN, INPEFA, INVOKANA, STEGLATRO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – SGLT2 INHIBITORS

Drug Class: Oral Hypoglycemics – SGLT2 Inhibitors

Preferred Agents: No Prior Authorization required

Farxiga®

Jardiance®

Non-Preferred Agents: Prior Authorization Criteria below
dapagliflozin

Inpefa®

Invokana®

Steglatro®

Non-preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR

- History of unacceptable side effects OR
- Therapeutic failure with a one-month trial with two preferred medications within the same class

Duration of Approval: 1 year

Effective 2/01/2022

Updated 11/1/24

UPHP MEDICAID - ORAL HYPOGLYCEMICS - TZDS

MEDICATION(S)

ACTOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ORAL HYPOGLYCEMICS – THIAZOLIDINEDIONES

Drug Class: Oral Hypoglycemics – Thiazolidinediones

Preferred Agents: No Prior Authorization required
pioglitazone tablets

Non-Preferred Agents: Prior Authorization Criteria below
Actos® tablets

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial with a preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 9/1/22

UPHP MEDICAID - OSTEOPOROSIS - BISPHOSPHONATES

MEDICATION(S)

ACTONEL, ALENDRONATE SOD 70 MG/75 ML, ATELVIA, BINOSTO, BONIVA, FOSAMAX, IBANDRONATE SODIUM 150 MG TAB, RISEDRONATE SODIUM, RISEDRONATE SODIUM DR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OSTEOPOROSIS AGENTS: BISPHOSPHONATES

Drug Class: OSTEOPOROSIS AGENTS: BISPHOSPHONATES

Preferred Agents: No Prior Authorization required
alendronate sodium

Non-Preferred Agents: Prior Authorization Criteria below

Actonel®

alendronate sodium oral solution

Atelvia®

Binosto®

Boniva®

Fosamax®

Fosamax Plus D®

Ibandronate

risedronate (Actonel)

risedronate (Atelvia)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Trial and failure with six months with one preferred medication
- Unique FDA approved indication not included in preferred medications
- See additional medication-specific criteria below:

DIDRONEL® (ETIDRONATE)

- Diagnosis of hypertrophic ossification secondary to hip replacement or spinal cord injury.

Quantity Limitations:

Atelvia® (risedronate) – brand & generic 4 per 30 days

Actonel® (risedronate) 75mg - 2 per 28 days

35mg - 4 per 28 days

Duration of Approval: 1 year

Effective 10/1/20

Effective 8/1/22

Updated 10/18/2024

UPHP MEDICAID - OSTEOPOROSIS - OTHER

MEDICATION(S)

FORTEO, TERIPARATIDE, TYMLOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OSTEOPOROSIS AGENTS: OTHER

Drug Class: OSTEOPOROSIS AGENTS: OTHER

Preferred Agents: No Prior Authorization required
calcitonin nasal spray

Non-Preferred Agents: Prior Authorization Criteria below

Forteo®

teriparatide

Tymlos®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Trial and failure with six months with one preferred medication

- Unique FDA approved indication not included in preferred medications
- See additional medication-specific criteria below:

FORTEO® (TERIPARATIDE) – PDL CRITERIA DOES NOT APPLY

- Treatment of osteoporosis in postmenopausal women who are at high risk for fractures
- Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures
- Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture
- Length of authorization: maximum cumulative duration of 2 years per lifetime, unless clinical documentation is provided showing patient remains at or has returned to having a high risk for fracture

TYMLOS® (ABALOPARATIDE) – PDL CRITERIA DOES NOT APPLY

- Treatment of osteoporosis in postmenopausal women who are at high risk for fractures, OR
- Treatment of osteoporosis in men who are at high risk for fractures
- Length of authorization: maximum cumulative duration of 2 years per lifetime (includes any prior use of Forteo)

Duration of Approval: 1 year (Forteo and Tymlos – maximum 2 years per lifetime)

Effective 10/1/20

Updated 11/1/24

UPHP MEDICAID - OSTEOPOROSIS - SERM

MEDICATION(S)

EVISTA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OSTEOPOROSIS AGENTS: SERMS

Drug Class: OSTEOPOROSIS AGENTS: SERMS

Preferred Agents: No Prior Authorization required
raloxifene

Non-Preferred Agents: Prior Authorization Criteria below
Evista®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

Trial and failure with six months with one preferred medication

Unique FDA approved indication not included in preferred medications

Duration of Approval: 1 year
Effective 10/1/20

UPHP MEDICAID - OTIC QUINOLONES

MEDICATION(S)

CIPRO HC, CIPROFLOXACIN 0.2% OTIC SOLN, CIPROFLOXACIN HCL-FLUOCINOLONE, OTOVEL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OTIC ANTIBIOTICS

Drug Class: Otic Antibiotics

Preferred Agents: No Prior Authorization required
ciprofloxacin-dexamethasone (generic for Ciprodex)
ofloxacin otic
neomycin-polymyxin-HC ear susp

Non-Preferred Agents: Prior Authorization Criteria below
ciprofloxacin otic
ciprofloxacin-fluocinolone (generic for Otovel)
Cipro HC®

Non-Preferred Agent PA Criteria:

•Allergy to the preferred medications OR

- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure (duration = 3 days) with one preferred medication

Duration of Approval: 1 year for all other medications

Effective 10/1/20

Updated 8/1/24 (Changed Drug Class/Market Basket from Otic Quinolones to Otic Antibiotics)

Updated 10/18/24

UPHP MEDICAID - OXAZOLIDINONES

MEDICATION(S)

LINEZOLID 100 MG/5 ML SUSP, ZYVOX 100 MG/5 ML SUSPENSION, ZYVOX 600 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OXAZOLIDINONES

Drug Class: Oxazolidinones

Preferred Agents: No Prior Authorization required

Linezolid tablets

Non-Preferred Agents: Prior Authorization Criteria below

Linezolid suspension

Sivextro®

Zyvox®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medication
- Contraindication or drug to drug interaction with the preferred medication
- History of unacceptable side effects
- See additional medication-specific criteria below:

SIVEXTRO® (TEDIZOLID PHOSPHATE)

For diagnosis of non-purulent cellulitis

- Trial, failure or intolerance to first line beta lactam therapy and
- Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (SMZ/TMP), tetracycline (minocycline or doxycycline) or
- Culture and sensitivity results demonstrate resistance to first line agents or
- Contraindication or intolerance to all other treatment options

For diagnosis of purulent cellulitis, abscess, or wound infection:

- Trial, failure or intolerance to at least two of the following agents: clindamycin, sulfamethoxazole/trimethoprim (smz/tmp), tetracycline (minocycline or doxycycline) or
- Culture and sensitivity results demonstrate resistance to first line agents or
- Contraindication or intolerance to all other treatment options

Quantity Limitations:

Linezolid tabs (Zyvox®) 28 per fill

SDivextro (tedizolid) 14 per fill

Zyvox® tabs (linezolid) 28 per fill

Duration of Approval: 2 months

Effective 10/1/20

UPHP MEDICAID - OXBRYTA

MEDICATION(S)

OXBRYTA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OXBRYTA® / VOXELOTOR

Drug Class: Sickle Hemoglobin (HbS) Polymerization Inhibitor

FDA-approved uses: sickle-cell disease

Available dosage forms: 500mg Tablet, 300 mg Tablet for Suspension

Coverage Criteria/Limitations for initial authorization:

Diagnoses: sickle-cell disease

Duration of approval:

oInitial authorization: 12 months

oContinuation of Therapy: 12 months

Prescriber Specialty: Prescribed by, or in consultation, with a hematologist or other specialist with expertise in the diagnosis and management of sickle cell disease

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oBaseline hemoglobin level between 5.5 g/dL and 10.5g/dL AND

Age:

Oxbryta 500mg tablet: greater than or equal to 12 years of age

Oxbryta 300mg tablet: 4 years or greater

Oxbryta 300mg tablet for suspension: greater than or equal to 4 years of age

Quantity: 90 tablets/30 days

Route of Administration: oral

Place of Service: outpatient

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPatient must show an increase in hemoglobin level from initial baseline OR

oProvider attests to other positive clinical response

Effective 10/1/20, Updated 1/1/22

UPHP MEDICAID - OXERVATE

MEDICATION(S)

OXERVATE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

OXERVATETM (CENEGERMIN-BKBJ)

Drug Class: Recombinant human nerve growth factor (rhNGF)

FDA-approved uses: Indicated for the treatment of neurotrophic keratitis

Available dosage forms: Ophthalmic solution, 0.002% (per mL)

Coverage Criteria/Limitations for initial authorization:

Diagnoses: FDA approved indications as listed above

Duration of approval:

oInitial authorization: 56 days

Prescriber Specialty: Prescribed by, or in consultation with, an ophthalmologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oAttestation that the patient or caregiver has been counseled on proper administration technique

oDocumentation that the member has a diagnosis of stage 2 (recurrent/persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis in affected eye(s)

oDocumentation that the member has tried and failed at least two conventional non-surgical treatments

(e.g. preservative-free artificial tears, lubricant eye ointment, topical antibiotic eye drops, therapeutic contact lenses)

Quantity: 28 vials every 28 days for the treatment of one eye (additional quantities may be approved for the treatment of the second eye when appropriate). Total of 8 kits (1 kit = 7 multi-dose vials) per affected eye per lifetime.

Age: 2 years of age or older

Route of Administration: Topical eye drop

Effective 10/1/20

MEDICATION(S)

ADCIRCA, ADEMPAS, ALYQ, AMBRISENTAN, BOSENTAN, LETAIRIS, LIQREV, OPSUMIT, OPSYNVI, ORENITRAM ER, ORENITRAM MONTH 1 TITRATION KT, ORENITRAM MONTH 2 TITRATION KT, ORENITRAM MONTH 3 TITRATION KT, REVATIO 10 MG/ML ORAL SUSP, REVATIO 20 MG TABLET, SILDENAFIL 10 MG/ML ORAL SUSP, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET, TADLIQ, TRACLEER, TYVASO, TYVASO DPI, TYVASO INSTITUTIONAL START KIT, TYVASO REFILL KIT, TYVASO STARTER KIT, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 200-800 TITRATION PACK, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET, VENTAVIS, WINREVAIR

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PULMONARY ARTERIAL HYPERTENSION (PAH) AGENTS

Drug Class: Pulmonary Arterial Hypertension (PAH) Agents

Preferred Agents: Prior Authorization Criteria below

Adempas

Alyq®

ambrisentan (generic for Letairis)

Opsumit®

sildenafil suspension (generic for Revatio)
sildenafil tablets (generic for Revatio®)
tadalafil (generic for Adcirca)
Tracleer® tablets
Tyvaso®
Uptravi®
Ventavis®

Clinical PA Criteria:

Diagnosis of pulmonary hypertension

Must be prescribed by or in consultation with a cardiologist or pulmonologist

Non-Preferred Agents: Prior Authorization Criteria below

Adcirca®
bosentan tablets (generic for Tracleer)
Letairis®
Liqrev®
Opsynvi®
Orenitram ER®
Orenitram Titration Kit
Revatio® suspension
Revatio® tablets
Tadliq®
Tracleer® suspension
Tyvaso DPI®
Winrevair

Non-Preferred Agent PA Criteria:

?Diagnosis of pulmonary hypertension, AND
?Must be prescribed by or in consultation with a cardiologist or pulmonologist, AND
?Allergy to the preferred medications, OR
?Contraindication or drug to drug interaction with the preferred medications, OR
?History of unacceptable side effects, OR
?Therapeutic failure with one-month trial of one preferred medication
?See additional medication-specific criteria below

OPSYNVI® (MACITENTAN/TADALAFIL)

- Patient is greater than or equal to 18 years of age
- Quantity limit: 1 per day

TADLIQ® (TADALAFIL)

- Patient is greater than or equal to 18 years of age

WINREVAIR® (SOTATERCEPT-CSRK)

- Diagnosis of PAH WHO group 1, functional class II or III, AND
- Documented trial and failure of, or contraindication to, at least 2 months of combination therapy including one PDE-5 inhibitor AND one ERA, AND
- Winrevair is being used as add on therapy to standard care, AND
- Platelet count of greater than 50,000/mm³ ((greater than 50x10⁹/L), acceptable hemoglobin levels, and other labs in accordance with the product label, AND
- Counseling has occurred regarding the need for effective contraception due to risk of embryo-fetal toxicity, and the risk of impaired fertility with use of this medication

Duration of Approval: 1 year

UPHP MEDICAID - PALFORZIA

MEDICATION(S)

PALFORZIA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PALFORZIA / PEANUT ALLERGEN POWDER-DNFP

Drug Class: Allergenic Extracts

FDA-approved uses: Mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanut

Available dosage forms: Powder for oral administration supplied in 0.5 mg 1 mg, 10 mg, 20 mg and 100 mg Capsules or 300 mg Sachets.

