InterCommunity Health Network CCO

Prior Authorization Criteria

InterCommunity Health Network

PLEASE READ: This document contains information about the criteria for coverage of provider administered drugs (PAD) and oral chemotherapy drugs for this plan.

Updated on 5/17/2024. For more recent information or other questions, please contact Pharmacy Services at **541-768-4550** or toll free **800-832-4580** (TTY 800-735-2900) or visit **samhealthplans.org**. Pharmacy Services is available Monday through Friday, from 8 a.m. to 5 p.m.

Actemra (tocilizumab)

Prior Authorization Guideline

Guideline ID	GL-127310
Guideline Name	Actemra (tocilizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	4/6/2010
P&T Revision Date:	09/18/2019 ; 10/16/2019 ; 04/15/2020 ; 09/16/2020 ; 12/16/2020 ; 05/20/2021 ; 04/20/2022 ; 05/19/2022 ; 10/19/2022 ; 12/14/2022 ; 02/16/2023 ; 05/18/2023 ; 7/19/2023

1 . Indications

Drug Name: Actemra (tocilizumab IV), Actemra (tocilizumab SC)
Rheumatoid arthritis (RA) Indicated for the treatment of adult patients with moderately- to severely-active rheumatoid arthritis who have had an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDs). **Systemic Juvenile Idiopathic Arthritis (SJIA)** Indicated for the treatment of active systemic juvenile idiopathic arthritis in patients 2 years of age and older. **Polyarticular Juvenile Idiopathic Arthritis (PJIA)** Indicated for the treatment of active polyarticular juvenile idiopathic arthritis in patients 2 years of age and older. **Giant Cell Arteritis (GCA)** Indicated for the treatment of giant cell arteritis (GCA) in adult patients.
Drug Name: Actemra (tocilizumab IV)

Cytokine Release Syndrome Indicated for the treatment of chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome in adults and pediatric patients 2 years of age and older. **Coronavirus Disease 2019 (COVID-19)** Indicated for the treatment of coronavirus disease 2019 (COVID-19) in hospitalized adult patients who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO).
Drug Name: Actemra (tocilizumab SC)
Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) Indicated for slowing the rate of decline in pulmonary function in adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD).

2 . Criteria

Product Name: Actemra IV or SC	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses [2, 3]:

- methotrexate
- leflunomide
- sulfasalazine

AND

4 - One of the following:

4.1 Trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate*

- Cimzia (certolizumab pegol)
- Enbrel (etanercept)
- Humira (adalimumab), Amjevita, Cyltezo, Hyrimoz, or Brand Adalimumab-adaz
- Rinvoq (upadacitinib)
- Simponi (golimumab)
- Xeljanz/XR (tofacitinib/ER)

OR

4.2 For continuation of prior Actemra therapy, defined as no more than a 45-day gap in therapy

Notes	*Includes attestation that a total of two TNF inhibitors have alre ady been tried in the past, and the patient should not be made to try a third TNF inhibitor.

Product Name: Actemra IV or SC	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following [1-3]:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

Product Name: Actemra IV or SC	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active systemic juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses [4]:

- Minimum duration of a 3-month trial and failure of methotrexate

- Minimum duration of a 1-month trial of nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen)
- Minimum duration of a 2-week trial of systemic glucocorticoid (e.g., prednisone)

Product Name: Actemra IV or SC	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following [4]:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline

Product Name: Actemra IV or SC	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active polyarticular juvenile idiopathic arthritis

AND

2 - Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses [5]:

- leflunomide
- methotrexate

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - One of the following:

4.1 Trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate*

- Enbrel (etanercept)
- Humira (adalimumab), Amjevita, Cyltezo, Hyrimoz, or Brand Adalimumab-adaz
- Xeljanz (tofacitinib)

OR

4.2 For continuation of Actemra therapy, defined as no more than a 45-day gap in therapy

Notes	* Includes attestation that a total of two TNF inhibitors have alre ady been tried in the past, and the patient should not be made to try a third TNF inhibitor.

Product Name: Actemra IV or SC	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following [1, 5]:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

Product Name: Actemra IV or SC	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of giant cell arteritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to a glucocorticoid

Product Name: Actemra IV or SC	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Actemra SC	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by the following [6-8]:

1.1 Exclusion of other known causes of interstitial lung disease (ILD)

AND

1.2 One of the following:

1.2.1 In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (e.g., fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD

OR

1.2.2 In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD

AND

2 - Prescribed by or in consultation with a pulmonologist or rheumatologist

Product Name: Actemra SC	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

Product Name: Actemra IV	
Diagnosis	Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy
Approval Length	2 Months [A]
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy (e.g., Kymriah [tisagenlecleucel], Yescarta [axicabtagene ciloleucel]) **AND** **2** - Prescribed by or in consultation with an oncologist or hematologist	

Product Name: Actemra IV	
Diagnosis	Coronavirus disease 2019 (COVID-19)
Approval Length	14 Days [B]
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of COVID-19	

AND

2 - Patient is hospitalized

AND

3 - Currently receiving systemic corticosteroids

AND

4 - Patient requires one of the following:

- Supplemental oxygen
- Non-invasive mechanical ventilation
- Invasive mechanical ventilation
- Extracorporeal membrane oxygenation (ECMO)

3 . Endnotes

A. Patients should have Actemra on board for initial CAR T-cell therapy and be evaluated for signs and symptoms of CRS for at least 4 weeks after, up to a total of 4 doses of Actemra with at least 8 hours between doses. [1]
B. The recommended dosage of Actemra for treatment of adult patients with COVID-19 is 8 mg/kg administered as a single 60-minute intravenous infusion. If clinical signs or symptoms worsen or do not improve after the first dose, one additional infusion of Actemra may be administered at least 8 hours after the initial infusion. [1]

4 . References

1. Actemra Prescribing Information. Genentech, Inc. South San Francisco, CA. December 2022.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care Res. 2015;68(1):1-25.

3. Fraenkel L, Bathon JM, England BR, et al. 2021 American College of Rheumatology guideline for the treatment of rheumatoid arthritis. 2021;73(7):924-939.
4. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for oligoarthritis, temporomandibular joint arthritis, and systemic juvenile idiopathic arthritis. Arthritis Rheumatol. 2022;74(4):553-569.
5. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. Arthritis Rheumatol. 2019;71(6):846-863.
6. Khanna D, Lin CJF, Furst DE, et al. Tocilizumab in systemic sclerosis: a randomized, double-blind, placebo-controlled, phase 3 trial. Lancet Respir Med. 2020;8:963–74.
7. Fischer A, Swigris JJ, Groshong SD, et al. Clinically significant interstitial lung disease in limited scleroderma: histopathology, clinical features, and survival. Chest 2008; 134:601.
8. UptoDate [internet database]. Waltham, MA. UpToDate, Inc. Clinical manifestations, evaluation, and diagnosis of interstitial lung disease in systemic sclerosis (scleroderma). Available by subscription at: https://www.uptodate.com. Accessed April 11, 2021.

5 . Revision History

Date	Notes
6/30/2023	Addition of Cyltezo, Hyrimoz, and brand Adalimumab-adaz as p referred step options for RA and PJIA

Actimmune (interferon gamma-1b)

Prior Authorization Guideline

Guideline ID	GL-123571
Guideline Name	Actimmune (interferon gamma-1b)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	3/21/2016
P&T Revision Date:	04/15/2020 ; 04/21/2021 ; 04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Actimmune (interferon gamma-1b)
Chronic Granulomatous Disease (CGD) Indicated for reducing the frequency and severity of serious infections associated with Chronic Granulomatous Disease (CGD). **Severe Malignant Osteopetrosis (SMO)** Indicated for delaying time to disease progression in patients with severe, malignant osteopetrosis (SMO).

2 . Criteria

Product Name: Actimmune	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Chronic granulomatous disease (CGD)
- Severe, malignant osteopetrosis (SMO)

Product Name: Actimmune	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

3 . Background

Benefit/Coverage/Program Information
Effective date Prior to 3/8/2023 Updates the effective date was 1/1/2021

4 . References

1. Actimmune Prescribing Information. Horizon Therapeutics USA, Inc. Deerfield, IL. March 2021.

5 . Revision History

Date	Notes
4/11/2023	Annual review

Prior Authorization Guideline

Guideline ID	GL-125930
Guideline Name	Acute Infectious Disease
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Avycaz, Cresemba, Fetroja, Nuzyra, Recarbrio, Vabomere, Xenleta, Xerava	
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of and FDA-approved indication or an off-label use supported by guidelines **AND** **2** - Prescribed by or in consultation with an infectious disease specialist	

2 . Revision History

Date	Notes
5/26/2023	New program

Adakveo (crizanlizumab-tmca)

Prior Authorization Guideline

Guideline ID	GL-118143
Guideline Name	Adakveo (crizanlizumab-tmca)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	3/1/2023
P&T Approval Date:	1/15/2020
P&T Revision Date:	02/13/2020 ; 01/20/2021 ; 01/19/2022 ; 1/18/2023

1 . Indications

Drug Name: Adakveo (crizanlizumab-tmca)
Sickle Cell Disease Indicated to reduce the frequency of vasoocclusive crises in adults and pediatric patients aged 16 years and older with sickle cell disease.

2 . Criteria

Product Name: Adakveo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Sickle Cell Disease	

AND

2 - Patient is 16 years of age and older

AND

3 - Documentation of 2 vaso-occlusive events that required medical facility visits and treatments in the past 12 months (e.g., sickle cell crisis, acute pain episodes, acute chest syndrome, hepatic sequestration, splenic sequestration, priapism) [1, 2]

AND

4 - Trial and failure or inadequate response, contraindication, or intolerance to one of the following: [3, 4, 5, 6]

- Hydroxyurea
- L-glutamine (i.e., Endari)

AND

5 - Prescribed by or in consultation with one of the following:

- Hematologist/Oncologist
- Specialist with expertise in the diagnosis and management of sickle cell disease

Product Name: Adakveo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy (e.g., reduction in annual rate of vaso-occlusive events, increased time between each vaso-occlusive event)	

3 . References

1. Adakveo (crizanlizumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; September 2022.
2. Ataga K, Kutlar A, Kanter J et al. Crizanlizumab for the Prevention of Pain Crises in Sickle Cell Disease. New England Journal of Medicine. 2017;376(5):429-439. doi:10.1056/nejmoa1611770.
3. Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014. Nhlbi.nih.gov. https://www.nhlbi.nih.gov/sites/default/files/media/docs/sickle-cell-disease-report%20020816_0.pdf. Published 2014. Accessed December 6, 2021.
4. Brawley O, Cornelius L, Edwards L et al. National Institutes of Health Consensus Development Conference Statement: Hydroxyurea Treatment for Sickle Cell Disease. Ann Intern Med. 2008;148(12):932. doi:10.7326/0003-4819-148-12-200806170-00220.
5. Niihara Y, Miller S, Kanter J et al. A Phase 3 Trial of l-Glutamine in Sickle Cell Disease. New England Journal of Medicine. 2018;379(3):226-235. doi:10.1056/nejmoa1715971.
6. Brandow A, Carroll C, Creary S et al. American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain. Blood Adv. 2020;4(12):2656-2701. doi:10.1182/bloodadvances.2020001851.

4 . Revision History

Date	Notes
1/4/2023	2023 UM Annual Review. Updated references

Adasuve (loxapine)

Prior Authorization Guideline

Guideline ID	GL-120911
Guideline Name	Adasuve (loxapine)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	4/8/2014
P&T Revision Date:	03/18/2020 ; 03/17/2021 ; 03/16/2022 ; 3/15/2023

1 . Indications

Drug Name: Adasuve (loxapine)
Agitation Indicated for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults. Limitations of Use: As part of the Adasuve REMS Program to mitigate the risk of bronchospasm, Adasuve must be administered only in an enrolled healthcare facility.

2 . Criteria

Product Name: Adasuve	
Approval Length	1 Time [A]
Guideline Type	Prior Authorization
Approval Criteria	

1 - One of the following diagnoses:

- Bipolar I disorder
- Schizophrenia

AND

2 - For the treatment of acute agitation

AND

3 - Patient does not have a history of lung disease associated with bronchospasm [e.g., asthma, chronic obstructive pulmonary disease (COPD)]

3 . Endnotes

A. Because clinical trials in patients with asthma or COPD demonstrated that the degree of bronchospasm, as indicated by changes in forced expiratory volume in 1 second (FEV1), was greater following a second dose of Adasuve, limit Adasuve use to a single dose within a 24 hour period.

4 . References

1. Adasuve Prescribing Information. Galen US, Inc.; Souderton, PA. January 2022.

5 . Revision History

Date	Notes
2/3/2023	2023 Annual Review - no criteria changes

Aduhelm (aducanumab-avwa) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-124387
Guideline Name	Aduhelm (aducanumab-avwa) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	2/18/2021
P&T Revision Date:	06/16/2021 ; 06/24/2021 ; 05/19/2022 ; 06/15/2022 ; 02/16/2023 ; 5/18/2023

1 . Indications

Drug Name: Aduhelm (aducanumab-avwa)
Alzheimer's Disease Indicated for the treatment of Alzheimer's disease. Treatment with ADUHELM should be initiated in patients with mild cognitive impairment or mild dementia stage of disease, the population in which treatment was initiated in clinical trials. There are no safety or effectiveness data on initiating treatment at earlier or later stages of the disease than were studied. This indication is approved under accelerated approval based on reduction in amyloid beta plaques observed in patients treated with ADUHELM. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).

2 . Criteria

Product Name: Aduhelm	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization, Non-Formulary

Approval Criteria

1 - Both of the following:

1.1 Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, one of the following: [1,2,9]

- Diagnosis of mild cognitive impairment due to Alzheimer's disease
- Diagnosis of probable Alzheimer's disease dementia

AND

1.2 Submission of medical records (e.g., chart notes) confirming both of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4 [3,4]
- Mini-Mental State Examination score of 24-30 [3,4]

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by one of the following:

2.1 Positive amyloid positron emission tomography (PET) scan

OR

2.2 Both of the following:

- Attestation that the patient does not have access to amyloid PET scanning
- Cerebrospinal fluid (CSF) biomarker or blood testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., Aβ42 level, Aβ42:Aβ40 ratio)

AND

3 - Provider attests that the patient's ApoE e4 carrier status is known prior to initiating treatment and a shared decision-making conversation regarding the results has been completed

AND

4 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.) have been ruled out

AND

5 - Both of the following:

- Patient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less) [3,4]
- Patient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment [3,4]

AND

6 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting [5]

AND

7 - Submission of medical records (e.g., chart notes) confirming a baseline brain

magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

8 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi)

AND

9 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name: Aduhelm	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization, Non-Formulary

Approval Criteria

1 - Patient is benefitting from therapy as defined by both of the following:

1.1 Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, one of the following: [1,2,9]

- Patient continues to have a diagnosis of mild cognitive impairment due to Alzheimer's disease
- Patient continues to have a diagnosis of probable Alzheimer's disease dementia

AND

1.2 Submission of medical records (e.g., chart notes) confirming both of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4 [3,4]
- Mini-Mental State Examination score of 24-30 [3,4]

AND

2 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th infusion treatment to show one of the following:

2.1 Both of the following:

- Less than 10 new incident microhemorrhages
- 2 or less focal areas of superficial siderosis

OR

2.2 If 10 or more new incident microhemorrhages or greater than 2 focal areas of superficial siderosis are present then both of the following:

- Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances)
- Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H)

AND

3 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi)

AND

4 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

3 . Definitions

Definition	Description
ARIA-E	Amyloid related imaging abnormality due to edema/effusion [5]
ARIA-H	Amyloid related imaging abnormality due to micro hemorrhages and hemosiderin deposits [5]

4 . References

1. McKhann GM, Knopman DS, Chertkow H, et al. The diagnosis of dementia due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimers Dement. 2011;7(3):263-269.
2. Albert MS, DeKosky ST, Dickson D, et al. The diagnosis of mild cognitive impairment due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimers Dement. 2011;7(3):270-279.
3. ClinicalTrials.gov: https://clinicaltrials.gov/ct2/show/NCT02477800.
4. ClinicalTrials.gov: https://clinicaltrials.gov/ct2/show/NCT02484547.
5. Aducanumab [unapproved dossier], Cambridge, MA: Biogen; 2020.
6. O'Bryant SE, Waring SC, Cullum CM, et al. Staging Dementia Using Clinical Dementia Rating Scale Sum of Boxes Scores: A Texas Alzheimer's Research Consortium Study. Arch Neurol. 2008;65(8):1091–1095.
7. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res. 1975;12(3):189-198.
8. Sevigny, J., Chiao, P., Bussière, T. et al. The antibody aducanumab reduces Aβ plaques in Alzheimer's disease. Nature 537, 50–56 (2016).
9. Per clinical consult with neurologist, January 21, 2021.
10. Aduhelm prescribing information. Biogen, Inc. Cambridge, MA. February 2023.
11. Blennow K, Mattsson N, Scholl M, et al. Amyloid biomarkers in Alzheimer's disease. Trends Pharmacol Sci 2015;36:297–309.
12. ClinicalTrials.gov: https://clinicaltrials.gov/ct2/show/NCT01677572.
13. ClinicalTrials.gov: https://clinicaltrials.gov/ct2/show/NCT04241068.
14. Wolk DA, Dickerson BC. Clinical features and diagnosis of Alzheimer disease. UpToDate Web site. http://www.uptodate.com. Accessed February 1, 2023.

5 . Revision History

Date	Notes
5/3/2023	Annual review - updated references.

Aldurazyme (laronidase)

Prior Authorization Guideline

Guideline ID	GL-126324
Guideline Name	Aldurazyme (laronidase)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	2/2/2004
P&T Revision Date:	06/17/2020 ; 06/16/2021 ; 06/15/2022 ; 6/21/2023

1 . Indications

Drug Name: Aldurazyme (laronidase)
Mucopolysaccharidosis I (MPS I) Indicated for adult and pediatric patients with Hurler and Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I) and for patients with the Scheie form who have moderate to severe symptoms. The risks and benefits of treating mildly affected patients with the Scheie form have not been established. Aldurazyme has not been evaluated for effects of the central nervous system manifestations of the disorder.

2 . Criteria

Product Name: Aldurazyme	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following: **1.1** Diagnosis of Hurler or Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I) **OR** **1.2** Diagnosis of Scheie form of Mucopolysaccharidosis I (MPS I) in patients with moderate to severe symptoms	

Product Name: Aldurazyme	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

3 . References

1. Aldurazyme Prescribing Information, BioMarin Pharmaceutical Inc. Novato, CA. December 2019.

4 . Revision History

Date	Notes
6/6/2023	Anual Review - Reauth criteria created with 24 month approval duration. Initial auth reduced to 12 month approval

Alpha-1 Proteinase Inhibitors

Prior Authorization Guideline

Guideline ID	GL-120995
Guideline Name	Alpha-1 Proteinase Inhibitors
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	2/25/2016
P&T Revision Date:	03/18/2020 ; 01/20/2021 ; 03/17/2021 ; 03/16/2022 ; 3/15/2023

1 . Indications

Drug Name: Aralast NP (alpha-1-proteinase inhibitor [human])
Alpha-1 proteinase inhibitor deficiency (also known as alpha-1-antitrypsin (AAT) deficiency) Indicated for chronic augmentation therapy in adults with clinically evident emphysema due to severe congenital deficiency of Alpha1-PI (alpha1-antitrypsin deficiency). Aralast NP increases antigenic and functional (anti-neutrophil elastase capacity, ANEC) serum levels and antigenic lung epithelial lining fluid levels of Alpha1-PI. The effect of augmentation therapy with Alpha1-PI, including Aralast NP, on pulmonary exacerbations and on the progression of emphysema in alpha-1-antitrypsin deficiency has not been conclusively demonstrated in randomized, controlled clinical trials. Clinical data demonstrating the long-term effects of chronic augmentation and maintenance therapy with Aralast NP or Aralast are not available. Aralast NP is not indicated as therapy for lung disease patients in whom severe congenital Alpha-1-PI deficiency has not been established.
Drug Name: Glassia (alpha-1-proteinase inhibitor [human])

Alpha-1 proteinase inhibitor deficiency (also known as alpha-1-antitrypsin (AAT) deficiency) Indicated for chronic augmentation and maintenance therapy in individuals with clinically evident emphysema due to severe hereditary deficiency of Alpha1-PI, also known as alpha1-antitrypsin (AAT) deficiency. Glassia increases antigenic and functional (anti-neutrophil elastase capacity, ANEC) serum levels and antigenic lung epithelial lining fluid levels of Alpha1-PI. Limitations of Use: The effect of augmentation therapy with Glassia or any Alpha1-PI product on pulmonary exacerbations and on the progression of emphysema in Alpha1-PI deficiency has not been conclusively demonstrated in randomized, controlled clinical trials. Clinical data demonstrating the long-term effects of chronic augmentation and maintenance therapy of individuals with Glassia are not available. Glassia is not indicated as therapy for lung disease in patients in whom severe Alpha1-PI deficiency has not been established.

Drug Name: Prolastin-C (alpha-1-proteinase inhibitor [human]), Prolastin-C liquid (alpha-1-proteinase inhibitor [human])

Alpha-1 proteinase inhibitor deficiency (also known as alpha-1-antitrypsin (AAT) deficiency) Indicated for chronic augmentation and maintenance therapy in adults with clinical evidence of emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin deficiency). Prolastin-C increases antigenic and functional (anti-neutrophil elastase capacity, ANEC) serum levels and antigenic lung epithelial lining fluid levels of Alpha1-PI. Limitations of Use: The effect of augmentation therapy with any Alpha-1-PI product on pulmonary exacerbations and on the progression of emphysema in Alpha1-PI deficiency has not been conclusively demonstrated in randomized, controlled clinical trials. Clinical data demonstrating the long-term effects of chronic augmentation or maintenance therapy with Prolastin-C are not available. Prolastin-C is not indicated as therapy for lung disease in patients in whom severe Alpha-1-PI deficiency has not been established.

Drug Name: Zemaira (alpha-1-proteinase inhibitor [human])

Alpha-1 proteinase inhibitor deficiency (also known as alpha-1-antitrypsin (AAT) deficiency) Indicated for chronic augmentation and maintenance therapy in adults with Alpha1-PI deficiency and clinical evidence of emphysema. Zemaira increases antigenic and functional (ANEC) serum levels and lung epithelial lining fluid levels of Alpha1-PI. Clinical data demonstrating the long-term effects of chronic augmentation therapy of individuals with Zemaira are not available. The effect of augmentation therapy with Zemaira or any Alpha1-PI product on pulmonary exacerbations and on the progression of emphysema in Alpha1-PI deficiency has not been demonstrated in randomized, controlled clinical trials. Zemaira is not indicated as therapy for lung disease patients in whom severe Alpha1-PI deficiency has not been established.

2 . Criteria

Product Name: Aralast NP, Glassia, Prolastin-C, Prolastin-C liquid, or Zemaira	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital alpha-1 antitrypsin (AAT) deficiency

AND

2 - Diagnosis of emphysema [A]

AND

3 - One of the following:

3.1 Pi*ZZ, Pi*Z(null) or Pi*(null)(null) protein phenotypes (homozygous) [6]

OR

3.2 Other rare AAT disease genotypes associated with pre-treatment serum alpha1-antitrypsin (AAT) level less than 11 micromole per liter [e.g., Pi(Malton, Malton), Pi(SZ)] [B]

AND

4 - One of the following:

4.1 Circulating pre-treatment serum alpha1-antitrypsin (AAT) level less than 11 micromole per liter (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry) [B, 10]

OR

4.2 Patient has a concomitant diagnosis of necrotizing panniculitis

AND

5 - Continued optimal conventional treatment for emphysema (e.g., bronchodilators)

AND

6 - One of the following: [8, 9, 10]

6.1 The FEV1 level is less than or equal to 65% of predicted

OR

6.2 Patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment [9]

OR

6.3 Patient has a concomitant diagnosis of necrotizing panniculitis

AND

7 - Patient is NOT a current smoker [C]

Product Name: Aralast NP, Glassia, Prolastin-C, Prolastin-C liquid, or Zemaira	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Continued optimal conventional treatment for emphysema (e.g., bronchodilators)

3 . Endnotes

A. Currently, augmentation therapy is not recommended for patients without emphysema. [3, 8] Some individuals with AAT deficiency will not go on to develop panacinar emphysema, only those with evidence of such disease should be considered for augmentation therapy.
B. Population studies suggest a minimum plasma threshold of 11 µmol/L (corresponding to 80 mg/dL in some assays and ~57 mg/dL by nephelometry), below which there is insufficient AAT to protect the lung, leading to a risk of developing emphysema. [3, 6-9]
C. The GOLD report recommends reserving alpha-1 antitrypsin augmentation therapy for those with evidence of continued and rapid progression following smoking cessation. [8]

4 . References

1. Aralast NP Prescribing Information. Baxalta US Inc. Westlake Village, CA. December 2022.
2. Zemaira Prescribing Information. CSL Behring LLC. Kankakee, IL. September 2022.
3. American Thoracic Society/European Respiratory Society Statement: Standards for diagnosis and management of individuals with alpha-1 antitrypsin deficiency. Am J Resp Care Med 2003; 168:818-900.
4. Prolastin-C Prescribing Information. Grifols Therapeutics, Inc. Research Triangle Park, NC. January 2022.
5. Glassia Prescribing Information. Baxalta US Inc. Lexington, MA. September 2022.

6. Marciniuk DD, Hernandez P, Balter M, et al. Alpha-1 antitrypsin deficiency targeted testing and augmentation therapy: A Canadian Thoracic Society clinical practice guideline. Canadian Respiratory Journal 2012;19(2):109-116.
7. Stoller JK. Treatment of of alpha-1 antitrypsin deficiency. UpToDate. Accessed March 12, 2019.
8. Vogelmeir C, Agusti A, et al. The global strategy for diagnosis, management and prevention of COPD (2020 Report). Global Initiative for Chronic Obstructive Lung Disease. Accessed January 21, 2020.
9. Brantly ML, Lascano JE, Shahmohammadi A. Intravenous alpha-1 antitrypsin therapy for alpha-1 antitrypsin deficiency: the current state of the evidence. Chronic Obstr Pulm Dis. 2019;6(1):100-114.
10. Sandhaus RA, Turino G, Brantly ML, et al. The diagnosis and management of alpha-1 antitrypsin deficiency in the adult. Chronic Obstr Pulm Dis. 2016; 3(3): 668-682.

5 . Revision History

Date	Notes
2/22/2023	2023 UM Annual Review. No changes to criteria. Updated refer ences

Amondys 45 (casimersen) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-124011
Guideline Name	Amondys 45 (casimersen) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/20/2021
P&T Revision Date:	12/15/2021 ; 05/19/2022 ; 06/15/2022 ; 5/18/2023

1 . Indications

Drug Name: Amondys 45 (casimersen)
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with Amondys 45. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

2 . Criteria

Product Name: Amondys 45	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Duchenne muscular dystrophy (DMD)

AND

2 - Documentation of a confirmed mutation of the dystrophin gene amenable to exon 45 skipping

AND

3 - Patient is 7 years of age or older

AND

4 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

5 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

6 - Patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA)

Product Name: Amondys 45	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

3 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

4 - Patient is maintaining ambulatory status, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA)

Product Name: Amondys 45	
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Documentation of a confirmed mutation of the dystrophin gene amenable to exon 45 skipping

AND

2 - Patient is 7 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA)

3 . References

1. Amondys 45 Prescribing Information. Sarepta Therapeutics, Inc. Cambridge, MA. March 2023..

4 . Revision History

Date	Notes
5/4/2023	Annual review: Background and formatting updates.

Prior Authorization Guideline

Guideline ID	GL-126397
Guideline Name	Antiemetics for Chemotherapy
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Emend (fosaprepitant) IV, Emend (aprepitant) capsules and for oral suspension, Cinvanti (aprepitant) IV, Varubi (rolapitant) tablets	
Diagnosis	Prevention of acute and delayed nausea and vomiting associated with highly emetogenic chemotherapy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chemotherapy-induced nausea and vomiting

AND

2 - Patient is receiving initial and repeat courses of highly emetogenic chemotherapy

AND

3 - Patient is receiving dexamethasone

AND

4 - Patient is receiving dolasetron, granisetron, ondansetron, or palonosetron

AND

5 - Prescribed by or in consultation with an oncologist

Product Name: Emend (fosaprepitant) IV, Emend (aprepitant) capsules and for oral suspension, Cinvanti (aprepitant) IV, Varubi (rolapitant) tablets, Akynzeo (fosnetupitant/palonosetron) IV, Akynzeo (netupitant/palonosetron) capsules	
Diagnosis	Prevention of acute and delayed nausea and vomiting associated with moderately emetogenic chemotherapy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chemotherapy-induced nausea and vomiting

AND

2 - Patient is receiving initial and repeat courses of moderately emetogenic chemotherapy

AND

3 - Patient is receiving dexamethasone

AND

4 - One of the following:

4.1 Patient is experiencing breakthrough nausea and vomiting

OR

4.2 Patient has one of the following risk factors:

- Younger age (less than 55 years)
- Female sex
- Previous history of chemotherapy-induced nausea and vomiting
- Little or no previous alcohol use
- Prone to motion sickness
- History of morning sickness during pregnancy
- Anxiety/high pretreatment expectation of nausea

AND

5 - Prescribed by or in consultation with an oncologist

Product Name: Akynzeo (fosnetupitant/palonosetron) IV, Akynzeo (netupitant/palonosetron) capsules	
Diagnosis	Prevention of acute and delayed nausea and vomiting associated with highly emetogenic chemotherapy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chemotherapy-induced nausea and vomiting

AND

2 - Patient is receiving initial and repeat courses of highly emetogenic chemotherapy

AND

3 - Patient is receiving dexamethasone

AND

4 - Prescribed by or in consultation with an oncologist

Product Name: Aloxi (palonosetron) IV; Sustol (granisetron extended release) IV	
Diagnosis	Prevention of acute and delayed nausea and vomiting associated with moderately emetogenic chemotherapy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chemotherapy-induced nausea and vomiting

AND

2 - Patient is receiving initial and repeat courses of moderately emetogenic chemotherapy

AND

3 - Patient is receiving dexamethasone

AND

4 - Prescribed by or in consultation with an oncologist

Product Name: Emend (fosaprepitant) IV, Emend (aprepitant) capsules and for oral suspension, Cinvanti (aprepitant) IV, Varubi (rolapitant) tablets, Akynzeo (fosnetupitant/palonosetron) IV, Akynzeo (netupitant/palonosetron) capsules, Aloxi (palonosetron) IV; Sustol (granisetron extended release) IV	
Diagnosis	All indications listed above
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
6/15/2023	New program

Anti-Parkinson’s Agents

Prior Authorization Guideline

Guideline ID	GL-125146
Guideline Name	Anti-Parkinson’s Agents
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	5/22/1998
P&T Revision Date:	03/18/2020 ; 06/17/2020 ; 03/17/2021 ; 04/21/2021 ; 01/19/2022 ; 03/16/2022 ; 03/15/2023 ; 5/18/2023

1 . Indications

Drug Name: Rytary (carbidopa and levodopa) extended-release capsules
Parkinson’s disease Indicated for the treatment of Parkinson's disease, post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication
Drug Name: Duopa (carbidopa and levodopa) enteral suspension
Advanced Parkinson's disease Indicated for the treatment of motor fluctuations in patients with advanced Parkinson’s disease.
Drug Name: Xadago (safinamide) tablets

Parkinson’s disease Indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing "off" episodes.
Drug Name: Gocovri (amantadine) extended-release capsules
Dyskinesia in Parkinson's disease Indicated for the treatment of dyskinesia in patients with Parkinson's disease receiving levodopa-based therapy, with or without concomitant dopaminergic medications. **"Off" Episodes in Parkinson's Disease** Indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson’s disease experiencing “off” episodes.
Drug Name: Osmolex ER (amantadine) extended-release tablets
Parkinson's Disease Indicated for the treatment of Parkinson's disease. **Drug-Induced Extrapyramidal Reactions** Indicated for the treatment of drug-induced extrapyramidal reactions in adult patients.
Drug Name: Dhivy (carbidopa-levodopa)
Parkinson's Disease Indicated for the treatment of Parkinson's disease, post-encephalitic parkinsonism, and symptomatic parkinsonism that may follow carbon monoxide intoxication or manganese intoxication.

2 . Criteria

Product Name: Rytary	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Requested drug is being used for a Food and Drug Administration (FDA)-approved indication

AND

2 - Trial and failure (of a minimum 30-day supply) of ONE of the following:

- Generic carbidopa-levodopa immediate release
- Generic carbidopa-levodopa extended release

Product Name: Xadago	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Requested drug is being used for a Food and Drug Administration (FDA)-approved indication

AND

2 - Trial and failure (of a minimum 30-day supply) of BOTH of the following:

- rasagiline mesylate
- selegiline

Product Name: Duopa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is levodopa-responsive [A, B]

AND

3 - Patient experiences disabling “Off” periods for a minimum of 3 hours/day [B]

AND

4 - Disabling “Off" periods occur despite therapy with both of the following: [A, C]

- Oral levodopa-carbidopa
- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT inhibitor [entacapone, tolcapone], MAO-B inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Duopa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Gocovri	
Diagnosis	Dyskinesia in Parkinson’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is experiencing dyskinesia

AND

3 - Patient is receiving concurrent levodopa-based therapy [5, D]

AND

4 - Trial and failure or intolerance to amantadine immediate release

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Gocovri	
Diagnosis	"Off" Episodes in Parkinson's Disease

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Patient is experiencing "off" episodes [E, 6]

AND

3 - Used in combination with levodopa/carbidopa therapy [1]

AND

4 - Both of the following:

4.1 Trial and failure, or intolerance to amantadine immediate release

AND

4.2 Trial and failure, contraindication or intolerance to one of the following:

- MAO-B inhibitor (e.g., rasagiline, selegiline)
- Dopamine Agonist (e.g., pramipexole, ropinirole)
- COMT inhibitor (e.g., entacapone)

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Gocovri	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decreased "off" periods, decreased "on" time with troublesome dyskinesia) [D]

Product Name: Osmolex ER	
Diagnosis	Parkinson's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Trial and failure, contraindication or intolerance to BOTH of the following:

2.1 amantadine immediate release

AND

2.2 ONE of the following: [9]

- carbidopa-levodopa
- MAO-B Inhibitor (e.g., rasagiline, selegiline)
- Dopamine Agonist (e.g., pramipexole, ropinirole)

AND

3 - Prescribed by or in consultation with a neurologist

Product Name: Osmolex ER	
Diagnosis	Drug-Induced Extrapyramidal Reactions
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is experiencing drug-induced extrapyramidal reactions

AND

2 - One of the following: [10]

2.1 Patient has persistent extrapyramidal symptoms despite a trial of dose reduction, tapering, or discontinuation of the offending medication

OR

2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

3 - Trial and failure or intolerance to amantadine immediate release

AND

4 - Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist

Product Name: Osmolex ER	
Diagnosis	Parkinson's Disease, Drug-Induced Extrapyramidal Reactions
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Dhivy	
Approval Length	12 month(s)

Guideline Type	Step Therapy

Approval Criteria

1 - Requested drug is being used for a Food and Drug Administration (FDA)-approved indication

AND

2 - Trial and failure (of a minimum 30-day supply) of both of the following:

- Generic carbidopa-levodopa immediate release (IR)
- Generic carbidopa-levodopa oral disintegraing tablet (ODT)

3 . Endnotes

A. The efficacy of Duopa was established in a randomized, double-blind, double-dummy, active controlled, parallel group, 12-week study in patients with advanced Parkinson's disease who were levodopa-responsive and had persistent motor fluctuations while on treatment with oral immediate-release carbidopa-levodopa and other Parkinson's disease medications. [2, 3]
B. Patients were eligible for participation in the studies if they were experiencing 3 hours or more of “Off” time on their current Parkinson's disease drug treatment and they demonstrated a clear responsiveness to treatment with levodopa. [2, 3]
C. Most patients (89%) were taking at least one concomitant medication for Parkinson’s disease (e.g., dopaminergic agonist, COMT-inhibitor, MAO B inhibitor) in addition to oral immediate-release carbidopa-levodopa. [2, 3]
D. The efficacy of Gocovri was established in two Phase III randomized, double-blind, placebo-controlled trials, a 12 week and 24 week study in patients with Parkinson's disease were treated with levodopa. Both studies demonstrate statistically significant and clinically relevant reduction in dyskinesia compared to placebo. Also, both studies showed that Gocovri-treated patients experienced an increase in functional time daily (defined as ON time without troublesome dyskinesia) compared to placebo-treated patients. [6, 7]
E. “Off” time is defined as the amount of time the Parkinson’s Disease medication was not controlling motor symptoms. [6]

4 . References

1. Duopa Prescribing Information. AbbVie Inc. North Chicago, IL. December 2019.
2. Olanow CW, Kieburtz K, Odin P, et al. Continuous intrajejunal infusion of levodopa-carbidopa intestinal gel for patients with advanced Parkinson's disease: a randomised, controlled, double-blind, double-dummy study. Lancet Neurol. 2014 Feb;13(2):141-9.
3. Rytary Prescribing Information. Amneal Pharmaceuticals LLC. Bridgewater, NJ. December 2019.
4. Xadago Prescribing Information. US WorldMeds, LLC. Louisville, KY. August 2021.
5. Gocovri Prescribing Information. Adamas Pharma, LLC. Emeryville, CA. January 2021.
6. Pahwa R, Tanner CM, Hauser RA, et al. ADS-5102 (Amantadine) Extended- Release Capsules for Levodopa-Induced Dyskinesia in Parkinson Disease (EASE LID Study): A Randomized Clinical Trial. JAMA Neurol. 2017 Aug:1;74(8): 941-949.
7. Pahwa R, Tanner CM, Hauser Ra, et al. Amantadine Extended Release for Levodopa-Induced Dyskinesia in Parkinson's Disease (EASED Study). Mov Disorder. 2015 May; 30(6):788-95.
8. Osmolex ER Prescribing Information. Vertical Pharmaceuticals, LLC. Bridgewater, NJ. March 2021.
9. National Institute of Health and Clinical Excellence (NICE). Parkinson's disease in adults. NICE guideline [NG71]. July 2017. Available at: https://www.nice.org.uk/guidance/ng71/chapter/Recommendations. Accessed January 28, 2021.
10. Muench J, Hamer AM. Adverse effects of antipsychotic medications. Am Fam Physician. 2010 Mar 1;81(5):617-622.
11. Oertel W, Eggert K, Pahwa R, et al. Randomized, placebo-controlled trial of ADS-5102 (amantadine) extended-release capsules for levodopa-induced dyskinesia in Parkinson's disease (EASE LID 3). Mov Disord. 2017;32(12):1701-1709.
12. Dhivy Prescribing Information. Riverside Pharmaceuticals Corporation. Washington, DC. November 2021.

5 . Revision History

Date	Notes
5/16/2023	update guideline

Apretude

Prior Authorization Guideline

Guideline ID	GL-126002
Guideline Name	Apretude
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Apretude	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection	

AND

2 - Submission of medical records (e.g., chart notes, lab values) documenting both of the following U.S. Food and Drug (FDA)-approved tests prior to use of Apretude:

- Negative HIV-1 antigen/antibody test
- Negative HIV-1 RNA assay

AND

3 - Trial and failure, contraindication, or intolerance to generic emtricitabine-tenofovir disoproxil fumarate 200/300mg

AND

4 - Patient weighs at least 35 kg

Product Name: Apretude	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that patient is adherent to the testing appointments and scheduled injections of Apretude

AND

2 - Submission of medical records (e.g., chart notes, lab values) documenting both of

the following U.S. Food and Drug (FDA)-approved tests prior to each maintenance injection of Apretude for HIV PrEP: • Negative HIV-1 antigen/antibody test • Negative HIV-1 RNA assay **AND** **3** - Patient weighs at least 35 kg

2 . Revision History

Date	Notes
6/5/2023	New program

Arcalyst (rilonacept)

Prior Authorization Guideline

Guideline ID	GL-110150
Guideline Name	Arcalyst (rilonacept)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	8/19/2008
P&T Revision Date:	08/13/2020 ; 02/18/2021 ; 05/20/2021 ; 08/19/2021 ; 04/20/2022 ; 8/18/2022

1 . Indications

Drug Name: Arcalyst (rilonacept) injection
Cryopyrin-Associated Periodic Syndromes (CAPS) Indicated for the treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and pediatric patients 12 years and older. **Deficiency of Interleukin-1 Receptor Antagonist (DIRA)** Indicated for the maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) in adults and pediatric patients weighing at least 10 kg.

Recurrent Pericarditis Indicated for the treatment of recurrent pericarditis and reduction in risk of recurrence in adults and pediatric patients 12 years and older.

2 . Criteria

Product Name: Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS) [A]

AND

2 - Prescribed by or in consultation with one of the following:

- Immunologist
- Allergist
- Dermatologist
- Rheumatologist
- Neurologist
- Specialist with expertise in the management of CAPS

AND

3 - The medication will not be used in combination with another biologic agent

Product Name: Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidenced by one of the following:

- Improvement in rash, fever, joint pain, headache, or conjunctivitis
- Decreased number of disease flare days
- Normalization of inflammatory markers (C-reactive protein [CRP], erythrocyte sedimentation rate [ESR], serum amyloid A [SAA])
- Corticosteroid dose reduction
- Improvement in MD global score or active joint count

Product Name: Arcalyst	
Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)

AND

2 - Patient weighs at least 10 kg

AND

3 - Patient is currently in remission (e.g., no fever, skin rash, and bone pain; no radiological evidence of active bone lesions; C-reactive protein [CRP] less than 5 mg/L)

Product Name: Arcalyst	
Diagnosis	Recurrent Pericarditis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart [1, 4-5]

AND

2 - Prescribed by or in consultation with a cardiologist

AND

3 - Trial and failure, contraindication, or intolerance to at least one of the following [4-5]:

- nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen)
- colchicine
- corticosteroids (e.g., prednisone)

Product Name: Arcalyst	
Diagnosis	Recurrent Pericarditis

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

3 . Definitions

Definition	Description
CIAS1 gene:	Also known as cold-induced auto-inflammatory syndrome 1, is a gene responsible for the regulation of IL-1 production. Mutation(s) in this gene leads to CAPS. [2]
Chronic Infantile Neurologic Cutaneous and Articular Syndrome:	Also known as neonatal-Onset Multisystem Inflammation, is the most severe form of the CAPS. It is characterized by nearly continuous symptoms of inflammation presenting first during the neonatal period or early infancy with migratory and nonpruritic urticaria-like rash and fever. Other features of this disease include chronic aseptic meningitis, sensorineural hearing loss and ocular changes (conjunctivitis, optic nerve atrophy), and disabling arthropathy caused by overgrowth of the patella and epiphyses of the long bones. Approximately 20% of patients with this disease die before reaching adulthood. [2, 3]
Cryopyrin-Associated Periodic Syndromes (CAPS):	A group of rare, autosomal dominantly inherited auto-inflammatory conditions comprising of Familial-Cold Auto-inflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS), Neonatal-Onset Multisystem Inflammatory Disease (NOMID) or also known as Chronic Infantile Neurologic Cutaneous Articular Syndrome (CINCA), which are caused by the CIAS1 gene mutation and characterized by recurrent symptoms (urticaria-like skin lesions, fever chills, arthralgia, profuse sweating, sensorineural hearing/vision loss, and

	increased inflammation markers the blood). Approximately 300 people in the United States are affected by CAPS. [2, 3]
Familial Cold Autoinflammatory Syndrome:	The mildest form of CAPS, is characterized by cold-induced, daylong episodes of fever associated with rash, arthralgia, headaches and less frequently conjunctivitis, but without other signs of CNS inflammation. Symptoms usually begin during the first 6 months of life and are predominantly triggered by cold exposure. Duration of episodes usually is less than 24 hours. [2, 3]
Muckle-Wells Syndrome:	A subtype of CAPS, which is characterized by episodic attacks of inflammation associated with a generalized urticaria-like rash, fever, malise, arthralgia, and progressive hearing loss. Duration of symptoms usually lasts from 24-48 hours. [2, 3]

4 . Endnotes

A. CAPS refer to rare genetic syndromes generally caused by mutations in the NLRP-3 [Nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]). CAPS disorders are inherited in an autosomal dominant pattern with male and female offspring equally affected. Features common to all disorders include fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis. In most cases, inflammation in CAPS is associated with mutations in the NLRP-3 gene which encodes the protein cryopyrin, an important component of the inflammasome. Mutations in NLRP-3 result in an overactive inflammasome resulting in excessive release of activated IL-1β that drives inflammation. [1]

5 . References

1. Arcalyst Prescribing Information. Regeneron Pharmaceuticals. Zug, Switzerland. May 2021.
2. Aksentijevich I, Putnam CD, Remmers EF, et al. The clinical continuum of cryopyrinopathies: novel CIAS1 mutations in North American Patients and a new cryopyrin model. Arthritis Rheum. 2007; 56(4):1273-1285.
3. McDermott M, Aksentijevich I. The auto-inflammatory syndromes. Curr Opin Allergy Clin Immunol. 2002; 2:511-516.
4. Chiabrando JG, Bonaventura A, Vecchie A, et al. Management of acute and recurrent pericarditis. J Am Coll Cardiol. 2020;75(1):76–92.

5. Klein AL, Imazio M, Cremer P, et al. Phase 3 trial of interleukin-1 trap rilonacept in recurrent pericarditis. N Engl J Med 2021;384:31-41.

6 . Revision History

Date	Notes
8/3/2022	Annual review - no criteria changes

Benlysta (belimumab)

Prior Authorization Guideline

Guideline ID	GL-124032
Guideline Name	Benlysta (belimumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	7/12/2011
P&T Revision Date:	10/16/2019 ; 08/13/2020 ; 02/18/2021 ; 08/19/2021 ; 12/15/2021 ; 08/18/2022 ; 09/21/2022 ; 4/19/2023

1 . Indications

Drug Name: Benlysta (belimumab IV), Benlysta (belimumab SC)
Systemic Lupus Erythematosus (SLE) Indicated for the treatment of patients aged 5 years and older with active, autoantibody-positive, systemic lupus erythematosus (SLE) who are receiving standard therapy. Limitations of Use: The efficacy of Benlysta has not been evaluated in patients with severe active central nervous system lupus. Use of Benlysta is not recommended in these situations. **Lupus Nephritis** Indicated for the treatment of patients aged 5 years and older with active lupus nephritis who are receiving standard therapy. Limitations of Use: The efficacy of Benlysta has not been evaluated in patients with severe active central nervous system lupus. Use of Benlysta is not recommended in these situations.

2 . Criteria

Product Name: Benlysta IV or Benlysta SC	
Diagnosis	Systemic lupus erythematosus
Approval Length	6 months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active systemic lupus erythematosus (SLE)

AND

2 - Autoantibody positive (i.e., anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL) [2, 3]

AND

3 - One of the following:

- For Benlysta IV, patient is 5 years of age or older
- For Benlysta SC, patient is 18 years of age or older

AND

4 - Trial and failure, contraindication, or intolerance to two standard of care treatments for active SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]) [5]

AND

5 - Currently receiving at least one standard of care treatment for active SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]) [2, 3]

AND

6 - Prescribed by or in consultation with a rheumatologist

Product Name: Benlysta IV or Benlysta SC	
Diagnosis	Lupus nephritis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - One of the following:

- For Benlysta IV, patient is 5 years of age or older
- For Benlysta SC, patient is 18 years of age or older

AND

3 - Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide) [1, 4]

AND

4 - Prescribed by or in consultation with one of the following:

- Nephrologist
- Rheumatologist

Product Name: Benlysta IV or Benlysta SC	
Diagnosis	All indications listed above
Approval Length	6 months [2, A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decrease or stabilization of symptoms, improvement in functional impairment, decrease of corticosteroid dose, decrease in pain medications)

Product Name: Benlysta IV	
Diagnosis	Systemic lupus erythematosus
Approval Length	6 months [A]
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of active systemic lupus erythematosus (SLE)

AND

2 - Autoantibody positive (i.e., anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL) [2, 3]

AND

3 - Patient is 5 years of age or older

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to two standard of care treatments for active SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]) [5]

AND

5 - Currently receiving at least one standard of care treatment for active SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]) [2, 3]

AND

6 - Prescribed by or in consultation with a rheumatologist

Product Name: Benlysta IV	
Diagnosis	Lupus nephritis
Approval Length	6 month(s)

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Patient is 5 years of age or older

AND

3 - Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide) [1, 4]

AND

4 - Prescribed by or in consultation with one of the following:

- Nephrologist
- Rheumatologist

3 . Endnotes

A. SLE is a disease that fluctuates. The undulating course of typical lupus patients requires frequent reassessment. A 6-month authorization period is reasonable. [2]

4 . References

1. Benlysta Prescribing Information. GlaxoSmithKline LLC. Philadelphia, PA. July 2022.
2. Per clinical consult with rheumatologist, October 4, 2017.

3. American College of Rheumatology Ad Hoc Committee on Systemic Lupus Erythematosus Guidelines. Guidelines for referral and management of systemic lupus erythematosus. Arthritis Rheum. 1999 Sep;42(9):1785-96.
4. American College of Rheumatology Guidelines for Screening, Case Definition, Treatment and Management of Lupus Nephritis. Arthritis Care Res (Hoboken). 2012 Jun; 64(6): 797-808.
5. Fanouriakis A, Kostopoulou M, Alunno A, et al. Ann Rheum Dis 2019;78:736–745.

5 . Revision History

Date	Notes
3/31/2023	Update to age criteria

Botulinum Toxins

Prior Authorization Guideline

Guideline ID	GL-126003
Guideline Name	Botulinum Toxins
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Abnormal Involuntary Movements
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Both of the following:	

1.1 Submission of medical records (e.g., chart notes) documenting functional impairment from dystonia related to one of the following diagnoses:

- Torsion dystonia
- Spasmodic torticollis (cervical dystonia) in a member at least 16 years old
- Blepharospasm in a member at least 12 years old
- Congenital sternocleidomastoid torticollis

AND

1.2 Prescribed by or in consultation with a neurologist, ophthalmologist, or physiatrist

OR

2 - All of the following:

2.1 Limb spasticity associated with cerebral palsy

AND

2.2 Prescribed by or in consultation with a neurologist, or physiatrist

AND

2.3 Abnormal muscle tone is causing functional impairment or expected to result in joint contracture

OR

3 - All of the following:

3.1 Limb spasticity from one of the following diagnoses:

- Hereditary spastic paraplegia

- Spastic hemiplegia due to stroke
- Traumatic brain or spinal cord injury with resultant paraplegia, hemiplegia, or quadriplegia
- Multiple sclerosis
- Neuromyelitis optica
- Other demyelinating diseases of the central nervous system

AND

3.2 Prescribed by or in consultation with a neurologist or physiatrist

AND

3.3 Abnormal muscle tone is causing functional impairment or expected to result in joint contracture

AND

3.4 Trial and failure or have contraindications to one of the following conventional non-pharmacologic treatments:

- Physical therapy
- Splinting
- Bracing
- Biofeedback
- Provider attests conventional non-pharmacological treatment has been ineffective or cannot be maximized due to significant contracture

AND

3.5 Trial and failure, contraindication, or intolerance to TWO of the following:

- Baclofen
- Dantrolene
- Tizanidine
- Benzodiazepine

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Abnormal Involuntary Movements
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming treatment goals have been met as defined by one of the following:

- Decrease in severity or frequency of abnormal movements
- Decrease in pain
- Decrease in disability

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Chronic Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic migraine, defined as headaches on at least 15 days per month of which at least 8 days are migraine

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Migraine has been appropriately managed for medication overuse

AND

4 - Trial and failure, contraindication, or intolerance to one drug from all of the following classes:

- Beta blockers (e.g., propranolol, metoprolol, atenolol, etc.)
- Anticonvulsants (e.g., divalproex sodium, sodium valproate, topiramate, or carbamazepine)
- Tricyclic antidepressants (e.g., amitriptyline)

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Chronic Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive response to therapy defined as a reduction of at least 7 headache days per month compared to baseline headache frequency

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Urinary Incontinence/Overactive Bladder
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of idiopathic detrusor over-activity (overactive bladder) or neurogenic detrusor over-activity (neurogenic bladder)

AND

2 - Prescribed by or in consultation with a neurologist or urologist

AND

3 - Trial and failure, contraindication, or intolerance to at least two anticholinergic medications (e.g., oxybutynin, solifenacin, tolterodine)

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Urinary Incontinence/Overactive Bladder
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as defined by one of the following:

- Reduction of urinary frequency by 8 episodes per day compared to baseline frequency
- Decrease in urinary incontinence by 2 episodes per day compared to baseline frequency

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Strabismus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of strabismus due to other neurologic disorders (H50.89) causing functional impairment

AND

2 - Prescribed by or in consultation with a neurologist or ophthalmologist

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Strabismus
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a neurologist or ophthalmologist

Product Name: Botox, Dysport, Xeomin, Myobloc

Diagnosis	Achalasia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of achalasia

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Patient is symptomatic after a prior pneumatic dilation or surgical myotomy

AND

4 - ONE of the following:

4.1 Patient is high surgical risk for pneumatic dilation or surgical myotomy

OR

4.2 Botulinum toxin is needed to help guide therapy or confirm diagnosis

Product Name: Botox, Dysport, Xeomin, Myobloc	
Diagnosis	Achalasia
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive response to therapy as defined as reduction in symptoms of dysphagia or reflux	

2 . Revision History

Date	Notes
6/5/2023	New program

Brineura (cerliponase alfa)

Prior Authorization Guideline

Guideline ID	GL-127088
Guideline Name	Brineura (cerliponase alfa)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	
P&T Revision Date:	05/14/2020 ; 05/20/2021 ; 05/19/2022 ; 05/18/2023 ; 5/18/2023

1 . Indications

Drug Name: Brineura (cerliponase alfa)
Late Infantile Neuronal Ceroid Lipofuscinosis Type 2 Indicated to slow the loss of ambulation in symptomatic pediatric patients 3 years of age and older with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency.

2 . Criteria

Product Name: Brineura	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) (also known as tripeptidyl peptidase 1 (TPP1) deficiency)

AND

2 - Diagnosis is confirmed by tripeptidyl peptidase 1 (TPP1) enzyme detected by a dried blood spot test and CLN2 genotype analysis

AND

3 - Patient is 3 years of age or older

AND

4 - Patient does not have acute intraventricular access-related complications (e.g., leakage, device failure, or device-related infections)

AND

5 - Patient does not have ventriculoperitoneal shunts

AND

6 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of CLN2

AND

7 - Administered by, or under the direction of, a physician knowledgeable in intraventricular administration [A]

Product Name: Brineura	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not have acute intraventricular access-related complications (e.g., leakage, device failure, or device-related infections)

AND

2 - Patient does not have ventriculoperitoneal shunts

AND

3 - Patient has experienced a benefit from therapy (e.g., improvement in walking or crawling, or no evidence of disease progression)

3 . Endnotes

A. Brineura (cerliponase alfa) is for intraventricular use only and should be administered by, or under the direction of a physician knowledgeable in intraventricular administration. [2]

4 . References

1. Batten Disease Support and Research Association: Batten Disease Neuronal Ceroid Lipofuscinosis. Available at: http://bdsra.org/wp-content/uploads/2012/01/Batten-Disease-An-Easy-To-Understand-Guide.pdf. Accessed March 29, 2022.
2. Brineura Prescribing Information. BioMarin Pharmaceutical Inc. Novato, CA. July 2020.
3. Fietz M, AlSayed M, Burke D, et al. Diagnosis of neuronal ceroid lipofuscinosis type 2 (CLN2 disease): Expert recommendations for early detection and laboratory diagnosis. Molecular Genetics and Metabolism. 2016 Sep;119(1-2):160-7.
4. National Institutes of Health (NIH). Bethesda, MD. CLN2 Disease. Available at: https://ghr.nlm.nih.gov/condition/cln2-disease. Accessed March 29, 2022.

5 . Revision History

Date	Notes
6/26/2023	Update effective date

Cablivi (caplacizumab-yhdp)

Prior Authorization Guideline

Guideline ID	GL-101562
Guideline Name	Cablivi (caplacizumab-yhdp)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2022
P&T Approval Date:	4/17/2019
P&T Revision Date:	02/13/2020 ; 02/18/2021 ; 2/17/2022

1 . Indications

Drug Name: Cablivi (caplacizumab-yhdp)
Acquired Thrombotic Thrombocytopenic Purpura (aTTP) Indicated for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.

2 . Criteria

Product Name: Cablivi	
Diagnosis	Acquired Thrombotic Thrombocytopenic Purpura (aTTP)
Approval Length	3 Months [A]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)

AND

2 - First dose was/will be administered by a healthcare provider as a bolus intravenous injection

AND

3 - Used in combination with immunosuppressive therapy (e.g., rituximab, glucocorticoids) [3]

AND

4 - One of the following:

4.1 Used in combination with plasma exchange

OR

4.2 Both of the following:

- Patient has completed plasma exchange

- Less than 59 days have or will have elapsed beyond the last plasma exchange [B]

AND

5 - Prescribed by or in consultation with a hematologist or oncologist[2]

3 . Endnotes

A. Three month approval duration, based on package insert stating longest therapy in trial was 77 days.
B. Per package insert, after the plasma exchange period can use injection once daily for 30 days beyond the last plasma exchange and after the initial treatment course, if signs of persistent underlying disease are present treatment can be extended for a maximum of 28 days, totaling 58 days of therapy after last plasma exchange.

4 . References

1. Cablivi Prescribing Information. Cambridge, MA. Genzyme Corporation. October 2021
2. Understanding TTP. https://www.understandingttp.com/patient/ttp-treatment/#overview-of-treatment. Accessed January 28, 2021.
3. FDA News Release: FDA approves first therapy for the treatment of adult patients with a rare blood clotting disorder. U.S. Food and Drug Administration; February 6, 2019. Available at: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm630851.htm. Accessed January 28, 2021.

5 . Revision History

Date	Notes
1/6/2022	2022 Annual Review - No changes to criteria, updated background information

Cabotegravir Containing Agents - PA, NF

Prior Authorization Guideline

Guideline ID	GL-121685
Guideline Name	Cabotegravir Containing Agents - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	3/17/2021
P&T Revision Date:	04/21/2021 ; 11/18/2021 ; 03/16/2022 ; 05/19/2022 ; 09/21/2022 ; 12/14/2022 ; 3/15/2023

1 . Indications

Drug Name: Cabenuva (cabotegravir and rilpivirine) Injection
Treatment of HIV-1 Infection Indicated as a complete regimen for the treatment of HIV-1 infection in adults and adolescents 12 years of age and older and weighing at least 35kg to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine.
Drug Name: Vocabria (cabotegravir) Tablet
Treatment of HIV-1 Infection Indicated in combination with EDURANT (rilpivirine) for short-term treatment of HIV-1 infection in adults and adolescents 12 years of age and

older and weighing at least 35kg who are virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine. Vocabria may be used as: 1) Oral lead-in to assess the tolerability of cabotegravir prior to administration of Cabenuva extended-release injectable suspension for HIV-1 treatment. 2) Oral therapy for patients who will miss planned injection dosing with Cabenuva for HIV-1 treatment. **HIV-1 Pre-Exposure Prophylaxis** Indicated in at-risk adults and adolescents weighing at least 35 kg for short-term pre exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection. Vocabria may be used as: 1) Oral lead-in to assess the tolerability of cabotegravir prior to administration of Apretude extended-release injectable suspension for HIV-1 PrEP. 2) Oral therapy for patients who will miss planned injection dosing with Apretude for HIV-1 PrEP.
Drug Name: Apretude (cabotegravir) Injection
HIV-1 Pre-exposure prophylaxis (PrEP) Indicated in at-risk adults and adolescents weighing at least 35 kg for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection. Individuals must have a negative HIV-1 test prior to initiating Apretude (with or without an oral lead-in with oral cabotegravir) for HIV-1 PrEP.

2 . Criteria

Product Name: Vocabria*, Cabenuva*	
Diagnosis	Treatment of HIV-1 Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Diagnosis of HIV-1 infection

AND

1.2 Patient is 12 years of age or older

AND

1.3 Patient's weight is greater than or equal to 35 kg

AND

1.4 Patient is currently virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable, uninterrupted antiretroviral regimen for at least 6 months

AND

1.5 Patient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine

AND

1.6 Provider attests that patient would benefit from long-acting injectable therapy over standard oral regimens

AND

1.7 Prescribed by or in consultation with a clinician with HIV expertise

OR

2 - For continuation of prior therapy

Notes	*If patient meets criteria above, please approve both Vocabria an d Cabenuva at GPI list “CABOTEGRPA”.

Product Name: Vocabria*, Cabenuva*	
Diagnosis	Treatment of HIV-1 Infection
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - All of the following:

1.1 Diagnosis of HIV-1 infection

AND

1.2 Patient is 12 years of age or older

AND

1.3 Patient's weight is greater than or equal to 35 kg

AND

1.4 Patient is currently virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable, uninterrupted antiretroviral regimen for at least 6 months

AND

1.5 Patient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine

AND

1.6 Provider attests that patient would benefit from long-acting injectable therapy over standard oral regimens

AND

1.7 Prescribed by or in consultation with a clinician with HIV expertise

OR

2 - Paid claims or submission of medical records (e.g., chart notes) confirming continuation of prior therapy, defined as no more than a 70-day gap in therapy [A]

Notes	*If patient meets criteria above, please approve both Vocabria an d Cabenuva at GPI list “CABOTEGRPA”.