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Peanut allergy

Duration of approval:

oInitial authorization: 1 year

oContinuation of Therapy: 1 year

Prescriber Specialty: Allergy or Immunology specialist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

o Documented clinical history of allergy to peanuts or peanut-containing foods

o A confirmed peanut diagnosis based on one of the following:

Peanut skin prick test greater than 8mm

Serum IgE to peanut greater than or equal to 14 kUA/L

A reaction that required epinephrine or ED visit

o Used in conjunction with a peanut-avoidant diet

o Patient has been prescribed and/or has a refill history of epinephrine auto-injector

o Prescriber, health care setting, pharmacy, patient must meet manufacturer's REMS requirements

Age: 1 years to 17 years of age

o Patients who start therapy prior to 18 years of age may continue therapy

Criteria for continuation of therapy:

Positive response to treatment as documented by at least ONE (1) of the following compared to pre-treatment:

o Reduction in severe allergic reactions

o Reduction in epinephrine use

o Reduction in physician/clinic visits due to peanut allergy (physician office/ER visits/hospitalizations)

o Improvement in quality of life or productivity

Contraindications/Exclusions/Discontinuation:

• History of severe or life-threatening episode of anaphylaxis or anaphylactic shock within 60 days

• Uncontrolled asthma

Contraindications/Exclusions/Discontinuation: continued

• History of eosinophilic esophagitis (EoE), other eosinophilic gastrointestinal disease, chronic, recurrent, or severe gastroesophageal reflux disease (GERD), symptoms of dysphagia or recurrent gastrointestinal symptoms of undiagnosed etiology

• History of a mast cell disorder, including mastocytosis, urticarial pigmentosa, and hereditary or idiopathic angioedema

• History of cardiovascular disease, including uncontrolled or inadequately controlled hypertension

Effective 1/1/20

Effective 10/1/24

UPHP MEDICAID - PANCREATIC ENZYMES

MEDICATION(S)

PERTZYE, VIOKACE, ZENPEP DR 10,000 UNIT CAPSULE, ZENPEP DR 25,000 UNIT CAPSULE, ZENPEP DR 3,000 UNIT CAPSULE, ZENPEP DR 40,000 UNIT CAPSULE, ZENPEP DR 5,000 UNIT CAPSULE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PANCREATIC ENZYMES

Drug Class: Pancreatic Enzymes

Preferred Agents: Clinical Prior Authorization below

Creon®

Zenpep®

Clinical PA Criteria:

CREON®, ZENPEP

Cystic fibrosis or chronic pancreatic insufficiency.

Non-Preferred Agents: Prior Authorization Criteria below

Pertzye®

Viokace®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR

Contraindication or drug to drug interaction with the preferred medications OR

History of unacceptable side effects OR

Therapeutic failure after one-month trial of one preferred agent

See additional medication-specific criteria below:

PERTYZE®, VIOKACE®

Must meet both PDL (trial on preferred medication) and clinical criteria

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - PCSK9 INHIBITORS

MEDICATION(S)

PRALUENT PEN, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

LIPOTROPICS: PCSK9 INHIBITORS

Drug Class: Lipotropics: PCSK9 Inhibitors

Preferred Agents: Clinical Prior Authorization below

Repatha®

REPATHA®

- Patient is at least 18 years old with a diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria), OR
- Patient is 13 years of age or older with a diagnosis of homozygous familial hypercholesterolemia (HoFH), AND
- Medication is requested by or in consultation with a specialist (including cardiologists, lipidologists and endocrinologists), AND
- Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND one other cholesterol lowering agent (such as an alternatively high-intensity statin or ezetimibe) for at least three continuous months (verified in pharmacy claims history) with

failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD), AND

- If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
 - oMuscle symptoms resolve after discontinuation of statin, AND
 - oMuscle symptoms occurred when rechallenged at a lower dose of the same statin, AND
 - oMuscle symptoms occurred after switching to an alternative statin, AND
 - oDocumentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease), OR
- The patient has been diagnosed with rhabdomyolysis associated with statin use [diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually greater than 5,000 IU/L or five times the upper limit of normal)]
- Length of Authorization: Initial – 3 months, Renewal – 12 months
- Renewal (may be requested by primary care physician): Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating med AND continued adherence to maximally tolerated statin dose established prior to the original approval will be required
- Quantity Limit: 140 mg/mL pen/syringe – 2 pens/syringes per 28 days, 420 mg/3.5 mL Pushtonex® – 3.5 mL per 28 days

Non-Preferred Agents: Prior Authorization Criteria below
Praluent®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Patient is clinically stable, and switching would cause a deterioration in condition
- Therapeutic failure with one-month trial of one preferred medication

PRALUENT®

- Patient is at least 18 years old with a diagnosis of atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH) as confirmed by genotyping or by clinical criteria (“definite FH” using either the Simon Broome or WHO/Dutch Lipid Network criteria), AND
- Medication is requested by or in consultation with a specialist (including cardiologists, lipidologists and endocrinologists), AND
- Prior treatment history with highest available dose or maximally-tolerated dose of high intensity statin (atorvastatin or rosuvastatin) AND one other cholesterol lowering agent (such as an alternatively high-

intensity statin or ezetimibe) for at least 3 continuous months (verified in pharmacy claims history) with failure to reach target LDL-C (70 mg/dL for patients with clinical ASCVD and 100 mg/dL for patients with HeFH and no history of clinical ASCVD), AND

- If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms. Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:

- oMuscle symptoms resolve after discontinuation of statin, AND

- oMuscle symptoms occurred when rechallenged at a lower dose of the same statin, AND

- oMuscle symptoms occurred after switching to an alternative statin, AND

- oDocumentation ruling out non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease), OR

- The patient has been diagnosed with rhabdomyolysis associated with statin use [diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually greater than 5,000 IU/L or five times the upper limit of normal)],

- Length of Authorization: Initial – 3 months, Renewal – 12 months

- Renewal (may be requested by primary care physician): Lipid panel showing a further reduction in LDL-C compared to the labs prior to initiating med AND continued adherence to maximally tolerated statin dose established prior to the original approval will be required.

- Quantity Limit – 2 pens/syringes per 28 days

Duration of Approval: 1 year

Effective 10/1/20

MEDICATION(S)

DALIRESP, ROFLUMILAST

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS

Drug Class: PHOSPHODIESTERASE-4 (PDE-4) INHIBITORS

Preferred Agents:

Roflumilast (generic for Daliresp)

Roflumilast

severe COPD associated with chronic bronchitis and history of exacerbations AND
trial/failure of at least one first-line or second-line agent AND
adjunctive therapy (roflumilast must be used in conjunction with first-line or second-line agent)

Non-Preferred Agents: Prior Authorization Criteria below

Daliresp®

roflumilast

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR
Contraindication or drug to drug interaction with preferred medications OR
History of unacceptable adverse effects OR
Therapeutic failure with one preferred medication
See addition medication specific criteria below

Daliresp® (roflumilast)

Severe COPD associated with chronic bronchitis and a history of exacerbations -AND-
Trial/failure on at least one first-line or second-line agent -AND-
Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent)

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - PLATELET INH

MEDICATION(S)

ASPIRIN-DIPYRIDAMOLE ER, DIPYRIDAMOLE 25 MG TABLET, DIPYRIDAMOLE 50 MG TABLET, DIPYRIDAMOLE 75 MG TABLET, EFFIENT, PLAVIX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PLATELET AGGREGATION INHIBITORS

Drug Class: PLATELET AGGREGATION INHIBITORS

Preferred Agents: No Prior Authorization required

Brilinta®

clopidogrel

prasugrel

Non-Preferred Agents: Prior Authorization Criteria below

aspirin/dipyridamole

dipyridamole

Effient®

Plavix®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications, OR

Contraindication or drug to drug interaction with the preferred medications, OR

History of unacceptable side effects, OR

Therapeutic failure with one-month trial of one preferred medication

See additional medication-specific criteria below:

EFFIENT®

Due to a black box warning related to increase in risk of bleeds in patients greater than 75

PDL criteria must be met and the MD will need to document medical necessity or clinical rationale for consideration.

ZONTIVITY®

Diagnosis of history of myocardial infarction (MI) or peripheral artery disease (PAD) without a history of stroke, transient ischemic attack (TIA), acute coronary syndrome (ACS), GI bleed or peptic ulcer AND

Concurrent use of aspirin and/or clopidogrel AND

Written by (or in collaboration with) a cardiologist or vascular surgeon

Duration of Approval: 1 year

Effective 10/1/20

Updated 9/1/22

Updated 1/25/22

MEDICATION(S)

ACIPHEX, DEXILANT, DEXLANSOPRAZOLE DR, CVS ESOMEPRAZOLE MAG 20 MG CAP, EQL ESOMEPRAZOLE MAG DR 20 MG, ESOMEPRAZOLE DR 10 MG PACKET, ESOMEPRAZOLE DR 20 MG PACKET, ESOMEPRAZOLE DR 40 MG PACKET, ESOMEPRAZOLE MAG DR 20 MG CAP, ESOMEPRAZOLE MAG DR 40 MG CAP, GNP ESOMEPRAZOLE MAG DR 20 MG, GS ESOMEPRAZOLE MAG DR 20 MG, HM ESOMEPRAZOLE MAG DR 20 MG, QC ESOMEPRAZOLE MAG DR 20 MG, RA ESOMEPRAZOLE MAG DR 20 MG, SM ESOMEPRAZOLE MAG DR 20 MG, KONVOMEF, LANSOPRAZOLE DR 15 MG CAPSULE, LANSOPRAZOLE DR 30 MG CAPSULE, NEXIUM DR 20 MG CAPSULE, NEXIUM DR 40 MG CAPSULE, CVS OMEPRAZOLE DR 20 MG ODT, CVS OMEPRAZOLE DR 20 MG TABLET, EQ OMEPRAZOLE DR 20 MG ODT, EQ OMEPRAZOLE DR 20 MG TABLET, EQL OMEPRAZOLE DR 20 MG ODT, EQL OMEPRAZOLE DR 20 MG TABLET, FT OMEPRAZOLE DR 20 MG TABLET, GNP OMEPRAZOLE DR 20 MG TABLET, GS OMEPRAZOLE DR 20 MG ODT, GS OMEPRAZOLE DR 20 MG TABLET, HM OMEPRAZOLE DR 20 MG TABLET, KRO OMEPRAZOLE DR 20 MG TABLET, OMEPRAZOLE DR 20 MG ODT, OMEPRAZOLE DR 20 MG TABLET, PUB OMEPRAZOLE DR 20 MG TABLET, RA OMEPRAZOLE DR 20 MG TABLET, SM OMEPRAZOLE DR 20 MG TABLET, SW OMEPRAZOLE DR 20 MG TABLET, CVS OMEPRAZOLE MAG DR 20 MG CP, EQ OMEPRAZOLE MAG DR 20.6 MG, GNP OMEPRAZOLE MAG DR 20 MG CP, OMEPRAZOLE MAG DR 20 MG CAP, OMEPRAZOLE MAG DR 20.6 MG CAP, QC OMEPRAZOLE MAG DR 20.6 MG, OMEPRAZOLE-BICARB 20-1,100 CAP, OMEPRAZOLE-BICARB 20-1,680 PKT, OMEPRAZOLE-BICARB 40-1,100 CAP, OMEPRAZOLE-BICARB 40-1,680 PKT, PREVACID DR 30 MG CAPSULE, PRILOSEC, PROTONIX DR 20 MG TABLET, PROTONIX DR 40 MG TABLET, RABEPRAZOLE SOD DR 20 MG TAB, ZEGERID

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PROTON PUMP INHIBITORS

Drug Class: PROTON PUMP INHIBITORS

Preferred Agents: No Prior Authorization required

Nexium susp pkts

omeprazole (Rx) capsules

pantoprazole tablets

Protonix® suspension

Non-Preferred Agents: Prior Authorization Criteria below

Aciphex® tabs

Dexilant® caps

dexlansoprazole

esomeprazole magnesium capsules, susp pkts

esomeprazole magnesium OTC caps, tabs

Konvomep®

lansoprazole caps, ODT

lansoprazole OTC caps

Nexium® capsules

omeprazole OTC caps, tabs, ODT

omeprazole/sodium bicarbonate caps, susp pkts

pantoprazole suspension

Prevacid caps, solutabs

Prilosec® susp

Protonix® tablets

Rabeprazole tabs

Zegerid® caps, susp pkts

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure after one-month trial with one preferred medication.

Duration of Approval: 1 year

Effective 10/1/20

Update 1/13/22
Update 9/1/22
Update 11/1/22
Updated 11/1/24

UPHP MEDICAID - PRETOMANID

MEDICATION(S)

PRETOMANID

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PRETOMANID (FOR CONCURRENT USE WITH BEDAQUILINE & LINEZOLID)

Drug Class: Nitroimidazole Antibiotic

FDA-approved uses: Pretomanid is indicated as part of a combination regimen with bedaquiline and linezolid, for the treatment of adults with pulmonary extensively drug resistant (XDR) treatment-intolerant, or nonresponsive multidrug-resistant (NDR) tuberculosis (TB).

Available dosage forms: 200mg oral tablets, taken with food.

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Pulmonary extensively drug resistant (XDR) or treatment intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB)

Prescriber Specialty: Prescribed by or in consultation with an infectious disease specialist or pulmonologist.

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

o Diagnosis of pulmonary extensively drug resistant (XDR) or treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB), AND

o Patient is concomitantly taking bedaquiline (Sirturo) and linezolid (Zyvox) as part of the recommended dosing regimen and use of bedaquiline and linezolid are not contraindicated in patient

Duration of approval: 6 months

UPHP MEDICAID - PROGESTATIONAL AGENTS

MEDICATION(S)

CRINONE, PROGESTERONE 500 MG/10 ML VIAL, PROMETRIUM, PROVERA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PROGESTATIONAL AGENTS

Drug Class: Progestational Agents

Preferred Agents:

medroxyprogesterone (oral)

progesterone (oral)

norethindrone (oral)

Non-Preferred Agents: Prior Authorization Criteria below

Crinone® (vaginal)

progesterone (intramuscular)

Prometrium® (oral)

Provera® (oral)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial of a preferred medication for the indication
- See additional medication-specific criteria below:

CRINONE® (PROGESTERONE VAGINAL)

- Excluded for diagnosis of fertility

Duration of Approval: 1 year

Duration of Approval: 1 year

Effective 10/1/20

Updated 1/1/22

Updated 6/8/22

Updated 8/1/22

Updated 8/15/22

Updated 9/11/24

UPHP MEDICAID - PROGESTINS FOR CACHEXIA

MEDICATION(S)

MEGESTROL 625 MG/5 ML SUSP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PROGESTINS FOR CACHEXIA

Drug Class: Progestins for Cachexia

Preferred Agents: No Prior Authorization required
megestrol oral suspension (generic Megace)

Non-Preferred Agents: Prior Authorization Criteria below
megestrol oral suspension (generic Megace ES®)

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR

Contraindication or drug to drug interaction with the preferred medications OR

History of unacceptable side effects OR

Therapeutic failure after one-month trial of one preferred medication

Duration of Approval: 1 year

Effective 10/1/20
Updated 8/15/22

UPHP MEDICAID - PULMOZYME

MEDICATION(S)

PULMOZYME

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

PULMOZYME® / DORNASE ALPHA

Drug Class: Mucolytics

FDA-approved uses:

In conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function.

To reduce the risk of respiratory tract infections requiring parenteral antibiotics in CF patients with an FVC ? 40% of predicted.

Available dosage forms: 2.5 mg/2.5 mL in single-use ampules

Coverage Criteria/Limitations for initial authorization:

Diagnoses: cystic fibrosis

Duration of Approval:

oInitial Authorization: 1 year

oContinuation of Therapy: 1 year

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oMedical records to support a diagnosis of CF

Prescriber Specialty:

oPulmonologist

oInfectious disease

Quantity: 30 ampules per 30 days

Age: at least 5 years of age

Gender: male or female

Route of Administration: inhalation

Place of Service: outpatient

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oFVC

oMedical records showing stable disease

oMedical records supporting decreased incidence of respiratory infections

Contraindications/Exclusions/Discontinuation:

•Pulmozyme® (dornase alpha) is not authorized for non-FDA-approved indication

•Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

•Per FDA-approved label: Pulmozyme® (dornase alpha) was studied in patients 3 months to 5 years of age, while clinical trial data are limited in patients less than 5 years, the use of Pulmozyme® (dornase alpha) should be considered for pediatric patients with CF who may experience potential benefit in pulmonary function or who may be at risk of respiratory tract infection.

Effective 10/1/20

UPHP MEDICAID - QUINOLONES

MEDICATION(S)

BAXDELA 450 MG TABLET, CIPRO 250 MG TABLET, CIPRO 500 MG TABLET, MOXIFLOXACIN HCL 400 MG TABLET, OFLOXACIN 300 MG TABLET, OFLOXACIN 400 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

QUINOLONES

Drug Class: QUINOLONES

Preferred Agents: No Prior Authorization required

Cipro suspension, ciprofloxacin tablets, suspension
levofloxacin

Non-Preferred Agents: Prior Authorization Criteria below

Avelox®

Baxdela®

Cipro® tablets

moxifloxacin

ofloxacin

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Infection is caused by an organism that is resistant to the NO PA REQUIRED quinolone medications
- Trial/failure (duration = 3 days) of any two preferred quinolone medications
- Antibiotic therapy initiated in hospital

Quantity Limitations:

Cipro® tabs (ciprofloxacin)42 per fill

ciprofloxacin (Cipro®)42 per fill

ciprofloxacin XR (Cipro XR®)14 per fill

levofloxacin tabs (Levaquin®)500mg - 14 per fill

750mg - 28 per fill

moxifloxacin (Avelox®)14 per fill

Duration of Approval: Date of service, if needed, longer lengths may be approved for transplant recipients

Effective 10/1/20

Updated 3/11/22

UPHP MEDICAID - RANEXA/RANOLAZINE

MEDICATION(S)

ASPRUZYO SPRINKLE, RANOLAZINE ER

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

RANEXA® / RANOLAZINE

Drug Class: Antianginal and Anti-ischemic Agents, Non-hemodynamic

FDA-approved uses: treatment of chronic angina

Available dosage forms:

- Ranolazine 500 mg and 1000 mg extended-release tablets
- Ranexa® 500 mg and 1000 mg extended-release tablets
- Aspruzyo Sprinkle® 500 and 1000 mg extended-release granules

Coverage Criteria/Limitations for initial authorization:

Diagnoses: chronic stable angina

Duration of Approval:

oInitial Authorization: 6 months

oContinuation of Therapy: 12 months

Prescriber Specialty: prescribed by, or in conjunction with, a cardiologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

Ranolazine ER (RANEXA®)

oCurrent progress notes supporting past medication usage, including at least 1 formulary anti-anginal agent from ALL 3 different drug classes:

?Beta Blocker: acebutolol, atenolol, carvedilol, metoprolol, nadolol, propranolol

?Calcium Channel Blocker: amlodipine, diltiazem, felodipine, isradipine, nifedipine, nicardipine, verapamil

?Long-Acting Nitrate: isosorbide dinitrate, isosorbide mononitrate, nitroglycerin patch

oLabs and medical records supporting indicated diagnosis of chronic angina

oMedical record detailing that Ranexa will be used in addition (add-on) to another anti-anginal medication (i.e., beta-blocker, calcium channel blocker, long-acting nitrate) or patient has contraindications to beta-blockers, calcium channel blockers AND long-acting nitrates

Aspruzo Sprinkle® (ranolazine)

oAll the above criteria are met

oContraindication to ranolazine (Ranexa) ER tablets due to swallowing difficulties OR

oAdministration via nasogastric (NG) or gastric tube

?Quantity: 60 tablets or 60 sachets every 30 days (500 mg PO BID initially; may increase to 1,000 mg PO BID)

?Age: 18 years of age or older

?Route of Administration:

ooral - extended-release tablet or granules

ovia NG/gastric tube with extended-release granules (Aspruzo)

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oCurrent medical records and labs to determine safety and efficacy of treatment

Contraindications/Exclusions/Discontinuation:

Hepatic impairment (Child-Pugh Classes A and B)

Combined administration with other drugs that are strong inhibitors of CYP3A including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir

Combined administration with other drugs that are inducers of CYP3A including rifampin, rifabutin, phenobarbital, phenytoin, carbamazepine, and St. John's wort

Moderate to severe renal impairment CrCl less than 60mL/min

Other special considerations:

Not for initial therapy because it can increase QT interval

Effective 10/1/20

Updated 8/7/24

MEDICATION(S)

ALBUTEROL SULFATE HFA, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL, LEVALBUTEROL TARTRATE HFA, PROAIR DIGIHALER, PROAIR RESPICLICK

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

BETA ADRENERGICS – SHORT ACTING

Drug Class: Beta Adrenergics – Short Acting

Preferred Agents: No Prior Authorization required

Albuterol sulfate nebulizer solution

Ventolin HFA® (MDI)

Xopenex HFA (MDI)

Non-Preferred Agents: Prior Authorization Criteria below

albuterol HFA (MDI)

levalbuterol HFA (MDI)

levalbuterol nebulizer solution

ProAir Digihaler® (DPI)

ProAir Respiclick® (DPI)

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure after a two-week trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

Updated 10/18/24

UPHP MEDICAID - SANDOSTATIN

MEDICATION(S)

OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

SANDOSTATIN® / OCTREOTIDE

Administration Disclaimer: The following criteria set is for the retail pharmacy benefit. This criteria set DOES NOT apply for administration as a medical benefit (“buy and bill”).

Drug Class: Somatostatic Agents

FDA-approved uses:

Acromegaly

Octreotide Acetate Injection is indicated to reduce blood levels of growth hormone and IGF-I (somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses.

Carcinoid Tumors

Octreotide Acetate Injection is indicated for the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease.

Vasoactive Intestinal Peptide Tumors (VIPomas)

Octreotide Acetate Injection is indicated for the treatment of the profuse watery diarrhea associated with VIP-secreting tumors.

Available dosage forms: Vial 50 mcg/mL, 100 mcg/mL, 200 mcg/mL, 1000 mcg/mL

Coverage Criteria/Limitations for initial authorization:

Diagnoses:

- oAcromegaly
- oMetastatic VIP
- oChemo/radiation
- oHIV/AIDS-induced diarrhea
- oMetastatic carcinoid tumors
- oCarcinoid tumors

Duration of Approval:

- oInitial Authorization: 6 months
- oContinuation of Therapy: 1 year

Prescriber Specialty: Prescribed by, or in consultation with, an endocrinologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oDiagnosis confirmed
- oPrescribed by, or in consultation with, an endocrinologist

Age: 18 years of age or older

Route of Administration: Subcutaneous, intramuscular injection

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oThe above criteria has been met
- oRequires decreased or normalized IGF-1 levels

Effective 10/1/20

UPHP MEDICAID - SENSIPAR/CINACALCET

MEDICATION(S)

CINACALCET HCL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

SENSIPAR® / CINACALCET

Drug Class: Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer

FDA-approved uses:

Hyperparathyroidism, primary: Treatment of severe hypercalcemia in adult patients with primary hyperparathyroidism for who parathyroidectomy would be indicated on the bases of serum calcium levels, but who are unable to undergo parathyroidectomy.

Hyperparathyroidism, secondary: Treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis.

Limitation of use: Not indicated for use in patients with CKD who are not on dialysis (due to increased risk of hypocalcemia)

Parathyroid carcinoma: Treatment of hypercalcemia in adult patients with parathyroid carcinoma.

Available dosage forms: Tablet 30 mg, 60 mg, 90 mg

Coverage Criteria/Limitations for initial authorization:

Diagnoses: FDA Approved Indication as listed above

Duration of Approval:

- o Initial Approval: 6 months
- o Continuation of Therapy: 12 months

Prescriber Specialty: Nephrologist, Endocrinologist or Oncologist prescriber in consultation with specialist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

o For Secondary hyperparathyroidism due to CKD on dialysis:

- Patient is at least 18 years of age, AND
- Trial, failure, or intolerance to an approved formulary phosphate binder trial AND
- Trial, failure, or intolerance to calcitriol or Vitamin D analogs for a minimum of a three month trial

o Labs:

iPTH, calcium, renal function, serum phosphorus. iPTH levels must be greater than 300 (biPTH greater than 160) and Ca greater than 8.4 in order to initiate therapy.

o For Parathyroid carcinoma (PC):

- Patient is at least 18 years of age, AND

o Labs:

Confirmation the patient has hypercalcemia as defined by baseline serum calcium (Ca) greater than 10mg/dL (corrected for albumin),

For Primary hyperparathyroidism:

- Patient is at least 18 years of age, AND
- Confirmation the parathyroidectomy is indicated by patient is unable to undergo parathyroidectomy

o Labs:

Severe hypercalcemia as defined by baseline (pre-treatment) serum calcium (Ca) greater than 12 mg/dL (corrected for albumin)

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

Absence of unacceptable toxicity from the drug (e.g., hypocalcemia, seizures, hypotension, worsening heart failure,

arrhythmia, adynamic bone disease), AND

Secondary Hyperparathyroidism (HPT)

- Adequate documentation of disease response as indicated by improvement of intact parathyroid hormone (iPTH) levels from baseline, AND
- Current intact parathyroid hormone (iPTH) greater than 150 pg/ml, AND
- Current serum calcium (Ca) greater than 7.5 mg/dL and the patient does not have symptoms of hypocalcemia

Parathyroid Carcinoma (PC)

- Adequate documentation of disease response as indicated by improvement of serum calcium (Ca) from baseline, AND

- Current serum calcium (Ca) greater than 8.4 mg/dL

Primary Hyperparathyroidism (HPT)

- Adequate documentation of disease response as indicated by improvement of serum calcium (Ca) from baseline, AND

- Current serum calcium (Ca) greater than 8.4 mg/dL

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to any components of Sensipar

- Hypocalcemia

- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

Updated 5/1/21

MEDICATION(S)

SIRTURO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

Drug Name: Sirutro (bedaquiline)

Drug Class Antitubercular - Diarylquinoline Antibiotics

FDA-approved uses: Multi-drug resistant tuberculosis (MDR-TB)

Available dosage forms: Tablets: 20mg, 100mg

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Multi-drug resistant tuberculosis (MDR-TB)

?Duration of approval:

oInitial authorization: 6 months

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPatient must be under observed therapy

UPHP MEDICAID - SKELETAL MUSCLE RELAXANTS

MEDICATION(S)

AMRIX, BACLOFEN 5 MG/5 ML SOLUTION, CHLORZOXAZONE, CYCLOBENZAPRINE HCL ER, DANTRIUM 25 MG CAPSULE, DANTROLENE SODIUM 100 MG CAP, DANTROLENE SODIUM 25 MG CAP, DANTROLENE SODIUM 50 MG CAP, FEXMID, FLEQSUVY, LORZONE, LYVISPAH, METAXALONE, NORGESIC FORTE, ORPHENADRIN-ASA-CAF 25-385-30MG, TANLOR, TIZANIDINE HCL 2 MG CAPSULE, TIZANIDINE HCL 4 MG CAPSULE, TIZANIDINE HCL 6 MG CAPSULE, ZANAFLEX

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

SKELETAL MUSCLE RELAXANTS

Drug Class: SKELETAL MUSCLE RELAXANTS

Preferred Agents: No Prior Authorization required (except baclofen solution)

baclofen tablets

baclofen oral solution (Ozobax)

cyclobenzaprine

methocarbamol

orphenadrine citrate

tizanidine tablets

BACLOFEN ORAL SOLUTION (OZOBAX)

Allow if patient has swallowing difficulties

Non-Preferred Agents: Prior Authorization Criteria below

Amrix®

baclofen suspension (generic Fleqsuvy)

cyclobenzaprine ER

chlorzoxazone

Dantrium®

dantrolene sodium

Fexmid®

Fleqsuvy®

Lorzone®

Lyvispah®

metaxalone

Norgesic Forte®

orphenadrine-aspirin-caffeine

Tanlor®

tizanidine capsules

Zanaflex® capsules and tablets

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with two preferred medications
- Non-preferred criteria does not apply to dantrolene if diagnosis is cerebral palsy
- See additional medication-specific criteria below

FLEQSUVY ORAL SOLUTION (BACLOFEN) (PDL criteria do not apply)

- Trial and failure with preferred oral solution

LYVISPAH ORAL SOLUTION (BACLOFEN) (PDL criteria do not apply)

- Trial and failure with preferred oral solution

Duration of Approval: 1 year

Effective 10/1/20

Updated 5/1/22

Updated 11/1/22

Updated 8/8/24

UPHP MEDICAID - SORIATANE/ACITRETIN

MEDICATION(S)

ACITRETIN

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

SORIATANE® / ACITRETIN

Drug Class: Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives

FDA-approved uses: Severe Psoriasis

Available dosage forms: Capsules 10 mg, 17.5 mg, 25 mg

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Moderate to Severe Psoriasis

Duration of Approval:

oInitial Authorization: 3 months

oContinuation of Therapy: 1 year

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

o90 day trial of methotrexate AND

o90 day trial of high dose topical steroid (e.g. betamethasone augmented, clobetasol, halobetasol)

Prescriber Specialty: Dermatology

Quantity: Max 2 capsules per day

Route of Administration: Oral

Criteria for continuation of therapy

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oRequires a positive response to therapy

Contraindications/Exclusions/Discontinuation:

- Soriatane must not be used by females who are pregnant, or who intend to become pregnant during therapy or at any time for at least 3 years following discontinuation of therapy.
- Soriatane is contraindicated in patients with impaired liver or kidney function and in patients with chronic abnormally elevated blood lipid values.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Pregnancy Category X.
- Soriatane should not be taken with methotrexate or tetracyclines.
- Soriatane should not be used in patients with known alcohol abuse.