Product Name: Vocabria**, Apretude**	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection

AND

2 - Patient's weight is greater than or equal to 35 kg

AND

3 - Documentation of both of the following U.S. Food and Drug (FDA)-approved test prior to use of Vocabria or Apretude:

- Negative HIV-1 antigen/antibody test
- Negative HIV-1 RNA assay

AND

4 - One of the following:

4.1 Trial of, contraindication or intolerance to generic emtricitabine-tenofovir disoproxil fumarate 200/300mg

OR

4.2 Provider attests to both of the following:

- Patient would benefit from long-acting injectable therapy over standard oral regimens
- Patient would be adherent to testing and dosing schedule

Notes	**If patient meets criteria above, please approve both Vocabria a nd Apretude at GPI list “APRETUDEPA”

Product Name: Vocabria**, Apretude**	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that patient is adherent to the testing appointments and scheduled injections of Apretude

AND

2 - Documentation of both of the following U.S. Food and Drug (FDA)-approved test prior to each maintenance injection of Apretude for HIV PrEP:

- Negative HIV-1 antigen/antibody test
- Negative HIV-1 RNA assay

Notes	**If patient meets criteria above, please approve both Vocabria a nd Apretude at GPI list “APRETUDEPA”

Product Name: Vocabria**, Apretude**	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection

AND

2 - Patient's weight is greater than or equal to 35 kg

AND

3 - Submission of medical records (e.g., chart notes) confirming documentation of both the following U.S. Food and Drug (FDA)-approved test prior to use of Vocabria or Apretude:

- Negative HIV-1 antigen/antibody test
- Negative HIV-1 RNA assay

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming one of the following:

4.1 Trial of, contraindication or intolerance to generic emtricitabine-tenofovir disoproxil fumarate 200/300mg

OR

4.2 Both of the following:

- Patient would benefit from long-acting injectable therapy over standard oral regimens
- Patient would be adherent to testing and dosing schedule

Notes	**If patient meets criteria above, please approve both Vocabria a nd Apretude at GPI list “APRETUDEPA”

Product Name: Vocabria**, Apretude**	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Non Formulary
Approval Criteria **1** - Provider attests that patient is adherent to the testing appointments and scheduled injections of Apretude **AND** **2** - Submission of medical records (e.g., chart notes) confirming documentation of both of the following U.S. Food and Drug (FDA)-approved test prior to each maintenance injection of Apretude for HIV PrEP: • Negative HIV-1 antigen/antibody test • Negative HIV-1 RNA assay	
Notes	**If patient meets criteria above, please approve both Vocabria a nd Apretude at GPI list “APRETUDEPA”

3 . Endnotes

A. Continuation of therapy for Cabenuva and Vocabria in NF criteria will allow for a 70-day gap to account for the 2-month dosing schedule +/- 7 days. [1]

4 . References

1. Cabenuva Prescribing Information. ViiV Healthcare Company. Research Triangle Park, NC. April 2022.
2. Vocabria Prescribing Information. ViiV Healthcare Company. Research Triangle Park, NC. March 2022.
3. Apretude Prescribing information. ViiV Healthcare Company. Research Triangle Park, NC. December 2021.

5 . Revision History

Date	Notes

3/15/2023	Annual review - no changes.

Cinqair (reslizumab)

Prior Authorization Guideline

Guideline ID	GL-124534
Guideline Name	Cinqair (reslizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/19/2016
P&T Revision Date:	02/13/2020 ; 03/17/2021 ; 03/16/2022 ; 05/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Cinqair (reslizumab)
Severe Eosinophilic Asthma Indicated for the add-on maintenance treatment of patients with severe asthma aged 18 years and older with an eosinophilic phenotype. Limitation of Use: Cinqair is not indicated for treatment of other eosinophilic conditions; Cinqair is not indicated for the relief of acute bronchospasm or status asthmaticus.

2 . Criteria

Product Name: Cinqair	
Approval Length	6 Months [H]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe asthma [1]

AND

2 - Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter [1, B, D]

AND

3 - One of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months [A]

OR

3.2 Prior asthma-related hospitalization within the past 12 months [D]

AND

4 - Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

4.1 Both of the following: [C, E, F]

- High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day]
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Age greater than or equal to 18 years

AND

6 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/immunologist

Product Name: Cinqair	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)

AND

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/Immunologist

3 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older [6]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country - specific depending on local availability, regulatory labelling and clinical guidelines.

	For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

4 . Endnotes

A. In two duplicate 52-week Phase III studies, eligible patients were required to have experienced at least one asthma exacerbation that required a systemic corticosteroid for at least 3 days within the past 12 months. [2, 3]
B. The Institute for Clinical and Economic Review (ICER) defines eosinophilic inflammation as a blood eosinophil level greater than or equal to 150 cells per microliter at initiation of therapy. This is the lowest measured threshold for eosinophilic asthma in pivotal trials. [8]
C. The ERS/ATS guidelines define severe asthma as that which requires treatment with high-dose ICSs plus a second controller (or systemic corticosteroids [CSs]) to prevent progression to uncontrolled disease status or continuing uncontrolled disease status despite this therapy. [4]
D. Recommended per national P&T committee meeting, December 2015, regarding similar agent first-in-class IL-5 antagonist Nucala (mepolizumab) in the use of severe eosinophilic asthma.
E. In the pivotal study for Nucala (mepolizumab), another IL-5 antagonist indicated for severe eosinophilic asthma, patients met the inclusion criteria with a well-documented requirement for regular treatment with high dose ICS (i.e., greater than or equal to 880 mcg/day fluticasone propionate or equivalent daily), with or without maintenance oral corticosteroids, in the 12 months prior to Visit 1. [5]
F. The Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention update lists anti-interleukin- 5 treatment or anti-interleukin 5 receptor treatment as an add on option for patients with severe eosinophilic asthma that is uncontrolled on two or more controllers plus as-needed reliever medication (Step 4-5 treatment). [6]
G. Asthma treatment can often be reduced, once good asthma control has been achieved and maintained for three months and lung function has hit a plateau. However the approach to stepping down will depend on patient specific factors (e.g., current medications, risk factors). At this time evidence for optimal timing, sequence and magnitude of treatment reductions is limited. It is feasible and safe for most patients to reduce the ICS dose by 25-50% at three month intervals, but complete cessation of ICS is associated with a significant risk of exacerbations [6].
H. The GINA Global Strategy for Asthma Management and Prevention update recommends that patients with asthma should be reviewed regularly to monitor their symptom control, risk factors and occurrence of exacerbations, as well as to document the response to any treatment changes. Ideally, response to Type 2-targeted therapy should be re-evaluated every 3-6 months, including re-evaluation

of the need for ongoing biologic therapy for patients with good response to Type 2 targeted therapy. [6]

5 . References

1. Cinqair Prescribing Information. Teva Respiratory, LLC. Frazer, PA. June 2020.
2. Castro M, Zangrilli J, Wechsler ME, et al. Reslizumab for inadequately controlled asthma with elevated blood eosinophil counts: results from two multicentre, parallel, doubleblind, randomised, placebo-controlled, phase 3 trials. Lancet Respir Med. 2015;3(5):355-366.
3. Bjermer L, Lemiere C, Maspero J, et al. A randomized phase 3 study of the efficacy and safety of reslizumab in subjects with asthma with elevated eosinophils. Eur Respir J. 2014;44(Suppl 58):P299. Paper presented at: European Respiratory Society International Congress; September 6-10, 2014; Munich, Germany.
4. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. Eur Respir J. 2014; 43:343-373.
5. Pavord ID, Korn S, Howarth P, et al. Mepolizumab for severe eosinophilic asthma (DREAM): a multicentre, double-blind, placebo-controlled trial. Lancet. 2012; 380: 651-59.
6. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention (2022 update). 2022 www.ginasthma.org. Accessed April 2023
7. Per clinical consult with allergist specialist. May 4, 2016.
8. Institute for Clinical and Economic Review (ICER). Biologic therapies for treatment of asthma associated with type 2 inflammation: effectiveness, value, and value-based price benchmarks. https://icer.org/wp-content/uploads/2020/10/ICER_Asthma-Final-Report_Unredacted_08122020.pdf. Published December 20, 2018. Accessed April 15, 2022.

6 . Revision History

Date	Notes
4/24/2023	2023 UM Annual Review. No criteria changes. Background updates

Clinical Duplicates Prior Authorization (PA) Program

Prior Authorization Guideline

Guideline ID	GL-125162
Guideline Name	Clinical Duplicates Prior Authorization (PA) Program
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	10/20/2021
P&T Revision Date:	11/18/2021 ; 01/19/2022 ; 03/16/2022 ; 04/20/2022 ; 05/19/2022 ; 06/15/2022 ; 08/18/2022 ; 09/21/2022 ; 10/19/2022 ; 11/17/2022 ; 04/19/2023 ; 04/19/2023 ; 6/21/2023

1 . Criteria

Product Name: Acuvail, Adlarity, Ala-Scalp lotion, Alkindi Sprinkle, Brand Allzital, Alocril, Alrex, Analpram-HC lotion, Antara, Aspruzyo Sprinkle, Brand Baclofen, Baclofen suspension, Brand Fenofibrate micronized capsules, Apexicon E cream, Betoptic-S, Bryhali lotion, Brand Butalbital/apap 50-300 mg capsules, Capex shampoo, Clarinex-D, Conjupri, Consensi, Cordran cream/tape, Cortisone tablets, Brand Cyclobenzaprine/Gabapentin pak 10/300, Brand Decadron, Denavir cream, Dexabliss, Brand Durezol, Durlaza, Dutoprol, Dxevo, Ecoza, Brand Epaned, Ertaczo, Exelderm, Brand Sulconazole nitrate cream/solution, Flector patch, Fleqsuvy susp, Brand Diclofenac

epolamine patch, Fosamax+D, Gialax, Gilphex TR, Giltuss, Giltuss TR, Gimoti, Glycate, Brand Glycopyrrolate, Halog ointment/solution, Hemady, Hidex, Impeklo, Inderal XL, Innopran XL, Karbinal ER, Katerzia, Kristalose, Lexette foam, Brand Halobetasol foam, Brand Levamlodipine, Licart patch, Loreev XR, Brand Lotemax gel, Lotemax ointment, Luzu cream, Brand Luliconazole cream, Lyvispah, generic methocarbamol 1000 mg, Brand Mentax cream, Generic metformin 625 mg, Brand Millipred, Motofen, Naprelan, Brand Naproxen ER, Neotuss Plus, Nexiclon XR, Brand Clonidine ER (Nexiclon XR ABA), Brand Norgesic Forte, Brand Orphengesic Forte, Oravig, Ortikos, Otovel, Brand Ciprofloxacin/Fluocinolone PF soln, Oxistat, Ozobax, Pandel cream, Pliaglis cream, Brand Lidocaine/Tetracaine cream, Generic prednisolone, Brand Psorcon cream, Qbrelis, Qmiiz ODT, Rayos, Relafen DS, Reltone, Brand Ursodiol, Sancuso, Seglentis, Semprex-D, Sitavig, Sivextro tab, Sorilux, Brand Calcipotriene Aer, Sulfamylon cream, Synera, Taperdex, Brand Trianex oint, Ultravate lotion, Brand Valsartan oral solution, Vanatol LQ, Vanatol S, VTOL, Verdeso, Veregen, Vusion, Brand Miconazole Nitrate/Zinc Oxide/White Petrolatum oint, Xolegel, Yosprala, Brand Aspirin/Omeprazole tab, Zcort, Zilretta inj, Zuplenz	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 One of the following:

1.1.1 Both of the following:

1.1.1.1 Requested drug is FDA-approved for the condition being treated

AND

1.1.1.2 Additional requirements listed in the "Indications and Usage" sections of the prescribing information (or package insert) have been met (e.g., first line therapies have been tried and failed, any testing requirements have been met, etc.)

OR

1.1.2 If requested for an off-label indication, the off-label guideline approval criteria have been met

AND

1.2 One of the following:

1.2.1 Patient has failed or has contraindications or intolerance to at least three generic formulary drugs. If only one or only two generic drugs are available, the patient must have failed or had contraindications or intolerance to all available generic formulary drugs. The clinician's judgment should be used to determine appropriate generic formulary drugs for the indication provided.*

OR

1.2.2 Both of the following:

1.2.2.1 Only over-the-counter (OTC) equivalents are available

AND

1.2.2.2 Patient has tried and failed or has contraindications or intolerance to three OTC equivalents. If only one or only two equivalents are available, the patient must have failed or had contraindications or intolerance to all available OTC equivalents [document drug(s), dose, duration of trial] The clinician's judgment should be used to determine equivalent formulary drugs for the indication provided.*

OR

1.2.3 No formulary or OTC drug is appropriate to treat the patient's condition

Notes	*Please consult client-specific resources to determine appropriate generic formulary drugs.

Product Name: Abilify Mycite, Spritam

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 One of the following:

1.1.1 Both of the following:

1.1.1.1 Requested drug is FDA-approved for the condition being treated

AND

1.1.1.2 Additional requirements listed in the "Indications and Usage" sections of the prescribing information (or package insert) have been met (e.g., first line therapies have been tried and failed, any testing requirements have been met, etc.)

OR

1.1.2 If requested for an off-label indication, the off-label guideline approval criteria have been met

AND

1.2 One of the following:

1.2.1 Patient has failed or has contraindications or intolerance to at least three generic formulary drugs. If only one or only two generic drugs are available, the patient must have failed or had contraindications or intolerance to all available generic formulary drugs. The clinician's judgment should be used to determine appropriate generic formulary drugs for the indication provided.*

OR

1.2.2 Both of the following:

1.2.2.1 Only over-the-counter (OTC) equivalents are available

AND

1.2.2.2 Patient has tried and failed or has contraindications or intolerance to three OTC equivalents. If only one or only two equivalents are available, the patient must have failed or had contraindications or intolerance to all available OTC equivalents [document drug(s), dose, duration of trial] The clinician's judgment should be used to determine equivalent formulary drugs for the indication provided.*

OR

1.2.3 No formulary or OTC drug is appropriate to treat the patient's condition

OR

1.2.4 For continuation of prior therapy

Notes	*Please consult client-specific resources to determine appropriate generic formulary drugs.

2 . Revision History

Date	Notes
5/1/2023	Added Baclofen suspension to guideline

Colony-Stimulating Factors (CSFs) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-126095
Guideline Name	Colony-Stimulating Factors (CSFs) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	8/1/2006
P&T Revision Date:	01/15/2020 ; 04/15/2020 ; 08/13/2020 ; 02/18/2021 ; 04/21/2021 ; 12/15/2021 ; 04/20/2022 ; 11/17/2022 ; 02/16/2023 ; 03/15/2023 ; 04/19/2023 ; 6/21/2023

1 . Indications

Drug Name: Fulphila (pegfilgrastim-jmdb, G-CSF), Fylnetra (pegfilgrastim-pbbk), Nyvepria (pegfilgrastim-apgf, G-CSF), Stimufend (pegfilgrastim-fpgk), Ziextenzo (pegfilgrastim-bmez, G-CSF)
Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. Limitations of Use: Pegfilgrastim is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. **Off Label Uses: Hematopoietic Subsyndrome of Acute Radiation Syndrome** To

increase survival in patients acutely exposed to myelosuppressive doses of radiation. [1, 33, 35, M]

Treatment of High-Risk Febrile Neutropenia (FN) For the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34, 35]

Drug Name: Granix (tbo-filgrastim, G-CSF)

Febrile Neutropenia (FN), Prophylaxis Indicated to reduce the duration of severe neutropenia in adult and pediatric patients 1 month and older with nonmyeloid malignancies receiving myelosuppressive anticancer drugs associated with a clinically significant incidence of febrile neutropenia.

Off Label Uses: Treatment of High-Risk Febrile Neutropenia (FN) Has been prescribed for the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34]

Hematopoietic Subsyndrome of Acute Radiation Syndrome To increase survival in patients acutely exposed to myelosuppressive doses of radiation. [16]

Drug Name: Leukine (sargramostim, GM-CSF)

Acute Myeloid Leukemia (AML) Following Induction Chemotherapy Indicated to shorten time to neutrophil recovery and to reduce the incidence of severe, life-threatening, or fatal infections following induction chemotherapy in adult patients 55 years and older with acute myeloid leukemia (AML).

Autologous Peripheral Blood Progenitor Cell Mobilization and Collection Indicated in adult patients with cancer undergoing autologous hematopoietic stem cell transplantation for the mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis.

Autologous Peripheral Blood Progenitor Cell and Bone Marrow Transplantation Indicated for the acceleration of myeloid reconstitution following autologous peripheral blood progenitor cell (PBPC) or bone marrow transplantation in adult and pediatric patients 2 years of age and older with non-Hodgkin's lymphoma (NHL), acute lymphoblastic leukemia (ALL) and Hodgkin's lymphoma (HL).

Allogeneic Bone Marrow Transplantation (BMT) Indicated for the acceleration of myeloid reconstitution in adult and pediatric patients 2 years of age and older undergoing allogeneic bone marrow transplantation from HLA-matched related donors.

Allogeneic or Autologous Bone Marrow Transplantation: Treatment of Delayed

Neutrophil Recovery or Graft Failure Indicated for the treatment of adult and pediatric patients 2 years and older who have undergone allogeneic or autologous bone marrow transplantation in whom neutrophil recovery is delayed or failed.

Hematopoietic Syndrome of Acute Radiation Syndrome (H-ARS) Indicated to increase survival in adult and pediatric patients from birth to 17 years of age acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]).

Off Label Uses: Febrile Neutropenia (FN), Prophylaxis Has been used in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever [11]

Human Immunodeficiency Virus (HIV)-Related Neutropenia Has been prescribed for HIV-related neutropenia [37]

Treatment of High-Risk Febrile Neutropenia (FN) Has been prescribed for the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34]

Drug Name: Neulasta, Neulasta Onpro (pegfilgrastim, G-CSF)

Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. Neulasta is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

Hematopoietic Subsyndrome of Acute Radiation Syndrome Indicated to increase survival in patients acutely exposed to myelosuppressive doses of radiation.

Off Label Uses: Treatment of High-Risk Febrile Neutropenia (FN) Has been prescribed for the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34]

Drug Name: Neupogen (filgrastim, G-CSF)

Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by FN, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.

Patients with Acute Myeloid Leukemia (AML) Receiving Induction or Consolidation

Chemotherapy Indicated for reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of adults with AML.

Patients with Cancer Undergoing Bone Marrow Transplantation (BMT) Indicated to reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation.

Patients Undergoing Autologous Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy Indicated for the mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

Patients with Severe Chronic Neutropenia (SCN) Indicated for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Hematopoietic Syndrome of Acute Radiation Syndrome Indicated to increase survival in patients acutely exposed to myelosuppressive doses of radiation.

Off Label Uses: Human Immunodeficiency Virus (HIV)-Related Neutropenia Has been prescribed for HIV-related neutropenia. [11-15, 37]

Hepatitis-C Interferon Induced Neutropenia Neupogen has been prescribed for interferon-induced neutropenia in Hepatitis C virus infected patients [4-10, 23, 24]

Treatment of High-Risk Febrile Neutropenia (FN) Has been prescribed for the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34]

Drug Name: Nivestym (filgrastim-aafi, G-CSF), Zarxio (filgrastim-sndz, G-CSF)

Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by FN, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.

Patients with Acute Myeloid Leukemia (AML) Receiving Induction or Consolidation Chemotherapy Indicated for reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with AML.

Patients with Cancer Undergoing Bone Marrow Transplantation Indicated to reduce the

duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation.

Patients Undergoing Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy Indicated for the mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

Patients with Severe Chronic Neutropenia (SCN) Indicated for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Off Label Uses: Hematopoietic Subsyndrome of Acute Radiation Syndrome Has been used to increase survival in patients acutely exposed to myelosuppressive doses of radiation. [1, 33, 35, M]

Hepatitis-C Interferon Induced Neutropenia Has been prescribed for interferon-induced neutropenia in Hepatitis C virus infected patients [4-10, 23, 24, M]

Human Immunodeficiency Virus (HIV)-Related Neutropenia Has been prescribed for HIV-related neutropenia. [11, 37]

Treatment of High-Risk Febrile Neutropenia (FN) Has been prescribed for the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34]

Drug Name: Releuko (filgrastim-ayow)

Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by FN, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever.

Patients with Acute Myeloid Leukemia (AML) Receiving Induction or Consolidation Chemotherapy Indicated for reducing the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with AML.

Patients with Cancer Undergoing Bone Marrow Transplantation Indicated to reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation.

Patients with Severe Chronic Neutropenia (SCN) Indicated for chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia.

Off Label Uses: Patients Undergoing Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy Indicated for the mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

Hematopoietic Subsyndrome of Acute Radiation Syndrome Has been used to increase survival in patients acutely exposed to myelosuppressive doses of radiation. [1, 33, 35, M]

Hepatitis-C Interferon Induced Neutropenia Has been prescribed for interferon-induced neutropenia in Hepatitis C virus infected patients [4-10, 23, 24, M]

Human Immunodeficiency Virus (HIV)-Related Neutropenia Has been prescribed for HIV-related neutropenia. [11, 37]

Treatment of High-Risk Febrile Neutropenia (FN) Has been prescribed for the treatment of FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34]

Drug Name: Rolvedon (eflapegrastim-xnst)

Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. Rolvedon is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

Drug Name: Udenyca (pegfilgrastim-cbqv, G-CSF)

Febrile Neutropenia (FN), Prophylaxis Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. Limitations of Use: Udenyca is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

Hematopoietic Subsyndrome of Acute Radiation Syndrome To increase survival in patients acutely exposed to myelosuppressive doses of radiation.

Off Label Uses: Treatment of High-Risk Febrile Neutropenia (FN) For the treatment of

FN in patients who have received or are receiving myelosuppressive anticancer drugs associated with neutropenia who are at high risk for infection-associated complications. [16, 17, 34, 35]

2 . Criteria

Product Name: Leukine, Neupogen, Nivestym, Releuko, or Zarxio	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient has non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - Patient is 2 years of age or older (applies to Leukine only)

AND

4 - Trial and failure or intolerance to both of the following (applies to Neupogen and Releuko only):

- Nivestym
- Zarxio

Product Name: Neupogen	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 months or duration of therapy
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following:

1.1 Patient has non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following:

- Nivestym
- Zarxio

Product Name: Leukine	
Diagnosis	Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy
Approval Length	3 months or duration of therapy [C]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML) [A]

AND

2 - Patient has completed induction or consolidation chemotherapy [27]

AND

3 - Patient is 55 years of age or older [3, B]

AND

4 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Neupogen, Nivestym, Releuko, or Zarxio	
Diagnosis	Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy
Approval Length	3 months or duration of therapy [C]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML) [A]

AND

2 - Patient has completed induction or consolidation chemotherapy [27]

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

AND

4 - Trial and failure or intolerance to both of the following (applies to Neupogen and Releuko only):

- Nivestym
- Zarxio

Product Name: Neupogen	
Diagnosis	Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy
Approval Length	3 months or duration of therapy [C]
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML) [A]

AND

2 - Patient has completed induction or consolidation chemotherapy [27]

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following:

- Nivestym
- Zarxio

Product Name: Fulphila, Fylnetra, Granix, Leukine (Off-Label), Neulasta/Neulasta Onpro, Releuko, Neupogen, Nivestym, Nyvepria, Stimufend, Udenyca, Zarxio, or Ziextenzo	
Diagnosis	Febrile Neutropenia Prophylaxis
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient will be receiving prophylaxis for febrile neutropenia (FN) due to one of the following:

1.1 Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (see Table 1 in Background section) [16-19, 34, D, E]

OR

1.2 Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown [E]

OR

1.3 One of the following:

1.3.1 Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN (see Table 2 in Background section) [16, 17, 34, I]

OR

1.3.2 Both of the following:

1.3.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN (see Table 3 in Background section) [16, J]

AND

1.3.2.2 Patient has one or more risk factors associated with chemotherapy induced infection, FN, or neutropenia [16, 17, 34, K]

OR

1.4 Both of the following:

1.4.1 Patient is receiving myelosuppressive anticancer drugs associated with neutropenia (see Table 4 in Background section) [L]

AND

1.4.2 Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis) [16, 17, 34]

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - One of the following:

3.1 Trial and failure or intolerance to both of the following (applies to Neupogen, Releuko, and Granix only):

- Nivestym
- Zarxio

OR

3.2 Trial and failure or intolerance to both of the following (applies to Fulphila, Fylnetra, Nyvepria, Stimufend, and Udenyca only):

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Fulphila, Fylnetra, Granix, Neupogen, Nyvepria, Udenyca	
Diagnosis	Febrile Neutropenia Prophylaxis
Approval Length	3 months or duration of therapy
Guideline Type	Non Formulary

Approval Criteria

1 - Patient will be receiving prophylaxis for febrile neutropenia (FN) due to one of the following:

1.1 Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (see Table 1 in Background section) [16-19, 34, D, E]

OR

1.2 Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown [E]

OR

1.3 One of the following:

1.3.1 Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN (see Table 2 in Background section) [16, 17, 34, I]

OR

1.3.2 Both of the following:

1.3.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN (see Table 3 in Background section) [16, J]

AND

1.3.2.2 Patient has one or more risk factors associated with chemotherapy induced infection, FN, or neutropenia [16, 17, 34, K]

OR

1.4 Both of the following:

1.4.1 Patient is receiving myelosuppressive anticancer drugs associated with neutropenia (see Table 4 in Background section) [L]

AND

1.4.2 Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis) [16, 17, 34]

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - One of the following:

3.1 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following (applies to Neupogen and Granix only):

- Nivestym
- Zarxio

OR

3.2 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following (applies to Fulphila, Fylnetra, Nyvepria, and Udenyca only):

- Neulasta/Neulasta Onpro

- Ziextenzo

Product Name: Rolvedon	
Diagnosis	Febrile Neutropenia Prophylaxis
Approval Length	3 months or duration of therapy
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient will be receiving prophylaxis for febrile neutropenia (FN) due to one of the following:

1.1 Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (see Table 1 in Background section) [16-19, 34, D, E]

OR

1.2 Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown [E]

OR

1.3 One of the following:

1.3.1 Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN (see Table 2 in Background section) [16, 17, 34, I]

OR

1.3.2 Both of the following:

1.3.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN (see Table 3 in Background section) [16, J]

AND

1.3.2.2 Patient has one or more risk factors associated with chemotherapy induced infection, FN, or neutropenia [16, 17, 34, K]

OR

1.4 Both of the following:

1.4.1 Patient is receiving myelosuppressive anticancer drugs associated with neutropenia (see Table 4 in Background section) [L]

AND

1.4.2 Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis) [16, 17, 34]

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - Trial and failure or intolerance to ONE of the following:

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Rolvedon

Diagnosis	Febrile Neutropenia Prophylaxis
Approval Length	3 months or duration of therapy
Guideline Type	Non Formulary

Approval Criteria

1 - Patient will be receiving prophylaxis for febrile neutropenia (FN) due to one of the following:

1.1 Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer (see Table 1 in Background section) [16-19, 34, D, E]

OR

1.2 Patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown [E]

OR

1.3 One of the following:

1.3.1 Patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN (see Table 2 in Background section) [16, 17, 34, I]

OR

1.3.2 Both of the following:

1.3.2.1 Patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN (see Table 3 in Background section) [16, J]

AND

1.3.2.2 Patient has one or more risk factors associated with chemotherapy induced infection, FN, or neutropenia [16, 17, 34, K]

OR

1.4 Both of the following:

1.4.1 Patient is receiving myelosuppressive anticancer drugs associated with neutropenia (see Table 4 in Background section) [L]

AND

1.4.2 Patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis) [16, 17, 34]

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to ONE of the following:

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Fulphila, Fylnetra, Granix, Leukine, Neulasta/Neulasta Onpro, Neupogen, Nivestym, Nyvepria, Releuko, Stimufend, Udenyca, Zarxio, or Ziextenzo	
Diagnosis	Treatment of High-Risk Febrile Neutropenia (Off-label) [34]
Approval Length	3 Months of duration of therapy
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia (see Table 4 in Background section) [34, l]

AND

2 - Diagnosis of febrile neutropenia (FN)

AND

3 - Patient is at high risk for infection-associated complications [16, 17, 34]

AND

4 - Prescribed by or in consultation with a hematologist/oncologist

AND

5 - One of the following:

5.1 Trial and failure or intolerance to both of the following (applies to Neupogen, Releuko, and Granix only):

- Nivestym
- Zarxio

OR

5.2 Trial and failure or intolerance to both of the following (applies to Fulphila, Fylnetra, Nyvepria, Stimufend, and Udenyca only):

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Fulphila, Fylnetra, Granix, Neupogen, Nyvepria, Udenyca	
Diagnosis	Treatment of High-Risk Febrile Neutropenia (Off-label) [34]
Approval Length	3 Months of duration of therapy
Guideline Type	Non Formulary

Approval Criteria

1 - Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia (see Table 4 in Background section) [34, l]

AND

2 - Diagnosis of febrile neutropenia (FN)

AND

3 - Patient is at high risk for infection-associated complications [16, 17, 34]

AND

4 - Prescribed by or in consultation with a hematologist/oncologist

AND

5 - One of the following:

5.1 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following (applies to Neupogen and Granix only):

- Nivestym
- Zarxio

OR

5.2 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following (applies to Fulphila, Fylnetra, Nyvepria, and Udenyca only):

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Neupogen, Nivestym, Releuko, or Zarxio	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For patients with severe chronic neutropenia (SCN) (i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count [ANC] less than or equal to 500 cells/mm^3) [16]

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - Trial and failure or intolerance to both of the following (applies to Neupogen and Releuko only):

- Nivestym
- Zarxio

Product Name: Neupogen	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - For patients with severe chronic neutropenia (SCN) (i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count [ANC] less than or equal to 500 cells/mm^3) [16]

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following:

- Nivestym

- Zarxio

Product Name: Fulphila (Off-Label), Fylnetra (Off-label), Granix (Off-Label), Leukine, Neulasta/Neulasta Onpro, Neupogen, Nivestym (Off-Label), Nyvepria (Off-Label), Releuko (Off-Label), Stimufend (Off-label), Udenyca, Zarxio (Off-Label), or Ziextenzo (Off-Label)	
Diagnosis	Acute Radiation Syndrome (ARS)
Approval Length	1 Months [N]
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient was/will be acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - One of the following:

3.1 Trial and failure or intolerance to both of the following (applies to Neupogen and Releuko only):

- Nivestym

- Zarxio

OR

3.2 Trial and failure or intolerance to both of the following (applies to Fulphila, Fylnetra, Nyvepria, and Stimufend, Udenyca only):

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Fulphila (Off-Label), Fylnetra (Off-Label), Granix (Off-Label), Neupogen, Nyvepria (Off-Label), Udenyca	
Diagnosis	Acute Radiation Syndrome (ARS)
Approval Length	1 Months [N]
Guideline Type	Non Formulary

Approval Criteria

1 - Patient was/will be acutely exposed to myelosuppressive doses of radiation

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

AND

3 - One of the following:

3.1 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following (applies to Neupogen only):

- Nivestym

- Zarxio

OR

3.2 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following (applies to Fulphila, Nyvepria, and Udenyca only):

- Neulasta/Neulasta Onpro
- Ziextenzo

Product Name: Leukine, Neupogen, Nivestym, Releuko, or Zarxio	
Diagnosis	Human Immunodeficiency Virus (HIV)-Related Neutropenia (Off-Label)
Approval Length	6 months [11, 15, H]
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is infected with HIV virus [11- 13]

AND

2 - ANC less than or equal to 1,000 (cells/mm3) [12, 13]

AND

3 - Prescribed by or in consultation with one of the following:

- Hematologist/oncologist
- Infectious disease specialist

AND

4 - Trial and failure or intolerance to both of the following (applies to Neupogen and Releuko only):

- Nivestym
- Zarxio

Product Name: Neupogen	
Diagnosis	Human Immunodeficiency Virus (HIV)-Related Neutropenia (Off-Label)
Approval Length	6 months [11, 15, H]
Guideline Type	Non Formulary

Approval Criteria

1 - Patient is infected with HIV virus [11- 13]

AND

2 - ANC less than or equal to 1,000 (cells/mm3) [12, 13]

AND

3 - Prescribed by or in consultation with one of the following:

- Hematologist/oncologist
- Infectious disease specialist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following:

- Nivestym
- Zarxio

Product Name: Neupogen, Nivestym, Releuko, Zarxio	
Diagnosis	Hepatitis-C Treatment Related Neutropenia (Off-Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Patient is infected with Hepatitis C virus

AND

1.1.2 Patient is undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)

AND

1.1.3 Patient has neutropenia (absolute neutrophil count [ANC] less than or equal to 500 cells/mm3) after dose reduction of Peg-Intron or Pegasys [F]

OR

1.2 Both of the following:

1.2.1 Patient is experiencing interferon-induced neutropenia (ANC less than or equal to 500 cells/mm3) due to treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)

AND

1.2.2 One of the following: [G]

1.2.2.1 Patient with Human Immunodeficiency Virus (HIV) co-infection

OR

1.2.2.2 Status post liver transplant

OR

1.2.2.3 Patient with established cirrhosis

AND

2 - Prescribed by or in consultation with one of the following:

- Hematologist/oncologist
- Infectious disease specialist
- Hepatologist
- Gastroenterologist

AND

3 - Trial and failure or intolerance to both of the following (applies to Neupogen and Releuko only):

- Nivestym
- Zarxio

Product Name: Neupogen	
Diagnosis	Hepatitis-C Treatment Related Neutropenia (Off-Label)
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Patient is infected with Hepatitis C virus

AND

1.1.2 Patient is undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)

AND

1.1.3 Patient has neutropenia (absolute neutrophil count [ANC] less than or equal to 500 cells/mm3) after dose reduction of Peg-Intron or Pegasys [F]

OR

1.2 Both of the following:

1.2.1 Patient is experiencing interferon-induced neutropenia (ANC less than or equal to 500 cells/mm3) due to treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)

AND

1.2.2 One of the following: [G]

1.2.2.1 Patient with Human Immunodeficiency Virus (HIV) co-infection

OR

1.2.2.2 Status post liver transplant

OR

1.2.2.3 Patient with established cirrhosis

AND

2 - Prescribed by or in consultation with one of the following:

- Hematologist/oncologist
- Infectious disease specialist
- Hepatologist
- Gastroenterologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to both of the following:

- Nivestym
- Zarxio

3 . Background

Benefit/Coverage/Program Information

Table 1. Intergroup C9741 Protocol [19]

Regimen	Drugs	G-CSF
Sequential	Doxorubicin q2 weeks x4 cycles, then paclitaxel q2 weeks x4 cycles, then cyclophosphamide q2 weeks x 4cycles	Days 3 to 10 of each cycle
Concurrent	Doxorubicin + cyclophosphamide q2 weeks x4 cycles, then paclitaxel q2 weeks x4 cycles	Days 3 to 10 of each cycle

Table 2. Examples of chemotherapy regimens with a high risk of FN (> 20%) [16]

Cancer	Regimen
Bladder Cancer	• Dose-dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
Bone Cancer	• VAI (vincristine, doxorubicin or dactinomycin, ifosfamide) • VDC-IE (vincristine, doxorubicin or dactinomycin, and cyclophosphamide alternating with ifosfamide and etoposide) • Cisplatin/doxorubicin • VDC (cyclophosphamide, vincristine, doxorubicin or dactinomycin) • VIDE (vincristine, ifosfamide, doxorubicin or dactinomycin, etoposide)
Breast Cancer[18]	• Dose-dense AC followed by dose-dense paclitaxel (doxorubicin, cyclophosphamide, paclitaxel) • TAX (docetaxel, doxorubicin, cyclophosphamide) • TC (docetaxel, cyclophosphamide) • TCH (docetaxel, carboplatin, trastuzumab)
Colorectal Cancer	• FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, irinotecan)
Head and Neck Squamous Cell Carcinoma	• TPF (docetaxel, cisplatin, 5-fluorouracil)
Hodgkin Lymphoma	• Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine) • Escalated BEACOPP (bleomycin, etoposide, doxorubivin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	• Doxorubicin/gemcitabine
Non-Hodgkin's Lymphomas	• Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) • ICE (ifosfamide, carboplatin, etoposide) • Dose-dense CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone) • MINE (mesna, ifosfamide, mitoxantrone, etoposide) • DHAP (dexamethasone, cisplatin, cytarabine) • ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine) • HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone)

Melanoma	• Dacarbazine-based combination with IL-2, interferon alfa (dacarbazine, cisplatin, vinblastine, IL-2, interferon alfa)
Multiple Myeloma	• DT-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophosphamide/etoposide) +/- bortezomib (VTD-PACE)
Ovarian Cancer	• Topotecan • Docetaxel
Pancreatic Cancer	• FOLFIRINOX (fluorouracil, leucovorin, irinotecan, oxaliplatin)
Soft Tissue Sarcoma	• MAID (mesna, doxorubicin, ifosfamide, dacarbazine) • Doxorubicin • Ifosfamide/doxorubicin
Small Cell Lung Cancer	• Topotecan
Testicular Cancer	• VIP (etoposide, ifosfamide, cisplatin) • VeIP (vinblastine, ifosfamide, cisplatin) • TIP (paclitaxel, ifosfamide, cisplatin)

Table 3. Examples of chemotherapy regimens with an intermediate risk of FN (10-20%) [16]

Cancer	**Regimen**
Occult Primary-Adenocarcinoma	• Gemcitabine/docetaxel
Breast Cancer	• Docetaxel • AC (doxorubicin, cyclophosphamide) + sequential docetaxel (adjuvant) (taxane portion only) • Paclitaxel every 21 days•
Cervical Cancer	• Cisplatin/topotecan • Paclitaxel/cisplatin • Topotecan • Irinotecan
Colorectal Cancer	• FOLFOX (fluorouracil, leucovorin, oxaliplatin)

Non-Hodgkin's Lymphomas (NHL)[26]	• GDP (gemcitabine, dexamethasone, cisplatin/carboplatin) • CHOP (cyclophosphamide, doxorubivin, vincristine, prednisone) including regimens with pegylated liposomal doxorubicin • CHP (cyclophosphamide, doxorubicin, prednisone) + brentuximab vedotin • Bendamustine
Non-Small Cell Lung Cancer	• Cisplatin/paclitaxel • Cisplatin/vinorelbine • Cisplatin/docetaxel • Cisplatin/etoposide • Carboplatin/paclitaxel • Docetaxel
Ovarian Cancer	• Carboplatin/docetaxel
Prostate Cancer	• Cabazitaxel
Testicular Cancer	• Etoposide/cisplatin • BEP (bleomycin, etoposide, cisplatin)
Esophageal and Gastric Cancer	• Irinotecan/cisplatin • Epirubicin/cisplatin/5-flurouracil • Epirubicin/cisplatin/capecitabine
Small Cell Lung Cancer	• Etoposide/carboplatin
Uterine Cancer	• Docetaxel

Table 4. Examples of FDA-approved chemotherapeutic agents with dose-limiting myelosuppression

Generic Name	**Brand Name**
Busulfan	Busulfex®, Myleran®
Carboplatin	Paraplatin®
Carmustine (BCNU)	BiCNU®, Gliadel®
Chlorambucil	Leukeran®
Cladribine	Luestatin®
Cyclophosphamide	Cytoxan®
Cytarabine	N/A
Dacarbazine (DTIC)	DTIC-Dome®
Dactinomycin	Actinomycin D®, Cosmegen®

Daunorubicin	Cerubidine®
Daunorubicin Liposomal	DaunoXome®
Doxorubicin	Adriamycin PFS®, Adriamycin RDF®, Adriamycin®
Doxorubicin Liposomal	Doxil®
Etoposide	Etopophos®, Toposar®, VePesid®
Fluorouracil (5-FU)	Adrucil®, Efudex®, Fluoroplex®
Floxuridine	FUDR®
Fludarabine	Fludara®
Hydroxyurea	Droxia®, Hydrea®
Ifosfamide/Mesna	Ifex®, Mesnex®
Lomustine (CCNU)	CeeNU®
Mechlorethamine (Nitrogen Mustard)	Mustargen®
Melphalan	Alkeran®
Mercaptopurine (6-MP)	Purinethol®
Methotrexate	Rheumatrex®, Trexall®
Mitomycin	N/A
Mitoxantrone	Novantrone®
Paclitaxel	Onxol™, Taxol®
Procarbazine	Matulane®
Teniposide	Vumon®
Thioguanine (6-TG)	Tabloid®
Thiotepa	Thiotepa®
Vinblastine	N/A
Vincristine	Vincasar® PFS
Vinorelbine	Navelbine®

4 . Endnotes

A. Currently there is no information available about the effect of longer acting pegylated G-CSF in patients with myeloid leukemias, therefore pegylated G-CSF should not be used in such patients outside of clinical trials. [17]
B. The safety and efficacy of Leukine in AML induction or consolidation in adults younger than 55 years old have not been established in clinical trials. [3]
C. Per hematology/oncology consultant and member of P&T, most cycles of induction or consolidation chemotherapy last ~ 1 month, but patients who complete therapy typically receive 1 induction and 2-3 consolidations, so re-approval would need to occur every month.

D. The safety and efficacy of pegylated G-CSF has not been fully established in the setting of dose-dense chemotherapy. [17]
E. Per hematology/oncology consultant and member of P&T, in general, dose-dense regimens require growth factor support for chemotherapy administration. [16] Also, Neulasta is commonly used to support dose dense regimens in current community practice. It would be reasonable to allow Neulasta use [in the INT C9741 Protocol] and to broaden its use for other forms of dose dense chemotherapy.
F. The product information for both PEG-Intron and Pegasys recommends dose reduction in patients with neutropenia with an ANC level < 750 cells/mm^3. [21, 22]
G. Per GI consultant and member of P&T, his medical group of practicing hepatologists recommends Neupogen for a special subpopulation of patients with HIV infection, status post liver transplant, or established cirrhosis who experience interferon-induced neutropenia (ANC less than or equal to 500 cells/mm^3) due to treatment with Peg-Intron or Pegasys.
H. Guidelines issued by the U.S. Public Health Service (USPHS) and the Infectious Diseases Society of America (IDSA) recommend for HIV-related neutropenia, the length of therapy with G-CSF and GM-CSF is 2-4 weeks. The clinical benefit of G-CSF therapy was evaluated in a randomized, double-blind, placebo controlled trial of 30 patients evaluating G-CSF 03 mg/mL subcutaneously 3 times a week or placebo for 12 weeks. The 6 month approval duration mirrors the 6 month approval duration for the erythropoietic agents, as G-CSF has been effective when used alone or in conjunction with epoetin alfa in adults with acquired immunodeficiency syndrome (AIDS) to ameliorate the hematologic toxicity (severe anemia and/or granulocytopenia) associated with zidovudine therapy. [11, 15, 37]
I. Note: This list is NOT inclusive of all chemotherapy regimens with a high risk of FN: See Table 2 in Background section
J. Note: This list is NOT inclusive of all chemotherapy regimens with an intermediate risk of FN: See Table 3 in Background section
K. Risk factors are based on provider information, not the list in the table below. Examples of risk factors may include (but are NOT limited to): Risk factors associated with chemotherapy-induced infection, FN, or neutropenia • Age > 65 years [16, 17] • History of extensive prior chemotherapy or radiation therapy including large radiation ports [16, 17] • Previous episodes of FN [16, 17] • Administration of combined chemoradiotherapy [17] • Pre-existing neutropenia or bone marrow involvement with tumor [16, 17] • Pre-existing conditions [16] • Neutropenia • Active infection/open wounds • Recent surgery • Poor performance status [16, 17] • Poor renal function [16] • Liver dysfunction [16] • Poor nutritional status [17] • More advanced cancer [17] • Hypotension and multiorgan dysfunction (Sepsis syndrome) [16, 17] • Pneumonia [16] • Invasive fungal infection [16, 17] • Other clinically documented infections [16] • Hospitalization at the time of fever [16] • Anticipated prolonged (> 10 days) and profound neutropenia (< 100/mm^3) [17] • Uncontrolled primary disease [17] • Other serious comorbidities [17]
L. Note: This list is NOT all inclusive: See Table 4 in Background section
M. The FDA defines biosimilar as a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference

product. [33] The American Society of Clinical Oncology states that pegfilgrastim, filgrastim, tbo-filgrastim, and filgrastim-sndz (and other biosimilars as they become available) can be used for the prevention of treatment-related febrile neutropenia. The choice of agent depends on convenience, cost, and clinical situation. [34] NCCN lists FDA-approved biosimilars as appropriate substitutes for filgrastim and pegfilgrastim. Limited data suggest that patients can alternate between the biosimilar and the originator biologic without any clinically meaningful differences regarding efficacy or safety. [16]

N. The efficacy of G-CSFs or GM-CSF for the acute radiation syndrome setting was studied in non-human primate models of radiation injury measuring 60-day survival. An expert panel convened by the World Health Organization recommends that patients receive G-CSF or GM-CSF treatment until their absolute neutrophil count reaches and maintains a level greater than 1.0 x 10^9 cells per liter in the absence of active infection. Patients with severe hematopoietic injury may recover, either spontaneously or after G-CSF treatment alone. In most cases, a duration of two to three weeks would be expected. [1-3, 36]

5 . References

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6 . Revision History

Date	Notes

5/26/2023	Addition of Udenyca auto-injector

Corticosteroid Intravitreal Implants

Prior Authorization Guideline

Guideline ID	GL-125937
Guideline Name	Corticosteroid Intravitreal Implants
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Iluvien, Ozurdex, Retisert, Yutiq	
Diagnosis	Chronic diabetic macular edema or Macular edema due to central retinal vein occlusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Trial and failure of any one anti-VEGF therapy

AND

2 - Prescribed by or in consultation with an ophthalmologist

AND

3 - Patient is 12 years of age or older

Product Name: Iluvien, Ozurdex, Retisert, Yutiq	
Diagnosis	Branch retinal vein occlusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Failure of photocoagulation or not suitable for photocoagulation because of extent of macular hemorrhage

AND

2 - Trial and failure of any one anti-VEGF therapy

AND

3 - Prescribed by or in consultation with an ophthalmologist

AND

4 - Patient is 12 years of age or older

Product Name: Iluvien, Ozurdex, Retisert, Yutiq	
Diagnosis	Chronic non-infectious uveitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by or in consultation with an ophthalmologist

AND

2 - Patient is 12 years of age or older

AND

3 - Trial and failure of ONE of the following:

- Both local and systemic corticosteroids, OR
- Immunosuppressive agents

Diagnosis	All indications listed above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with an ophthalmologist

AND

3 - Patient is 12 years of age or older

2 . Revision History

Date	Notes
5/26/2023	New program

Crysvita (burosumab-twza)

Prior Authorization Guideline

Guideline ID	GL-110082
Guideline Name	Crysvita (burosumab-twza)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	6/20/2018
P&T Revision Date:	12/18/2019 ; 08/13/2020 ; 08/19/2021 ; 8/18/2022

1 . Indications

Drug Name: Crysvita (burosumab-twza)
X-Linked Hypophosphatemia (XLH) Indicated for the treatment of X-linked hypophosphatemia (XLH) in adult and pediatric patients 6 months of age and older. **Tumor-Induced Osteomalacia** Indicated for the treatment of FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized in adult and pediatric patients 2 years of age and older.

2 . Criteria

Product Name: Crysvita	
Diagnosis	X-Linked Hypophosphatemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of X-linked hypophosphatemia

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Specialist experienced in the treatment of inborn errors of metabolism

AND

3 - One of the following:

3.1 Patient is 6 months to 17 years of age

OR

3.2 Both of the following:

3.2.1 Patient is 18 years of age or older

AND

3.2.2 Patient is a candidate for pharmacologic therapy by meeting one of the following: [2]

- Spontaneous insufficiency fractures
- Pending orthopedic procedures (e.g., joint replacement)
- Biochemical evidence of osteomalacia (i.e., elevated serum alkaline phosphatase)
- Disabling skeletal pain

AND

4 - Trial and failure, contraindication, or intolerance to conventional treatment with both of the following: [2, 3]

- Phosphate supplementation
- Vitamin D analog-based therapy (e.g, calcitriol, paricalcitol, doxercalciferol)

Product Name: Crysvita	
Diagnosis	X-Linked Hypophosphatemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., improvement in rickets, improvement in serum phosphorus or Radiographic Global Impression of Change [RGI-C] scores)

Product Name: Crysvita	
Diagnosis	Tumor-Induced Osteomalacia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of FGF23-related hypophosphatemia in Tumor-Induced Osteomalacia (TIO)

AND

2 - Tumor could not be curatively resected or localized

AND

3 - Patient is 2 years of age or older

AND

4 - Trial and failure, contraindication, or intolerance to conventional treatment with both of the following: [4, 5]

- Phosphate supplementation
- Vitamin D analog-based therapy (e.g., calcitriol, paricalcitol, doxercalciferol)

AND

5 - Prescribed by or in consultation with one of the following:

- Oncologist
- Endocrinologist

Product Name: Crysvita	
Diagnosis	Tumor-Induced Osteomalacia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., increase in serum phosphorus level, improvement in osteoid thickness, osteoid surface, osteoid volume, mineralization lag time, or improvement as indicated by bone biopsy)

3 . References

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4 . Revision History

Date	Notes
8/3/2022	Annual Review - No clinical criteria changes

Daxxify (botulinum toxin type a injection)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Daxxify (botulinum toxin type a injection)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Daxxify (botulinum toxin type a injection)
Cervical Dystonia indicated for the treatment of cervical dystonia in adult patients. **Cosmetic Uses [Non-approvable Use]** Indicated for the temporary improvement in the appearance of moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity in adult patients. **Please Note: The request for Daxxify (botulinum toxin type a injection) injections to treat the appearance of glabellar lines is not authorized given that this use is for cosmetic purposes only.

2 . Criteria

Product Name: Daxxify	
Diagnosis	Cervical Dystonia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cervical dystonia

AND

2 - Trial and failure, contraindication, or intolerance to one of the following:

- Xeomin
- Dysport
- Myobloc

Product Name: Daxxify	
Diagnosis	Cervical Dystonia
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - At least 3 months have or will have elapsed since the last treatment

Product Name: Daxxify

Diagnosis	Cosmetic Use
Guideline Type	Prior Authorization

Approval Criteria

1 - Requests for coverage of any Daxxify product for treating the appearance of facial lines are not authorized and will not be approved. These uses are considered cosmetic only.

3 . References

1. Daxxify Prescribing Information. Revance Therapeutics, Inc. Newark, CA. August 2023.

4 . Revision History

Date	Notes
10/11/2023	New Program for Daxxify

Dextenza

Prior Authorization Guideline

Guideline ID	GL-125936
Guideline Name	Dextenza
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Dextenza	
Diagnosis	Ocular Postoperative Inflammation and Pain
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ocular inflammation and pain following cataract surgery	

AND

2 - Prescribed by or in consultation with an ophthalmologist

AND

3 - Patient has tried and had an inadequate response, contraindication, or intolerance to at least one corticosteroid ophthalmic drops post operatively

AND

4 - Patient will not receive the requested drug in combination with other intravitreal implants or inserts

Product Name: Dextenza	
Diagnosis	Ocular Itching associated with Allergic Conjunctivitis
Guideline Type	Prior Authorization

Approval Criteria

1 - The Oregon Health Plan (OHP) has a list of medical conditions called the Prioritized List. OHP only pays to treat a condition if it is on this list between line 1 and 472. The submitted condition, Allergic Conjunctivitis, is on line 562. This means it is not covered by the OHP because it is “below the line” of coverage.

2 . Revision History

Date	Notes
5/26/2023	New program

Dojolvi (triheptanoin)

Prior Authorization Guideline

Guideline ID	GL-111073
Guideline Name	Dojolvi (triheptanoin)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2022
P&T Approval Date:	9/16/2020
P&T Revision Date:	09/15/2021 ; 9/21/2022

1 . Indications

Drug Name: Dojolvi (triheptanoin)
Long-Chain Fatty Acid Oxidation Disorders (LC-FAOD) Indicated as a source of calories and fatty acids for the treatment of pediatric and adult patients with molecularly confirmed long-chain fatty acid oxidation disorders (LC-FAOD).

2 . Criteria

Product Name: Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a long-chain fatty acid oxidation disorder (LC-FAOD) has been confirmed by at least two of the following:

- Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma
- Low enzyme activity in cultured fibroblasts
- One or more known pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB

AND

2 - Not used with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.)

Product Name: Dojolvi

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to continued need of therapy [A]

AND

2 - Not used with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.)

3 . Endnotes

A. This reauthorization criteria was recommended by the clinical consultant since LA-FAODs are progressive even with therapy. Patients will need lifelong therapy even though positive clinical response may not be seen.

4 . References

1. Dojolvi (triheptanoin) prescribing information. Ultragenyx Pharmaceutical Inc. Novato, CA. November 2021.
2. Per clinical consult with internal medicine/pediatric specialist, September 24, 2020.

5 . Revision History

Date	Notes
9/14/2022	Annual Review

Elaprase (idursulfase)

Prior Authorization Guideline

Guideline ID	GL-109068
Guideline Name	Elaprase (idursulfase)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2022
P&T Approval Date:	7/30/2004
P&T Revision Date:	07/08/2020 ; 07/21/2021 ; 7/20/2022

1 . Indications

Drug Name: Elaprase (idursulfase) [1]
Hunter Syndrome Is indicated for patients with Hunter syndrome (Mucopolysaccharidosis II, MPS II). Elaprase has been shown to improve walking capacity in patients 5 years and older. In patients 16 months to 5 years of age, no data are available to demonstrate improvement in disease-related symptoms or long term clinical outcome; however, treatment with Elaprase has reduced spleen volume similarly to that of adults and children 5 years of age and older. The safety and efficacy of Elaprase have not been established in pediatric patients less than 16 months of age.

2 . Criteria

Product Name: Elaprase (idursulfase)	
Approval Length	60 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Hunter syndrome (Mucopolysaccharidosis II, MPS II)	

3 . References

1. Elaprase Prescribing Information. Takeda Pharmaceuticals U.S.A., Inc. Lexington, MA. October 2021.

4 . Revision History

Date	Notes
7/6/2022	Annual Review, no criteria changes.

mpaveli (pegcetacoplan)

Prior Authorization Guideline

Guideline ID	GL-115065
Guideline Name	Empaveli (pegcetacoplan)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/15/2022
P&T Approval Date:	7/21/2021
P&T Revision Date:	10/20/2021

1 . Indications

Drug Name: Empaveli (pegcetacoplan)
Paroxysmal Nocturnal Hemoglobinuria Indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

2 . Criteria

Product Name: Empaveli	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

Product Name: Empaveli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy (e.g., improvement in hemoglobin level, hemoglobin stabilization, decrease in the number of red blood cell transfusions)	

3 . References

1. Empaveli Prescribing Information. Apellis Pharmaceuticals, Inc. Waltham, MA. May 2021.
2. Per clinical consultation with specialist, June 18, 2021.
3. Kulasekararaj AG., et al. “Ravulizumab (ALXN1210) vs Eculizumab in C5-Inhibitor–Experienced Adult Patients with PNH: the 302 Study.” Blood, vol. 133, no. 6, 2019, pp. 540–549.
4. Hillmen P, et al. “Pegcetacoplan versus Eculizumab in Paroxysmal Nocturnal Hemoglobinuria.” New England Journal of Medicine, vol. 384, no. 11, 2021, pp. 1028–1037.

4 . Revision History

Date	Notes
10/6/2022	GPI Reclassification

Elrexfio (elranatamab-bcmm)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Elrexfio (elranatamab-bcmm)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Elrexfio (elranatamab-bcmm)
Multiple Myeloma Indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody. This indication is approved under accelerated approval based on response rate and durability of response. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial(s).

2 . Criteria

Product Name: Elrexfio	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple myeloma

AND

2 - Disease is one of the following:

- Relapsed
- Refractory

AND

3 - Patient has received at least four prior lines of therapy which include all of the following:

- An immunomodulatory agent (e.g., lenalidomide, thalidomide)
- A proteasome inhibitor (e.g., bortezomib, carfilzomib)
- A CD38-directed monoclonal antibody (e.g., daratumumab)

Product Name: Elrexfio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

3 . References

1. Elrexfio Prescribing Information. Pfizer, Inc. New York, NY. August 2023.

4 . Revision History

Date	Notes
9/28/2023	New program

Enjaymo (sutimlimab-jome)

Prior Authorization Guideline

Guideline ID	GL-122716
Guideline Name	Enjaymo (sutimlimab-jome)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	4/20/2022
P&T Revision Date:	4/19/2023

1 . Indications

Drug Name: Enjaymo (sutimlimab-jome)
Cold agglutinin disease Indicated for the treatment of hemolysis in adults with cold agglutinin disease.

2 . Criteria

Product Name: Enjaymo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cold agglutinin disease (CAD) based on ALL of the following: [A, 2, 3]

- Presence of chronic hemolysis (e.g., bilirubin level above the normal reference range, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count)
- Positive polyspecific direct antiglobulin test (DAT)
- Monospecific DAT strongly positive for C3d
- Cold agglutinin titer greater than or equal to 64 measured at 4 degree celsius
- Direct antiglobulin test (DAT) result for Immunoglobulin G (IgG) of 1 plus or less

AND

2 - Patient does not have cold agglutinin syndrome secondary to other factors (e.g., overt hematologic malignancy, primary immunodeficiency, infection, rheumatologic disease, systemic lupus erythematosus or other autoimmune disorders) [A, 1, 3]

AND

3 - Baseline hemoglobin level less than or equal to 10.0 gram per deciliter (g/dL) [3]

AND

4 - One of the following: [B,1, 3]

- Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg
- Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater

AND

5 - Prescribed by or in consultation with a hematologist

Product Name: Enjaymo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy as evidenced by ALL of the following: [1, 3]

- The patient has not required any blood transfusions after the first 5 weeks of therapy with Enjaymo
- Hemoglobin level greater than or equal to 12 gram per deciliter (g/dL) or increased greater than or equal to 2 g/dL from baseline

AND

2 - One of the following: [B,1, 3]

- Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg
- Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater

AND

3 - Prescribed by or in consultation with a hematologist

3 . Background

Clinical Practice Guidelines

Weight-Based Dosing

The dosing is 6,500mg or 7,500mg Enjaymo (based on body weight) intravenously over approximately 60 minutes on Day 0, Day 7, and every 14 days thereafter	
Body Weight Range	Dose
39kg to less than 75kg	6,500 mg
75kg or greater	7,500 mg

4 . Endnotes

A. Patients with a confirmed diagnosis of CAD based on chronic hemolysis, polyspecific direct antiglobulin test (DAT), monospecific DAT specific for C3d, cold agglutinin titer ≥64 at 4°C, and IgG DAT ≤1+ and a recent blood transfusion in the 6 months prior to enrollment were administered 6.5 g or 7.5 g Enjaymo (based on body weight). Patients with cold agglutinin syndrome secondary to infection, rheumatologic disease, systemic lupus erythematosus, or overt hematologic malignancy were excluded. [1]
B. The recommended dosage of Enjaymo for patients with CAD is based on body weight. For patients weighing 39 kg to less than 75 kg, the recommended dose is 6,500 mg and for patients weighing 75 kg or more, the recommended dose is 7,500 mg [1]

5 . References

1. Enjaymo Prescribing Information. Bioverativ USA Inc. Waltham, MA. January 2023.
2. Diagnosing Cold Agglutinin Disease (CAD) available at https://www.understandingcad.com/diagnosing-cold-agglutinin-disease/. Accessed March 8, 2022.
3. A Study to Assess the Efficacy and Safety of BIVV009 (Sutimlimab) in Participants with Primary Cold Agglutinin Disease Who Have a Recent History of Blood Transfusion (Cardinal Study). Available at https://clinicaltrials.gov/ct2/show/NCT03347396. Accessed March 8, 2022.
4. Roth, A., Barcellini, W., et al. Sutimlimab in Cold Agglutinin Disease. N Engl J Med 2021; 384:1323-1334. Available at https://www.nejm.org/doi/10.1056/NEJMoa2027760?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed. Accessed March 8, 2022.

6 . Revision History

Date	Notes
3/9/2023	2023 Annual Review.

Enspryng (satralizumab-mwge)

Prior Authorization Guideline

Guideline ID	GL-113446
Guideline Name	Enspryng (satralizumab-mwge)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	12/1/2022
P&T Approval Date:	10/21/2020
P&T Revision Date:	01/20/2021 ; 10/20/2021 ; 10/19/2022

1 . Indications

Drug Name: Enspryng (satralizumab-mwge)
Neuromyelitis Optica Spectrum Disorder (NMOSD) Indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

2 . Criteria

Product Name: Enspryng	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Patient is anti-aquaporin-4 (AQP4) antibody positive

AND

3 - Prescribed by or in consultation with one of the following:

- Neurologist
- Ophthalmologist

AND

4 - One of the following:

4.1 Trial and failure, contraindication, or intolerance to rituximab

OR

4.2 For continuation of prior Enspryng therapy

Product Name: Enspryng	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

3 . References

1. Enspryng Prescribing Information. Genentech, Inc. South San Francisco, CA. March 2022.

4 . Revision History

Date	Notes
10/5/2022	Annual review: Background updates.

Entyvio (vedolizumab)

Prior Authorization Guideline

Guideline ID	GL-127406
Guideline Name	Entyvio (vedolizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	7/8/2014
P&T Revision Date:	09/18/2019 ; 11/14/2019 ; 08/13/2020 ; 09/16/2020 ; 09/15/2021 ; 04/20/2022 ; 08/18/2022 ; 09/21/2022 ; 10/19/2022 ; 12/14/2022 ; 7/19/2023

1 . Indications

Drug Name: Entyvio (vedolizumab) IV & SC
Crohn's Disease (CD) Indicated in adults for the treatment of moderately to severely active Crohn's disease. **Ulcerative Colitis (UC)** Indicated in adults for the treatment of moderately to severely active ulcerative colitis.