Effective 10/1/20

MEDICATION(S)

SYNAGIS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

SYNAGIS® / PALIVIZUMAB

Administration Disclaimer: The following criteria set is for the retail pharmacy benefit. This criteria set DOES NOT apply for administration as a medical benefit (“buy and bill”).

Drug Class: Immunological Agent/Monoclonal Antibody

FDA-approved uses: Prevention of RSV for children less than 2yo at high risk of RSV disease

Respiratory syncytial virus (RSV) prophylaxis with palivizumab (Synagis®) may be considered medically necessary in the following infants and children to a maximum of five monthly doses per RSV season:

Prematurity:

oInfants who are younger than 12 months of age at the start of RSV season and are born before 29 weeks 0 days gestation.

Chronic Lung Disease (CLD):

oPreterm infants younger than 12 months of age who develop CLD of prematurity (defined as gestational age less than 32 weeks, 0 days) and required greater than 21% oxygen for at least the first 28 days after birth.

Infants between 12 and 24 months of age who developed CLD of prematurity as defined above and who continue to require medical support (chronic corticosteroid therapy, diuretic therapy, supplemental oxygen or bronchodilator therapy) within 6 months of the start of RSV season.

Heart Disease:

Infants who are 12 months of age or younger with hemodynamically significant Congenital Heart Disease (CHD). Those children with CHD who are most likely to benefit from immunoprophylaxis include those with: cyanotic heart disease who are receiving medication to control congestive heart failure (documentation required) and will require cardiac surgical procedures or moderate to severe pulmonary hypertension, or cyanotic heart disease (if recommended by a pediatric cardiologist).

Additionally, children younger than 24 months who undergo cardiac transplantation during the RSV season may be considered for prophylaxis.

Immune prophylaxis for RSV is considered not medically necessary for

Infants and children with hemodynamically insignificant heart disease including but not limited to:

secundum atrial septal defect,

small ventricular septal defect,

pulmonic stenosis,

uncomplicated aortic stenosis,

mild coarctation of the aorta,

patent ductus arteriosus

Lesions adequately corrected by surgery unless they continue to require medication for congestive heart failure.

Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

Note: Because a mean decrease in palivizumab serum concentration of 58% was observed after surgical procedures that involve cardiopulmonary bypass, for children who are receiving prophylaxis and who continue to require prophylaxis after a surgical procedure, a post-operative dose of palivizumab (15mg/kg) should be considered after cardiac bypass or at the conclusion of extra-corporeal membrane oxygenation for infants and children younger than 24 months.

Neuromuscular disease, congenital airway anomaly or pulmonary abnormality

Infants under 12 months of age with neuromuscular disease, congenital anomalies of the airway or pulmonary abnormalities that impair the ability to clear secretions from the upper airway because of ineffective cough.

Immunocompromised

Infants and children, who are 24 months of age or younger, who are profoundly immunocompromised because of chemotherapy or other conditions during the RSV season.

Available dosage forms: Solution: 50 mg/0.5 ml vial, 100 mg/ml vial for IM injection

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Medically necessary FDA-approved uses as listed above

Duration of Approval

oInitial Approval: Maximum of 5 doses per RSV season. Typically RSV season is October 1- May 1. This must be confirmed on an annual basis.

oContinuation of Therapy: Considered in a case by case basis by each plan.

If any infant or young child receiving monthly Synagis prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued because of the extremely low likelihood of a second RSV hospitalization in the same season (less than 0.5%).

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- o Children who have not had a dose of Beyfortus (nirsevimab) in the current RSV season AND
- o Mother did not received vaccination against RSV in teh 2nd or 3rd trimester AND
- o Infants who are younger than 12 months of age at the start of the Synagis season and who are born before 29 weeks, 0 days' gestation.

oInfants in the first 12 months of life, who are diagnosed with CLD (chronic lung disease) of prematurity defined as birth at less than 32 weeks, 0 days' gestation and a requirement for greater than 21% oxygen for at least 28 days after birth.

oInfants in the second year of life who are diagnosed with CLD (as per above criteria) AND who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy) within the 6-month period before the start of the second RSV season.

oChildren who are 12 months or younger with hemodynamically significant CHD as evidenced by: acyanotic heart disease and are receiving medication to control congestive heart failure, and will require cardiac surgical procedures

Documentation Requirements continued (e.g. Labs, Medical Record, Special Studies):

oInfants with moderate to severe pulmonary hypertension. Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways may be considered for prophylaxis in the first year of life.

oChild younger than 24 months who will be profoundly immunocompromised during the RSV season.

Quantity:

oThe recommended dose of Synagis is 15mg/kg body weight administered intramuscularly. Because 5 monthly doses of palivizumab at 15 mg/kg per dose will provide more than 6 months (greater than 24 weeks) of serum palivizumab concentrations above the desired level for most children. For qualifying infants up to 5 doses per RSV season must be allowed. Qualifying infants born during the RSV season may require fewer doses.

Age: 24 months and younger, See criteria for authorization for age specific indications.

Route of Administration: Intramuscular

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oRequests for coverage outside of RSV season will require authorization.

Contraindications/Exclusions/Discontinuation:

- History of severe prior reaction to palivizumab or any component of the formulation.
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Routine use in cystic fibrosis and Down Syndrome is not recommended.
- The clinical reviewer, in his or her professional judgment, will override criteria when the requested item is medically necessary. In addition, because there is no definite evidence for the treatment of patients undergoing stem cell transplant or infants and children with Cystic Fibrosis, the approval of Synagis for these patients will be done on a case by case basis by the clinical reviewer.

References

The American Academy has issued updated guidance for the 2021-2022 season.

Updated Guidance: Use of Palivizumab Prophylaxis to Prevent Hospitalization From Severe Respiratory Syncytial Virus Infection During the 2021-2022 RSV Season (aap.org)

To see RSV virology trends by state/region, please click the link below:

<https://www.cdc.gov/surveillance/nrevss/rsv/state.html>

Effective 10/1/20

Updated 1/3/22

UPHP MEDICAID - TOPICAL ANTIBIOTICS

MEDICATION(S)

CENTANY, CENTANY AT, MUPIROCIN 2% CREAM, XEPI

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

TOPICAL ANTIBIOTICS

Drug Class: Topical Antibiotics

Preferred Agents: No Prior Authorization required
mupirocin ointment

Non-Preferred Agents: Prior Authorization Criteria below
Centany®
mupirocin cream
Xepi Cream

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

Therapeutic failure after one month with one preferred medication

See additional medication-specific criteria below:

XEPI® CREAM (OZENOXACIN)

- Quantity Limit = 2 tubes per month
- Length of authorization – 1 month

Duration of Approval: 1 year

Effective 10/1/20

UPHP MEDICAID - TOPICAL ANTIFUNGALS

MEDICATION(S)

BUTENAFINE HCL 1% CREAM, CICLODAN, CICLOPIROX 0.77% GEL, CICLOPIROX 0.77% TOPICAL SUSP, CICLOPIROX 1% SHAMPOO, CICLOPIROX 8% TREATMENT KIT, CLOTRIMAZOLE-BETAMETHASONE LOT, ECONAZOLE NITRATE 1% CREAM, ERTACZO, EXTINA, JUBLIA, KETOCONAZOLE 2% FOAM, KETODAN, LOPROX 0.77% CREAM, LOPROX 0.77% CREAM KIT, LOPROX 0.77% SUSPENSION KIT, LOPROX 0.77% TOPICAL SUSP, LOTRIMIN AF 1% CREAM, LULICONAZOLE, LUZU, MENTAX, MICONAZOLE-ZINC OXIDE-PETROLTM, MYCOZYL AC, NAFTIFINE HCL 1% CREAM, NAFTIFINE HCL 2% CREAM, NAFTIN, OXISTAT, TAVABOROLE, VUSION

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIFUNGALS – TOPICAL

Drug Class: Antifungals – Topical

Preferred Agents: No Prior Authorization required

ciclopirox 8% soln (generic Ciclodan)

ciclopirox 0.77% cream (generic for Loprox and Ciclodan)

clotrimazole OTC cream, solution

clotrimazole Rx cream

clotrimazole/betamethasone cream

ketoconazole

miconazole nitrate
nystatin
nystatin/triamcinolone cream, ointment
tolnaftate cream, powder

Non-Preferred Agents: Prior Authorization Criteria below

butenafine
Ciclodan®
ciclopirox suspension (generic for Loprox)
ciclopirox gel, shampoo, kit
clotrimazole / betamethasone lotion
econazole nitrate
Ertaczo®
Extina®
Jublia ®
ketoconazole foam
Ketodan®
Loprox®
Lotrimin AF®
luliconazole
Luzu®
Mentax®
miconazole/zinc oxide/petrolatum
Mycozyl AC
Naftin®
naftifine
Oxistat®
tavaborole
Vusion®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Trial and failure with two weeks with two preferred medications OR
- Organism resistant to the preferred medications OR
- See additional medication-specific criteria below:

- Bypass trial and failure of two preferred medications and instead allow a trial and failure of two weeks with one preferred shampoo medication

JUBLIA®(efinaconazole)

- Diagnosis of toenail onychomycosis, and patient age 6 years or older, and trial and failure on ciclopirox or allergy to ciclopirox

Tavaborole

- Diagnosis of toenail onychomycosis, and patient must be 6 years or older, and documented trial and failure on ciclopirox or allergy to ciclopirox (applies to brand and generic)

VUSION® (MICONAZOLE NITRATE/ZINC OXIDE/PETROLATUM)

- Maximum patient age = 16 years

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 8/1/21

Updated 5/1/22

Updated 9/11/24

Updated 10/18/24

UPHP MEDICAID - TOPICAL ANTIVIRALS

MEDICATION(S)

PENCICLOVIR 1% CREAM, XERESE, ZOVIRAX 5% CREAM, ZOVIRAX 5% OINTMENT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIVIRALS – TOPICAL

Drug Class: Antivirals – Topical

Preferred Agents: No Prior Authorization required

acyclovir cream

acyclovir ointment

Denavir®

Non-Preferred Agents: Prior Authorization Criteria below

penciclovir (generic for Denavir)

Xerese® cream

Zovirax® cream

Zovirax® ointment

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications -OR-
- Contraindication or drug to drug interaction with the preferred medications -OR-
- History of unacceptable side effects -OR-
- Therapeutic failure with a one-month trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 8/1/21

Updated 6/1/22

Updated 8/1/24

UPHP MEDICAID - TOPICAL STEROIDS - HIGH POTENCY

MEDICATION(S)

AMCINONIDE 0.1% CREAM, BETAMETHASONE DIPROP AUGMENTED, DESOXIMETASONE 0.05% CREAM, DESOXIMETASONE 0.05% GEL, DESOXIMETASONE 0.05% OINTMENT, DESOXIMETASONE 0.25% CREAM, DESOXIMETASONE 0.25% OINTMENT, DESOXIMETASONE 0.25% SPRAY, DIFLORASONE DIACETATE, DIPROLENE, FLUOCINONIDE, FLUOCINONIDE-E, HALCINONIDE 0.1% CREAM, HALOG 0.1% CREAM, HALOG 0.1% OINTMENT, KENALOG, TOPICORT, TRIAMCINOLONE 0.147 MG/G SPRAY, TRIANEX, VANOS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

TOPICAL STEROIDS – HIGH POTENCY

Drug Class: TOPICAL STEROIDS – HIGH POTENCY

Preferred Agents: No Prior Authorization required
betamethasone dipropionate cream, lotion, ointment
betamethasone valerate cream, lotion, ointment
triamcinolone acetonide cream, lotion, ointment

Non-Preferred Agents: Prior Authorization Criteria below
amcinonide cream

betamethasone dipropionate augmented cream, gel
betamethasone dipropionate augmented lotion, ointment
desoximetasone cream, ointment, gel, and spray
diflorasone diacetate cream and ointment
Diprolene® ointment
flucinonide cream, ointment, and gel
flucinonide emollient and solution
halcinonide
Halog® cream, ointment, solution
Kenalog® aerosol
Topicort® cream, ointment, gel and spray
triamcinolone spray
Vanos®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

For medium potency and high potency medications, trial and failure of 14 days with both of the preferred medications

For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 10/22/24

UPHP MEDICAID - TOPICAL STEROIDS - LOW POTENCY

MEDICATION(S)

DERMA-SMOOTH-FS, DESONIDE 0.05% CREAM, DESONIDE 0.05% LOTION, DESONIDE 0.05% OINTMENT, FLUOCINOLONE 0.01% BODY OIL, FLUOCINOLONE 0.01% SCALP OIL, SCALPICIN, TEXACORT

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

TOPICAL STEROIDS – LOW POTENCY

Drug Class: TOPICAL STEROIDS – LOW POTENCY

Preferred Agents: No Prior Authorization required

hydrocortisone acetate cream

hydrocortisone acetate ointment

hydrocortisone/aloe

hydrocortisone cream

hydrocortisone lotion

hydrocortisone ointment

Non-Preferred Agents: Prior Authorization Criteria below

aclometasone dipropionate ointment and cream

Derma-smooth – FS ®

Desonate® gel

Desonide® ointment, cream, lotion

fluocinolone 0.01% oil

Micort-HC®

Pediaderm TA®, Pediaderm HC®

Scalpicin®

Texacort ®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

For low potency and very high potency medications, trial and failure of 14 days with one of the preferred medications

For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

UPHP MEDICAID - TOPICAL STEROIDS - MEDIUM POTENCY

MEDICATION(S)

BESER, BESER KIT, BETAMETHASONE VALER 0.12% FOAM, CLOCORTOLONE PIVALATE, FLUOCINOLONE 0.01% CREAM, FLUOCINOLONE 0.01% SOLUTION, FLUOCINOLONE 0.025% CREAM, FLUOCINOLONE 0.025% OINTMENT, FLURANDRENOLIDE, FLUTICASONE PROP 0.05% LOTION, HYDROCORT BUTY 0.1% LIPO CREAM, HYDROCORTISONE BUTY 0.1% CREAM, HYDROCORTISONE BUTYR 0.1% LOTN, HYDROCORTISONE BUTYR 0.1% OINT, HYDROCORTISONE BUTYR 0.1% SOLN, HYDROCORTISONE VALERATE, LOCOID, LOCOID LIPOCREAM, PANDEL, PREDNICARBATE, SYNALAR, SYNALAR TS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

TOPICAL STEROIDS – MEDIUM POTENCY

Drug Class: TOPICAL STEROIDS – MEDIUM POTENCY

Preferred Agents: No Prior Authorization required

fluticasone propionate cream

fluticasone propionate ointment

mometasone furoate ointment

mometasone furoate cream

mometasone furoate solution

Non-Preferred Agents: Prior Authorization Criteria below

Beser Kit

Beser Lotion

betamethasone valerate foam

clocortolone cream

flucinolone acetonide cream, solution

flurandrenolide cream, lotion, ointment

fluticasone propionate lotion

hydrocortisone butyrate cream, lotion, ointment, solution

hydrocortisone valerate cream and ointment

Locoid® cream, lotion, solution

Locoid Lipocream®

Pandel®

prednicarbate cream and ointment

Synalar® solution, cream and ointment

Synalar TS® kit

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications OR

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

For medium potency and high potency medications, trial and failure of 14 days with both of the preferred medications

For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 9/11/24

UPHP MEDICAID - TOPICAL STEROIDS - VERY HIGH POTENCY

MEDICATION(S)

APEXICON E, BRYHALI, CLOBETASOL EMOLLIENT, CLOBETASOL EMULSION, CLOBETASOL 0.05% SHAMPOO, CLOBETASOL 0.05% TOPICAL LOTN, CLOBETASOL PROP 0.05% FOAM, CLOBETASOL PROP 0.05% SPRAY, CLOBEX, CLODAN, HALOBETASOL PROP 0.05% FOAM, OLUX, TEMOVATE, TOVET EMOLLIENT, TOVET KIT, ULTRAVATE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

TOPICAL STEROIDS – VERY HIGH POTENCY

Drug Class: TOPICAL STEROIDS – VERY HIGH POTENCY

Preferred Agents: No Prior Authorization required

clobetasol propionate solution

clobetasol propionate cream

clobetasol propionate ointment

halobetasol propionate cream

halobetasol propionate ointment

Non-Preferred Agents: Prior Authorization Criteria below

ApexiCon® E Cream

Bryhali®

clobetasol emollient and lotion
clobetasol propionate foam, gel, spray and shampoo
Clobex® spray and shampoo
Clodan® shampoo and kit
halobetasol propionate (generic for Lexette®)
Olux®
Temovate ointment
Tovet Kit
Tovet Emollient
Ultravate® lotion

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

For low potency and very high potency medications, trial and failure of 14 days with one of the preferred medications

For immunocompromised patients, trial and failure of 14 days with one preferred topical steroid

Duration of Approval: For the duration of the prescription up to 6 months

Effective 10/1/20

Updated 9/11/24

Updated 10/18/24

UPHP MEDICAID - TRIPTANS

MEDICATION(S)

ALMOTRIPTAN MALATE, ELETRIPTAN HBR, FROVA, FROVATRIPTAN SUCCINATE, IMITREX 100 MG TABLET, IMITREX 25 MG TABLET, IMITREX 4 MG/0.5 ML CARTRIDGES, IMITREX 4 MG/0.5 ML PEN INJECT, IMITREX 50 MG TABLET, IMITREX 6 MG/0.5 ML CARTRIDGES, IMITREX 6 MG/0.5 ML PEN INJECT, IMITREX 6 MG/0.5 ML VIAL, MAXALT, MAXALT MLT, NARATRIPTAN HCL, RELPAX, SUMATRIPTAN SUCC-NAPROXEN SOD, TOSYMRA, ZEMBRACE SYMTOUCH, ZOLMITRIPTAN 2.5 MG NASAL SPRY, ZOLMITRIPTAN 2.5 MG TABLET, ZOLMITRIPTAN 5 MG NASAL SPRAY, ZOLMITRIPTAN 5 MG TABLET, ZOLMITRIPTAN ODT, ZOMIG 2.5 MG TABLET, ZOMIG 5 MG NASAL SPRAY, ZOMIG 5 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANTIMIGRAINE AGENTS, TRIPTANS

Drug Class: Antimigraine Agents, Triptans

Preferred Agents: No Prior Authorization required

Imitrex nasal spray

rizatriptan tab and ODT

sumatriptan tablets, injection, nasal spray

Non-Preferred Agents: Prior Authorization Criteria below

almotriptan
eletriptan
Frova®
frovatriptan
Imitrex®
naratriptan
Maxalt®/ Maxalt MLT®
Relpax
sumatriptan-naproxen
Tosymra®
Zembrace Symtouch®
Zolmitriptan, zolmitriptan ODT
zolmitriptan nasal spray
Zomig® tablet/ Zomig ZMT®
Zomig Nasal Spray

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications OR
- Contraindication or drug to drug interaction with the preferred medications OR
- History of unacceptable side effects OR
- Therapeutic failure with treatment for three migraine episodes with use of two of the preferred agents

QUANTITY LIMITS

almotriptan (Axert)9 per fill
Frova® (frovatriptan)18 per fill
Imitrex® (sumatriptan)18 per fill
Imitrex Injection® (sumatriptan)Vial – 2 per fill
Kit and Injection – 4 per fill
Imitrex® Nasal Spray (sumatriptan)6 per fill
Maxalt®/ Maxalt MLT® (rizatriptan)18 per fill
naratriptan (Amerge®)9 per fill
Relpax® (eletriptan)12 per fill
rizatriptan (Maxalt®/ Maxalt MLT®)18 per fill
sumatriptan (Imitrex®)18 per fill
sumatriptan Injection (Imitrex®) Vial – 2 per fill
Injection – 4 per fill
sumatriptan Spray, Nasal (Imitrex®, Tosymra®)6 per fill
zolmitriptan (Zomig®/ Zomig ZMT®)12 per fill
Zomig®/Zomig ZMT® (zolmitriptan)12 per fill

Duration of Approval: 6 months

Effective 10/1/20

Update 7/1/21

Updated 8/1/22

Updated 8/7/24

UPHP MEDICAID - ULCERATIVE COLITIS - ORAL

MEDICATION(S)

AZULFIDINE, BALSALAZIDE DISODIUM, BUDESONIDE ER, COLAZAL, DELZICOL, DIPENTUM, LIALDA, MESALAMINE 800 MG DR TABLET, MESALAMINE DR, MESALAMINE ER, UCERIS 9 MG ER TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ULCERATIVE COLITIS – ORAL

Drug Class: Ulcerative Colitis – Oral

Preferred Agents: No Prior Authorization required

Apriso®

mesalamine (generic for Lialda)

Pentasa®

sulfasalazine/ sulfasalazine DR

Non-Preferred Agents: Prior Authorization Criteria below

Azulfidine DR®

Balsalazide

budesonide ER (generic for Uceris)

Colazal®

Delzicol®

Dipentum®

Giazo®

Lialda®

mesalamine (generic for Apriso)

mesalamine (generic for Asacol)

mesalamine (generic for Delzicol)

mesalamine (generic for Pentasa)

Uceris®

Non-Preferred Agent PA Criteria:

Allergy to the preferred medications

Contraindication or drug to drug interaction with the preferred medications

History of unacceptable side effects

Therapeutic failure after one-month trial with one preferred medication

Duration of Approval: 1 year

Effective 10/1/20

Updated 6/15/22

uPDATED 10/22/24

UPHP MEDICAID - URINARY TRACTS ANTISPASMODICS

MEDICATION(S)

DARIFENACIN ER, DETROL, DETROL LA, DITROPAN XL, FLAVOXATE HCL, GELNIQUE, GEMTESA, MIRABEGRON ER, MYRBETRIQ, OXYTROL, TOLTERODINE TARTRATE, TOLTERODINE TARTRATE ER, TOVIAZ, TROSPIUM CHLORIDE, TROSPIUM CHLORIDE ER, VESICARE, VESICARE LS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

URINARY TRACT ANTISPASMODICS

Drug Class: Urinary Tract Antispasmodics

Preferred Agents: No Prior Authorization required

oxybutynin / oxybutynin ER

solifenacin

fesoterodine ER

Non-Preferred Agents: Prior Authorization Criteria below

darifenacin ER

Detrol®/ Detrol LA®

Ditropan XL®

flavoxate HCL

Gelnique®

Gemtesa®
mirabegron ER
Myrbetriq®
Oxytrol®
tolterodine/ tolterodine ER
Toviaz
trospium/ trospium ER
Vesicare®
Vesicare LS Suspension®

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- Therapeutic failure with a one-month trial of one preferred medication
- See additional medication-specific criteria below:

GELNIQUE

- Clinical rationale why preferred agents inappropriate: inability to swallow, etc.

Duration of Approval: 1 year

Effective 10/1/20

Updated 11/1/21

Updated 8/1/22

Updated 9/1/22

Updated 6/1/24

UPHP MEDICAID - UTERINE DISORDER TREATMENTS

MEDICATION(S)

MYFEMBREE, ORIAHNN, ORILISSA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

UTERINE DISORDER TREATMENTS

Drug Class: Uterine Disorder Treatments

Preferred Agents: Clinical Prior Authorization below

Myfembree®

Oriahnn®

Orilissa®

ORIAHNN®(ELAGOLIX/ESTRADIOL/NORETHINDRONE)

- Patient greater than or equal to 18 years old AND
- Patient is premenopausal AND
- Confirmed diagnosis of uterine leiomyomas (fibroids) with heavy menstrual bleeding AND
- Failure on an adequate trial of hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device) AND
- Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist AND
- Pregnancy is excluded prior to treatment AND

- Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy AND
- Patient does not have osteoporosis AND
- Patient does not have severe hepatic impairment (Child Pugh C) AND
- Patient has not completed a previous course of hormonal treatment that could contribute to bone loss AND
- Quantity limit: 56 tablets per 28 days

ORILISSA®(ELAGOLIX) 150mg

- Patient greater than or equal to 18 years old AND
- Confirmed diagnosis of endometriosis AND
- Failure on an adequate trial of the following therapies:
 - oNon-steroidal anti-inflammatory drugs (NSAIDs)AND
 - oHormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device) AND
- Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist AND
- Pregnancy is excluded prior to treatment AND
- Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy AND
- Patient does not have osteoporosis AND
- Patient does not have severe hepatic impairment (Child Pugh C) AND
- Patient has not completed a previous course of hormonal treatment that could contribute to bone loss AND
- Quantity limit: 28 tablets per 28 days

ORILISSA® (ELAGOLIX) 200MG

- Patient ? 18 years old AND
- Confirmed diagnosis of endometriosis with dyspareunia AND
- Failure on an adequate trial of the following therapies:
 - oNon-steroidal anti-inflammatory drugs (NSAIDs) AND
 - oHormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device) AND
- Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist AND
- Pregnancy is excluded prior to treatment AND
- Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy AND
- Patient does not have osteoporosis AND
- Patient does not have severe hepatic impairment (Child Pugh C) AND
- Patient has not completed a previous course of hormonal treatment that could contribute to bone loss AND
- Treatment duration of Orilissa 200mg twice daily has not exceeded a total of 6 months AND
- Quantity limit: 56 tablets per 28 days

MYFEMBREE® (RELUGOLIX/NORETHINDRONE)