2 . Criteria

Product Name: Entyvio IV & SC	
Diagnosis	Crohn's Disease (CD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis Crohn's disease

AND

2 - One of the following
2.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

2.2 Submission of medical records (e.g., chart notes) documenting trial and failure of at least 1 of the following: 6-mercaptopurine, azathioprine, corticosteroid, methotrexate

AND

3 - Prescribed by, or in consultation with, a gastroenterologist

AND

4 - Trial and failure of both infliximab and adalimumab

Product Name: Entyvio IV & SC	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as demonstrated by one of the following:

- Decrease in bloody stools per day
- Elimination of signs of toxicity
- Clinical remission

Product Name: Entyvio IV & SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

1 - Diagnosis of Ulcerative Colitis

AND

2 - Prescribed by, or in consultation with, a gastroenterologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Submission of medical records (e.g., chart notes) documenting trial and failure of at least 1 of the following:

- Mesalamine
- sulfasalazine
- Mercaptopurine
- azathioprine
- Corticosteroids (e.g. prednisone, methylprednisolone)

AND

4 - Trial and failure of both infliximab and adalimumab

Notes	* Includes attestation that the patient has failed to respond to the TNF inhibitor mechanism of action in the past and should not be made to try a second TNF inhibitor. In this case, only a single step through a preferred agent is required.

Product Name: Entyvio IV & SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as demonstrated by one of the following:

- Decrease in bloody stools per day
- Elimination of signs of toxicity

3 . Endnotes

A. Entyvio should be discontinued in patients who do not show evidence of therapeutic benefit by week 14. [1]

4 . References

1. Entyvio Prescribing Information. Takeda Pharmaceuticals of America, Inc. Deerfield, IL. June 2022..
2. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG clinical guideline: management of Crohn's disease in adults. Am J Gastroenterol. 2018;113:481-517.
3. Feuerstein JD, Ho EY, Shmidt E, et al. AGA Clinical Practice Guidelines on the Medical Management of Moderate to Severe Luminal and Perianal Fistulizing Crohn's Disease. Gastroenterology. 2021;160(7):2496-2508.
4. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG clinical guideline: ulcerative colitis in adults. Am J Gastroenterol. 2019;114:384-413.
5. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterol. 2020;158:1450-1461.

5 . Revision History

Date	Notes
	New Programs

Erythropoietic Agents - PA, NF

Prior Authorization Guideline

Guideline ID	GL-125950
Guideline Name	Erythropoietic Agents - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	3/17/2000
P&T Revision Date:	11/14/2019 ; 04/15/2020 ; 11/12/2020 ; 01/20/2021 ; 11/18/2021 ; 12/15/2021 ; 02/17/2022 ; 11/17/2022 ; 6/21/2023

1 . Indications

Drug Name: Aranesp (darbepoetin alfa)
Anemia Due to Chronic Kidney Disease Indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis. **Anemia Due to Chemotherapy in Patients with Cancer** Indicated for treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of 2 additional months of planned chemotherapy. Limitations of Use: Aranesp has not been shown to improve quality of life, fatigue, or patient well-being. Aranesp is not indicated for use: (1) In patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy; (2) In patients with cancer receiving myelosuppressive chemotherapy

when the anticipated outcome is cure; (3) In patients with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion; and (4) As a substitute for red blood cell (RBC) transfusions in patients who require immediate correction of anemia.

Off Label Uses: Anemia in patients with Myelodysplastic Syndrome (MDS) Has been used for the treatment of anemia in patients with MDS. [20]

Drug Name: Epogen (epoetin alfa), Procrit (epoetin alfa), and Retacrit (epoetin alfa-epbx)

Anemia Due to Chronic Kidney Disease Indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and not on dialysis to decrease the need for red blood cell (RBC) transfusion.

Anemia Due to Zidovudine in Patients with HIV-infection Indicated for the treatment of anemia due to zidovudine administered at less than or equal to 4200 mg/week in patients with HIV-infection with endogenous serum erythropoietin levels of less than or equal to 500 mUnits/mL.

Anemia Due to Chemotherapy in Patients with Cancer Indicated for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy and upon initiation, there is a minimum of 2 additional months of planned chemotherapy. Limitations of Use: Epoetin alfa has not been shown to improve quality of life, fatigue, or patient well-being. Epoetin alfa is not indicated for use: (1) In patients with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy; (2) In patients with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure; (3) In patients with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion; (4) As a substitute for red blood cell (RBC) transfusions in patients who require immediate correction of anemia.

Reduction of Allogeneic Red Blood Cell Transfusions in Patients Undergoing Elective, Noncardiac, Nonvascular Surgery Indicated to reduce the need for allogeneic RBC transfusions among patients with perioperative hemoglobin greater than 10 to less than or equal to 13 g/dL who are at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery. Epoetin alfa is not indicated for patients who are willing to donate autologous blood preoperatively. Limitations of Use: Epoetin alfa has not been shown to improve quality of life, fatigue, or patient well-being. Epoetin alfa is not indicated for use: (1) In patients scheduled for surgery who are willing to donate autologous blood; (2) In patients undergoing cardiac or vascular surgery.

Off Label Uses: Anemia associated with HIV infection Have been used for the treatment of anemia associated with HIV infection in patients not receiving zidovudine.

[5]

Anemia in Hepatitis C virus (HCV) infected patients due to combination therapy of ribavirin and interferon or peg-interferon Have been used for the treatment of anemia in patients with hepatitis C virus (HCV) infection who are being treated with the combination of ribavirin and interferon or peginterferon alfa. [20]

Anemia in patients with Myelodysplastic Syndrome (MDS) Have been used for the treatment of anemia in patients with MDS. [5, 20]

Drug Name: Mircera (methoxy polyethylene glycol-epoetin beta)
Anemia Due to Chronic Kidney Disease Indicated for the treatment of anemia associated with chronic kidney disease (CKD) in: (1) adult patients on dialysis and adult patients not on dialysis; (2) pediatric patients 5 to 17 years of age on hemodialysis who are converting from another ESA after their hemoglobin level was stabilized with an ESA. Limitations of use: Mircera is not indicated and is not recommended: (1) In the treatment of anemia due to cancer chemotherapy; or (2) As a substitute for RBC transfusions in patients who require immediate correction of anemia. Mircera has not been shown to improve symptoms, physical functioning, or health-related quality of life.

2 . Criteria

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Verification of iron evaluation for adequate iron stores^ [A, J]

AND

3 - Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request: [1-3, 9, 13-17, 29, 33, B]

- Hematocrit (Hct) less than 30%
- Hemoglobin (Hgb) less than 10 g/dL

AND

4 - One of the following: [1-3, 33, L]

4.1 Patient is on dialysis

OR

4.2 All of the following:

4.2.1 Patient is NOT on dialysis

AND

4.2.2 The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

AND

4.2.3 Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

AND

5 - History of use or unavailability of both of the following (applies to Epogen only): [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Mircera	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Verification of iron evaluation for adequate iron stores^ [A, J]

AND

3 - One of the following:

3.1 All of the following:

3.1.1 Patient is greater than or equal to 18 years of age

AND

3.1.2 Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request: [9, 13-17, 29, 31, B]

- Hematocrit (Hct) less than 30%
- Hemoglobin (Hgb) less than 10 g/dL

AND

3.1.3 One of the following: [31]

3.1.3.1 Patient is on dialysis

OR

3.1.3.2 All of the following:

3.1.3.2.1 Patient is NOT on dialysis

AND

3.1.3.2.2 The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

AND

3.1.3.2.3 Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

OR

3.2 All of the following:

3.2.1 Patient is between 5 and 17 years of age

AND

3.2.2 Patient is on hemodialysis

AND

3.2.3 Patient's hemoglobin level has been stabilized by treatment with another erythropoietin stimulating agent (ESA) (e.g., Aranesp, Retacrit)

AND

3.2.4 Patient is converting to Mircera from another ESA (e.g., Aranesp, Retacrit)

AND

4 - History of use or unavailability of both of the following: [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Aranesp, Epogen, Mircera, Procrit, or Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - One of the following:

2.1 Both of the following:

- Patient is on dialysis
- Most recent or average Hct over 3 months is 33% or less (Hgb 11 g/dL or less)

OR

2.2 Both of the following:

- Patient is not on dialysis
- Most recent or average (avg) Hct over 3 mo is 30% or less (Hgb 10 g/dL or less)

OR

2.3 Both of the following:

- Request is for a pediatric patient
- Most recent or average Hct over 3 mo is 36% or less (Hgb 12 g/dL or less)

AND

3 - One of the following: [1-3, 31, 33]

3.1 Decrease in the need for blood transfusion

OR

3.2 Hemoglobin (Hgb) increased greater than or equal to 1g/dL from pre-treatment level

AND

4 - Verification of iron evaluation for adequate iron stores^ [A, J]

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Verification of iron evaluation for adequate iron stores^ [A, J]

AND

3 - Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request: [1-3, 9, 13-17, 29, 33, B]

- Hematocrit (Hct) less than 30%

- Hemoglobin (Hgb) less than 10 g/dL

AND

4 - One of the following: [1-3, 33, L]

4.1 Patient is on dialysis

OR

4.2 All of the following:

4.2.1 Patient is NOT on dialysis

AND

4.2.2 The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

AND

4.2.3 Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming history of use or unavailability of both of the following (applies to Epogen only): [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit, or Retacrit	
Diagnosis	Anemia in Patients with HIV-infection
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Verification of iron evaluation for adequate iron stores^ [2-3, 33]

AND

2 - Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request:

- Hemoglobin (Hgb) less than 12 g/dL [11, 25-28, K]
- Hematocrit (Hct) less than 36%

AND

3 - Serum erythropoietin level less than or equal to 500 mU/mL [2-3, 24, 26, 33]

AND

4 - One of the following:

- Patient is receiving zidovudine therapy [2-3, 33]
- Diagnosis of HIV infection [off-label] [5, 11, 24-28]

AND

5 - History of use or unavailability of Retacrit or Procrit (applies to Epogen only) [O]

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit, or Retacrit	
Diagnosis	Anemia in Patients with HIV-infection
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Verification of anemia as defined by one of the following: [2, 3, 33]

- Most recent or average hematocrit (Hct) over a 3-month period was below 36%
- Most recent or average hemoglobin (Hgb) over a 3-month period was below 12 g/dL

AND

2 - One of the following: [2, 3, 33]

2.1 Decrease in the need for blood transfusion

OR

2.2 Hemoglobin (Hgb) increased greater than or equal to 1g/dL from pre-treatment level

Product Name: Epogen, Procrit	
Diagnosis	Anemia in Patients with HIV-infection
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Verification of iron evaluation for adequate iron stores^ [2-3, 33]

AND

2 - Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request:

- Hemoglobin (Hgb) less than 12 g/dL [11, 25-28, K]
- Hematocrit (Hct) less than 36%

AND

3 - Serum erythropoietin level less than or equal to 500 mU/mL [2-3, 24, 26, 33]

AND

4 - One of the following:

- Patient is receiving zidovudine therapy [2-3, 33]
- Diagnosis of HIV infection [off-label] [5, 11, 24-28]

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming history of use or unavailability of Retacrit or Procrit (applies to Epogen only) [O]

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia Due to Chemotherapy in Patients with Cancer

Approval Length	3 Months [C]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Verification that other causes of anemia have been ruled out [1-3, 33, M]

AND

2 - Verification of anemia as defined by one of the following laboratory values collected within the prior two weeks of the request: [1-3, 33]

- Hematocrit (Hct) less than 30%
- Hemoglobin (Hgb) less than 10 g/dL [N]

AND

3 - Verification of iron evaluation for adequate iron stores ^ [1-3, 8, 33, G]

AND

4 - Verification that the cancer is a non-myeloid malignancy [1-3, 33, F]

AND

5 - Patient is receiving chemotherapy [1-3, 33, D]

AND

6 - History of use or unavailability of both of the following (applies to Epogen only): [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia Due to Chemotherapy in Patients with Cancer
Approval Length	3 Months [C]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Verification of anemia as defined by one of the following laboratory values collected within the prior two weeks of the request: [1-3, 33]

- Hemoglobin (Hgb) less than 10 g/dL
- Hematocrit (Hct) less than 30% [10, 18-19]

AND

2 - One of the following: [1-3, 33]

2.1 Decrease in the need for blood transfusion

OR

2.2 Hemoglobin (Hgb) increased greater than or equal to 1 g/dL from pre-treatment level

AND

3 - Patient is receiving chemotherapy [D]

Product Name: Epogen, Procrit	
Diagnosis	Anemia Due to Chemotherapy in Patients with Cancer
Approval Length	3 Months [C]
Guideline Type	Non Formulary

Approval Criteria

1 - Verification that other causes of anemia have been ruled out [1-3, 33, M]

AND

2 - Verification of anemia as defined by one of the following laboratory values collected within the prior two weeks of the request: [1-3, 33]

- Hematocrit (Hct) less than 30%
- Hemoglobin (Hgb) less than 10 g/dL [N]

AND

3 - Verification of iron evaluation for adequate iron stores ^ [1-3, 8, 33, G]

AND

4 - Verification that the cancer is a non-myeloid malignancy [1-3, 33, F]

AND

5 - Patient is receiving chemotherapy [1-3, 33, D]

AND

6 - Paid claims or submission of medical records (e.g., chart notes) confirming history of use or unavailability of both of the following (applies to Epogen only): [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit, or Retacrit	
Diagnosis	Preoperative use for reduction of allogeneic blood transfusion in patients undergoing surgery
Approval Length	1 month [2]
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery

AND

2 - Hemoglobin (Hgb) is greater than 10 to less than or equal to 13 g/dL

AND

3 - Patient is at high risk for perioperative transfusions

AND

4 - Patient is unwilling or unable to donate autologous blood pre-operatively

AND

5 - Verification of iron evaluation for adequate iron stores^ [2-3, 33]

AND

6 - History of use or unavailability of Retacrit or Procrit (applies to Epogen only) [0]

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit	
Diagnosis	Preoperative use for reduction of allogeneic blood transfusion in patients undergoing surgery
Approval Length	1 month [2]
Guideline Type	Non Formulary

Approval Criteria

1 - Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery

AND

2 - Hemoglobin (Hgb) is greater than 10 to less than or equal to 13 g/dL

AND

3 - Patient is at high risk for perioperative transfusions

AND

4 - Patient is unwilling or unable to donate autologous blood pre-operatively

AND

5 - Verification of iron evaluation for adequate iron stores^ [2-3, 33]

AND

6 - Paid claims or submission of medical records (e.g., chart notes) confirming history of use or unavailability of Retacrit or Procrit (applies to Epogen only) [O]

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia in Myelodysplastic Syndrome (MDS) patients [off-label] [4-6, 20]
Approval Length	3 months [I]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Myelodysplastic Syndrome (MDS) [4]

AND

2 - One of the following: [4]

- Serum erythropoietin level less than or equal to 500 mU/mL
- Diagnosis of transfusion-dependent MDS

AND

3 - Verification of iron evaluation for adequate iron stores ^ [4, A, H]

AND

4 - History of use or unavailability of both of the following (applies to Epogen only): [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Aranesp, Epogen, Procrit, or Retacrit	
Diagnosis	Anemia in Myelodysplastic Syndrome (MDS) patients [off-label]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Verification of anemia as defined by one of the following: [4, E]

- Most recent or average hematocrit (Hct) over a 3-month period was less than or equal to 36%
- Most recent or average hemoglobin (Hgb)over a 3-month period was less than or equal to 12 g/dL

AND

2 - One of the following: [1-3, 33]

2.1 Decrease in the need for blood transfusion

OR

2.2 Hemoglobin (Hgb) increased greater than or equal to 1 g/dL from pre-treatment level

Product Name: Epogen, Procrit	
Diagnosis	Anemia in Myelodysplastic Syndrome (MDS) patients [off-label] [4-6, 20]
Approval Length	3 months [I]
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Myelodysplastic Syndrome (MDS) [4]

AND

2 - One of the following: [4]

- Serum erythropoietin level less than or equal to 500 mU/mL
- Diagnosis of transfusion-dependent MDS

AND

3 - Verification of iron evaluation for adequate iron stores ^ [4, A, H]

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming history of use or unavailability of both of the following (applies to Epogen only): [O]

- Aranesp
- Retacrit or Procrit

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit, or Retacrit	
Diagnosis	Anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon [off-label] [6]
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hepatitis C viral (HCV) infection [12, 20]

AND

2 - Verification of iron evaluation for adequate iron stores^ [2-3, 33]

AND

3 - Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request: [P]

- Hematocrit (Hct) less than 36%
- Hemoglobin (Hgb) less than 12 g/dL

AND

4 - Verification of both of the following:

4.1 Patient is receiving ribavirin

AND

4.2 Patient is receiving one of the following:

- interferon alfa-2b
- interferon alfacon-1
- peginterferon alfa-2b
- peginterferon alfa-2a

AND

5 - History of use or unavailability of Retacrit or Procrit (applies to Epogen only) [O]

Notes	^Authorization will be given if physician is aware of iron deficienc y and is taking steps to replenish iron stores.

Product Name: Epogen, Procrit, or Retacrit	
Diagnosis	Anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon [off-label]
Approval Length	3 Months or if patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy.

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Verification of anemia as defined by one of the following: [35]

- Most recent or average hematocrit (Hct) over a 3-month period was 36% or less
- Most recent or average hemoglobin (Hgb) over a 3-month period was 12 g/dL or less

AND

2 - One of the following: [2, 3, 33]

2.1 Decrease in the need for blood transfusion

OR

2.2 Hemoglobin (Hgb) increased greater than or equal to 1 g/dL from pre-treatment level

Product Name: Epogen, Procrit	
Diagnosis	Anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon [off-label] [6]
Approval Length	3 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of hepatitis C viral (HCV) infection [12, 20]

AND

2 - Verification of iron evaluation for adequate iron stores^ [2-3, 33]

AND

3 - Verification of anemia as defined by one of the following laboratory values collected within 30 days of the request: [P]

- Hematocrit (Hct) less than 36%
- Hemoglobin (Hgb) less than 12 g/dL

AND

4 - Verification of both of the following:

4.1 Patient is receiving ribavirin

AND

4.2 Patient is receiving one of the following:

- interferon alfa-2b
- interferon alfacon-1
- peginterferon alfa-2b
- peginterferon alfa-2a

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming history of use or unavailability of Retacrit or Procrit (applies to Epogen only) [O]

Notes	^Authorization will be given if physician is aware of iron deficiency and is taking steps to replenish iron stores.

Product Name: Aranesp, Epogen, Mircera, Procrit, or Retacrit	
Diagnosis	Other Off-Label Uses
Guideline Type	Prior Authorization
Approval Criteria **1** - Off-label guideline approval criteria have been met* **AND** **2** - Off-label requests other than those listed above for coverage in patients with Hgb greater than 10 g/dL or Hct greater than 30% will not be approved [1-3, 31, 33]	
Notes	*Off-label requests will be evaluated on a case-by-case basis by a clinical pharmacist

Product Name: Epogen, Procrit	
Diagnosis	Other Off-Label Uses
Guideline Type	Non Formulary
Approval Criteria **1** - Off-label guideline approval criteria have been met* **AND** **2** - Off-label requests other than those listed above for coverage in patients with Hgb greater than 10 g/dL or Hct greater than 30% will not be approved [1-3, 31, 33]	
Notes	*Off-label requests will be evaluated on a case-by-case basis by a clinical pharmacist

3 . Endnotes

A. Aranesp, Epogen, Mircera, Procrit, and Retacrit Prescribing Information recommend prior and during therapy, the patient's iron stores should be evaluated. Administer supplemental iron therapy when serum ferritin is less than 100 mcg/L or when serum transferrin saturation is less than 20%. The majority of patients with CKD will require supplemental iron during the course of ESA therapy. [1-3, 31, 33]
B. Aranesp, Epogen, Mircera, Procrit, or Retacrit Prescribing Information states that dialysis, and non-dialysis patients with symptomatic anemia considered for therapy should have a Hgb < 10 g/dL. [1-3, 31, 33]
C. ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen. [18]
D. ESAs are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure. [1-3, 33]
E. NCCN panel recommends MDS patients aim for a target hemoglobin level of less than or equal to 12 g/dL. [4]
F. The American Cancer Society definition of "non-myeloid malignancy" is any malignancy that is not a myeloid leukemia. Non-myeloid cancers include all types of carcinoma, all types of sarcoma, melanoma, lymphomas, lymphocytic leukemias (ALL and CLL), and multiple myeloma. [30]
G. Absolute iron deficiency is defined as ferritin <30 ng/mL and TSAT <20%. Functional iron deficiency in patients receiving ESAs is defined as ferritin 30-800 ng/mL and TSAT 20%-50%. No iron deficiency is defined as ferritin >800 ng/mL or TSAT greater or equal to 50%. [8]
H. Iron repletion needs to be verified before instituting Epo therapy. [4]
I. Detection of erythroid responses generally occurs within 6 to 8 weeks of treatment. If no response occurs in this time frame, this treatment should be considered a failure and discontinued. [4]
J. Iron stores evaluation is recommended to occur every month during initial erythropoietin treatment in adults with chronic kidney disease or at least every 3 months during stable ESA treatment or in patients with HD-CKD not treated with an erythropoietin. [7]
K. Anemia in HIV patients has been defined as hemoglobin less than 10 g/dL [11, 25-26], hemoglobin less than 11 g/dL [11, 27], or hemoglobin less than 12 g/dL. [17]
L. Although primarily used in patients with ESRD, ESAs such as erythropoietin and darbepoetin alfa also correct the anemia in those with CKD who do not yet require dialysis. [21, 32]
M. Examples of other anemias include: vitamin B12, folate or iron deficiency anemia, hemolysis, or gastrointestinal bleeding.
N. Data from a systematic review by the Agency for Healthcare Research and Quality (AHRQ) determined that delaying ESA treatment until hemoglobin is less than 10 g/dL resulted in fewer thromboembolic events and a reduced mortality. [8]
O. Per consult with hematologist/oncologist, if a patient does not respond to one short-acting ESA, switching to another short-acting agent would not provide any

added benefit; instead, one would increase the dose or perhaps switch to a long-acting agent. [34]

P. Epoetin alfa was effective in maintaining the dose of rivabirin in anemic patients with chronic hepatitis C virus in patients with a baseline hemoglobin of 12 g/dL or less. [20]

4 . References

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5 . Revision History

Date	Notes
5/22/2023	update guideline

Evenity (romosozumab-aqqg injection)

Prior Authorization Guideline

Guideline ID	GL-125513
Guideline Name	Evenity (romosozumab-aqqg injection)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	5/16/2019
P&T Revision Date:	05/14/2020 ; 06/16/2021 ; 6/21/2023

1 . Indications

Drug Name: Evenity (romosozumab-aqqg injection)
Postmenopausal women with osteoporosis at high risk of fracture Indicated for the treatment of osteoporosis in postmenopausal women at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy.

2 . Criteria

Product Name: Evenity	
Approval Length	12 Months [A]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of postmenopausal osteoporosis or osteopenia

AND

2 - One of the following:

2.1 For diagnosis of osteoporosis, both of the following:

2.1.1 Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

2.1.2 One of the following:

2.1.2.1 History of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

OR

2.1.2.2 Trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) [B]

OR

2.2 For diagnosis of osteopenia, both of the following:

2.2.1 BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

2.2.2 One of the following:

2.2.2.1 History of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

OR

2.2.2.2 Both of the following:

2.2.2.2.1 Trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) [B]

AND

2.2.2.2.2 One of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: [C]

- Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
- Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

AND

3 - Trial of, contraindication, or intolerance to one of the following:

- Forteo (teriparatide)
- Tymlos (abaloparatide)

AND **4** - Treatment duration of Evenity (romosozumab-aqqg) has not exceeded a total of 12 months during the patient's lifetime [A]	
Notes	Evenity (romosozumab-aqqg) not to exceed the FDA-recommend ed treatment duration of 12 monthly doses.

3 . Endnotes

A. The anabolic effect of Evenity wanes after 12 monthly doses of therapy. Therefore, the duration of Evenity use should be limited to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered. [1]
B. Antiresorptive agents work by slowing the resorption or breakdown part of the remodeling cycle. Examples of antiresorptive agents include bisphosphonates (alendronate, ibandronate, risedronate, zoledronic acid), Prolia (denosumab), calcitonin, and selective estrogen receptor modulators (raloxifene). [2-4]
C. The WHO FRAX tool is available at www.shef.ac.uk/FRAX and incorporates multiple clinical factors that predict fracture risk, largely independent of BMD. [2]

4 . References

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5 . Revision History

Date	Notes
5/9/2023	2023 UM Annual Review. Update criteria to say "For diagnosis of osteoporosis" and "For diagnosis of osteopenia" to align with Tymlos. No changes to clinical intent

Evkeeza (evinacumab-dgnb)

Prior Authorization Guideline

Guideline ID	GL-123203
Guideline Name	Evkeeza (evinacumab-dgnb)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	
P&T Revision Date:	04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Evkeeza (evinacumab-dgnb)
Homozygous Familial Hypercholesterolemia (HoFH) Indicated as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, aged 5 years and older, with homozygous familial hypercholesterolemia (HoFH). **Limitations of Use** The safety and effectiveness of Evkeeza have not been established in patients with other causes of hypercholesterolemia, including those with heterozygous familial hypercholesterolemia (HeFH). The effects of Evkeeza on cardiovascular morbidity and mortality have not been determined.

2 . Criteria

Product Name: Evkeeza	
Diagnosis	Homozygous Familial Hypercholesterolemia [HoFH]
Approval Length	6 Months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 5 years of age or older

AND

2 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by one of the following: [2-4]

2.1 Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

2.2 Both of the following:

2.2.1 One of the following:

- Untreated/pre-treatment LDL-C greater than 500 mg/dL
- Treated LDL-C greater than 300 mg/dL

AND

2.2.2 One of the following:

- Xanthoma before 10 years of age

- Evidence of heterozygous familial hypercholesterolemia in both parents

AND

3 - Patient has failed to achieve a low-density lipoprotein-cholesterol (LDL-C) goal of less than 100 mg/dL despite use of both of the following: [2,5-9]

3.1 One of the following:

3.1.1 Patient is currently treated with maximally tolerated statin therapy plus ezetimibe

OR

3.1.2 Patient is unable to tolerate statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms: [B]

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

OR

3.1.3 Patient has a labeled contraindication to all statins

OR

3.1.4 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3.2 One of the following:

- Patient has been treated with PCSK9 therapy or did not respond to PCSK9 therapy
- Physician attests that the patient is known to have two LDL-receptor negative alleles (little to no residual function) and therefore would not respond to PCSK9 therapy
- Patient has a history of intolerance or contraindication to PCSK9 therapy
- Patient has previously been treated with Juxtapid (lomitapide)
- Patient has previously been treated with lipoprotein apheresis

AND

4 - Patient will continue other traditional lipid-lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza

AND

5 - Dose will not exceed 15 milligrams per kilogram of bodyweight infused once every 4 weeks

AND

6 - Prescribed by one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name: Evkeeza	
Diagnosis	Homozygous Familial Hypercholesterolemia [HoFH]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of LDL-C reduction from baseline while on Evkeeza therapy

AND

2 - Patient will continue other traditional lipid-lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza

AND

3 - Dose will not exceed 15 milligrams per kilogram of bodyweight infused once every 4 weeks

AND

4 - Prescribed by one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

3 . Endnotes

A. Per the 2018 ACC/AHA national treatment guidelines, adherence, response to therapy, and adverse effects should be monitored within 4 -12 weeks following LDL-C lowering medication initiation or dose adjustment, repeated every 3 to 12 months as needed. Additionally, in the Evkeeza pivotal trial the primary outcome of change in LDL-C was evaluated at 24 weeks. [1,2,6]
B. In patients treated with statins, it is recommended to measure creatine kinase levels in individuals with severe statin-associated muscle symptoms. [6]

4 . References

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5 . Revision History

Date	Notes
3/27/2023	Annual review - submission of medical records removed. Age cri teria updated to reflect label update

Excluded Drugs Administrative Policy - IHN

Prior Authorization Guideline

Guideline ID	GL-126072
Guideline Name	Excluded Drugs Administrative Policy - IHN
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Caverject, Muse, Edex, Kybella, Durolane, Euflexxa, Gel-One, Gelsyn-3. GenVisc, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, Trivisc, Visco-3	
Approval Length	N/A - Requests should not be approved
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests are not authorized and will not be approved. See Background Section for details.	

2 . Background

Benefit/Coverage/Program Information
Caverject, Muse, Edex
1. Is the requested medication being used to treat erectile dysfunction?
Yes = Deny. The Oregon Health Plan (OHP) has a list of medical conditions called the Prioritized List. OHP only pays to treat a condition if it is on this list between line 1 and 4 The submitted condition, erectile dysfunction, is on line 523. This means it is not covere the OHP because it is “below the line” of coverage. This denial is based on Oregon Administrative Rule (OAR): 410-120-0000, 410-121-0000 (2), 410-121-0147(1)(a), 410-14 3820(1)(10), 410-141-3825(1)(c), 410-141-3830. No = Deny. Medicaid does not cover drugs that do not have clear information to prove it the problem. This should come from reliable medical sources. Samaritan uses these so to define which treatments have been proven to work. The drug you have requested doe meet these requirements. This denial is based on Oregon Administrative Rule (OAR): 41 1200 (2)(b,i), 410-120-0000 (146)(b,e)(147)(e), 410-141-3820 (1)(b), and 410-141-3825 (1)(a)(2)(a).
Kybella
1. Is the requested medication being used for improving appearance?
Yes = Deny. Medicaid does not cover drugs used for improving appearance. For this reas Kybella requested for <diagnosis> is not covered. Please talk to your doctor about your n steps. This denial is based on Oregon Administrative Rule 410-120-1200 (2) (m). No = Deny. Medicaid does not cover drugs that do not have clear information to prove it the problem. This should come from reliable medical sources. Samaritan uses these so to define which treatments have been proven to work. The drug you have requested doe meet these requirements. This denial is based on Oregon Administrative Rule (OAR): 41 1200 (2)(b,i), 410-120-0000 (146)(b,e)(147)(e), 410-141-3820 (1)(b), and 410-141-3825 (1)(a)(2)(a).

Durolane, Euflexxa, Gel-One, Gelsyn-3, GenVisc, Hyalgan, Hymovis, Monovisc, Orthovisc, Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, Trivisc, Visco-3

1. Is the requested medication being used to treat osteoarthritis?
Yes = Deny. <drug> is excluded from coverage. Medicaid does not cover these types of injections for arthritis (joint pain). This denial is based on guideline note 104, Oregon Administrative Rule (OAR): 410-120-0000, 410-121-0000 (2), 410-121-0147(1)(a), 410-14 3820(1)(10), 410-141-3825(1)(c), 410-141-3830, and OAR: 410-130-0180 (4)(e). No = Deny. Medicaid does not cover drugs that do not have clear information to prove it the problem. This should come from reliable medical sources. Samaritan uses these so to define which treatments have been proven to work. The drug you have requested does meet these requirements. This denial is based on Oregon Administrative Rule (OAR): 410 1200 (2)(b,i), 410-120-0000 (146)(b,e)(147)(e), 410-141-3820 (1)(b), and 410-141-3825 (1)(a)(2)(a).

3 . Revision History

Date	Notes
6/5/2023	New program

Exondys 51 (eteplirsen) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-124049
Guideline Name	Exondys 51 (eteplirsen) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	11/17/2016
P&T Revision Date:	02/13/2020 ; 05/14/2020 ; 05/20/2021 ; 06/16/2021 ; 12/15/2021 ; 05/19/2022 ; 06/15/2022 ; 5/18/2023

1 . Indications

Drug Name: Exondys 51 (eteplirsen)
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with Exondys 51. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

2 . Criteria

Product Name: Exondys 51	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Duchenne muscular dystrophy (DMD)

AND

2 - Documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping

AND

3 - Patient is 7 years of age or older [2-4]

AND

4 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

5 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

6 - Patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [2-4]

Product Name: Exondys 51	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

3 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

4 - Patient is maintaining ambulatory status, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA)

Product Name: Exondys 51	
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping

AND

2 - Patient is 7 years of age or older [2-4]

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [2-4]

3 . References

1. Exondys 51 Prescribing Information. Sarepta Therapeutics, Inc. Cambridge, MA. January 2022.
2. Mendell JR, Goemans N, Lowes LP, et al. Longitudinal effect of eteplirsen versus historical control on ambulation in Duchenne muscular dystrophy. Ann Neurol. 2016;79(2):257-271. doi: 10.1002/ana.24555
3. Mendell JR, Rodino-Klapac LR, Sahenk Z, et al. Eteplirsen for the treatment of Duchenne muscular dystrophy. Ann Neurol. 2013;74(5):637-647.
4. Per Clinical Consultation with a Pediatrician, October 5, 2016 and January 22, 2020.

4 . Revision History

Date	Notes
5/4/2023	Annual review: Formatting updates.

Fabry Disease Agents

Prior Authorization Guideline

Guideline ID	GL-126824
Guideline Name	Fabry Disease Agents
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	
P&T Revision Date:	10/16/2019 ; 10/21/2020 ; 05/20/2021 ; 10/20/2021 ; 10/19/2022 ; 7/19/2023

1 . Indications

Drug Name: Fabrazyme (agalsidase beta)
Fabry disease Indicated for the treatment of adult and pediatric patients 2 years of age and older with confirmed Fabry disease.
Drug Name: Elfabrio (pegunigalsidase alfa-iwxj)
Fabry disease Indicated for the treatment of adults with confirmed Fabry disease.

2 . Criteria

Product Name: Fabrazyme	
Approval Length	60 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Patient is 2 years of age or older

AND

3 - One of the following: [3, 4]

- Detection of pathogenic mutations in the GLA gene by molecular genetic testing
- Deficiency in α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS)
- Significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata)

AND

4 - Will not be used in combination with Galafold (migalastat) [A]

Product Name: Elfabrio

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Disease confirmed by one of the following: [3, 4]

- Detection of pathogenic mutations in the GLA gene by molecular genetic testing
- Deficiency in α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS)
- Significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata)

AND

3 - Will not be used in combination with Galafold (migalastat) [A]

Product Name: Elfabrio	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

3 . Endnotes

A. The safety and effectiveness of concomitant use of Galafold (migalastat) and Fabrazyme (agalsidase beta) has not been established. [2, 6]

4 . References

1. Fabrazyme prescribing information. Genzyme Corporation. Cambridge, MA. August 2021.
2. Per clinical consultation with geneticist. October 11, 2018.
3. Ortiz A, Germain DP, Desnick RJ, et al. Fabry disease revisited: Management and treatment recommendations for adult patients. Mol Genet Metab. 2018;123(4):416-427. doi:10.1016/j.ymgme.2018.02.014.
4. Michaud M, Mauhin W, Belmatoug N, et al. When and How to Diagnose Fabry Disease in Clinical Pratice. Am J Med Sci. 2020;360(6):641-649. doi:10.1016/j.amjms.2020.07.011.
5. Elfabrio prescribing information. Chiesi USA, Inc. Cary, NC. May 2023.
6. UptoDate. Fabry disease:Treatment and prognosis. Available at: https://www.uptodate.com/contents/fabry-disease-treatment-and-prognosis?search=fabry%20disease&source=search_result&selectedTitle=2~68&usage_type=default&display_rank=2. Accessed June 12, 2023.

5 . Revision History

Date	Notes
6/29/2023	New UM PA Criteria for Elfabrio

Fasenra (benralizumab)

Prior Authorization Guideline

Guideline ID	GL-124552
Guideline Name	Fasenra (benralizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	1/24/2018
P&T Revision Date:	05/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Fasenra (benralizumab)
Severe Eosinophilic Asthma Indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype. Limitations of use: Fasenra is not indicated for treatment of other eosinophilic conditions. Fasenra is not indicated for the relief of acute bronchospasm or status asthmaticus.

2 . Criteria

Product Name: Fasenra	
Approval Length	6 Months [F]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe asthma

AND

2 - Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter [6, C, G]

AND

3 - One of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months [2, 3, C]

OR

3.2 Prior asthma-related hospitalization within the past 12 months [D]

AND

4 - Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

4.1 Both of the following [4, 5, A, B]:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Patient is 12 years of age or older

AND

6 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/Immunologist

Approval Length	12 Months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)

AND

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/Immunologist

3 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older [5]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country - specific depending on local availability, regulatory labelling and clinical guidelines.

	For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

4 . Endnotes

A. The American Thoracic Society (ATS) defines severe asthma as asthma which requires treatment with high dose inhaled corticosteroids (ICS) plus a second controller (and/or systemic corticosteroids) to prevent it from becoming 'uncontrolled' or which remains 'uncontrolled' despite this therapy. In patients greater than 6 years of age, "Gold Standard/International Guidelines treatment" is high dose ICS plus a long acting beta-2-agonist (LABA), leukotriene modifier or theophylline and/or continuous or near continuous systemic corticosteroids as background therapy [4].
B. The Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention update lists anti-interleukin- 5 treatment or anti-interleukin 5 receptor treatment as an add on option for patients with severe eosinophilic asthma that is uncontrolled on two or more controllers plus as-needed reliever medication (Step 4-5 treatment). [5]
C. The SIROCCO and CALIMA trials evaluated the effect of benralizumab 30mg administered in 4 week and 8 week regimens as add on therapy to standard of care medicine. The trials enrolled patients 12 to 75 years of age with severe asthma defined as a history of two or more exacerbations in the previous year which needed systemic corticosteroids or a temporary increase in the patient's usual maintenance dose of oral corticosteroids. Patients were also required to have received treatment with a medium dose or high dose ICS plus LABA for at least one year before enrollment. Both trials confirmed benralizumab significantly reduced the annual exacerbation rates and was generally well tolerated in patients who were uncontrolled on high dose ICS plus LABA and had a baseline blood eosinophil count of 300 cells per microliter or greater [2, 3]. The baseline eosinophil level requirement of greater than or equal to 150 cells per microliter and the requirement for a history of one or more exacerbations listed in the criteria comes from the inclusion criteria allowed in the ZONDA trial. The ZONDA trial was a 28-week, Phase 3, randomized, double blind, placebo controlled, multicenter, oral corticosteroid reduction trial [6].
D. Recommendation inferred from the national P&T committee meeting, December 2015, regarding similar agent first-in-class IL-5 antagonist Nucala (mepolizumab) in the use of severe eosinophilic asthma.
E. Asthma treatment can often be reduced, once good asthma control has been achieved and maintained for three months and lung function has hit a plateau. However, the approach to stepping down will depend on patient specific factors (e.g., current medications, risk factors). At this time evidence for optimal timing,

sequence, and magnitude of treatment reductions is limited. It is feasible and safe for most patients to reduce the ICS dose by 25-50% at three month intervals, but complete cessation of ICS is associated with a significant risk of exacerbations [5].

F. The GINA Global Strategy for Asthma Management and Prevention update recommends that patients with asthma should be reviewed regularly to monitor their symptom control, risk factors and occurrence of exacerbations, as well as to document the response to any treatment changes. Ideally, response to Type 2-targeted therapy should be re-evaluated every 3-6 months, including re-evaluation of the need for ongoing biologic therapy for patients with good response to Type 2 targeted therapy. [5]
G. The Institute for Clinical and Economic Review (ICER) defines eosinophilic inflammation as a blood eosinophil level greater than or equal to 150 cells per microliter at initiation of therapy. This is the lowest measured threshold for eosinophilic asthma in pivotal trials. [7]

5 . References

1. Fasenra Prescribing Information. AstraZeneca Pharmaceuticals LP. Wilmington, DE. February 2021.
2. FitzGerald JM, Bleecker ER, Nair P, et al. Benralizumab, an anti-interleukin-5 receptor α monoclonal antibody, as add-on treatment for patients with severe, uncontrolled, eosinophilic asthma (CALIMA): a randomised, double-blind, placebo-controlled phase 3 trial. Lancet. 2016 Oct 29;388(10056):2128-2141.
3. Bleecker ER, FitzGerald JM, Chanez P, et al. Efficacy and safety of benralizumab for patients with severe asthma uncontrolled with high-dosage inhaled corticosteroids and long-acting Beta two agonist (SIROCCO): a randomised, multicentre, placebo-controlled phase 3 trial. Lancet. 2016 Oct 29;388(10056):2115-2127.
4. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. Eur Respir J. 2014;43:343-373.
5. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention (2022 update). 2022 www.ginasthma.org. Accessed April 2023.
6. Nair P, Wenzel S, Rabe KF, et al. ZONDA Trial Investigators. Oral glucocorticoid-sparing effect of benralizumab in severe asthma. N Engl J Med. 2017;376(25):2448-2458.
7. Institute for Clinical and Economic Review (ICER). Biologic therapies for treatment of asthma associated with type 2 inflammation: effectiveness, value, and value-based price benchmarks. https://icer.org/wp-content/uploads/2020/10/ICER_Asthma-Final-Report_Unredacted_08122020.pdf. Published December 20, 2018. Accessed April 15, 2022.

6 . Revision History

Date	Notes
4/24/2023	2023 UM Annual Review. No criteria changes. Background updates

Firmagon (degarelix)

Prior Authorization Guideline

Guideline ID	GL-112099
Guideline Name	Firmagon (degarelix)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2022
P&T Approval Date:	5/18/2010
P&T Revision Date:	09/18/2019 ; 09/16/2020 ; 10/20/2021 ; 9/21/2022

1 . Indications

Drug Name: Firmagon (degarelix)
Advanced Prostate Cancer Indicated for treatment of patients with advanced prostate cancer.

2 . Criteria

Product Name: Firmagon	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced prostate cancer [1-2]

AND

2 - Prescribed by or in consultation with an oncologist

Product Name: Firmagon	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

3 . References

1. Firmagon prescribing information. Ferring Pharmaceuticals Inc. Parsippany, NJ. March 2020.
2. Klotz L, Boccon-Gibod L, Shore ND, et al. The efficacy and safety of Firmagon: a 12-month, comparative, randomized, open-label, parallel-group phase III study in patients with prostate cancer. BJU Int. 2008;102:1531-1538.

4 . Revision History

Date	Notes
8/22/2022	2022 Annual Review

Gamifant (emapalumab-lzsg)

Prior Authorization Guideline

Guideline ID	GL-120194
Guideline Name	Gamifant (emapalumab-lzsg)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	
P&T Revision Date:	02/13/2020 ; 02/18/2021 ; 02/17/2022 ; 2/16/2023

1 . Indications

Drug Name: Gamifant (emapalumab-lzsg)
Primary Hemophagocytic Lymphohistiocytosis (HLH) Indicated for the treatment of adult and pediatric (newborn and older) patients with primary HLH with refractory, recurrent or progressive disease or intolerance with conventional HLH therapy.

2 . Criteria

Product Name: Gamifant	
Approval Length	6 Months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary hemophagocytic lymphohistiocytosis (HLH)

AND

2 - One of the following:

2.1 Disease is one of the following:

- Refractory
- Recurrent
- Progressive

OR

2.2 Trial and failure, contraindication, or intolerance to conventional HLH therapy (e.g., etoposide, dexamethasone, cyclosporine A, intrathecal methotrexate)

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

AND

4 - Patient has not received hematopoietic stem cell transplantation (HSCT)

Product Name: Gamifant	
Approval Length	6 Months [A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improvement in hemoglobin/lymphocyte/platelet counts, afebrile, normalization of inflammatory factors/markers)

AND

2 - Patient has not received HSCT

3 . Endnotes

A. Per clinical consultation, it is appropriate to limit authorization duration to no more than 6 months at a time, given that the ultimate goal in therapy is to receive HSCT and treatment with Gamifant should be viewed as bridge therapy to HSCT. Pivotal trial data duration was also less than 3 months. [2]

4 . References

1. Gamifant Prescribing Information. Sobi Inc. Waltham, MA. June 2020.
2. Per clinical consult with a pediatric hematologist/oncologist, January 18, 2019.

5 . Revision History

Date	Notes
1/15/2023	Annual Review - no criteria changes

Gaucher Disease Agents

Prior Authorization Guideline

Guideline ID	GL-118474
Guideline Name	Gaucher Disease Agents
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	11/20/2000
P&T Revision Date:	02/13/2020 ; 02/18/2021 ; 02/17/2022 ; 05/19/2022 ; 2/16/2023

1 . Indications

Drug Name: Cerezyme (imiglucerase for injection)
Type 1 Gaucher Disease Indicated for treatment of adults and pediatric patients 2 years of age and older with Type 1 Gaucher disease that results in one or more of the following conditions: - anemia - thrombocytopenia - bone disease - hepatomegaly or splenomegaly
Drug Name: Elelyso (taliglucerase alfa) for injection
Type 1 Gaucher Disease Indicated for the treatment of patients 4 years and older with a confirmed diagnosis of Type 1 Gaucher disease.
Drug Name: VPRIV (velaglucerase alfa for injection)

Type 1 Gaucher Disease Indicated for long-term enzyme replacement therapy (ERT) for patients with type 1 Gaucher disease.
Drug Name: Cerdelga (eliglustat)
Type 1 Gaucher Disease Indicated for the long-term treatment of adult patients with Gaucher disease type 1 (GD1) who are CYP2D6 extensive metabolizers (EMs), intermediate metabolizers (IMs), or poor metabolizers (PMs) as detected by an FDA-cleared test. Limitations of Use: Patients who are CYP2D6 ultra-rapid metabolizers (URMs) may not achieve adequate concentrations of CERDELGA to achieve a therapeutic effect. A specific dosage cannot be recommended for those patients whose CYP2D6 genotype cannot be determined (indeterminate metabolizers).
Drug Name: Zavesca (miglustat)
Type 1 Gaucher Disease Indicated as monotherapy for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).

2 . Criteria

Product Name: Cerezyme, Elelyso, or VPRIV	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Type 1 Gaucher disease

AND

2 - Patient has evidence of symptomatic disease (e.g., moderate to severe anemia [A], thrombocytopenia [B], bone disease [C], hepatomegaly [D], or splenomegaly [D])

AND

3 - One of the following:

3.1 Patient is 4 years of age or older (applies to Elelyso and VPRIV only)

OR

3.2 Patient is 2 years of age or older (applies to Cerezyme only)

Product Name: Cerdelga	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Type 1 Gaucher disease

AND

2 - Patient is an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test

AND

3 - Patient is 18 years of age or older

Product Name: Generic miglustat or Brand Zavesca	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate Type 1 Gaucher disease [E]

AND

2 - Patient is 18 years of age or older

3 . Endnotes

A. Goals of treatment with anemia are to increase hemoglobin to greater than or equal to 12.0 g/dL for males (greater than 12 years of age), and to greater than or equal to 11.0 g/dL for both children (less than or equal to 12 years of age) and females (greater than 12 years of age). [6, 8]
B. Moderate thrombocytopenia is defined as a platelet count of 60,000 to 120,000/microliter. A platelet count of 120,000/microliter to meet the criterion of thrombocytopenia is based on the upper end of the range that defines moderate thrombocytopenia. [6]
C. In bone disease, the goal is to lessen or eliminate bone pain and prevent bone crises. Bone disease can be diagnosed using MRI, bone scan, and X-ray. [6-8]
D. Hepatomegaly is defined as a liver mass of greater than 1.25 times normal value. Splenomegaly is defined as a splenic mass greater than the normal, and moderate splenomegaly is considered a spleen volume of greater than 5 and less than or equal to 15 times normal. [6]
E. Zavesca may be prescribed only by physicians knowledgeable in the management of Gaucher disease (GD). In order to prescribe Zavesca, physicians must read the letter to doctors from Actelion, then sign and fax the one-page physician statement affirming that they are qualified to manage patients with GD and that they have read the Zavesca review booklet containing the full prescribing information. Zavesca is dispensed exclusively by Accredo specialty pharmacy. [10]

4 . References

1. Cerezyme Prescribing Information. Genzyme Corporation. Cambridge, MA. December 2021.
2. Elelyso Prescribing Information. Pfizer, Inc. New York, NY. August 2022.
3. VPRIV Prescribing Information. Takeda Pharmaceuticals U.S.A., Inc. Lexington, MA. September 2021.
4. Cerdelga Prescribing Information. Genzyme Ireland, Ltd. Waterford, Ireland. July 2021.
5. Zavesca Prescribing Information. Actelion Pharmaceuticals US, Inc. Titusville, NJ. August 2022.
6. Pastores GM, Weinreb NJ, Aerts H, et al. Therapeutic goals in the treatment of Gaucher disease. Semin Hematol. 2004;41(4 Suppl 5):4-14.
7. Weinreb NJ, Aggio MC, Andersson HC, et al. Gaucher disease type 1: revised recommendations on evaluations and monitoring for adult patients. Semin Hematol. 2004;41(suppl 5):15-22.
8. Weinreb N, Taylor J, Cox T, et al. A benchmark analysis of the achievement of therapeutic goals for type 1 Gaucher disease patients treated with imiglucerase. Am J Hematol. 2008;83:890-895.
9. Hollak CE, vom Dahl S, Aerts JM, et al. Force majeure: therapeutic measures in response to restricted supply of imiglucerase (Cerezyme) for patients with Gaucher disease. Blood Cells Mol Dis. 2010;44(1):41-7.
10. Actelion Pharmaceuticals US, Inc. Zavesca (miglustat). Available at: https://www.zavesca.com/hcp-home.html. Accessed on January 5, 2023.
11. Per clinical consult with geneticist, November 11, 2010.

5 . Revision History

Date	Notes
2/17/2023	Annual review - no criteria changes.

Givlaari (givosiran)

Prior Authorization Guideline

Guideline ID	GL-118098
Guideline Name	Givlaari (givosiran)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	3/1/2023
P&T Approval Date:	1/15/2020
P&T Revision Date:	02/13/2020 ; 01/20/2021 ; 01/19/2022 ; 1/18/2023

1 . Indications

Drug Name: Givlaari (givosiran)
Acute Hepatic Porphyria Indicated for the treatment of adults with acute hepatic porphyria (AHP).

2 . Criteria

Product Name: Givlaari	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute hepatic porphyria (i.e., acute intermittent porphyria, hereditary coproporphyria, variegate porphyria, ALA dehydrase deficient porphyria)

AND

2 - Patient has active disease with at least two documented porphyria attacks within the past 6 months

AND

3 - Provider attestation documenting elevated urinary or plasma levels of one of the following within the past 12 months:

- Porphobilinogen (PBG)
- Delta-aminolevulinic acid (ALA)

AND

4 - Patient has not had a liver transplant

AND

5 - Prescribed by or in consultation with a gastroenterologist or a specialist with expertise in the diagnosis and management of acute hepatic porphyria

Product Name: Givlaari	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response while on therapy as demonstrated by both of the following:

- Reduction in hemin administration requirements
- Reduction in the rate or number of porphyria attacks

AND

2 - Patient has not had a liver transplant

AND

3 - Prescribed by or in consultation with a gastroenterologist or a specialist with expertise in the diagnosis and management of acute hepatic porphyria

3 . References

1. Givlaari Prescribing Information. Alnylam Pharmaceuticals, Inc. Cambridge, MA. October 2021.

4 . Revision History

Date	Notes
1/4/2023	Annual review - no changes.

Gonadotropin-Releasing Hormone Agonists

Prior Authorization Guideline

Guideline ID	GL-126091
Guideline Name	Gonadotropin-Releasing Hormone Agonists
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	12/12/2005
P&T Revision Date:	12/18/2019 ; 02/13/2020 ; 07/15/2020 ; 09/16/2020 ; 01/20/2021 ; 09/15/2021 ; 06/15/2022 ; 08/18/2022 ; 09/21/2022 ; 01/18/2023 ; 6/21/2023

1 . Indications

Drug Name: Lupron Depot (leuprolide acetate) 1-Month 7.5 mg, Lupron Depot 3-Month 22.5 mg, Lupron Depot 4-Month 30 mg, Lupron Depot 6-Month 45 mg
Prostate Cancer Indicated for treatment of advanced prostatic cancer. **Off Label Uses: Gender Dysphoria [18, 19]** Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and

emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Lupron Depot 3.75 mg

Endometriosis Indicated for the management of endometriosis, including pain relief and reduction of endometriotic lesions. In combination with a norethindrone acetate, it is also indicated for initial management of the painful symptoms of endometriosis and for management of recurrence of symptoms. Limitations of Use: The total duration of therapy with LUPRON DEPOT 3.75 mg plus add-back therapy should not exceed 12 months due to concerns about adverse impact on bone mineral density.

Uterine Leiomyomata (Fibroids) Indicated for concomitant use with iron therapy for preoperative hematologic improvement of women with anemia caused by fibroids for whom three months of hormonal suppression is deemed necessary. Limitations of Use: Not indicated for combination use with norethindrone acetate add-back therapy for the preoperative hematologic improvement of women with anemia caused by heavy menstrual bleeding due to fibroids.

Off Label Uses: Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would.

Drug Name: Lupron Depot 3-Month 11.25 mg

Endometriosis Indicated for the management of endometriosis, including pain relief and reduction of endometriotic lesions. In combination with a norethindrone acetate, it is also indicated for initial management of the painful symptoms of endometriosis and for management of recurrence of symptoms. Limitations of Use: The total duration of therapy with LUPRON DEPOT 11.25 mg plus add-back therapy should not exceed 12 months due to concerns about adverse impact on bone mineral density.

Uterine Leiomyomata (Fibroids) Indicated for concomitant use with iron therapy for preoperative hematologic improvement of women with anemia caused by fibroids for whom three months of hormonal suppression is deemed necessary. Limitations of Use: Not indicated for combination use with norethindrone acetate add-back therapy for the preoperative hematologic improvement of women with anemia caused by heavy menstrual bleeding due to fibroids.

Off Label Uses: Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would.

Drug Name: Leuprolide Acetate

Prostate Cancer Indicated for the palliative treatment of advanced prostatic cancer.

Off Label Uses: Infertility Used for controlled ovarian hyperstimulation to enhance the in vitro fertilization-embryo transfer (IVF-ET) procedure. [6]

Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Leuprolide Acetate Depot

Prostate Cancer Indicated for the palliative treatment of advanced prostate cancer.

Off Label Uses: Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Lupron Depot-PED (leuprolide acetate)

Central Precocious Puberty (CPP) Indicated in the treatment of pediatric patients with central precocious puberty (CPP).

Off Label Uses: **Gender Dysphoria [18, 19]** Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Lupaneta Pack (leuprolide acetate inj; norethindrone acetate tablets) 1-Month 3.75mg, 3-Month 11.25 mg

Endometriosis Indicated for initial management of the painful symptoms of endometriosis and for management of recurrence of symptoms. Limitation of use: Duration of use is limited due to concerns about adverse impact on bone mineral density. The initial treatment course of Lupaneta Pack is limited to 6 months. A single retreatment course of not more than 6 months may be administered after the initial course of treatment if symptoms recur. Use of Lupaneta for longer than a total of 12 months is not recommended.

Drug Name: Camcevi (leuprolide)

Prostate Cancer Indicated for the treatment of adult patients with advanced prostate cancer.

Drug Name: Eligard (leuprolide acetate)

Prostate Cancer Indicated for the palliative treatment of advanced prostate cancer.

Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Fensolvi (leuprolide acetate)

Central Precocious Puberty (CPP) Indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty (CPP).

Drug Name: Supprelin LA (histrelin acetate)

Central Precocious Puberty (CPP) Indicated for the treatment of children with CPP. Children with CPP (neurogenic or idiopathic) have an early onset of secondary sexual characteristics (earlier than 8 years of age in females and 9 years of age in males). They also show a significantly advanced bone age that can result in diminished adult height attainment. Prior to initiation of treatment a clinical diagnosis of CPP should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor), and adrenal steroids to exclude congenital adrenal hyperplasia.

Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Trelstar (triptorelin pamoate)

Prostate Cancer Indicated for the palliative treatment of advanced prostate cancer.

Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]

Drug Name: Triptodur (triptorelin)

Central Precocious Puberty (CPP) Indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty (CPP).

Gender Dysphoria [18, 19] Suppression of pubertal development and gonadal function is accomplished most effectively by gonadotropin suppression with gonadotropin releasing hormone analogues and antagonists. Analogues suppress gonadotropins after a short period of stimulation, whereas antagonists immediately suppress pituitary

secretion. Since no long-acting antagonists are available for use as pharmacotherapy, long-acting analogues are the currently preferred treatment option. [18] Early use of puberty-suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. [19]
Drug Name: Vantas (histrelin acetate)
Prostate Cancer Indicated for the palliative treatment of advanced prostate cancer.

2 . Criteria

Product Name: Lupron Depot (3.75 mg and 11.25 mg)	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endometriosis

AND

2 - One of the following: [9, 13]

2.1 History of inadequate pain control response following a trial of at least 6 months, or history of intolerance or contraindication to one of the following:

- Danazol
- Combination (estrogen/progestin) oral contraceptive
- Progestins

OR

2.2 Patient has had surgical ablation to prevent recurrence

Product Name: Lupron Depot (3.75 mg and 11.25 mg)	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Recurrence of symptoms following a trial of at least 6 months with leuprolide acetate

AND

2 - Used in combination with one of the following:

- Norethindrone 5 mg daily
- Other "add-back" sex-hormones (e.g., estrogen, medroxyprogesterone)
- Other bone-sparing agents (e.g., bisphosphonates)

Product Name: Lupron Depot (3.75 mg and 11.25 mg)	
Diagnosis	Uterine Leiomyomata (Fibroids) - For the reduction of the size of fibroids [off-label]
Approval Length	4 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For use prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy) [6]

Product Name: Lupron Depot (3.75 mg and 11.25 mg)	
Diagnosis	Uterine Leiomyomata (Fibroids) - Anemia [5,7]
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For the treatment of anemia

AND

2 - Anemia is caused by uterine leiomyomata (fibroids)

AND

3 - Patient has tried and had an inadequate response to at least 1 month of monotherapy with iron

AND

4 - Used in combination with iron therapy

AND

5 - For use prior to surgery

Product Name: Fensolvi, Lupron Depot-PED, Supprelin LA, Triptodur

Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of central precocious puberty (idiopathic or neurogenic)

AND

2 - Early onset of secondary sexual characteristics in one of the following:

- Females less than 8 years of age
- Males less than 9 years of age

AND

3 - Advanced bone age of at least one year compared with chronological age

AND

4 - One of the following:

4.1 Both of the following:

- Patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing
- Peak luteinizing hormone (LH) level above pre-pubertal range

OR

4.2 Patient has a random LH level in the pubertal range

AND

5 - One of the following:

5.1 Patient had one of the following diagnostic evaluations to rule out tumors, when suspected:

- Diagnostic imaging of the brain (MRI or CT scan) (in patients with symptoms suggestive of a brain tumor or in those 6 years of age or younger)
- Pelvic/testicular/adrenal ultrasound (if steroid levels suggest suspicion)
- Adrenal steroids to rule out congenital adrenal hyperplasia (when pubarche precedes thelarche or gonadarche)

OR

5.2 Patient has no suspected tumors

AND

6 - Prescribed by or in consultation with a pediatric endocrinologist

Product Name: Fensolvi, Lupron Depot-PED, Supprelin LA, Triptodur	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - LH levels have been suppressed to pre-pubertal levels

AND

2 - Prescribed by or in consultation with a pediatric endocrinologist

Product Name: Generic leuprolide acetate*	
Diagnosis	Treatment of Infertility (off-label) [6]
Approval Length	2 Month [A] (or per plan benefit design)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of infertility **AND** **2** - Used as part of an assisted reproductive technology (ART) protocol	
Notes	*Please consult client-specific resources to confirm whether ben efit exclusions should be reviewed for medical necessity.

Product Name: Eligard, Leuprolide Acetate, generic leuprolide acetate, Trelstar, Vantas	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of advanced or metastatic prostate cancer [6, 16]

AND

2 - Trial and failure, contraindication, or intolerance to any brand Lupron formulation

Product Name: Camcevi, Lupron Depot (7.5 mg, 22.5 mg, 30 mg and 45 mg)	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced or metastatic prostate cancer [6, 16]

Product Name: Camcevi, Eligard, Leuprolide Acetate, generic leuprolide acetate, Lupron Depot (7.5 mg, 22.5 mg, 30 mg and 45 mg), Trelstar, Vantas	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Lupaneta Pack	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endometriosis

AND

2 - One of the following: [9, 13]

2.1 History of inadequate pain control response following a trial of at least 6 months, or history of intolerance or contraindication to one of the following:

- Danazol
- Combination (estrogen/progestin) oral contraceptive
- Progestins

OR

2.2 Patient has had surgical ablation to prevent recurrence

Product Name: Lupaneta Pack	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Recurrence of symptoms following a trial of at least 6 months with leuprolide therapy

Product Name: Lupron Depot, Lupron Depot-PED, Leuprolide Acetate, generic leuprolide acetate, Eligard, Supprelin LA, Trelstar, Triptodur	
Diagnosis	Gender Dysphoria/Gender Incongruence (off-label) [18, 19]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Using gonadotropin for suppression of puberty [18,19]

AND

2 - Diagnosis of gender dysphoria/gender incongruence

3 . Endnotes

A. Sixty days would be a reasonable length of authorization for the treatment of infertility. [14]

4 . References

1. Leuprolide acetate prescribing information. Sandoz Inc. Princeton, NJ. June 2020.
2. Vantas prescribing information. Endo Pharmaceuticals Solutions Inc. Malvern, PA. December 2020.
3. Lupron Depot (3.75 mg) prescribing information. AbbVie Inc. North Chicago, IL. July 2022.

4. Lupron Depot (3-Month 11.25 mg) prescribing information. AbbVie Inc. North Chicago, IL. March 2020.
5. Friedman AJ, Harrison-Atlas D, Barbieri RL, et al. A randomized, placebo-controlled, double-blind study evaluating the efficacy of leuprolide acetate depot in the treatment of uterine leiomyomata. Fertil Steril 1989;51:251-256.
6. DRUGDEX System [Internet database]. Greenwood Village, Colorado: Thomson Micromedex. Updated periodically. Accessed August 31, 2022.
7. Lethaby A, Vollenhoven B, Sowter M. Pre-operative GnRH analogue therapy before hysterectomy or myomectomy for uterine fibroids. Cochrane Database Syst Rev. 2001;(2):CD000547.
8. Supprelin LA prescribing information. Endo Pharmaceutical Inc. Malvern, PA. April 2022.
9. Ferrero, S., Barra, F. & Leone Roberti Maggiore, U. Current and Emerging Therapeutics for the Management of Endometriosis. Drugs 78, 995–1012 (2018).
10. Lupron Depot (7.5 mg, 22.5 mg, 30 mg, 45 mg) prescribing information. AbbVie Inc. North Chicago, IL. April 2022.
11. Eligard prescribing information. Tolmar Pharmaceuticals, Inc. Fort Collins, CO. April 2019.
12. Trelstar prescribing information. Verity Pharmaceuticals, Inc. Wayne, PA. October 2020.
13. Practice bulletin no. 114: management of endometriosis. Obstet Gynecol. 2010 Jul; 116 (1): 223-36.
14. Per clinical consult with reproductive endocrinologist, April 10, 2013.
15. Lupaneta Pack prescribing information. AbbVie Inc. North Chicago, IL. October 2019.
16. National Comprehensive Cancer Network Drugs and Biologics Compendium (NCCN Compendium). Available at: http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed August 31, 2022.
17. Lupron Depot-PED prescribing information. AbbVie Inc. North Chicago, IL. April 2023.
18. Hembree, Wylie C, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. "Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline." The Journal of clinical endocrinology and metabolism 94.9 (2009):3132-3154.
19. Coleman E, Bockting W, Botzer M et al. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. International Journal of Transgenderism. 13:165-232, 2011.
20. Triptodur prescribing information. Arbor Pharmaceuticals, LLC. Atlanta, GA. April 2022.
21. Fensolvi prescribing information. Tolmar Pharmaceuticals, Inc. Fort Collins, CO. April 2022.
22. Camcevi Prescriber Information. Accord BioPharma, Inc. Durham, NC. May 2021.
23. Leuprolide Acetate Depot Prescribing Information. Cipla USA, Inc. Warren, NJ. May 2022.

5 . Revision History

Date	Notes
5/26/2023	Addition of new Lupron Depot 45 mg pediatric kit as target for th e existing CPP indication

Hereditary Angioedema Agents

Prior Authorization Guideline

Guideline ID	GL-124256
Guideline Name	Hereditary Angioedema Agents
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	2/17/2009
P&T Revision Date:	09/18/2019 ; 03/18/2020 ; 07/15/2020 ; 12/16/2020 ; 02/18/2021 ; 04/21/2021 ; 08/19/2021 ; 10/20/2021 ; 10/20/2021 ; 04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Berinert (C1 esterase inhibitor [Human])
Acute treatment of Hereditary Angioedema (HAE) Indicated for the treatment of acute abdominal, facial, or laryngeal attacks of HAE in adult and adolescent patients. The safety and efficacy of Berinert for prophylactic therapy have not been established.
Drug Name: Cinryze (C1 esterase inhibitor [Human])
Prophylaxis of Hereditary Angioedema (HAE) Indicated for routine prophylaxis against angioedema attacks in adults, adolescents and pediatric patients (6 years old and above) with HAE.

Off Label Uses: **Acute treatment of Hereditary Angioedema (HAE)** Following treatment with nanofiltered C1 inhibitor concentrate (Cinryze) for an acute attack, the median time to response was 30 minutes in 82 patients with HAE. [3]
Drug Name: Firazyr (icatibant)
Acute treatment of Hereditary Angioedema (HAE) Indicated for the treatment of acute attacks of HAE in adults 18 years of age and older.
Drug Name: Haegarda (C1 esterase inhibitor [Human])
Prophylaxis of Hereditary Angioedema (HAE) Indicated for routine prophylaxis to prevent HAE attacks in patients 6 years of age and older.
Drug Name: Kalbitor (ecallantide)
Acute treatment of Hereditary Angioedema (HAE) Indicated for treatment of acute attacks of HAE in patients 12 years of age and older.
Drug Name: Orladeyo (berotralstat)
Prophylaxis of Hereditary Angioedema (HAE) Indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years of age and older. Limitations of Use: The safety and effectiveness of ORLADEYO for the treatment of acute HAE attacks have not been established. ORLADEYO should not be used for treatment of acute HAE attacks. Additional doses or doses of ORLADEYO higher than 150 mg once daily are not recommended due to the potential for QT prolongation.
Drug Name: Ruconest (C1 esterase inhibitor [Recombinant])
Acute treatment of Hereditary Angioedema (HAE) Indicated for the treatment of acute attacks in adult and adolescent patients with HAE. Limitation of Use: Effectiveness was not established in HAE patients with laryngeal attacks.
Drug Name: Takhzyro (lanadelumab-flyo)
Prophylaxis of Hereditary Angioedema (HAE) Indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients 2 years and older.
Drug Name: Sajazir (icatibant)
Acute treatment of Hereditary Angioedema (HAE) Indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.

2 . Criteria

Product Name: Cinryze, Haegarda, Orladeyo or Takhzyro	
Diagnosis	Prophylaxis of HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) [A]

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following:

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

AND

3 - For prophylaxis against HAE attacks [3]

AND

4 - One of the following:

- Patient is 6 years of age or older (applies to Cinryze and Haegarda only)
- Patient is 12 years of age or older (applies to Orladeyo only)
- Patient is 2 years of age or older (applies to Takhzyro only)

AND

5 - Prescribed by or in consultation with one of the following: [B]

- Immunologist
- Allergist

Product Name: Cinryze [off-label], Brand Firazyr, Generic icatibant, Sajazir, or Ruconest	
Diagnosis	Treatment of acute HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) [3, A]

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following:

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

AND

3 - For the treatment of acute HAE attacks [3, C]

AND

4 - Not used in combination with other approved treatments for acute HAE attacks

AND

5 - One of the following:

- Patient is 6 years of age or older (applies to Cinryze only)
- Patient is 18 years of age or older (applies to Brand Firazyr, generic icatibant, and Sajazir only)

AND

6 - Prescribed by or in consultation with one of the following: [B]

- Immunologist
- Allergist

AND

7 - Trial and failure or intolerance to one of the following (applies to brand Firazyr only):

- generic icatibant
- Sajazir

Product Name: Kalbitor	
Diagnosis	Treatment of acute HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) [A]

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following:

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

AND

3 - For the treatment of acute HAE attacks

AND

4 - Patient is greater than or equal to 12 years of age [D]

AND

5 - Not used in combination with other approved treatments for acute HAE attacks

AND

6 - Prescribed by or in consultation with one of the following: [B]

- Immunologist
- Allergist

Product Name: Berinert	
Diagnosis	Treatment of acute HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) [3, A]

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following:

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

AND

3 - For the treatment of acute HAE attacks [3, C]

AND

4 - Not used in combination with other approved treatments for acute HAE attacks

AND

5 - One of the following:

5.1 Trial and failure, contraindication, or intolerance to Ruconest

OR

5.2 One of the following:

- Patient is 12 years of age or younger
- Documentation that patient has history of laryngeal attacks

AND

6 - Prescribed by or in consultation with one of the following: [B]

- Immunologist
- Allergist

3 . Endnotes

A. HAE is a rare genetic disorder caused by a deficiency of C1-inhibitor and is inherited in an autosomal dominant manner. This condition is characterized by recurrent episodes of angioedema, without urticaria or pruritus, which most often affect the skin or mucosal tissues of the upper respiratory and gastrointestinal tracts. Diagnosis of HAE requires a blood test to confirm low or abnormal levels of C1-inhibitor. [10]

B. Includes immunologist and allergist specialties to ensure the requirement for proper diagnosing and assessing the severity of the symptoms. In the pivotal Cinryze trial, criteria for participation of long term prophylaxis included patients 9 years and older with documented HAE (based on: a low C4 level plus low C1 inhibitor antigenic level/or low C1 inhibitor functional level OR a known HAE causing mutation) AND a history of at least two HAE attack per month. [1, 8] Berinert is approved for the treatment of acute attacks in patients who are 13 years and older. In the pivotal Berinert trial patients had laboratory-confirmed C1-inhibitor deficiency (type I or II HAE). [9]

C. Following treatment with nanofiltered C1 inhibitor concentrate (Cinryze) for an acute attack, the median time to response was 30 minutes in 82 patients with hereditary angioedema (median number of attacks per patient, 3; range, 1 to 57 attacks) in an open-label extension trial (median follow-up of 11 months). Additionally, 93% of attacks responded within 4 hr after C1 inhibitor concentrate treatment. [3]

D. Kalbitor carries a black box warning that states the following: "Anaphylaxis has been reported after administration of Kalbitor. Because of the risk of anaphylaxis, Kalbitor should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema (HAE).

Healthcare professionals should be aware of the similarity of symptoms between hypersensitivity reactions and hereditary angioedema and patients should be monitored closely. Do not administer Kalbitor to patients with known clinical hypersensitivity to Kalbitor." In 255 HAE patients treated with intravenous or subcutaneous Kalbitor in clinical studies, 10 patients (3.9%) experienced anaphylaxis. For the subgroup of 187 patients treated with subcutaneous Kalbitor, 5 patients (2.7%) experienced anaphylaxis. Symptoms associated with these reactions have included chest discomfort, flushing, pharyngeal edema, pruritus, rhinorrhea, sneezing, nasal congestion, throat irritation, urticaria, wheezing, and hypotension. These reactions occurred within the first hour after dosing. Other adverse reactions indicative of hypersensitivity reactions included the following: pruritus (5.1%), rash (3.1%), and urticaria (2.0%). Patients should be observed for an appropriate period of time after administration of Kalbitor, taking into account the time to onset of anaphylaxis seen in clinical trials. In the Kalbitor HAE program, patients developed antibodies to ecallantide. Rates of seroconversion increased with exposure to ecallantide over time. Overall, 7.4% of patients seroconverted to anti-ecallantide antibodies. Neutralizing antibodies to ecallantide were determined in vitro to be present in 4.7% of patients. Anti-ecallantide and anti-Po pastoris IgE antibodies were also detected. While the long-term effects of antibodies to Kalbitor are not known, patients who seroconvert may be at a higher risk of a hypersensitivity reaction. The manufacturer developed a Risk Evaluation and Mitigation Strategy (REMS) program consisting of a Medication Guide and Communication Plan to notify healthcare professionals of the risk of anaphylaxis and the need to distinguish signs and symptoms of anaphylaxis and HAE attack as they may overlap. The presence of the black box warning necessitating administration by a healthcare professional; development of antibodies to ecallantide that may predispose patients to higher risks of hypersensitivity reactions; and the requirement for a REMS program offer compelling evidence to warrant the continued inclusion of an age criterion. [7]

4 . References

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12. Orladeyo Prescribing Information. BioCryst Pharmaceuticals, Inc. Durham, NC. March 2022.
13. Sajazir Prescribing Information. Cipla Ltd., India. May 2022.

5 . Revision History

Date	Notes
4/5/2023	Annual review: Updated Takhzyro criteria age requirement. Added new 150 mg/mL syringe formulation of Takhzyro (GPI 85842040020E510) to existing Takhzyro criteria. Updated references and background/indications.

Ilaris (canakinumab injection)

Prior Authorization Guideline

Guideline ID	
Guideline Name	Ilaris (canakinumab injection)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2023
P&T Approval Date:	11/17/2009
P&T Revision Date:	08/15/2019 ; 08/13/2020 ; 08/19/2021 ; 08/18/2022 ; 10/19/2022 ; 8/17/2023

1 . Indications

Drug Name: Ilaris (canakinumab injection)
Periodic Fever Syndromes: Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), Familial Mediterranean Fever(FMF) Indicated for the treatment of the following autoinflammatory Periodic Fever Syndromes: Cryopyrin-Associated Periodic Syndromes (CAPS), in adults and children 4 years of age and older including, Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS); Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) in adult and pediatric patients; Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) in adult and pediatric patients; Familial Mediterranean Fever (FMF) in adult and pediatric patients. **Systemic Juvenile Idiopathic Arthritis (SJIA)** Indicated for the treatment of active Systemic Juvenile Idiopathic Arthritis (SJIA) in patients aged 2 years and older.

Still's disease (Adult-Onset Still's Disease [AOSD]) Indicated for the treatment of active Still's disease, including Adult-Onset Still's Disease (AOSD) in patients aged 2 years and older.

2 . Criteria

Product Name: Ilaris	
Diagnosis	Periodic Fever Syndromes [Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency(MKD), Familial Mediterranean Fever(FMF)]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following periodic fever syndromes:

- cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)
- tumor necrosis factor (TNF) receptor associated periodic syndrome (TRAPS)
- hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS/mevalonate kinase deficiency (MKD)
- familial mediterranean fever (FMF)

AND

2 - Prescribed by or in consultation with one of the following:

- Immunologist Allergist
- Dermatologist
- Rheumatologist
- Neurologist

AND

3 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name: Ilaris	
Diagnosis	Periodic Fever Syndrome [CAPS, TRAPS, HIDS/MKD, FMF]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name: Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active systemic juvenile idiopathic arthritis (SJIA)

AND

2 - Trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses [1, 2]:

- Minimum duration of a 3-month trial and failure of methotrexate
- Minimum duration of a 1-month trial of a nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen)
- Minimum duration of a 2-week trial of a systemic glucocorticoid (e.g., prednisone)

AND

3 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following [1, 2]:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline

AND

2 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name: Ilaris	
Diagnosis	Still's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- Diagnosis of Still's Disease, including Adult-Onset Still's Disease (AOSD)

AND

2- Trial and failure, contraindication, or intolerance to one of the following: [1-3]

- Corticosteroids (e.g., prednisone)
- Methotrexate
- Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

AND

3- Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Ilaris	
Diagnosis	Still's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

3 . Definitions

Definition	Description
Cryopyrin-Associated Periodic Syndromes (CAPS):	A group of rare, autosomal dominantly inherited auto-inflammatory conditions comprising of Familial-Cold Auto-inflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS), Neonatal-Onset Multisystem Inflammatory Disease (NOMID) or also known as

	Chronic Infantile Neurologic Cutaneous Articular Syndrome (CINCA), which are caused by the CIAS1 gene mutation and characterized by recurrent symptoms (urticaria-like skin lesions, fever chills, arthralgia, profuse sweating, sensorineural hearing/vision loss, and increased inflammation markers the blood). Approximately 300 people in the United States are affected by CAPS. [1, 4, 5]
Familial Cold Autoinflammatory Syndrome (FCAS):	The mildest form of CAPS, is characterized by cold-induced, daylong episodes of fever associated with rash, arthralgia, headaches and less frequently conjunctivitis, but without other signs of CNS inflammation. Symptoms usually begin during the first 6 months of life and are predominantly triggered by cold exposure. Duration of episodes usually is less than 24 hours. [5]
Muckle-Wells Syndrome (MWS):	A subtype of CAPS, which is characterized by episodic attacks of inflammation associated with a generalized urticaria-like rash, fever, malaise, arthralgia, and progressive hearing loss. Duration of symptoms usually lasts from 24-48 hours. [5]

4 . References

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5. Revision History

Date	Notes
8/1/2023	2023 UM Annual Review. Removal of "Other medical specialist" requ irement. Removed Ilaris 180mg as it is discontinued.

Immune Globulins - PA, NF

Prior Authorization Guideline

Guideline ID	GL-121785
Guideline Name	Immune Globulins - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	9/5/2000
P&T Revision Date:	07/17/2019 ; 09/18/2019 ; 08/15/2019 ; 10/16/2019 ; 11/14/2019 ; 12/18/2019 ; 04/15/2020 ; 05/14/2020 ; 04/21/2021 ; 09/15/2021 ; 12/15/2021 ; 01/19/2022 ; 02/17/2022 ; 04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Bivigam and Octagam 5% (immune globulin [Human])
Primary Immunodeficiency Disorders Indicated for the treatment of primary immunodeficiency disorders associated with defects in humoral immunity. These include, but are not limited to: congenital agammaglobulinemia, X-linked agammaglobulinemia, common variable immunodeficiency, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.
Drug Name: Flebogamma 5% (immune globulin [Human])

Primary Immunodeficiency Disorders Indicated in adults and pediatric patients 2 years of age and older for the treatment of primary immunodeficiency (PI), including the humoral immune defects in common variable immunodeficiency, x-linked agammaglobulinemia, severe combined immunodeficiency, and Wiskott-Aldrich syndrome.

Drug Name: Flebogamma 10% (immune globulin [Human])

Primary Immunodeficiency Disorders Indicated as replacement therapy in primary immunodeficiency (PI) including the humoral immune defects in common variable immunodeficiency, xlinked agammaglobulinemia, severe combined immunodeficiency, and Wiskott-Aldrich syndrome.

Chronic Primary Immune Thrombocytopenia (ITP) Indicated for the treatment of patients 2 years of age and older with chronic primary ITP to raise platelet count.

Drug Name: Gamastan (immune globulin [Human])

Measles (Rubeola) Indicated to prevent or modify measles in a susceptible person exposed fewer than 6 days previously. A susceptible person is one who has not been vaccinated and has not had measles previously. Gamastan may be especially indicated for susceptible household contacts of measles patients, particularly contacts under 1 year of age, for whom the risk of complications is highest. Gamastan is also indicated for pregnant women without evidence of immunity. Gamastan and measles vaccine should not be given at the same time. If a child is older than 12 months and has received Gamastan, he should be given measles vaccine about 5 months later when the measles antibody titer will have disappeared. If a susceptible child exposed to measles is immunocompromised, give Gamastan immediately.

Rubella Indicated to modify rubella in exposed women who will not consider a therapeutic abortion. Some studies suggest that the use of Gamastan in exposed, susceptible women can lessen the likelihood of infection and fetal damage; therefore, Gamastan may benefit those women who will not consider a therapeutic abortion. Do not give Gamastan for routine prophylaxis of rubella in early pregnancy to an unexposed woman.

Hepatitis A Indicated for prophylaxis following exposure to hepatitis A. The prophylactic value of Gamastan is greatest when given before or soon after exposure to hepatitis A. Gamastan is not indicated in persons with clinical manifestations of hepatitis A or in those exposed more than 2 weeks previously.

Varicella Indicated to modify varicella. Passive immunization against varicella in immunosuppressed patients is best accomplished by use of Varicella Zoster Immune

globulin (Human) [VZIG]. If VZIG is unavailable, Gamastan, promptly given, may also modify varicella.

Drug Name: Carimune NF (immune globulin [Human])

Idiopathic Thrombocytopenic Purpura (ITP) (1) Acute ITP: A controlled study was performed in children in which Carimune was compared with steroids for the treatment of acute (defined as less than 6 months duration) ITP. In this study sequential platelet levels of 30,000, 100,000, and 150,000/microliter were all achieved faster with Carimune than with steroids and without any of the side effects associated with steroids. However, it should be noted that many cases of acute ITP in childhood resolve spontaneously within weeks to months. Carimune has been used with good results in the treatment of acute ITP in adult patients. In a study involving 10 adults with ITP of less than 16 weeks duration, Carimune therapy raised the platelet count to the normal range after a 5 day course. This effect lasted a mean of over 173 days, ranging from 30 to 372 days. (2) Chronic ITP: Children and adults with chronic (defined as greater than 6 months duration) ITP have also shown an increase (sometimes temporary) in platelet counts upon administration of Carimune. Therefore, in situations that require a rapid rise in platelet count, for example prior to surgery or to control excessive bleeding, use of Carimune should be considered. In children with chronic ITP, Carimune therapy resulted in a mean rise in platelet count of 312,000/microliter with a duration of increase ranging from 2 to 6 months. Carimune therapy may be considered as a means to defer or avoid splenectomy. In adults, Carimune therapy has been shown to be effective in maintaining the platelet count in an acceptable range with or without periodic booster therapy. The mean rise in platelet count was 93,000/microliter and the average duration of the increase was 20-24 days. However, it should be noted that not all patients will respond. Even in those patients who do respond, this treatment should not be considered to be curative.

Primary Immunodeficiency Disorders Indicated for the maintenance treatment of patients with primary immunodeficiencies (PID), e.g., common variable immunodeficiency, X-linked agammaglobulinemia, severe combined immunodeficiency. Carimune NF is preferable to intramuscular Immune Globulin (Human) preparations in treating patients who require an immediate and large increase in the intravascular immunoglobulin level, in patients with limited muscle mass, and in patients with bleeding tendencies for whom intramuscular injections are contraindicated. The infusions must be repeated at regular intervals.

Drug Name: Privigen (immune globulin [Human])

Chronic Immune Thrombocytopenic Purpura (ITP) Indicated for the treatment of patients age 15 years and older with chronic ITP to raise platelet counts.

Primary Immunodeficiency Disorders Indicated as replacement therapy for primary humoral immunodeficiency (PI). This includes, but is not limited to, the humoral

immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Indicated for the treatment of adults with chronic inflammatory demyelinating polyneuropathy (CIDP) to improve neuromuscular disability and impairment. Limitation of Use: Privigen maintenance therapy in CIDP has not been studied for periods longer than 6 months. After responding during an initial treatment period, not all patients require indefinite maintenance therapy with Privigen in order to remain free of CIDP symptoms. Individualize the duration of any treatment beyond 6 months based upon the patient's response and demonstrated need for continued therapy.

Drug Name: Gammagard S/D (immune globulin [Human])

Kawasaki Disease Indicated for the prevention of coronary artery aneurysms associated with Kawasaki syndrome in pediatric patients.

B-cell Chronic Lymphocytic Leukemia (CLL) Indicated for prevention of bacterial infections in hypogammaglobulinemia and/or recurrent bacterial infections associated with B-cell Chronic Lymphocytic Leukemia (CLL).

Idiopathic Thrombocytopenic Purpura (ITP) Indicated for the treatment of adult chronic idiopathic thrombocytopenic purpura to increase platelet count and to prevent and/or to control bleeding.

Primary Immunodeficiency Disorders Indicated for the treatment of primary immunodeficiency (PI) associated with defects in humoral immunity, in adults and children two years and older. This includes, but is not limited to, congenital agammaglobulinemia, common variable immunodeficiency, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Drug Name: Gammaked and Gamunex-C (immune globulin [Human])

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Indicated for the treatment of CIDP in adults to improve neuromuscular disability and impairment and for maintenance therapy to prevent relapse.

Idiopathic Thrombocytopenic Purpura (ITP) Indicated for the treatment of adults and children with idiopathic thrombocytopenic purpura to raise platelet counts to prevent bleeding or to allow a patient with ITP to undergo surgery.

Primary Immunodeficiency Disorders Indicated for treatment of primary humoral immunodeficiency in patients 2 years of age and older. This includes, but is not limited to, congenital agammaglobulinemia, common variable immunodeficiency, X-linked

agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Drug Name: Immune globulin products (IVIG)

Off Label Uses: Bone Marrow Transplant (BMT) [6, 21-24] Has been used to decrease the incidence of infections and graft versus host disease (GVHD) in patients 20 years of age and older who underwent bone marrow transplantation.

Dermatomyositis [6, 25-29] In patients with treatment-resistant dermatomyositis, IVIG therapy resulted in improvements in muscle strength and neuromuscular symptoms.

Multifocal Motor Neuropathy (MMN) [6, 30, 34] In placebo-controlled trials, IVIG has been shown to improve strength and reduce disability and conduction block in patients with MMN.

Pediatric HIV [6, 35-37, 75] Used to decrease the frequency of serious and minor bacterial infections; the frequency of hospitalization; and to increase the time free of serious bacterial infections in patients with HIV.

Guillain-Barre Syndrome [6, 38-40] Considered to be equally effective as plasma exchange for the treatment of Guillain-Barre Syndrome.

Lambert-Eaton Myasthenic Syndrome [6, 41] Shown to produce short-term improvement in strength in patients with Lambert-Eaton Myasthenic Syndrome.

Myasthenia Gravis [6, 72, 74] A clinical study comparing IVIG with plasma exchange did not show a significant difference between the two treatments in patients with myasthenia gravis exacerbation. Several open studies support beneficial effects of IVIG in treating myasthenia gravis.

Relapsing Remitting Multiple Sclerosis [6, 50, 52] Published studies indicate that IVIG may reduce the frequency of acute exacerbations and provide symptomatic relief in patients with relapsing-remitting forms of multiple sclerosis.

Stiff-Person Syndrome [6, 83, 84] The efficacy of IVIG for the treatment of stiff-person syndrome was demonstrated in a randomized, double-blind, placebo-controlled, crossover trial.

Polymyositis [6, 64] Found to be effective in reversing chronic polymyositis previously unresponsive to immunosuppressive therapy.

Drug Name: Gammagard liquid (immune globulin [Human])

Primary Immunodeficiency Disorders Indicated as replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age or older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Multifocal Motor Neuropathy (MMN) Indicated as a maintenance therapy to improve muscle strength and disability in adult patients with Multifocal Motor Neuropathy (MMN).

Drug Name: Gammaplex (immune globulin [Human])

Primary Immunodeficiency Disorders Indicated for replacement therapy in primary humoral immunodeficiency (PI) in adults and pediatric patients two years of age and older. This includes, but is not limited to, the humoral immune defect in common variable immunodeficiency, X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Chronic Immune Thrombocytopenic Purpura (ITP) Indicated for the treatment of adults with chronic immune thrombocytopenic purpura (ITP) to raise platelet counts.

Drug Name: Octagam 10% (immune globulin [Human])

Chronic Immune Thrombocytopenic Purpura Indicated in chronic immune thrombocytopenic purpura to rapidly raise platelet counts to control or prevent bleeding in adults.

Dermatomyositis Indicated for the treatment of dermatomyositis in adults.

Drug Name: Cytogam (human cytomegalovirus immune globulin liquid)

Cytomegalovirus Indicated for the prophylaxis of cytomegalovirus disease associated with transplantation of kidney, lung, liver, pancreas and heart. In transplants of these organs other than kidney from CMV seropositive donors into seronegative recipients, prophylactic CMV-IGIV should be considered in combination with ganciclovir.

Drug Name: Varizig (varicella zoster immune globulin [Human] solution)

Post-exposure prophylaxis of varicella Indicated for post-exposure prophylaxis of varicella in high risk individuals. High risk groups include: immunocompromised children and adults, newborns of mothers with varicella shortly before or after delivery, premature infants, neonates and infants less than one year of age, adults without evidence of immunity, pregnant women. Limitations of Use: There is no convincing evidence that Varizig reduces the incidence of chickenpox infection after exposure to

VZV. There is no convincing evidence that established infections with VZV can be modified by Varizig administration. There is no indication for the prophylactic use of Varizig in immunodeficient children or adults when there is a past history of varicella, unless the patient is undergoing bone marrow transplantation.

Drug Name: Hizentra (immune globulin [Human] liquid)

Primary Immunodeficiency Disorders Indicated as replacement therapy for primary humoral immunodeficiency (PI) in adults and pediatric patients 2 years of age and older. This includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Indicated for the treatment of adult patients with chronic inflammatory demyelinating polyneuropathy (CIDP) as maintenance therapy to prevent relapse of neuromuscular disability and impairment. Limitations of Use: Hizentra maintenance therapy in CIDP has been systematically studied for 6 months and for a further 12 months in a follow-up study. Maintenance therapy beyond these periods should be individualized based upon the patient's response and need for continued therapy.

Drug Name: Panzyga (immune globulin intravenous [Human] - ifas)

Primary Immunodeficiency Disorders Indicated for treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older. This includes, but is not limited to, congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Chronic Immune Thrombocytopenia (ITP) Indicated for the treatment of adult patients with ITP to raise platelet counts to control or prevent bleeding.

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Indicated for the treatment of adults with chronic inflammatory demyelinating polyneuropathy (CIDP) to improve neuromuscular disability and impairment.

Drug Name: Cuvitru (immune globulin [Human])

Primary Immunodeficiency Disorders Indicated as replacement therapy for primary humoral immunodeficiency (PI) in adult and pediatric patients two years of age and older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.

Drug Name: Cutaquig (Immune globulin subcutaneous [Human] - hipp)
Primary Immunodeficiency Disorders Indicated as replacement therapy for primary humoral immunodeficiency (PI) in adults and pediatric patients 2 years of age and older. This includes, but is not limited to, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, congenital agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.
Drug Name: Xembify (immune globulin subcutaneous, human - klhw)
Primary Immunodeficiency Disorders Indicated for treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older. This includes, but is not limited to, congenital agammaglobulinemia, common variable immunodeficiency, X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies.
Drug Name: Asceniv (immune globulin intravenous, human - slra)
Primary Immunodeficiency Disorders Indicated for the treatment of primary humoral immunodeficiency (PI) in adults and adolescents (12 to 17 years of age). PI includes, but is not limited to, the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies (SCID).

2 . Criteria

Product Name: Intravenous or subcutaneous immune globulins (IVIG or SCIG)	
Diagnosis	Primary Immunodeficiency Syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - For patients with a primary immunodeficiency syndrome [1, 3, 5, 6, 57, 61, 65-71, I, J]	

AND

2 - Clinically significant functional deficiency of humoral immunity as evidenced by one of the following: [73]

2.1 Documented failure to produce antibodies to specific antigens

OR

2.2 History of significant recurrent infections

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

OR

3.2 Trial and failure, contraindication, or intolerance to two of the following (applies to Cutaquig only):

- Cuvitru
- Hizentra
- Xembify

Diagnosis	Primary Immunodeficiency Syndrome
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - For patients with a primary immunodeficiency syndrome [1, 3, 5, 6, 57, 61, 65-71, I, J]

AND

2 - Clinically significant functional deficiency of humoral immunity as evidenced by one of the following: [73]

2.1 Documented failure to produce antibodies to specific antigens

OR

2.2 History of significant recurrent infections

AND

3 - One of the following:

3.1 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

OR

3.2 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following (applies to Cutaquig only):

- Cuvitru
- Hizentra
- Xembify

Product Name: Intravenous immune globulins (IVIG)	
Diagnosis	Idiopathic Thrombocytopenic Purpura (ITP)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of idiopathic thrombocytopenic purpura (ITP) [3, 5, 62, 68-70, 88]

AND

2 - Documented platelet count of less than 50 x 10^9 / L [85]

AND

3 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Asceniv, Panzyga

Diagnosis	Idiopathic Thrombocytopenic Purpura (ITP)
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of idiopathic thrombocytopenic purpura (ITP) [3, 5, 62, 68-70, 88]

AND

2 - Documented platelet count of less than 50 x 10^9 / L [85]

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulins (IVIG)	
Diagnosis	Kawasaki Disease (KD) [5, 7-9]
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Kawasaki Disease [5]

AND

2 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Asceniv, Panzyga	
Diagnosis	Kawasaki Disease (KD) [5, 7-9]
Approval Length	1 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Kawasaki Disease [5]

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C

- Privigen

Product Name: Intravenous immune globulins (IVIG)	
Diagnosis	B-cell Chronic Lymphocytic Leukemia (CLL) [5, 10-14]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of B-cell chronic lymphocytic leukemia (CLL) [5]

AND

2 - One of the following:

2.1 Documented hypogammaglobulinemia (IgG less than 500 mg/dL) [13, 14, 78, B]

OR

2.2 History of bacterial infection(s) associated with B-cell CLL [13-15, 78, A]

AND

3 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Asceniv, Panzyga	
Diagnosis	B-cell Chronic Lymphocytic Leukemia (CLL) [5, 10-14]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of B-cell chronic lymphocytic leukemia (CLL) [5]

AND

2 - One of the following:

2.1 Documented hypogammaglobulinemia (IgG less than 500 mg/dL) [13, 14, 78, B]

OR

2.2 History of bacterial infection(s) associated with B-cell CLL [13-15, 78, A]

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG), Hizentra	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) [15-20, 55, 58, 62, C, H]

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) as confirmed by all of the following [77, C]:

1.1 Progressive symptoms present for at least 2 months

AND

1.2 Symptomatic polyradiculoneuropathy as indicated by one of the following:

1.2.1 Progressive or relapsing motor impairment of more than one limb

OR

1.2.2 Progressive or relapsing sensory impairment of more than one limb

AND

1.3 Electrophysiologic findings when three of the following four criteria are present:

- Partial conduction block of 1 or more motor nerve
- Reduced conduction velocity of 2 or more motor nerves
- Prolonged distal latency of 2 or more motor nerves
- Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves

AND

2 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG), Hizentra	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) [15-20, 55, 58, 62, C, H]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as measured by an objective scale (e.g., Rankin, Modified Rankin, Medical Research Council [MRC] scale) [77, H, P]

AND

2 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect [P]

Product Name: Asceniv, Panzyga	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) [15-20, 55, 58, 62, C, H]
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) as confirmed by all of the following [77, C]:

1.1 Progressive symptoms present for at least 2 months

AND

1.2 Symptomatic polyradiculoneuropathy as indicated by one of the following:

1.2.1 Progressive or relapsing motor impairment of more than one limb

OR

1.2.2 Progressive or relapsing sensory impairment of more than one limb

AND

1.3 Electrophysiologic findings when three of the following four criteria are present:

- Partial conduction block of 1 or more motor nerve
- Reduced conduction velocity of 2 or more motor nerves
- Prolonged distal latency of 2 or more motor nerves
- Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Gamastan	
Diagnosis	Hepatitis A
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For prophylaxis of Hepatitis A before or soon after exposure [57, 93]

AND

2 - Patient does not have clinical manifestations of hepatitis A [57, 93]

AND

3 - Patient does not have exposure to hepatitis A for more than 2 weeks previously [57, 93]

Product Name: Gamastan	
Diagnosis	Measles (Rubeola)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For use in susceptible individuals exposed to measles fewer than 6 days previously [57, 93]

AND

2 - Patient is not receiving measles vaccine at the same time [57, 93]

Product Name: Gamastan	
Diagnosis	Varicella
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For passive immunization against varicella [57, 93]

AND

2 - Patient is immunosuppressed [57, 93]

AND

3 - Varicella Zoster Immune Globulin (Human) vaccine is not available

Product Name: Gamastan	
Diagnosis	Rubella
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For pregnant women who are exposed or susceptible to Rubella [57, 93]

AND

2 - Patient will not consider a therapeutic abortion [57, 93]

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Bone Marrow Transplantation (off-label) [21-24]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Confirmed allogeneic bone marrow transplant within the last 100 days [21-23, D]

AND

2 - Documented severe hypogammaglobulinemia (IgG less than 400 mg/dL) [21, D]

AND

3 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Asceniv, Panzyga

Diagnosis	Bone Marrow Transplantation (off-label) [21-24]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Confirmed allogeneic bone marrow transplant within the last 100 days [21-23, D]

AND

2 - Documented severe hypogammaglobulinemia (IgG less than 400 mg/dL) [21, D]

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	HIV (off-label) [35-37, 75, 79, 80]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of HIV disease [35, 75, K]

AND

2 - Patient is less than or equal to 13 years of age [75, 80]

AND

3 - One of the following:

3.1 Documented hypogammaglobulinemia (IgG less than 400 mg/dL) [75, L]

OR

3.2 Functional antibody deficiency as demonstrated by one of the following: [79]

- Poor specific antibody titers
- Recurrent bacterial infections

AND

4 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Asceniv, Panzyga	
Diagnosis	HIV (off-label) [35-37, 75, 79, 80]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of HIV disease [35, 75, K]

AND

2 - Patient is less than or equal to 13 years of age [75, 80]

AND

3 - One of the following:

3.1 Documented hypogammaglobulinemia (IgG less than 400 mg/dL) [75, L]

OR

3.2 Functional antibody deficiency as demonstrated by one of the following: [79]

- Poor specific antibody titers
- Recurrent bacterial infections

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)

Diagnosis	Multifocal Motor Neuropathy (off-label) [30-34]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multifocal motor neuropathy (MMN) as confirmed by all of the following [76, 86, 87, N]:

1.1 Weakness with slowly progressive or stepwise progressive course over at least one month

AND

1.2 Asymmetric involvement of two or more nerves

AND

1.3 Absence of both of the following:

1.3.1 Motor neuron signs

AND

1.3.2 Bulbar signs

AND

2 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard

- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Multifocal Motor Neuropathy (off-label) [30-34]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale] [76, 87]

AND

2 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name: Asceniv, Panzyga	
Diagnosis	Multifocal Motor Neuropathy (off-label) [30-34]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of multifocal motor neuropathy (MMN) as confirmed by all of the following [76, 86, 87, N]:

1.1 Weakness with slowly progressive or stepwise progressive course over at least one month

AND

1.2 Asymmetric involvement of two or more nerves

AND

1.3 Absence of both of the following:

1.3.1 Motor neuron signs

AND

1.3.2 Bulbar signs

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Relapsing-Remitting Multiple Sclerosis (off-label) [50-52]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of relapsing remitting multiple sclerosis (RRMS)) [6, 50, 52, 75, G]

AND

2 - Documentation of an MS exacerbation or progression (worsening) of the patient's clinical status from the visit prior to the one prompting the decision to initiate immune globulin therapy [6, 50, 52, 75, G, M, O]

AND

3 - Trial and failure, contraindication, or intolerance to two of the following agents: [52, G, M, O]

- Aubagio (teriflunomide)*
- Avonex (interferon beta-1a)*
- Betaseron (interferon beta-1b)*
- Copaxone/Glatopa (glatiramer acetate)*
- Extavia (interferon beta-1b)*
- Gilenya (Fingolimod)*
- Lemtrada (alemtuzumab)*
- Plegridy (peginterferon beta-1a)*
- Rebif (interferon beta-1a)*
- Tecfidera (dimethyl fumarate)*
- Tysabri (natalizumab)*

AND

4 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Notes	*This agent may require prior authorization.

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Relapsing-Remitting Multiple Sclerosis (off-label) [50-52]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The prescriber maintains and provides chart documentation of the patient's evaluation, including both of the following [6, 50, 52, 75, O]:

1.1 Findings of interval examination including neurological deficits incurred

AND

1.2 Assessment of disability (e.g., Expanded Disability Status Score [EDSS], Functional Systems Score [FSS], Multiple Sclerosis Functional Composie [MSFC], Disease Steps [DS])

AND

2 - Stable or improved disability score (e.g., EDSS, FSS, MSFC, DS) [6, 50, 52, 75]

AND

3 - Documentation of decreased number of relapses since starting immune globulin therapy [6, 50, 52, 75]

AND

4 - Diagnosis continues to be the relapsing-remitting form of MS (RRMS)

AND

5 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name: Asceniv, Panzyga	
Diagnosis	Relapsing-Remitting Multiple Sclerosis (off-label) [50-52]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of relapsing remitting multiple sclerosis (RRMS)) [6, 50, 52, 75, G]

AND

2 - Documentation of an MS exacerbation or progression (worsening) of the patient's clinical status from the visit prior to the one prompting the decision to initiate immune globulin therapy [6, 50, 52, 75, G, M, O]

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following agents: [52, G, M, O]

- Aubagio (teriflunomide)*
- Avonex (interferon beta-1a)*
- Betaseron (interferon beta-1b)*
- Copaxone/Glatopa (glatiramer acetate)*
- Generic dimethyl fumarate
- Gilenya (Fingolimod)*
- Lemtrada (alemtuzumab)*

- Tysabri (natalizumab)*

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Notes	*This agent may require prior authorization.

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Myasthenia Gravis Exacerbation (off-label) [45-49]
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis [45, 72, 74, F, R]

AND

2 - Evidence of myasthenic exacerbation, defined by one of the following symptoms in the last month: [45, 72, 74, F, R]

2.1 Difficulty swallowing

OR

2.2 Acute respiratory failure

OR

2.3 Major functional disability responsible for the discontinuation of physical activity

AND

3 - Concomitant immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine), unless contraindicated, will be used for long-term management of myasthenia gravis [45, 72, 74, F, R]

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Diagnosis	Myasthenia Gravis Exacerbation (off-label) [45-49]
Approval Length	3 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis [45, 72, 74, F, R]

AND

2 - Evidence of myasthenic exacerbation, defined by one of the following symptoms in the last month: [45, 72, 74, F, R]

2.1 Difficulty swallowing

OR

2.2 Acute respiratory failure

OR

2.3 Major functional disability responsible for the discontinuation of physical activity

AND

3 - Concomitant immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine), unless contraindicated, will be used for long-term management of myasthenia gravis [45, 72, 74, F, R]

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Stiff Person Syndrome (off-label) [53]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of stiff-person syndrome [55, 83, 84]

AND

2 - Trial and failure, contraindication or intolerance to GABAergic medication (e.g., baclofen, benzodiazepines) [55, 83, 84]

AND

3 - Trial and failure, contraindication or intolerance to immunosuppressive therapy (e.g., azathioprine, corticosteroids) [55, 83, 84]

AND

4 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Stiff Person Syndrome (off-label) [53]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name: Asceniv, Panzyga	
Diagnosis	Stiff Person Syndrome (off-label) [53]
Approval Length	12 month(s)

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of stiff-person syndrome [55, 83, 84]

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication or intolerance to GABAergic medication (e.g., baclofen, benzodiazepines) [55, 83, 84]

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication or intolerance to immunosuppressive therapy (e.g., azathioprine, corticosteroids) [55, 83, 84]

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Dermatomyositis and Polymyositis (off-label) [6, 25-29, 64]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses [29]:

- Dermatomyositis
- Polymyositis

AND

2 - Trial and failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azathioprine, corticosteroids, cyclophosphamide, methotrexate) [29, Q]

AND

3 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Dermatomyositis and Polymyositis (off-label) [6, 25-29, 64]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name: Asceniv, Panzyga	
Diagnosis	Dermatomyositis and Polymyositis (off-label) [6, 25-29, 64]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following diagnoses [29]:

- Dermatomyositis
- Polymyositis

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azathioprine, corticosteroids, cyclophosphamide, methotrexate) [29, Q]

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Guillain-Barre Syndrome (off-label) [38-40]
Approval Length	3 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Guillain-Barre Syndrome

AND

2 - Patients with severe disease requiring aid to walk [40, E]

AND

3 - Onset of neuropathic symptoms within the last four weeks [40, E]

AND

4 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Guillain-Barre Syndrome (off-label) [38-40]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name: Asceniv, Panzyga	
Diagnosis	Guillain-Barre Syndrome (off-label) [38-40]
Approval Length	3 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Guillain-Barre Syndrome

AND

2 - Patients with severe disease requiring aid to walk [40, E]

AND

3 - Onset of neuropathic symptoms within the last four weeks [40, E]

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Lambert-Eaton Myasthenic Syndrome (off-label) [41]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) [41]

AND

2 - History of failure, contraindication, or intolerance to immunomodulator monotherapy (e.g., azathioprine, corticosteroids) [81, 82]

AND

3 - Concomitant immunomodulator therapy (eg, azathioprine, corticosteroids), unless contraindicated, will be used for long-term management of LEMS [81, 82]

AND

4 - Trial and failure, contraindication, or intolerance to two of the following (applies to Asceniv and Panzyga only):

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Intravenous immune globulin (IVIG)	
Diagnosis	Lambert-Eaton Myasthenic Syndrome (off-label) [41]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name: Asceniv, Panzyga	
Diagnosis	Lambert-Eaton Myasthenic Syndrome (off-label) [41]
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Lambert-Eaton Myasthenic Syndrome (LEMS) [41]

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to immunomodulator monotherapy (e.g., azathioprine, corticosteroids) [81, 82]

AND

3 - Concomitant immunomodulator therapy (e.g., azathioprine, corticosteroids), unless contraindicated, will be used for long-term management of LEMS [81, 82]

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to two of the following:

- Gammagard
- Gammaplex
- Gamunex-C
- Privigen

Product Name: Cytogam	
Diagnosis	Prophylaxis for CMV Infection
Approval Length	16 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Patient requires prophylaxis for CMV infection following kidney transplantation

AND

1.1.2 Patient is CMV- seronegative and organ donor is CMV-seropositive

OR

1.2 All of the following:

1.2.1 Patient requires prophylaxis for CMV infection following liver, heart, lung, or pancreas transplantation

AND

1.2.2 Patient is CMV- seronegative and organ donor is CMV-seropositive

AND

1.2.3 Used in combination with ganciclovir or valganciclovir unless the patient has a hypersensitivity to, is intolerant of, or therapy is deemed inappropriate

Product Name: Varizig	
Diagnosis	Varicella
Approval Length	1 Dose
Guideline Type	Prior Authorization

Approval Criteria

1 - For passive immunization or post exposure-prophylaxis of varicella

AND

2 - Patient is considered a high risk individual (e.g., immune compromised, pregnant woman, newborn of mother with varicella, premature infant, and infant less than 1 year old)

AND

3 - Prescribed immune globulin is being used intramuscularly

3 . Endnotes

A. Guidelines from the British Committee for Standards in Haematology [11] and the National Comprehensive Cancer Network [16] state that IVIG therapy may be beneficial in patients with recurrent infections. Clinical studies show that IVIG reduces the number of bacterial infections, but not viral or fungal infections. [24]
B. Based on inclusion criteria from Molica et al. [14]
C. According to published data, there appears to be no difference in efficacy among IVIG, plasma exchange, and corticosteroids. [15, 17, 20]
D. A controlled trial indicated that treatment with IVIG beyond three months was associated with a delayed recovery of humoral immunity, and the rate of infections after two years of treatment was increased significantly in IVIG recipients. [25] Centers for Disease Control and Prevention, Infectious Disease Society of America, and American Society of Blood and Marrow Transplantation guidelines recommended routine IVIG use to prevent bacterial infections among BMT recipients with unrelated marrow grafts who experience severe hypogammaglobulinemia (e.g., IgG < 400 mg/dl) within the first 100 days after transplant. [21]
E. The American Academy of Neurology recommends that IVIG is for patients with GBS who require aid to walk within 2 weeks from the onset of neuropathic symptoms. [40]
F. The effectiveness of IVIG for moderate-to-severe but stable myasthenia gravis, or for moderate exacerbations of myasthenia gravis have not been demonstrated in adequately controlled trials. [48] IVIG may be as effective as plasma exchange for patients with acute exacerbations of myasthenia gravis. [45] The indications for the use of IVIG are the same as those for plasma exchange: to produce rapid improvement to help the patient through a difficult period of myasthenic weakness.

It has the advantages of not requiring special equipment or large-bore vascular access. [59] The usual dose of immune globulin is 400 mg per kilogram per day for five successive days. The improvement rate after immune globulin treatment, calculated from eight published reports, was 73 percent, but this figure is likely to be biased by selective reporting of positive uncontrolled trials. In patients who respond, improvement begins within four to five days. The effect is temporary but may be sustained for weeks to months, allowing intermittent long-term therapy in patients with otherwise refractory disease.

G. Guidelines from the American Academy of Neurology [42] state that interferon Beta or glatirimer are appropriate treatments for patients who have relapsing-remitting multiple sclerosis. The guidelines state that it is only possible that IVIG reduces the attack rate in RRMS, and that current evidence suggests IVIG is of little benefit with regard to slowing disease progression.
H. Treatment for CIDP includes corticosteroids such as prednisone, which may be prescribed alone or in combination with immunosuppressant drugs. [58] Plasmapheresis and intravenous immunoglobulin (IVIG) therapy are effective. IVIG may be used even as a first-line therapy. Physiotherapy may improve muscle strength, function and mobility, and minimize the shrinkage of muscles and tendons and distortions of the joints.
I. Subcutaneous formulations of immune globulin are available for the treatment of patients with primary immune deficiency. Subcutaneous infusions may be an alternative for patients with adverse effects to intravenous infusions of immune globulin or with poor venous access. Other advantages include decreased cost of administration, independence from scheduled home nursing visits, better maintenance of intravenous immune globulin trough levels, and a serum IgG profile (smaller variation in the peak and trough IgG concentrations compared to intravenous administration) that is similar to that in a normal population. Disadvantages include more frequent infusions and local reactions. [6]
J. There are good data to show that all immune globulins (IVIG/SCIG) are effective for primary immunodeficiency. There are no data for SCIG for indications other than PI. Efficacy is a class effect for all immune globulins products. It is appropriate to combine all IVIG/SCIG products as they are used interchangeably for PI; can combine all IVIG for other indications. Gamastan S/D (IMIG) has unique indications and should be available on the formulary. [74]
K. IVIG has been used in children with symptomatic human immunodeficiency virus (HIV) infection who are immunosuppressed in association with acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC) in an attempt to control or prevent infections and improve immunologic parameters. Results of studies in adults and children with symptomatic HIV infection indicate that IVIG, used in dosages similar to those used for replacement therapy in patients with primary immunodeficiencies, reduces the incidence of recurrent bacterial infections and sepsis, including upper respiratory tract infections. [75]
L. The ACIP, American Academy of Pediatrics (AAP), Centers for Disease Control (CDC), National Institutes of Health (NIH), HIV Medicine Association of the Infectious Diseases Society of America (IDSA), Pediatric Infectious Diseases

Society, and other experts state that HIV-infected infants and children who have hypogammaglobulinemia (IgG less than 400 mg/dL) should receive IVIG (400 mg/kg once every 2-4 weeks) to prevent serious bacterial infections. [75]

M. Per expert consultant regarding MS: IVIG is only used in acute, severe MS. IVIG is used for bad relapses of MS with significant neurological dysfunction when a patient is breaking through their regular maintenance medications. It takes about 3 months to see if there is improvement in MS and one cannot say a patient has failed a medication if they have a breakthrough episode of MS within this 3 month period [86].
N. Per expert consultant regarding multifocal motor neuropathy: the European Federation of Neurological Societies (EFNS) guidelines [88] as outlined on page 344 and in the table are fairly reasonable: 1. Weakness with slowly progressive or stepwise progressive course 2. Asymmetric involvement of two or more nerves 3. Absence of upper motor neuron signs and bulbar signs [87].
O. Per expert consultant regarding MS: there are no data to support the initial length of IVIG treatment in MS. I would suggest 3 months and then reevaluate. An appropriate length of time for reauthorization of IVIG is 12 months. Patients who receive IVIG for RRMS should be in acute exacerbation, should have tried steroids, have documentation of inability to tolerate other disease modifying drugs, as well as show progression of disease. IVIG should be used 2nd or 3rd line if other injectable disease modifying drugs are not tolerated. Guidelines do not support IVIG as first line treatment for MS [87].
P. Per expert consultant regarding CIDP: It is important to reevaluate a patient after initial treatment. Some patients may need changes in dosing intervals due to wearing off of a dose within 2-3 weeks. Treatment can be lifelong for some patient [87].
Q. Per expert consultant regarding dermatomyositis: It is reasonable to ask a patient to try steroids prior to treatment with IVIG. [87]
R. Per expert consultant regarding MG: IVIG should be used in patients with moderate to severe myasthenia gravis with acute exacerbation. Most MDs favor plasma exchange for maintenance therapy in MG patients. Myasthenic exacerbation = myasthenic crisis. [87]

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5 . Revision History

Date	Notes
4/5/2023	Annual review: Removed obsolete/unavailable product GPI. Upd ated Gamastan's authorization duration and background.

Increlex (mecasermin [rDNA origin])

Prior Authorization Guideline

Guideline ID	GL-116419
Guideline Name	Increlex (mecasermin [rDNA origin])
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	1/1/2023
P&T Approval Date:	4/4/2006
P&T Revision Date:	11/14/2019 ; 11/12/2020 ; 11/18/2021 ; 11/17/2022

1 . Indications

Drug Name: Increlex (mecasermin [rDNA origin]) injection
Severe Primary IGF-1 deficiency (Primary IGFD) Indicated for the treatment of growth failure in pediatric patients 2 years of age and older with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Severe Primary IGFD is defined by: height standard deviation score less than or equal to -3.0, basal IGF-1 standard deviation score less than or equal to -3.0, and normal or elevated GH. Limitations of use: Increlex is not a substitute to GH for approved GH indications. Increlex is not indicated for use in patients with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacological doses of anti-inflammatory corticosteroids.

2 . Criteria

Product Name: Increlex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following: [A]

1.1 All of the following:

1.1.1 Diagnosis of severe primary IGF-1 deficiency [3]

AND

1.1.2 Height standard deviation score less than or equal to -3.0

AND

1.1.3 Basal IGF-1 standard deviation score less than or equal to -3.0

AND

1.1.4 Normal or elevated growth hormone

AND

1.1.5 Prescribed by or in consultation with a pediatric endocrinologist

OR

1.2 Both of the following:

1.2.1 Diagnosis of growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH

AND

1.2.2 Prescribed by or in consultation with a pediatric endocrinologist

Notes	NOTE: Documentation of previous height, current height and goal expected adult height will be required for renewal. Increlex is not a substitute for GH for approved GH indications.

Product Name: Increlex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Growth increase of at least 2 cm/year over the previous year of treatment as documented by both of the following: [2, B]

- Previous height and date obtained
- Current height and date obtained

AND

2 - Both of the following:

• Expected adult height is not obtained • Documentation of expected adult height goal	
Notes	NOTE: Increlex is not a substitute for GH for approved GH indicati ons.

3 . Endnotes

A. Growth Hormone Deficiency (GHD) and severe Primary IGF-1 Deficiency (IGFD) are two distinct hormone disorders. Patients with severe Primary IGFD are not GH deficient, and therefore, exogenous GH treatment cannot be expected to resolve the patient's growth deficiency. [1]
B. Typically near-adult height is defined as bone age of 16 years or more for males and 14 years or more for females and a growth rate less than 2 cm/year for 1 year. [2]

4 . References

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5 . Revision History

Date	Notes
11/2/2022	2022 Annual Review

Injectable Iron Products

Prior Authorization Guideline

Guideline ID	GL-103641
Guideline Name	Injectable Iron Products
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2022
P&T Approval Date:	10/20/2021
P&T Revision Date:	3/16/2022

1 . Indications

Drug Name: Accrufer (ferric maltol)
Iron deficiency Indicated for the treatment of iron deficiency in adults
Drug Name: Feraheme (ferumoxytol injection)
Iron deficiency Indicated for the treatment of iron deficiency anemia (IDA) in adult patients who have intolerance to oral iron or have had unsatisfactory response to oral iron or who have chronic kidney disease (CKD).
Drug Name: Injectafer (ferric carboxymaltose injection)
Iron deficiency Indicated for the treatment of iron deficiency anemia (IDA) in adult and pediatric patients 1 year of age and older who have either intolerance to oral iron or an

unsatisfactory response to oral iron or adult patients who have non-dialysis dependent chronic kidney disease (CKD).
Drug Name: Monoferric (ferric derisomaltose injection)
Iron deficiency Indicated for the treatment of iron deficiency anemia (IDA) in adult patients who have intolerance to oral iron or have had unsatisfactory response to oral iron or who have non-hemodialysis dependent chronic kidney disease (CKD).

2 . Criteria

Product Name: Accrufer, Feraheme, Injectafer, and Monoferric	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Requested drug is being used for a Food and Drug Administration (FDA)-approved indication

AND

2 - Trial and failure of a minimum 30-day supply or intolerance to one of the following generics:

- ferrous sulfate
- ferrous gluconate
- ferrous fumarate

3 . References

1. Accrufer Prescribing Information. Shield Therapeutics Inc. October 2020.

2. Feraheme Prescribing Information. AMAG Pharmaceuticals, Inc. Waltham, MA. September 2020.
3. Injectafer Prescribing Information. American Regent, Inc. Shirley, NY. November 2021.
4. Monoferric Prescribing Information. Pharmacosmos Therapeutics, Inc. Morristown, NJ. September 2020.

4 . Revision History

Date	Notes
3/3/2022	Updated to add Feraheme, Injectafer, and Monoferric as targets

Infliximab

Prior Authorization Guideline

Guideline ID	GL-131607
Guideline Name	Infliximab
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name: Avsola, Inflectra, Remicade, Infliximab, Renflexis	
Diagnosis	Ankylosing Spondylitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting moderate-to-severe ankylosing spondylitis or axial spondyloarthritis as defined by all of the following:	

- Back pain and stiffness for more than 3 months
- Signs of active inflammation on MRI OR radiological evidence of sacroiliitis OR HLA-B27 positive
- BASDAI score of greater than of equal to 4

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Both of the following:

3.2.1 Trial and failure, contraindication, or intolerance to two different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen)

AND

3.2.2 Trial of a physical therapy/exercise program

Diagnosis	Crohn's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn’s disease

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to ONE of the following:

- 6-mercaptopurine
- azathioprine
- corticosteroids (e.g., prednisone, methylprednisolone)
- methotrexate

OR

3.2 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

Diagnosis	Hidradenitis Suppurativa
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of moderate to severe hidradenitis suppurativa (Hurley Stage II or Hurley Stage III)

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Documented failure of conventional therapy (e.g. oral antibiotics)

Product Name: Avsola, Inflectra, Remicade, Infliximab, Renflexis	
Diagnosis	Plaque Psoriasis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting severe plaque psoriasis defined as having functional impairment as indicated by one of the following:

- Dermatology Life Quality Index (DLQI) = 11 or
- Children's Dermatology Life Quality Index (CDLQI) = 13 or
- Severe score on other validated tool

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

- Greater than or equal to 10% body surface area involvement
- Hand, foot, face, or mucous membrane involvement

AND

4 - One of the following:

4.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan.

OR

4.2 Trial and failure, contraindication, or intolerance to ALL of the following:

- High-potency topical corticosteroids (augmented betamethasone, clobetasol, etc.)
- A second topical treatment (e.g., vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar)
- PUVA or UVB phototherapy
- Methotrexate

- At least 1 other second line systemic agent such as cyclosporine or acitretin

Product Name: Avsola, Inflectra, Remicade, Infliximab, Renflexis	
Diagnosis	Psoriatic Arthritis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting psoriatic arthritis based on at least 3 out of 5 of the following:

- Psoriasis (1 point for personal or family history, 2 points for current)
- Psoriatic nail dystrophy
- Negative test result for RF
- Dactylitis (current of history)
- Radiological evidence of juxta-articular new bone formation

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Methotrexate
- Sulfasalazine
- Cyclosporine
- Leflunomide

AND

4 - Trial and failure, contraindication, or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID) (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen)

Product Name: Avsola, Inflectra, Remicade, Infliximab, Renflexis	
Diagnosis	Rheumatoid Arthritis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Methotrexate
- Leflunomide
- Sulfasalazine

Product Name: Avsola, Inflectra, Remicade, Infliximab, Renflexis	
Diagnosis	Ulcerative Colitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Dependent on, or refractory to, corticosteroids

OR

3.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, sulfasalazine)
- azathioprine

Product Name: Avsola, Inflectra, Remicade, Infliximab, Renflexis	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
	New program

Izervay (avacincaptad pegol)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Izervay (avacincaptad pegol)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Reblozyl (luspatercept-aamt)
Beta Thalassemia Indicated for the treatment of anemia in adult patients with beta thalassemia who require regular red blood cell (RBC) transfusions. Limitations of Use: Reblozyl is not indicated for use as a substitute for RBC transfusions in patients who require immediate correction of anemia. **Myelodysplastic Syndromes with Ring Sideroblasts or Myelodysplastic/ Myeloproliferative Neoplasm with Ring Sideroblasts and Thrombocytosis Associated Anemia** Indicated for the treatment of anemia failing an erythropoiesis stimulating agent and

2 . Criteria

Product Name: Izervay	
Approval Length	6 months [A, 1]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration

AND

2 - Disease is confirmed by one of the following:

- Fundus photography (e.g. fundus autofluorescence [FAF])
- Optical coherence tomography (OCT)
- Fluorescein angiography

AND

3 - GA is not secondary to any other conditions (e.g., Stargardt disease, cone rod dystrophy, toxic maculopathies)

AND

4 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Product Name: Izervay	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., reduction in growth rate of GA lesion)

AND

2 - Patient has not exceeded a total of 12 months treatment [B, 1]

3. End Notes

A. In GATHER1 and GATHER2, the mean rate of GA growth (slope) from baseline to Month 12, measured by Fundus Autofluorescence (FAF) was evaluated at 3 time points: baseline, Month 6, and Month 12. [1]
B. The recommended dose for Izervay is 2 mg (0.1 mL of 20 mg/mL solution) administered by intravitreal injection to each affected eye once monthly (approximately 28 ± 7 days) for up to 12 months. [1]

4 References

1. Izervay Precribing Information. Iveric Bio, Inc. Parsippany, NJ. August 2023.
2. FDA Product Review. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/nda/2023/217225Orig1s000TOC.cfm. Accessed September 11, 2023.
3. Lexicomp. Izervay. Available at: https://www.uptodate.com/contents/avacincaptad-pegol- drug-information?search=geotrophic%20atropgy%20secondary%20to%20amd&source=search_result&selectedTitle=5~150&usage_type=default&display_rank=5. Accessed September 11, 2023.

5 . Revision History

Date	Notes
9/25/2023	New UM PA Program

Jakafi (ruxolitinib)

Prior Authorization Guideline

Guideline ID	GL-121959
Guideline Name	Jakafi (ruxolitinib)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	2/21/2012
P&T Revision Date:	08/15/2019 ; 03/18/2020 ; 03/17/2021 ; 11/18/2021 ; 03/16/2022 ; 05/19/2022 ; 3/15/2023

1 . Indications

Drug Name: Jakafi (ruxolitinib)
Myelofibrosis Indicated for treatment of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis in adults. **Polycythemia Vera** Indicated for treatment of polycythemia vera (PV) in adults who have had an inadequate response to or are intolerant of hydroxyurea. **Acute Graft Versus Host Disease** Indicated for treatment of steroid-refractory acute graft-versus-host disease (GVHD) in adult and pediatric patients 12 years and older. **Chronic Graft Versus Host Disease** Indicated for treatment of chronic graft-versus-host

disease (cGVHD) after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older.

2 . Criteria

Product Name: Jakafi	
Diagnosis	Myelofibrosis
Approval Length	6 Months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

2 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Jakafi	
Diagnosis	Polycythemia Vera
Approval Length	8 Months [B]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of polycythemia vera [1]

AND

2 - Trial and failure, contraindication, or intolerance to hydroxyurea [1]

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Jakafi	
Diagnosis	Myelofibrosis, Polycythemia Vera
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Jakafi therapy (e.g., spleen volume reduction, symptom improvement, hematocrit control)

Notes	If the member does not meet the medical necessity reauthorizati on criteria requirements, a denial should be issued and a 2-month

	authorization should be issued one time for Jakafi gradual therapy discontinuation.

Product Name: Jakafi	
Diagnosis	Acute Graft Versus Host Disease
Approval Length	6 Month(s) [C]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute graft-versus-host disease

AND

2 - Disease is steroid-refractory

AND

3 - Patient is 12 years of age or older

AND

4 - Prescribed by or in consultation with one of the following:

- Hematologist
- Oncologist
- Physician experienced in the management of transplant patients

Diagnosis	Chronic Graft Versus Host Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic graft-versus-host disease

AND

2 - Patient is 12 years of age or older

AND

3 - Trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.)