- Confirmed diagnosis of
 - oUterine leiomyomas (fibroids) with heavy menstrual bleeding OR
 - oModerate to severe pain associated with endometriosis AND

- Patient greater than or equal 18 years old, AND
- Patient is premenopausal, AND
- Failure on an adequate trial of hormonal contraceptives (including oral or transdermal formulations, vaginal ring or intrauterine device), AND
- Prescribed by or in consultation with an obstetrics/gynecology or reproductive specialist, AND
- Pregnancy is excluded prior to treatment, AND
- Patient will use effective non-hormonal contraception during treatment with requested medication and one week after stopping therapy, AND
- Patient does not have osteoporosis, AND
- Patient does not have severe hepatic impairment (Child Pugh C)

Duration of Approval: 1 year (maximum total duration of 24 months)

Effective 10/1/20

Updated 2/1/22

Updated 11/1/22

UPHP MEDICAID - VAGINAL ANTIBIOTICS

MEDICATION(S)

CLEOCIN 2% VAGINAL CREAM, METRONIDAZOLE VAGINAL 1.3% GEL, VANDAZOLE, XACIATO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

VAGINAL ANTIBIOTICS

Drug Class: Vaginal Antibiotics

Preferred Agents: No Prior Authorization required

Cleocin (clindamycin) Ovules

Clindamycin (generic for Cleocin) 2% cream

Clindesse (clindamycin 2% cream)

metronidazole (generic for Metro-Gel and Vandazole) 0.75% gel

Nuversa (metronidazole) 1.3% Gel

Non-Preferred Agents: Prior Authorization Criteria below

Cleocin (clindamycin) 2% Cream

Vandazole (metronidazole) 0.75% Gel

Xacialto

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications
- Contraindication or drug to drug interaction with the preferred medications
- History of unacceptable side effects
- Therapeutic failure with one preferred medication
- See additional medication-specific criteria below

XACIATO (CLINDAMYCIN)

Patient is age 12 or older

Duration of Approval: 6 months

Effective 10/1/20

Update 8/1/21

UPHP MEDICAID - VALCYTE/VALGANCYCLOVIR

MEDICATION(S)

VALGANCICLOVIR 450 MG TABLET

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

VALCYTE® / VALGANCICLOVIR

Drug Class: CMV Antiviral Agent – Nucleotide Analogs

FDA-approved uses: VALCYTE is a cytomegalovirus (CMV) nucleoside analogue DNA polymerase inhibitor indicated for:

Adult Patients

- oTreatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS).

- oPrevention of CMV disease in kidney, heart, and kidney-pancreas transplant patients at high risk.

Pediatric Patients

- oPrevention of CMV disease in kidney and heart transplant patients at high risk.

Available dosage forms: Tablets- 450 mg

Coverage Criteria/Limitations for initial authorization

Diagnoses:

- oCytomegalovirus (CMV) retinitis in HIV-infected patient

- oCMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney

Duration of Approval:

oInitial Approval: 1 year

oContinuation of Therapy: 1 year

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oCytomegalovirus (CMV) retinitis in HIV-infected patient AND

Documented use in combination with Vitrasert (ganciclovir intraocular implant), OR

oCMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney

Criteria for continuation of therapy:

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPatient tolerating and responding to treatment

Contraindications/Exclusions/Discontinuation:

•Hypersensitivity to valganciclovir or ganciclovir

•patient is noncompliant with medical or pharmacologic therapy

•No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Effective 10/1/20

UPHP MEDICAID - VEMLIDY/TENOFOVIR ALAFENAMIDE

MEDICATION(S)

VEMLIDY

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

VEMLIDY/ TENOFOVIR ALAFENAMIDE

Drug Class: Anti-Retroviral – Nucleotide Reverse Transcriptase Inhibitor

FDA-approved uses: Treatment of Chronic Hepatitis B Infection

Available dosage forms: Tablet 25 mg

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Chronic Hepatitis B Infection

?Duration of approval:

a.Initial authorization: 6 months

b.Continuation of Therapy: 12 months

? Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- a. Diagnosis of Chronic Hepatitis B infection with compensated liver disease” “ AND
- b. Trial, failure, or contraindication to Entecavir” “ AND
- c. Trial of tenofovir disoproxil fumarate unless one of the following conditions are met:
 - i. History of osteoporosis or osteopenia
 - ii. Renal impairment defined by creatinine clearance (CrCl) less than 50 mL/min or history of chronic renal disease.
 - iii. Trial of tenofovir disoproxil fumarate is inappropriate” “ OR
- d. Persistent viremia or breakthrough infection while taking lamivudine or adefovir [NOTE: lamivudine and adefovir are no longer recommended in current guidelines]” “ AND
- e. Attestation: Confirmation of no HIV risk or negative HIV status

?Quantity: 30 tablets per 30 days

?Age: 6 and older

Criteria for continuation of therapy:

1. Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- a. Confirmation of positive clinical response.
- b. Confirmation of continued monitoring according to available guidelines (i.e. HBV DNA, ALT, etc.)
- c. CrCl remains \geq 15 mL/min

Contraindications/Exclusions/Discontinuation:

- 1. HIV and HBV coinfection: Should not be used as a single agent for the treatment of HIV due to resistance development risk
- 2. If HIV positive - provide further justification
- 3. For females: There have been no data reported to the antiretroviral registry related to the use of this drug in pregnancy. The Health and Human Services (HHS) Perinatal HIV Guidelines note data are insufficient to recommend tenofovir alafenamide for initial therapy in antiretroviral-naive pregnant women. Tenofovir disoproxil fumarate (Viread) preferred in pregnant women.
- 4. Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

MEDICATION(S)

VERQUVO

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

VERQUVO / VERICIGUAT

Drug Class : soluble guanylate cyclase (sGC) stimulator

FDA-approved uses: To reduce the risk of cardiovascular death and heart failure (HF) hospitalization following a hospitalization for heart failure or need for outpatient IV diuretics, in adults with symptomatic chronic HF and ejection fraction less than 45%.

Available dosage forms: 2.5 mg, 5 mg, 10 mg tablets

Coverage Criteria/Limitations for initial authorization:

Diagnoses: Symptomatic chronic heart failure with ejection fraction less than 45%

Duration of approval:

oInitial authorization: 6 months

oContinuation of Therapy: 12 months

Prescriber Specialty: Cardiology, or prescribed in consult with cardiology

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oDocumentation that member has chronic heart failure, New York Heart Association [NYHA] Class II-IV who has had a decompensation while on standard therapy for heart failure
- oDocumentation of a left ventricular ejection fraction (LVEF) of less than 45%
- oDocumentation that member is currently taking or has a contraindication to ALL of the following:
 - ACE inhibitor or ARB or Entresto
 - Beta blocker
 - Oral diuretic (not applicable if member had IV diuretics in previous 3 months)
- oHistory of hospitalization for heart failure in the previous 6 months or required outpatient IV diuretics for heart failure in the previous 3 months.
- oFor female patients of childbearing potential: Documentation of a negative pregnancy test in the previous 30 days and provider attestation that member has been counseled on the risks and advised to use contraception throughout treatment with and one month following Verquvo administration.
- oPrescriber attestation that member is not or will not be using VERQUVO concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or PDE-5 inhibitors (e.g. sildenafil, tadalafil, vardenafil and avanafil).

Quantity: maintenance dosing, 30 tablets per 30 days

Age: 18 years or older

Route of Administration: Oral

Criteria for continuation of therapy:

Documentation that member has had no intolerable adverse effects from treatment

Documentation that member is responding positively to treatment demonstrated by improvement or slowing of decline in signs and symptoms of heart failure.

Contraindications/Exclusions/Discontinuation:

VERQUVO is contraindicated in patients with concomitant use of other soluble guanylate cyclase (sGC) stimulators. VERQUVO is contraindicated in pregnancy.

Other special considerations:

Obtain a pregnancy test in females of reproductive potential prior to initiating treatment with VERQUVO in females of reproductive potential. Based on data from animal reproduction studies, VERQUVO may cause fetal harm when administered to a pregnant woman. Advise females of reproductive potential to use effective contraception during treatment with VERQUVO and for at least one month after the final dose. Concomitant use of VERQUVO with PDE-5 inhibitors is not recommended because of the potential for hypotension.

Effective 8/1/21

MEDICATION(S)

VOQUEZNA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

VOQUEZNA (VONOPRAZAN)

Drug Class: potassium-competitive acid blocker

FDA-approved uses:

- healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults
- maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults

Available dosage forms:

Oral Tablet: 10 MG, 20 MG

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Erosive esophagitis, non-erosive gastroesophageal reflux disease (GERD)

?Duration of approval:

oInitial authorization: 8 months

oContinuation of Therapy: 6 months

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oDiagnosis of erosive esophagitis, OR

oDiagnosis of non-erosive gastroesophageal reflux disease (GERD), AND

oClinical documentation demonstrates patient had a therapeutic failure after one-month trial with one preferred proton pump inhibitor (PPI)

?Quantity: 1 tablet per day

?Age: 18 years of age and older

Criteria for continuation of therapy:

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oClinical documentation demonstrates significant improvement in signs and symptoms of erosive esophagitis or non-erosive gastroesophageal reflux disease (GERD)

oProvider attests that continuation beyond the FDA-approved duration of therapy is medically necessary

oProvider attests risks vs. benefits of continuation have been weighed and discussed with the patient (i.e. Risks of *C. difficile*-associated infection, fractures, fundic gland polyps, hypomagnesemia, tubulointerstitial nephritis, vitamin B12 deficiency, etc.)

Updated 9/11/24

Effective 10/1/24

UPHP MEDICAID - VTAMA (TAPINAROF)

MEDICATION(S)

VTAMA

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

VTAMA / TAPINAROF

Drug Class: Dermatological - Antipsoriatic Agents Topical

FDA-approved uses:

- An aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults.

Available dosage forms:

- Cream, 1% (10mg/gram)

Coverage Criteria/Limitations for initial authorization:

oDiagnoses: Plaque psoriasis

oDuration of approval:

oInitial authorization: 6 months

oContinuation of Therapy: for up to 12 months

oPrescriber Specialty: Prescribed by, or in consultation with, a dermatologist

- oDocumentation Requirements (e.g. Labs, Medical Record, Special Studies):
- oPrescribed to treat an FDA approved indication for topical Tapinarof AND
- oDocumented trial, failure, or intolerance to at least one high potency or very high potency topical steroid AND
- oDocumented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients OR
- oClinical documentation as to why therapies listed above are not appropriate AND
- oPrescribed volume is appropriate for treating the estimated body surface area affected or prescriber attests that the volume is necessary for up to a 34-day supply per fill.
- ?Quantity: See criteria
- ?Age 18 AND OVER
- ?Route of Administration: Topical

Criteria for continuation of therapy:

- ?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):
- oAttestation that topical tapinarof has contributed to a positive response or patient is stable on therapy.

MEDICATION(S)

XATMEP

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

XATMEP®/ METHOTREXATE

Drug Class: Folate Analog Metabolic Inhibitor

FDA-approved uses:

Treatment of pediatric patients with acute lymphoblastic leukemia (ALL) as a component of a combination chemotherapy maintenance regimen

Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA) who are intolerant of or had an inadequate response to first-line therapy

Available dosage forms: 2.5 mg/ml Oral Solution

Diagnosis: Treatment of pediatric patients with acute lymphoblastic leukemia (ALL)

Coverage Criteria/Limitations for initial authorization

Diagnoses: Cancer

Duration of Approval:

oInitial Authorization: 3 months

oContinuation of Therapy: 3-month increments

Prescriber Specialty: Oncologist

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oProper diagnosis of an FDA Approved Indication OR

oIf request is for a non-FDA Approved indication, the request must be for a “medically accepted indication” as noted in the following Compendia:

American Hospital Formulary Drug Service (AHFS-DI)

NCCN Drugs and Biologic Compendium/ NCCN Guidelines

•Categories 1, 2a, and 2b will be accepted. (See Table 1 for explanation of Categories)

Micromedex DrugDex

Clinical Pharmacology

oMember must be under the care of an Oncologist

oDocumentation of dose and dates of all previous therapy and the resulting outcomes

oDocumentation that the proper succession of the therapies has been tried and failed (i.e. intolerance, contraindication, or progression)

oChart notes detailing the member’s current clinical status

oRelated lab work, test results, or clinical markers supporting the diagnosis and or continuing treatment

Not Approved If:

oPatient has any contraindications to the use of any requested ingredients

oRequest is for experimental/investigational use

oMember is enrolled in a clinical trial

Dosing:

oAs noted in Package Insert

oAs noted in Above described Compendium

Diagnosis: Treatment of pediatric patients with acute lymphoblastic leukemia (ALL), continued

Criteria for continuation of therapy

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oCurrent chart notes detailing response and compliance to therapy

oDocumented clinically significant improvements in the disease state, and stability on the medication

Contraindications/Exclusions/Discontinuation:

•Hypersensitivity to the requested agent or any component of the formulation

•Member at risk through drug-drug interactions or contraindications noted in the package insert

•Patient is noncompliant with medical or pharmacologic therapy

•No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy

References:

•National Comprehensive Cancer Network® (NCCN), “Clinical Practice Guidelines in Oncology™: Available at <http://www.nccn.org>

Table 1: NCCN Categories of Evidence and Consensus.

Diagnosis: Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA)

Coverage Criteria/Limitations for initial authorization:

Duration of approval:

- oInitial authorization: 6 months

- oContinuation of Therapy: 1 year

Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

- oPatient must try or have a documented reason that they cannot tolerate oral tablets

Criteria for continuation of therapy:

- Requires a positive response to therapy

- Patient continues to be unable to tolerate oral tablets

Effective 10/1/20

Updated 11/1/21

MEDICATION(S)

ZORYVE

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ZORYVE / ROFLUMILAST

Drug Class: Dermatological - Antipsoriatic Agents Topical

FDA-approved uses:

- Zoryve 0.15% Cream - A phosphodiesterase 4 (PDE-4) inhibitor indicated for mild to moderate atopic dermatitis in adults and pediatric patients 6 years and older.
- Zoryve 0.3% Cream - A phosphodiesterase 4 (PDE-4) inhibitor indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 6 years of age and older.
- Zoryve Foam - A phosphodiesterase 4 (PDE-4) inhibitor indicated for seborrheic dermatitis in patients 9 years of age and older.

Available dosage forms:

- Cream, 0.15% (1.5mg/gram)
- Cream, 0.3% (3mg/gram)

- Foam, 0.3% (3mg/gram)

Coverage Criteria/Limitations for initial authorization:

?Diagnoses:

- oPlaque psoriasis (Zoryve 0.3% Cream)
- oMild to moderate atopic dermatitis (Zoryve 0.15% Cream)
- oSeborrheic dermatitis (Zoryve Foam)

?Duration of approval:

- oInitial authorization: 6 months
- oContinuation of Therapy: for up to 12 months

?Prescriber Specialty: Prescribed by, or in consultation with, a dermatologist

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oAll requests

?Prescribed to treat an FDA approved indication for topical Roflumilast AND

?Prescribed volume is appropriate for treating the estimated body surface area affected or prescriber attests that the volume is necessary for up to a 34-day supply per fill. AND

?Additional diagnosis-specific criteria below:

oFor Plaque psoriasis

?Documented trial, failure, or intolerance to at least one high potency or very high potency topical steroid AND

?Documented trial, failure, or intolerance to topical calcipotriene, calcitriol, tazarotene, or combination products containing prior stated ingredients OR

?Clinical documentation as to why therapies listed above are not appropriate

oFor Seborrheic dermatitis

?Documented trial, failure, or intolerance to at least one topical steroid AND

?Documented trial, failure, or intolerance to at least one topical antifungal OR

?Clinical documentation as to why prerequisite therapies listed above are not appropriate.

oFor Mild to moderate atopic dermatitis

?Documented trial, failure, or intolerance to at least one topical steroid, OR

?Clinical documentation as to why prerequisite therapies listed above are not appropriate.

?Quantity: See criteria

?Age:

oCream ? 6 years old

oFoam ? 9 years old

?Route of Administration: Topical

Criteria for continuation of therapy:

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oAttestation that topical roflumilast has contributed to a positive response or patient is stable on therapy.

UPHP MEDICAID BIOLOGIC IMMUNOMODULATORS

MEDICATION(S)

ABRILADA(CF), ABRILADA(CF) PEN, ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN, ADALIMUMAB-AACF(CF), ADALIMUMAB-AACF(CF) PEN, ADALIMUMAB-AATY(CF), ADALIMUMAB-AATY(CF) 80MG/0.8ML, ADALIMUMAB-ADBM(CF), ADALIMUMAB-ADBM(CF) PEN, ADALIMUMAB-ADBM(CF) PEN CROHNS, ADALIMUMAB-ADBM(CF) PEN PS-UV, ADALIMUMAB-ADBM(CF)PEN, ADALIMUMAB-FKJP(CF), ADALIMUMAB-FKJP(CF) PEN, ADALIMUMAB-RYVK(CF), ADALIMUMAB-RYVK(CF) AUTOINJECT, AMJEVITA(CF) 10MG/0.2ML SYRING, AMJEVITA(CF) 20MG/0.4ML SYRING, AMJEVITA(CF) 40MG/0.8ML SYRING, AMJEVITA(CF) 40MG/0.8ML AUTOIN, BIMZELX, BIMZELX AUTOINJECTOR, CIMZIA 2X200 MG/ML SYRINGE KIT, CIMZIA 2X200 MG/ML(X3)START KT, CYLTEZO(CF), CYLTEZO(CF) PEN, CYLTEZO(CF) PEN CROHN'S-UC-HS, CYLTEZO(CF) PEN PSORIASIS-UV, ENTYVIO, ENTYVIO PEN, HADLIMA, HADLIMA PUSHTOUCH, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH, HULIO(CF), HULIO(CF) PEN, HYRIMOZ(CF) 10 MG/0.1 ML SYRNG, HYRIMOZ(CF) 20 MG/0.2 ML SYRNG, HYRIMOZ(CF) 40 MG/0.4 ML SYRNG, HYRIMOZ(CF) PEDIATRIC CROHN'S, HYRIMOZ(CF) PEN 40 MG/0.4 ML, HYRIMOZ(CF) PEN 80 MG/0.8 ML, HYRIMOZ(CF) PEN CROHN-UC 80 MG, HYRIMOZ(CF) PEN PSORIA 80-40MG, IDACIO(CF), IDACIO(CF) PEN, IDACIO(CF) PEN CROHN'S-UC, IDACIO(CF) PEN PSORIASIS, ILUMYA, KEVZARA, OLUMIANT, OMVOH PEN, ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, OTEZLA 30 MG TABLET, RINVOQ, SILIQ, SIMLANDI(CF) AUTOINJECTOR, SIMPONI, SIMPONI ARIA, SKYRIZI 150 MG/ML SYRINGE, SKYRIZI ON-BODY, SKYRIZI PEN, SOTYKTU, STELARA 45 MG/0.5 ML SYRINGE, STELARA 90 MG/ML SYRINGE, TALTZ AUTOINJECTOR, TALTZ AUTOINJECTOR (2 PACK), TALTZ AUTOINJECTOR (3 PACK), TALTZ 80 MG/ML SYRINGE, TREMFYA 100 MG/ML INJECTOR, TREMFYA 100 MG/ML SYRINGE, TYENNE 162 MG/0.9 ML SYRINGE, TYENNE AUTOINJECTOR, VELSIPITY, XELJANZ, XELJANZ XR, YUFLYMA(CF), YUFLYMA(CF) AI CROHN'S-UC-HS, YUFLYMA(CF) AUTOINJECT (2 PCK), YUFLYMA(CF) AUTOINJECTOR, YUSIMRY(CF) PEN, ZYMFENTRA, ZYMFENTRA (2 PENS), ZYMFENTRA (2 SYRINGES)

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

ANKYLOSING SPONDYLITIS

Preferred : No PA required: Cosentyx® Enbrel® Humira®

Non-Preferred : PA Criteria: Abrilada® adalimumab-aacf (unbranded Idacio)adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)Amjevita® Bimzelx®Cimzia®, Cimzia Kit®Cyltezo® Hadlima®Hulio® Hyrimoz® Idacio® Rinvoq® Rinvoq LQ®Simlandi®Simponi®, Simponi ARIA®Taltz®
Xeljanz®, Xeljanz XR®Yuflyma® Yusimry®

CROHN'S DISEASE

Preferred : No PA required: Humira

Non-Preferred : PA Criteria: Abrilada®adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma) adalimumab-adaz (unbranded Hyrimoz) adalimumab-adbm (unbranded Cyltezo)
Non-Preferred : PA Criteria
adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi)Amjevita®Cimzia®, Cimzia Kit®Cyltezo® Entyvio®Hadlima®Hulio
Hyrimoz® Idacio®Rinvoq®Rinvoq LQ®Simlandi®Skyrizi®Stelara®Yuflyma® Yusimry®Zymfentra®
pen/syringe

HIDRADENITIS SUPPURATIVA

Preferred : No PA required Cosentyx Humira

Non-Preferred : PA Criteria Abrilada®adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)AmjevitaCyltezo
HadlimaHulioHyrimozIdacioSimlandiYuflymaYusimry

JUVENILE IDIOPATHIC ARTHRITIS

Preferred : No PA required Enbrel Humira

Non-Preferred : PA Criteria AbriladaActemra® SCadalimumab-aacf (unbranded Idacio)adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio) adalimumab-ryvk (unbranded Simlandi)AmjevitaCimzia, Cimzia Kit Cyltezo Hadlima Hulio Hyrimoz Idacio
Kevzara Orenzia SC Rinvoq Rinvoq LQ Simlandi Simponi ARIA Tyenne Xeljanz® tabs, solution Yuflyma

Yusimry

NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS

Preferred : No PA required Cosentyx

Non-Preferred : PA Criteria Cimzia®, Cimzia Kit®Bimzelx®Rinvoq®Rinvoq LQ®Taltz®

PLAQUE PSORIASIS

Preferred: No PA required Cosentyx® Enbrel® Humira®

Non-Preferred : PA Criteria Abrilada®adalimumab-aacf (unbranded Idacio)adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)Amjevita®Bimzelx®Cimzia®, Cimzia Kit®Cyltezo® Hadlima®Hulio® Hyrimoz®

Idacio®Ilumya®Otezla®Siliq®Simlandi®Skyrizi®Sotyktu®Stelara®Taltz®Tremfya®Yuflyma®Yusimry®

PSORIATIC ARTHRITIS

Preferred : No PA required Cosentyx® Enbrel® Humira®

Non-Preferred : PA Criteria Abrilada adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)Amjevita®Bimzelx®Cimzia®, Cimzia Kit®Cyltezo® Hadlima®Hulio® Hyrimoz® Idacio®Orencia® SCOtezla®Rinvoq®Rinvoq LQ®Simlandi®Simponi®, Simponi ARIA®Stelara®Skyrizi®Taltz®Tremfya®Xeljanz®, Xeljanz XR®Yuflyma® Yusimry®

RHEUMATOID ARTHRITIS

Preferred : No PA required

Enbrel® Humira®

Non-Preferred : PA Criteria

Abrilada®Actemra® SCadalimumab-aacf (unbranded Idacio)adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)Amjevita®Cimzia®, Cimzia Kit®Cyltezo® Hadlima®Hulio® Hyrimoz® Idacio®Kevzara®Kineret®Olumiant®Orencia® SCRinvoq® Rinvoq LQ®Simlandi®Simponi®, Simponi ARIA®Tyenne®Xeljanz®, Xeljanz XR®Yuflyma® Yusimry®

ULCERATIVE COLITIS

Preferred : No PA required Humira®

Non-Preferred : PA Criteria

Abrilada®adalimumab-aacf (unbranded Idacio)adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)Amjevita®Cyltezo® Entyvio®Hadlima®Hulio® Hyrimoz® Idacio®Omvoh®Rinvoq®Rinvoq LQ®Simlandi®Simponi®Skyrizi®Stelara®Tremfya®Velsipity®Xeljanz®,

UVEITIS

Preferred : No PA required Humira®

Non-Preferred : PA Criteria below

Abrilada adalimumab-aacf (unbranded Idacio) adalimumab-aaty (unbranded Yuflyma)adalimumab-adaz (unbranded Hyrimoz)adalimumab-adbm (unbranded Cyltezo)adalimumab-fkjp (unbranded Hulio)adalimumab-ryvk (unbranded Simlandi)Amjevita®Cyltezo® Hadlima®Hulio® Hyrimoz® Idacio®Simlandi Yuflyma Yusimry

Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications, OR
- Contraindication or drug to drug interaction with the preferred medications, OR
- History of unacceptable side effects, OR
- The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition, OR
- Therapeutic failure with one preferred medication in the same subclass
- Bypass PDL criteria of failure with a preferred agent in cases when the non-preferred product has a unique FDA approved indication.

•See additional medication-specific criteria below:

ABRILADA® (ADALIMUMAB-AFZB)

- Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn's disease
- Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR
 - oDiagnosis of moderate to severe hidradenitis suppurative: OR
 - oDiagnosis of non-infectious intermediate, posterior, or panuveitis

ACTEMRA® (TOCILIZUMAB)

- Patient is 2 years of age or older, AND
 - oDiagnosis of active polyarticular juvenile idiopathic arthritis, OR
 - oDiagnosis of active systemic juvenile idiopathic arthritis, OR
- Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of giant cell arteritis, OR
 - oDiagnosis of systemic sclerosis-associated interstitial lung disease

AMJEVITA® (ADALIMUMAB-ATT0)

- Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn's disease, OR
- Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR
 - oDiagnosis of moderate to severe hidradenitis suppurativa, OR
 - oDiagnosis of non-infectious intermediate, posterior, or panuveitis

BIMZELX® (BIMEKIZUMAB-BKZX)

- Diagnosis of moderate to severe plaque psoriasis, OR
- Diagnosis of active psoriatic arthritis, OR
- Diagnosis of active non-radiographic axial Spondyloarthritis (nr-axSpA), OR
- Diagnosis of active ankylosing spondylitis, AND
- Patient must be 18 years or older

CYLTEZO® (ADALIMIMAB-ADBM)

- Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn's disease, OR
- Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR
 - oDiagnosis of moderate to severe hidradenitis suppurativa, OR
 - oDiagnosis of non-infectious intermediate, posterior, or panuveitis

ENTYVIO® (VEDOLIZUMAB)

- Diagnosis of Crohn's disease, OR
- Diagnosis of ulcerative colitis, AND
- Patient must be 18 years or older, AND
- Trial and failure on one medication from each of the following classes:
 - oAminosalicylate [i.e., mesalamine (Pentasa®, Lialda®, Apriso®, Delzicol®), olsalazine (Dipentum®), balsalazide (Colazal®), sulfasalazine (Azulfidine®)]
 - oOral steroid