AND

4 - Prescribed by or in consultation with one of the following:

- Hematologist
- Oncologist
- Physician experienced in the management of transplant patients

Product Name: Jakafi	
Diagnosis	Chronic Graft Versus Host Disease

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

3 . Endnotes

A. Jakafi should be discontinued after 6 months if there is no spleen size reduction or symptom improvement since initiation of therapy. [1]
B. The initial authorization duration of 8 months is based on clinical trials (primary endpoint of hematocrit control and spleen volume reduction was evaluated at 32 weeks). [1]
C. Authorization duration of 6 months is based median time from response to death or need for new therapy for acute GVHD in clinical trials (173 days). Additionally, tapering of Jakafi may be considered after 6 months of treatment in patients with response who have discontinued therapeutic doses of corticosteroids. [1]

4 . References

1. Jakafi Prescribing Information. Incyte Corp. Wilmington, DE. January 2023.

5 . Revision History

Date	Notes
3/2/2023	2023 Annual Review

Kanuma (sebelipase alfa)

Prior Authorization Guideline

Guideline ID	GL-108422
Guideline Name	Kanuma (sebelipase alfa)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2022
P&T Approval Date:	2/25/2016
P&T Revision Date:	07/15/2020 ; 07/21/2021 ; 7/20/2022

1 . Indications

Drug Name: Kanuma (sebelipase alfa)
Lysosomal Acid Lipase (LAL) deficiency Indicated for the treatment of patients with a diagnosis of Lysosomal Acid Lipase (LAL) deficiency.

2 . Criteria

Product Name: Kanuma	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of lysosomal acid lipase deficiency (LAL-D, Wolman Disease, Cholesteryl ester storage disease) [B]

AND

2 - Diagnosis was confirmed by one of the following: [A]

2.1 Enzymatic blood test (e.g., dried blood spot test) demonstrating a deficiency of LAL enzyme activity

OR

2.2 Genetic testing for mutations in the lipase A, lysosomal acid type (LIPA) gene

AND

3 - Prescribed by or in consultation with one of the following:

- A specialist experienced in the treatment of inborn errors of metabolism
- Gastroenterologist
- Lipidologist

Product Name: Kanuma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in LDL, triglycerides, AST or ALT, increase in HDL, reduction in liver fat content)

AND

2 - Prescribed by or in consultation with one of the following:

- A specialist experienced in the treatment of inborn errors of metabolism
- Gastroenterologist
- Lipidologist

3 . Endnotes

A. Due to similar clinical presentations, LAL-D is often misdiagnosed as familial defective apolipoprotein B (ApoB) deficiency, heterozygous familial hypercholesterolemia (HeFH), familial combined hyperlipidemia (FCH), or polygenic hypercholesterolaemia [3]. A diagnosis of LAL-D can be confirmed by identification of a LIPA mutation or a deficient LAL enzyme in peripheral blood leukocytes, fibroblasts, or dried blood spots. A biopsy and/or radiographic findings may help support a LAL-D diagnosis, however these are not considered diagnostic. [2,3]
B. LAL deficiency is sub-classified as Wolman disease in infants and cholesteryl ester storage disease (CESD) in children and adults. [4]

4 . References

1. Kanuma prescribing information, Alexion Pharmaceuticals. Cheshire, CT. December 2015.

2. Burton BK, Balwani M, Feillet F, et al. A Phase 3 Trial of Sebelipase Alfa in Lysosomal Acid Lipase Deficiency. N Engl J Med. 2015;373(11):1010-20.
3. Reiner, Guardamagna, Nair, et al. Lysosomal acid lipase deficiency - an under-recognized cause of dyslipidaemia and liver dysfunction. Atherosclerosis. 2014;235(1): 21-30.
4. Strebinger G, Müller E, Feldman A, Aigner E. Lysosomal acid lipase deficiency - early diagnosis is the key. Hepat Med. 2019 May 23;11:79-88.

5 . Revision History

Date	Notes
7/1/2022	Annual Review - criteria updated to have initial and reauth criteri a and respective approval lengths updated; specialist requireme nt options expanded

Ketoconazole, topical

Prior Authorization Guideline

Guideline ID	GL-16262
Guideline Name	Ketoconazole, topical
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name: Ketoconazole, topical	
Guideline Type	Prior Authorization
Approval Criteria **1** - See Background section for clinical criteria.	

2 . Background

Clinical Practice Guidelines
Clinical Criteria <u>Policy/Criteria:</u> • For the treatment of the above conditions • Not covered for conditions below the line on the HSC prioritized health services list • Initial authorization will be 3 months in duration **<u>Renewal PA Criteria:</u>** • Documented continued need. • 3 months additional renewal **<u>Documentation:</u>** • Chart Notes

Kimyrsa

Prior Authorization Guideline

Guideline ID	GL-126049
Guideline Name	Kimyrsa
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Kimyrsa	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of an FDA-approved indication

OR

1.2 If requested for an off-label diagnosis, the off-label guideline approval criteria have been met

AND

2 - Prescribed by or in consultation with an infectious disease specialist

AND

3 - Trial and failure of, or clinical rationale why Orbactiv (oritavancin) can't be used

2 . Revision History

Date	Notes
6/5/2023	New program

Korsuva (difelikefalin)

Prior Authorization Guideline

Guideline ID	GL-124264
Guideline Name	Korsuva (difelikefalin)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/19/2022
P&T Revision Date:	5/18/2023

1 . Indications

Drug Name: Korsuva (difelikefalin) injection
Chronic kidney disease (CKD) Indicated for the treatment of moderate-to-severe pruritus associated with chronic kidney disease (CKD-aP) in adults undergoing hemodialysis (HD). Limitations of use: Korsuva has not been studied in patients on peritoneal dialysis and is not recommended for use in this population.

2 . Criteria

Product Name: Korsuva	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Patient is currently undergoing hemodialysis (HD) at an optimal dialysis dose (e.g., Kt/V greater than or equal to 1.2) [A, B, 4]

AND

3 - Patient is experiencing moderate to severe pruritus associated with CKD (CKD-aP)

AND

4 - Exclusion of other causes of pruritus (e. g., eczema, infections, drug-induced skin dryness) [C, 3]

AND

5 - Trial and failure, contraindication, or intolerance to ONE topical anti-pruritic treatment: [2,3]

- emollient cream
- analgesics (e.g., pramoxine lotion, capsaicin)

- corticosteroids (e.g., hydrocortisone, triamcinolone)

AND

6 - Trial and failure, contraindication, or intolerance to ONE oral treatment: [2,3]

- antihistamine (e.g., diphenhydramine, hydroxyzine, loratadine)
- gabapentin
- pregabalin

AND

7 - Prescribed by or in consultation with one of the following:

- Nephrologist
- Dermatologist

Product Name: Korsuva	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is currently undergoing hemodialysis [A]

AND

2 - Documentation of positive clinical response to therapy (e.g., improved quality of life, improved worst itching intensity numerical rating score from baseline)

3 . Endnotes

A. Korsuva is administered by intravenous bolus injection into the venous line of the dialysis circuit at the end of each HD treatment. [1]
B. On average, a Kt/V of 1.2 is roughly equivalent to a URR of about 63 percent. Thus, another standard of adequate dialysis is a minimum Kt/V of 1.2. The Kidney Disease Outcomes Quality Initiative (KDOQI) group has adopted the Kt/V of 1.2 as the standard for dialysis adequacy. [4]
C. Pruritus associated with Chronic Kidney Disease (CKD-aP), previously known as uremic pruritus, may vary from a localized itch, commonly in the back, face, and arms, to a generalized itch involving the entire body. Primary skin lesions may present with similar symptoms, and any suspicion of an underlying primary lesion should be first evaluated by dermatology. [3]

4 . References

1. Korsuva Prescribing Information. Cara Therapeutics, Inc. Stamford, CT. August 2021.
2. Davison SN, Levin A, Moss AH, et al. Executive summary of the KDIGO Controversies Conference on Supportive Care in Chronic Kidney Disease: developing a roadmap to improving quality care. Kidney International. 2015;88(3):447-459.
3. Ragazzo J, Cesta A, Jassal SV, Chiang N, Battistella M. Development and Validation of a Uremic Pruritus Treatment Algorithm and Patient Information Toolkit in Patients With Chronic Kidney Disease and End Stage Kidney Disease. Journal of Pain and Symptom Management. 2020;59(2):279-292.e5.
4. Hemodialysis: Dose & Adequacy | NIDDK. National Institute of Diabetes and Digestive and Kidney Diseases. Accessed April 4, 2022.

5 . Revision History

Date	Notes
5/3/2023	2023 Annual Review - no changes

Krystexxa (pegloticase)

Prior Authorization Guideline

Guideline ID	GL-108900
Guideline Name	Krystexxa (pegloticase)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2022
P&T Approval Date:	2/15/2011
P&T Revision Date:	07/15/2020 ; 07/21/2021 ; 7/20/2022

1 . Indications

Drug Name: Krystexxa (pegloticase)
Refractory gout Indicated for the treatment of chronic gout in adult patients refractory to conventional therapy. Gout refractory to conventional therapy occurs in patients who have failed to normalize serum uric acid and whose signs and symptoms are inadequately controlled with xanthine oxidase inhibitors at the maximum medically appropriate dose or for whom these drugs are contraindicated. Important Limitations of Use: Krystexxa is not recommended for the treatment of asymptomatic hyperuricemia.

2 . Criteria

Product Name: Krystexxa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gout

AND

2 - Trial and failure, contraindication, or intolerance to maximum recommended doses to both of the following conventional therapies: [A]

- Xanthine oxidase inhibitor (i.e., allopurinol, febuxostat)
- Uricosuric agent (e.g., probenecid)

AND

3 - One of the following:

- History of at least two gout flares in the previous 12 months
- At least 1 gouty tophus

AND

4 - Prescribed by or in consultation with a rheumatologist or nephrologist

Product Name: Krystexxa	
Approval Length	12 Months [B]

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Krystexxa therapy demonstrated by both of the following:

- Serum urate level has decreased since initiating therapy
- Clinical improvement in the signs and symptoms of gout (e.g., decrease in tophi size or frequency of gouty flares per year from baseline or improvement in chronic arthropathy or quality of life)

3 . Endnotes

A. Additional inclusion criteria in pivotal trials were as follows: Contraindication to treatment with allopurinol or history of failure to normalize serum uric acid despite 3 or more months of treatment with the maximum medically appropriate allopurinol dose (determined by the treating physician) [2]. Febuxostat is another first-line pharmacologic agent for the treatment of gout [3]
B. The efficacy and safety profile of long-term pegloticase treatment (mean follow-up of 2.5 years) has been shown to be consistent with that observed in the 6 month pivotal trials. [4]

4 . References

1. Krystexxa Prescribing Information. Horizon Therapeutics, Inc. Deerfield, IL. March 2021.
2. Sundy JS, Baraf HS, Yood RA, et al. Efficacy and tolerability of pegloticase for the treatment of chronic gout in patients refractory to conventional treatment: two randomized controlled trials. JAMA. 2011;306(7):711-20.
3. Fitzgerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology Guideline for Management of Gout. Arthritis Care Res (Hoboken). 2020 Jun;72(6):774-60.
4. Becker MA, Baraf HS, Yood RA. Long-term safety of pegloticase in chronic gout refractory to conventional treatment. Ann Rheum Dis. 2013;72(9):1469-74.

5 . Revision History

Date	Notes
7/22/2022	Annual review: no criteria changes.

Leqvio (inclisiran) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-127651
Guideline Name	Leqvio (inclisiran) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	
P&T Revision Date:	06/15/2022 ; 03/15/2023 ; 7/19/2023

1 . Indications

Drug Name: Leqvio (inclisiran) injection, for subcutaneous use
Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD) Indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD), who require additional lowering of low-density lipoprotein cholesterol (LDL-C). Limitations of Use: The effect of Leqvio on cardiovascular morbidity and mortality has not been determined.

2 . Criteria

Product Name: Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following:

1.1.1 Both of the following: [5]

1.1.1.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.1.2 One of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 Both of the following: [5]

1.1.2.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.2.2 One of the following:

- Functional mutation in the LDL receptor, ApoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by one of the following: [2,4]

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

AND

2 - One of the following: [4]

2.1 Patient has been receiving at least 12 consecutive weeks of HIGH-INTENSITY statin therapy [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a HIGH-INTENSITY statin at maximally tolerated dose

OR

2.2 Both of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

2.2.2 One of the following:

- Patient has been receiving at least 12 consecutive weeks of MODERATE-INTENSITY statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg] and will continue to receive a MODERATE-INTENSITY statin at maximally tolerated dose
- Patient has been receiving at least 12 consecutive weeks of LOW-INTENSITY statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, Livalo (pitavastatin) 1 mg] and will continue to receive a LOW-INTENSITY statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.4 Patient has a labeled contraindication to all statins

OR

2.5 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN [4]

AND

3 - One of the following:

3.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2 Patient has a history of contraindication or intolerance to ezetimibe

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 Patient has been receiving at least 12 consecutive weeks of Repatha therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe)

AND

4.1.2 Despite adherence to Repatha therapy, patient has been unable to achieve LDL-C goal as evidenced by one of the following within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL for diagnosis of ASCVD [2]
- LDL-C greater than or equal to 100 mg/dL for diagnosis of HeFH [3]

OR

4.2 Patient is unable to maintain adherence to Repatha therapy due to one of the following:

- Manual dexterity problems (e.g., tremors, arthritis)
- Visual impairment (e.g., best-corrected visual acuity of 20/200 or worse) [6]

OR

4.3 Patient has experienced a hypersensitivity reaction, defined as angioedema, vasculitis, urticaria, to Repatha therapy

AND

5 - Prescribed by or in consultation with one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

6 - Medication will not be used in combination with PCSK9 inhibitor therapy [2,3]

Product Name: Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of LDL-C reduction from baseline while on therapy

AND

2 - One of the following:

2.1 Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose

OR

2.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

3 - Medication will not be used in combination with PCSK9 inhibitor therapy [2,3]

Product Name: Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following diagnoses:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following:

1.1.1 Both of the following: [5]

1.1.1.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.1.2 One of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 Both of the following: [5]

1.1.2.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following:

- Functional mutation in the LDL receptor, ApoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by one of the following: [2,4]

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

AND

2 - One of the following: [4]

2.1 Patient has been receiving at least 12 consecutive weeks of HIGH-INTENSITY statin therapy [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a HIGH-INTENSITY statin at maximally tolerated dose

OR

2.2 Both of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

2.2.2 One of the following:

- Patient has been receiving at least 12 consecutive weeks of MODERATE-INTENSITY statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg] and will continue to receive a MODERATE-INTENSITY statin at maximally tolerated dose
- Patient has been receiving at least 12 consecutive weeks of LOW-INTENSITY statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, Livalo (pitavastatin) 1 mg] and will continue to receive a LOW-INTENSITY statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

2.4 Patient has a labeled contraindication to all statins

OR

2.5 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN [4]

AND

3 - One of the following:

3.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

3.2 Patient has a history of contraindication or intolerance to ezetimibe

AND

4 - Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following:

4.1 Both of the following:

4.1.1 Patient has been receiving at least 12 consecutive weeks of Repatha therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe)

AND

4.1.2 Despite adherence to Repatha therapy, patient has been unable to achieve LDL-C goal as evidenced by one of the following within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL for diagnosis of ASCVD [2]
- LDL-C greater than or equal to 100 mg/dL for diagnosis of HeFH [3]

OR

4.2 Patient is unable to maintain adherence to Repatha therapy due to one of the following:

- Manual dexterity problems (e.g., tremors, arthritis)
- Visual impairment (e.g., best-corrected visual acuity of 20/200 or worse) [6]

OR

4.3 Patient has experienced a hypersensitivity reaction, defined as angioedema, vasculitis, urticaria, to Repatha therapy

AND

5 - Prescribed by or in consultation with one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

6 - Medication will not be used in combination with PCSK9 inhibitor therapy [2,3]

Product Name: Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria	

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C reduction from baseline while on therapy

AND

2 - One of the following:

2.1 Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose

OR

2.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following:

3.1 Both of the following:

3.1.1 Patient has previously received at least 12 consecutive weeks of Repatha therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe)

AND

3.1.2 Despite adherence to Repatha therapy, patient was unable to achieve LDL-C goal as evidenced by one of the following:

- LDL-C greater than or equal to 55 mg/dL for diagnosis of ASCVD [2]
- LDL-C greater than or equal to 100 mg/dL for diagnosis of HeFH [3]

OR

3.2 Patient continues to be unable to maintain adherence to Repatha therapy due to one of the following:

- Manual dexterity problems (e.g., tremors, arthritis)
- Visual impairment (e.g., best-corrected visual acuity of 20/200 or worse) [6]

OR

3.3 Patient has experienced a hypersensitivity reaction, defined as angioedema, vasculitis, urticaria, to Repatha therapy

AND

4 - Medication will not be used in combination with PCSK9 inhibitor therapy [2,3]

3 . References

1. Leqvio prescribing information. East Hanover, NJ: Novartis Pharmaceuticals Corp; 2021.
2. Ray KK, Wright RS, Kallend D, et al. Two phase 3 trials of inclisiran in patients with elevated LDL cholesterol. N Engl J Med. 2020;382(16):1507-1519.
3. Raal FJ, Kallend D, Ray KK, et al. Inclisiran for the Treatment of Heterozygous Familial Hypercholesterolemia. N Engl J Med. 2020;382(16):1520-1530.
4. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol 2019; 73:e285-e350.
5. Scientific Steering Committee on behalf of the Simon Broome Register Group. Risk of fatal coronary heart disease in familial hypercholesterolaemia. BMJ. 1991;303:893-6.
6. Vision Impairment and Blindness | Examination-Based Studies | Information on Data Sources | Vision and Eye Health Surveillance System | Vision Health Initiative (VHI) | CDC. www.cdc.gov. Published February 27, 2019. Accessed April 5, 2022.

4 . Revision History

Date	Notes
7/6/2023	Update to account for 2022 ACC recommendations of a lower L DL threshold of 55mg/dl for patients with ASCVD at very high ris k.

Lumizyme (alglucosidase alfa)

Prior Authorization Guideline

Guideline ID	GL-125299
Guideline Name	Lumizyme (alglucosidase alfa)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	12/5/2006
P&T Revision Date:	06/17/2020 ; 05/20/2021 ; 11/18/2021 ; 05/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Lumizyme (alglucosidase alfa)
Pompe Disease Indicated for patients with Pompe disease [acid alpha-glucosidase (GAA) deficiency].

2 . Criteria

Product Name: Lumizyme	
Diagnosis	Infantile Onset Pompe Disease (IOPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of infantile-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: [3]

1.1 Absence or deficiency (less than 1% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay

OR

1.2 Molecular genetic testing confirms mutations in the GAA gene

AND

2 - Presence of clinical signs and symptoms of the disease (e.g., cardiomegaly, hypotonia, etc.)

AND

3 - Patient is less than or equal to 12 months of age

Product Name: Lumizyme

Diagnosis	Infantile Onset Pompe Disease (IOPD)
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Lumizyme	
Diagnosis	Late Onset Pompe Disease (LOPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: [3, 5]

1.1 Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay

OR

1.2 Molecular genetic testing confirms mutations in the GAA gene

AND

2 - Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.) [A]

AND

3 - Patient is 1 year of age or older

Product Name: Lumizyme	
Diagnosis	Late Onset Pompe Disease (LOPD)
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

3 . Endnotes

A. Consensus recommendation based on current clinical guidelines indicate that treatment should be started in patients with late onset Pompe disease when they become symptomatic and/or show signs of disease progression [3, 5].

4 . References

1. Lumizyme Prescribing Information. Genzyme Corporation. Cambridge, MA. May 2022.
2. Kronn DF, Day-Salvatore D, Hwu WL, et al. Management of Confirmed Newborn-Screened Patients With Pompe Disease Across the Disease Spectrum.
3. Kishani PS, Steiner RD, Bali, D. ACMG Practice Guideline. Pompe disease diagnosis and management guideline. Genet Med. 2006;8(5):267-88.
4. Diagnosing Pompe Disease (also known as Acid Maltase Deficiency). Available at: https://www.pompe.com/-/media/EMS/Conditions/RareDiseases/Brands/pompe-us/hcp/PDF/SAUSPD18042050bk1vFinal10.pdf?la=en-US and

https://www.pompe.com/-/media/EMS/Conditions/RareDiseases/Brands/pompe-us/hcp/PDF/SAUSPD18042050bj1vFinal10.pdf?la=en-US. Accessed May 12, 2020.
5. Barba-Romero MA, Barrot E, Bautista-Lorite J, et al. Clinical guidelines for late-onset Pompe disease. Rev Neurol 2012; 54 (8): 497-507.

5 . Revision History

Date	Notes
5/5/2023	Annual review: No criteria changes. Updated reauthorization criteria approval length to 24 months for both indications. Updated references.

Luxturna (voretigene neparvovec)

Prior Authorization Guideline

Guideline ID	GL-126108
Guideline Name	Luxturna (voretigene neparvovec)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	11/16/2017
P&T Revision Date:	06/17/2020 ; 06/16/2021 ; 06/15/2022 ; 6/21/2023

1 . Indications

Drug Name: Luxturna (voretigene neparvovec)
RPE65 Mutation-Associated Retinal Dystrophy Indicated for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s).

2 . Criteria

Product Name: Luxturna	
Approval Length	1 time for each eye [D]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of confirmed biallelic RPE65 mutation-associated retinal dystrophy (e.g., Leber's congenital amaurosis [LCA], retinitis pigmentosa [RP], early onset severe retinal dystrophy [EOSRD], etc.) [1-6]

AND

2 - Patient is 12 months of age or older [6, A]

AND

3 - Used for the treatment of vision loss defined by one of the following: [1]

- Visual acuity worse than 20/60 in both eyes
- Visual field less than 20 degrees in any meridian as measured by III4e isopter or equivalent in both eyes

AND

4 - Patient has sufficient viable retinal cells as determined by optical coherence tomography (OCT) demonstrating an area of retina within the posterior pole of greater than 100 micron thickness [1, 6, C]

AND

5 - Prescribed by or in consultation with one of the following physicians associated with an ocular gene therapy treatment Center of Excellence: [B]

- Ophthalmologist
- Retinal specialist/surgeon

AND

6 - Administered by a retinal specialist/surgeon experienced in performing intraocular surgery [2-6, B]

AND

7 - Patient has not previously received RPE65 gene therapy in the intended eye [2-5, D, E]

3 . Endnotes

A. Per Luxturna Prescribing Information (PI), treatment with Luxturna is not recommended for patients younger than 12 months of age, because the retinal cells are still undergoing cell proliferation, and Luxturna would potentially be diluted or lost during cell proliferation. [6] This is consistent with the IHN-CCO age policy, as there is a specific efficacy concern when using the medication in patients of a certain age.
B. Voretigene neparvovec will be administered solely through a small number of Centers of Excellence associated with an active ophthalmology practice that treats patients with inherited retinal diseases including RPE65 mutation-associated retinal dystrophy. Voretigene neparvovec will only be prepared and administered by surgeons who have completed the in-person training programs. [5, 6]
C. According to the FDA Advisory Committee discussions and PI, voretigene neparvovec should only be administered to patients with sufficient viable retinal cells. Treatment failure may occur if patients do not have enough viable retinal cells for exposure to the vector. The injection is also only targeted at 1/5 of the retina, and if not delivered to the appropriate location, may not be able to exert action or may be degraded by other precipitants within the eye (i.e., enzymes). [2-6]
D. The recommended voretigene neparvovec administration regimen consists of sequential, bilateral subretinal injections of 1.5E11 (or 150 billion) vg delivered in a total subretinal volume of 0.3 mL per eye per lifetime (total of 2 injections per

lifetime). The individual administration procedures to each eye are to be performed on separate days no more than 6 to 18 days apart. This interval between administrations was used in the pivotal trial to afford an opportunity for identification of early-emergent potential surgical complications prior to a patient undergoing the second procedure, and to reduce the risk of a deleterious immune response by carrying out the two administration procedures in a near-simultaneous fashion, rather than a more widely spaced interval that could facilitate a prime boost response. [5, 6]

E. Since there are other RPE65 gene therapies in the pipeline that will also be administered once per lifetime, voretigene neparvovec was not specified in this criterion to concede the possibility that patients may have already received RPE65 gene therapy through participation in clinical trials.

4 . References

1. Russell S, Bennett J, Wellman JA, et al. Efficacy and safety of voretigene neparvovec (AAV2-hRPE65v2) in patients with RPE65-mediated inherited retinal dystrophy: a randomised, controlled, open-label, phase 3 trial. Lancet. 2017;390:849-60.
2. Food and Drug Administration (FDA) Advisory Committee. Cellular, Tissue and Gene Therapies Advisory Committee Meeting Announcement. Website. October 12, 2017. https://www.fda.gov/advisorycommittees/calendar/ucm574394.htm. June 1, 2022.
3. FDA. Voretigene briefing information. Website. October 12, 2017. https://www.fda.gov/downloads/advisorycommittees/committeesmeetingmaterials/bloodvaccinesandotherbiologics/cellulartissueandgenetherapiesadvisorycommittee/ucm579290.pdf. Accessed June 1, 2022.
4. FDA. Voretigene briefing information. [errata]. Website. October 12, 2017. https://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/BloodVaccinesandOtherBiologics/CellularTissueandGeneTherapiesAdvisoryCommittee/UCM579307.pdf. Accessed June 1, 2022.
5. Spark Therapeutics. Voretigene briefing information. Website. October 12, 2017. https://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/BloodVaccinesandOtherBiologics/CellularTissueandGeneTherapiesAdvisoryCommittee/UCM579300.pdf. Accessed June 1, 2022.
6. Luxturna Prescribing Information. Spark Therapeutics, Inc. Philadelphia, PA. May 2022.

5 . Revision History

Date	Notes
6/12/2023	Annual review - updated references.

Mepsevii (vestronidase alfa-vjbk)

Prior Authorization Guideline

Guideline ID	GL-125304
Guideline Name	Mepsevii (vestronidase alfa-vjbk)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	2/15/2018
P&T Revision Date:	06/17/2020 ; 05/20/2021 ; 04/20/2022 ; 5/18/2023

1 . Indications

Drug Name: Mepsevii (vestronidase alfa-vjbk)
Mucopolysaccharidosis (MPS VII, Sly Syndrome) Indicated for the treatment of Mucopolysaccharidosis (MPS VII, Sly Syndrome) in pediatric and adult patients. Limitations of use: The effect of Mepsevii on the central nervous system manifestations of MPS VII has not been determined.

2 . Criteria

Product Name: Mepsevii	
Diagnosis	Mucopolysaccharidosis (MPS VII, Sly Syndrome)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Mucopolysaccharidosis VII (MPS VII, Sly syndrome)	

Product Name: Mepsevii	
Diagnosis	Mucopolysaccharidosis (MPS VII, Sly Syndrome)
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

3 . References

1. Mepsevii Prescribing Information. Ultragenyx Pharmaceutical Inc. Novato CA. December 2020.

4 . Revision History

Date	Notes
5/3/2023	Annual review: Initial authorization approval duration updated to 12 months. New reauthorization section added.

Mitoxantrone

Prior Authorization Guideline

Guideline ID	GL-125170
Guideline Name	Mitoxantrone
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/18/2001
P&T Revision Date:	05/14/2020 ; 05/20/2021 ; 05/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Mitoxantrone
Multiple Sclerosis Indicated for reducing neurologic disability and/or the frequency of clinical relapses in patients with secondary (chronic) progressive, progressive relapsing, or worsening relapsing-remitting multiple sclerosis (i.e., patients whose neurologic status is significantly abnormal between relapses). It is not indicated in the treatment of patients with primary progressive multiple sclerosis. **Prostate Cancer** Indicated, in combination with corticosteroids, as initial chemotherapy for the treatment of patients with pain related to advanced hormone-refractory prostate cancer. **Acute Non-Lymphocytic Leukemia (ANLL)** Indicated, in combination with other

approved drug(s), in the initial therapy of ANLL in adults. This category includes myelogenous, promyelocytic, monocytic, and erythroid acute leukemias.

2 . Criteria

Product Name: Generic mitoxantrone	
Diagnosis	Multiple Sclerosis
Approval Length	6 Months [5-6, A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

1.1 Secondary progressive multiple sclerosis: gradually worsening disability with or without superimposed relapses [2]

OR

1.2 Progressive relapsing multiple sclerosis: progression of disability from the onset with superimposed relapses [2]

OR

1.3 Worsening relapsing-remitting multiple sclerosis: neurological status remains significantly abnormal in between multiple sclerosis relapses [3]

AND

2 - Trial and failure, contraindication, or intolerance to two of the following disease-modifying therapies for MS: [B, 3, 11]

- Aubagio (teriflunomide)
- Lemtrada (alemtuzumab)
- Mavenclad (cladribine)
- Plegridy (peginterferon beta-1a)
- Tysabri (natalizumab)
- Any one of the interferon beta-1a injections (e.g., Avonex)
- Any one of the interferon beta-1b injections (e.g., Betaseron)
- Any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate)
- Any one of the oral fumarates (e.g., generic dimethyl fumarate)
- Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya, Mayzent, Zeposia)
- Any one of the B-cell targeted therapies (e.g., Kesimpta)

AND

3 - Left ventricular ejection fraction (LVEF) greater than or equal to 50% [2, 4-6]

AND

4 - Neutrophil count greater than or equal to 1,500 cell/mm^3

AND

5 - Prescribed by or in consultation with a neurologist

Diagnosis	Multiple Sclerosis
Approval Length	6 Months [5-6, A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Left ventricular ejection fraction (LVEF) greater than or equal to 50% [2, 4-6]

AND

3 - A lifetime cumulative dose less than 140 mg/m^2 [1]

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Generic mitoxantrone	
Diagnosis	Prostate Cancer
Approval Length	6 Months [5-6, A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced hormone-refractory (castration-resistant) prostate cancer

AND

2 - Used in combination with corticosteroids (e.g., prednisone, methylprednisolone) [7, 8, 10]

AND

3 - Left ventricular ejection fraction (LVEF) greater than or equal to 50% [2, 4-6]

AND

4 - Neutrophil count greater than or equal to 1,500 cell/mm^3

AND

5 - Prescribed by or in consultation with an oncologist

Product Name: Generic mitoxantrone	
Diagnosis	Prostate Cancer
Approval Length	6 Months [5-6, A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

AND

2 - Left ventricular ejection fraction (LVEF) greater than or equal to 50% [2, 4-6]

AND

3 - A lifetime cumulative dose less than 140mg/m^2 [1]

Product Name: Generic mitoxantrone	
Diagnosis	Acute Non-Lymphocytic Leukemia (ANLL)
Approval Length	6 Months [5-6, A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute non-lymphocytic leukemia (ANLL) (e.g., myelogenous, promyelocytic, monocytic, and erythroid)

AND

2 - Used in combination with other medications used for the treatment of ANLL [9, 10]

AND

3 - Left ventricular ejection fraction (LVEF) greater than or equal to 50% [2, 4-6]

AND

4 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Generic mitoxantrone	
Diagnosis	Acute Non-Lymphocytic Leukemia (ANLL)
Approval Length	6 Months [5-6, A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

AND

2 - Left ventricular ejection fraction (LVEF) greater than or equal to 50% [2, 4-6]

AND

3 - A lifetime cumulative dose less than 140mg/m^2 [1]

3 . Endnotes

A. All patients should be carefully assessed for cardiac signs and symptoms by history and physical examination prior to start of Novantrone therapy. Left ventricular ejection fraction (LVEF) should be evaluated prior to administration of the initial dose of mitoxantrone and all subsequent doses. Mitoxantrone is recommended to be dosed once every three months. Additional doses of mitoxantrone should not be administered to multiple sclerosis patients who have experienced either a drop in LVEF to below 50% or a clinically significant reduction in LVEF during mitoxantrone therapy. [1]
B. Per 2018 American Academy of Neurology (AAN) Multiple Sclerosis (MS) guideline, mitoxantrone should not be prescribed to people with MS due to the high frequency of severe adverse effects unless the potential benefit greatly outweighs the risk. Another MS agent that has relatively more side effects include Lemtrada and its prescribing information recommends reserving use after two prior lines of therapies have been tried. Due to this, a requirement of two prior

agents for Mitoxantrone would be more appropriate to align with other MS agents that have more risks than benefit. [11]

4 . References

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5 . Revision History

Date	Notes
5/3/2023	Annual Review, no changes.

Multiple Sclerosis (MS) Agents - PA, NF

Prior Authorization Guideline

Guideline ID	GL-125951
Guideline Name	Multiple Sclerosis (MS) Agents - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	11/20/2000
P&T Revision Date:	09/18/2019 ; 01/15/2020 ; 03/18/2020 ; 05/14/2020 ; 07/15/2020 ; 07/15/2020 ; 08/13/2020 ; 09/16/2020 ; 11/12/2020 ; 12/16/2020 ; 01/20/2021 ; 03/17/2021 ; 05/20/2021 ; 06/16/2021 ; 08/19/2021 ; 08/19/2021 ; 12/15/2021 ; 12/15/2021 ; 03/16/2022 ; 04/20/2022 ; 05/19/2022 ; 11/17/2022 ; 12/14/2022 ; 02/16/2023 ; 03/15/2023 ; 04/19/2023 ; 04/19/2023 ; 05/18/2023 ; 5/18/2023

1 . Indications

Drug Name: Aubagio (teriflunomide)
Relapsing forms of multiple sclerosis (MS) Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Avonex (interferon beta-1a)

Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Bafiertam (monomethyl fumarate)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Betaseron (interferon beta-1b)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Briumvi (ublituximab-xiiy)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Copaxone (glatiramer acetate), Glatopa (glatiramer acetate)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Extavia (interferon beta-1b)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Kesimpta (ofatumumab)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Lemtrada (alemtuzumab)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include relapsing-remitting disease and active secondary progressive disease, in adults. Because of its safety profile, the use of Lemtrada should generally be reserved for patients who have had an inadequate response to two or more drugs

indicated for the treatment of MS. Limitations of Use: Lemtrada is not recommended for use in patients with clinically isolated syndrome (CIS) because of its safety profile.
Drug Name: Mavenclad (cladribine)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include relapsing-remitting disease and active secondary progressive disease, in adults. Because of its safety profile, use of Mavenclad is generally recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for the treatment of MS. Limitations of Use: Mavenclad is not recommended for use in patients with clinically isolated syndrome (CIS) because of its safety profile.
Drug Name: Mayzent (siponimod)
Relapsing forms of MS Indicated for the treatment of relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Ocrevus (ocrelizumab)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. **Primary Progressive Forms of Multiple Sclerosis (PPMS)** Indicated for the treatment of primary progressive MS, in adults.
Drug Name: Plegridy (peginterferon beta-1a)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Ponvory (ponesimod)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Rebif (interferon beta-1a)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Drug Name: Vumerity (diroximel fumarate)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Drug Name: Tascenso ODT (fingolimod)
Relapsing forms of MS Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in patients 10 years of age and older.

2 . Criteria

Product Name: Brand Aubagio, Avonex, Bafiertam, Betaseron, Brand Copaxone, Generic glatiramer acetate, Glatopa, Kesimpta*, Mayzent, Generic Teriflunomide, Vumerity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A-D]

AND

2 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - For Brand Aubagio, trial and failure or intolerance to generic teriflunomide

Notes	*For Kesimpta, there is a QL Override (For new starts only): Please enter 2 PAs as follows with the same start date: First PA: Approve 3 syringes or pens per 28 days for the first month (Loading dose has a MDD of 0.05); Second PA: Approve 1 syringe or pen per 28 days (no overrides needed) for 12 months. (Kesimpta is hard-coded with a quantity of 1 syringe or pen per 28 days; 0.4 mL per 20 mg pen or syringe. Maintenance dose has a MDD of 0.02)

Product Name: Extavia, Plegridy, Ponvory, Rebif	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - One of the following:

2.1 For continuation of therapy

OR

2.2 Failure after a trial of at least 4 weeks, contraindication, or intolerance to at least two of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Bafiertam (monomethyl fumarate)
- Copaxone/Glatopa (glatiramer acetate)
- Kesimpta (ofatumumab)
- Dimethyl fumarate
- Vumerity (diroximel fumarate)

AND

3 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Tascenso ODT	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - Patient is 10 years of age or older

AND

3 - One of the following:

3.1 Both of the following:

3.1.1 Patient is 18 years of age or older

AND

3.1.2 One of the following:

3.1.2.1 For continuation of therapy

OR

3.1.2.2 Failure after a trial of at least 4 weeks, contraindication, or intolerance to at least two of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Bafiertam (monomethyl fumarate)
- Copaxone/Glatopa (glatiramer acetate)
- Kesimpta (ofatumumab)
- Dimethyl fumarate
- Vumerity (diroximel fumarate)

OR

3.2 Both of the following:

- Patient is younger than 18 years of age
- Failure after a trial of at least 4 weeks or intolerance to Gilenya (fingolimod)

AND

4 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Brand Aubagio, Avonex, Bafiertam, Betaseron, Brand Copaxone, Extavia, Generic glatiramer acetate, Glatopa, Kesimpta, Mayzent, Plegridy, Ponvory, Rebif, Tascenso ODT, Generic Teriflunomide, Vumerity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

AND

2 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - For Brand Aubagio, trial and failure or intolerance to generic teriflunomide

Product Name: Extavia, Plegridy, Ponvory, Rebif	
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Paid claims or submission of medical records (e.g., chart notes) confirming continuation of prior therapy, defined as no more than a 45-day gap in therapy for continuation of therapy

AND

2.1.2 Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

OR

2.2 Paid claims or submission of medical records (e.g., chart notes) confirming failure after a trial of at least 4 weeks, contraindication, or intolerance to at least two of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)

- Betaseron (interferon beta-1b)
- Bafiertam (monomethyl fumarate)
- Copaxone/Glatopa (glatiramer acetate)
- Kesimpta (ofatumumab)
- Dimethyl fumarate
- Vumerity (diroximel fumarate)

AND

3 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Briumvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated

syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - One of the following:

2.1 Failure after a trial of at least 4 weeks, contraindication, or intolerance of at least two of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Kesimpta (ofatumumab)
- Lemtrada (alemtuzumab)
- Mavenclad (cladribine)
- Plegridy (peginterferon beta-1a)
- Tysabri (natalizumab)
- Any one of the interferon beta-1a injections (e.g., Avonex)
- Any one of the interferon beta-1b injections (e.g., Betaseron)
- Any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate)
- Any one of the oral fumarates (e.g., generic dimethyl fumarate)
- Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya, Mayzent, Zeposia)

OR

2.2 For continuation of prior therapy

AND

3 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

4 - Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]) [16]

AND

5 - Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone)

AND

6 - Prescribed by or in consultation with a neurologist

Product Name: Briumvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

AND

2 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

3 - Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]) [16]

AND

4 - Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone)

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Lemtrada	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient has not been previously treated with alemtuzumab

AND

2.1.2 Failure after a trial of at least 4 weeks, contraindication, or intolerance to two of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Mavenclad (cladribine)
- Plegridy (peginterferon beta-1a)
- Tysabri (natalizumab)

- Any one of the interferon beta-1a injections (e.g., Avonex)
- Any one of the interferon beta-1b injections (e.g., Betaseron)
- Any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate)
- Any one of the B-cell targeted therapies (e.g., Kesimpta)
- Any one of the oral fumarates (e.g., generic dimethyl fumarate)
- Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya, Mayzent, Zeposia)

OR

2.2 Both of the following: [E]

2.2.1 Patient has previously received treatment with alemtuzumab

AND

2.2.2 At least 12 months have or will have elapsed since the most recent treatment course with alemtuzumab

AND

3 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Mavenclad	
Approval Length	2 Month(s) [H]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of MS (e.g., relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient has not been previously treated with cladribine

AND

2.1.2 Failure after a trial of at least 4 weeks, contraindication, or intolerance to one of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Lemtrada (alemtuzumab)
- Plegridy (peginterferon beta-1a)
- Tysabri (natalizumab)
- Any one of the interferon beta-1a injections (e.g., Avonex)
- Any one of the interferon beta-1b injections (e.g., Betaseron)
- Any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate)
- Any one of the B-cell targeted therapies (e.g., Kesimpta)
- Any one of the oral fumarates (e.g., generic dimethyl fumarate)
- Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya, Mayzent, Zeposia)

OR

2.2 Both of the following:

2.2.1 Patient has previously received treatment with cladribine

AND

2.2.2 Patient has not already received the FDA-recommended lifetime limit of 2 treatment courses (or 4 treatment cycles total) of cladribine

AND

3 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Ocrevus	
Diagnosis	Relapsing Forms of MS
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [A]

AND

2 - One of the following:

2.1 Failure after a trial of at least 4 weeks, contraindication, or intolerance to one of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Kesimpta (ofatumumab)
- Lemtrada (alemtuzumab)
- Mavenclad (cladribine)
- Plegridy (peginterferon beta-1a)
- Tysabri (natalizumab)
- Any one of the interferon beta-1a injections (e.g., Avonex)
- Any one of the interferon beta-1b injections (e.g., Betaseron)
- Any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate)
- Any one of the oral fumarates (e.g., generic dimethyl fumarate)
- Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya, Mayzent, Zeposia)

OR

2.2 For continuation of prior therapy

AND

3 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

4 - Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]) [14]

AND

5 - Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone)

AND

6 - Prescribed by or in consultation with a neurologist

Product Name: Ocrevus	
Diagnosis	Relapsing Forms of MS
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

AND

2 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

3 - Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]) [14]

AND

4 - Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone)

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Ocrevus	
Diagnosis	Primary Progressive Multiple Sclerosis (PPMS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Primary Progressive Multiple Sclerosis (PPMS)

AND

2 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

3 - Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]) [14]

AND

4 - Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone)

AND

5 - Prescribed by or in consultation with a neurologist

Product Name: Ocrevus	
Diagnosis	Primary Progressive Multiple Sclerosis (PPMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

AND

2 - Not used in combination with another disease-modifying therapy for MS [G, 22, 23]

AND

3 - Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ofatumumab [Arzerra, Kesimpta]) [14]

AND

4 - Not used in combination with another lymphocyte trafficking blocker (e.g., alemtuzumab [Lemtrada], mitoxantrone)

AND

5 - Prescribed by or in consultation with a neurologist

3 . Endnotes

A. According to the National MS Society, of the four disease courses that have been identified in MS, relapsing-remitting MS (RRMS) is characterized primarily by relapses, and secondary-progressive MS (SPMS) has both relapsing and progressive characteristics. These two constitute “relapsing forms of MS” if they describe a disease course that is characterized by the occurrence of relapses. [7] The effectiveness of interferon beta in SPMS patients without relapses is uncertain. [6]
B. Initiation of treatment with an interferon beta medication or glatiramer acetate should be considered as soon as possible following a definite diagnosis of MS with active, relapsing disease, and may also be considered for selected patients with a first attack who are at high risk of MS. [6]
C. Based on several years of experience with glatiramer acetate and interferon beta 1a and 1b, it is the consensus of researchers and clinicians with expertise in MS that these agents are likely to reduce future disease activity and improve quality of life for many individuals with relapsing forms of MS, including those with secondary progressive disease who continue to have relapses. For those who are appropriate candidates for one of these drugs, treatment must be sustained for years. Cessation of treatment may result in a resumption of pre-treatment disease activity. [6]
D. MS specialists will use Copaxone in relapsing forms of disease, including SPMS with relapses. While there have been no trials of Copaxone in SPMS (so we have no evidenced-based data upon which to make decisions or recommendations), it's clear that where there are relapses, the injectable therapies are partially effective – they reduce relapses and new lesions on MRI. In SPMS, the trials suggest that the interferons work better in earlier, more inflammatory (i.e. those with relapses prior to the trial and with gadolinium-enhancing lesions, which is the MRI equivalent of active inflammation). Since Copaxone and the interferons appear to have rather similar efficacy in the head-to-head trials, most assume that Copaxone has a similar efficacy in SPMS: where there are relapses or active inflammation on MRI, it will likely have some benefit. Thus, most MS specialists will use Copaxone in patients with SPMS who have persistent relapses. [8]
E. According to Prescribing Information, the recommended dosage of Lemtrada is 12 mg/day administered by intravenous infusion for 2 treatment courses (first treatment course: 12 mg/day on 5 consecutive days; second treatment course: 12 mg/day on 3 consecutive days administered 12 months after the first treatment course). Following the second treatment course, subsequent treatment courses of 12 mg per day on 3 consecutive days (36 mg total dose) may be administered, as needed, at least 12 months after the last dose of any prior treatment courses. [11]
F. Not to exceed the FDA-recommended dosage of 2 treatment courses (with the second course administered 43 weeks following the last dose of the first course).

According to Prescribing Information, the recommended cumulative dosage of Mavenclad is 3.5 mg per kg body weight administered orally and divided into 2 yearly treatment courses (1.75 mg per kg per treatment course). Each treatment course is divided into 2 treatment cycles with the second cycle of each course administered 23 to 27 days after the last dose of the first cycle. Following the administration of 2 treatment courses, do not administer additional Mavenclad treatment during the next 2 years. Treatment during these 2 years may further increase the risk of malignancy. The safety and efficacy of reinitiating Mavenclad more than 2 years after completing 2 treatment courses has not been studied. [16]

G. The advantage of using combination disease-modifying therapy (DMT) compared to monotherapy DMT use has not been demonstrated, but there are safety concerns, such as reduced efficacy or disease aggravation, with combination use. [22, 23]
H. Due to the unique dosing regimen of Mavenclad, a two-month PA approval length is implemented to ensure medication for the second cycle of the same treatment course is accessible to patients before the auth expires. [16]

4 . References

1. Avonex Prescribing Information. Biogen Inc. Cambridge, MA. November 2021.
2. Betaseron Prescribing Information. Bayer. Whippany, NJ. November 2021
3. Copaxone Prescribing Information. Teva Pharmaceuticals. North Wales, PA. February 2023.
4. Extavia Prescribing Information. Novartis. East Hanover, NJ. November 2021.
5. Rebif Prescribing Information. Serono Inc. Rockland, MA. November 2021.
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8. Per clinical consultation with MS specialist, December 29, 2010.
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11. Lemtrada Prescribing Information. Genzyme Corporation. Cambridge, MA. January 2023.
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14. Ocrevus Prescribing Information. Genentech, Inc. San Francisco, CA. August 2022.
15. Mayzent Prescribing Information. Novartis Pharmaceuticals Corporation. East Hanover, NJ. January 2023.

16. Mavenclad Prescribing Information. EMD Serono, Inc. Rockland, MA. September 2022.
17. Vumerity Prescribing Information. Biogen Inc. Cambridge, MA. February 2023.
18. Bafiertam Prescribing Information. Banner Life Sciences. High Point, NC. January 2023.
19. Kesimpta Prescribing Information. Novartis Pharmaceuticals Corporation. East Hanover, NJ. September 2022.
20. Hauser S, Bar-Or A, Cohen J et al. Ofatumumab versus Teriflunomide in Multiple Sclerosis. New England Journal of Medicine. 2020;383(6):546-557.
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22. Wingerchuk, D., & Carter, J. (2014). Multiple Sclerosis: Current and Emerging Disease-Modifying Therapies and Treatment Strategies. Mayo Clinic Proceedings, 89(2), 225-240.
23. Sorensen, P., Lycke, J., Erälinna, J., Edland, A., Wu, X., & Frederiksen, J. et al. (2011). Simvastatin as add-on therapy to interferon beta-1a for relapsing-remitting multiple sclerosis (SIMCOMBIN study): a placebo-controlled randomised phase 4 trial. The Lancet Neurology, 10(8), 691-701.
24. Tascenso ODT Prescribing Information. Cycle Pharmaceuticals Ltd. Cambridge, United Kingdom. December 2022.
25. Briumvi Prescribing Information. TG Therapeutics, Inc. Morrisville, NC. December 2022.

5 . Revision History

Date	Notes
5/23/2023	For brand Aubagio, requiring trial and failure or intolerance of ge neric teriflunomide

Myalept (metreleptin for injection)

Prior Authorization Guideline

Guideline ID	GL-109361
Guideline Name	Myalept (metreleptin for injection)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	5/21/2014
P&T Revision Date:	08/13/2020 ; 08/19/2021 ; 8/18/2022

Note:

2021 Annual Review

1 . Indications

Drug Name: Myalept (metreleptin for injection)
Congenital or acquired generalized lipodystrophy Indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy

2 . Criteria

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy

AND

2 - Patient is refractory to current standards of care for lipid and diabetic management

AND

3 - Prescribed by or in consultation with an endocrinologist

AND

4 - Documentation demonstrates that patient has at least one of the following metabolic abnormalities: [2]

- Insulin resistance (defined as requiring more than 200 units per day)
- Hypertriglyceridemia
- Diabetes

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy, such as one of the following:

- Sustained reduction in hemoglobin A1c level from baseline
- Sustained reduction in triglyceride levels from baseline

3 . References

1. Myalept Prescribing Information. Amryt Pharmaceuticals DAC. Dublin, Ireland. February 2022.
2. Handelsman Y, Oral EA, Bloomgarden ZT, et al. The clinical approach to the detection of lipodystrophy – an AACE consensus statement. Endocrine Practice 2013;19(1):107-116.
3. Araujo-Vilar, D., Santini, F. Diagnosis and Treatment of Lipodystrophy: A Step-by-Step Approach. Journal of Endocrinological Investigation volume 42, pages61–73 (2019). Available at https://link.springer.com/article/10.1007/s40618-018-0887-z. Accessed July 13, 2022.

4 . Revision History

Date	Notes
7/13/2022	2022 Annual Review

Naglazyme (galsulfase injection)

Prior Authorization Guideline

Guideline ID	GL-125185
Guideline Name	Naglazyme (galsulfase injection)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	8/1/2006
P&T Revision Date:	06/17/2020 ; 06/16/2021 ; 06/15/2022 ; 6/21/2023

1 . Indications

Drug Name: Naglazyme (galsulfase injection)
Mucopolysaccharidosis (MPS VI) Indicated for patients with Mucopolysaccharidosis VI (MPS VI). Naglazyme has been shown to improve walking and stair-climbing capacity.

2 . Criteria

Product Name: Naglazyme	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy Syndrome)	

Product Name: Naglazyme	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

3 . References

1. Naglazyme Prescribing Information. BioMarin Pharmaceuticals Inc. April 2020.

4 . Revision History

Date	Notes
6/6/2023	Initial auth shortened to 12 months. Reauth criteria created with 24 month approval.

Nexviazyme (avalglucosidase alfa-ngpt)

Prior Authorization Guideline

Guideline ID	GL-113432
Guideline Name	Nexviazyme (avalglucosidase alfa-ngpt)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2022
P&T Approval Date:	10/21/2021
P&T Revision Date:	11/18/2021 ; 02/17/2022 ; 9/21/2022

1 . Indications

Drug Name: Nexviazyme (avalglucosidase alfa-ngpt)
Pompe Disease Indicated for the treatment of patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).

2 . Criteria

Product Name: Nexviazyme	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) as confirmed by one of the following: [2, 3]

1.1 Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay

OR

1.2 Molecular genetic testing confirms mutations in the GAA gene

AND

2 - Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.) [A]

AND

3 - Patient is 1 year of age or older

AND

4 - Trial and failure, contraindication, or intolerance to Lumizyme

Product Name: Nexviazyme	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

3 . Endnotes

A. Consensus recommendation based on current clinical guidelines indicate that treatment should be started in patients when they become symptomatic and/or show signs of disease progression [2, 3].

4 . References

1. Nexviazyme Prescribing Information. Genzyme Corporation. Cambridge, MA. August 2021.
2. Barba-Romero MA, Barrot E, Bautista-Lorite J, et al. Clinical guidelines for late-onset Pompe disease. Rev Neurol 2012; 54 (8): 497-507.
3. Kishnani PS, Steiner RD, Bali D, et al. Pompe disease diagnosis and management guideline. Genet Med. May 2006; 8(5): 267–288.

5 . Revision History

Date	Notes
9/7/2022	Annual review: No criteria changes.

Nplate (romiplostim)

Prior Authorization Guideline

Guideline ID	GL-118126
Guideline Name	Nplate (romiplostim)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	4/7/2009
P&T Revision Date:	02/13/2020 ; 02/18/2021 ; 04/21/2021 ; 02/17/2022 ; 2/16/2023

1 . Indications

Drug Name: Nplate (romiplostim)
Immune Thrombocytopenia (ITP) Indicated for the treatment of thrombocytopenia in adult patients with immune thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy and in pediatric patients 1 year of age and older with ITP for at least 6 months who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy. Limitations of Use: - Nplate is not indicated for the treatment of thrombocytopenia due to myelodysplastic syndrome (MDS) or any cause of thrombocytopenia other than ITP. - Nplate should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increases the risk for bleeding. - Nplate should not be used in an attempt to normalize platelet counts. **Hematopoietic Syndrome of Acute Radiation Syndrome** Indicated to increase survival

in adults and in pediatric patients (including term neonates) acutely exposed to myelosuppressive doses of radiation.

2 . Criteria

Product Name: Nplate	
Diagnosis	Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Immune thrombocytopenia (ITP) [A]
- Relapsed/refractory ITP [4]

AND

2 - Baseline platelet count is less than 30,000/mcL [2-4]

AND

3 - Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding

AND

4 - Trial and failure, contraindication, or intolerance to one of the following: [2]

- Corticosteroids (e.g., dexamethasone, prednisone)
- Immune globulins (e.g., Gammaplex, Gammagard S/D)
- Splenectomy

AND

5 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Nplate	
Diagnosis	Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding

Product Name: Nplate	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hematopoietic syndrome of acute radiation syndrome

AND

2 - Patient is acutely exposed to myelosuppressive doses of radiation

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

3 . Endnotes

A. ITP has previously been called idiopathic thrombocytopenic purpura, immune thrombocytopenic purpura, or autoimmune thrombocytopenic purpura (AITP). These terms have been replaced by "immune thrombocytopenia" to reflect the known autoantibody mechanism and the absence of purpura in some patients. [5]

4 . References

1. Nplate Prescribing Information. Amgen Inc. Thousand Oaks, CA. February 2022.
2. Kuter DJ, Bussel JB, Lyons RM, et al. Efficacy of romiplostim in patients with chronic immume thrombocytopenic purpura: a double-blind randomised controlled trial. Lancet. 2008; 371:395-403.
3. American Society of Hematology 2019 guidelines for immune thrombocytopenia. Available at: https://ashpublications.org/bloodadvances/article/3/23/3829/429213/American-Society-of-Hematology-2019-guidelines-for. Accessed December 9, 2022.
4. Per clinical consult with hematologist/oncologist, June 20, 2018.
5. Immune thrombocytopenia (ITP) in adults: Clinical manifestations and diagnosis. UpToDate Website. Available at: www.uptodate.com. Accessed December 9, 2022.

5 . Revision History

Date	Notes
2/1/2023	Annual review: Background updates.

Nucala (mepolizumab)

Prior Authorization Guideline

Guideline ID	GL-124557
Guideline Name	Nucala (mepolizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	11/17/2015
P&T Revision Date:	08/15/2019 ; 11/14/2019 ; 02/13/2020 ; 12/16/2020 ; 03/17/2021 ; 09/15/2021 ; 03/16/2022 ; 07/20/2022 ; 05/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Nucala (mepolizumab)
Severe Eosinophilic Asthma Indicated for the add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype. Limitations of Use: Nucala is not indicated for the relief of acute bronchospasm or status asthmaticus. **Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)** Indicated for the add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids. **Eosinophilic Granulomatosis with Polyangiitis** Indicated for the treatment of adult

patients with eosinophilic granulomatosis with polyangiitis (EGPA).

Hypereosinophilic Syndrome Indicated for the treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) for greater than or equal to 6 months without an identifiable non-hematologic secondary cause.

2 . Criteria

Product Name: Nucala	
Diagnosis	Severe Asthma
Approval Length	6 Months [G]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe asthma [1, A]

AND

2 - Asthma is an eosinophilic phenotype as defined by one of the following [1, 3, B]:

- Baseline (pre-treatment) peripheral blood eosinophil level is greater than or equal to 150 cells/microliter
- Peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months

AND

3 - One of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months [2-4, H]

OR

3.2 Prior asthma-related hospitalization within the past 12 months

AND

4 - Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications [2-4, D]:

4.1 Both of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Age greater than or equal to 6 years [1]

AND

6 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name: Nucala	
Diagnosis	Severe Asthma
Approval Length	12 Months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications) [C]

AND

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

3 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Allergist/Immunologist

Product Name: Nucala	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP)

AND

2 - Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone) [10, 11]

AND

3 - Used in combination with another agent for CRSwNP [J]

AND

4 - Prescribed by or in consultation with one of the following:

- Allergist/Immunologist
- Otolaryngologist
- Pulmonologist

Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS; 0-8 scale], improvement in nasal obstruction symptoms via visual analog scale [VAS; 0-10 scale])

AND

2 - Used in combination with another agent for CRSwNP [J]

AND

3 - Prescribed by or in consultation with one of the following:

- Allergist/Immunologist
- Otolaryngologist
- Pulmonologist

Product Name: Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)

Approval Length	12 Months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)

AND

2 - Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy) [F, 7]

AND

3 - Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) [F, 7]

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name: Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)

Approval Length	12 Months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., increase in remission time)

Product Name: Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 Months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypereosinophilic syndrome (HES)

AND

2 - Patient has been diagnosed for at least 6 months

AND

3 - Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)

AND

4 - Patient is Fip1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRA)-negative

AND

5 - Patient has uncontrolled HES defined as both of the following:

- History of 2 or more flares within the past 12 months [I]
- Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter

AND

6 - Trial and failure, contraindication, or intolerance to one of the following:

- Corticosteroid therapy (e.g., prednisone)
- Cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib)

AND

7 - Prescribed by or in consultation with one of the following:

- Allergist/Immunologist
- Hematologist

Product Name: Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 Months
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in flares, decreased blood eosinophil count, reduction in corticosteroid dose)

3 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older [6]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		

Mometasone furoate (pMDI, standard particle, HFA)	200-400	> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

This is not a table of equivalence, but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country - specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

4 . Endnotes

A. Patients included across the 3 pivotal studies (DREAM, MENSA, and SIRIUS) [2-4] were characterized with clinical features of severe refractory asthma per American Thoracic Society (ATS) criteria [5]. Per the ATS: "Severe asthma is defined as asthma which requires treatment with high dose inhaled corticosteroids (ICS) plus a second controller (and/or systemic corticosteroids) to prevent it from becoming 'uncontrolled' or which remains 'uncontrolled' despite this therapy.'' This definition includes patients who received an adequate trial of these therapies in whom treatment was stopped due to lack of response. In patients greater than 6 years of age, ''Gold Standard/International Guidelines treatment'' is high dose ICS plus a long-acting beta 2-agonist (LABA), leukotriene modifier or theophylline and/or continuous or near continuous systemic corticosteroids as background therapy."
B. Inclusion criteria was modified from the DREAM study to the MENSA study to be limited to patients with eosinophils greater than or equal to 150 cells/mcL in the peripheral blood at screening or greater than or equal to 300 cells/mcL at some time during the previous year [3].
C. The primary endpoint for the DREAM and MENSA studies was the annual rate of clinically significant asthma exacerbations as a composite of the required use of systemic corticosteroids for at least 3 days, admission, or ED visit. Both studies showed mepolizumab-treated patients experienced a significant improvement in exacerbation rates compared with baseline and compared with placebo. [2, 3]

D. The Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention update lists anti-interleukin- 5 treatment or anti-interleukin 5 receptor treatment as an add on option for patients with severe eosinophilic asthma that is uncontrolled on two or more controllers plus as-needed reliever medication (Step 4-5 treatment). [6]
E. Asthma treatment can often be reduced, once good asthma control has been achieved and maintained for three months and lung function has hit a plateau. However the approach to stepping down will depend on patient specific factors (e.g., current medications, risk factors). At this time evidence for optimal timing, sequence and magnitude of treatment reductions is limited. It is feasible and safe for most patients to reduce the ICS dose by 25-50% at three month intervals, but complete cessation of ICS is associated with a significant risk of exacerbations [6].
F. Nucala was approved for Eosinophilic Granulomatosis with Polyangiitis (EGPA) based on the results from the pivotal, 52-week, Phase III MIRRA study. MIRRA looked at the efficacy and safety of 300 mg of mepolizumab administered SQ every four weeks versus placebo as add-on therapy to standard of care (corticosteroids plus or minus immunosuppressants) in 136 patients with relapsing and/or refractory EGPA. MIRRA reported statistically significant outcomes with both co-primary endpoints (i.e., accrued time in remission and proportion of patients achieving remission) in favor of the treatment group [7, 8].
G. The GINA Global Strategy for Asthma Management and Prevention update recommends that patients with asthma should be reviewed regularly to monitor their symptom control, risk factors and occurrence of exacerbations, as well as to document the response to any treatment changes. Ideally, response to Type 2-targeted therapy should be re-evaluated every 3-6 months, including re-evaluation of the need for ongoing biologic therapy for patients with good response to Type 2 targeted therapy. [6]
H. Per P&T Committee, February 2019, revised exacerbation requirement to mirror other IL-5 antagonists.
I. Historical flares were defined as a worsening of HES-related clinical symptoms or a blood eosinophil count requiring an escalation in therapy. [1]
J. Other agents used for CRSwNP include intranasal corticosteroids and nasal saline.

5 . References

1. Nucala prescribing information. GlaxoSmithKline LLC. Philadelphia, PA. March 2023.
2. Pavord ID, Korn S, Howarth P, et al. Mepolizumab for severe eosinophilic asthma (DREAM): a multicentre, double-blind, placebo-controlled trial. Lancet. 2012;380: 651-59.
3. Ortega HG, Liu MC, Pavord ID, et al. Mepolizumab treatment in patients with severe eosinophilic asthma. N Engl J Med. 2014;371(13):1198-1207.

4. Bel EH, Wenzel SE, Thompson PJ, et al. Oral Glucocorticoid-Sparing Effect of Mepolizumab in Eosinophilic Asthma. N Engl J Med. 2014;371:1189-1197.
5. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. Eur Respir J. 2014;43:343-373.
6. Global Initiative for Asthma (GINA). Global Strategy for Asthma Management and Prevention (2022 update). 2022 www.ginasthma.org. Accessed April 2023.
7. Wechsler ME, Akuthota P, Jayne D, et al. Mepolizumab or Placebo for Eosinophilic Granulomatosis with Polyangiitis. N Engl J Med. 2017;376(20):1921-1932.
8. GlaxoSmithKline Press Release. GSK achieves approval for Nucala (mepolizumab) for the treatment of eosinophilic granulomatosis with polyangiitis (EGPA) for adults in the US. Website. Available from: https://www.gsk.com/en-gb/media/press-releases/gsk-achieves-approval-for-nucala-mepolizumab-for-the-treatment-of-eosinophilic-granulomatosis-with-polyangiitis-egpa-for-adults-in-the-us/. Accessed March 11, 2021.
9. ClinicalTrials.gov Web site. https://clinicaltrials.gov/ct2/show/NCT03085797. Accessed August 15, 2021.
10. Peters AT, Spector S, Hsu J, et al. Diagnosis and management of rhinosinusitis: a practice parameter update. Ann Allergy Asthma Immunol. 2014;113(4):347-85.
11. Orlandi RR, Kingdom TT, Hwang PH, et al. International consensus statement on allergy and rhinology: rhinosinusitis. Int Forum Allergy Rhinol. 2016 Feb; Suppl 1:S22-209.

6 . Revision History

Date	Notes
4/24/2023	2023 UM Annual Review. No criteria changes. Background updates

Nulibry (fosdenopterin)

Prior Authorization Guideline

Guideline ID	GL-123199
Guideline Name	Nulibry (fosdenopterin)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	
P&T Revision Date:	04/20/2022 ; 06/15/2022 ; 4/19/2023

1 . Indications

Drug Name: Nulibry (fosdenopterin)
Molybdenum cofactor deficiency (MoCD) Type A Indicated to reduce the risk of mortality in patients with molybdenum cofactor deficiency (MoCD) Type A.

2 . Criteria

Product Name: Nulibry	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

- Diagnosis of molybdenum cofactor deficiency (MoCD) Type A
- Genetic mutation in the MOCS1 gene

AND

2 - Patient has clinical and/or laboratory signs and symptoms consistent with MOCD Type A (e.g., seizures, limb/axial hypertonia, elevated levels of urinary sulfite/SSC [s-sulfocysteine] or xanthine in blood/urine, low uric acid in blood/urine)

AND

3 - Prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders

Product Name: Nulibry	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by or in consultation with a physician who specializes in the treatment of inherited metabolic disorders

AND

2 - Patient continues to benefit from medication

3 . References

1. Nulibry Prescribing Information. Origin Biosciences, Inc. Boston, MA. March 2021.
2. Study of ORGN001 (formerly ALXN1101) in neonates, infants and children with molybdenum cofactor deficiency (MOCD) type A. ClinicalTrials.gov identifier: NCT02629393. Updated February 26, 2021. Accessed April 12, 2021. https://www.clinicaltrials.gov/ct2/show/study/NCT02629393.
3. Per clinical consultation with pediatrician, April 30, 2021.
4. Mechler, K., Mountford, W., Hoffmann, G. et al. Ultra-orphan diseases: a quantitative analysis of the natural history of molybdenum cofactor deficiency. Genet Med 17, 965–970 (2015). https://doi.org/10.1038/gim.2015.12

4 . Revision History

Date	Notes
3/13/2023	Annual review - no criteria changes

Octreotide Products - PA, NF

Prior Authorization Guideline

Guideline ID	GL-116110
Guideline Name	Octreotide Products - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	1/1/2023
P&T Approval Date:	1/19/2001
P&T Revision Date:	11/14/2019 ; 07/15/2020 ; 09/16/2020 ; 12/16/2020 ; 11/18/2021 ; 01/19/2022 ; 11/17/2022

1 . Indications

Drug Name: Sandostatin (octreotide acetate)
Acromegaly Indicated to reduce blood levels of growth hormone and IGF-1 (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. The goal is to achieve normalization of growth hormone and IGF-I (somatomedin C) levels. In patients with acromegaly, Sandostatin reduces growth hormone to within normal ranges in 50% of patients and reduces IGF-I (somatomedin C) to within normal ranges in 50%-60% of patients. Since the effects of pituitary irradiation may not become maximal for several years, adjunctive therapy with Sandostatin to reduce blood levels of growth hormone and IGF-I (somatomedin C) offers potential benefit before the effects of irradiation are manifested. Improvement in clinical signs and symptoms, or reduction in tumor size or rate of growth, were not

shown in clinical trials performed with Sandostatin; these trials were not optimally designed to detect such effects.

Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing 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. Sandostatin studies were not designed to show an effect on the size, rate of growth or development of metastases.

Vasoactive Intestinal Peptide Tumors (VIPomas), for Symptomatic Treatment of Diarrhea Indicated for the treatment of the profuse watery diarrhea associated with VIP-secreting tumors. Sandostatin studies were not designed to show an effect on the size, rate of growth or development of metastases.

Drug Name: Sandostatin LAR Depot (octreotide acetate)

General Indicated in patients in whom initial treatment with Sandostatin Injection has been shown to be effective and tolerated.

Acromegaly Indicated for long-term maintenance therapy in acromegalic patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option. The goal of treatment in acromegaly is to reduce GH and IGF-1 levels to normal.

Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing Indicated for long-term treatment of the severe diarrhea and flushing episodes associated with metastatic carcinoid tumors. Limitation of Use: The effect of Sandostatin LAR on tumor size, rate of growth and development of metastases, has not been determined.

Vasoactive Intestinal Peptide Tumors (VIPomas), for Symptomatic Treatment of Diarrhea Indicated for long-term treatment of the profuse watery diarrhea associated with VIP-secreting tumors. Limitation of Use: The effect of Sandostatin LAR on tumor size, rate of growth and development of metastases, has not been determined.

Drug Name: Bynfezia (octreotide acetate injection)

Acromegaly Indicated to reduce blood levels of growth hormone (GH) and insulin-like growth factor 1 (IGF-1) [somatomedin C] in adult patients with acromegaly who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses. Limitations of Use: In patients with acromegaly, the effect of Bynfezia Pen on improvement in clinical signs and symptoms, reduction in tumor size, and rate of growth has not been determined.

Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing Indicated for

the treatment of adult patients with severe diarrhea and flushing episodes associated with metastatic carcinoid tumors. Limitations of Use: In patients with carcinoid syndrome, the effect of Bynfezia Pen on the tumor size, rate of growth and development of metastases has not been determined. **Vasoactive Intestinal Peptide Tumors (VIPomas), for Symptomatic Treatment of Diarrhea** Indicated for the treatment of adult patients with the profuse watery diarrhea associated with VIP-secreting tumors. Limitations of Use: In patients with VIPomas, the effect of Bynfezia Pen on the tumor size, rate of growth and development of metastases has not been determined.
Drug Name: Mycapssa (octreotide capsule, delayed release)
Acromegaly Indicated for long-term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide.

2 . Criteria

Product Name: Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Trial and failure, contraindication, or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses

AND

4 - One of the following:

4.1 Patient has had a trial of short-acting generic octreotide and responded to and tolerated therapy (Applies to Sandostatin LAR only)

OR

4.2 Trial and failure, or intolerance to generic octreotide (Applies to Brand Sandostatin and Bynfezia only)

Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Patient has responded to and tolerated treatment with generic octreotide or lanreotide

Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size)

Product Name: Brand Sandostatin, Bynfezia	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, or intolerance to generic octreotide

Product Name: Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming patient has responded to and tolerated treatment with generic octreotide or lanreotide

Product Name: Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes

AND

2 - One of the following:

2.1 Patient has had a trial of short-acting generic octreotide and responded to and tolerated therapy (Applies to Sandostatin LAR only)

OR

2.2 Trial and failure, or intolerance to generic octreotide (Applies to Brand Sandostatin and Bynfezia only)

Product Name: Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of an improvement in the number of diarrhea or flushing episodes

Product Name: Brand Sandostatin, Bynfezia	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, or intolerance to generic octreotide

Product Name: Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea

AND

2 - One of the following:

2.1 Patient has had a trial of short-acting generic octreotide and responded to and tolerated therapy (Applies to Sandostatin LAR only)

OR

2.2 Trial and failure, or intolerance to generic octreotide (Applies to Brand Sandostatin and Bynfezia only)

Product Name: Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of an improvement in the number of diarrhea episodes

Product Name: Brand Sandostatin, Bynfezia	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, or intolerance to generic octreotide

3 . References

1. Sandostatin Prescribing Information. Novartis Pharmaceuticals Corporation. East Hanover, NJ. May 2021.
2. Sandostatin LAR Prescribing Information. Novartis Pharmaceuticals Corporation. East Hanover, NJ. March 2021.
3. Octreotide Prescribing Information. Mylan Institutional LLC. Morgantown, WV. June 2021.
4. Bynfezia Prescribing Information. Sun Pharmaceutical Industries, Inc. Cranbury, NJ. April 2020.
5. Mycapssa Prescribing Information. MW Encap Ltd. Scotland, UK. June 2020.

4 . Revision History

Date	Notes
11/22/2022	Annual review: no criteria changes.

Onpattro (patisiran) & Tegsedi (inotersen)

Prior Authorization Guideline

Guideline ID	GL-122099
Guideline Name	Onpattro (patisiran) & Tegsedi (inotersen)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	10/17/2018
P&T Revision Date:	04/15/2020 ; 04/21/2021 ; 04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Onpattro (patisiran), Tegsedi (inotersen)
Hereditary transthyretin-mediated amyloidosis Indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

2 . Criteria

Product Name: Onpattro or Tegsedi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy

AND

2 - Patient has a transthyretin (TTR) mutation (e.g., V30M) [1-4]

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - One of the following [2, 4]:

- Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient has a baseline neuropathy impairment score (NIS) between 5 and 130 for Onpattro or a baseline neuropathy impairment score (NIS) between 10 and 130 for Tegsedi

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy) [2, 4]

Product Name: Onpattro or Tegsedi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has demonstrated a benefit from therapy (e.g., improved neurologic impairment, slowing of disease progression, quality of life assessment)

AND

2 - One of the following [2, 4]:

- Patient continues to have a polyneuropathy disability (PND) score ≤ IIIb
- Patient continues to have a familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient continues to have a neuropathy impairment score (NIS) between 5 and 130 for Onpattro or a neuropathy impairment score (NIS) between 10 and 130 for Tegsedi

3 . References

1. Onpattro Prescribing Information. Alnylam Pharmaceuticals, Inc. Cambridge, MA. January 2023.
2. Adams D, Suhr OB, Dyck PJ, et al. Trial design and rationale for APOLLO, a phase 3, placebo-controlled study of patisiran in patients with hereditary ATTR amyloidosis with polyneuropathy. BMC Neurol. 2017;17:181.
3. Tegsedi Prescribing Information. Akcea Therapeutics, Inc. Boston, MA. June 2022.
4. Benson MD, Waddington-Cruz M, Berk JL, et al. Inotersen treatment for patients with hereditary transthyretin amyloidosis. N Engl J Med. 2018;379(1):22-31.

4 . Revision History

Date	Notes
3/6/2023	2023 Annual Review.

Orencia IV (abatacept)

Prior Authorization Guideline

Guideline ID	GL-126089
Guideline Name	Orencia IV (abatacept)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Orencia IV	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active rheumatoid arthritis (RA)	

AND

2 - Minimum duration of a 3-month trial and failure, contraindication, or intolerance to TWO of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide
- sulfasalazine
- hydroxychloroquine

AND

3 - Patient has a negative tuberculin test (TB) prior to initiating therapy

AND

4 - Patient is 18 years of age or older

AND

5 - Prescribed by or in consultation with a rheumatologist

Product Name: Orencia IV	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severely active Polyarticular Juvenile Idiopathic Arthritis (PJIA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- leflunomide
- methotrexate

AND

4 - Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one systematic corticosteroid (e.g., prednisone, methylprednisolone)

AND

5 - Patient is 2 years of age or older

AND

6 - Patient has a negative tuberculin test (TB) prior to initiating therapy

Product Name: Orencia IV	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis (PsA)

AND

2 - Minimum duration of a 3-month trial and failure, contraindication, or intolerance to methotrexate at maximally tolerated doses

AND

3 - Prescribed by or in consultation with one of the following:

- Dermatologist
- Rheumatologist

AND

4 - Patient has a negative tuberculin test (TB) prior to initiating therapy

Product Name: Orencia IV

Diagnosis	Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis (PJIA), Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Orencia IV	
Diagnosis	Prophylaxis for Acute Graft versus Host Disease (aGVHD)
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for prophylaxis of acute graft versus host disease (aGVHD)

AND

2 - Patient is 2 years of age or older

AND

3 - Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor

AND

4 - Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT

AND

5 - Used in combination with both of the following:

- calcineurin inhibitor (e.g., cyclosporine, tacrolimus)
- methotrexate

AND

6 - Patient has a negative tuberculin test (TB) prior to initiating therapy

2 . Revision History

Date	Notes
6/8/2023	New program

Oxervate (cenegermin-bkbj) - PA, QL

Prior Authorization Guideline

Guideline ID	GL-125314
Guideline Name	Oxervate (cenegermin-bkbj) - PA, QL
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	1/16/2019
P&T Revision Date:	05/14/2020 ; 05/20/2021 ; 12/15/2021 ; 05/19/2022 ; 09/21/2022 ; 09/21/2022 ; 5/18/2023

1 . Indications

Drug Name: Oxervate (cenegermin-bkbj)
Neurotrophic Keratitis (NK) Indicated for the treatment of neurotrophic keratitis (NK).

2 . Criteria

Product Name: Oxervate	
Approval Length	8 weeks*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of neurotrophic keratitis **AND** **2** - Trial and failure or intolerance to at least one over-the-counter ocular lubricant used at an optimal dose and frequency for at least two weeks (e.g., artificial tears, lubricating gels/ointments, etc.) [3] **AND** **3** - Prescribed by or in consultation with an ophthalmologist	
Notes	*Initial authorization maximum coverage is limited to one 8-week approval. Oxervate is hard-coded with a quantity limit of 112 mL per lifetime.

Product Name: Oxervate	
Approval Length	One 8-Week Approval*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - One of the following:

1.1 Both of the following:

1.1.1 Provider attests patient is being treated for disease recurrence (e.g., new corneal damage following prior corneal healing)

AND

1.1.2 Provider attests patient has not experienced treatment failure (e.g., patient has not experienced corneal healing after a previous course of Oxervate)

OR

1.2 Provider attests treatment is for an eye that has not previously been treated with Oxervate

Notes	*Reauthorization maximum coverage is limited to one 8-week approval. Oxervate is hard-coded with a quantity limit of 112 mL per lifetime. Subsequent request will be denied for off-label

Product Name: Oxervate	
Guideline Type	Quantity Limit*
Approval Criteria **1** - Requests for additional quantity will not be approved	
Notes	*Requests will be denied off-label.

3 . References

1. Oxervate Prescribing Information. Dompe U.S. Inc. Boston, MA. October 2019.
2. FDA Medical Review: Oxervate. Drugs at FDA Web site. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2018/761094Orig1s000MedR.pdf. Accessed April 1, 2021.

3. Per clinical consult with ophthalmologist, December 12, 2018.

4 . Revision History

Date	Notes
5/3/2023	Annual review: No criteria changes. Updated operational notes.

Oxlumo (lumasiran)

Prior Authorization Guideline

Guideline ID	GL-118914
Guideline Name	Oxlumo (lumasiran)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	2/18/2021
P&T Revision Date:	02/17/2022 ; 11/17/2022 ; 2/16/2023

1 . Indications

Drug Name: Oxlumo (lumasiran) injection
Primary Hyperoxaluria Type 1 Indicated for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary and plasma oxalate levels in pediatric and adult patients.

2 . Criteria

Product Name: Oxlumo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary hyperoxaluria type 1 (PH1)

AND

2 - Diagnosis has been confirmed by both of the following:

2.1 One of the following:

- Elevated urinary oxalate excretion
- Elevated plasma oxalate concentration
- Spot urinary oxalate to creatinine molar ratio greater than normal for age

AND

2.2 One of the following:

- Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene
- Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity

AND

3 - Patient has not received a liver transplant

AND

4 - Prescribed by or in consultation with one of the following:

- Hepatologist
- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

Product Name: Oxlumo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decreased urinary oxalate excretion, decreased plasma oxalate concentration)

AND

2 - Patient has not received a liver transplant

AND

3 - Prescribed by or in consultation with one of the following:

- Hepatologist
- Nephrologist
- Urologist
- Geneticist

- Specialist with expertise in the treatment of PH1

3 . References

1. Oxlumo prescribing information. Alnylam Pharmaceuticals, Inc. Cambridge, MA. October 2022.
2. UptoDate: Primary hyperoxaluria. Available at https://www.uptodate.com/contents/primary-hyperoxaluria?search=primary%20hyperoxaluria%20type%201&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1. Accessed October 19, 2022.

4 . Revision History

Date	Notes
1/1/2023	2023 Annual Review.

Palforzia [Peanut (Arachis hypogaea)] - PA, NF

Prior Authorization Guideline

Guideline ID	GL-119940
Guideline Name	Palforzia [Peanut (Arachis hypogaea)] - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	11/14/2019
P&T Revision Date:	02/13/2020 ; 02/18/2021 ; 12/15/2021 ; 02/17/2022 ; 2/16/2023

1 . Indications

Drug Name: Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]
Peanut Allergy Indicated for the mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanut. PALFORZIA is approved for use in patients with a confirmed diagnosis of peanut allergy. Initial Dose Escalation may be administered to patients aged 4 through 17 years. Up-Dosing and Maintenance may be continued in patients 4 years of age and older. Limitation of Use: Not indicated for the emergency treatment of allergic reactions, including anaphylaxis.

2 . Criteria

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis and clinical history of peanut allergy as documented by both of the following:

- A serum peanut-specific IgE level of greater than or equal to 0.35 kUA/L
- A mean wheal diameter that is at least 3mm larger than the negative control on skin-prick testing for peanut

AND

2 - One of the following:

2.1 Both of the following:

- Patient is 4 to 17 years of age
- Patient is in the initial dose escalation phase of therapy

OR

2.2 Both of the following:

- Patient is 4 years of age and older
- Patient is in the up-dosing or maintenance phase of therapy

AND

3 - Patient does not have any of the following:

- History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease
- History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months
- Severe or poorly controlled asthma

AND

4 - Prescribed by or in consultation with an allergist/immunologist

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by or in consultation with an allergist/immunologist

Product Name: Palforzia	
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis and clinical history of peanut allergy as documented by both of the following:

- A serum peanut-specific IgE level of greater than or equal to 0.35 kUA/L
- A mean wheal diameter that is at least 3mm larger than the negative control on skin-prick testing for peanut

AND

2 - One of the following:

2.1 Both of the following:

- Patient is 4 to 17 years of age
- Patient is in the initial dose escalation phase of therapy

OR

2.2 Both of the following:

- Patient is 4 years of age and older
- Patient is in the up-dosing or maintenance phase of therapy

AND

3 - Patient does not have any of the following:

- History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease
- History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months
- Severe or poorly controlled asthma

AND

4 - Prescribed by or in consultation with an allergist/immunologist

3 . References

1. Palforzia prescribing information. Aimmune Therapeutics, Inc. Brisbane, CA. February 2020.
2. The PALISADE Group of Clinical Investigators. AR101 Oral Immunotherapy for Peanut Allergy. N Engl J Med. 379(21):1991-2001.

4 . Revision History

Date	Notes
1/31/2023	Annual review - no changes.

Palynziq (pegvaliase-pqpz) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-123742
Guideline Name	Palynziq (pegvaliase-pqpz) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	8/16/2018
P&T Revision Date:	10/21/2020 ; 10/20/2021 ; 10/19/2022 ; 2/16/2023

1 . Indications

Drug Name: Palynziq (pegvaliase-pqpz)
Phenylketonuria (PKU) Indicated to reduce blood phenylalanine concentrations in adult patients with phenylketonuria (PKU) who have uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management.

2 . Criteria

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management (e.g., phenylalanine restricted diet, Kuvan [sapropterin])

AND

3 - One of the following:

3.1 Patient has had a trial and failure or intolerance to generic sapropterin

OR

3.2 Patient is not a candidate for generic sapropterin) therapy due to the presence of two null mutations in trans

AND

4 - Patient will have phenylalanine blood levels measured every 4 weeks until a maintenance dose is established and periodically thereafter [A]

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced an objective response to therapy, defined by one of the following [B, C]:

1.1 At least a 20% reduction in blood phenylalanine concentrations from pre-treatment baseline

OR

1.2 Blood phenylalanine concentrations less than or equal to 600 micromol/L

AND

2 - Patient will continue to have phenylalanine blood levels measured periodically during therapy [A]

Product Name: Palynziq	
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management (e.g., phenylalanine restricted diet, Kuvan [sapropterin])

AND

3 - Submission of medical records (e.g., chart notes) or paid claims for one of the following:

3.1 Patient has had a trial and failure or intolerance to generic sapropterin

OR

3.2 Patient is not a candidate for generic sapropterin therapy due to the presence of two null mutations in trans

AND

4 - Patient will have phenylalanine blood levels measured every 4 weeks until a maintenance dose is established and periodically thereafter [A]

3 . Endnotes

A. Patients should have blood phenylalanine (Phe) concentrations measured every 4 weeks after initiation of Palynziq (pegvaliase-pqpz), until a maintenance dosage is established. Periodic monitoring should continue after a maintenance dose is established [1].
B. Therapy should be discontinued in patients who do not achieve at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline or a blood phenylalanine concentration less than or equal to 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40 mg once daily. Based on the recommended dosing regimen, patients could be evaluated for

discontinuation after 49 weeks of therapy. This would allow for induction, titration, maintenance on 20 mg for 24 weeks, and maintenance on 40mg for 16 weeks.

C. The American College of Medical Genetics and Genomics guideline suggests blood Phe levels should be maintained in the range of 120–360 micromol/L for all patients [2].

4 . References

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5 . Revision History

Date	Notes
4/6/2023	update guideline

Prolia (denosumab)

Prior Authorization Guideline

Guideline ID	GL-110165
Guideline Name	Prolia (denosumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	8/17/2010
P&T Revision Date:	07/15/2020 ; 08/13/2020 ; 08/19/2021 ; 8/18/2022

1 . Indications

Drug Name: Prolia (denosumab)
Treatment of postmenopausal women with osteoporosis at high risk for fracture Indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy. In postmenopausal women with osteoporosis, Prolia reduces the incidence of vertebral, nonvertebral, and hip fractures. **Treatment to increase bone mass in men with osteoporosis at high risk for fracture** Indicated for treatment to increase bone mass in men with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy.

Treatment of bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer [A] Indicated as a treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer. In these patients Prolia also reduced the incidence of vertebral fractures. NOTE: The use of Prolia for the treatment of bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer should not be confused with the use of Xgeva (another injectable formulation of denosumab) for the prevention of skeletal-related events (SREs) in patients with bone metastases from solid tumors (including breast cancer and prostate cancer).

Treatment of bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer [B] Indicated as a treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. NOTE: The use of Prolia for the treatment of bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer should not be confused with the use of Xgeva (another injectable formulation of denosumab) for the prevention of skeletal-related events (SREs) in patients with bone metastases from solid tumors (including breast cancer and prostate cancer).

Treatment of Glucocorticoid-Induced Osteoporosis Indicated for the treatment of glucocorticoid-induced osteoporosis in men and women at high risk of fracture who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on glucocorticoids for at least 6 months. High risk of fracture is defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.

2 . Criteria

Product Name: Prolia	
Diagnosis	Bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer
Approval Length	12 months [D]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nonmetastatic prostate cancer

AND

2 - Patient is undergoing androgen deprivation therapy with one of the following: [11,A]

2.1 Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), and Zoladex (goserelin)]

OR

2.2 Bilateral orchiectomy (i.e., surgical castration)

AND

3 - One of the following:

3.1 Age greater than or equal to 70 years [11,C]

OR

3.2 Both of the following:

3.2.1 Age less than 70 years [11]

AND

3.2.2 One of the following:

3.2.2.1 Bone mineral density (BMD) scan T-score less than -1.0 (1.0 standard deviation or greater below the mean for young adults) [11]

OR

3.2.2.2 History of one of the following resulting from minimal trauma: [9,11]

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

AND

4 - Trial and failure, intolerance, or contraindication to one bisphosphonate (e.g., zoledronic acid) [19]

Product Name: Prolia	
Diagnosis	Bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer

Approval Length	12 months [D]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is undergoing androgen deprivation therapy with one of the following: [11,A]

1.1 Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), and Zoladex (goserelin)]

OR

1.2 Bilateral orchiectomy (i.e., surgical castration)

AND

2 - No evidence of metastases

AND

3 - Patient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.)

Product Name: Prolia	
Diagnosis	Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer
Approval Length	12 months [D]

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Patient is receiving adjuvant aromatase inhibitor therapy (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole]) [12,B]

AND

3 - One of the following:

3.1 Bone mineral density (BMD) scan T-score less than -1.0 (1.0 standard deviation or greater below the mean for young adults) [12,E]

OR

3.2 History of one of the following resulting from minimal trauma: [9]

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

AND

4 - Trial and failure, intolerance, or contraindication to one bisphosphonate (e.g., alendronate) [20]

Product Name: Prolia	
Diagnosis	Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer
Approval Length	12 months [D]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving adjuvant aromatase inhibitor therapy (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole]) [12]

AND

2 - Patient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.)

Product Name: Prolia	
Diagnosis	Postmenopausal women with osteoporosis or osteopenia at a high risk for fracture
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of postmenopausal osteoporosis or osteopenia [2,5]

AND

2 - One of the following: [5,17]

2.1 Bone mineral density (BMD) scan indicative of osteoporosis: T-score less than or equal to -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

OR

2.2 Both of the following:

2.2.1 BMD scan indicative of osteopenia: T-score between -1.0 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1.0) in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

2.2.2 One of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

- Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
- Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

OR

2.3 History of one of the following resulting from minimal trauma:

- Vertebral compression fracture

- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

AND

3 - Trial and failure, intolerance, or contraindication to one bisphosphonate (e.g., alendronate)

Product Name: Prolia	
Diagnosis	Postmenopausal women with osteoporosis or osteopenia at a high risk for fracture
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.) without significant adverse effects

Product Name: Prolia	
Diagnosis	Increase bone mass in men at high risk for fracture
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is a male with osteoporosis or osteopenia

AND

2 - One of the following: [16,17]

2.1 Bone mineral density (BMD) scan indicative of osteoporosis: T-score less than or equal to -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

OR

2.2 Both of the following:

2.2.1 BMD scan indicative of osteopenia: T-score between -1.0 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1.0) in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

2.2.2 One of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

- Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
- Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

OR

2.3 History of one of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis

- Fracture of the proximal humerus

AND

3 - Trial and failure, intolerance, or contraindication to one bisphosphonate (e.g., alendronate)

Product Name: Prolia	
Diagnosis	Increase bone mass in men at high risk for fracture
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.) without significant adverse effects

Product Name: Prolia	
Diagnosis	Glucocorticoid-induced osteoporosis at high risk for fracture
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of glucocorticoid-induced osteoporosis

AND

2 - Patient is initiating or continuing on greater than or equal to 7.5 mg/day of prednisone (or its equivalent) and is expected to remain on glucocorticoid therapy for at least 6 months

AND

3 - One of the following: [F]

3.1 BMD T-score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site)

OR

3.2 One of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

- Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
- Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

OR

3.3 History of one of the following fractures resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

AND

4 - Trial and failure, contraindication, or intolerance to one bisphosphonate (e.g., alendronate) [G]

Product Name: Prolia	
Diagnosis	Glucocorticoid-induced osteoporosis at high risk for fracture
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.) without significant adverse effects	

3 . Definitions

Definition	Description
Bone mineral density (BMD) [3]	A risk factor for fractures. By DXA, BMD is expressed as the amount of mineralized tissue in the area scanned (g/cm(to the power of 2)); with some technologies, BMD is expressed as the amount per volume of bone (g/cm(to the power of 3)). Hip BMD by DXA is considered the best predictor of hip fracture; it appears to predict other types of fractures as well as measurements made at other skeletal sites. Spine BMD may be preferable to assess changes early in menopause and after bilateral ovariectomy.

Dual x-ray absorptiometry (DXA) [3]	A diagnostic test used to assess bone density in the spine, hip, or wrist using radiation exposure about one tenth that of a standard chest x-ray. Central DXA (spine, hip) is the preferred measurement for definitive diagnosis and for monitoring the effects of therapy.
Fracture [3]	Breakage of a bone, either complete or incomplete. Most studies of osteoporosis focus on hip, vertebra and/or distal forearm fractures. Vertebral fractures include morphometric as well as clinical fractures.
Osteopenia [3]	The designation for bone density between 1.0 and 2.5 standard deviations below the mean for young normal adults (T-score between -1 and -2.5).
Osteoporosis [3]	A chronic, progressive disease characterized by low bone mass, microarchitectural deterioration and decreased bone strength, bone fragility and a consequent increase in fracture risk; bone density 2.5 or more standard deviations below the young normal mean (T-score at or below -2.5).
Peripheral DXA [3]	A DXA test used to assess bone density in the forearm, finger and heel.
Quantitative computed tomography (QCT) [3]	A diagnostic test used to assess bone density; reflects three-dimensional bone mineral density. Usually used to assess the lumbar spine, but has been adapted for other skeletal sites. It is also possible to measure trabecular and cortical bone density in the periphery by peripheral QCT (pQCT).
Quantitative ultrasound densitometry (QUS) [3]	A diagnostic test used to assess bone density at the calcaneus or patella. Ultrasound measurements correlate only modestly with other assessments of bone density in the same patient, yet some prospective studies indicate that ultrasound may predict fractures as well as other measures of bone density.
Remodeling [3]	The ongoing dual processes of bone formation and bone resorption after cessation of growth.
Resorption [3]	The loss of substance (in this case, bone) through physiological or pathological means.
Risk factors [3]	For osteoporotic fractures, includes low BMD, parental history of hip fracture, low body weight, previous fracture, smoking, excess alcohol intake, glucocorticoid use, secondary osteoporosis (e.g., rheumatoid arthritis) and history of falls.

	These readily accessible and commonplace factors are associated with the risk of hip fracture and, in most cases, with that of vertebral and other types of fracture as well.
Severe or "established" osteoporosis [3]	Osteoporosis characterized by bone density that is 2.5 standard deviations or more below the young normal mean (T-score at or below -2.5), accompanied by the occurrence of at least one fragility-related fracture.
T-score [3]	In describing bone mineral density, the number of standard deviations above or below the mean for young normal adults of the same sex.
Z-score [3]	In describing bone mineral density, the number of standard deviations above or below the mean for persons of the same age and sex.

4 . Endnotes

A. Androgen deprivation therapy (ADT) is commonly used in the treatment of prostate cancer. ADT can be accomplished using luteinizing hormone-releasing hormone (LHRH) agonists (medical castration), also known as gonadotropin releasing hormone (GnRH) agonists, or bilateral orchiectomy (surgical castration), which are equally effective. [13] Examples of LHRH agonists include Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), and Zoladex (goserelin).
B. Aromatase inhibitors (AIs) include selective, nonsteroidal AIs (Arimidex [anastrozole] and Femara [letrozole]) and steroidal AIs (Aromasin [exemestane]).
C. Meta-analyses have shown that advancing age increases fracture risk beyond that predicted by age related loss of BMD. Although typical changes in BMD would predict a 4-fold increase in fracture risk from ages 50 to 90 years, fracture risk actually increases 30-fold. Estimated fracture rates using FRAX calculations reflect a strong influence of older age on risk for clinical fracture. When clinical factors were used without BMD in one cross-sectional study, FRAX estimated that 76.6% of men in their 70s and virtually all men 80 years old or older exceeded the NOF recommended risk threshold for drug therapy. [14]
D. Most men run a 2-year course of androgen deprivation therapy while most women receive treatment with aromatase inhibitors for about 5 years. A one year treatment authorization is reasonable. [15]
E. Owing to the rate of bone loss associated with breast cancer treatments (i.e., aromatase inhibitors), and uncertainties about the interaction between aromatase inhibitor use and BMD for fracture risk, the threshold for intervention has been set

at a higher level than that generally recommended for postmenopausal osteoporosis. [8]

F. According to the American College of Rheumatology (ACR) guidelines for the prevention and treatment of glucocorticoid-induced osteoperosis, patients considered at high risk of fractures are as follows: (a) prior osteoporotic fracture, (b) a hip or spine BMD T-score less than or equal to -2.5, or (c) FRAX 10-year risk of hip or major osteoporotic fracture at 3 percent or more and 20 percent or more, respectively. [18]
G. According to ACR, oral bisphosphonates are considered first-line for patients with glucocorticod-induced osteoperosis at high risk for fractures. For patients in whom oral bisphosphonates are not appropriate, IV bisphosphonates should be considered. [18]

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6 . Revision History

Date	Notes
8/4/2022	2022 Annual Review - No changes to criteria, updated backgroun d information

Pulmonary Arterial Hypertension Agents - PA, NF

Prior Authorization Guideline

Guideline ID	GL-126185
Guideline Name	Pulmonary Arterial Hypertension Agents - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	8/15/2005
P&T Revision Date:	07/17/2019 ; 11/14/2019 ; 12/18/2019 ; 02/13/2020 ; 02/18/2021 ; 06/16/2021 ; 10/20/2021 ; 11/18/2021 ; 02/17/2022 ; 07/20/2022 ; 10/19/2022 ; 02/16/2023 ; 03/15/2023 ; 04/19/2023 ; 7/19/2023

1 . Indications

Drug Name: Adcirca (tadalafil) Tablets, Alyq (tadalafil) Tablets, Tadliq (tadalafil) Oral Suspension
Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group I) to improve exercise ability. Studies establishing effectiveness included predominately patients with New York Heart Association (NYHA) Functional Class II–III symptoms and etiologies of idiopathic or heritable PAH (61%) or PAH associated with connective tissue diseases (23%).
Drug Name: Adempas (riociguat) Tablets

Pulmonary Arterial Hypertension (PAH) Indicated for treatment of adults with PAH (WHO Group I) to improve exercise capacity, WHO Functional Class, and to delay clinical worsening. Efficacy was shown in patients on riociguat monotherapy or in combination with endothelin receptor antagonists or prostanoids. Studies establishing effectiveness included predominantly patients with WHO Functional Class II to III and etiologies of idiopathic or heritable PAH (61%) or PAH associated with connective tissue diseases (25%).

Chronic-Thromboembolic Pulmonary Hypertension (CTEPH) Indicated for treatment of adults with persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH), (WHO Group 4) after surgical treatment, or inoperable CTEPH, to improve exercise capacity and WHO Functional Class.

Drug Name: Flolan (epoprostenol sodium) Injection

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to improve exercise capacity. Studies establishing effectiveness included predominantly (97%) patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH (49%) or PAH associated with connective tissue diseases (51%).

Drug Name: Letairis (ambrisentan) Tablets

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to 1) improve exercise ability and delay clinical worsening and 2) in combination with tadalafil to reduce the risks of disease progression and hospitalization for worsening PAH, and to improve exercise ability. Studies establishing effectiveness included predominantly patients with WHO Functional Class II-III symptoms and etiologies of idiopathic or heritable PAH (60%) or PAH associated with connective tissue diseases (34%).

Drug Name: Liqrev (sildenafil) suspension

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group I) in adults to improve exercise ability and delay clinical worsening.

Drug Name: Opsumit (macitentan) Tablets

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to reduce the risks of disease progression and hospitalization for PAH. Effectiveness was established in a long-term study in PAH patients with predominantly WHO Functional Class II-III symptoms treated for an average of 2 years. Patients had

idiopathic and heritable PAH (57%), PAH caused by connective tissue disorders (31%), and PAH caused by congenital heart disease with repaired shunts (8%).

Drug Name: Orenitram (treprostinil) Tablets

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to delay disease progression and to improve exercise capacity. The studies that established effectiveness included predominately patients with WHO functional class II-III symptoms and etiologies of idiopathic or heritable PAH (66%) or PAH associated with connective tissue disease (26%).

Drug Name: Remodulin (treprostinil sodium) Injection

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to diminish symptoms associated with exercise. Studies establishing effectiveness included patients with NYHA Functional Class II-IV symptoms and etiologies of idiopathic or heritable PAH (58%), PAH associated with congenital systemic-to-pulmonary shunts (23%), or PAH associated with connective tissue diseases (19%). Indicated to diminish the rate of clinical deterioration in patients with PAH requiring transition from epoprostenol. Consider the risks and benefits of each drug prior to transition.

Drug Name: Revatio (sildenafil) Injection, Tablets, Oral Suspension

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I): 1) In adults to improve exercise ability and delay clinical worsening. 2) in pediatric patients 1 to 17 years old to improve exercise ability and, in pediatric patients too young to perform standardized exercise testing, pulmonary hemodynamics thought to underly improvements in exercise.

Drug Name: Tracleer (bosentan) Tablets, Tablets for Suspension

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group I): 1) In adults to improve exercise ability and to decrease clinical worsening. Studies establishing effectiveness included predominantly patients with WHO Functional Class II-IV symptoms and etiologies of idiopathic or heritable PAH (60%), PAH associated with connective tissue diseases (21%), and PAH associated with congenital heart disease with left-to right shunts (18%). 2) In pediatric patients aged 3 years and older with idiopathic or congenital PAH to improve pulmonary vascular resistance (PVR), which is expected to result in an improvement in exercise ability.

Drug Name: Tyvaso (treprostinil) Inhalation Solution, Tyvaso (treprostinil) DPI Inhalation Powder

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to improve exercise ability. Studies establishing effectiveness included predominately patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH (56%) or PAH associated with connective tissue diseases (33%). The effects diminish over the minimum recommended dosing interval of 4 hours; treatment timing can be adjusted for planned activities. While there are long-term data on use of treprostinil by other routes of administration, nearly all controlled clinical experience with inhaled treprostinil has been on a background of bosentan (an endothelin receptor antagonist) or sildenafil (a phosphodiesterase type 5 inhibitor). The controlled clinical experience was limited to 12 weeks in duration.

Pulmonary Hypertension Associated with Interstitial Lung Disease (ILD) Indicated for the treatment of pulmonary hypertension associated with ILD (PH-ILD; WHO Group 3) to improve exercise ability. The study establishing effectiveness predominately included patients with etiologies of idiopathic interstitial pneumonia (IIP) (45%) inclusive of idiopathic pulmonary fibrosis (IPF), combined pulmonary fibrosis and emphysema (CPFE) (25%), and WHO Group 3 connective tissue disease (22%).

Drug Name: Veletri (epoprostenol) Injection

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group I) to improve exercise capacity. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH or PAH associated with connective tissue diseases.

Drug Name: Ventavis (iloprost) Inhalation Solution

Pulmonary Arterial Hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration. Studies establishing effectiveness included predominately patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH (65%) or PAH associated with connective tissue diseases (23%).

Drug Name: Uptravi (selexipag) Tablets and Injection

Pulmonary Arterial Hypertension Indicated for the treatment of PAH (WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH. Effectiveness was established in a long-term study in PAH patients with WHO Functional Class II-III symptoms. Patients had idiopathic and heritable PAH (58%), PAH associated with connective tissue disease (29%), PAH associated with congenital heart disease with repaired shunts (10%).

2 . Criteria

Product Name: Generic Alyq tablet, Generic tadalafil tablet, Adempas tablet, Brand Flolan injection, Generic epoprostenol injection, Generic ambrisentan tablet, Opsumit tablet, Orenitram tablet, Generic treprostinil injection, Generic sildenafil tablet, Generic bosentan tablet, Tracleer tablet for suspension, Tyvaso inhalation solution, Tyvaso Refill inhalation solution, Tyvaso Starter inhalation solution, Tyvaso DPI, Veletri injection, or Ventavis inhalation solution	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

Product Name: Brand Adcirca tablet, Tadliq oral suspension	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Trial and failure or intolerance to generic tadalfil

Product Name: Brand Letairis tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Trial and failure or intolerance to generic ambrisentan

Product Name: Brand Remodulin injection

Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Trial and failure or intolerance to generic treprostinil

Product Name: Brand Revatio tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Trial and failure or intolerance to generic sildenafil tablet

Product Name: Brand Tracleer tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Trial and failure or intolerance to generic bosentan tablet

Product Name: Brand Revatio injection or Generic sildenafil injection	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Patient is unable to take oral medications [2]

Product Name: Liqrev, Brand Revatio oral suspension or Generic sildenafil oral suspension	
Diagnosis	Pulmonary Arterial Hypertension

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - One of the following:

5.1 History of intolerance to generic Revatio tablets

OR

5.2 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following:

- Age
- Oral-motor difficulties
- Dysphagia

AND

6 - For Liqrev, trial and failure or intolerance to generic sildenafil suspension

Product Name: Adempas tablet	
Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)

AND

1.1.2 CTEPH is symptomatic

OR

1.2 Patient is currently on any therapy for the diagnosis of CTEPH

AND

2 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

Product Name: Tyvaso inhalation solution, Tyvaso Refill inhalation solution, or Tyvaso Start inhalation solution, Tyvaso DPI	
Diagnosis	Pulmonary Hypertension associated with Interstitial Lung Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary hypertension associated with interstitial lung disease

AND

2 - Diagnosis of pulmonary hypertension associated with interstitial lung disease was confirmed by diagnostic test(s) (e.g., right heart catheterization, doppler echocardiogram, computerized tomography imaging)

AND

3 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

Product Name: Brand Adcirca tablet, Generic tadalafil tablet, Generic Alyq tablet, Tadliq oral suspension, Adempas tablet, Brand Flolan injection, Generic epoprostenol injection, Brand Letairis tablet, Liqrev, Generic ambrisentan tablet, Opsumit tablet, Orenitram tablet, Brand Remodulin injection, Generic treprostinil injection, Brand Revatio injection, Generic sildenafil injection, Brand Revatio tablet, Generic sildenafil tablet, Brand Revatio oral suspension, Generic sildenafil oral suspension, Brand Tracleer tablet, Generic bosentan tablet, Tracleer tablet for suspension, Tyvaso inhalation solution, Tyvaso Refill inhalation solution, Tyvaso Starter inhalation solution, Tyvaso DPI, Veletri injection, or Ventavis inhalation solution	
Diagnosis	All indications listed above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Uptravi tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 Trial and failure, contraindication, or intolerance to one of the following:

- PDE-5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)]
- Adempas (riociguat)

AND

4.1.2 Trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), Tracleer (bosentan)]

OR

4.2 For continuation of prior therapy

AND

5 - Not taken in combination with a prostanoid/prostacyclin analogue [e.g., Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)]

AND

6 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

Product Name: Uptravi injection	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 Trial and failure, contraindication, or intolerance to one of the following:

- PDE-5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)]
- Adempas (riociguat)

AND

4.1.2 Trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), Tracleer (bosentan)]

OR

4.2 For continuation of prior therapy

AND

5 - Not taken in combination with a prostanoid/prostacyclin analogue [e.g., Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)]

AND

6 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

7 - Patient is unable to take oral medications [13]

Product Name: Uptravi tablet/injection	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Not taken in combination with a prostanoid/prostacyclin analogue [e.g., Flolan (epoprostenol), Ventavis (iloprost), Tyvaso/Remodulin/Orenitram (treprostinil)]

Product Name: Brand Adcirca tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure or intolerance to generic tadalfil

Product Name: Brand Letairis tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure or intolerance to generic ambrisentan

Product Name: Brand Remodulin injection	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - One of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure or intolerance to generic treprostinil

Product Name: Brand Tracleer tablet	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Submission of medical records (e.g., chart notes) confirming pulmonary arterial hypertension is symptomatic

AND

3 - Submission of medical records (e.g., chart notes) confirming one of the following:

3.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization [A]

OR

3.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

4 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Cardiologist

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure or intolerance to generic bosentan tablet

3 . Endnotes

A. Require right heart catheterization in order to confirm pulmonary arterial hypertension diagnosis: Per clinical consult with cardiologist, PAH specialist, and P&T committee recommendation, February 20, 2014.

4 . References

1. Flolan Prescribing Information. GlaxoSmithKline. Research Triangle Park, NC. August 2021.
2. Revatio Prescribing Information. Pfizer Inc. New York, NY. January 2023.
3. Ventavis Prescribing Information. Actelion Pharmaceuticals US, Inc. Titusville, NJ. March 2022.
4. Tyvaso Prescribing Information. United Therapeutics Corp. Research Triangle Park, NC. May 2022.
5. Remodulin Prescribing Information. United Therapeutics Corp. Research Triangle Park, NC. July 2021.
6. Adcirca Prescribing Information. Eli Lilly and Company. Indianapolis, IN. September 2020.
7. Letairis Prescribing Information. Gilead Sciences, Inc. Foster City, CA. August 2019.
8. Tracleer Prescribing Information. Actelion Pharmaceuticals US, Inc. Titusville, NJ. July 2022.
9. Veletri Prescribing Information. Actelion Pharmaceuticals US, Inc. Titusville, NJ. July 2022.
10. Opsumit Prescribing Information. Actelion Pharmaceuticals US, Inc. Titusville, NJ. July 2022.
11. Adempas Prescribing Information. Bayer HealthCare Pharmaceuticals Inc. Whippany, NJ. September 2021.
12. Orenitram Prescribing Information. United Therapeutics Corp. Research Triangle Park, NC. May 2021.
13. Uptravi Prescribing Information. Actelion Pharmaceuticals US, Inc. Titusville, NJ. July 2022.
14. Alyq Prescribing Information. Teva Pharmaceuticals USA, Inc. North Wales, PA. September 2021.

15. Tyvaso DPI Prescribing Information. United Therapeutics Corporation. Research Triangle Park, NC. May 2022.
16. Tadliq Prescribing Information. CMP Pharma, Inc. Farmville, NC. June 2022.
17. Liqrev Prescribing Information. CMP Pharma, Inc. Farmville, NC. April 2023.

Qutenza (capsaicin)

Prior Authorization Guideline

Guideline ID	GL-113650
Guideline Name	Qutenza (capsaicin)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	12/1/2022
P&T Approval Date:	2/25/2016
P&T Revision Date:	08/13/2020 ; 10/21/2020 ; 11/12/2020 ; 11/18/2021 ; 10/19/2022

1 . Indications

Drug Name: Qutenza (capsaicin)
Neuropathic pain associated with postherpetic neuralgia Indicated for the treatment of neuropathic pain associated with postherpetic neuralgia (PHN). **Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet** Indicated for the treatment of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet.

2 . Criteria

Product Name: Qutenza	
Diagnosis	Neuropathic pain associated with postherpetic neuralgia (PHN)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuropathic pain associated with postherpetic neuralgia (PHN)

AND

2 - Trial and failure, contraindication, or intolerance to generic lidocaine 5% patch [A]

AND

3 - Trial and failure, contraindication, or intolerance to one of the following [A]:

- gabapentin
- pregabalin
- tricyclic antidepressant (e.g., amitriptyline, nortriptyline, desipramine)

Product Name: Qutenza	
Diagnosis	Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet

AND

2 - Trial and failure, contraindication, or intolerance to generic lidocaine 5% patch

AND

3 - Trial and failure, contraindication, or intolerance to one of the following:

- gabapentin
- pregabalin
- tricyclic antidepressant (e.g., amitriptyline, nortriptyline, desipramine)
- duloxetine

Product Name: Qutenza	
Diagnosis	All indications
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - It has been at least 3 months since the last application/administration [B]

AND

2 - Patient experienced pain relief with a prior course of therapy

AND

3 - Patient is experiencing a return of neuropathic pain

3 . Endnotes

A. The following agents are recommended: gabapentin, pregabalin, tricyclic antidepressants (TCAs), lidocaine patch, and controlled-release oxycodone or morphine sulfate. These agents are considered to have medium to high efficacy in managing PHN, good strength of evidence and a low level of side effects. [2]
B. Treatment with capsaicin may be repeated every three months as warranted by the return of pain (but not more frequently than every three months). [1]
C. Cavalli, E., Mammana, S., et al. The neuropathic pain: An overview of the current treatment and future therapeutic approaches. Int J Immunopathol Pharmacol. 2019 Jan-Dec; 33: 2058738419838383., Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6431761/. Accessed October 1, 2021.
D. Snyder, M., Gibbs, L. Treating Painful Diabetic Peripheral Neuropathy: An Update. Am Fam Physician. 2016 Aug 1;94(3):227-234.. Available at https://www.aafp.org/afp/2016/0801/p227.html. Accessed October 1, 2021.

E. Treatment of Painful Diabetic Neuropathy. American Academy of Neurology. Available at file:///C:/Users/kdekhtaw/Downloads/Treatment%20of%20Painful%20Diabetic%20Neuropathy.pdf. Accessed October 1, 2021.
F. Cohen, K., Shinkazh, N., et al. Pharmacological Treatment Of Diabetic Peripheral Neuropathy. 2015 Jun; 40(6): 372, 375-388. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450668/. Accessed October 21, 2021.

4 . References

1. Qutenza Prescribing Information. Acorda Therapeutics, INC. Ardsley, NY. August 2022.
2. Dubinsky RM, Kabbani H, El-Chammi Z, et al. Practice parameter: treatment of postherpetic neuralgia: an evidence-based report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2004; 63(6):959-965.
3. Cavalli, E., Mammana, S., et al. The neuropathic pain: An overview of the current treatment and future therapeutic approaches. Int J Immunopathol Pharmacol. 2019 Jan-Dec; 33: 2058738419838383., Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6431761/. Accessed October 1, 2021.
4. Snyder, M., Gibbs, L. Treating Painful Diabetic Peripheral Neuropathy: An Update. Am Fam Physician. 2016 Aug 1;94(3):227-234.. Available at https://www.aafp.org/afp/2016/0801/p227.html. Accessed October 1, 2021.
5. Treatment of Painful Diabetic Neuropathy. American Academy of Neurology. Available at file:///C:/Users/kdekhtaw/Downloads/Treatment%20of%20Painful%20Diabetic%20Neuropathy.pdf. Accessed October 1, 2021.
6. Cohen, K., Shinkazh, N. et al. Pharmacological Treatment Of Diabetic Peripheral Neuropathy. P T. 2015 Jun; 40(6): 372, 375-388. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450668/. Accessed October 21, 2021.

5 . Revision History

Date	Notes
9/11/2022	2022 Annual Review

Radicava (edaravone)

Prior Authorization Guideline

Guideline ID	GL-110180
Guideline Name	Radicava (edaravone)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	7/26/2017
P&T Revision Date:	08/13/2020 ; 08/19/2021 ; 06/15/2022 ; 07/20/2022 ; 8/18/2022

1 . Indications

Drug Name: Radicava (edaravone) injection, Radicava ORS (edaravone) oral suspension
Amyotrophic Lateral Sclerosis (ALS) Indicated for the treatment of Amyotrophic Lateral Sclerosis (ALS).

2 . Criteria

Product Name: Radicava IV, Radicava ORS	
Diagnosis	Amyotrophic Lateral Sclerosis (ALS)
Approval Length	6 Months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the revised EL Escorial and Airlie House diagnostic criteria

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient has scores greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment

AND

4 - Patient has a percent (%) forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

Product Name: Radicava IV, Radicava ORS	
Diagnosis	Amyotrophic Lateral Sclerosis (ALS)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., slowing in the decline of functional abilities)

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

3 . Endnotes

A. Authorization period is based on the pivotal study duration of 24 weeks. [1-3]

4 . References

1. Abe K, Itoyama Y, Sobue G, et al. Confirmatory double-blind, parallel-group, placebo-controlled study of efficacy and safety of edaravone (MCI-186) in amyotrophic lateral sclerosis patients. Amyotroph Lateral Scler Frontotemporal Degener. 2014; 15(7-8):610-7.
2. Radicava Prescribing Information. Mitsubishi Tanabe Pharma. March 2021.
3. The Writing Group. Safety and efficacy of edaravone in well defined patients with amyotrophic lateral sclerosis: a randomized, double-blind, placebo-controlled trial. Lancet Neurol 2017; 16(7):505-512.
4. Radicava ORS Prescribing Information. Mitsubishi Tanabe Pharma. Jersey City, NJ. May 2022.

5 . Revision History

Date	Notes
8/4/2022	2022 Annual Review - no criteria changes

Repository Corticotropin Gel Products - PA, N

Guideline ID	GL-110157
Guideline Name	Repository Corticotropin Gel Products - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	5/19/2009
P&T Revision Date:	08/15/2019 ; 08/15/2019 ; 08/13/2020 ; 08/19/2021 ; 02/17/2022 ; 8/18/2022

1 . Indications

Drug Name: Acthar Gel (repository corticotropin injection)
Infantile spasms [2, 3] Indicated as monotherapy for the treatment of infantile spasms in infants and children under 2 years of age. **Exacerbations of Multiple Sclerosis [4, 5]** Indicated for the treatment of acute exacerbations of multiple sclerosis in adults. Controlled clinical trials have shown Acthar Gel to be effective in speeding the resolution of acute exacerbations of multiple sclerosis. However, there is no evidence that it affects the ultimate outcome or natural history of the disease. **All Other Disease States [A]** *Please Note: The request for Acthar for the treatment of a condition other than Infantile Spasms (IS) or Exacerbations of Multiple Sclerosis (MS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the efficacy, safety, or long-term consequences of using repository corticotropin over conventional corticosteroids in these steroid-responsive conditions. **[Non-Approvable Use] Rheumatic Disorders* [6, 7, A]** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: Psoriatic arthritis, Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), Ankylosing spondylitis. **[Non-Approvable Use] Collagen Diseases* [8-10, A]** During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, systemic dermatomyositis (polymyositis). **[Non-Approvable Use] Dermatologic Diseases* [A]** Severe erythema multiforme,

Stevens-Johnson syndrome.

[Non-Approvable Use] Allergic States* [A] Serum sickness.

[Non-Approvable Use] Ophthalmic Diseases* [14, A] Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis; optic neuritis; chorioretinitis; anterior segment inflammation.

[Non-Approvable Use] Respiratory Diseases* [11, A] Symptomatic sarcoidosis

[Non-Approvable Use] Edematous State* [12, 13, 15, A] To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.

Drug Name: Purified Cortrophin Gel (repository corticotropin injection)

Exacerbations of Multiple Sclerosis [4, 5] Indicated for acute exacerbations of multiple sclerosis.

All Other Disease States [A] *Please Note: The request for Purified Cortrophin Gel for the treatment of a condition other than Infantile Spasms (IS) or Exacerbations of Multiple Sclerosis (MS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the efficacy, safety, or long-term consequences of using repository corticotropin over conventional corticosteroids in these steroid-responsive conditions.

[Non-Approvable Use] Rheumatic Disorders* [6, 7, A] Indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: Psoriatic arthritis; Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy); Ankylosing spondylitis; Acute gouty arthritis.

[Non-Approvable Use] Collagen Diseases* [8-10, A] Indicated during an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, systemic dermatomyositis (polymyositis).

[Non-Approvable Use] Dermatologic Diseases* [A] Indicated for severe erythema multiforme (Stevens-Johnson syndrome), severe psoriasis.

[Non-Approvable Use] Allergic States* [A] Indicated for atopic dermatitis, serum sickness.

[Non-Approvable Use] Ophthalmic Diseases* [14, A] Indicated for severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as:

allergic conjunctivitis, keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation.

[Non-Approvable Use] Respiratory Diseases* [11, A] Indicated for symptomatic sarcoidosis.

[Non-Approvable Use] Edematous States* [12, 13, 15, A] Indicated to induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.

Off Label Uses: Infantile spasms [2, 3] Indicated as monotherapy for the treatment of infantile spasms in infants and children under 2 years of age.

2 . Criteria

Product Name: Acthar Gel, Purified Cortrophin Gel [off-label]	
Diagnosis	Infantile Spasms (West Syndrome)
Approval Length	4 Week(s)
Guideline Type	Prior Authorization, Non Formulary

Approval Criteria

1 - Diagnosis of infantile spasms (West Syndrome)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Patient is less than 2 years of age

Product Name: Acthar Gel, Purified Cortrophin Gel	
Diagnosis	Multiple Sclerosis
Approval Length	3 Week(s)
Guideline Type	Prior Authorization, Non Formulary

Approval Criteria

1 - Diagnosis of acute exacerbation of multiple sclerosis

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - One of the following:

3.1 Both of the following:

- Patient is new to therapy with corticotropin
- Trial and failure, contraindication, or intolerance to treatment with two high dose corticosteroid treatments (e.g., prednisone, IV methylprednisolone)

OR

3.2 All of the following:

- Patient's multiple sclerosis exacerbations have been treated in the past with corticotropin
- Patient has benefitted from treatment with corticotropin for acute exacerbations of multiple sclerosis
- Medication is being used to treat a new exacerbation of multiple sclerosis

Product Name: Acthar Gel, Purified Cortrophin Gel	
Diagnosis	All Other Indications [A]
Approval Length	N/A - Requests for non-approvable diagnoses should not be approved
Guideline Type	Prior Authorization, Non Formulary

Approval Criteria

1 - The request for Acthar Gel and Purified Cortrophin Gel for the treatment of a condition other than Infantile Spasms (IS) or Exacerbations of Multiple Sclerosis (MS) is not authorized and will not be approved. There is no consensus in current peer-reviewed medical literature regarding the efficacy, safety, or long-term consequences of using repository corticotropin over conventional corticosteroids in these steroid-responsive conditions:

- Rheumatic Disorders* [6, 7, A] As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: Psoriatic arthritis, Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), Ankylosing spondylitis, Acute gouty arthritis.
- Collagen Diseases* [8-10, A] During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, systemic dermatomyositis (polymyositis).
- Dermatologic Diseases* [A] Severe erythema multiforme, Stevens-Johnson syndrome, Severe psoriasis.
- Allergic States* [A] Serum sickness, Atopic dermatitis.
- Ophthalmic Diseases* [14, A] Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis; optic neuritis; chorioretinitis; anterior segment inflammation; Allergic conjunctivitis.
- Respiratory Diseases* [11, A] Symptomatic sarcoidosis.
- Edematous State* [12, 13, 15, A] To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus.
- Any other disease state not mentioned [A]*

Notes	*Other disease states lack published clinical literature to support the use of Acthar or Purified Cortrophin Gel [A]

3 . Endnotes

A. Grandfathered indications, although briefly mentioned in the labeling, do not have clinical studies in the prescribing information or medical literature supporting their use of Acthar or Purified Cortrophin Gel.

4 . References

1. Acthar prescribing information. Mallinckrodt ARD LLC. Bedminster, NJ. October 2021.
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15. Madan A, Mojovic-Das S, Stankovic A, et al. Acthar gel in the treatment of nephrotic syndrome: a multicenter retrospective case series. BMC Nephrol. 2016;17:37.
16. Purified Cortrophin Gel prescribing information. ANI Pharmaceuticals, Inc. Baudette, MN. June 2022.

5 . Revision History

Date	Notes
8/4/2022	Annual Review: No criteria changes. Updated references, indicati ons, and background.

Reblozyl (luspatercept-aamt)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Reblozyl (luspatercept-aamt)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	3/1/2023
P&T Approval Date:	3/1/2021
P&T Revision Date:	06/17/2020 ; 01/20/2021 ; 01/19/2022 ; 1/18/2023

1 . Indications

Drug Name: Reblozyl (luspatercept-aamt)
Beta Thalassemia Indicated for the treatment of anemia in adult patients with beta thalassemia who require regular red blood cell (RBC) transfusions. Limitations of Use: Reblozyl is not indicated for use as a substitute for RBC transfusions in patients who require immediate correction of anemia. **Myelodysplastic Syndromes with Ring Sideroblasts or Myelodysplastic/ Myeloproliferative Neoplasm with Ring Sideroblasts and Thrombocytosis Associated Anemia** Indicated for the treatment of anemia failing an erythropoiesis stimulating agent and requiring 2 or more red blood cell units over 8 weeks in adult patients with very low- to intermediate-risk myelodysplastic syndromes with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T). Limitations of Use: Reblozyl is not indicated for use as a substitute for RBC transfusions in patients who require immediate correction of anemia

2 . Criteria

Product Name: Reblozyl	
Diagnosis	Beta Thalassemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of beta thalassemia major [3]

AND

1.1.2 Patient requires regular red blood cell (RBC) transfusions

OR

1.2 Diagnosis of transfusion-dependent beta thalassemia [3]

AND

2 - Prescribed by or in consultation with one of the following:

- Hematologist
- Oncologist

Product Name: Reblozyl	
Diagnosis	Beta Thalassemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., reduction in RBC transfusion burden) [1,2]

Product Name: Reblozyl	
Diagnosis	Myelodysplastic Syndromes, Myelodysplastic/Myeloproliferative Neoplasm (MDS-RS, MDS/MPN-RS-T)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- One of the following diagnoses:

1.1 Very low-to intermediate-risk myelodysplastic syndrome with ring sideroblasts (MDS-RS)

OR

1.2 Myelodysplastic or myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

AND

2 - Patient has failed an erythropoiesis stimulating agent [e.g., Epogen (epoetin alfa), Aranesp (darbepoetin)]

AND

3 - Patient requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks

AND

4 - Prescribed by or in consultation with one of the following:

- Hematologist
- Oncologist

Product Name: Reblozyl	
Diagnosis	Myelodysplastic Syndromes, Myelodysplastic/Myeloproliferative Neoplasm (MDS-RS, MDS/MPN-RS-T)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., RBC transfusion independence, improvement in hemoglobin levels) [1,4]

3 . References

1. Reblozyl Prescribing Information. Celgene Corporation. Summit, NJ. September 2022.
2. Piga A, Perrotta S, Gamberini M, et al. Luspatercept improves hemoglobin levels and blood transfusion requirements in a study of patients with β-thalassemia. Blood 2019; 133 (12): 1279–1289.
3. Per clinical consult with oncologist, December 19, 2019.
4. Fenaux P, Platzbecker U, Ghulam J, et al. Luspatercept in patients with lower-risk myelodysplastic syndromes. N Engl J Med 2020;382:140-151.

4 . Revision History

Date	Notes
1/4/2023	2023 UM Annual Review. No changes to criteria. Updated references

Retinal Vascular Disease Agents – PA, NF

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Retinal Vascular Disease Agents - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	7/15/2022
P&T Revision Date:	04/21/2021 ; 01/19/2022 ; 04/20/2022 ; 07/20/2022 ; 08/18/2022 ;

1 . Indications

Drug Name: Beovu (brolucizumab)
Neovascular (Wet) Age-Related Macular Degeneration Indicated for the treatment of neovascular (wet) age-related macular degeneration (nAMD). **Diabetic Macular Edema (DME)** Indicated for the treatment of diabetic macular edema (DME).
Drug Name: Eylea (aflibercept)
Neovascular (Wet) Age-Related Macular Degeneration Indicated for the treatment of neovascular (wet) age-related macular degeneration (nAMD). **Macular Edema Following Retinal Vein Occlusion** Indicated for the treatment of

patients with macular edema following retinal vein occlusion (RVO). **Diabetic Macular Edema** Indicated for the treatment of patients with diabetic macular edema (DME). **Diabetic Retinopathy** Indicated for the treatment of diabetic retinopathy (DR). **Retinopathy of Prematurity (ROP)** Indicated for the treatment of retinopathy of prematurity (ROP).
Drug Name: Eylea HD (aflibercept)
Neovascular (Wet) Age-Related Macular Degeneration Indicated for the treatment of neovascular (wet) age-related macular degeneration (nAMD). **Diabetic Macular Edema** Indicated for the treatment of patients with diabetic macular edema (DME). **Diabetic Retinopathy** Indicated for the treatment of diabetic retinopathy (DR).
Drug Name: Lucentis 0.5mg (ranibizumab), Byooviz (ranibizumab-nuna), Cimerli 0.5mg (ranibizumab-eqrn)
Neovascular (Wet) Age-Related Macular Degeneration Indicated for the treatment of patients with neovascular (wet) age-related macular degeneration (nAMD). **Macular Edema Following Retinal Vein Occlusion** Indicated for the treatment of patients with macular edema following retinal vein occlusion (RVO). **Myopic Choroidal Neovascularization** Indicated for the treatment of patients with myopic choroidal neovascularization (mCNV).
Drug Name: Lucentis 0.3 mg (ranibizumab), Cimerli 0.3mg (ranibizumab-eqrn)
Diabetic Macular Edema Indicated for the treatment of patients with diabetic macular edema (DME). **Diabetic Retinopathy** Indicated for the treatment of diabetic retinopathy (DR).
Drug Name: Susvimo (ranibizumab)
Neovascular (Wet) Age-Related Macular Degeneration Indicated for the treatment of patients with neovascular (wet) age-related macular degeneration (nAMD) who have previously responded to at least two intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor.

Drug Name: Vabysmo (faricimab-svoa)
Diabetic Macular Edema Indicated for the treatment of patients with diabetic macular edema (DME). **Neovascular (Wet) Age-Related Macular Degeneration** Indicated for the treatment of patients with neovascular (wet) age-related macular degeneration (nAMD).

2 . Criteria

Product Name: Beovu, Vabysmo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1-- One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Diabetic macular edema (DME)

AND

2- - Trial and failure, contraindication, or intolerance to BOTH of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3- Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial and failure of compounded bevacizumab can be accepted as meeting the trial and failure of compounded Avastin requirement

Product Name: Lucentis 0.3mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)

AND

2 - Trial and failure, contraindication, or intolerance to both of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Product Name: Byooviz, Lucentis 0.5mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Macular edema following retinal vein occlusion (RVO)
- Myopic choroidal neovascularization (mCNV)

AND

2- Trial and failure, contraindication, or intolerance to both of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Product Name: Cimerli 0.3mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- One of the following diagnoses:

- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)

AND

2- Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Product Name: Cimerli 0.5mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Macular edema following retinal vein occlusion (RVO)
- Myopic choroidal neovascularization (mCNV)

AND

2- Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial and failure of compounded bevacizumab can be accepted as meeting the trial and failure of compounded Avastin requirement

Product Name: Eylea	
Diagnosis	Neovascular (Wet) Age-Related Macular Degeneration, Macular Edema Following Retinal Vein Occlusion, Diabetic Macular Edema, Diabetic Retinopathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Macular edema following retinal vein occlusion (RVO)
- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)

AND

2 - Trial and failure, contraindication, or intolerance to BOTH of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

2 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial and failure of compounded bevacizumab can be accepted as meeting the trial and failure of compounded Avastin requirement

Product Name: Eylea Injectable Vial	
Diagnosis	Retinopathy of Prematurity (ROP) [2, C]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of retinopathy of prematurity (ROP)

AND

2 - ONE of the following: [2]

- Patient gestational age at birth less than or equal to 32 weeks [D]
- Patient birth weight less than or equal to 1500 grams

AND

3 - Patient weight greater than 800 grams on day of treatment [2]

AND

4 - Retinopathy of prematurity (ROP) is present in at least one eye with one of the following classifications: [2, E-H]

- ROP zone 1, stage 1 plus, 2 plus, 3, or 3 plus
- ROP zone 2, stage 2 plus or 3 plus
- AP - ROP (aggressive posterior ROP)

AND

9 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases [I, 13 -14]

Product Name: Eylea Injectable Vial	
Diagnosis	Retinopathy of Prematurity (ROP) [2, C]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1- Documentation of positive clinical response to therapy as evidenced by the absence of active ROP and unfavorable structural outcomes (e.g., retinal detachment, macular dragging, macular fold, retrolental opacity) [2]

AND

2- Prescribed by or in consultation with an ophthalmologist experienced in the treatment of etinal diseases [I, 13 -14]

Product Name: Eylea HD	
Diagnosis	Neovascular (Wet) Age-Related Macular Degeneration, Diabetic Macular Edema, Diabetic Retinopathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)

AND

2- Trial and failure, contraindication, or intolerance to BOTH of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3 - Trial and failure, or intolerance to Eylea

AND

4 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial and failure of compounded bevacizumab can be accepted as meeting the trial and failure of compounded Avastin requirement

Product Name: Eylea, Eylea HD	
Diagnosis	All Other Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., Improvement in Best Corrected Visual Acuity (BCVA) compared to baseline, stable vision)

Product Name: Susvimo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neovascular (wet) age-related macular degeneration (nAMD) [A]

AND

2 - Trial and positive response to at least 2 intravitreal injections of BOTH of the following: [6]

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial of compounded bevacizumab can be accepted as meetin g the trial of compounded Avastin requirement

Product Name: Beovu, Byooviz, Cimerli, Lucentis, Susvimo, Vabysmo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., Improvement in Best Corrected Visual Acuity (BCVA) compared to baseline, stable vision)

Product Name: Beovu	
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Diabetic macular edema (DME)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to BOTH of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial and failure of compounded bevacizumab can be accepted as meeting the trial and failure of compounded Avastin requirement

Product Name: Byooviz	
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following diagnoses:

- Neovascular (wet) age-related macular degeneration (nAMD) [A]
- Macular edema following retinal vein occlusion (RVO)
- Myopic choroidal neovascularization (mCNV)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to BOTH of the following:

- Compounded Avastin* prepared by a 503(B) Outsourcing Facility [B]
- Cimerli (ranibizumab-eqrn)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*Note: Trial and failure of compounded bevacizumab can be accepted as meeting the trial and failure of compounded Avastin requirement

1. Definitions

Definition	Description
Retinopathy of Prematurity (ROP)	Retinopathy of prematurity (ROP) is a developmental vascular proliferative disorder that occurs in the retina of preterm infants with incomplete retinal vascularization. ROP is an important cause of severe visual impairment in childhood. [11]

2. End Notes

A. Neovascular Age-Related Macular Degeneration (nAMD) may also be referred to as wet or exudative AMD. [1]

B. Congress established the 503(B) facilities to provide compounded pharmaceuticals for office use without a prescription. 503(B) Outsourcing Facilities are compounding pharmacies that must meet higher federal safety, sterility, and quality control standards. [4,5]

C. Each sterile vial should only be used for the treatment of a single eye. Do not use the EYLEA pre-filled syringe for the treatment of ROP. [2]
D . Gestational age: The length of time between a baby's conception and birth. [10]
E. How serious the ROP is depends on what part of the eye is affected (the zone); how far the disease has progressed (the stage); and whether the blood vessels themselves are markedly abnormal (plus disease). Stages 1 and 2 are considered mild; Stages 3-5 are increasingly serious. [10]
F. Zone 1: This represents the least amount of retinal vascular development and includes retinal vascularization limited to a circular area centered around the optic nerve. Zone I ROP is a strong predictor for severe ROP. Zone 2: Vascularization limited to the circular area outside zone I with the optic nerve as the center. Zone 3: Vascularization within the remaining temporal, crescent-shaped area. Once vascularization extends to the nasal ora serrata and into zone III, there is little risk of a poor visual outcome from ROP. [11]
G. Plus disease. Defined as two quadrants of dilated and tortuous vessels and is a strong predictor of severe ROP. [11]
H. Stage 1. A demarcation line between vascularized and avascular retina. Stage 2. A ridge with volume in the region of the demarcation line. Stage 3. Neovascularization growing into the vitreous at the ridge. Stage 3 is a strong predictor of severe ROP and a poor outcome. Stage 4. A partial retinal detachment. Treatment of progressive stage 4 ROP can preserve and improve visual outcomes by preventing stage 5 ROP. Stage 4 is further classified by whether the macula is involved (4A without macular involvement and 4B with macular involvement) and by whether it is predominantly exudative or tractional. Exudative ROP that occurs after treatment with laser or cryotherapy may resolve spontaneously. Stage 5. Total retinal detachment. [11]
I. Examinations for ROP should be performed by an ophthalmologist who is experienced in the examination of preterm infants for ROP using a binocular indirect ophthalmoscope. Pediatric ophthalmology and retina fellows are less adept than experienced attending ophthalmologists at identifying clinically significant ROP when examining digital images. [13, 14]
J. Eylea HD contains a higher molar dose of aflibercept designed to allow for longer dosing intervals between treatments. [16]

References

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2. Eylea Prescribing Information. Regeneron Pharmaceuticals, Inc. Tarrytown, NY. February 2023.
3. Lucentis Prescribing information. Genentech, Inc. South San Francisco, CA. October 2020.
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5. Compounding-American Academy of Ophthalmology - AAO.org. Available at: https://www.aao.org/headline/compounding. Accessed April 7, 2021.
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7. Vabysmo Prescribing information. Genentech, Inc. South San Francisco, CA. January 2023.
8. Byooviz Prescribing Information. Biogen, Inc. Cambridge, MA. April 2022.
9. Cimerli Prescribing Information. Coherus BioSciences, Inc. Redwood City, CA. August 2022.
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16. Eylea Healthcare Professionals website. Available at: https://eyleahcp.us/s/. Accessed September 26, 2023.

4 . Revision History

Date	Notes
10/8/2023	New UM PA Program for Eylea HD

Revcovi (elapegademase-lvlr)

Prior Authorization Guideline

Guideline ID	GL-120496
Guideline Name	Revcovi (elapegademase-lvlr)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	1/16/2019
P&T Revision Date:	01/15/2020 ; 02/17/2022 ; 2/16/2023

1 . Indications

Drug Name: Revcovi (elapegademase-lvlr)
Adenosine deaminase severe combined immune deficiency (ADA-SCID) Indicated for the treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients.

2 . Criteria

Product Name: Revcovi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID)	

Product Name: Revcovi	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient demonstrates positive clinical response to therapy	

3 . References

1. Revcovi Prescribing Information. Leadiant Biosciences, Inc. Gaithersburg, MD. December 2020.
2. Immune Deficiency Foundation Patient & Family Handbook for Primary Immunodeficiency Diseases. Fifth Edition. 2013.

4 . Revision History

Date	Notes
1/25/2023	Update program

Rituxan Hycela (rituximab and hyaluronidase human)

Prior Authorization Guideline

Guideline ID	GL-123436
Guideline Name	Rituxan Hycela (rituximab and hyaluronidase human)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	7/26/2017
P&T Revision Date:	03/18/2020 ; 04/15/2020 ; 04/21/2021 ; 04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Rituxan Hycela (rituximab and hyaluronidase human)
Rheumatoid Athritis
Non-Hodgkin's Lymphoma
Chronic Lymphocytic
Immune or Idiopathic Thrombocytopenic Purpura (off-label)
Pemphigus Vulgaris
Waldenstrom's macroglobulinemia
Wegener's Granulomatosis and Microscopic Polyangiitis

2 . Criteria

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	**Rheumatoid Arthritis**
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - One of the following:

2.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

2.2 Trial and failure, contraindication or intolerance to one of the following: Methotrexate, Leflunomide, Sulfasalazine

OR

2.3 Disease is non-progressing or stable following prior treatment with first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy

AND

3 - Trial and failure to infliximab and adalimumab

AND

4 - Prescribed by or in consultation with rheumatologist

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	**Rheumatoid Arthritis**
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Non-Hodgkin's Lymphoma
Approval Length	12 months [A]
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma and used as a first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens

OR

1.2 Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma and used as a first-line treatment in combination with chemotherapy**.**

OR

1.3 Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma and patient achieved a complete or partial response to a rituximab product in combination with chemotherapy and followed by rituximab used as monotherapy for maintenance therapy.

OR

1.4 Diagnosis of low-grade, CD20-positive, B-cell non Hodgkin's lymphoma and patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy and patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy

OR

1.5 Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma

OR

1.6 Diagnosis of one of the following previously untreated, advanced stage indications

1.6.1 - CD-20-positive diffuse large B-cell lymphoma (DLBCL)
1.6.2 Burkitt lymphoma (BL)

1.6.3 Burkitt-like lymphoma (BLL)
1.6.4 Mature B-cell acute leukemia (B-AL)

AND

2. USED IN COMBINATION WITH CHEMOTHERAPY

3 – Patient is 6months of age or older

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Chronic Lymphocytic Leukemia
Approval Length	12 months [B]
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia

AND

2 - Medication is being used in combination with fludarabine and cyclophosphamide (FC) therapy

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Immune or Idiopathic Thrombocytopenic Purpura (Off-Label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of immune or idiopathic thrombocytopenic purpura (off-label)

AND

2 - Trial and failure, contraindication, or intolerance to at least ONE of the following:

2.1 Glucocorticoids (e.g., prednisone, methylprednisolone)

OR

2.2 Immunoglobulins (e.g., IVIg)

OR

2.3 Splenectomy

AND

3 - Documented platelet count of less than 50 x 10^9 / L

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Pemphigus Vulgaris
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe Pemphigus Vulgaris

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Pemphigus Vulgaris
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rituxan therapy

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Waldenstrom's macroglobulinemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - DIAGNOSIS OF RELAPSED/REFRACTORY WALDENSTROM'S MACROGLOBULINEMIA

Product Name: Rituxan Hycela (rituximab and hyaluronidase human)	
Diagnosis	Wegener's Granulomatosis and Microscopic Polyangiitis
Approval Length	3 months
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following: **1.1** Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) **OR** **1.2** Microscopic Polyangiitis **AND** **2** – Used in combination with glucocorticoids (e.g., prednisone)	

3 . Endnotes

A. Treatment for DLBCL consists of up to 8 cycles of 21 days each, a total duration of 6 months [1,3]. There is little evidence that use of rituximab as continuation therapy following R-CHOP induction provides additional benefit above induction alone. [2] This is in contrast with follicular lymphoma, where evidence does support maintenance [4] therapy and NCCN recommends consolidation with rituximab monotherapy [3]. However, to account for potential delays in therapy without interrupting treatment, a 12 month authorization is provided.
B. Treatment for CLL consists of up to 6 cycles of 28 days each, a total duration of 6 months [1]. To account for potential delays in therapy without interrupting treatment, a 12 month authorization is provided.
C. An FDA-approved biosimilar is an appropriate substitute for rituximab. [3]
D. The FDA defines biosimilar as a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product. [4]

4 . References

1. Rixtuan Hycela Prescribing Information. Genentech, Inc. South San Francisco, CA. June 2021.
2. Habermann TM, Weller EA, Morrison VA, et al. Rituximab-CHOP versus CHOP alone or with maintenance rituximab in older patients with diffuse large B-cell lymphoma. J Clin Oncol. 2006;24(19):3121-3127.
3. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed March 10, 2023.
4. U.S. Food and Drug Administration (FDA). Biosimilar and Interchangeable Products. Silver Spring, MD: FDA; October 23, 2017. Available at: https://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm580419.htm#biosimilar. Accessed February 27, 2020.
5. Salles G, Seymour JF, Lopez-Guillermo A, et al. Rituximab maintenance for 2 years in patients with high tumour burden follicular lymphoma responding to rituximab plus chemotherapy (PRIMA): a phase 3, randomized controlled trial. Lancet. 2011;377(9759):42-51.

5 . Revision History

Date	Notes
4/4/2023	Annual review - updated references.

Prior Authorization Guideline

Guideline Name	Rituximab
Formulary	• Samaritan Medicaid SP (SAMCAID)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name: Ruxience, Riabni, Rituxan, Truxima	
Diagnosis	Rheumatoid Arthritis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 100 MG/10ML (10 MG/ML)	21351860102020	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 500 MG/50ML (10 MG/ML)	21351860102040	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	21351860142020	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 500 MG/50ML (10 MG/ML)	21351860142040	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 100 MG/10ML (10 MG/ML)	21351860602020	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 500 MG/50ML (10 MG/ML)	21351860602040	Brand

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Methotrexate
- Leflunomide
- Sulfasalazine

AND

4 - Trial and failure of infliximab and adalimumab

Product Name: Ruxience, Riabni, Rituxan, Truxima	
Diagnosis	Non-Hodgkin's Lymphoma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand

TRUXIMA	RITUXIMAB-ABBS IV SOLN 100 MG/10ML (10 MG/ML)	21351860102020	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 500 MG/50ML (10 MG/ML)	21351860102040	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	21351860142020	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 500 MG/50ML (10 MG/ML)	21351860142040	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 100 MG/10ML (10 MG/ML)	21351860602020	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 500 MG/50ML (10 MG/ML)	21351860602040	Brand

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin’s lymphoma
- Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens

OR

1.2 Both of the following:

- Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma
- Used as first-line treatment in combination with chemotherapy

OR

1.3 All of the following:

- Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma
- Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy
- Followed by rituximab used as monotherapy for maintenance therapy

OR

1.4 Both of the following:

1.4.1 Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma

AND

1.4.2 One of the following:

- Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy
- Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy

OR

1.5 Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma

OR

1.6 All of the following

1.6.1 Diagnosis of one of the following previously untreated, advanced stage indications:

- CD-20-positive diffuse large B-cell lymphoma (DLBCL)
- Burkitt lymphoma (BL)
- Burkitt-like lymphoma (BLL)
- Mature B-cell acute leukemia (B-AL)

AND

1.6.2 Patient is 6 months of age or older

AND

1.6.3 Used in combination with chemotherapy

Diagnosis	Chronic Lymphocytic Leukemia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia

AND

2 - Used in combination with fludarabine and cyclophosphamide

Product Name: Rituxan	
Diagnosis	Immune or Idiopathic Thrombocytopenic Purpura [1, 2] (Off-Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand

Approval Criteria

1 - Diagnosis of immune or idiopathic thrombocytopenic purpura (off-label)

AND

2 - Trial and failure, contraindication, or intolerance to at least ONE of the following:

- Glucocorticoids (e.g., prednisone, methylprednisolone)
- Immunoglobulins (e.g., IVIg)
- Splenectomy

AND

3 - Documented platelet count of less than 50 x 10^9 / L

Product Name: Rituxan	
Diagnosis	Pemphigus Vulgaris
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand

Approval Criteria

1 - Diagnosis of moderate to severe Pemphigus Vulgaris

Product Name: Rituxan	
Diagnosis	Pemphigus Vulgaris
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand

Approval Criteria

1 - Documentation of positive clinical response to Rituxan therapy

Product Name: Ruxience, Riabni, Rituxan, Truxima	
Diagnosis	Wegener's Granulomatosis and Microscopic Polyangiitis
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 100 MG/10ML (10 MG/ML)	21351860102020	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 500 MG/50ML (10 MG/ML)	21351860102040	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	21351860142020	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 500 MG/50ML (10 MG/ML)	21351860142040	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 100 MG/10ML (10 MG/ML)	21351860602020	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 500 MG/50ML (10 MG/ML)	21351860602040	Brand

Approval Criteria

1 - One of the following diagnoses:

- Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis)
- Microscopic Polyangiitis

AND

2 - Used in combination with glucocorticoids (e.g., prednisone)

Product Name: Rituxan	
Diagnosis	Waldenstrom's macroglobulinemia

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Product Name	Generic Name	GPI	Brand/Generic
RITUXAN	RITUXIMAB IV SOLN 100 MG/10ML	21351860002020	Brand
RITUXAN	RITUXIMAB IV SOLN 500 MG/50ML	21351860002040	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 100 MG/10ML (10 MG/ML)	21351860102020	Brand
TRUXIMA	RITUXIMAB-ABBS IV SOLN 500 MG/50ML (10 MG/ML)	21351860102040	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 100 MG/10ML (10 MG/ML)	21351860142020	Brand
RIABNI	RITUXIMAB-ARRX IV SOLN 500 MG/50ML (10 MG/ML)	21351860142040	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 100 MG/10ML (10 MG/ML)	21351860602020	Brand
RUXIENCE	RITUXIMAB-PVVR IV SOLN 500 MG/50ML (10 MG/ML)	21351860602040	Brand

Approval Criteria

1 - Diagnosis of relapsed/refractory Waldenstrom’s macroglobulinemia (off-label)

2 . Revision History

Date	Notes
	New Program

Ryplazim (plasminogen, human-tvmh)

Prior Authorization Guideline

Guideline ID	GL-116462
Guideline Name	Ryplazim (plasminogen, human-tvmh)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	1/1/2023
P&T Approval Date:	11/18/2021
P&T Revision Date:	11/17/2022

1 . Indications

Drug Name: Ryplazim (plasminogen, human-tvmh)
Hypoplasminogenemia Indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia).

2 . Criteria

Product Name: Ryplazim	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of plasminogen deficiency type 1 (hypoplasminogenemia) as confirmed by both of the following [2, A, B]:

1.1 Deficiency of plasminogen activity evidenced by a level of less than or equal to 50%, as confirmed by a chromogenic assay [3-5, B]

AND

1.2 Abnormal plasminogen antigen plasma level of less than 9 mg/dL, as confirmed by an enzyme-linked immunosorbent assay [3-5, B]

AND

2 - Presence of clinical symptoms and signs of the disease (e.g., ligneous conjunctivitis, ligneous gingivitis, occlusive hydrocephalus) [1, 5, A]

AND

3 - Prescribed by or in consultation with a hematologist

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., plasminogen activity trough level increased by at least 10 percentage points from baseline, improvement or resolution of lesions) [5, C]

3 . Endnotes

A. The diagnosis of pseudo-membranous disease secondary to plasminogen deficiency requires both clinical and laboratory findings. Clinical symptoms from ligneous lesions and abnormally decreased plasminogen activity establishes the diagnosis [1].
B. Laboratory evaluation for plasminogen deficiency should include both plasminogen antigen and activity level. The study procedures in the Shapiro et al clinical trial included measuring plasminogen activity using a commercially available chromogenic assay and measuring plasminogen antigen using a commercially available enzyme-linked immunosorbent assay. Decreased plasminogen activity and concordant decrease in protein level is associated with plasminogen deficiency type 1, whereas patients with plasminogen deficiency type II have reduced plasminogen activity but normal or only slightly reduced plasminogen antigen level and have never been reported to develop pseudo-membranous lesions at other mucosal sites. Plasminogen values in patients with hypoplasminogenemia ranged from < 1 to 9 mg/dL for plasminogen antigen plasma level and < 1%-51% for functional plasminogen activity. These values provide a rough threshold between symptomatic and asymptomatic hypoplasminogenemia [3-5].
C. The primary end point success of the clinical study was defined as at least 80% of evaluable patients achieving target trough plasminogen activity levels, which was an increase of individual plasminogen activity trough level by at least an absolute 10% above baseline for at least 3 measurements in 12 weeks. The secondary end point success was defined as 50% of patients with clinically visible or other measurable lesions achieving ≥ 50% reduction in lesion number and/or size or improved organ function [5].

4 . References

1. Mehta R and Shapiro AD. Plasminogen deficiency. Haemophilia. 2008; 14:1261-1268. doi: 10.1111/j.1365-2516.2008.01825.x
2. Ryplazim Prescribing Information. Prometic Biotherapeutics, Inc. Fort Lee, New Jersey. November 2021.
3. Schuster V, Hügle B, Tefs K. Plasminogen deficiency. J Thromb Haemost. 2007;5(12):2315-2322. doi:10.1111/j.1538-7836.2007.02776.x
4. Schuster V, Seregard S. Ligneous conjunctivitis. Surv Ophthalmol. 2003;48(4):369-388. doi:10.1016/s0039-6257(03)00056-0
5. Shapiro AD, Nakar C, Parker JM, et al. Plasminogen replacement therapy for the treatment of children and adults with congenital plasminogen deficiency. Blood. 2018;131(12):1301-1310. doi:10.1182/blood-2017-09-806729

5 . Revision History

Date	Notes
11/18/2022	Annual review - updated references.

Saphnelo (anifrolumab-fnia)

Prior Authorization Guideline

Guideline ID	GL-113478
Guideline Name	Saphnelo (anifrolumab-fnia)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2022
P&T Approval Date:	10/20/2021
P&T Revision Date:	10/19/2022

1 . Indications

Drug Name: Saphnelo (anifrolumab-fnia)
Systemic Lupus Erythematosus (SLE) Indicated for the treatment of adult patients with moderate to severe SLE, who are receiving standard therapy. Limitations of Use: The efficacy of Saphnelo has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Use of Saphnelo is not recommended in these situations.

2 . Criteria

Product Name: Saphnelo	
Approval Length	6 Months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe systemic lupus erythematosus (SLE)

AND

2 - Trial and failure, contraindication, or intolerance to two standard of care treatments for active SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]) [4]

AND

3 - Currently receiving standard of care treatment for SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)]) [1-3]

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Saphnelo	
Approval Length	6 Months [A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decrease or stabilization of symptoms, improvement in functional impairment, decrease of corticosteroid dose, decrease in pain medications)

3 . Endnotes

A. SLE is a disease that fluctuates. The undulating course of typical lupus patients requires frequent reassessment. A 6-month authorization period is reasonable. [2]

4 . References

1. Saphnelo Prescribing Information. AstraZeneca Pharmaceuticals LP. Wilmington, DE. July 2021.
2. Per clinical consult with rheumatologist, October 4, 2017.
3. American College of Rheumatology Ad Hoc Committee on Systemic Lupus Erythematosus Guidelines. Guidelines for referral and management of systemic lupus erythematosus. Arthritis Rheum. 1999 Sep;42(9):1785-96.
4. Fanouriakis A, Kostopoulou M, Alunno A, et al. Ann Rheum Dis 2019;78:736–745.

5 . Revision History

Date	Notes
10/5/2022	Annual review: Updated criteria and background.

Scenesse (afamelanotide)

Prior Authorization Guideline

Guideline ID	GL-124311
Guideline Name	Scenesse (afamelanotide)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	4/15/2020
P&T Revision Date:	04/21/2021 ; 04/20/2022 ; 4/19/2023

1 . Indications

Drug Name: Scenesse (afamelanotide)
Erythropoietic protoporphyria - Phototoxic dermatitis Indicated to increase pain free light exposure in adult patients with a history of phototoxic reactions from erythropoietic protoporphyria (EPP).

2 . Criteria

Product Name: Scenesse	
Approval Length	6 Month(s) [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of erythropoietic protoporphyria (EPP) confirmed by laboratory or genetic testing [B]

AND

2 - Patient has history of phototoxic reactions

AND

3 - Prescribed by or in consultation with one of the following:

- Dermatologist
- Hepatologist

Product Name: Scenesse	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., increased duration of exposure to direct sunlight without pain, decreased number of phototoxic reactions)

3 . Endnotes

A. Patients enrolled in clinical trial (Study CUV039, NCT 01605136) were assessed after 180 days and consultant agreed that 6 month approval duration is appropriate to determine if patient is responding to therapy. [1, 2]
B. Per recommendation from consultant to avoid off-label use, diagnosis of erythropoietic protoporphyria (EPP) should be confirmed by laboratory (porphyrin levels in serum and stool) or genetic testing. [2]

4 . References

1. Scenesse Prescribing Information. Clinuvel, Inc. West Menlo Park, CA. January 2023.
2. Per clinical consult with dermatologist, December 19, 2019.

5 . Revision History

Date	Notes
4/7/2023	Annual Review, no criteria changes.

Signifor, Signifor LAR (pasireotide) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-115519
Guideline Name	Signifor, Signifor LAR (pasireotide) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	1/1/2023
P&T Approval Date:	2/19/2013
P&T Revision Date:	11/14/2019 ; 11/12/2020 ; 11/18/2021 ; 01/19/2022 ; 11/17/2022

1 . Indications

Drug Name: Signifor LAR (pasireotide)
Acromegaly Indicated for the treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option. **Cushing's disease** Indicated for the treatment of patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.
Drug Name: Signifor (pasireotide)
Cushing's disease Indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.

2 . Criteria

Product Name: Signifor LAR	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

- Inadequate response to surgery
- Patient is not a candidate for surgery

Product Name: Signifor LAR	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., patient's growth

hormone level or insulin-like growth factor 1 level for age and gender has normalized/improved)

Product Name: Signifor, Signifor LAR	
Diagnosis	Cushing’s disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endogenous Cushing’s disease

AND

2 - One of the following:

2.1 Pituitary surgery has not been curative for the patient

OR

2.2 Patient is not a candidate for pituitary surgery

AND

3 - Prescribed by or in consultation with an endocrinologist

Product Name: Signifor, Signifor LAR	
Diagnosis	Cushing's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease)

Product Name: Signifor	
Diagnosis	Cushing's disease
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of endogenous Cushing's disease

AND

2 - One of the following:

2.1 Pituitary surgery has not been curative for the patient

OR

2.2 Patient is not a candidate for pituitary surgery

AND **3** - Prescribed by or in consultation with an endocrinologist

3 . Background

Benefit/Coverage/Program Information
Quantity Limit These products are subject to an IHN-CCO standard quantity limit. The quantity limit may vary from the standard limit based upon plan-specific benefit design. Please refer to your benefit materials.

4 . References

1. Signifor LAR Prescribing Information. Recordati Rare Diseases Inc. Lebanon, NJ. July 2020.
2. Signifor Prescribing Information. Recordati Rare Diseases Inc. Lebanon, NJ . March 2020.

5 . Revision History

Date	Notes
11/22/2022	Annual review: update initial authorization duration for acromegaly from 6 months to 12 months

Simponi Aria

Prior Authorization Guideline

Guideline ID	GL-131914
Guideline Name	Simponi Aria
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name: Simponi Aria	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active rheumatoid arthritis (RA)	

AND

2 - One of the following:

2.1 Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide
- sulfasalazine

OR

2.2 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

AND

3 - Trial and failure of both infliximab and adalimumab

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Simponi Aria	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - One of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Trial and failure, contraindication, or intolerance to both of the following conventional therapies at maximally tolerated doses:

- Two NSAIDs for a minimum duration of 3 months each at maximum recommended or tolerated anti-inflammatory dose unless contraindicated
- Minimum duration of at least 6 months of two of the following: Methotrexate, leflunomide, sulfasalazine, hydroxychloroquine, or systemic corticosteroids

AND

4 - Trial and failure to adalimumab

Product Name: Simponi Aria	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting psoriatic arthritis based on at least 3 out of 5 of the following:

- Psoriasis (1 point for personal or family history, 2 points for current)
- Psoriatic nail dystrophy
- Negative test result for RF
- Dactylitis (current of history)
- Radiological evidence of juxta-articular new bone formation

AND

2 - One of the following:

2.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

2.2 Submission of medical records (e.g., chart notes) documenting failure of conventional therapy with both of the following:

- Two NSAIDs for a minimum duration of 3 months each at maximum recommended or tolerated anti-inflammatory dose unless contraindicated,
- Methotrexate or one other DMARD such as leflunomide, sulfasalazine, or cyclosporine

AND

3 - Trial and failure of both infliximab and adalimumab

AND

4 - Prescribed by or in consultation with one of the following:

- Dermatologist
- Rheumatologist

Diagnosis	Ankylosing Spondylitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting moderate-to-severe ankylosing spondylitis or axial spondyloarthritis as defined by all of the following:

- Back pain and stiffness for more than 3 months
- Signs of active inflammation on MRI OR radiological evidence of sacroiliitis OR HLA-B27 positive
- BASDAI score of greater than or equal to 4

AND

2 - One of the following:

2.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

2.2 Submission of medical records (e.g., chart notes) documenting failure of conventional therapy with both of the following:

- At least two NSAIDs for a minimum duration of 3 months each at maximum recommended or tolerated anti-inflammatory dose unless contraindicated
- Physical therapy/exercise program

AND

3 - Trial and failure of both infliximab and adalimumab

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name: Simponi Aria	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Skyrizi IV

Prior Authorization Guideline

Guideline ID	GL-126052
Guideline Name	Skyrizi IV
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Skyrizi IV	
Diagnosis	Crohn's Disease
Approval Length	3 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active Crohn’s disease	

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following:

- 6-mercaptopurine
- azathioprine
- corticosteroids (e.g., prednisone, methylprednisolone)
- methotrexate

AND

4 - Trial and failure, contraindication, or intolerance to ALL of the following:

- adalimumab
- infliximab
- vedolizumab
- ustekinumab

AND

5 - Will be administered as an intravenous induction dose

2 . Revision History

Date	Notes
6/5/2023	New program

Soliris (eculizumab)

Prior Authorization Guideline

Guideline ID	GL-118741
Guideline Name	Soliris (eculizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	11/19/2014
P&T Revision Date:	09/18/2019 ; 12/18/2019 ; 02/13/2020 ; 01/20/2021 ; 02/18/2021 ; 02/17/2022 ; 09/21/2022 ; 2/16/2023

1 . Indications

Drug Name: Soliris (eculizumab)
Paroxysmal Nocturnal Hemoglobinuria (PNH) Indicated for the treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis. **Atypical Hemolytic Uremic Syndrome (aHUS)** Indicated for the treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy. Limitations of Use: Soliris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS). **Generalized Myasthenia Gravis (gMG)** Indicated for the treatment of adult patients with generalized Myasthenia Gravis (gMG) who are anti-acetylcholine receptor (AchR)

antibody positive.

Neuromyelitis Optica Spectrum Disorder (NMOSD) Indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

2 . Criteria

Product Name: Soliris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2 - Trial and failure, contraindication, or intolerance to Ultomiris (ravulizumab)

AND

3 - One of the following:

3.1 Prescribed medication is used for induction therapy and will not exceed 600 mg weekly for the first 4 weeks

OR

3.2 Prescribed medication is used for maintenance therapy and will not exceed 900 mg weekly at week 5, then 900 mg every 2 weeks thereafter

AND

4 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Soliris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

AND

2 - Prescribed medication is used for maintenance therapy and will not exceed 900 mg every 2 weeks

Product Name: Soliris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of atypical hemolytic uremic syndrome (aHUS)

AND

2 - Trial and failure, contraindication, or intolerance to Ultomiris (ravulizumab)

AND

3 - One of the following:

3.1 For patients 18 years of age and older:

3.1.1 Prescribed medication is used for induction therapy and will not exceed 900 mg weekly for the first 4 weeks

OR

3.1.2 Prescribed medication is used for maintenance therapy and will not exceed 1200 mg weekly at week 5, then 1200 mg every 2 weeks thereafter

OR

3.2 For patients less than 18 years of age, dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for aHUS (refer to Table 1 in Background Section for dosing schedule)

AND

4 - Prescribed by or in consultation with one of the following:

- Hematologist
- Nephrologist

Product Name: Soliris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., increase in mean platelet counts, hematologic normalization) to therapy

AND

2 - One of the following:

2.1 For patients 18 years of age and older, prescribed medication is used for maintenance therapy and will not exceed 1200 mg every 2 weeks

OR

2.2 For patients less than 18 years of age, dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for aHUS (refer to Table 1 in Background Section for MAINTENANCE dosing schedule)

Product Name: Soliris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis (gMG)

AND

2 - Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

3 - One of the following: [2, 3]

3.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

3.2 Both of the following:

3.2.1 Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

3.2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

4 - Trial and failure, contraindication, or intolerance to one of the following:

- Ultomiris (ravulizumab)
- Vyvgart (efgartigimod)

AND

5 - One of the following:

5.1 Prescribed medication is used for induction therapy and will not exceed 900 mg weekly for the first 4 weeks

OR

5.2 Prescribed medication is used for maintenance therapy and will not exceed 1200 mg at week 5, then 1200 mg every 2 weeks thereafter

AND

6 - Prescribed by or in consultation with a neurologist

Product Name: Soliris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed medication is used for maintenance therapy and will not exceed 1200 mg every 2 weeks

Product Name: Soliris	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Patient is anti-aquaporin-4 (AQP4) antibody positive

AND

3 - One of the following:

3.1 Prescribed medication is used for induction therapy and will not exceed 900 mg weekly for the first 4 weeks

OR

3.2 Prescribed medication is used for maintenance therapy and will not exceed 1200 mg at week 5, then 1200 mg every 2 weeks thereafter

AND

4 - Prescribed by or in consultation with one of the following:

- Neurologist
- Ophthalmologist

Product Name: Soliris	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed medication is used for maintenance therapy and will not exceed 1200 mg every 2 weeks

3 . Background

Benefit/Coverage/Program Information

Table 1. Dosing Recommendations for Atypical Hemolytic Uremic Syndrome (aHUS) in Patients Less Than 18 Years of Age

Patient Body Weight	Induction Therapy	Maintenance Therapy
40 kg and over	900 mg weekly for 4 dose	1200 mg at week 5; Then 1200 mg every 2 weeks
30 kg to less than 40 kg	600 mg weekly for 2 doses	900 mg at week 3; Then 900 mg every 2 weeks
20 kg to less than 30 kg	600 mg weekly for 2 doses	600 mg at week 3; Then 600 mg every 2 weeks
10 kg to less than 20 kg	600 mg weekly for 1 dose	300 mg at week 2; Then 300 mg every 2 weeks
5 kg to less than 10 kg	300 mg weekly for 1 dose	300 mg at week 2; Then 300 mg every 3 weeks

4 . References

1. Soliris Prescribing Information. Alexion Pharmaceuticals, Inc. Boston, MA. November 2020.
2. Howard JF Jr, Utsugisawa K, Benatar M, et al. Safety and efficacy of eculizumab in anti-acetylcholine receptor antibody-positive refractory generalised myasthenia gravis (REGAIN): a phase 3, randomised, double-blind, placebo-controlled, multicentre study. Lancet Neurol. 2017;16(12):976-986.
3. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. Neurology. 2016;87(4):419-25.

5 . Revision History

Date	Notes
1/25/2023	2023 UM Annual Review. No changes.

Somatuline Depot (lanreotide) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-114114
Guideline Name	Somatuline Depot (lanreotide) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	12/1/2022
P&T Approval Date:	11/13/2007
P&T Revision Date:	11/14/2019 ; 10/21/2020 ; 10/20/2021 ; 03/16/2022 ; 07/20/2022 ; 10/19/2022

1 . Indications

Drug Name: Somatuline Depot (lanreotide)
Acromegaly Indicated for the long-term treatment of acromegalic patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option. The goal of treatment in acromegaly is to reduce growth hormone (GH) and insulin growth factor-1 (IGF-1) levels to normal. **Gastroenteropancreatic Neuroendocrine Tumors (GEP-NET)** Indicated for the treatment of adult patients with unresectable, well or moderately differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival. **Carcinoid Syndrome** Indicated for the treatment of adults with carcinoid syndrome;

when used, it reduces the frequency of short-acting somatostatin analog rescue therapy.
Drug Name: Lanreotide Injection
Acromegaly Indicated for the long-term treatment of acromegalic patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option. The goal of treatment in acromegaly is to reduce growth hormone (GH) and insulin growth factor-1 (IGF-1) levels to normal. **Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs)** Indicated for the treatment of adult patients with unresectable, well or moderately differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival. **Off Label Uses: Carcinoid Syndrome [3]** Indicated for the treatment of adults with carcinoid syndrome; when used, it reduces the frequency of short-acting somatostatin analog rescue therapy.

2 . Criteria

Product Name: Somatuline Depot, Brand Lanreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Radiotherapy

OR

2.2 Not a candidate for one of the following:

- Surgery
- Radiotherapy

AND

3 - Trial and failure or intolerance to Somatuline Depot (Applies to Brand Lanreotide only)

AND

4 - Prescribed by or in consultation with an endocrinologist

Product Name: Somatuline Depot, Brand Lanreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy, such as a reduction or normalization of IGF-1/GH level for same age and sex

Product Name: Brand Lanreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Radiotherapy

OR

2.2 Not a candidate for one of the following:

- Surgery
- Radiotherapy

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to Somatuline Depot

AND

4 - Prescribed by or in consultation with an endocrinologist

Product Name: Somatuline Depot 120mg/0.5mL, Brand Lanreotide 120mg/0.5ml	
Diagnosis	Advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gastroenteropancreatic neuroendocrine tumor (GEP-NET)

AND

2 - Disease is one of the following:

- Unresectable, locally advanced
- Metastatic

AND

3 - Trial and failure or intolerance to Somatuline Depot (Applies to Brand Lanreotide only)

AND

4 - Prescribed by or in consultation with an oncologist

Product Name: Somatuline Depot 120mg/0.5mL, Brand Lanreotide 120mg/0.5ml	
Diagnosis	Advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name: Brand Lanreotide 120mg/0.5ml	
Diagnosis	Advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET)
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of gastroenteropancreatic neuroendocrine tumor (GEP-NET)

AND

2 - Disease is one of the following:

- Unresectable, locally advanced
- Metastatic

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to Somatuline Depot

AND

4 - Prescribed by or in consultation with an oncologist

Product Name: Somatuline Depot 120mg/0.5mL, Brand Lanreotide 120mg/0.5ml [off-label]	
Diagnosis	Carcinoid Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of carcinoid syndrome

AND

2 - Used to reduce the frequency of short-acting somatostatin analog rescue therapy

AND

3 - Trial and failure or intolerance to Somatuline Depot (Applies to Brand Lanreotide only)

AND

4 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Oncologist

Product Name: Somatuline Depot 120mg/0.5mL, Brand Lanreotide 120mg/0.5ml [off-label]	
Diagnosis	Carcinoid Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Brand Lanreotide 120mg/0.5ml [off-label]	
Diagnosis	Carcinoid Syndrome
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of carcinoid syndrome

AND

2 - Used to reduce the frequency of short-acting somatostatin analog rescue therapy

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure or intolerance to Somatuline Depot

AND

4 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Oncologist

3 . References

1. Somatuline Depot Prescribing Information. Ipsen Biopharmaceuticals, Inc. Cambridge, MA. June 2019.
2. Lanreotide Injection Prescribing Information. Exelan Pharmaceuticals, Inc. Boca Raton, FL. February 2022.
3. Lanreotide Acetate. In: IBM Micromedex® DRUGDEX® (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com/. Accessed September 19, 2022.

4 . Revision History

Date	Notes
10/20/2022	Annual review: no criteria changes.

Spinraza (nusinersen)

Prior Authorization Guideline

Guideline ID	GL-126112
Guideline Name	Spinraza (nusinersen)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	
P&T Revision Date:	12/16/2020 ; 06/16/2021 ; 06/15/2022 ; 6/1/2023

1 . Indications

Drug Name: Spinraza (nusinersen)
Spinal Muscular Atrophy Indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.

2 . Criteria

Product Name: Spinraza	
Diagnosis	Spinal Muscular Atrophy
Approval Length	3 Months [A]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of spinal muscular atrophy (SMA) Type I, II, or III [1-4, B]

AND

2 - Both of the following: [1-7]

2.1 The mutation or deletion of genes in chromosome 5q resulting in one of the following: [C]

2.1.1 Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

2.1.2 Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2.2 Patient has at least 2 copies of SMN2 [D]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy [2-4, E]

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep [2-4, E]

AND

5 - At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability*: [2-10]

- Hammersmith Infant Neurological Exam (HINE) (infant to early childhood)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test (Non ambulatory)
- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

AND

6 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

AND

7 - Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures [1]

AND

8 - Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Evrysdi) [2-4, F]

AND

9 - One of the following: [2-4, 11, F]

9.1 Patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma)

OR

9.2 Both of the following:

- Patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma)
- Documentation of an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months)

AND

10 - One of the following:

10.1 Trial and failure or intolerance to Evrysdi

OR

10.2 Patient is younger than 2 months

Notes	*Baseline assessments for patients less than 2 months of age requesting nusinersen proactively are not necessary in order to not delay access to initial therapy in recently diagnosed infants. Initial assessments shortly post-therapy can serve as baseline with respect to efficacy reauthorization assessment.

Product Name: Spinraza	
Diagnosis	Spinal Muscular Atrophy

Approval Length	12 Months [A]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy from pretreatment baseline status as demonstrated by the most recent results from one of the following exams:

1.1 One of the following HINE-2 milestones: [2]

- Improvement or maintenance of previous improvement of at least a 2 point (or maximal score) increase in ability to kick
- Improvement or maintenance of previous improvement of at least a 1 point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp
- Patient exhibited improvement, or maintenance of a previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
- Patient has achieved and maintained any new motor milestones from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

1.2 One of the following HFMSE milestones: [3, 9-10]

- Improvement or maintenance of a previous improvement of at least a 3 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

1.3 One of the following ULM test milestones: [3, 12-13]

- Improvement or maintenance of a previous improvement of at least a 2 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

1.4 One of the following CHOP INTEND milestones: [2, 4]

- Improvement or maintenance of a previous improvement of at least a 4 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

AND

2 - Patient continues to not be dependent on invasive ventilation or tracheostomy [2-4, E]

AND

3 - Patient continues to not be dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep [2-4, E]

AND

4 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

AND

5 - Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures [1]

AND

6 - Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Evrysdi) [2-4, F]

AND

7 - One of the following: [2-4, 11, F]

7.1 Patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma)

OR

7.2 Both of the following:

- Patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma)
- Documentation of an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months)

3 . Endnotes

A. Spinraza is for intrathecal use only. Treatment is initiated with 4 loading doses; the first 3 loading doses should be administered at 14-day intervals, and the 4th loading dose should be administered 30 days after the 3rd loading dose. A maintenance dose should be administered once every 4 months thereafter. If a loading dose is delayed or missed, Spinraza should be administered as soon as possible, with at least 14 days between doses. If a maintenance dose is delayed or missed, Spinraza should be administered as soon as possible with continued dosing every 4 months. [1]

B. There were 3 key pivotal trials demonstrating safety and efficacy of Spinraza (ENDEAR, CHERISH, NURTURE). ENDEAR enrolled patients with infantile-onset SMA (defined by the study as individuals diagnosed with 5q SMA and symptom onset at younger than 6 months of age), also known as SMA Type 1. CHERISH enrolled patients with later-onset SMA (defined by the study as individuals diagnosed with 5q SMA and symptom onset after 6 months of age), generally considered as SMA Type 2 or 3. NURTURE only enrolled patients with a diagnosis of 5q SMA who were ≤6 weeks old at first dose of Spinraza. This would be considered SMA Type 1. [2-4]
C. This is the definition that the clinical trials ENDEAR, CHERISH, and NURTURE used. Also consistent with clinical guidelines. [2-7]
D. ENDEAR required patients to have 2 copies of SMN2, CHERISH included patients with 2 to 4 copies of SMN2, and NURTURE only enrolled patients with 2 or 3 copies of SMN2. [2-4]
E. Invasive ventilation or tracheostomy was an exclusion criteria in the ENDEAR, CHERISH, and NURTURE trials. [2-4]
F. A recent European ad-hoc consensus statement on SMA stated that there currently is no published evidence that the combination of two disease modifying therapies (e.g., Spinraza and Evrysdi) is superior to any single treatment alone. Both ENDEAR, CHERISH, and NURTURE excluded patients that were had previous treatment with either gene therapy or prior antisense oligonucleotide (ASO) treatment (e.g., Zolgensma). RESPOND is a phase 4 clinical study that will assess the efficacy and safety of Spinraza in patients with suboptimal clinical response to Zolgensma. It is planned to begin enrollment in 2021. [2-4, 11, 14]

4 . References

1. Spinraza Prescribing Information. Biogen, Inc. Cambridge, MA. June 2020.
2. Finkel RS, Mercuri E, Darras, BT, et al. Nusinersen versus Sham Control in Infantile-Onset Spinal Muscular Atrophy. N Engl J Med. 2017; 377:1723-1732.
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4. De Vivo DC, Bertini E, Swoboda KJ, et al. Nusinersen initiated in infants during the pre-symptomatic stage of spinal muscular atrophy: Interim efficacy and safety results from the Phase 2 NURTURE study. Neuromuscul Disord. 2019;29(11):P842-856.
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10. O'Hagen JM, Glanzman AM, McDermott MP, et al. An expanded version of the Hammersmith Functional Motor Scale for SMA II and III patients. Neuromuscular disorders : NMD. 2007;17(9-10):693-7.
11. Kirschner J, Butoianu N, Goemans N, et al. European ad-hoc consensus statement on gene replacement therapy for spinal muscular atrophy. Eur J Paediatr Neurol. 2020. https://doi.org/10.1016/j.ejpn.2020.07.001.
12. Pera , M., Coratti, G., Mazzone, E., et al. (2019). Revised upper limb module for spinal muscular atrophy: 12 month changes. Muscle Nerve. Apr;59(4):426-430.
13. Stolte B, Bois JM, Kizina K, et al. Minimal clinically important differences in functional motor scores in adults with spinal muscular atrophy. Eur. J. Neurol. 2020; 0:1-9.
14. Biogen. Biogen plans to initiate phase 4 study evaluating benefit of Spinraza® (nusinersen) in patients treated with Zolgensma® (onasemnogene abeparvovec). https://investors.biogen.com/news-releases/news-release-details/biogen-plans-initiate-phase-4-study-evaluating-benefit-spinrazar. July 21, 2020. Accessed October 6, 2020.

5 . Revision History

Date	Notes
6/19/2023	Annual review

Spravato (esketamine) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-124281
Guideline Name	Spravato (esketamine) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/16/2019
P&T Revision Date:	05/14/2020 ; 10/21/2020 ; 05/20/2021 ; 05/19/2022 ; 07/20/2022 ; 5/18/2023

1 . Indications

Drug Name: Spravato (esketamine)
Depression Indicated, in conjunction with an oral antidepressant, for the treatment of: - Treatment-resistant depression (TRD) in adults - Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior. Limitations of Use: The effectiveness of Spravato in preventing suicide or in reducing suicidal ideation or behavior has not been demonstrated. Use of Spravato does not preclude the need for hospitalization if clinically warranted, even if patients experience improvement after an initial dose of Spravato. Spravato is not approved as an anesthetic agent. The safety and effectiveness of Spravato as an anesthetic agent have not been established.

2 . Criteria

Product Name: Spravato	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of major depressive disorder

AND

1.1.2 Patient has not experienced a clinical meaningful improvement after treatment with at least two antidepressants from different classes for an adequate duration (at least 4 weeks each) in the current depressive episode [1-5, A, B]

OR

1.2 Both of the following:

1.2.1 Diagnosis of major depressive disorder

AND

1.2.2 Patient has both of the following:

- Depressive symptoms
- Acute suicidal ideation or behavior

AND

2 - Used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline)

AND

3 - Prescribed by or in consultation with a psychiatrist

Product Name: Spravato	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline)

Product Name: Spravato	
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following:

1.1 Submission of medical records (e.g. chart notes) documenting Both of the following:

1.1.1 Diagnosis of major depressive disorder

AND

1.1.2 Patient has not experienced a clinical meaningful improvement after treatment with at least two antidepressants from different classes for an adequate duration (at least 4 weeks each) in the current depressive episode [1-5, A, B]

OR

1.2 Submission of medical records (e.g. chart notes) documenting Both of the following:

1.2.1 Diagnosis of major depressive disorder

AND

1.2.2 Patient has both of the following:

- Depressive symptoms
- Acute suicidal ideation or behavior

AND

2 - Submission of medical records (e.g. chart notes) or paid claims documenting use in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline)

AND

3 - Prescribed by or in consultation with a psychiatrist

3 . Endnotes

A. According to the American Psychiatric Association, generally, 4–8 weeks of treatment are needed before concluding that a patient is partially responsive or unresponsive to a specific intervention. [2]
B. Per clinical consults with psychiatrists: A trial of antidepressants should include different classes (mechanisms of action) when defining treatment resistance. [4-5]

4 . References

1. Spravato Prescribing Information. Janssen Pharmaceuticals, Inc. Titusville, NJ. July 2020.
2. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder (3rd Edition). October 2010. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. Accessed March 31, 2022.
3. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. Am J Psychiatry. 2006;163(11):1905-17.
4. Per clinical consult with psychiatrist, April 25, 2019.
5. Per clinical consult with psychiatrist, April 18, 2019.

5 . Revision History

Date	Notes
4/10/2023	Annual review - criteria update for clinical clarity

Stelara IV (ustekinumab)

Prior Authorization Guideline

Guideline ID	GL-131593
Guideline Name	Stelara IV (ustekinumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name: Stelara IV	
Diagnosis	Crohn's Disease
Approval Length	1 Time (30 days)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active Crohn’s disease	

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to ONE of the following:

- 6-mercaptopurine
- azathioprine
- corticosteroids (e.g., prednisone, methylprednisolone)
- methotrexate

OR

3.2 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

AND

4 - Trial and failure, contraindication, or intolerance to adalimumab and infliximab

AND

5 - Stelara is to be administered as an intravenous induction dose

Product Name: Stelara IV	
Diagnosis	Ulcerative Colitis
Approval Length	1 Time (30 days)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - ONE of the following:

3.1 The member is transitioning to the requested treatment from a different biologic product previously approved by the plan

OR

3.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, sulfasalazine)
- azathioprine

AND

4 - Trial and failure, contraindication, or intolerance to adalimumab and infliximab

AND

5 - Stelara is to be administered as an intravenous induction dose

2 . Revision History

Date	Notes
	New program

Synagis (palivizumab)

Prior Authorization Guideline

Guideline ID	GL-103382
Guideline Name	Synagis (palivizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2022
P&T Approval Date:	3/17/2000
P&T Revision Date:	10/21/2020 ; 10/20/2021 ; 3/16/2022

1 . Indications

Drug Name: Synagis (palivizumab)
Prophylaxis of respiratory syncytial virus (RSV) Indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients: with a history of premature birth (less than or equal to 35 weeks gestational age) and who are 6 months of age or younger at the beginning of respiratory syncytial virus (RSV) season; with bronchopulmonary dysplasia (BPD) that required medical treatment within the previous 6 months and who are 24 months of age or younger at the beginning of respiratory syncytial virus (RSV) season; with hemodynamically significant congenital heart disease (CHD) and who are 24 months of age or younger at the beginning of respiratory syncytial virus (RSV) season. Limitations of use: The safety and efficacy of Synagis have not been established for treatment of RSV disease.

2 . Criteria

Product Name: Synagis	
Diagnosis	Premature Infants (without other indications)
Approval Length	5 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Born prematurely at or before 29 weeks, 0 days gestation [2, B]

AND

2 - Age < 12 months at the start of the respiratory syncytial virus (RSV) season [A].

AND

3 - Used for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) during the respiratory syncytial virus (RSV) season for the patient's geographic region.

Notes	Authorization will be issued for up to a maximum of 5 months (5 doses) during respiratory syncytial virus (RSV) season. Initiation of Synagis prophylaxis after start of respiratory syncytial virus (R SV) season will not require all 5 doses for these conditions. [A] Typical RSV season is from November through March; however, RSV season can fall outside this time frame. If outside this time f rame, refer to the CDC surveillance reports (http://www.cdc.gov/ surveillance/nrevss/rsv/index.html) to confirm the start of RSV s eason based on region.

Product Name: Synagis	
Diagnosis	Chronic Lung Disease of Prematurity
Approval Length	5 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Chronic lung disease (CLD) of prematurity [2]

AND

2 - Born before 32 weeks, 0 days gestation [2]

AND

3 - Received greater than 21% oxygen supplementation for at least the first 28 days after birth

AND

4 - One of the following:

4.1 Age < 12 months at the start of the respiratory syncytial virus (RSV) season.

OR

4.2 Both of the following:

- Age at least 12 to < 24 months at the start of the RSV season
- Received medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season

AND

5 - Prescribed by or in consultation with one of the following:

- Pediatric pulmonologist
- Neonatologist
- Pediatric intensivist
- Infectious disease specialist

AND

6 - Used for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) during the respiratory syncytial virus (RSV) season for the patient's geographic region.

Notes	Authorization will be issued for up to a maximum of 5 months (5 doses) during respiratory syncytial virus (RSV) season. Initiation of Synagis prophylaxis after start of respiratory syncytial virus (RSV) season will not require all 5 doses for these conditions. [A] Typical RSV season is from November through March; however, RSV season can fall outside this time frame. If outside this time frame, refer to the CDC surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) to confirm the start of RSV season based on region.

Product Name: Synagis	
Diagnosis	Hemodynamically Significant Congenital Heart Disease
Approval Length	5 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Age < 12 months at the start of the respiratory syncytial virus (RSV) season, with one of the following: [C] (persons of all ages).

1.1.1 All of the following:

- Acyanotic heart failure
- Receiving medication to control congestive heart failure
- Patient will require a cardiac surgical procedure

OR

1.1.2 Moderate to severe pulmonary hypertension

OR

1.1.3 Cyanotic heart defect

OR

1.2 Both of the following*: [D]

- Age < 24 months
- Patient will or has undergone a cardiac transplantation during the respiratory syncytial virus (RSV)season

AND

2 - Prescribed by or in consultation with a pediatric cardiologist

AND

3 - Used for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) during the respiratory syncytial virus (RSV) season for the patient's geographic region

Notes	Authorization will be issued for up to a maximum of 5 months (5 doses) during respiratory syncytial virus (RSV) season. Initiation of Synagis prophylaxis after start of respiratory syncytial virus (RSV) season will not require all 5 doses for these conditions. *ONE additional postoperative dose allowed for patients undergoing cardiac transplantation, cardiac bypass or extracorporeal membrane oxygenation. [A, D] Typical RSV season is from November through March; however, RSV season can fall outside this time frame. If outside this time frame, refer to the CDC surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) to confirm the start of RSV season based on region.

Product Name: Synagis	
Diagnosis	Pulmonary Abnormality or Neuromuscular Disorder
Approval Length	5 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Pulmonary abnormalities (e.g., pulmonary malformations, tracheoesophageal fistula, conditions requiring tracheostomy) or neuromuscular disease (e.g., cerebral palsy) [2]

AND

2 - Age < 12 months at the start of the respiratory syncytial virus (RSV) season.

AND

3 - Impaired ability to clear secretions from the upper airway due to an ineffective cough

AND

4 - Prescribed by or in consultation with one of the following:

- Pediatric pulmonologist
- Neurologist

AND

5 - Used for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) during the respiratory syncytial virus (RSV) season for the patient's geographic region

Notes	Authorization will be issued for up to a maximum of 5 months (5 doses) during respiratory syncytial virus (RSV) season. Initiation of Synagis prophylaxis after start of respiratory syncytial virus (RSV) season will not require all 5 doses for these conditions. [A] Typical RSV season is from November through March; however, RSV season can fall outside this time frame. If outside this time frame, refer to the CDC surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) to confirm the start of RSV season based on region.

Product Name: Synagis	
Diagnosis	Immunocompromised Children
Approval Length	5 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Received or will receive a solid organ transplant, hematopoietic stem cell transplant, or chemotherapy during the respiratory syncytial virus (RSV) season.

AND

2 - Age < 24 months

AND

3 - Lymphocyte count is below the normal range for patient's age

AND

4 - Prescribed by or in consultation with one of the following:

- Pediatric pulmonologist
- Infectious disease specialist
- Pediatric intensivist

AND

5 - Used for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) during the respiratory syncytial virus (RSV) season for the patient's geographic region

Notes	Authorization will be issued for up to a maximum of 5 months (5 doses) during respiratory syncytial virus (RSV) season. Initiation of Synagis prophylaxis after start of respiratory syncytial virus (RSV) season will not require all 5 doses for these conditions. [A] Typical RSV season is from November through March; however, RSV season can fall outside this time frame. If outside this time frame, refer to the CDC surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) to confirm the start of RSV season based on region.

Product Name: Synagis	
Diagnosis	Children with Cystic Fibrosis
Approval Length	5 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis [2]

AND

2 - One of the following:

2.1 Both of the following:

- Age < 12 months
- Clinical evidence of chronic lung disease (CLD) and/or nutritional compromise (i.e., failure to thrive)

OR

2.2 Both of the following:

- Age at least 12 to < 24 months
- Severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life, abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length < 10th percentile on pediatric growth chart [E]

Notes	Authorization will be issued for up to a maximum of 5 months (5 doses) during respiratory syncytial virus (RSV) season. Initiation of Synagis prophylaxis after start of respiratory syncytial virus (RSV) season will not require all 5 doses for these conditions. [A] Typical RSV season is from November through March; however, RSV season can fall outside this time frame. If outside this time frame, refer to the CDC surveillance reports (http://www.cdc.gov/surveillance/nrevss/rsv/index.html) to confirm the start of RSV season based on region.

3 . Endnotes

A. Five monthly doses of palivizumab will provide more than 6 months of prophylactic serum palivizumab concentrations. Administration of more than five monthly doses is not recommended. If RSV season onset is in November, the first dose should be administered in November, and the fifth and final dose should be administered in March. If RSV season onset is in November and the first dose is given in January, the third and final dose should be administered in March. In most of North America, peak RSV activity typically occurs between November and March, usually beginning in November or December, peaking in January or February, and ending by the end of March or sometime in April. Communities in the southern United States, particularly some communities in the state of Florida, tend to experience the earliest onset of RSV. Data from the Centers for Disease Control and Prevention (CDC) have identified variations in the onset and offset of the RSV "season" in the state of Florida that could affect the timing of palivizumab administration. [2] For analysis of National Respiratory and Enteric Virus Surveillance System (NREVSS) reports in the CDC Morbidity and Mortality Weekly Report (MMWR), season onset is defined as the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is at least 10% and RSV season offset is defined as the last of 2 consecutive weeks during which the mean percentage of positive specimens is at least 10%. [3] NREVSS surveillance data can be viewed here (http://www.cdc.gov/surveillance/nrevss/rsv/)
B. Palivizumab prophylaxis is not recommended for otherwise healthy infants born at or after 29 weeks, 0 days' gestation. [2]
C. The following conditions are NOT considered hemodynamically significant congenital heart disease: secundum atrial septal defect, small ventricular septal defect, pulmonary stenosis, uncomplicated aortic stenosis, mild coaractation of the aorta, and patent ductus arteriosus; lesions adequately corrected by surgery, unless continuing required medication for congestive heart failure; mild cardiomyopathy and not receiving medical therapy for the condition; children in the second year of life. [2]
D. Pediatric growth charts can be viewed here (http://www.cdc.gov/growthcharts/who_charts.htm)
E. Children undergoing these procedures should receive an additional dose of palivizumab as soon as possible after the procedure. Thereafter, doses should be administered monthly as scheduled. [2]
F. Monthly prophylaxis should be discontinued in any infant or child who experiences a breakthrough RSV hospitalization. [2]
G. Palivizumab prophylaxis is not recommended for prevention of health care-associated RSV disease. [2]
H. The burden of RSV disease and costs associated with transport from remote locations may result in a broader use of palivizumab for RSV prevention in Alaska Native populations and possibly in selected other American Indian populations. [2]

4 . References

1. Synagis Prescribing Information. Swedish Orphan Biovitrum AB (publ). Stockholm, Sweden September 2021.
2. Commitee on Infectious Diseases and Bronchiolitis Guidelines Committee. Updated guidance for palivizumab prophylaxis among infants and young children at increased risk of hospitalizations for respiratory syncytial virus infection. Pediatrics. 2014 Aug;134(2):415-20. doi: 10.1542/peds.2014-1665.
3. Panozzo CA, Stockman LJ, et al. Use of respiratory syncytial virus surveillance data to optimize the timing of immunoprophylaxis. Pediatrics. 2010 Jul;126(1):e116-23.

5 . Revision History

Date	Notes
3/3/2022	Updated notes to add guidance on RSV season variance

Talvey (talquetamab-tgvs)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Talvey (talquetamab-tgvs)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Talvey (talquetamab-tgvs)
Multiple Myeloma Indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody. This indication is approved under accelerated approval based on response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

2 . Criteria

Product Name: Talvey	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- Diagnosis of multiple myeloma

AND

2- Disease is one of the following:

- Relapsed
- Refractory

AND

3- Patient has received at least four prior lines of therapy which include all of the following:

- An immunomodulatory agent (e.g., lenalidomide, thalidomide)
- A proteasome inhibitor (e.g., bortezomib, carfilzomib)
- A CD38-directed monoclonal antibody (e.g. daratumumab)

Product Name: Talvey	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

3 . References

2 Talvey Prescribing Information. Janssen Biotech, Inc. Horsham, PA. August 2023.

4 . Revision History

Date	Notes
9/28/2023	New program

Tecvayli (teclistamab-cqyv)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Tecvayli (teclistamab-cqyv)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	9/1/2023
P&T Approval Date:	12/14/2022
P&T Revision Date:	7/19/2023

1 . Indications

Drug Name: Tecvayli (teclistamab-cqyv)
Multiple Myeloma Indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody.

2 . Criteria

Product Name: Tecvayli	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- Diagnosis of multiple myeloma

AND

2- Disease is one of the following:

- Relapsed
- Refractory

AND

3- Patient has received at least four prior lines of therapy which include all of the following:

- An immunomodulatory agent (e.g., lenalidomide, thalidomide)
- A proteasome inhibitor (e.g., bortezomib, carfilzomib)
- A CD38-directed monoclonal antibody (e.g. daratumumab)

Product Name: Tecvayli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	

3 . References

1. Tecvayli Prescribing Information. Janssen Biotech, Inc. Horsham, PA. October 2022.

4 . Revision History

Date	Notes
7/5/2023	Removed specialist requirement

Tepezza (teprotumumab-trbw)

Prior Authorization Guideline

Guideline ID	GL-125572
Guideline Name	Tepezza (teprotumumab-trbw)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	3/18/2020
P&T Revision Date:	03/17/2021 ; 03/16/2022 ; 03/15/2023 ; 6/21/2023

1 . Indications

Drug Name: Tepezza (teprotumumab-trbw)
Thyroid Eye Disease (TED) Indicated for the treatment of thyroid eye disease regardless of Thyroid Eye Disease (TED) activity or duration.

2 . Criteria

Product Name: Tepezza	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of thyroid eye disease (TED)

AND

2 - Prescribed by or in consultation with one of the following: [3]

- Endocrinologist
- Ophthalmologist

AND

3 - Treatment with Tepezza has not exceeded a total of 8 infusions [1]

3 . References

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4. ClinicalTrials.gov. A Study Evaluating Tepezza Treatment in Patients with Chronic (Inactive) Thyroid Eye Disease. Available at:

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4 . Revision History

Date	Notes
5/10/2023	update guideline

Testosterone

Prior Authorization Guideline

Guideline ID	GL-124160
Guideline Name	Testosterone
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	
P&T Revision Date:	11/14/2019 ; 02/13/2020 ; 02/13/2020 ; 04/15/2020 ; 04/21/2021 ; 03/16/2022 ; 05/19/2022 ; 09/21/2022 ; 08/18/2022 ; 09/21/2022 ; 11/17/2022 ; 01/18/2023 ; 02/16/2023 ; 03/15/2023 ; 4/19/2023

1 . Indications

Drug Name: Androderm (testosterone [T] patch), Androgel (T gel and pump), Fortesta (T gel), Natesto (T nasal gel), Testim (T gel), and Vogelxo (T gel and pump)
Primary hypogonadism (congenital or acquired) Indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired) is testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy or toxic damage from alcohol or heavy metals. These men usually have low testosterone serum levels and gonadotropins (FSH, LH) above the normal range. Important limitations of use: Safety and efficacy in men with

"age-related hypogonadism (also referred to as "late-onset hypogonadism") have not been established. Safety and efficacy in males less than 18 years old have not been established. Topical testosterone products may have different doses, strengths, or application instructions that may result in different systemic exposure.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. Gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but have gonadotropins in the normal or low range. Important limitations of use: Safety and efficacy in men with "age-related hypogonadism (also referred to as "late-onset hypogonadism") have not been established. Safety and efficacy in males less than 18 years old have not been established. Topical testosterone products may have different doses, strengths, or application instructions that may result in different systemic exposure.

Drug Name: Methitest (methyltestosterone) tablet

Delayed puberty in males Indicated for stimulation of puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An X-ray of the hand and wrist to determine bone age should be obtained every six months to assess the effect of treatment on the epiphyseal centers.

Metastatic mammary cancer in females Indicated for secondary use in women with advancing inoperable metastatic (skeletal) mammary cancer who are 1 to 5 years postmenopausal. Primary goals of therapy in these women include ablation of the ovaries. Other methods of counteracting estrogen activity are adrenalectomy, hypophysectomy, and/or antiestrogen therapy. This treatment has also been used in premenopausal women with breast cancer who have benefited from oophorectomy and are considered to have a hormone-responsive tumor. Judgment concerning androgen therapy should be made by an oncologist with expertise in this field.

Primary hypogonadism (congenital or acquired) Indicated for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired) is testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, or orchidectomy.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for replacement

therapy in conditions associated with a deficiency or absence of endogenous testosterone. Hypogonadotropic hypogonadism (congenital or acquired) is idiopathic gonadotropin or LHRH deficiency, or pituitary hypothalamic injury from tumors, trauma, or radiation. If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sexual characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty.

Drug Name: Depo-Testosterone (testosterone cypionate) injection

Primary hypogonadism (congenital or acquired) Indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchiectomy. Safety and efficacy of Depo-Testosterone (testosterone cypionate) in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone. Hypogonadotropic hypogonadism (congenital or acquired) - Gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. Safety and efficacy of Depo-Testosterone (testosterone cypionate) in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.

Drug Name: Testopel (testosterone) pellet

Primary hypogonadism (congenital or acquired) Indicated for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchiectomy. If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sex characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty. Safety and efficacy of Testopel in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism" have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone. Hypogonadotropic hypogonadism (congenital or acquired)-idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury

from tumors, trauma, or radiation. If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sexual characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty. If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sex characteristics. Prolonged androgen treatment will be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty. Safety and efficacy of Testopel in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism" have not been established.

Delayed puberty in males Indicated for stimulation of puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An X-ray of the hand and wrist to determine bone age should be obtained every six months to assess the effect of treatment on the epiphyseal centers.

Drug Name: Aveed (testosterone undecanoate) injection

Primary hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired): testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range. Aveed should only be used in patients who require testosterone replacement therapy and in whom the benefits of the product outweigh the serious risks of pulmonary oil microembolism and anaphylaxis. Limitations of use: Safety and efficacy of Aveed in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established. Safety and efficacy of Aveed in males less than 18 years old have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. Hypogonadotropic hypogonadism (congenital or acquired): idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation.

These men have low testosterone serum concentrations but have gonadotropins in the normal or low range. Aveed should only be used in patients who require testosterone replacement therapy and in whom the benefits of the product outweigh the serious risks of pulmonary oil microembolism and anaphylaxis. Limitations of use: Safety and efficacy of Aveed in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established. Safety and efficacy of Aveed in males less than 18 years old have not been established.

Drug Name: Testone CIK (testosterone cypionate) injection

Primary hypogonadism (congenital or acquired) Indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome; or orchidectomy. Limitations of Use: Safety and efficacy of testosterone cypionate in men with “age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for replacement therapy in the male in conditions associated with symptoms of deficiency or absence of endogenous testosterone. Hypogonadotropic hypogonadism (congenital or acquired) - idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. Limitations of Use: Safety and efficacy of testosterone cypionate in men with “age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.

Drug Name: Xyosted (testosterone enanthate) injection

Primary hypogonadism (congenital or acquired) Indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. Primary hypogonadism (congenital or acquired) - Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter’s syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (FSH, LH) above the normal range. Safety and efficacy of Xyosted in males less than 18 years old have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. Hypogonadotropic hypogonadism (congenital or acquired) - Gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but

have gonadotropins in the normal or low range. Safety and efficacy of Xyosted in males less than 18 years old have not been established.

Drug Name: Jatenzo (testosterone undecanoate) capsule

Primary hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Primary hypogonadism (congenital or acquired) is testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range. Limitations of Use: Safety and efficacy of Jatenzo in males less than 18 years old have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Hypogonadotropic hypogonadism (congenital or acquired) is gonadotropin or luteinizing hormone releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but have gonadotropins in the normal or low range. Limitations of Use: Safety and efficacy of Jatenzo in males less than 18 years old have not been established.

Drug Name: Tlando (testosterone undecanoate) capsule

Primary hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Primary hypogonadism (congenital or acquired) is testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range. Limitations of Use: Safety and efficacy of Tlando in males less than 18 years old have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Hypogonadotropic hypogonadism (congenital or acquired) is gonadotropin or luteinizing hormone releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but have gonadotropins in the

normal or low range. Limitations of Use: Safety and efficacy of Tlando in males less than 18 years old have not been established.

Drug Name: Kyzatrex (testosterone undecanoate) capsule

Primary hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Primary hypogonadism (congenital or acquired) is testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range. Limitations of Use: Safety and efficacy of Kyzatrex in males less than 18 years old have not been established.

Hypogonadotropic hypogonadism (congenital or acquired) Indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Hypogonadotropic hypogonadism (congenital or acquired) is gonadotropin or luteinizing hormone releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but have gonadotropins in the normal or low range. Limitations of Use: Safety and efficacy of Kyzatrex in males less than 18 years old have not been established.

Drug Name: Androderm, Androgel, Aveed, Depo-Testosterone, Fortesta, Methitest, Natesto, Testone CIK, Testim, Testopel, Vogelxo, Xyosted

Off Label Uses: Transgender male (female-to-male) - Gender Dysphoria/Gender Incongruence [11-12, 17, 28-29] Testosterone in 3 different formulations, including transdermal gel, significantly increased testosterone levels from the physiological range for women to the normal male range by week 30 of treatment in an observational study in transgender male (female-to-male) individuals. Hormonal sex reassignment therapy was associated with significantly fewer symptoms related to social distress, anxiety, and depression compared with those not receiving hormonal therapy in 1 cross-sectional study. Gender transition treatment can be initiated in adults and adolescents with confirmed persistent gender dysphoria/gender incongruence who have the capacity to make fully informed decisions and consent, usually by age 16 years, and have well-controlled, if any, mental health concerns. The goals of therapy are to suppress endogenous sex hormones of the designated gender and to replace these with endogenous sex hormones of the affirmed gender. Either parenteral or transdermal testosterone may be used to achieve and maintain testosterone levels in the normal male range. Avoid sustained supraphysiologic levels to reduce risk of adverse reactions. Compelling reasons may exist to initiate therapy at younger than 16 years; although, studies in this population are minimal. Initial

therapy to undergo suppression of pubertal development at Tanner stages G2/B2 is suggested. Neither puberty suppression nor gender-affirming hormone therapies are recommended in pre-pubertal children.

2 . Criteria

Product Name: Androderm, Brand Androgel gel and pump (1%), Brand Androgel gel and pump (1.62%), Generic testosterone gel and pump 20.25 mg/1.25 g, 40.5 mg/2.5 g (1.62%), Natesto, Generic testosterone gel 25 mg/2.5 g (1%), Generic testosterone gel 50 mg/5 g (1%), Generic testosterone gel pump (1%), Generic testosterone topical solution 30 mg/act, Generic testosterone gel 10 mg/act (2%), Aveed, Generic testosterone enanthate, Brand Depo-Testosterone, Brand Fortesta, Brand Testim, Brand Testosterone Cypionate, Testone CIK, Testopel, Testosterone implant pellets, Brand Testosterone Propionate, Xyosted, Brand Vogelxo	
Diagnosis	Male hypogonadism
Approval Length	6 months for patients new to testosterone therapy; or 12 months for patients continuing testosterone therapy but without a current authorization on file with IHN-CCO [B]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypogonadism (e.g., testicular hypofunction, male hypogonadism)

AND

2 - Male patient at birth [C]

AND

3 - Patient is 18 years of age or older

AND

4 - One of the following:

4.1 Two pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab** [7, 9]

OR

4.2 Both of the following:

4.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

4.2.2 One pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range for the lab**

OR

4.3 Patient has a history of one of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

4.4 Both of the following:

4.4.1 Patient is continuing testosterone therapy

AND

4.4.2 One of the following:

4.4.2.1 Follow-up total serum testosterone level or calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal limits of the reporting lab

OR

4.4.2.2 Follow-up total serum testosterone level or calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted

AND

5 - Trial and failure or intolerance to both of the following (applies to Aveed, Testopel, Testosterone implant pellets, Testone CIK, Brand Depo-Testosterone, Brand Testosterone Cypionate and Brand Testosterone Propionate only):

- Generic testosterone cypionate
- Generic testosterone enanthate

AND

6 - Trial and failure or intolerance to generic testosterone gel (applies to Brand Androgel, Brand Fortesta, Brand Testim, Brand Vogelxo, and Brand Natesto only)

Notes	**This may require treatment to be temporarily held.

Product Name: Generic testosterone cypionate	
Diagnosis	Male hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypogonadism (e.g., testicular hypofunction, male hypogonadism)

AND

2 - Male patient at birth [C]

AND

3 - Patient is 18 years of age or older

AND

4 - One of the following:

4.1 Two pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab** [7, 8]

OR

4.2 Both of the following:

4.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

4.2.2 One pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range for the lab**

OR

4.3 Patient has a history of one of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

4.4 Both of the following:

4.4.1 Patient is continuing testosterone therapy

AND

4.4.2 One of the following:

4.4.2.1 Follow-up total serum testosterone level or calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal limits of the reporting lab

OR

4.4.2.2 Follow-up total serum testosterone level or calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted	
Notes	**This may require treatment to be temporarily held.

Product Name: Methitest, Generic methyltestosterone, Jatenzo, Kyzatrex, Tlando	
Diagnosis	Male hypogonadism
Approval Length	6 months for patients new to testosterone therapy; or 12 months for patients continuing testosterone therapy but without a current authorization on file with IHN-CCO [B]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypogonadism (e.g., testicular hypofunction, male hypogonadism)

AND

2 - Male patient at birth [C]

AND

3 - Patient is 18 years of age or older

AND

4 - One of the following:

4.1 Two pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab*** [7, 8]

OR

4.2 Both of the following:

4.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

4.2.2 One pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range for the lab***

OR

4.3 Patient has a history of one of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

4.4 Both of the following:

4.4.1 Patient is continuing testosterone therapy

AND

4.4.2 One of the following:

4.4.2.1 Follow-up total serum testosterone level or calculated free or bioavailable

testosterone level drawn within the past 12 months is within or below the normal limits of the reporting lab

OR

4.4.2.2 Follow-up total serum testosterone level or calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted

AND

5 - Trial and failure or intolerance to both of the following:

- Androderm (testosterone patch)
- Generic testosterone gel

Notes	***This may require treatment to be temporarily held.

Product Name: Androderm, Brand Androgel gel and pump (1%), Generic testosterone gel 25 mg/2.5 g (1%), Brand Androgel gel and pump (1.62%), Generic testosterone gel and pump 20.25 mg/1.25 g, 40.5 mg/2.5 g (1.62%), Generic testosterone topical solution 30 mg/act, Brand Fortesta, Generic testosterone gel 10 mg/act (2)%, Jatenzo, Kyzatrex, Methitest, Natesto, Brand Testim, Generic methyltestosterone, Brand Vogelxo gel and pump (1%), Generic testosterone gel 50 mg/5 g (1%), Generic testosterone pump (1%), Aveed, Generic testosterone enanthate, Brand Depo-Testosterone, Brand Testosterone Cypionate, Testone CIK, Testopel, Testosterone implant pellets, Brand Testosterone Propionate, Tlando, Xyosted	
Diagnosis	Gender Dysphoria/Gender Incongruence (off-label) [11-12, 17, 26 D]
Approval Length	6 months for patients new to testosterone therapy; or 12 months for patients continuing testosterone therapy but without a current authorization on file with IHN-CCO [B]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gender dysphoria/gender incongruence [11-12, 17, 26]

AND

2 - Using hormones to change characteristics to align with gender expression [11, 17, 28-29]

AND

3 - Trial and failure or intolerance to both of the following (applies to Aveed, Testopel, Testosterone implant pellets, Testone CIK, Brand Depo-Testosterone, Brand Testosterone Cypionate, Brand Testosterone Propionate):

- Generic testosterone cypionate
- Generic testosterone enanthate

AND

4 - Trial and failure or intolerance to generic testosterone (applies to Brand Androgel, Brand Fortesta, Brand Testim, Brand Vogelxo, Brand Natesto only)

Product Name: Generic testosterone cypionate	
Diagnosis	Gender Dysphoria/Gender Incongruence (off-label) [11-12, 17, 26 D]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gender dysphoria/gender incongruence [11-12, 17, 26]

AND

2 - Using hormones to change characteristics to align with gender expression [11, 17, 28-29]

Product Name: Androderm, Brand Androgel gel and pump (1%), Generic testosterone gel 25 mg/2.5 g (1%), Brand Androgel gel and pump (1.62%), Generic testosterone gel and pump 20.25 mg/1.25 g, 40.5 mg/2.5 g (1.62%), Generic testosterone topical solution 30 mg/act, Brand Fortesta, Generic testosterone gel 10 mg/act (2)%, Jatenzo, Kyzatrex, Methitest, Natesto, Brand Testim, Generic methyltestosterone, Brand Vogelxo gel and pump (1%), Generic testosterone gel 50 mg/5 g (1%), Generic testosterone pump (1%), Aveed, Generic testosterone enanthate, Brand Depo-Testosterone, Brand Testosterone Cypionate, Generic testosterone cypionate, Testone CIK, Testopel, Testosterone implant pellets, Brand Testosterone Propionate, Tlando, Xyosted

Diagnosis	Male hypogonadism, Gender dysphoria/Gender incongruence
Approval Length	12 Month [B]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Follow-up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, is within or below the normal limits of the reporting lab

OR

1.2 Follow-up total serum testosterone level drawn within the past 6 months for

patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, is outside of upper limits of normal for the reporting lab and the dose is adjusted

OR

1.3 Both of the following:

1.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

1.3.2 One of the following:

1.3.2.1 Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, is within or below the normal limits of the reporting lab

OR

1.3.2.2 Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy, or 12 months for patients continuing testosterone therapy, is outside of upper limits of normal for the reporting lab and the dose is adjusted

Product Name: Methitest, Generic testosterone enanthate, Testopel, Testosterone implant pellets, Generic methyltestosterone, Brand Testosterone Cypionate [off-label]	
Diagnosis	Delayed puberty [E]
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of delayed puberty [A]

AND

2 - Male patient at birth [C]

AND

3 - Trial and failure or intolerance to both of the following (applies to Testopel and Testosterone implant pellets only):

- Generic testosterone cypionate [F]
- Generic testosterone enanthate

Product Name: Generic testosterone cypionate [off-label]	
Diagnosis	Delayed puberty [E]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of delayed puberty [A]

AND

2 - Male patient at birth [C]

Product Name: Methitest, Generic methyltestosterone, Generic testosterone enanthate

Diagnosis	Inoperable breast cancer in women
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Breast cancer is inoperable

AND

3 - Used for palliative treatment

AND

4 - Female patient at birth [C]

3 . Endnotes

A. Delayed puberty is defined as the lack of the initial signs of sexual maturation by an age that is more than 2-2.5 standard deviations above the mean for the population (traditionally, the age of 14 years in boys and 13 years in girls). In most cases, delayed puberty is not due to an underlying pathology, but instead represents an extreme end of the normal spectrum of pubertal timing, a developmental pattern referred to as constitutional delay of growth and puberty (CDGP). CDGP is the most common cause of delayed puberty in both sexes, but it can be diagnosed only after underlying conditions have been ruled out. Management of CDGP may involve expectant observation or therapy with low-dose sex steroids. [9]

B. Initial authorization of 6 months, and reauthorization of 12 months is based on the Endocrine Society's Clinical Practice Guideline's recommendation to monitor testosterone level 3 to 6 months after initiation of testosterone therapy, and then annually to assess whether symptoms have responded to treatment and whether the patient is suffering from any adverse effects. [8]
C. The gender criteria in place for male hypogonadism, delayed puberty, and inoperable breast cancer are to ensure safe and effective medication utilization due to FDA-approved labeling supporting the gender restriction [refer to individual Package Inserts]. Age and/or gender criteria will remain in the guideline, consistent with the following direction approved by IHN-CCO Legal & Regulatory: “Age and gender edits in place due to FDA safety guidance, labeling or supported by medical literature to satisfy medical necessity criteria would not be inconsistent with the [Section 1557 HCR non-discrimination] regulation."
D. According to DRUGDEX, for the treatment of transgender male (female-to-male) patients with gender dysphoria, various forms and dosages of testosterone have been used. [12] Clinical studies have also demonstrated the efficacy of several different androgen preparations to induce masculinization in female-to-male transgender persons. Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism. Either parenteral or transdermal preparations can be used to achieve testosterone values in the normal male range. [11]
E. An X-ray of the hand and wrist to determine bone age should be taken every 6 months to assess the effect of treatment on epiphyseal center [19-20].
F. Per consult with specialist, the pharmacokinetics of T. cypionate and T. enanthate are quite similar and physiologically produce similar results. The two agents are very close in efficacy and behavioral effects. Although T. cypionate isn't FDA-approved for delayed puberty, it is used in practice due to its similarity to T. enanthate. [25]

4 . References

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4. Fortesta Prescribing Information. Endo Pharmaceuticals. Malvern, PA. June 2020.
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6. Testim Prescribing Information. Endo Pharmaceuticals Inc. Malvern, PA. August 2021.

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16. Methyltestosterone Prescribing Information. Impax Generics. Hayward, CA. January 2017.
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18. Depo-Testosterone Prescribing information. Pfizer. New York, NY. November 2018.
19. Testosterone Enanthate Prescribing Information. Actavis Pharma, Inc. Corona, CA. December 2017.
20. Testopel Prescribing Information. Slate Pharma. Rye, NY. August 2018.
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22. Testone CIK Prescribing Information. Asclemed USA, Inc. Torrance, CA. November 2018.
23. Xyosted Prescribing Information. Antares Pharma, Inc. Ewing, NJ. November 2019.
24. Jatenzo Prescribing Information. Clarus Therapeutics, Inc. Northbrook, IL. June 2019.
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Gender Affirming Health Program, Department of Family and Community Medicine, University of California San Francisco. June 2016
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5 . Revision History

Date	Notes
4/5/2023	Updated the step through both Generic testosterone cypionate and Generic testosterone enanthate as drug shortage has been resolved

Thalomid (thalidomide)

Prior Authorization Guideline

Guideline ID	GL-124374
Guideline Name	Thalomid (thalidomide)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/22/2007
P&T Revision Date:	05/14/2020 ; 05/20/2021 ; 05/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Thalomid (thalidomide)
Erythema Nodosum Leprosum (ENL) Indicated for the acute treatment of the cutaneous manifestations of moderate to severe ENL. Not indicated as monotherapy for such ENL treatment in the presence of moderate to severe neuritis. Also indicated as a maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence. **Newly Diagnosed Multiple Myeloma** Indicated in combination with dexamethasone for the treatment of patients with newly diagnosed multiple myeloma.

2 . Criteria

Product Name: Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe erythema nodosum leprosum (ENL) with cutaneous manifestations

AND

2 - Thalomid is not used as monotherapy if moderate to severe neuritis is present

Product Name: Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name: Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple myeloma

AND

2 - Used in combination with dexamethasone, unless the patient has an intolerance to steroids

AND

3 - Prescribed by or in consultation with an oncologist/hematologist

Product Name: Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

3 . References

1. Thalomid Prescribing Information. Celgene Corporation. Summit, NJ. December 2022.

4 . Revision History

Date	Notes
5/3/2023	Annual review - updated references.

Tysabri (natalizumab)

Prior Authorization Guideline

Guideline ID	GL-124857
Guideline Name	Tysabri (natalizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	11/20/2000
P&T Revision Date:	05/14/2020 ; 01/20/2021 ; 05/20/2021 ; 05/19/2022 ; 10/19/2022 ; 5/18/2023

1 . Indications

Drug Name: Tysabri (natalizumab)
Multiple Sclerosis (MS) Indicated as monotherapy for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. Tysabri increases the risk of progressive multifocal leukoencephalopathy (PML). When initiating and continuing treatment with Tysabri, physicians should consider whether the expected benefit of Tysabri is sufficient to offset this risk. **Crohn's Disease (CD)** Indicated for inducing and maintaining clinical response and remission in adult patients with moderately to severely active CD with evidence of inflammation who have had an inadequate response to, or are unable to tolerate,

conventional CD therapies and inhibitors of TNF-alpha. In CD, Tysabri should not be used in combination with immunosuppressants (e.g., 6-mercaptopurine, azathioprine, cyclosporine, or methotrexate) or inhibitors of TNF-alpha.

2 . Criteria

Product Name: Tysabri	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions) [B]

AND

2 - One of the following:

2.1 Trial and failure, contraindication, or intolerance to one of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Lemtrada (alemtuzumab)
- Mavenclad (cladribine)
- Plegridy (peginterferon beta-1a)
- Any one of the interferon beta-1a injections (e.g., Avonex)
- Any one of the interferon beta-1b injections (e.g., Betaseron)
- Any one of the glatiramer acetate injections (e.g., Copaxone, Glatopa, generic glatiramer acetate)
- Any one of the oral fumarates (e.g., generic dimethyl fumarate)

- Any one of the Sphingosine 1-Phosphate (S1P) receptor modulators (e.g., Gilenya, Mayzent, Zeposia)
- Any one of the B-cell targeted therapies (e.g., Kesimpta)

OR

2.2 Patient is not a candidate for any of the drugs listed as prerequisites due to the severity of their multiple sclerosis [2]

OR

2.3 For continuation of prior therapy [2]

AND

3 - Not used in combination with another disease-modifying therapy for MS

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Tysabri	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

AND

2 - Not used in combination with another disease-modifying therapy for MS

AND

3 - Prescribed by or in consultation with a neurologist

Product Name: Tysabri	
Diagnosis	Crohn’s Disease (CD)
Approval Length	3 Months [1]**
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - Crohn's disease has evidence of inflammation (e.g., elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes)

AND

3 - Trial and failure, contraindication, or intolerance to one of the following conventional therapies [3, 7]:

- corticosteroids (e.g., prednisone)
- 6-mercaptopurine

- azathioprine
- methotrexate

AND

4 - Trial and failure, contraindication, or intolerance to a tumor necrosis factor (TNF)-inhibitor (e.g., Cimzia [certolizumab pegol], Humira [adalimumab], infliximab)

AND

5 - Not used in combination with an immunosuppressant (e.g., 6-MP, azathioprine, cyclosporine, or methotrexate) [A, C]

AND

6 - Not used in combination with a TNF-inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab], or infliximab) [A, C]

AND

7 - Prescribed by or in consultation with a gastroenterologist

Notes	**In CD, discontinue Tysabri in patients that have not experienced therapeutic benefit by 12 weeks of induction therapy, and in patients that cannot discontinue chronic concomitant steroids within six months of starting therapy. [1]

Product Name: Tysabri	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following [1, 3, 7]:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Not used in combination with an immunosuppressant (e.g., 6-MP, azathioprine, cyclosporine, or methotrexate) [A, C]

AND

3 - Not used in combination with a TNF-inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab], or infliximab) [A, C]

3 . Endnotes

A. To minimize the risk of progressive multifocal leukoencephalopathy, natalizumab must be administered as a monotherapy without concomitant immunosuppressive therapy. Aminosalicylates may be continued during treatment with Tysabri. [1, 3]
B. Of the four disease courses of MS, relapse-remitting MS (RRMS) is characterized primarily by relapse, while secondary-progressive MS (SPMS) has both relapsing and progressive characteristics. Most patients with RRMS eventually develop

SPMS. As a person transitions from RRMS to SPMS, the disease begins to worsen more steadily, with or without occasional relapses, slight remissions, or plateaus. As long as the patient continues to have relapses, the SPMS course is considered to be both progressive and relapsing. [4]

C. In the postmarketing setting, additional cases of PML have been reported in multiple sclerosis and Crohn's disease patients who were receiving no concomitant immunomodulatory therapy. Three factors that are known to increase the risk of PML in TYSABRI-treated patients have been identified: 1) Longer treatment duration, especially beyond 2 years. There is limited experience in patients who have received more than 4 years of TYSABRI treatment. 2) Prior treatment with an immunosuppressant (e.g., mitoxantrone, azathioprine, methotrexate, cyclophosphamide, mycophenolate mofetil). 3) The presence of anti-JCV antibodies. Patients who are anti-JCV antibody positive have a higher risk for developing PML. [1]

4 . References

1. Tysabri Prescribing Information. Biogen Inc. Cambridge, MA. April 2023.
2. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline: Disease-modifying therapies for adults with multiple sclerosis. Neurology 2018;90:777-788.
3. Lichtenstein GR, Loftus EV, Isaacs KL, et al. Management of Crohn's disease in adults. Am J Gastroenterol. 2018;113:481-517.
4. National Multiple Sclerosis Society. Types of MS. Available at: https://www.nationalmssociety.org/What-is-MS/Types-of-MS. Accessed April 11, 2022.
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5 . Revision History

Date	Notes
4/26/2023	2023 UM Annual Review. No criteria changes. Updated referenc es

Ultomiris (ravulizumab-cwvz)

Prior Authorization Guideline

Guideline ID	GL-120947
Guideline Name	Ultomiris (ravulizumab-cwvz)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	2/14/2019
P&T Revision Date:	12/18/2019 ; 03/18/2020 ; 12/16/2020 ; 03/17/2021 ; 08/19/2021 ; 03/16/2022 ; 09/21/2022 ; 3/15/2023

1 . Indications

Drug Name: Ultomiris (ravulizumab-cwvz)
Paroxysmal Nocturnal Hemoglobinuria (PNH) Indicated for the treatment of patients one month of age and older with paroxysmal nocturnal hemoglobinuria (PNH). **Atypical Hemolytic Uremic Syndrome (aHUS)** Indicated for the treatment of adults and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA). **Generalized Myasthenia Gravis (gMG)** Indicated for the treatment of adult patients

with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) antibody-positive.

2 . Criteria

Product Name: Ultomiris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2 - Patient is one month of age and older

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name: Ultomiris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

Product Name: Ultomiris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of atypical hemolytic uremic syndrome (aHUS) [1]

AND

2 - Patient is one month of age and older

AND

3 - Prescribed by or in consultation with one of the following:

- Hematologist

- Nephrologist

Product Name: Ultomiris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

Product Name: Ultomiris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis (gMG)

AND

2 - Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

3 - One of the following: [2]

3.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

3.2 Both of the following:

3.2.1 Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

3.2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Ultomiris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

3 . References

1. Ultomiris Prescribing Information. Alexion Pharmaceuticals, Inc. Boston, MA. April 2022.
2. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis. Neurology. 2016;87(4):419-25.

4 . Revision History

Date	Notes
2/22/2023	2023 UM Annual Review. No changes

Uplizna (inebilizumab-cdon)

Prior Authorization Guideline

Guideline ID	GL-125365
Guideline Name	Uplizna (inebilizumab-cdon)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	8/13/2020
P&T Revision Date:	01/20/2021 ; 06/16/2021 ; 06/15/2022 ; 6/21/2023

1 . Indications

Drug Name: Uplizna (inebilizumab-cdon)
Neuromyelitis Optica Spectrum Disorder (NMOSD) Indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

2 . Criteria

Product Name: Uplizna	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Patient is anti-aquaporin-4 (AQP4) antibody positive

AND

3 - Prescribed by or in consultation with one of the following:

- Neurologist
- Ophthalmologist

AND

4 - One of the following:

4.1 Trial and failure, contraindication, or intolerance to rituximab

OR

4.2 For continuation of prior therapy

Product Name: Uplizna	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

3 . References

1. Uplizna Prescribing Information. Horizon Therapeutics USA, Inc. Deerfield, IL. July 2021.

4 . Revision History

Date	Notes
6/7/2023	Annual review: No updates required.

Veopoz (pozelimab)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Veopoz (pozelimab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Veopoz (pozelimab)
CD55-deficient protein-losing enteropathy (PLE) Indicated for the treatment of adult and pediatric patients 1 year of age and older with CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease.

2 . Criteria

Product Name: Veopoz	
Diagnosis	CD55-deficient protein-losing enteropathy (PLE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1- Diagnosis of active CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease

AND

2- Patient has a confirmed genotype of biallelic CD55 loss-of-function mutation

AND

3- Patient is 1 year of age or older

AND

4- Patient has hypoalbuminemia (serum albumin concentration of ≤3.2 g/dL)

AND

5- Patient has at least one of the following signs or symptoms within the last six months:

- abdominal pain
- diarrhea
- peripheral edema
- facial edema

AND

6 - Prescribed by or in consultation with one of the following:

- Immunologist
- Geneticist
- Hematologist

Product Name: Veopoz	
Diagnosis	CD55-deficient protein-losing enteropathy (PLE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g. decrease in albumin transfusions and hospitalizations, normalization of serum IgG concentrations, etc.)

3 . References

1. Veopoz Prescribing Information. Regeneron Pharmaceuticals, Inc. Tarrytown, NY. August 2023.

4 . Revision History

Date	Notes
9/29/2023	New Program for Veopoz

Viltepso (viltolarsen) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-113471
Guideline Name	Viltepso (viltolarsen) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	12/1/2022
P&T Approval Date:	10/21/2020
P&T Revision Date:	06/16/2021 ; 10/20/2021 ; 12/15/2021 ; 06/15/2022 ; 10/19/2022

1 . Indications

Drug Name: Viltepso (viltolarsen)
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with Viltepso. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

2 . Criteria

Product Name: Viltepso	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 4 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly

AND

5 - Documentation that the patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [2, 3]

Product Name: Viltepso	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Documentation that the patient is maintaining ambulatory status, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA)

Product Name: Viltepso	
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 4 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [2, 3]

3 . References

1. Viltepso Prescribing Information. NS Pharma, Inc. Paramus, NJ. March 2021.
2. ClinicalTrials.gov. Safety and Dose Finding Study of NS-065/NCNP-01 in Boys With Duchenne Muscular Dystrophy (DMD). NCT02740972. Website. Available at: https://clinicaltrials.gov/ct2/show/NCT02740972?term=NCT02740972&draw=2&rank=1. Accessed September 7, 2022.
3. Per Clinical Consultation with a Pediatrician, April 25, 2019 and January 22, 2020.

4 . Revision History

Date	Notes
10/5/2022	Annual review: Background updates.

Vimizim (elosulfase alfa)

Prior Authorization Guideline

Guideline ID	GL-109146
Guideline Name	Vimizim (elosulfase alfa)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	10/1/2022
P&T Approval Date:	6/24/2015
P&T Revision Date:	07/15/2020 ; 07/21/2021 ; 8/18/2022

1 . Indications

Drug Name: Vimizim (elosulfase alfa)
Mucopolysaccharidosis type IVA Indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome).

2 . Criteria

Product Name: Vimizim	
Approval Length	60 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome) confirmed by both of the following: [1-3]

1.1 Documented clinical signs and symptoms of the disease (e.g., kyphoscoliosis, genu valgum, pectus carinatum, gait disturbance, growth deficiency, etc.)

AND

1.2 Documented reduced fibroblast or leukocyte GALNS enzyme activity or molecular genetic testing of GALNS

3 . References

1. Vimizim prescribing information. BioMarin Pharmaceutical Inc. Novato, CA. December 2019.
2. UptoDate. Mucopolysaccharidoses: Clinical features and diagnosis. Available at https://www.uptodate.com/contents/mucopolysaccharidoses-clinical-features-and-diagnosis?search=Mucopolysaccharidoses:%20clinical%20features%20and%20diagnosis.%20&source=search_result&selectedTitle=1~66&usage_type=default&display_rank=1. Accessed July 6, 2022.
3. Mucopolysaccharidosis IV. Available at https://rarediseases.org/rare-diseases/morquio-syndrome/#:~:text=Excessive%20amounts%20of%20keratan%20sulfate,to%20identify%20GALNS%20gene%20mutations. Accessed July 6, 2022.

4 . Revision History

Date	Notes
8/18/2022	2022 Annual Review.

Vyepti (eptinezumab)

Prior Authorization Guideline

Guideline ID	GL-126057
Guideline Name	Vyepti (eptinezumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Vyepti	
Diagnosis	Migraine Prophylaxis
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of episodic migraines

AND

1.1.2 Patient has at least 4 migraines per month

OR

1.2 All of the following:

1.2.1 Diagnosis of chronic migraines

AND

1.2.2 Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days

AND

1.2.3 Patient has a trial and failure, or contraindication to Botox

AND

2 - Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Paid claims or submission of medical records (e.g., chart notes) confirming failure (after at least a two month trial) of at least 3 prophylactic agents from TWO of the following categories (three two month trials in total):

- Antidepressants: Elavil (amitriptyline), Effexor (venlafaxine)
- Anticonvulsants: Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)
- Beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

OR

3.2 Submission of medical records (e.g., chart notes) confirming patient has a contraindication to all of the following drugs:

- Antidepressants: Elavil (amitriptyline), Effexor (venlafaxine)
- Anticonvulsants: Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)
- Beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

AND

4 - Prescribed by or in consultation with a Neurologist

Product Name: Vyepti	
Diagnosis	Migraine Prophylaxis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming reduction in monthly headache days by at least 2 days compared to pre-CGRP treatment baseline

AND

2 - Submission of medical records (e.g., chart notes) confirming improvement in any one migraine related disability

AND

3 - Prescribed by or in consultation with a Neurologist

2 . Revision History

Date	Notes
6/8/2023	New program

Vyondys 53 (golodirsen) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-118142
Guideline Name	Vyondys 53 (golodirsen) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	5/16/2019
P&T Revision Date:	02/13/2020 ; 02/18/2021 ; 06/16/2021 ; 12/15/2021 ; 02/17/2022 ; 06/15/2022 ; 2/16/2023

1 . Indications

Drug Name: Vyondys 53 (golodirsen)
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with VYONDYS 53. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

2 . Criteria

Product Name: Vyondys 53	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Duchenne muscular dystrophy (DMD)

AND

2 - Documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping

AND

3 - Patient is 6 years of age or older [2, 3]

AND

4 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

5 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

6 - Patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [2, 3]

Product Name: Vyondys 53	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Patient is maintaining ambulatory status, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA)

Product Name: Vyondys 53	
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 6 years of age or older [2, 3]

AND

3 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient is ambulatory, as evaluated via the 6-minute walk test (6MWT) or North Star ambulatory assessment (NSAA) [2, 3]

3 . References

1. Vyondys 53 Prescribing Information. Sarepta Therapeutics, Inc. Cambridge, MA. February 2021.
2. Muntoni F, Frank DE, Morgan J, et al. Golodirsen induces exon skipping leading to sarcolemmal dystrophin expression in patients with genetic mutations amenable to exon 53 skipping [abstract]. Neuromuscul Disord. 2018;28:S5. Abstract D01.
3. Per Clinical Consultation with a Pediatrician, April 25, 2019 and January 22, 2020.

4 . Revision History

Date	Notes
2/2/2023	Annual review: No updates required.

Vyvgart (efgartigimod alfa-fcab)

Prior Authorization Guideline

Guideline ID	GL-118755
Guideline Name	Vyvgart (efgartigimod alfa-fcab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	2/17/2022
P&T Revision Date:	09/21/2022 ; 2/16/2023

1 . Indications

Drug Name: Vyvgart (efgartigimod alfa)
Generalized Myasthenia Gravis (gMG) Indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

2 . Criteria

Product Name: Vyvgart	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis (gMG)

AND

2 - Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

3.2 Both of the following:

3.2.1 Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

3.2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

4 - Prescribed by or in consultation with a neurologist

Product Name: Vyvgart	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

3 . References

1. Vyvgart Prescribing Information. Argenx US, Inc. Boston, MA. April 2022.

4 . Revision History

Date	Notes
1/25/2023	2023 UM Annual Review. No changes to criteria. Updated references

Xenpozyme (olipudase alfa)

Prior Authorization Guideline

Guideline ID	GL-114909
Guideline Name	Xenpozyme (olipudase alfa)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	12/1/2022
P&T Approval Date:	11/17/2022
P&T Revision Date:	

1 . Indications

Drug Name: Xenpozyme (olipudase alfa)
Acid Sphingomyelinase Deficiency (ASMD) Indicated for treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult and pediatric patients.

2 . Criteria

Product Name: Xenpozyme	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acid sphingomyelinase deficiency (ASMD)*

AND

2 - Disease confirmed by ONE of the following: [2]

2.1 Molecular genetic testing confirms biallelic pathogenic variants in the SMPD1 (sphingomyelin phophodiesterase-1) gene

OR

2.2 Residual acid sphingomyelinase activity that is less than 10% of controls (in peripheral blood lymphocytes or cultured skin fibroblasts)

AND

3 - Submission of medical records (e.g., chart notes) documenting patient has non-central nervous system manifestations of ASMD

AND

4 - Prescribed by or in consultation with ONE of the following:

• Metabolic disease specialist • Geneticist

Notes	*Acid Sphingomyelinase Deficiency is also known as Niemann-Pick Disease types A, A/B, and B [1]

Product Name: Xenpozyme	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., decrease in spleen size, decrease in liver size, increase in platelet count, improved lung function)

3 . References

1. Healthcare professional brochure. Available at www.xenpozyme.com/pdfs/v0.0.1/hcp/hcp-brochure.pdf. Accessed October 4, 2022.
2. Wasserstein, M., Schuchman, E., et al. Acid Sphingomyelinase Deficiency. Available at https://pubmed.ncbi.nlm.nih.gov/20301544/. Accessed October 4, 2022.
3. McGovern, M., Dionisi-Vici, C., et al. Consensus recommendation for a diagnostic guideline for acid sphingomyelinase deficiency. Available at https://pubmed.ncbi.nlm.nih.gov/28406489/. Accessed October 4, 2022.
4. Living with ASMD. Available at Proactive Symptom Management While Living with ASMD (asmdfacts.com). Accessed October 4, 2022.
5. Xenpozyme prescribing information. Cambridge, MA. Genzyme Corporation. August 2022.

4 . Revision History

Date	Notes
11/21/2022	New UM PA criteria

Xiaflex (collagenase clostridium histolyticum)

Prior Authorization Guideline

Guideline ID	GL-126070
Guideline Name	Xiaflex (collagenase clostridium histolyticum)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Xiaflex	
Diagnosis	Dupuytren’s Contracture
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of Dupuytren's Contracture

AND

2 - Patient is 18 years of age or older

AND

3 - Xiaflex dosing does not exceed 1 injection per cord with a maximum of 2 cords

Product Name: Xiaflex	
Diagnosis	Dupuytren's Contracture
Approval Length	1 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Dupuytren's Contracture

AND

2 - Patient is 18 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) confirming persistence of condition requiring additional therapy

AND

4 - If treating same cord, at least 4 weeks have passed between treatment sessions

AND

5 - Xiaflex dosing does not exceed 1 injection per cord

AND

6 - Patient has not exceeded 3 treatments per cord

Product Name: Xiaflex	
Diagnosis	Peyronie's disease
Approval Length	N/A - Requests should not be approved
Guideline Type	Prior Authorization

Approval Criteria

1 - Requests for Peyronie's disease are not authorized and will not be approved. The plan does not cover medications that are being used for a diagnosis that falls below the line on the OHA Prioritized List unless an above the line comorbid condition will be indirectly treated by the requested medication. This denial is based on Oregon Administrative Rule (OAR): 410-120-0000, 410-121-0000 (2), 410-121-0147(1)(a), 410-141-3820(1)(10), 410-141-3825(1)(c), 410-141-3830

2 . Revision History

Date	Notes
6/5/2023	New program

Xipere (triamcinolone acetonide injectable suspension)

Prior Authorization Guideline

Guideline ID	GL-119348
Guideline Name	Xipere (triamcinolone acetonide injectable suspension)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	1/19/2022
P&T Revision Date:	2/16/2023

1 . Indications

Drug Name: Xipere
Uveitis Indicated for the treatment of macular edema associated with uveitis.

2 . Criteria

Product Name: Xipere	
Diagnosis	Uveitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of macular edema due to uveitis is confirmed by ONE of the following tests: [2, 3]

- Slit lamp exam
- Fundoscopic exam
- Fluorescein angiography
- Optical coherence tomography (OCT)

AND

2 - Patient is free of ocular and peri-ocular infections [1]

AND

3 - Patient does not have untreated intraocular pressure or uncontrolled glaucoma [1]

AND

4 - Trial and failure, contraindication or intolerance to at least ONE other corticosteroid (e.g., methylprednisolone, Ozurdex, prednisolone, prednisone, triamcinolone) [3]

AND

5 - Patient has not received any of the following sustained-release intravitreal corticosteroids: [4, 5]

- Dexamethasone (e.g., Ozurdex) within the past 6 months
- Fluocinolone acetonide within the past 30 months (e.g., Retisert) or 36 months (e.g., Iluvien, Yutiq)

AND

6 - Prescribed by or in consultation with an ophthalmologist

Product Name: Xipere	
Diagnosis	Uveitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improvement in Best Corrected Visual Acuity, stable vision)

AND

2 - Prescribed by or in consultation with an ophthalmologist

3 . References

1. Xipere Prescribing Information. Clearside Biomedical, Inc. Alpharetta, GA. February 2022.
2. National Organization for Rare Disorders. Posterior Uveitis. Available at https://rarediseases.org/rare-diseases/posterior-uveitis/. Acessed December 19, 2021
3. Koronis, S., Stavrakas, P., et al. Update in Treatment of Uveitic Macular Edema. Available at https://www.dovepress.com/update-in-treatment-of-uveitic-macular-edema-peer-reviewed-fulltext-article-DDDT. Accessed December 19, 2021.
4. Haghjou, N., Soheilian, M., et al. Sustained Release Intracoular Drug Delivery Devices for Treatment of Uveitis. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3306122/. Accessed December 19, 2021.
5. Yutiq Prescribing Information. EyePoint Pharmaceuticals, Inc. Watertown, MA. October 2018.

4 . Revision History

Date	Notes
1/3/2023	2023 Annual Review.

Xolair (omalizumab)

Prior Authorization Guideline

Guideline ID	GL-126099
Guideline Name	Xolair (omalizumab)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Xolair	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of moderate to severe persistent asthma

AND

2 - Submission of medical records (e.g., chart notes) documenting smoking status

AND

3 - Patient has positive skin test or RAST to a perennial aeroallergen

AND

4 - Patient baseline IgE serum level is within FDA label

AND

5 - Submission of medical records (e.g., chart notes) documenting steps taken to avoid within reason environmental allergens and other triggers

AND

6 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure to all of the following:

- High dose inhaled corticosteroid with a long-acting beta agonist (e.g., Advair)
- Long acting anti-muscarinic (e.g., Spiriva)
- Leukotriene Inhibitor (e.g., Singulair)

AND

7 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure of, or contraindication to allergen immunotherapy

AND

8 - Paid claims or submission of medical records (e.g., chart notes) confirming history of compliance/adherence with prescribed asthma medications

AND

9 - Prescribed by or in consultation with a pulmonologist or immunologist

AND

10 - Patient is 6 years of age and older

Product Name: Xolair	
Diagnosis	Nasal Polyps
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming recurrent nasal polyps after prior sinus surgery

AND

2 - Trial and failure of at least 2 intranasal corticosteroids

AND

3 - Trial and failure of Sinuva nasal implant

AND

4 - Submission of medical records (e.g., chart notes) confirming adherence to a nasal corticosteroid with Xolair intended as adjunct therapy

AND

5 - Submission of medical records (e.g., chart notes) documenting risk of another sinus surgery, or a provider statement why sinus surgery is not medically appropriate

AND

6 - Prescribed by or in consultation with an allergist or ENT

AND

7 - Patient is 18 years of age and older

Product Name: Xolair	
Diagnosis	Severe Asthma, Nasal Polyps
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of clinically significant improvement in symptoms

Product Name: Xolair	
Diagnosis	Chronic Idiopathic Urticaria (CIU)
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming chronic spontaneous or idiopathic urticaria

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure for at least 6 weeks, including dose escalation, of both the following:

- 1st generation antihistamine (e.g., doxepin, hydroxyzine)
- 2nd generation antihistamine (e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine)

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure for at least 6 weeks of one H2 antihistamine (e.g., famotidine, cimetidine)

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial

and failure for at least 4 weeks, or contraindication, to one leukotriene inhibitor (e.g., montelukast, zafirlukast)

AND

5 - Prescribed by or in consultation with an immunologist

AND

6 - Patient is 12 years of age and older

Product Name: Xolair	
Diagnosis	Chronic Idiopathic Urticaria (CIU)
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of clinically significant improvement in symptoms

2 . Revision History

Date	Notes
6/8/2023	New program

Zoladex (goserelin)

Prior Authorization Guideline

Guideline ID	GL-126482
Guideline Name	Zoladex (goserelin)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name: Zoladex (goserelin)	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient is diagnosed with prostate cancer

AND

2 - Drug is being used for one of the following:

2.1 In combination with first generation antiandrogen therapy for management of stage T2b-T4 with radiation therapy with one of the following:

- Bicalutamide, or
- Flutamide, or
- Nilutamide

OR

2.2 Adjuvant therapy for lymph node positive disease found during pelvic lymph node dissection (PLND)

OR

2.3 Initial androgen deprivation therapy for one of the following risk groups:

- Intermediate risk group; or
- High or very high risk group; or
- Regional risk group; or
- Metastatic disease

OR

2.4 Palliative treatment of advanced/metastatic prostate cancer

OR

2.5 Recurrent disease in patients who experienced treatment failure after previous therapy

OR

2.6 Progressive castration-naïve disease

AND

3 - Prescribed by or in consultation with an oncologist or urologist

Product Name: Zoladex (goserelin)	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is diagnosed with breast cancer

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Patient is premenopausal

AND

2.1.2 Patient has hormone receptor (HR)-positive disease in combination with one of the following:

- Adjuvant endocrine therapy; or
- Endocrine therapy for recurrent or metastatic disease

OR

2.2 All of the following:

2.2.1 Patient has advanced breast cancer

AND

2.2.2 One of the following:

- Patient is premenopausal; or
- Patient is perimenopausal; or
- Patient is male with suppression of testicular steroidogenesis

AND

2.2.3 Treatment is palliative

AND

3 - Prescribed in consultation with an oncologist

Product Name: Zoladex (goserelin)	
Diagnosis	Prostate Cancer, Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
6/15/2023	New program

Zolgensma (onasemnogene abeparvovec-xioi) - PA, NF

Prior Authorization Guideline

Guideline ID	GL-126111
Guideline Name	Zolgensma (onasemnogene abeparvovec-xioi) - PA, NF
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	
P&T Revision Date:	06/17/2020 ; 11/12/2020 ; 04/21/2021 ; 06/16/2021 ; 06/15/2022 ; 12/14/2022 ; 6/21/2023

1 . Indications

Drug Name: Zolgensma (onasemnogene abeparvovec-xioi)
Spinal Muscular Atrophy (SMA) Indicated for the treatment of pediatric patients less than 2 years of age with spinal muscular atrophy (SMA) with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene. Limitation of Use: • The safety and effectiveness of repeat administration of ZOLGENSMA have not been evaluated. • The use of ZOLGENSMA in patients with advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence) has not been evaluated.

2 . Criteria

Product Name: Zolgensma	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - The mutation or deletion of genes in chromosome 5q resulting in one of the following: [1-8, A]

1.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

1.2 Compound heterozygous mutation of SMN1 gene (e.g., deletion of Survival of Motor Neuron 1 [SMN1] exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2 - One of the following:

2.1 Both of the following: [1-5]

2.1.1 Diagnosis of symptomatic spinal muscular atrophy (SMA) confirmed by a neurologist with expertise in the diagnosis and treatment of SMA [B]

AND

2.1.2 Patient is less than or equal to 2 years of age

OR

2.2 All of the following:

2.2.1 Diagnosis of SMA based on the results of SMA newborn screening

AND

2.2.2 Patient has 4 copies or less of Survival of Motor Neuron 2 (SMN 2)

AND

2.2.3 Patient is less than or equal to 6 months of age [2-5]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy [2-5, C]

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep [2-5, C]

AND

5 - Documentation of anti-AAV9 antibody titers being less than or equal to 1:50 [1]

AND

6 - Patient is not to receive concomitant chronic survivor motor neuron (SMN) modifying therapy for the treatment of SMA (e.g. Spinraza, Evrysdi) [2-5,D]

AND

7 - Prescribed by a neurologist with expertise in the diagnosis and treatment of SMA

AND

8 - Patient has never received Zolgensma treatment in their lifetime [1]

Product Name: Zolgensma	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting the mutation or deletion of genes in chromosome 5q resulting in one of the following: [1-8, A]

1.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

1.2 Compound heterozygous mutation of SMN1 gene (e.g., deletion of Survival of Motor Neuron 1 [SMN1] exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2 - One of the following:

2.1 Both of the following: [1-5]

2.1.1 Diagnosis of symptomatic spinal muscular atrophy (SMA) confirmed by a neurologist with expertise in the diagnosis and treatment of SMA [B]

AND

2.1.2 Patient is less than or equal to 2 years of age

OR

2.2 All of the following:

2.2.1 Diagnosis of SMA based on the results of SMA newborn screening

AND

2.2.2 Patient has 4 copies or less of Survival of Motor Neuron 2 (SMN 2)

AND

2.2.3 Patient is less than or equal to 6 months of age [2-5]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy [2-5, C]

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep [2-5, C]

AND

5 - Submission of medical records (e.g., chart notes) documenting anti-AAV9 antibody titers being less than or equal to 1:50 [1]

AND

6 - Patient is not to receive concomitant chronic survivor motor neuron (SMN) modifying therapy for the treatment of SMA (e.g. Spinraza, Evrysdi) [2-5,D]

AND

7 - Prescribed by a neurologist with expertise in the diagnosis and treatment of SMA

AND

8 - Patient has never received Zolgensma treatment in their lifetime [1]

3 . Endnotes

A. This is the definition that the clinical trials used. Also consistent with clinical guidelines. [2-8]
B. There were 3 key clinical trials for Zolgensma (START, STR1VE, SPR1NT). START and STR1VE only enrolled patients with SMA Type 1 and SPR1NT enrolled pre-symptomatic SMA patients. [2-5]
C. Exclusion criteria found in clinical trials. [2-5]
D. A recent European ad-hoc consensus statement on SMA stated that there currently is no published evidence that the combination of two disease modifying therapies (e.g., Spinraza and Zolgensma) is superior to any single treatment alone. RESPOND is a phase 4 trial that will assess the efficacy and safety of Spinraza in patients with suboptimal clinical response to Zolgensma. It is planned to begin enrollment in 2021. [9-10]

4 . References

1. Zolgensma Prescribing Information. AveXis Inc. Bannockburn, IL. October 2021.
2. Mendell J.R., Al-Zaidy S, Shell R, etc. Single-Dose Gene Replacement Therapy for Spinal Muscular Atrophy. New Eng J of Med. 2017; 377:1713-22.
3. Al-Zaidy S, Pickard AS, Kotha K, et al. Health outcomes in spinal muscular atrophy type 1 following AVXS-101 gene replacement therapy. Pediatr Pulmonol. 2019;54(2):179-185.
4. Day JW, Chiriboga CA, Crawford TO, et al. AVXS-101 gene-replacement therapy for spinal muscular atrophy type 1: phase 3 study (STR1VE) update. Poster presented at: The 71st Annual American Academy of Neurology Meeting, Philadelphia PA, May 4-10, 2019.
5. Strauss KA, Swoboda KJ, Farrar MA, et al. AVXS-101 gene-replacement therapy in presymptomatic spinal muscular atrophy: SPR1NT study update. Poster presented at the 71st Annual American Academy of Neurology Meeting; May 4-10; 2019; Philadelphia, PA.
6. Markowitz JA, Sing P, Darras BT. Spinal muscular atrophy: a clinical and research update. Pediatr Neurol. 2012;46(1):1-12.
7. Wang CH, Finkel RS, Bertini ES, et al. Consensus statement for standard of care in spinal muscular atrophy. J Child Neurol. 2007;22(8):1027-1049.
8. Mercuri E, Finkel RS, Muntoni F, et al. Diagnosis and management of spinal muscular atrophy: Part 1: Recommendations for diagnosis, rehabilitation, orthopedic and nutritional care. J Neuromuscul Dis. 2018;28(2):103-115.
9. Kirschner J, Butoianu N, Goemans N, et al. European ad-hoc consensus statement on gene replacement therapy for spinal muscular atrophy. Eur J Paediatr Neurol. 2020. https://doi.org/10.1016/j.ejpn.2020.07.001.
10. Biogen. Biogen plans to initiate phase 4 study evaluating benefit of Spinraza® (nusinersen) in patients treated with Zolgensma® (onasemnogene abeparvovec). https://investors.biogen.com/news-releases/news-release-details/biogen-plans-initiate-phase-4-study-evaluating-benefit-spinrazar. July 21, 2020. Accessed October 6, 2020.

5 . Revision History

Date	Notes
6/19/2023	Annual Review

Zulresso (brexanolone)

Prior Authorization Guideline

Guideline ID	GL-124083
Guideline Name	Zulresso (brexanolone)
Formulary	• IHN-CCO

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	5/16/2019
P&T Revision Date:	05/14/2020 ; 05/20/2021 ; 05/19/2022 ; 08/18/2022 ; 5/18/2023

1 . Indications

Drug Name: Zulresso (brexanolone)
Postpartum Depression (PPD) Indicated for the treatment of PPD in patients 15 years of age or older.

2 . Criteria

Product Name: Zulresso	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of postpartum depression (PPD)

AND

2 - Patient is 15 years of age or older

AND

3 - Onset of symptoms during the third trimester of pregnancy or within 4 weeks of delivery [1, 2]

AND

4 - Patient is 6 months postpartum or less [2]

AND

5 - Prescribed by or in consultation with a psychiatrist

3 . References

1. Zulresso Prescribing Information. Sage Therapeutics, Inc. Cambridge, MA. June 2022.

2. Psychopharmacologic Drugs Advisory Committee and Drug Safety and Risk Management Advisory Committee Meeting. FDA Briefing Document. November 2, 2018. Available at: https://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/PsychopharmacologicDrugsAdvisoryCommittee/UCM624643.pdf. Accessed March 31, 2023.

4 . Revision History

Date	Notes
5/4/2023	Annual review: Background updates.