- oThiopurine [i.e., azathioprine (Imuran®), mercaptopurine (Purinethol®)]
- oTNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade®), adalimumab (Humira®)]
- OLength of authorization: Initial approval = 14 weeks, renewal = 1 year
- HADLIMA® (ADALIMUMAB-BWWD)
 - Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
 - Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn’s disease, OR
 - Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR
 - oDiagnosis of moderate to severe hidradenitis suppurativa, OR
 - oDiagnosis of non-infectious intermediate, posterior, or panuveitis
- HULIO® (ADALIMUMAB-FKJP)
 - Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
 - Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn’s disease, OR
 - Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR
 - oDiagnosis of moderate to severe hidradenitis suppurativa, OR
 - oDiagnosis of non-infectious intermediate, posterior, or panuveitis
- HYRIMOZ® (ADALIMUMAB-ADAZ)
 - Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
 - Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn’s disease, OR
 - Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR

- oDiagnosis of moderate to severe hidradenitis suppurativa, OR
- oDiagnosis of non-infectious intermediate, posterior, or panuveitis
- IDACIO® (ADALIMUMAB-AACF)
- Patient is 2 years of age or older, AND
- oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
- oDiagnosis of moderate to severe Crohn’s disease, OR
- Patient is 18 years of age or older, AND
- oDiagnosis of moderate to severe rheumatoid arthritis, OR
- oDiagnosis of psoriatic arthritis, OR
- oDiagnosis of ankylosing spondylitis, OR
- oDiagnosis of moderate to severe ulcerative colitis, OR
- oDiagnosis of moderate to severe plaque psoriasis, OR
- oDiagnosis of moderate to severe hidradenitis suppurativa, OR
- oDiagnosis of non-infectious intermediate, posterior, or panuveitis
- ILUMYA® (TILDRAKIZUMAB)
- Diagnosis of moderate to severe plaque psoriasis, AND
- Patient must be 18 years or older
- KEVZARA® (SARILUMAB) – PDL CRITERIA DO NOT APPLY FOR POLYMYALGIA RHEUMATICA
- Patient must be 18 years or older, AND
- oDiagnosis of Polymyalgia Rheumatica (PMR), OR
- oDiagnosis of moderately to severely active rheumatoid arthritis (RA), OR
- Patient weight is 63 kg or greater, AND
- oDiagnosis of polyarticular juvenile idiopathic arthritis
- OLUMIANT® (BARICITINIB) – PDL CRITERIA DO NOT APPLY FOR ALOPECIA AREATA
- Diagnosis of moderate to severe rheumatoid arthritis, OR
- Diagnosis of severe alopecia areata, AND
- oPatient must be 18 years or older
- OMVOH
- Diagnosis of moderately to severely active ulcerative colitis (UC), AND
- Patient must be 18 years or older, AND
- Prescribed by or in consultation with a gastroenterologist
- OTEZLA® (APREMILAST)
- Patient must be 6 years or older, AND
- oDiagnosis of plaque psoriasis, OR
- Patient must be 18 years or older, AND
- oDiagnosis of psoriatic arthritis with 3 or more swollen and tender joints, OR
- oDiagnosis of oral ulcers associated with Behcet’s Disease, AND
- Must be prescribed by or in consultation with a rheumatologist or dermatologist
- RINVOQ® / RINVOQ LQ® (UPADACITINIB)

- Patient must be 2 years of older, AND
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of polyarticular juvenile idiopathic arthritis, OR
- Patient must be 18 years or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of non-radiographic axial spondyloarthritis (nr-axSpA), OR
 - oDiagnosis of moderately to severely active Crohn's disease, OR
 - oDiagnosis of moderately to severely active ulcerative colitis
- SILIQ (BRODALUMAB)
- Diagnosis of plaque psoriasis, AND
 - oPatient must be 18 years or older
- SIMLANDI (ADALIMUMAB-RYVK)
- Patient is 2 years of age or older, AND
 - oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
 - oDiagnosis of moderate to severe Crohn's disease, OR
- Patient is 18 years of age or older, AND
 - oDiagnosis of moderate to severe rheumatoid arthritis, OR
 - oDiagnosis of psoriatic arthritis, OR
 - oDiagnosis of ankylosing spondylitis, OR
 - oDiagnosis of moderate to severe ulcerative colitis, OR
 - oDiagnosis of moderate to severe plaque psoriasis, OR
 - oDiagnosis of moderate to severe hidradenitis suppurativa, OR
 - oDiagnosis of non-infectious intermediate, posterior, or panuveitis
- SKYRIZI (RISANKIZUMAB)
- Patient is 18 years of age or older, AND
 - Diagnosis of moderate to severe plaque psoriasis, OR
 - Diagnosis of active psoriatic arthritis, AND
- OPrescribed by or in consultation with a dermatologist or rheumatologist, OR
- Diagnosis of Crohn's disease, OR
- Diagnosis of ulcerative colitis, AND
- OPrescribed by or in consultation with a gastroenterologist or rheumatologist
- SOTYKTU (DEUCRAVACITINIB)
- Diagnosis of moderate to severe plaque psoriasis, AND
 - oPatient greater than or equal to 18 years of age: AND
 - oMust be prescribed by or in consultation with a dermatologist, AND
 - oQuantity Limit: 1 per day
- STELARA® (USTEKINUMAB)
- ?Diagnosis of psoriasis or psoriatic arthritis, AND

oQuantity limit:

?90 mg every 12 weeks with initial dose Week 0 and 4

?Diagnosis of Crohn's disease or ulcerative colitis, AND

oQuantity limit:

?520 mg for initial dose

?90 mg every 8 weeks

TALTZ (IXEKIZUMAB)

•Patient must be 6 years of age or older with a diagnosis of moderate to severe plaque psoriasis, OR

•Patient must be 18 years or older, AND

•Diagnosis of psoriatic arthritis, OR

•Diagnosis of active ankylosing spondylitis, OR

•Diagnosis of non-radiographic axial spondyloarthritis (nr-axSpA), AND

•Must be prescribed by a rheumatologist or dermatologist or asthma/allergy specialist

TREMFYA (GUSELKUMAB)

•Diagnosis of moderate to severe plaque psoriasis, OR

•Diagnosis of moderate to severe active ulcerative colitis (UC)

•Diagnosis of psoriatic arthritis, AND

•Patient must be 18 years or older

TYENNE (TOCILIZUMAB-AAZG)

•Patient is 2 years of older, AND

oDiagnosis of active polyarticular juvenile idiopathic arthritis, OR

oDiagnosis of active systemic juvenile idiopathic arthritis, OR

•Patient is 18 years or older, AND

oDiagnosis of moderate to severe rheumatoid arthritis, OR

oDiagnosis of giant cell arteritis

VELSIPITY (ETRASIMOD ARGININE)

•Diagnosis of moderately to severely active ulcerative colitis (UC), AND

•Patient must be 18 years or older, AND

•Prescribed by or in consultation with a gastroenterologist, AND

•Patient has obtained a baseline electrocardiogram (ECG), AND

•Patient does NOT have an active infection, including clinically important localized infections, AND

•Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy, AND

•For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, has been performed before starting treatment, AND

•Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have been obtained for the patient in the past 6 months.

XELJANZ (TOFACITINIB)

•Patient is 2 years of age or older, AND

oDiagnosis of polyarticular juvenile idiopathic arthritis (pJIA) (Note: Xeljanz Solution is only approved for

pJIA.), OR

- Patient is 18 years of age or older, AND
- Diagnosis of rheumatoid arthritis (RA), OR
- Diagnosis of psoriatic arthritis (PsA) OR
- Diagnosis of ankylosing spondylitis (AS), AND
- Must be prescribed by or in consultation with a rheumatologist or dermatologist, OR
- Diagnosis of ulcerative colitis, AND
- Prescribed by or in consultation with a gastroenterologist

YUFLYMA (ADALIMUMAB-AATY)

- Patient is 2 years of age or older, AND
- oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
- oDiagnosis of moderate to severe Crohn's disease, OR
- Patient is 18 years of age or older, AND
- oDiagnosis of moderate to severe rheumatoid arthritis, OR
- oDiagnosis of psoriatic arthritis, OR
- oDiagnosis of ankylosing spondylitis, OR
- oDiagnosis of moderate to severe ulcerative colitis, OR
- oDiagnosis of moderate to severe plaque psoriasis, OR
- oDiagnosis of moderate to severe hidradenitis suppurativa, OR
- oDiagnosis of non-infectious intermediate, posterior, or panuveitis

YUSIMRY (ADALIMUMAB-AQVH)

- Patient is 2 years of age or older, AND
- oDiagnosis of moderate to severe polyarticular juvenile idiopathic arthritis, OR
- Patient is 6 years of age or older, AND
- oDiagnosis of moderate to severe Crohn's disease, OR
- Patient is 18 years of age or older, AND
- oDiagnosis of moderate to severe rheumatoid arthritis, OR
- oDiagnosis of psoriatic arthritis, OR
- oDiagnosis of ankylosing spondylitis, OR
- oDiagnosis of moderate to severe ulcerative colitis, OR
- oDiagnosis of moderate to severe plaque psoriasis, OR
- oDiagnosis of moderate to severe hidradenitis suppurativa, OR
- oDiagnosis of non-infectious intermediate, posterior, or panuveitis

ZEPOSIA® (OZANIMOD)

- Diagnosis of moderately to severely active ulcerative colitis (UC), AND
- Prescribed by or in consultation with a gastroenterologist, AND
- Patient has obtained a baseline electrocardiogram (ECG), AND
- Patient does NOT have an active infection, including clinically important localized infections, AND

- Patient has been tested for antibodies to the varicella zoster virus (VZV) or has completed the immunization series for VZV prior to beginning therapy, AND
- For patients with a history of uveitis and/or diabetes ONLY: A baseline ophthalmic evaluation of the fundus, including the macula, has been performed before starting treatment, AND Prescriber attests that a CBC with lymphocyte count, ALT, AST, and total bilirubin have

been obtained for the patient in the past 6 months

ZYMFENTRA® (INFLIXIMAB-DYYB)

- Patient is 18 years of age or older, AND
- Diagnosis is moderate to severe Crohn's disease, OR
- Diagnosis of moderate to severe ulcerative colitis, AND

Prescriber attests that the patient has completed an intravenous induction regimen with an infliximab product, AND

Prescribed by or in consultation with a gastroenterologist

Duration of Approval: 1 year, unless otherwise noted in Medication-Specific Information

UPHP MEDICAID COMBINATION NASAL SPRAYS

MEDICATION(S)

AZELASTINE-FLUTICASONE, DYMISTA, RYALTRIS

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

COMBINATION NASAL SPRAYS

Drug Class: Combination Nasal Sprays

Preferred Agents:

Non-Preferred Agents: Prior Authorization Criteria below

azelastine/fluticasone spray

Dymista®

Ryaltris®

Non-Preferred Agent PA Criteria:

- 1 month trial and failure of one –preferred nasal antihistamine; AND
- 1 month trial and failure of one preferred nasal corticosteroid

Duration of Approval: 1 year

UPHP MEDICAID TAZAROTENE

MEDICATION(S)

TAZAROTENE 0.05% GEL, TAZAROTENE 0.1% CREAM, TAZAROTENE 0.1% GEL

COVERED USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

TAZORAC/TAZAROTENE

Drug Class (ETC_Name): Dermatological - Antipsoriatic Agents Topical

FDA-approved uses:

- Indicated for the topical treatment of plaque psoriasis and acne vulgaris

Available dosage forms:

Formulary:

- Tazarotene Cream, 0.1%
- Tazarotene Gel, 0.05% and 0.1%

Non-Formulary:

- Tazorac 0.05% Cream, Tazorac 0.1% Cream
- Tazorac 0.05% Gel, Tazorac 0.1% Gel

Coverage Criteria/Limitations for initial authorization:

?Diagnoses: Psoriasis or acne vulgaris

?Duration of approval:

oInitial authorization: 6 months

oContinuation of Therapy: for up to 12 months

?Prescriber Specialty: N/A

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oPrescribed to treat an FDA approved indication for Tazarotene AND

oDiagnosis specific requirements:

?For the treatment of psoriasis

•Documented trial, failure, or intolerance to at least one high potency or very high potency topical steroid

•OR

•Documented, trial, failure or intolerance of one low or medium potency topical steroid and justification for avoidance of a higher potency topical steroid OR

•Topical steroid avoidance due to pediatric age AND

•Documented trial, failure or intolerance to a topical vitamin D analogue (i.e. calcipotriene or calcitriol) or a clinical reason why both cannot be used.

?For the treatment of acne vulgaris

•Documented trial, failure or intolerance to one of the following:

oTopical adapalene

oTopical tretinoin

oRequest for a non-formulary Tazarotene product requires trial of formulary Tazarotene product and justification for an inability to utilize a formulary product.

?Quantity: Appropriate amount to cover affected area for up to 34 days based on provider estimate or body surface area (BSA) estimate.

oPrescribing information recommends a “thin layer” defined as 2 mg/cm² for approved diagnoses.

?Age:

oTreatment of acne vulgaris: patients ? 12 years old

oTreatment of psoriasis:

?Cream – patients ? 18 years old

?Gel – patients ? 12 years old

?Gender: N/A

?Route of Administration: Topical

?Place of Service: N/A

Criteria for continuation of therapy:

?Documentation Requirements (e.g. Labs, Medical Record, Special Studies):

oAttestation that tazarotene has contributed to a positive response or patient is stable on therapy.

Contraindications/Exclusions/Discontinuation:

?Warning of embryofetal toxicity:

oUse of topical retinoids should be avoided during pregnancy.

?Females of child-bearing potential should have a negative pregnancy test within 2 weeks prior to initiating treatment and use an effective method of contraception during treatment.

?If member is pregnant, Tazarotene is contraindicated and alternate therapy should be utilized.

?For the treatment of psoriasis in children, using the gel form, it is recommended to limit application to ? 20% of BSA.

Other special considerations: