Umpqua Health Alliance

Pharmacy Utilization Management Guidelines

Effective November 1, 2023

Contents

General Utilization Management Criteria

Policy Number: Rx001

I. MEDICATION NAME(S):

- Multiple

II. LENGTH OF AUTHORIZATION:

- Variable

III. QUANTITY LIMITS:

- Multiple (see formulary)

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services OR is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #4)
    b. No (go to #forward to pharmacist for review [deny 3a/3c])
4. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy? (Refer to Table 1 in 'Additional Information' for recommendation, evidence and efficacy ratings: the strength of recommendation must be class IIa or higher; the strength of evidence must be category B or higher; and the efficacy must be IIa or higher.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 12a if drug not FDA-approved, or 8a if indication not FDA-approved])
5. Is the drug prescribed at the appropriate FDA-approved dose to treat the covered condition?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the prescribed dose within UHA's quantity limits?

    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Does the member have any contraindications to therapy according to FDA-approved labeling?
    a. Yes (deny)
    b. No (go to #9)
9. If FDA-approved labeling or national clinical guidelines categorize this drug as a second line therapy, has there been trial and failure of or contraindication to the first-line therapies?
    a. Yes or N/A (go to #10)
    b. No (forward to pharmacist for review)
10. Has the member tried and failed all less costly alternative therapies that are similar or identical to the requested therapy (within the same drug class, therapeutic class, or used to treat the member's condition according to UpToDate)?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 7a, or deny 5k for formulary exception requests])
11. Has documentation been submitted to support medical necessity, including chart notes, a treatment plan, monitoring parameters, and laboratory values (if applicable)?
    a. Yes or N/A (go to #12)
    b. No (forward to pharmacist for review [deny 5a])
12. Has the member been adherent to first-line therapies used to treat this condition? (Adherent is defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes or N/A (go to #13)
    b. No (forward to pharmacist for review [deny 5u])
13. Is the drug requested primarily for the convenience of the member and not medically necessary?
    a. Yes (deny 5o)
    b. No (approve)

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (deny 8a)
    b. No (go to #2)
2. Has documentation been submitted to support the continued medical necessity and safety, including chart notes, a treatment plan, monitoring parameters, and laboratory values (if applicable)?
    a. Yes or N/A (go to #3)
    b. No (forward to pharmacist for review [deny 5a])

3. When appropriate, has the member been non-adherent to therapy and unlikely to benefit from additional therapy? (Non-adherent is defined as a MPR less than 80% or gaps between fills that exceed 5 days.)
    a. Yes (deny 5u)
    b. No or N/A (approve)

VI. ADDITIONAL INFORMATION:

- Table 1. Recommendation, Evidence and Efficacy Ratings

1. Strength Of Recommendation		
Class I	Recommended	The given test or treatment has been proven to be useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test, or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended, In Some Cases	The given test, or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test, or treatment is not useful, and should be avoided.
Class Indeterminate	Evidence Inconclusive	
2. Strength Of Evidence		
Category A	Category A evidence is based on data derived from: Meta-analyses of randomized controlled trials with homogeneity with regard to the directions and degrees of results between individual studies. Multiple, well-done randomized clinical trials involving large numbers of patients.	
Category B	Category B evidence is based on data derived from: Meta-analyses of randomized controlled trials with conflicting conclusions with regard to the directions and degrees of results between individual studies. Randomized controlled trials that involved small numbers of patients or had significant methodological flaws (e.g., bias, drop-out rate, flawed analysis, etc.). Nonrandomized studies (e.g., cohort studies, case-control studies, observational studies).	
Category C	Category C evidence is based on data derived from: Expert opinion or consensus, case reports or case series.	
No Evidence		
3. Efficacy		
Class I	Effective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective.
Class IIa	Evidence Favors Efficacy	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy.
Class IIb	Evidence is Inconclusive	Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion argues against efficacy.
Class III	Ineffective	Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is ineffective.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Stimulants

Policy Number: Rx002

I. MEDICATION NAME(S):

- dexmethylphenidate HCl
- dexmethylphenidate HCl ER
- dextroamphetamine sulfate ER
- dextroamphetamine sulfate
- Zenzedi (dextroamphetamine sulfate)
- dextroamphetamine-amphet ER
- dextroamphetamine-amphetamine
- Vyvanse (lisdexamfetamine dimesylate)
- methylphenidate LA
- methylphenidate HCl CD
- methylphenidate ER
- methylphenidate HCl
- methylphenidate HCl ER
- Metadate ER (methylphenidate HCl ER)

II. LENGTH OF AUTHORIZATION:

- Initial, members age 19 and older: six months
- Initial, members age 18 and younger: one year
- Renewal, members age 19 and older: six months
- Renewal, members age 18 and younger: one year

III. QUANTITY LIMITS:

- Multiple (see formulary)

IV. INITIAL CRITERIA:

1. Is the drug prescribed for a diagnosis of ADD/ADHD by a licensed mental health provider?
    a. Yes (go to #8)
    b. No (go to #2)
2. Is the drug prescribed for a diagnosis of ADD/ADHD by the member's primary care provider using a validated symptom checklist or in consultation with a licensed mental health provider or substance use disorder treatment provider? (See Additional Information section for validated symptom checklists.)
    a. Yes (go to #4)
    b. No (go to #3)
3. Does the member have an established diagnosis of narcolepsy from a neurologist or pulmonologist?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5z])

4. Is the member using any medications or substances that have the potential to cause sedation or lack of focus including opiates (with the exception of buprenorphine for SUD), benzodiazepines, marijuana, and alcohol?)
    a. Yes (forward to pharmacist for review [deny 5z])
    b. No (go to #5)
5. Is the member age 19 or older?
    a. Yes (go to #6)
    b. No (go to #7)
6. Has the requesting provider performed a urine drug screen and provided appropriate results at the initial visit when the stimulant was initially prescribed? (Appropriate results would include the absence of THC, opiates, benzodiazepines, cocaine.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5z])
7. Is the member age 5 and under with a documented trial of structured "parent-behavior training" OR is the member age 6 or older? (Note: For children age 5 and under diagnosed with disruptive behavior disorders, including those at risk for ADHD, first line therapy is evidenced-based, structured parent behavior training. Second line therapy is pharmacotherapy.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5a])
8. Is the medication being prescribed in a manner that is supported by the FDA approved indications and dosing recommendations?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 8a])
9. Does the member have any co-morbid conditions such as uncontrolled hypertension, cardiac arrhythmias, untreated or uncontrolled anxiety or agitation, or hyperthyroidism? (Note: uncontrolled anxiety or agitation is allowed when the medication is managed by a liscensed mental health provider.)
    a. Yes (forward to pharmacist for review)
    b. No (go to #10)
10. Has the member failed less costly alternative stimulants?
    a. Yes (for members age 19 and older: approve for six months; for members age 18 and younger: approve for one year)
    b. No (forward to pharmacist for review [deny 7a or 5k])

V. RENEWAL CRITERIA:

1. Is the drug prescribed by a licensed mental health provider?
    a. Yes (for members age 19 and older: approve for six months; for members age 18 and younger: approve for one year)
    b. No (go to #2)
2. Is the member currently using any medications or substances that have the potential to cause sedation or lack of focus including opiates (with the exception of buprenorphine for SUD), benzodiazepines, marijuana, and alcohol?
    a. Yes (forward to pharmacist for review [deny 5z])
    b. No (go to #3)
3. Is the member age 19 or older?

a. Yes (go to #4)
b. No (approve for one year)

4. Is the requesting provider performing random urine drug screens at least every six months and has the provider included documentation of an appropriate UDS within the last three months? (Appropriate results would include the absence of THC, opiates, benzodiazepines, cocaine, and presence of the prescribed stimulant if applicable.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5z])

VI. ADDITIONAL INFORMATION:

- Accepted validated symptom checklists, Adults: Adult ADHD Self-Report Scale (ASRS-v1.1); Copeland Symptom List for Adult Attention Deficit Disorder; Conners' Adult ADHD Rating Scale (CAARS)
- Accepted validated symptom checklists, Children: Conners 3rd Edition; Behavior Assessment System for Children (BASC); Child Behavior Checklist/Teacher Report Form; ADHD Comprehensive Teacher's Rating Scale (ACTeRS); ADHD Rating Scale; Childhood Attention Problem Scale; Vanderbilt Assessment Scales
- If the member has ever had a history of substance abuse, we recommend considering use of an alternative medication: TCA (desipramine, nortriptyline), Strattera, or bupropion if a TCA is not tolerated. However, this is not a requirement.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Opiate Agonists

Policy Number: Rx005

I. MEDICATION NAME(S):

- acetaminophen with codeine
- Capital W-Codeine (acetaminophen with codeine)
- butalbital/acetaminophen/caffeine/codeine
- codeine sulfate
- codeine/butalbital/aspirin/caffeine
- Ascomp With Codeine (codeine/butalbital/aspirin/caffeine)
- fentanyl
- fentanyl citrate
- Vicodin HP (hydrocodone/acetaminophen)
- hydrocodone/acetaminophen
- Co-Gesic (hydrocodone/acetaminophen)
- Lorcet (hydrocodone/acetaminophen)
- Lorcet Plus (hydrocodone/acetaminophen)
- Lorcet HD (hydrocodone/acetaminophen)
- Stagesic (hydrocodone/acetaminophen)
- Zydone (hydrocodone/acetaminophen)
- hydrocodone/ibuprofen
- hydromorphone HCl
- meperidine HCl
- methadone HCl
- morphine sulfate
- morphine sulfate ER
- oxycodone HCl
- oxycodone HCl ER
- Oxycontin (oxycodone HCl ER)
- oxycodone HCl/acetaminophen
- Roxicet (oxycodone HCl/acetaminophen)
- Endocet (oxycodone HCl/acetaminophen)
- oxycodone HCl/aspirin
- Endodan (oxycodone HCl/aspirin)
- oxymorphone HCl
- tramadol HCl
- Multiple Non-Formulary Opiates

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: six weeks up to 90 days for conditions of the spine and back, six months for cancer pain or palliative care, and three months for all other diagnoses

III. QUANTITY LIMITS:

- 90 mg morphine equivalents per day, 7 days per 60 days (short-acting opioids), 30 days per 180 days
- tramadol: 8 tablets per day
- oxycodone 5 mg/5 mL oral solution: 100 mL per year
- acetaminophen with codeine 120-12 mg/5 oral solution: 300 mL per year
- hydrocodone/acetaminophen 7.5-325/15 oral solution: 480 mL per year

- For treatment of acute pain for all opioid naïve members (except for cancer pain or palliative care): limit to 7 days per fill
    - Opioid naïve is defined as no opioid fills within the past 60 days
- Additional quantity limits for dose optimization will apply to all long-acting opioids, including but not limited to the following formulary agents:
    - fentanyl transdermal patches: 1 patch per 3 days
    - morphine ER capsules: 2 capsules per day
    - morphine ER tablets: 3 tablets per day
    - oxycodone ER, Oxycontin: 2 tablets per day

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 3a])
4. Does Prioritized List of Health Services Guideline Note 60 apply (opioid prescribing for conditions of the back and spine)?
    a. Yes (go to #5)
    b. No (go to #6)
5. Does the request meet Guideline Note #60, Opioid for Conditions of the Back and Spine? For acute use, the following provisions must be met: for immediate-release opiates, trial and failure of non-opiates such as NSAIDs, APAP, muscle relaxants; use of other interventions such as physical therapy; no current or history of opiate abuse and documented verification that the patient is not high risk for opioid misuse or abuse. For acute use greater than 6 weeks and less than 90 days post injury or flare, there must be documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tool (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ). Chronic use (greater than 90 days) requires an individual treatment plan with a taper plan or documentation that it is unsafe to initiate taper at this time.
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny GLN 60])
6. Is the drug prescribed for migraine headache?
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (go to #7)
7. Has the member failed less costly alternative opioids? (For example, morphine ER must be tried and failed before fentanyl or oxycodone ER.)
    a. Yes (go to #8)

    b. No (forward to pharmacist for review [deny 7a])
8. Is the drug prescribed for cancer pain, or is the patient receiving hospice or end-or-life care?
    a. Yes (approve for six months)
    b. No (go to #9)
9. Does the patient have a history of diversion, history of opioid abuse, active substance abuse as defined as any illicit or non-prescribed substance (including alcohol and marijuana) within the past year?
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (go to #10)
10. Is there a pain contract in place limiting the patient to one provider and one pharmacy?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 5g])
11. Has the prescriber submitted a written treatment plan stating goals used to determine treatment successes such as pain relief and improved physical and psychosocial function?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review [deny 5g])
12. Has the member had a mental health screening within the last year?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 5g])
13. Has the requesting provider performed a urine drug screen and provided appropriate results and is the member free from any duplicative or contraindicated medications? (Appropriate results would include the absence of THC, cocaine, benzodiazepines, other opioids, and any non-prescribed substances. Concurrent opioid and benzodiazepine use will not be approved due to risk of respiratory depression. Duplicative opioids are not covered unless clinically appropriate.)
    a. Yes (go to #14)
    b. No (forward to pharmacist for review [deny 5g])
14. Has the provider reviewed the Oregon Prescription Monitoring Program registry and documented appropriate results?
    a. Yes (go to #15)
    b. No (forward to pharmacist for review [deny 5g])
15. Is the member taking greater than 90 MED per day?
    a. Yes (forward to pharmacist for review [deny for QL over 90 MED])
    b. No (approve for six weeks for back pain and three months for all other conditions)

V. RENEWAL CRITERIA:

1. Is the drug prescribed for cancer pain, or is the patient receiving hospice or end-or-life care?
    a. Yes (approve for six months)
    b. No (go to #2)
2. Does Prioritized List of Health Services Guideline Note 60 apply (opioid prescribing for conditions of the back and spine)?
    a. Yes (go to #3)

b. No (go to #4)

3. Does the request meet Guideline Note #60, Opioid for Conditions of the Back and Spine? For acute use, the following provisions must be met: for immediate-release opiates, trial and failure of non-opiates such as NSAIDs, APAP, muscle relaxants; use of other interventions such as physical therapy; no current or history of opiate abuse and documented verification that the patient is not high risk for opioid misuse or abuse. For acute use greater than 6 weeks and less than 90 days post injury or flare, there must be documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tool (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ). Chronic use (greater than 90 days) requires an individual treatment plan with a taper plan or documentation that it is unsafe to initiate taper at this time.
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny GLN 60])
4. Is the request for acute use (treatment less than 90 days), OR is the request for chronic use and the requesting provider has submitted documentation of reduction in pain and a taper plan or rational explaining why a taper plan is not medically indicated?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5g])
5. Has the requesting provider performed a urine drug screen within the last six months and provided appropriate results? (Appropriate results would include the absence of THC, cocaine, benzodiazepines, and any non-prescribed substances.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5g])
6. Has the provider reviewed the Oregon Prescription Monitoring Program registry regularly, at least once since the last approval, and documented appropriate results?
    a. Yes (approve for six weeks for back pain and three months for all other conditions)
    b. No (forward to pharmacist for review [deny 5g])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists (i.e. Incretin Mimetics)

Policy Number: Rx007

I. MEDICATION NAME(S):

- Byetta (exenatide) *preferred*
- Bydureon (exenatide microspheres) *preferred*
- Rybelsus (semaglutide) *preferred*
- Trulicity (dulaglutide) *preferred*
- Victoza (liraglutide)
- Ozempic (semaglutide)
- Mounjaro (tirzepatide)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for glycemic control in a member diagnosed with Type 2 diabetes mellitus? (Refer to Table 1. Criteria for Diagnosis of Diabetes)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had an adequate trial and failure of, contraindication to, or intolerance to metformin dosed at 2,000mg per day? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days. (See Additional Information section for metformin initiation guidance.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Does the member have established atherosclerotic cardiovascular disease (ASCVD) defined as ischemic heart disease, ischemic cerebrovascular disease, or peripheral artery disease? (Note: examples include MI, stroke, revascularization prodecure, transiant ischemic attack, unstable angina, amputation, coronary artery disease.)
    a. Yes (go to #8)
    b. No (go to #4)
4. Does the member have a high risk for ASCVD defined as age 55 years or older AND two or more traditional risk factors including obesity, hypertension, dyslipidemia (LDL > 130 mg/dL or taking lipid-lowering therapies), albuminuria, or tobacco use?
    a. Yes (go to #8)

b. No (go to #5)

5. Is the member above their individual glycemic target despite an adequate trial and failure of, contraindication to, or intolerance to a drug in at least one of the following drug classes: (a) sulfonylurea (e.g. glipizide), (b) TZD (e.g. pioglitazone), (c) dipeptidyl peptidase-4 (DPP-4) inhibitor (e.g. alogliptin)? (Contraindication may include risk of hypoglycemia with appropriate documentation.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the member's most recent A1c (within the last six months) equal to or greater than 9%?
    a. Yes (go to #7)
    b. No (go to #8)
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to insulin, OR has the the provider submitted an acceptable, medical rationale for why insulin cannot be used?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the maximum tolerated dose of an SGLT2 inhibitor such as Steglatro (ertugliflozin), Invokana (canagliflozin), Farxiga (dapagliflozin propanediol), or Jardiance (empagliflozin)? (Adequate trial is defined as adherent to therapy for at least three to six consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Is the member actively participating in a lifestyle or nutrition support program? (note: UHA requires attestation of partipation in a program such as Diabetes Self Management, Food Smart, or a similar clinic based program.)
    a. Yes (go to #10)
    b. No (forward to pharmacist for review and medication therapy management/CM)
10. Is the requested medication on formulary?
    a. Yes (approve for six months)
    b. No (go to #11)
11. Has the member tried and failed all the formulary alternative medications?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member actively participating in a lifestyle or nutrition support program? DPP, DSM, FoodSmart, or similar clinic based program?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)

3. Has the member had a positive clinical response to therapy (such as at least a 10% reduction in A1c or A1c is at goal), OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria? (A1c value must be recently measured within the last six months.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- **Criteria for diagnosis of diabetes**

One of the following per ADA 2023 Guidelines

• FPG > or equal 126 mg/dL (7.0 mmol/L). Fasting defined as no caloric intake for at least 8 h.*
• 2-h PG ≥200 mg/dL (11.1 mmol/L) during OGTT. The test should be performed as described by WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*
• A1C ≥6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.*
• In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (11.1 mmol/L).

*DCCT, Diabetes Control and Complications Trial; FPG, fasting plasma glucose; OGTT, oral glucose tolerance test; NGSP, National Glycohemoglobin Standardization Program; WHO, World Health Organization; 2-h PG, 2-h plasma glucose. *In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples*

- **Metformin Titration**

Initiating Metformin

1. Begin with low-dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mg once per day.
2. After 5-7 days, if gastrointestinal side effects have not occurred, advance dose to 850 mg, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner).
3. If gastrointestinal side effects appear with increasing doses, decrease to previous lower dose and try to advance the dose at a later time.
4. The maximum effective dose can be up to 1,000 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.

Nathan, et al. Medical management of hyperglycemia in Type 2 Diabetes: a consensus algorithm for the initiation and adjustment of therapy. *Diabetes Care*. 2008; 31;1-11.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 3/15/2023

Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors

Policy Number: Rx008

I. MEDICATION NAME(S):

- Invokana (canagliflozin)
- Farxiga (dapagliflozin propanediol)
- Jardiance (empagliflozin)

Inpefa (sotogliflizon)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for glycemic control in a member diagnosed with Type 2 diabetes mellitus? (Refer to Table 1. Criteria for Diagnosis of Diabetes.)
    a. Yes (go to #2)
    b. No (go to #7)
2. Has the member had an adequate trial and failure of, contraindication to, or intolerance to metformin dosed at 2,000mg per day? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days. (See Additional Information section for metformin initiation guidance.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Does the member have any of the following: (1) established atherosclerotic cardiovascular disease (ASCVD) defined as ischemic heart disease, ischemic cerebrovascular disease, or peripheral artery disease; (2) heart failure with a LVEF <45%; (3) chronic kidney disease (CKD) with an eGFR 30-60 mL/min? (Note: examples of ASCVD include MI, stroke, revascularization prodecure, transiant ischemic attack, unstable angina, amputation, coronary artery disease.)
    a. Yes (approve for six months)
    b. No (go to #4)
4. Does the member have a high risk for ASCVD defined as age 55 years or older AND two or more traditional risk factors including obesity, hypertension, dyslipidemia (LDL > 130 mg/dL or taking lipid-lowering therapies), albuminuria, or tobacco use?
    a. Yes (approve for six months)
    b. No (go to #5)

5. Has the member had an adequate trial and failure of or contraindication to a dipeptidyl peptidase-4 (DPP-4) inhibitor? (Note: Alogliptin is available without a prior authorization.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Steglatro (ertugliflozin)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)
7. Is the requested medication Farxiga (dapaglifozin),Jardiance (empagliflozin) or Inpefa (sotagliflozin)as secondary therapy for a diagnosis of heart failure and within New York Heart Association class II-IV or initiated at hospital discharge? (Note: Patient should continue all initial therapy including a diuretic; an ACE/ARB or ARNI; and a beta-blocker.)
    a. Yes (go to #8)
    b. No (go to #9)
8. Is the drug prescribed by or in consultation with a cardiologist or cardiac care specialist?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)
9. Is the requested medication Farxiga (dapagliflozin) used as a secondary agent for a diagnosis of chronic kidney disease with persistently elevated urinary albumin excretion? (note: Studies showing renal benefit were conducted in patients with severely increased albuminuria [eg, urinary albumin excretion >300 mg/day].)
    a. Yes (go to #10)
    b. No (forward to pharmacist for review)
10. Is the drug prescribed by or in consultation with a nephrologist or kidney care specialist?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had a positive clinical response to therapy (such as at least a 10% reduction in A1c or A1c is at goal), OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria? (A1c value must be recently measured within the last six months.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- **Criteria for diagnosis of diabetes**

One of the following per ADA 2023 Guidelines

• FPG > or equal 126 mg/dL (7.0 mmol/L). Fasting defined as no caloric intake for at least 8 h.*

• 2-h PG ≥200 mg/dL (11.1 mmol/L) during OGTT. The test should be performed as described by WHO, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.*
• A1C ≥6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay. *
• In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dL (11.1 mmol/L).

*DCCT, Diabetes Control and Complications Trial; FPG, fasting plasma glucose; OGTT, oral glucose tolerance test; NGSP, National Glycohemoglobin Standardization Program; WHO, World Health Organization; 2-h PG, 2-h plasma glucose. *In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples*

- **Metformin Titration**

Initiating Metformin

1. Begin with low-dose metformin (500 mg) taken once or twice per day with meals (breakfast and/or dinner) or 850 mg once per day.
2. After 5-7 days, if gastrointestinal side effects have not occurred, advance dose to 850 mg, or two 500 mg tablets, twice per day (medication to be taken before breakfast and/or dinner).
3. If gastrointestinal side effects appear with increasing doses, decrease to previous lower dose and try to advance the dose at a later time.
4. The maximum effective dose can be up to 1,000 mg twice per day. Modestly greater effectiveness has been observed with doses up to about 2,500 mg/day. Gastrointestinal side effects may limit the dose that can be used.

Nathan, et al. Medical management of hyperglycemia in Type 2 Diabetes: a consensus algorithm for the initiation and adjustment of therapy. *Diabetes Care*. 2008; 31;1-11.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 9/20/2023

Insulins

Policy Number: Rx009

I. MEDICATION NAME(S):

- Novolog (insulin aspart) cartridge
- Novolog Flexpen (insulin aspart) pen
- Novolog Mix 70-30 Flexpen (insulin aspart protamine/insulin aspart) pen
- Levemir (insulin detemir) vial
- Levemir Flextouch (insulin detemir) pen
- Basaglar (insulin glargine) *non-formulary*
- Toujeo Solostar (insulin glargine) pen
- Admelog Solostar (insulin lispro) pen
- Humalog (insulin lispro) cartridge
- Humalog Mix 50-50 Kwikpen (insulin lispro protamine/lispro) pen
- Humalog Mix 75-25 Kwikpen (insulin lispro protamine/lispro) pen
- Humulin 70-30 Kwikpen (insulin NPH/insulin regular) pen
- Novolin 70-30 Flexpen (insulin NPH/insulin regular) pen
- Humulin N Kwikpen (insulin NPH) pen
- Humulin R U-500 (insulin regular) pen
- Humulin R U-500 Kwikpen (insulin regular) pen

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for diabetes mellitus (type 1 or 2)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the request for Basaglar, Levemir, or Toujeo?
    a. Yes (go to #3)
    b. No (go to #7)
3. Has the member had an adequate trial and failure of or contraindication to both of UHA's preferred long-acting insulin, insulin glargine-YFGN (generic Semglee-YFGN) and insulin glargine (generic Lantus)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 7a])
4. Is the request for Toujeo?
    a. Yes (go to #5)
    b. No (approve for LOB)

5. Does the member require greater than 80 units per day, but less than or equal to 200 units per day of basal insulin? (Toujeo was not studied in patients with insulin resistance (total daily insulin dose >200 units/day) and is not intended to be a replacement for those requiring U-500 insulin.)
    a. Yes (approve for LOB)
    b. No (go to #6)
6. Does the member have nocturnal hypoglycemia after other inventions have been made to address hypoglycemia?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 5a])
7. Is the request for Admelog, Novolog or Humalog?
    a. Yes (go to #8)
    b. No (go to #9)
8. Has the member had an adequate trial and failure of or contraindication to UHA's preferred rapid-acting insulins, insulin lispro or insulin aspart? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 7a])
9. Is the request for Humulin R U-500?
    a. Yes (go to #10)
    b. No (go to #11)
10. Does the member have insulin resistance requiring greater than 200 units per day?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 5a]))
11. Is the request for an insulin pen or cartridge?
    a. Yes (go to #12)
    b. No (approve for LOB)
12. Does the member meet ANY of the following criteria: (1) Age 18 years or younger (approve until age 19); (2) Member demonstrates an inability to draw insulin from a multidose vial into a syringe documented by provider; (3) Use short-acting insulin in intensive multi-dose therapy (i.e. greater than 4 times a day injections); OR (4) Member has uncontrolled diabetes due to poor compliance evident by claims history?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- For members already started and stabilized on a non-preferred insulin, UHA will allow a transition fill to allow time to switch to the preferred insulin.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Topical Antifungals

Policy Number: Rx010

I. MEDICATION NAME(S):

- ciclopirox
- ketoconazole
- naftifine HCl
- Lamisil (terbinafine HCl)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Fungal infections of the skin, scalp, groin and nails are not funded for most members. Some conditions are covered if the member is immunocompromised, like those with AIDS or cancer.)
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed? For example, type 2 diabetes or other conditions that may increase the risk of serious secondary skin infections.
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a/3c])

6. Has the member tried and failed clotrimazole 1% cream; nystatin cream, ointment, or powder; miconazole 2% cream; and terbinafine 1% cream (on formulary without PA) or are these medications not appropriate to treat the member's condition?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Is the requested medication on formulary?
    a. Yes (approve for six months)
    b. No (go to #8)
8. Has the member tried and failed all less-costly formulary alternative medications?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Clonazepam

Policy Number: Rx013

I. MEDICATION NAME(S):

- clonazepam

II. LENGTH OF AUTHORIZATION:

- Initial: one to six months (one year for seizures, oncology, or palliative care)
- Renewal: up to six months (one year for seizures, oncology, or palliative care)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm or other end-of-life diagnosis?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the drug used for a member with a diagnosed seizure disorder?
    a. Yes (approve for length of benefit)
    b. No (go to #3)
3. Is the drug used for anxiety or panic disorder?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Has the member had an adequate trial and failure of or contraindication to first-line treatment options including antidepressants AND psychotherapy (e.g. behavioral therapy, relaxation response training, mindfulness meditation training, eye movement desensitization and reprocessing)? Note: An adequate trial to determine efficacy of an SSRI or SNRI is 4-6 weeks.
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Is the member taking a concurrent sedative, hypnotic or opioid?
    a. Yes (forward to pharmacist for review)
    b. No (go to #6)
6. Has the provider reviewed the Oregon Prescription Monitoring Program registry within the last three months and documented appropriate results?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Is this a new start request for short-term use (less than 4 weeks)?
    a. Yes (approve for one month)

b. No (go to #8)

8. Is there appropriate rationale to support long-term benzodiazepine use for this indication?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm or other end-of-life diagnosis?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the drug used for a member with a diagnosed seizure disorder?
    a. Yes (approve for length of benefit)
    b. No (go to #3)
3. Is the member taking a concurrent sedative, hypnotic or opioid?
    a. Yes (forward to pharmacist for review)
    b. No (go to #4)
4. Has the provider reviewed the Oregon Prescription Monitoring Program registry within the last three months and documented appropriate results?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Is there appropriate rationale to support long-term benzodiazepine use for this indication? (Exceptions may be made to allow time to taper off of medication.)
    a. Yes (approve for up to six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 9/20/2023

Topical Corticosteroids

Policy Number: Rx015

I. MEDICATION NAME(S):

- amcinonide
- betamethasone dipropionate
- clobetasol propionate
- clobetasol emollient
- clobetasol emulsion
- clocortolone pivalate
- Apexicon E (diflorasone diacetate/emoll)
- fluocinolone acetonide
- fluocinonide
- Scalacort DK (hydrocort/sal acid/sulf/shamp1)
- hydrocortisone (Ala-Cort, Ala-Scalp, Anti-Itch, Cortaid, Cortisone, Cortizone-10, Cortizone-10 Plus, Eczema Anti-Itch, Hydrocream, Noble Formula HC, Preparation H, Procto-Pak, Scalp Relief, Scalpicin, Soothing Care)
- Texacort (hydrocortisone)
- Nucort (hydrocortisone acet/aloe vera)
- hydrocortisone acetate
- hydrocortisone butyrate
- Pandel (hydrocortisone probutate)
- hydrocortisone/aloe vera (Cortizone-10, Hydrocortisone Plus, Hydrocortisone-Aloe, Hydroskin)
- mometasone furoate
- triamcinolone acetonide (Trianex, Triderm)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- Multiple (see formulary)

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)

b. No (forward to pharmacist for review [deny 5a])

4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Mild to moderate inflammatory skin conditions are not funded. Refer to Guideline Note 21 for coverage of severe inflammatory skin disease: functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% of body surface area involved; OR (2) hand, foot, face, or mucous membrane involvement.)
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a/3c and/or 5a GLN21 for mild/moderate skin conditions])
6. Has the member tried and failed triamcinolone 0.1% cream or ointment (on formulary without PA) or is this medication not appropriate to treat the member's condition?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member tried and failed all less-costly formulary alternative medications?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a or 5k])

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Neoplastic Disease

Policy Number: Rx018

I. MEDICATION NAME(S):

- abiraterone acetate
- Hexalen (altretamine)
- azacitidine
- Treanda (bendamustine HCl)
- bexarotene
- Myleran (busulfan)
- Jevtana (cabazitaxel)
- capecitabine
- Erbitux (cetuximab)
- Leukeran (chlorambucil)
- cyclophosphamide
- dactinomycin
- Sprycel (dasatinib)
- Docefrez (docetaxel)
- docetaxel
- Tarceva (erlotinib HCl)
- Emcyt (estramustine phosphate sodium)
- Afinitor (everolimus)
- Iressa (gefitinib)
- gemcitabine HCl
- imatinib mesylate
- Camptosar (irinotecan HCl)
- Tykerb (lapatinib ditosylate)
- Revlimid (lenalidomide)
- Gleostine (lomustine)
- lomustine
- Lysodren (mitotane)
- Tasigna (nilotinib HCl)
- nilutamide
- oxaliplatin
- Votrient (pazopanib HCl)
- Sylatron (peginterferon alfa-2b)
- Sylatron 4-Pack (peginterferon alfa-2b)
- Folotyn (pralatrexate)
- Matulane (procarbazine HCl)
- romidepsin
- Nexavar (sorafenib tosylate)
- Sutent (sunitinib malate)
- temozolomide
- Tabloid (thioguanine)
- Hycamtin (topotecan HCl)
- topotecan HCl
- toremifene citrate
- tretinoin
- Caprelsa (vandetanib)
- Zolinza (vorinostat)
- Multiple non-formulary antineoplastics (must first try and fail formulary alternatives if applicable)

II. LENGTH OF AUTHORIZATION:

- Variable

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication, OR a medically appropriate off-label use with strong evidence supporting safety and efficacy, AND listed as a preferred intervention by NCCN with quality and consistency of evidence of at least 3, OR listed as an alternative options with additional compelling information provided? NOTE: Includes all information required in the FDA approval or NCCN recommendation, including but not limited to diagnosis, stage of cancer, biomarkers, place in therapy, and use as monotherapy or combination therapy. (Refer to Table 1 in 'Additional Information' for NCCN quality of evidence and consistency of evidence ratings.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a/3c])
6. If applicable, does the request meet criteria for treatment coverage specified in Guideline Note 12 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services, considering treatment of cancer with little or no benefit (see 'Additional Information' section for Guideline Note 12)?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a GLN12])
7. Is the medication prescribed by or in consultation with a hematologist or oncologist, as appropriate, for the type of cancer?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Does the member have a Karnofsky Performance Status 50% or less or ECOG performance score 3 or greater?
    a. Yes (forward to pharmacist for review)
    b. No (go to #9)
9. According to NCCN guidelines, are there alternative less-costly therapies recommended at the same or better evidence level?
    a. No (approve for three months or other appropriate duration based on indication, treatment regimen, and monitoring requirements)
    b. Yes (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. According to FDA labeling and NCCN guidelines, is treatment still indicated?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has there been evidence of disease responsiveness to therapy?
    a. Yes (approve for appropriate duration up to one year)
    b. No (forward to pharmacist for review [deny 5a])

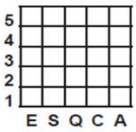
VI. ADDITIONAL INFORMATION:

- Prioritized List of Health Services Guideline Note 12, Patient-Centered Care of Advanced Cancer:
    - Cancer is a complex group of diseases with treatments that vary depending on the specific subtype of cancer and the patient's unique medical and social situation. Goals of appropriate cancer therapy can vary from intent to cure, disease burden reduction, disease stabilization and control of symptoms. Cancer care must always take place in the context of the patient's support systems, overall heath, and core values. Patients should have access to appropriate peer-reviewed clinical trials of cancer therapies. A comprehensive multidisciplinary approach to treatment should be offered including palliative care services (see STATEMENT OF INTENT 1, PALLIATIVE CARE).
    - Treatment with intent to prolong survival is not a covered service for patients who have progressive metastatic cancer with:
        - Severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR
        - A continued decline in spite of best available therapy with a non reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.
    - Treatments with intent to relieve symptoms or improve quality of life are covered as defined in STATEMENT OF INTENT 1, PALLIATIVE CARE. Examples:
        - Single-dose radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
        - Surgical decompression for malignant bowel obstruction. Single fraction radiotherapy should be given strong consideration for use over multiple fraction radiotherapy when clinically appropriate (e.g., not contraindicated by risk of imminent pathologic fracture, worsening neurologic compromise or radioresistant histologies such as sarcoma, melanoma, and renal cell carcinoma).
        - Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
    - To qualify for treatment coverage, the cancer patient must have a documented discussion about treatment goals, treatment prognosis and the side effects, and knowledge of the realistic expectations of treatment efficacy. This discussion

may take place with the patient's oncologist, primary care provider, or other health care provider, but preferably in a collaborative interdisciplinary care coordination discussion. Treatment must be provided via evidence-driven pathways (such as NCCN, ASCO, ASH, ASBMT, or NIH Guidelines) when available.

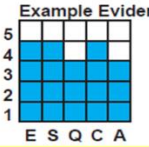
- Table 1. NCCN Evidence Blocks Categories and Definitions

NCCN EVIDENCE BLOCKS CATEGORIES AND DEFINITIONS



E = Efficacy of Regimen/Agent
S = Safety of Regimen/Agent
Q = Quality of Evidence
C = Consistency of Evidence
A = Affordability of Regimen/Agent

Example Evidence Block



E = 4
S = 4
Q = 3
C = 4
A = 3

Efficacy of Regimen/Agent

5	**Highly effective:** Cure likely and often provides long-term survival advantage
4	**Very effective:** Cure unlikely but sometimes provides long-term survival advantage
3	**Moderately effective:** Modest impact on survival, but often provides control of disease
2	**Minimally effective:** No, or unknown impact on survival, but sometimes provides control of disease
1	**Palliative:** Provides symptomatic benefit only

Safety of Regimen/Agent

5	**Usually no meaningful toxicity:** Uncommon or minimal toxicities; no interference with activities of daily living (ADLs)
4	**Occasionally toxic:** Rare significant toxicities or low-grade toxicities only; little interference with ADLs
3	**Mildly toxic:** Mild toxicity that interferes with ADLs
2	**Moderately toxic:** Significant toxicities often occur but life threatening/fatal toxicity is uncommon; interference with ADLs is frequent
1	**Highly toxic:** Significant toxicities or life threatening/fatal toxicity occurs often; interference with ADLs is usual and severe

Note: For significant chronic or long-term toxicities, score decreased by 1

Quality of Evidence

5	**High quality:** Multiple well-designed randomized trials and/or meta-analyses
4	**Good quality:** One or more well-designed randomized trials
3	**Average quality:** Low quality randomized trial(s) or well-designed non-randomized trial(s)
2	**Low quality:** Case reports or extensive clinical experience
1	**Poor quality:** Little or no evidence

Consistency of Evidence

5	**Highly consistent:** Multiple trials with similar outcomes
4	**Mainly consistent:** Multiple trials with some variability in outcome
3	**May be consistent:** Few trials or only trials with few patients, whether randomized or not, with some variability in outcome
2	**Inconsistent:** Meaningful differences in direction of outcome between quality trials
1	**Anecdotal evidence only:** Evidence in humans based upon anecdotal experience

Affordability of Regimen/Agent (includes drug cost, supportive care, infusions, toxicity monitoring, management of toxicity)

5	**Very inexpensive**
4	**Inexpensive**
3	**Moderately expensive**
2	**Expensive**
1	**Very expensive**

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Hepatitis C Direct Acting Antivirals

Policy Number: Rx019

I. MEDICATION NAME(S):

- Daklinza (daclatasvir dihydrochloride)
- Zepatier (elbasvir/grazoprevir)
- Mavyret (glecaprevir/pibrentasvir)*
- Harvoni (ledipasvir/sofosbuvir)
- ledipasvir/sofosbuvir
- Viekira Pak (ombita/paritap/riton/dasabuvir)
- Sovaldi (sofosbuvir)
- Vosevi (sofosbuvir/velpatas/voxilaprev)
- Epclusa (sofosbuvir/velpatasvir)*
- sofosbuvir/velpatasvir*

**preferred agents according to the Oregon Health Authority (OHA) fee-for-service (FFS) preferred drug list (PDL)*

II. LENGTH OF AUTHORIZATION:

- 8-24 weeks (internal note: extend the PA end date for 4 weeks to allow for a delayed start)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. See FFS Approval Criteria: https://www.orpdl.org/durm/PA_Docs/HCV_directactingantivirals.pdf

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- UHA aligns with the OHA FFS PDL and prior authorization criteria.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

HIV Antiretrovirals

Policy Number: Rx020

I. MEDICATION NAME(S):

- All HIV antiretrovirals

II. LENGTH OF AUTHORIZATION:

- Variable (see criteria)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for the treatment of HIV infection?
    a. Yes (go to #6)
    b. No (go to #2)
2. Is the drug prescribed for post-exposure prophylaxis (PEP) for HIV-uninfected individuals who have experienced a high-risk exposure to HIV within the past 72 hours (e.g. condomless receptive or insertive anal or vaginal intercourse, or percutaneous exposure to blood)?
    a. Yes (approve for 28 days)
    b. No (go to #3)
3. Is the request prescribed for pre-exposure prophylaxis (PrEP) in combination with safer sex practices for HIV-uninfected individuals who are at high risk for acquiring HIV for an FDA approved treatment option?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 8a])
4. Has member been assessed for acute HIV infection and has a recent HIV screening confirmed member is HIV negative? Note: Patients with acute HIV infection may present with a viral syndrome (e.g., lymphadenopathy, fever, malaise, and/or a maculopapular eruption).
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Has the member tried and failed tenofovir/emtracitibine OR has the provider submitted documentation that the member has a genotype supporting use of the requested medication over the preferred medications?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a]
6. Is the request for a product containing abacavir (e.g. abacavir, abacavir/lamivudine, abacavir/lamivudine/zidovudine, Epzicom, Triumeq, Trizivir or Ziagen)?

    a. Yes (go to #7)
    b. No (go to #8)
7. Has the provider submitted documentation that the member is HLA-B*5701 negative?
    a. Yes (go to #16)
    b. No (forward to pharmacist for review [deny 5a, abacavir])
8. Is the request for Selzentry (maraviroc)?
    a. Yes (go to #9)
    b. No (go to #10)
9. Has the provider submitted documentation that the member has CCR5-tropic HIV infection?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a, miraviroc])
10. Is the request for Aptivus, Crixivan, Invirase, or Viracept?
    a. Yes (go to #11)
    b. No (go to #12)
11. Has the member tried and failed one of the following: darunavir, atazanavir, or lopinavir OR has the provider submitted documentation that the member has a genotype supporting use of the requested medication over the preferred medications?
    a. Yes (go to #16)
    b. No (forward for pharmacist review [deny 7a, darunavir, atazanavir, or lopinavir])
12. Is the request for stavudine, didanosine, or Videx powder for solution?
    a. Yes (go to #13)
    b. No (go to #14)
13. Has the member tried and failed one of the following: tenofovir, emtricitibine, lamivudine, or abacavir OR has the provider submitted documentation that the member has a genotype supporting use of the requested medication over the preferred medications?
    a. Yes (go to #16)
    b. No (forward to pharmacist for review [deny 7a, abacavir, tenofovir, emtricitibine, or lamivudine])
14. Is the request for Rescriptor, Viramune XR, or nevirapine?
    a. Yes (go to #15)
    b. No (go to #18)
15. Has the member had a previous trial of one of the following: efavirenz or rilpivirine OR has the provider submitted documentation that the member has a genotype supporting use of the requested medication over the preferred medications?
    a. Yes (go to #16)
    b. No (forward to pharmacist for review [deny 7a, efavirenze or rilpivirine])
16. Has the provider submitted a recent comprehensive metabolic panel (CMP) and complete blood count (CBC)? (Note: refer to the drug's 'Monitoring Parameters' section in UpToDate.)
    a. Yes (go to #17)
    b. No (forward to pharmacist for review [deny 5a, request a recent CMP and CBC])
17. Are the member's liver function tests (LFT) and pancreatic enzymes within normal limits with no evidence of neutropenia on the CBC?
    a. Yes (approve for one year)

b. No (forward to pharmacist for review [deny 5a or contact HIV Alliance for consult])

18. For other ART products that are restricted at point-of-sale: has the prescriber submitted documentation to support that the member is being treated in accordance with the FDA-approved labeling?
    a. Yes (approve for one year)
    b. No (go to #19)
19. Has the provider submitted documented rationale that supports off-label use of the medication?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a or contact HIV Alliance for consult])

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5u or send MonitorRx Report to provider])
2. Is the request for tenofovir/emtricitabine prescribed for pre-exposure prophylaxis (PrEP) in combination with safer sex practices?
    a. Yes (go to #3)
    b. No (go to #4)
3. Has documentation been submitted confirming the member is HIV-negative (tested within the past three months) and is still at high risk for acquiring HIV?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])
4. Has documentation been submitted to demonstrate of efficacy (viral load suppression), and appropriate monitoring? (Refer to UpToDate or product labeling.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a or contact HIV Alliance for consult])

VI. ADDITIONAL INFORMATION:

- If members come onto plan and are started an stabilized on antiretroviral therapy (ART), then UHA will allow continuation of the current regimen.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/29/2021
- **Last Updated Date:** 9/29/2021

Skeletal Muscle Relaxants

Policy Number: Rx021

I. MEDICATION NAME(S):

- chlorzoxazone 500 mg tablet
- orphenadrine citrate ER 100 mg tablet
- multiple nonformulary medications

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: three months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for treatment of muscle spasm or pain associated with an acute musculoskeletal condition?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the request for a nonformulary medication?
    a. Yes (go to #4)
    b. No (go to #3)
3. Has the member tried and failed baclofen, cyclobenzaprine, methocarbamol, and tizanidine or are these medications not appropriate to treat the member's condition?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to all formulary medications: baclofen, cyclobenzaprine, methocarbamol, tizanidine, chlorzoxazone (requires PA), and orphenadrine (requires PA)? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

1. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 12/11/2019

Selective Serotonin Agonists

Policy Number: Rx023

I. MEDICATION NAME(S):

- *almotriptan oral tablet (non-formulary)*
- *eletriptan oral tablet (non-formulary)*
- *frovatriptan (non-formulary)*
- Reyvow (lasmiditan) oral tablet (PA, QL)
- naratriptan HCl oral tablet (QL)
- rizatriptan oral tablet (QL)
- rizatriptan ODT (QL)
- sumatriptan oral tablet (QL)
- sumatriptan nasal spray (PA, QL)
- sumatriptan SQ pen (PA, QL)
- sumatriptan SQ cartridge (PA, QL)
- sumatriptan SQ vial (PA, QL)
- zolmitriptan oral tablet (QL)
- zolmitriptan ODT (QL)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- Reyvow (lasmiditan) oral tablets: 4 tablets per 30 days
- almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan and zolmitriptan oral tablets and ODT: 9 tablets per 30 days
- sumatriptan nasal spray: 1 package (6 mL) per 30 days
- sumatriptan SQ pen and cartridge: 1 package (1 ml) per 30 days
- sumatriptan SQ vial: 1 vial (2.5 mL) per 30 days

IV. INITIAL CRITERIA:

1. Is the drug used for the treatment of migraine headaches?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the request for an oral formulary triptan (naratriptan, rizatriptan, sumatriptan, or zolmitriptan)?
    a. Yes (go to #4)
    b. No (go to #3)
3. Has the member tried and failed at least three oral formulary triptans (naratriptan, rizatriptan, sumatriptan, or zolmitriptan) or has the prescriber submitted appropriate documentation explaining why these medications cannot be used?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the request for a quantity exception to exceed the quantity limit (QL)?
    a. Yes (forward to pharmacist for review)
    b. No (approve for LOB)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- According to product labeling, the safety and effectiveness of treating more than 4 headaches in a 30-day period. Furthermore, triptans should be used less than ten days per month to avoid medication overuse headaches. UHA will not exceed our quantity limits which are in alignment with these guidelines and product labeling.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 9/30/2020

Ropinirole

Policy Number: Rx024

I. MEDICATION NAME(S):

- ropinirole ER

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Restless legs syndrome is not a funded condition.)
    a. Yes (approve for LOB)
    b. No (go to #3)
3. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 3a, RLS])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 6/12/2019

Interferon Beta-1a

Policy Number: Rx025

I. MEDICATION NAME(S):

- Avonex Kit (interferon beta-1a/albumin)
- Avonex Pen (interferon beta-1a)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for the treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/30/2022
- **Last Updated Date:** 12/11/2019

Dimethyl Fumarate

Policy Number: Rx026

I. MEDICATION NAME(S):

- dimethyl fumarate

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- 120-240 mg: 60 capsules in 30 days
- 120 mg: 14 capsules in 7 days
- 240 mg: 60 capsules in 30 days

IV. INITIAL CRITERIA:

1. Is the drug used for the treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the request for monotherapy and is not intended to be used in combination with other MS drugs?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/30/2022
- **Last Updated Date:** 3/30/2022

Antineoplastic Gonadotropin Releasing Hormone Agonist

Policy Number: Rx028

I. MEDICATION NAME(S):

- Zoladex (goserelin acetate)
- Vantas (histrelin acetate)
- Eligard (leuprolide acetate)
- leuprolide acetate
- Lupron depot (leuprolide acetate)
- Lupaneta (leuprolide/norethindrone)
- Trelstar (triptorelin pamoate)

II. LENGTH OF AUTHORIZATION:

- Cancer: initial and renewal: one year
- Endometriosis: initial and renewal: six months (max duration is one year)
- Leiomyoma: initial: three months (max duration)
- Gender dysphoria: initial and renewal: one year (up to age 18 years)
- Precocious puberty: initial and renewal: one year (up to age 11 years for females and 12 years for males)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy (cancer, endometriosis, gender dysphoria, leiomyoma, precocious puberty)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the treatment appropriate for the member's age and condition according to product labeling?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition: hematologist/oncologist for cancer; obstetrician/gynecologist for endometriosis and leiomyoma; or pediatric endocrinologist for gender dysphoria and precocious puberty?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the request for a leuprolide product?
    a. Yes (go to #6)
    b. No (go to #5)

5. Has the member had an adequate trial and failure of, contraindication to, or intolerance to a leuprolide product, or is leuprolide not indicated? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5k])
6. Is the drug prescribed for a diagnosis of cancer?
    a. Yes (go to #12)
    b. No (go to #7)
7. Is the drug prescribed for a diagnosis of endometriosis?
    a. Yes (go to #15)
    b. No (go to #8)
8. Is the drug prescribed for a diagnosis of leiomyoma?
    a. Yes (go to #17)
    b. No (go to #9)
9. Is the drug prescribed for a diagnosis of gender dysphoria?
    a. Yes (go to #18)
    b. No (go to #10)
10. Is the drug prescribed for a diagnosis of precocious puberty)?
    a. Yes (go to #20)
    b. No (forward to pharmacist for review [deny 8a])
11. Is the drug used for an FDA-approved indication, OR a medically appropriate off-label use with strong evidence supporting safety and efficacy, AND listed as a preferred intervention by NCCN with quality and consistency of evidence of at least 3, OR listed as an alternative options with additional compelling information provided? NOTE: Includes all information required in the FDA approval or NCCN recommendation, including but not limited to diagnosis, stage of cancer, biomarkers, place in therapy, and use as monotherapy or combination therapy. (Refer to Table 1 in 'Additional Information' for NCCN quality of evidence and consistency of evidence ratings.)
    a. Yes (go to #12)
    b. No (forward to pharmacist for review [deny 8a])
12. Is the member under age 21?
    a. Yes (go to #13)
    b. No (go to #14)
13. Is the intent of treatment to prolong survival for progressive metastatic cancer with: A) Severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR B) A continued decline in spite of best available therapy with a non-reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (approve for one year)
14. If applicable, does the request meet criteria for treatment coverage specified in Guideline Note 12 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services, considering treatment of cancer with little or no benefit (Refer to Guideline Note 12)?

a. Yes (approve for one year)
b. No (forward to pharmacist for review [deny 5a GLN 12])

15. Has the endometriosis diagnosis been confirmed by laparoscopy?
    a. Yes (go to #16)
    b. No (forward to pharmacist for review [deny 5a])
16. Has the member had an adequate trial and failure of, contraindication to, or intolerance to hormonal therapies (combined oral contraceptives, progestins, or levonorgestrel IUD)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
17. Is the request for preoperative treatment of anemia caused by fibroids (uterine leiomyoma)?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 8a])
18. Is the member's age less than 18 years?
    a. Yes (go to #19)
    b. No (forward to pharmacist for review [deny 5a])
19. Is there documentation the member meets all of all of the following criteria: (1) Puberty confirmed by physical changes and hormone levels, but not earlier than Tanner Stages two; (2) A diagnosis of gender dysphoria made by a mental health professional with experience in gender dysphoria; (3) Persistent well-documented gender dysphoria; (4) The capacity to make fully informed decisions and to give consent to treatment; (5) Any significant medical or mental health concerns are reasonably well controlled; and (6) A comprehensive mental health evaluation provided in accordance with the Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org)?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
20. Is the member's age less than 11 years for females and 12 years for males?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

1. Is the drug prescribed for a diagnosis of cancer?
    a. Yes (go to #6)
    b. No (go to #2)
2. Is the drug prescribed for a diagnosis of endometriosis?
    a. Yes (go to #7)
    b. No (go to #3)
3. Is the drug prescribed for a diagnosis of leiomyoma?
    a. Yes (forward to pharmacist for review [deny 8a, max treatment duration is three months])
    b. No (go to #4)
4. Is the drug prescribed for a diagnosis of gender dysphoria?

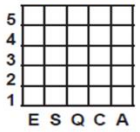
a. Yes (go to #8)
b. No (go to #5)

5. Is the drug prescribed for a diagnosis of precocious puberty)?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 8a])
6. Has there been evidence of disease responsiveness to therapy?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
7. Has the length of therapy been less than one year?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 8a])
8. Is the member's age less than 18 years?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
9. Is the member's age less than 11 years for females and 12 years for males?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 8a])

VI. ADDITIONAL INFORMATION:

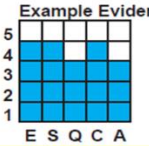
- Guideline Note 127: To qualify for cross-sex hormone therapy, the patient must:
    - Have persistent, well-documented gender dysphoria;
    - Have the capacity to make a fully informed decision and to give consent for treatment;
    - Have any significant medical or mental health concerns reasonably well controlled; and
    - Have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org).
- Table 1. NCCN Evidence Blocks Categories and Definitions

NCCN EVIDENCE BLOCKS CATEGORIES AND DEFINITIONS



E = Efficacy of Regimen/Agent
S = Safety of Regimen/Agent
Q = Quality of Evidence
C = Consistency of Evidence
A = Affordability of Regimen/Agent

Example Evidence Block



E = 4
S = 4
Q = 3
C = 4
A = 3

Efficacy of Regimen/Agent

5	**Highly effective:** Cure likely and often provides long-term survival advantage
4	**Very effective:** Cure unlikely but sometimes provides long-term survival advantage
3	**Moderately effective:** Modest impact on survival, but often provides control of disease
2	**Minimally effective:** No, or unknown impact on survival, but sometimes provides control of disease
1	**Palliative:** Provides symptomatic benefit only

Safety of Regimen/Agent

5	**Usually no meaningful toxicity:** Uncommon or minimal toxicities; no interference with activities of daily living (ADLs)
4	**Occasionally toxic:** Rare significant toxicities or low-grade toxicities only; little interference with ADLs
3	**Mildly toxic:** Mild toxicity that interferes with ADLs
2	**Moderately toxic:** Significant toxicities often occur but life threatening/fatal toxicity is uncommon; interference with ADLs is frequent
1	**Highly toxic:** Significant toxicities or life threatening/fatal toxicity occurs often; interference with ADLs is usual and severe

Note: For significant chronic or long-term toxicities, score decreased by 1

Quality of Evidence

5	**High quality:** Multiple well-designed randomized trials and/or meta-analyses
4	**Good quality:** One or more well-designed randomized trials
3	**Average quality:** Low quality randomized trial(s) or well-designed non-randomized trial(s)
2	**Low quality:** Case reports or extensive clinical experience
1	**Poor quality:** Little or no evidence

Consistency of Evidence

5	**Highly consistent:** Multiple trials with similar outcomes
4	**Mainly consistent:** Multiple trials with some variability in outcome
3	**May be consistent:** Few trials or only trials with few patients, whether randomized or not, with some variability in outcome
2	**Inconsistent:** Meaningful differences in direction of outcome between quality trials
1	**Anecdotal evidence only:** Evidence in humans based upon anecdotal experience

Affordability of Regimen/Agent (includes drug cost, supportive care, infusions, toxicity monitoring, management of toxicity)

5	**Very inexpensive**
4	**Inexpensive**
3	**Moderately expensive**
2	**Expensive**
1	**Very expensive**

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Desmopressin

Policy Number: Rx029

I. MEDICATION NAME(S):

- desmopressin acetate nasal spray

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of hemophilia A with factor VIII level greater than 5% or von Willebrand disease type 1 with factor VIII levels greater than 5%?
    a. Yes (approve nasal spray for LOB)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Growth Hormones

Policy Number: Rx030

I. MEDICATION NAME(S):

- **Norditropin (somatropin) (*preferred)***
- Genotropin (somatropin)
- Humatrope (somatropin) cartridge
- Omnitrope (somatropin)
- Multiple non-formulary drugs

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy (see chart under Additional Information section)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services, OR is there a comorbid condition for which coverage would be allowed? (Treatment with a growth hormone is not funded for most adult conditions. Refer to Guideline Note 74 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services for coverage of hypopituitarism.)
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 3a, and 5a GLN 74])
5. Is the drug used for a member who is less than 18 years of age OR a member with bone age that is less than or equal to 14 years for females or 16 years for males?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])

6. Does the member have documented biochemical Growth Hormone Deficiency (GHD) by one of the following tests: (1) Two growth hormone (GH) stimulations tests < 10 ng/mL (microgram/L); OR (2) One GH stimulation test < 15 ng/mL and IGF – 1 below normal for bone age and sex?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
7. Is the member over 12 years of age?
    a. Yes (go to #8)
    b. No (go to #9)
8. Is there evidence of non-closure of epiphyses confirmed by X-ray?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 5a])
9. Is the medication prescribed by or in consultation with a pediatric endocrinologist or a pediatric nephrologist?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 5a])
10. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Norditropin, OR is Norditropin not appropriate for the diagnosis (see chart under Additional Information section)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Is there evidence of growth velocity (GV) greater than 2.5 cm/year?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the member over 12 years of age?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there evidence of non-closure of epiphyses confirmed by X-ray?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the member's bone age not reached height potential defined as bone age not exceeding 16 years for males (required annually when chronological age reaches 15) and bone age not exceeding 14 years for females (required annually when chronological age reaches 13)?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a)

VI. ADDITIONAL INFORMATION:

- **Pediatric and Adult FDA Approved Indications for Growth Hormone**

	Genotropin®	Humatrope®	Norditropin®	Nutropin AQ®	Omnitrope®	Saizen®	Serostim®	Zomacton®	Zorbtive®
Pediatric Indications									
GHD	x	x	x	x	x	x		x	
Prader-Willi Syndrome	x		x		x				
Noonan Syndrome			x						
Turner Syndrome	x	x	x	x	x			x	
Idiopathic Short Stature	x	x	x	x	x			x	
SHOX Deficiency		x						x	
CKD with Growth Failure				x					
Small for Gestational Age	x	x	x		x			x	
HIV Associated Cachexia							x		
Adult Indications (not funded)									
GHD	x	x	x	x	x	x		x	
HIV Associated Cachexia							x		
Short Bowel Syndrome									x

ABBREVIATIONS: CKD = CHRONIC KIDNEY DISEASE; FDA = FOOD AND DRUG ADMINISTRATION; GHD = GROWTH HORMONE DEFICIENCY; HIV = HUMAN IMMUNODEFICIENCY VIRUS; SHOX = SHORT STATURE HOMEOBOX-CONTAINING GENE

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Pancreatic Enzymes

Policy Number: Rx031

I. MEDICATION NAME(S):

- Creon (lipase/protease/amylase)
- Pancreaze (lipase/protease/amylase)
- Zenpep (lipase/protease/amylase)
- Multiple non-formulary drugs (Pertzye, Viokace)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug being used for a diagnosis of cystic fibrosis?
    a. Yes (go to #6)
    b. No (go to #2)
2. Has the member had a pancreatectomy?
    a. Yes (go to #6)
    b. No (go to #3)
3. Is the drug being used for a diagnosis of exocrine pancreatic cancer?
    a. Yes (go to #6)
    b. No (go to #4)
4. Is the drug being used for a diagnosis of chronic pancreatitis confirmed by imaging?
    a. Yes (go to #6)
    b. No (go to #5)
5. Does the member have exocrine pancreatic insufficiency confirmed with one of the following methods: (1) Confirmed steatorrhea with fecal fat determination; (2) Measurement of fecal elastase; OR (3) Secretin or CCK pancreatic function testing?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a, 8a])
6. Is the request for a drug that is on the UHA formulary (Creon, Pancreaze, or Zenpep)?
    a. Yes (approve for LOB)
    b. No (go to #7)
7. Is the request for Viokace?
    a. Yes (go to #8)
    b. No (go to #9)

8. Is the member taking a proton pump inhibitor like omeprazole or pantoprazole? (Note: Viokace must be administered with a proton pump inhibitor (PPI) since it is not enteric coated.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 5a])
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to all formulary drugs (Creon, Pancreaze, and Zenpep)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 12/11/2019

Aprepitant

Policy Number: Rx032

I. MEDICATION NAME(S):

- aprepitant capsules

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member currently receiving moderate to highly emetogenic chemotherapy (refer to NCCN antiemesis guidelines)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a, 7a])
2. Is the member receiving concurrent treatment with IV or oral ondansetron, granisetron, or palonosetron, AND dexamethasone?
    a. Yes (approve for three months)
    b. No (deny 5a)

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

EMETOGENIC POTENTIAL OF INTRAVENOUS ANTICANCER AGENTS[a]

LEVEL	AGENT		
High emetic risk (>90% frequency of emesis)[b,c]	• AC combination defined as any chemotherapy regimen that contains an anthracycline and cyclophosphamide • Carboplatin AUC ≥4	• Carmustine >250 mg/m² • Cisplatin • Cyclophosphamide >1,500 mg/m² • Dacarbazine • Doxorubicin ≥60 mg/m²	• Epirubicin >90 mg/m² • Ifosfamide ≥2 g/m² per dose • Mechlorethamine • Streptozocin
Moderate emetic risk (>30%–90% frequency of emesis)[b,c]	• Aldesleukin >12–15 million IU/m² • Amifostine >300 mg/m² • Arsenic trioxide • Azacitidine • Bendamustine • Busulfan • Carboplatin AUC <4[d] • Carmustine[d] ≤250 mg/m² • Clofarabine • Cyclophosphamide ≤1500 mg/m² • Cytarabine >200 mg/m²	• Dactinomycin[d] • Daunorubicin[d] • Dual-drug liposomal encapsulation of cytarabine and daunorubicin • Dinutuximab • Doxorubicin[d] <60 mg/m² • Epirubicin[d] ≤90 mg/m² • Idarubicin • Ifosfamide[d] <2 g/m² per dose • Interferon alfa ≥10 million IU/m² • Irinotecan[d]	• Melphalan • Methotrexate[d] ≥250 mg/m² • Oxaliplatin[d] • Temozolomide • Trabectedin[d]

LEVEL	AGENT		
Low emetic risk (10%–30% frequency of emesis)[b]	• Ado-trastuzumab emtansine • Aldesleukin ≤12 million IU/m² • Amifostine ≤300 mg/m² • Atezolizumab • Belinostat • Blinatumomab • Brentuximab vedotin • Cabazitaxel • Carfilzomib • Cytarabine (low dose) 100–200 mg/m² • Docetaxel • Doxorubicin (liposomal) • Eribulin	• Etoposide • 5-Fluorouracil (5-FU) • Floxuridine • Gemcitabine • Interferon alfa >5 - <10 million international units/m² • Irinotecan (liposomal) • Ixabepilone • Methotrexate >50 mg/m² - <250 mg/m² • Mitomycin • Mitoxantrone • Necitumumab • Olaratumab	• Omacetaxine • Paclitaxel • Paclitaxel-albumin • Pemetrexed • Pentostatin • Pralatrexate • Romidepsin • Talimogene laherparepvec • Thiotepa • Topotecan • Ziv-aflibercept
Minimal emetic risk (<10% frequency of emesis)[b]	• Alemtuzumab • Avelumab • Asparaginase • Bevacizumab • Bleomycin • Bortezomib • Cetuximab • Cladribine • Cytarabine <100 mg/m² • Daratumumab • Decitabine • Denileukin diftitox • Dexrazoxane • Durvalumab	• Elotuzumab • Fludarabine • Interferon alpha ≤5 million IU/m² • Ipilimumab • Methotrexate ≤50 mg/m² • Nelarabine • Nivolumab • Obinutuzumab • Ofatumumab • Panitumumab • Pegaspargase • Peginterferon • Pembrolizumab • Pertuzumab	• Ramucirumab • Rituximab • Rituximab and hyaluronidase human injection for SQ use • Siltuximab • Temsirolimus • Trastuzumab • Valrubicin • Vinblastine • Vincristine • Vincristine (liposomal) • Vinorelbine

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 12/11/2019

Temazepam

Policy Number: Rx033

I. MEDICATION NAME(S):

- temazepam capsules

II. LENGTH OF AUTHORIZATION:

- Initial: one to six months (one year for oncology or palliative care)
- Renewal: up to six months (one year for oncology or palliative care)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm or other end-of-life diagnosis?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the drug used for insomnia?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is there a comorbid condition for which coverage would be allowed (for example, mental health conditions that would be impacted by untreated insomnia)?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the member taking a concurrent sedative, hypnotic or opioid?
    a. Yes (forward to pharmacist for review)
    b. No (go to #5)
5. Has the provider reviewed the Oregon Prescription Monitoring Program registry within the last three months and documented appropriate results?
    a. Yes (go to #6)
    b. No (forward to pharamcist for review)
6. Is this a new start request for short-term use (less than 4 weeks)?
    a. Yes (approve for one month)
    b. No (go to #7)
7. Is there appropriate rationale to support long-term benzodiazepine use?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the drug used for a member with a malignant neoplasm or other end-of-life diagnosis?
    a. Yes (approve for one year)
    b. No (go to #2)
2. Is the member taking a concurrent sedative, hypnotic or opioid?
    a. Yes (forward to pharmacist for review)
    b. No (go to #3)
3. Has the provider reviewed the Oregon Prescription Monitoring Program registry within the last three months and documented appropriate results?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is there appropriate rationale to support long-term benzodiazepine use? (Exceptions may be made to allow time to taper off of medication.)
    a. Yes (approve for up to six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 9/20/2023

Pulmonary Antihypertensive Phosphodiesterase Inhibitors

Policy Number: Rx034

I. MEDICATION NAME(S):

- sildenafil citrate (generic Revatio)
- Alyq (tadalafil)
- tadalafil (generic Adcirca)

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of pulmonary arterial hypertension WHO Group I diagnosed by right heart catheterization? (Note: Sexual dysfunction is not a condition funded by the Oregon Health Plan (OHP) according to the Health Evidence Review Commission (HERC) Prioritized List of Health Services.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the drug prescribed by or in consultation with a pulmonologist or cardiologist?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the request for sildenafil (generic Revatio)?
    a. Yes (approve for LOB)
    b. No (go to #4)
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to sildenafil? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 12/11/2019

Omalizumab

Policy Number: Rx035

I. MEDICATION NAME(S):

- Xolair (omalizumab)

II. LENGTH OF AUTHORIZATION:

- Initial: four months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug being used for a diagnosis of moderate to severe persistent asthma?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member six years of age or older?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the drug prescribed by or in consultation with a pulmonologist or immunologist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the member a current smoker?
    a. Yes (forward to pharmacist for review)
    b. No (go to #5)
5. Does the member have a positive skin test or RAST to a perennial aeroallergen?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the member's baseline IgE serum level between 30 to 1,300 IU/mL for members age 6 to 11, OR between 30 to 700 IU/mL for members age 12 and older?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)
7. Have the provider and member taken all steps to reduce and maximally manage environmental allergens and other triggers (e.g., tobacco smoke, dust mites, pets, molds, occupational exposures, GERD)?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Has the member had an adequate trial and failure of, contraindication to, or intolerance to all of the following agents used as combination therapy: (1) High-dose inhaled

corticosteroid with a long-acting beta agonist (such as fluticasone-salmeterol [generic Advair] or Symbicort); (2) Long-acting muscarinic antagonist (such as Incruse Ellipta, Tudorza, or Spiriva); AND (3) Leukotriene inhibitor (such as montelukast)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Has the member tried and failed or have contraindications to allergen immunotherapy?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review)
10. Does the member have a history of compliance with all asthma medications?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review)
11. In the past year has the member had frequent asthma exacerbations resulting in repeated use of health care services, such as urgent care or ED visits or hospitalization?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review)
12. Will this drug be professionally administered and billed under the medical benefit?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Has the member had a reduction in asthma exacerbations necessitating frequent office visits, ED or urgent care visits, hospitalizations, oral steroids and demonstrated sustained clinical improvement from baseline while on omalizumab?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review)
2. Will this drug be professionally administered and billed under the medical benefit?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 12/11/2019

Topical Immunosuppressants

Policy Number: Rx036

I. MEDICATION NAME(S):

- tacrolimus oint.

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
3. Is the drug prescribed for chronic, severe atopic dermatitis with functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% body surface area involved; or (2) hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #5)
    b. No (go to #4)
4. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Has the member experienced an adequate trial and failure of, contraindication to, or intolerance to high-potency topical corticosteroids – betamethasone dipropionate, clobetasol, fluocinonide (all require prior authorization) (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 3/15/2023

Topical Antipsoriatic Agents

Policy Number: Rx037

I. MEDICATION NAME(S):

- calcipotriene cream
- calcipotriene oint.
- calcipotriene solution
- tazarotene cream

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
3. Is the drug prescribed for chronic, moderate to severe plaque psoriasis with functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% body surface area involved; or (2) hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #5)
    b. No (go to #4)
4. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
5. Has the member experienced an adequate trial and failure of, contraindication to, or intolerance to high-potency topical corticosteroids – betamethasone dipropionate, clobetasol, fluocinonide (all require prior authorization)? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 3/15/2023

Acitretin

Policy Number: Rx038

I. MEDICATION NAME(S):

- acitretin capsule

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for chronic, moderate to severe plaque psoriasis with functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) AND one or more of the following: (1) at least 10% body surface area involved; or (2) hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #3)
    b. No (go to #2)
2. Is there a comorbid condition for which coverage would be allowed?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the medication prescribed by or in consultation with a dermatologist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a (prescriber)])
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to **all** of the following: (1) high-potency topical corticosteroids – betamethasone dipropionate, clobetasol, fluocinonide (all require prior authorization); (2) at least one other topical – calcipotriene, tazarotene, anthralin (all require prior authorization); (3) PUVA or UVB phototherapy; (4) methotrexate; and (5) at least one other second line systemic agent such as cyclosporine? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the prescriber submitted documentation of at least a 50% reduction in plaques and/or is there evidence of functional improvement?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a (renewal)])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/31/2021
- **Last Updated Date:** 3/31/2021

Tolterodine

Policy Number: Rx039

I. MEDICATION NAME(S):

- tolterodine tartrate tablets
- tolterodine tartrate ER capsules

II. LENGTH OF AUTHORIZATION:

- Length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for overactive bladder that is a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had an adequate trial and failure of, contraindication to, or intolerance to oxybutynin IR, oxybutynin ER, or trospium IR? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a, oxybutynin IR/ER or trospium IR])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/29/2021
- **Last Updated Date:** 9/29/2021

Biologics for Inflammatory Disease

Policy Number: Rx040

I. MEDICATION NAME(S):

- Humira (adalimumab)
- Siliq (brodalumab)
- Cimzia (certolizumab pegol)
- Enbrel (etanercept)
- Simponi (golimumab)
- Simponi Aria (golimumab)
- Tremfya (guselkumab)
- Remicade (infliximab)
- Renflexis (infliximab-abda)
- Inflectra (infliximab-dyyb)
- Taltz (ixekizumab)
- Skyrizi (risankizumab-rzaa)
- Cosentyx (secukinumab)
- Ilumya (tildrakizumab-asmn)
- Stelara (ustekinumab)
- Entyvio (vedolizumab)

II. LENGTH OF AUTHORIZATION:

- Initial: three months for HS, six months for all others
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy (see indications chart under the 'Additional Information' section)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the request for maintenance of remission in a patient who already achieved remission with the requested product or has already initiated therapy?
    a. Yes (go to 'Renewal Criteria')
    b. No (go to #3)
3. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition (rheumatologist, gastroenterologist, or dermatologist)?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the risk of infection been assessed including: (1) Initial testing for latent TB and treatment (if necessary); (2) No current active infection; (3) Risks and benefits documented in cases of chronic or recurrent infection?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])

5. Is the requested drug to be used in combination with another biologic or Otezla?
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (go to #6)
6. Is the request for the least costly infliximab biosimilar (Remicade, Inflectra, or Renflexis) (refer to DMAP fee schedule if professionally administered)?
    a. Yes (go to #10)
    b. No (go to #7)
7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the least costly infliximab biosimilar (Remicade, Inflectra or Renflexis), if appropriate to treat the member's condition (see indications chart under the 'Additional Information' section)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Is the request for Enbrel (etanercept) or Humira (adalimumab)?
    a. Yes (go to #10)
    b. No (go to #9)
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Enbrel (etanercept) AND Humira (adalimumab) if appropriate for the condition (see indications chart under the 'Additional Information' section)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 7a])
10. Is the diagnosis ankylosing spondylitis (AS) or axial spondyloarthritis (axSpA)?
    a. Yes (go to #19)
    b. No (go to #11)
11. Is the diagnosis Crohn's disease (CD)?
    a. Yes (go to #23)
    b. No (go to #12)
12. Is the diagnosis hidradenitis suppurativa (HS)?
    a. Yes (go to #32)
    b. No (go to #13)
13. Is the diagnosis juvenile idiopathic arthritis (JIA)?
    a. Yes (go to #34)
    b. No (go to #14)
14. Is the diagnosis plaque psoriasis (Ps)?
    a. Yes (go to #40)
    b. No (go to #15)
15. Is the diagnosis psoriatic arthritis (PsA)?
    a. Yes (go to #44)
    b. No (go to #16)
16. Is the diagnosis rheumatoid arthritis (RA)?
    a. Yes (go to #48)
    b. No (go to #17)

17. Is the diagnosis ulcerative colitis (UC)?
    a. Yes (go to #53)
    b. No (go to #18)
18. Is the diagnosis non-infectious uveitis?
    a. Yes (go to #61)
    b. No (forward to pharmacist for review [deny 8a])
19. Does the member have a definitive diagnosis ankylosing spondylitis or axial spondyloarthritis (radiographic or non-radiographic)? Diagnosis is definitive if the following are met: (1) Back pain and stiffness for more than 3 months; AND (2) Signs of active inflammation on MRI OR radiological evidence of sacroiliitis OR HLA-B27 positive.
    a. Yes (go to #20)
    b. No (forward to pharmacist for review [deny 5a])
20. Does the member have moderate to severe active disease at baseline, evidenced by a Bath AS Disease Activity Index (BASDAI) score of at least 4?
    a. Yes (go to #21)
    b. No (forward to pharmacist for review [deny 5a])
21. Is the member transitioning to the requested drug from a different biologic product?
    a. Yes (approve for six months)
    b. No (go to #22)
22. Has the member tried and failed conventional therapy with both of the following: (1) At least two NSAIDs for three months at maximum recommended or tolerated anti-inflammatory dose unless contraindicated; AND (2) Physical therapy/exercise program?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
23. Does the member have a diagnosis of severe fistulizing Crohn's disease?
    a. Yes (go to #30)
    b. No (go to #24)
24. Does the member have moderate to severe Crohn's disease?
    a. Yes (go to #25)
    b. No (forward to pharmacist for review [deny 5a])
25. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #30)
    b. No (go to #26)
26. Is the request for induction of remission?
    a. Yes (go to #27)
    b. No (go to #28)
27. Has the member failed to achieve remission with a systemic corticosteroid?
    a. Yes (go to #30)
    b. No (forward to pharmacist for review [deny 7a])
28. Is the member currently stable on steroids and considered steroid-dependent?
    a. Yes (go to #29)
    b. No (forward to pharmacist for review [deny 5a])
29. Has the member tried and failed azathioprine, 6-mercaptopurine, or methotrexate for maintenance?
    a. Yes (go to #30)

    b. No (forward to pharmacist for review [deny 7a])
30. Is the request for Stelara (ustekinumab)?
    a. Yes (go to #31)
    b. No (approve for six months)
31. Has the member tried and failed ALL the following biologics: (1) Cimzia (certolizumab); AND (2) An anti-integrin alpha-4 (i.e., Entyvio [vedolizumab] or Tysabri [natalizumab])? Note: as asked above, member must have also tried and failed infliximab (Remicade, Inflectra or Renflexis) and adalimumab (Humira).
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
32. Does the member have a diagnosis of moderate to severe hidradenitis suppurativa (Hurley II/Hurley III stage), characterized by recurrent, painful, and suppurating lesions recurring at least twice in 6 months?
    a. Yes (go to #33)
    b. No (forward to pharmacist for review [deny 5a])
33. Has the member tried and failed a three-month treatment course of ALL the following: (1) Oral antibiotics, such as clindamycin and rifampin, dapsone, or doxycycline; (2) Intralesional corticosteroid injections; (3) Antiandrogenic hormonal treatments for women (OCP or spironolactone); AND (4) Acitretin if not of child-bearing potential?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 5a, and 7a])
34. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (approve for six months)
    b. No (go to #35)
35. Does the member have juvenile idiopathic arthritis with active systemic features of juvenile idiopathic arthritis, with a physician global assessment of 5 or higher (or any systemic activity in the absence of active joint involvement)?
    a. Yes (go to #38)
    b. No (go to #36)
36. Does the member have juvenile idiopathic arthritis without active systemic features of juvenile idiopathic arthritis?
    a. Yes (go to #37)
    b. No (forward to pharmacist for review [deny 5a])
37. Has the member tried and failed either: (1) Intra-articular glucocorticoid injections (if fewer than 4 joints affected); OR (2) NSAIDS for at least one month?
    a. Yes (go to #39)
    b. No (forward to pharmacist for review [deny 7a])
38. Has the member had an adequate trial and failure of, contraindication to, or intolerance to systemic corticosteroids? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #39)
    b. No (forward to pharmacist for review [deny 7a])
39. Has the member had an adequate trial and failure of methotrexate or leflunomide, or a contraindication to both? (Adequate trial is defined as adherent to therapy for at least

three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
40. Does the member have chronic, moderate to severe plaque psoriasis defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) and one or more of the following: (1) At least 10% body surface area involved; OR (2) Hand, foot, face, or mucous membrane involvement?
    a. Yes (go to #41)
    b. No (forward to pharmacist for review [deny 5a])
41. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #43)
    b. No (go to #42)
42. Has the member tried and failed or have contraindications to ALL the following: (1) High-potency topical corticosteroids, such as augmented betamethasone cream 0.05%, desoximetasone 0.25% cream, or clobetasol; (2) At least one other topical agent, such as calcipotriene, tazarotene, anthralin, or tar; (3) PUVA or UVB Phototherapy; (4) Methotrexate; AND (5) At least one other second line systemic agent, such as cyclosporine or acitretin?
    a. Yes (go to #43)
    b. No (forward to pharmacist for review [deny 5a, and 7a])
43. Has the member tried and failed other less costly biologics, if indicated (see indications chart under the 'Additional Information' section)?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
44. Does the member have psoriatic arthritis based on presence of at least 3 out of 5 of the following: (1) Psoriasis (1 point for personal or family history, 2 points for current); (2) Psoriatic nail dystrophy; (3) Negative test result for rheumatoid factor; (4) Dactylitis (current or history); or (5) Radiological evidence of juxta-articular new bone formation?
    a. Yes (go to #45)
    b. No (forward to pharmacist for review [deny 5a])
45. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #47)
    b. No (go to #46)
46. Has the member had an adequate trial and failure of, contraindication to, or intolerance to conventional therapy with ALL the following: (1) NSAIDs; AND (2) Methotrexate or other DMARD such as leflunomide, sulfasalazine, or cyclosporine? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #47)
    b. No (forward to pharmacist for review [deny 7a])
47. Has the member tried and failed other less costly biologics, if indicated (see indications chart under the 'Additional Information' section)?

a. Yes (approve for six months)
b. No (forward to pharmacist for review [deny 7a])

48. Does the member have a baseline of moderate to high disease activity of rheumatoid arthritis measured as such by an accepted assessment instrument (PAS, PASII, RAPID3, CDAI, DAS28, SDAI)?
    a. Yes (go to #49)
    b. No (forward to pharmacist for review [deny 5a])
49. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #52)
    b. No (go to #50)
50. Has the member had an adequate trial and failure of, contraindication to, or intolerance to methotrexate dosed at least 20 mg per week? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #51)
    b. No (forward to pharmacist for review [deny 7a])
51. Has the member had an adequate trial and failure of, contraindication to, or intolerance to leflunomide, hydroxychloroquine, or sulfasalazine? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #52)
    b. No (forward to pharmacist for review [deny 7a])
52. Is the requested product being prescribed along with at least one of the following DMARDs (unless contraindicated): methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])
53. Does the member have a diagnosis of moderate to severe ulcerative colitis defined by the following criteria: (1) for moderate, greater than or equal to four stools daily; OR (2) for severe, greater than or equal to six bloody stools daily and evidence of toxicity such as fever, anemia, elevated ESR, or tachycardia?
    a. Yes (go to #54)
    b. No (forward to pharmacist for review [deny 5a])
54. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (go to #59)
    b. No (go to #55)
55. Is the request for induction of remission?
    a. Yes (go to #56)
    b. No (go to #57)
56. Has the member failed to achieve remission with a systemic corticosteroid?
    a. Yes (go to #59)
    b. No (forward to pharmacist for review [deny 5a, 7a])
57. Is the member currently stable on steroids and considered steroid-dependent?
    a. Yes (go to #58)

b. No (forward to pharmacist for review [deny 5a])

58. Has the member had an adequate trial and failure of, contraindication to, or intolerance to azathioprine, 6-mercaptopurine, or a 5-ASA for maintenance? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #59)
    b. No (forward to pharmacist for review [deny 7a])
59. Is the request for Stelara?
    a. Yes (go to #60)
    b. No (approve for six months)
60. Has the member had an adequate trial and failure of, contraindication to, or intolerance to Entyvio (vedolizumab) AND Simponi (golimumab) (in addition to infliximab, Humira and Enbrel as mentioned above)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])
61. Does the member have a diagnosis of non-infectious, intermediate, posterior or panuveitis?
    a. Yes (go to #62)
    b. No (forward to pharmacist for review [deny 5a])
62. Is the member transitioning to the requested treatment from a different biologic product?
    a. Yes (approve for six months)
    b. No (go to #63)
63. Has the member had an adequate trial and failure of, contraindication to, or intolerance to ALL of the following: (1) Topical glucocorticoids for at least one month, or periocular steroid injections; (2) Oral corticosteroids; AND (3) one immunomodulatory – mycophenolate, tacrolimus, cyclosporine, azathioprine, or methotrexate?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Is the diagnosis ankylosing spondylitis (AS) or axial spondyloarthritis (axSpA)?
    a. Yes (go to #10)
    b. No (go to #2)
2. Is the diagnosis Crohn's disease (CD)?
    a. Yes (go to #11)
    b. No (go to #3)
3. Is the diagnosis hidradenitis suppurativa (HS)?
    a. Yes (go to #12)
    b. No (go to #4)
4. Is the diagnosis juvenile idiopathic arthritis (JIA)?
    a. Yes (go to #14)
    b. No (go to #5)
5. Is the diagnosis plaque psoriasis (Ps)?

    a. Yes (go to #15)
    b. No (go to #6)
6. Is the diagnosis psoriatic arthritis (PsA)?
    a. Yes (go to #16)
    b. No (go to #7)
7. Is the diagnosis rheumatoid arthritis (RA)?
    a. Yes (go to #17)
    b. No (go to #8)
8. Is the diagnosis ulcerative colitis (UC)?
    a. Yes (go to #18)
    b. No (go to #9)
9. Is the diagnosis non-infectious uveitis?
    a. Yes (go to #19)
    b. No (forward to pharmacist for review [deny 8a])
10. Does the member have significant improvement in signs and symptoms of AS/axSpA and/or functioning, such as 50% relative change or 2-point improvement in BASDAI?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
11. Has the member experienced a decrease in symptoms, reduction in enterocutaneous fistulas or clinical remission?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
12. Is there a valid, medical reason surgical intervention is not being pursued?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 5a])
13. Has there been a significant treatment response as defined as ALL the following: (1) A reduction of 25% or more in the total abscess and inflammatory nodule count; AND (2) No increase in abscesses and draining fistulas?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
14. Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or has there been an improvement in functional ability?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
15. Has the member experienced a clinically significant response, such as PASI-75 (75% improvement) or is there evidence of functional improvement?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
16. Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or has there been an improvement in functional ability?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
17. Has the member experienced 20% or greater improvement in tender joint count and swollen joint count or has there been and improvement in functional ability?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

18. Has the member demonstrated a significant response including the following: (1) Decrease in bloody stools per day; OR (2) Elimination of signs of toxicity?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
19. Is there documentation that disease activity has been controlled, such as a lack of inflammation, no new inflammatory vascular lesions, no vitreous haze or decreases in visual acuity?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

- Indications:

Drug	AS	axSpA	CD	HS	JIA	Ps	PsA	RA	UC	Uveitis
Humira (adalimumab)	x	x*	x	x	x	x	x	x	x	x
Siliq (brodalumab)						x				
Cimzia (certolizumab pegol)	x	x	x			x	x	x		
Enbrel (etanercept)	x				x	x	x	x		
Simponi, Simponi Aria (golimumab)	x	x*			x		x	x	x	
Tremfya (guselkumab)						x	x			
Remicade, Renflexis, Inflectra (infliximab)	x		x	x*		x	x	x	x	
Taltz (ixekizumab)	x	x				x	x			
Skyrizi (risankizumab)			x			x	x			
Cosentyx (secukinumab)	x	x				x	x			
Ilumya (tildrakizumab)						x				
Stelara (ustekinumab)			x			x	x		x	
Entyvio (vedolizumab)			x						x	

**Off-label*

Abbrebreviations:

AS = Ankylosing Spondylitis
axSpA = Axial Spondyloarthritis
CD = Crohn's Disease
HS = Hidradenitis Suppurativa
JIA = Juvenile Idiopathic Arthritis
Ps = Plaque Psoriasis
PsA = Psoriatic Arthritis
RA = Rheumatoid Arthritis
UC = Ulcerative Colitis

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Long-Acting Muscarinic Antagonist/Long-acting Beta-agonist/ Inhaled Corticosteroid (LAMA/LABA/ICS) Combinations

Policy Number: Rx041

I. MEDICATION NAME(S):

- Trelegy Ellipta (fluticasone/umeclidinium/vilanterol)
- Breztri Aerosphere (budesonide/glycopyrrolate/formoterol)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of asthma or COPD and prescribed at an FDA approved dose and indication?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has the member had an adequate trial and failure of either a combined LAMA/LABA (Bevespi Aerosphere, Utibron Neohaler, Stiolto Respimat, or Anoro Ellipta) OR a combined LABA/ICS (fluticasone/salmeterol, Dulera or Symbicort) inhaler? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days AND documentation of persistent symptoms or exacerbations.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Has documentation been submitted stating this medication has been effective for reducing COPD or asthma symptoms or exacerbations?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/15/2023
- **Last Updated Date:** 3/15/2023

Erythropoiesis-Stimulating Agents (ESA)

Policy Number: Rx042

I. MEDICATION NAME(S):

- Aranesp (darbepoetin alfa)
- Epogen (epoetin alfa)
- Procrit (epoetin alfa)
- Retacrit (epoetin alfa-epbx)

II. LENGTH OF AUTHORIZATION:

- Initial: three months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug being used for a diagnosis of chronic renal failure (CRF) OR anemia due to myelosuppressive chemotherapy?
    a. Yes (go to #2)
    b. No (go to #3)
2. Does the member meet all of the following criteria: (1) hemoglobin (HGB) less than 10 g/dL or hematocrit (HCT) less than 30%; (2) transferrin saturation greater than 20%; AND (3) ferritin greater than 100 ng/mL?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug being used for a diagnosis of anemia associated with HIV/AIDS zidovudine therapy?
    a. Yes (go to #4)
    b. No (go to #5)
4. Does the member meet all of the following criteria: (1) HGB less than 10 g/dL or HCT less than 30%; (2) transferrin saturation greater than 20%; (3) ferritin greater than 100 ng/mL; (4) endogenous erythropoietin levels of 500IU/L or less; AND (5) zidovudine dose of 4200 mg per week or less?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
5. Is the drug being used for pre-operative treatment to raise hemoglobin and hematocrit prior to scheduled surgical procedures AND the member has religious beliefs that preclude blood product transfusions?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 8a])

6. Is the member currently anemic with a hemoglobin less than 13 g/dL for men or less than 12 g/dL for women?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 5a])
7. Is the medication prescribed by or in consultation with an appropriate health care provider with expertise in treating this condition (e.g. hematologist/oncologist, nephrologist, surgeon etc.)?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 5a])
8. Is the request for the least costly product (refer to DMAP fee schedule if professionally administered)?
    a. Yes (approve for three months)
    b. No (go to #9)
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the less costly alternative agent(s)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the member maintained adequate iron stores (transferrin saturation greater than 20%)?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has the member continued to see a response to treatment demonstrated by an increase from baseline HGB/HCT or at HGB/HCT target?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/23/2021
- **Last Updated Date:** 6/23/2021

Colony-Stimulating Factors

Policy Number: Rx043

I. MEDICATION NAME(S):

- Neupogen (filgrastim)
- **Nivestym (filgrastim-aafi)** ***preferred***
- **Zarxio (filgrastim-sndz)** ***preferred***
- **Granix (tbo-filgrastim)** ***preferred***
- Neulasta (pegfilgrastim)
- Udenyca (pegfilgrastim-cbqv)
- Fulphila (pegfilgrastim-jmdb)
- Leukine (sargramostim)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: four months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the request for pegfilgrastim?
    a. Yes (go to #2)
    b. No (go to #3)
2. Has the provider submitted medically appropriate rationale explaining why filgrastim cannot be used (i.e., dexterity issues)?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 7a])
3. Is the request for Neupogen?
    a. Yes (go to #4)
    b. No (go to #5)
4. Has the provider submitted medically appropriate rationale explaining why a filgrastim biosimilar cannot be used (Nivestym, Zarxio, or Granix)?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 7a])
5. Is the drug being used to treat chemotherapy-induced neutropenia?
    a. Yes (go to #6)
    b. No (go to #8)
6. Has the member been on prophylactic therapy with a colony-stimulating factor?
    a. Yes (approve for four months)
    b. No (go to #7)
7. Does the member have one or more of the following risk factors for developing infection-related complications: Sepsis Syndrome; age over 65 or older; absolute neutrophil count [ANC] <100/mcL; duration of neutropenia expected to be greater than

10 days; pneumonia or other clinically documented infections; invasive fungal infection; hospitalization at the time of fever; prior episode of febrile neutropenia?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review [deny 5a])
8. Is the drug being used for Myelodysplastic Syndromes (MDS)?
    a. Yes (go to #9)
    b. No (go to #13)
9. Does the member have an endogenous serum erythropoietin level of 500 mU/mL or less?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review [deny 5a])
10. Does the member have lower risk disease (i.e., defined as IPSS-R [Very Low, Low, Intermediate], IPSS [Low/Intermediate-1], WPSS [Very Low, Low, Intermediate])?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 5a])
11. Is the drug being used for treatment of symptomatic anemia in members without del(5q)?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review [deny 5a])
12. Is the member receiving concurrent therapy with an Erythropoiesis Stimulating Agent (ESA) and have one of the following: (1) Ring sideroblasts less than 15% and will use in combination with lenalidomide following no response (despite adequate iron stores) or loss of response to an ESA alone; OR (2) Ring sideroblasts greater than or equal to 15%?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review [deny 5a])
13. Is the drug being used prophylactically in a member with a non-myeloid malignancy?
    a. Yes (go to #14)
    b. No (go to #16)
14. Is the member undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 20% or greater? (See NCCN Guidelines for Management of Neutropenia https://www.nccn.org/professionals/physician_gls/pdf/growthfactors.pdf.)
    a. Yes (approve for four months)
    b. No (go to #15)
15. Is the member undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10% or greater AND has one or more of the following comorbidities: age 65 or older receiving full dose intensity chemotherapy; history of recurrent febrile neutropenia from chemotherapy; extensive prior exposure to chemotherapy; previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation; pre-existing neutropenia (ANC ≤ 1000/mm3) or bone marrow involvement with tumor; patient has a condition that can potentially increase the risk of serious infection (i.e. HIV/AIDS); infection/open wounds; recent surgery; poor performance status; poor renal function (creatinine clearance <50); liver dysfunction (elevated bilirubin >2.0); chronic immunosuppression in the post-transplant setting including organ transplant? (See NCCN Guidelines for Management of Neutropenia https://www.nccn.org/professionals/physician_gls/pdf/growthfactors.pdf.)
    a. Yes (approve for four months)

b. No (forward to pharmacist for review [deny 5a])

16. Is the drug being used for a member who experienced a neutropenic complication from a prior cycle of the same chemotherapy?
    a. Yes (approve for four months)
    b. No (go to #17)
17. Is the drug being used for Bone Marrow Transplantation (BMT) failure or Engraftment Delay?
    a. Yes (approve for four months)
    b. No (go to #18)
18. Is the drug being used for Peripheral Blood Stem Cell (PBSC) mobilization and transplant?
    a. Yes (approve for four months)
    b. No (go to #19)
19. Is the drug being used for members acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome)?
    a. Yes (approve for four months)
    b. No (forward to pharmacist for review [deny 8a])

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

- Febrile neutropenia is defined as:
    - A single temperature ≥38.3 °C orally or ≥38.0 °C over 1 hour; AND
    - Neutropenia <500 neutrophils/mcL or <1,000 neutrophils/mcL and a predicted decline to ≤500 neutrophils/mcL over the next 48 hours.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 12/11/2019

Nicotine Replacement Preparations

Policy Number: Rx044

I. MEDICATION NAME(S):

- nicotine gum (QL)
- Nicorelief gum (QL)
- Quit 2 gum (QL)
- Quit 4 gum (QL)
- nicotine lozenge (QL)
- Nicorette lozenge (QL)
- Quit 2 lozenge (QL)
- Quit 4 lozenge (QL)
- Stop Smoking Aid lozenge (QL)
- nicotine patch (QL)
- Nicotrol inhaler (PA, non-preferred)
- Nicotrol NS nasal spray (PA, non-preferred)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: up to 12 weeks

III. QUANTITY LIMITS:

- All products are limited to two quit attempts per year
- Patches: 30 patches per 30 days; 180 patches per year
- Gum and lozenges: 120 units per 5 days; 4,320 units per year

IV. INITIAL CRITERIA:

1. Is the request for a quantity exception for nicotine gum, lozenge or patches?
    a. Yes (go to #2)
    b. No (go to #5)
2. Has the member completed two quit attempts in the past year?
    a. Yes (forward to pharmacist for review [deny 5q])
    b. No (go to #3)
3. Has the provider submitted documentation that the member has stopped using tobacco?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the member enrolled in a tobacco cessation support program, such as Quit 4 Life?
    a. Yes (approve up to 12 weeks [QL: patches 30/30; gum and lozenges 120/5])
    b. No (approve up to 12 weeks [QL: patches 30/30; gum and lozenges 120/5] and refer to tobacco cessation support program))
5. Has the member had a documented medical reason why they cannot use ALL of the following: nicotine gum, nicotine lozenge, AND nicotine patch?
    a. Yes (approve for 12 weeks)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

- For tobacco cessation support, UHA recommends using Quit 4 Life. Quit 4 Life has a team of trained experts to help members develop a quit plan and provides tools for tobacco cessation. Expert support and assistance is available from coaches who specialize in tobacco cessation. For additonal details or for enrollment, call 1-866-QUIT-4-LIFE (1-866-784-8454), or visit www.quitnow.net.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/22/2022
- **Last Updated Date:** 6/22/2022

Testosterone Cypionate

Policy Number: Rx045

I. MEDICATION NAME(S):

- testosterone cypionate vials
- all other products, see Additional Information section

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for a diagnosis of gender dysphoria, female-to-male transsexualism?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation the member meets all of all of the following criteria: (1) Puberty confirmed by physical changes and hormone levels, but not earlier than Tanner Stages two; (2) A diagnosis of gender dysphoria made by a mental health professional with experience in gender dysphoria; (3) Persistent well-documented gender dysphoria; (4) The capacity to make fully informed decisions and to give consent to treatment; (5) Any significant medical or mental health concerns are reasonably well controlled; and (6) A comprehensive mental health evaluation provided in accordance with the Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org)??
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug used for a diagnosis of primary or secondary hypogonadism?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 8a])
4. Is the member a male age 12 years or older?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 8a])
5. Does the member have a total testosterone level < 300ng/dL or a free testosterone level < 50ng/dL? For obese members with a BMI greater than 30, use free testosterone levels only. (For renewals or new members previously taking testosterone, proceed to renewal criteria.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a, initial labs])

V. RENEWAL CRITERIA:

1. Has testosterone levels been drawn after the member initiated therapy and/or after any dose changes?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Are total testosterone levels within therapeutic range (320 to 1000 ng/dL for gender dysphoria and 450 to 600 ng/dL for primary or secondary hypogonadism)?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a, renewal labs])

VI. ADDITIONAL INFORMATION:

- All other testosterone products are not on the UHA formulary. These products must meet this criteria as well as the General Utilization Management criteria. Specifically, trial and failure of formulary alternatives (testosterone cypionate vials) and all less-costly non-formulary alternatives.
- Guideline Note 127: To qualify for cross-sex hormone therapy, the patient must:
    - Have persistent, well-documented gender dysphoria;
    - Have the capacity to make a fully informed decision and to give consent for treatment;
    - Have any significant medical or mental health concerns reasonably well controlled; and
    - Have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org).

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Oral Antifungals

Policy Number: Rx046

I. MEDICATION NAME(S):

- itraconazole capsule
- ketoconazole tablet
- Lamisil (terbinafine HCl) gran pack

II. LENGTH OF AUTHORIZATION:

- Initial: up to six months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member under age 21?
    a. Yes (go to #3)
    b. No (go to #4)
3. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Fungal infections of the skin, scalp, groin and nails are not funded for most members. Some conditions are covered if the member is immunocompromised, like those with AIDS or cancer.)
    a. Yes (go to #6)
    b. No (go to #5)
5. Is there a comorbid condition for which coverage would be allowed? For example, type 2 diabetes or other conditions that may increase the risk of serious secondary skin infections.
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a/3c])
6. Is the request for itraconazole?

a. Yes (go to #7)
b. No (approve for up to six months)

7. Has the member tried and failed terbinafine and ketoconazole, if indicated, and all less costly topical options when appropriate for the submitted condition?
    a. Yes (approve for up to six months)
    b. No (forward to pharmacist for review [deny 5k])

V. RENEWAL CRITERIA:

1. Is the requested drug being used outside of the FDA-approved treatment duration?
    a. Yes (deny 8a)
    b. No (go to #2)
2. Has documentation been submitted to support the continued use of this medication in accordance with clinical guidelines? (Refer to UpToDate or product labeling for appropriate treatment duration.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Rifaximin

Policy Number: Rx047

I. MEDICATION NAME(S):

- Xifaxan (rifaximin)

II. LENGTH OF AUTHORIZATION:

- Length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #5)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug used for an FDA-approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 8a])
4. Has the member tried and failed all less costly alternative therapies used to treat the member's condition according to UpToDate)?
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a and/or 5k])
5. Is the drug used for hepatic encephalopathy associated with chronic liver disease? Note: Irritable bowel syndrome (IBS) and travelers' diarrhea are not funded conditions according to the Oregon Health Plan Prioritized List of Health Services.
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 3a or 8a])
6. Has the member had an adequate trial and failure of, contraindication to, or intolerance to lactulose? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a, lactulose])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Palivizumab

Policy Number: Rx048

I. MEDICATION NAME(S):

- Synagis (palivizumab)

II. LENGTH OF AUTHORIZATION:

- Typically, approval is given from November 1st through March 31st of the following year for a maximum of five doses during each season. Authorizations may be allowed outside of this window depending on the start and end of Respiratory Syncytial Virus (RSV) season according to the OHA RSV surveillance data for Southern Oregon (report link: https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Pages/RespiratorySyncytialVirusSurveillanceData.aspx). As defined by the CDC:
    - RSV season onset is the first of two consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is ≥10% or the mean percentage of specimens testing positive for RSV by PCR is ≥3%, whichever occurs first.
    - RSV season offset is the last of two consecutive weeks during which the mean percentage of positive specimens by antigen is <10%, or the mean percentage of positive specimens by PCR is <3%, whichever occurs last.
- Qualifying infants born during RSV season may require fewer doses. If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued.

III. QUANTITY LIMITS:

- A maximum of five doses per season.
- A maximum of two seasons may be allowed for some members; until the member's age is 24 months or less at the start of RSV season.

IV. INITIAL CRITERIA:

1. See FFS Approval Criteria https://www.orpdl.org/durm/PA_Docs/palivizumab.pdf

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- UHA aligns with the OHA FFS PDL and prior authorization criteria for the duration of Governor Brown's emergency declaration for the 2022-2023 RSV season, whichever is longer

- Dose: 15 mg/kg via intramuscular injection once monthly throughout RSV season.
- The start date for Synagis® is November 1 each year (or sooner when the Oregon Public Health Division has determined that RSV season onset has occurred) for a total of up to 5 doses.
- Approval for more than 5 doses or additional doses after March 31 will be considered on a case-by-case basis.
- Results from clinical trials indicate that Synagis® trough concentrations greater than 30 days after the 5th dose are well above the protective concentration. Therefore, 5 doses will provide more than 20 weeks of protection.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/2/2022

Lacosamide

Policy Number: Rx049

I. MEDICATION NAME(S):

- lacosamide tablets

II. LENGTH OF AUTHORIZATION:

- Length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug used for partial-onset seizures?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member at least four years of age?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Has the member failed to achieve successful control of their seizures with at least two other antiepileptic drugs, such as carbamazepine, oxcarbazepine, phenytoin, topiramate, or valproic acid? (Note: members who are currently taking lacosamide should not be required to try and fail alternative agents.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/22/2022
- **Last Updated Date:** 12/11/2019

Mesalamine

Policy Number: Rx050

I. MEDICATION NAME(S):

- mesalamine DR 800 mg tab (generic Asacol HD)
- Apriso (mesalamine) 0.375 g cap ER 24h
- mesalamine DR 400 mg cap (generic Delzicol)
- mesalamine DR 1.2 g tab (generic Lialda)
- mesalamine 1000 mg rectal suppository
- *Pentasa (mesalamine) 250 mg cap ER (non-formulary)*
- *Pentasa (mesalamine) 500 mg cap ER (non-formulary)*

II. LENGTH OF AUTHORIZATION:

- Initial: length of benefit (LOB)

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for Crohn's disease?
    a. Yes (go to #4)
    b. No (go to #2)
2. Is the drug prescribed for ulcerative colitis?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Is the disease described as active in the small bowel (proximal to the colon)?
    a. Yes (go to #5)
    b. No (go to #4)
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to one of the following: sulfasalazine or balsalazide? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])
5. Is the request for Pentasa?
    a. Yes (go to #6)
    b. No (go to #7)
6. Does the member have full GI tract involvement that requires the Pentasa release mechanism?

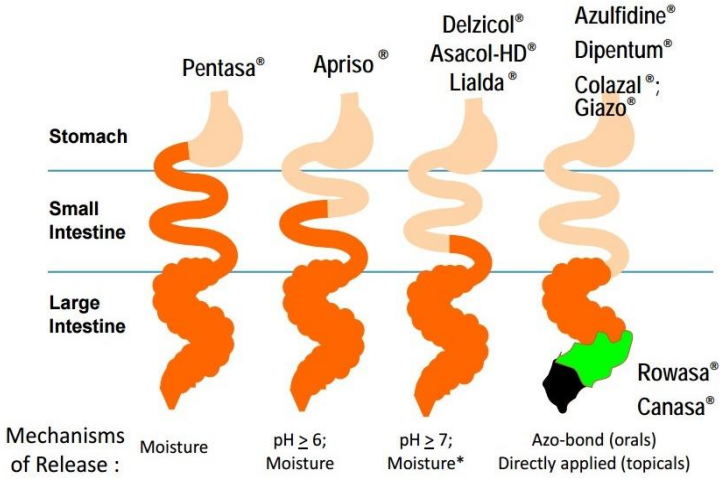
a. Yes (approve for LOB)
b. No (go to #7)

7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to at least one generic oral mesalamine product (generic Lialda, Asacol, Delzicol) or Apriso? (Adequate trial is defined as compliant with therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for LOB)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

VI. ADDITIONAL INFORMATION:

- 5-ASA Release Sites:



- Medications:

Drug Name	Strength	Site of Delivery	Qt/DS	Price	Ulcerative Colitis		Crohn's Colitis		Crohn's Ileitis	
					Active	Maint	Active	Maint	Active	Maint
Pentasa (mesalamine CR) oral cap	500 mg	Jejunum, ileum, colon	240/30	$1,404	4	2-4	4*	2-4*	4*	2-4*
Pentasa (mesalamine CR) oral cap	250 mg	Jejunum, ileum, colon	480/30	$1,404	4	2-4	4*	2-4*	4*	2-4*
Apriso (mesalamine ER) oral cap	0.375 g	Terminal ileum, colon	120/30	$489	1.5-3*	1.5	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
mesalamine DR (generic Asacol HD) oral tab	800 mg	Distal ileum, colon	180/30	$1,107	2.4-4.8	2.4-4.8	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
mesalamine DR (generic Delzicol) oral cap	400 mg	Distal ileum, colon	180/30	$395	2.4-4.8	2.4-4.8	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
mesalamine DR (generic Lialda) oral tab	1.2 g	Distal ileum, colon	120/30	$443	2.4-4.8	2.4	2.4-4.8*	2.4-4.8*	2.4-4.8*	2.4-4.8*
sulfasalazine (generic Azulfidine) oral tab	500 mg	Colon	120/30	$21	2-4	2-4	2-4*	NR	NR	ID
sulfasalazine DR (generic Azulfidine EC) oral tab	500 mg	Colon	120/30	$37	2-4	2-4	2-4*	NR	NR	ID
Dipentum (olsalazine sodium) oral cap	250 mg	Colon	120/30	$1,567	2-3*	1	2-3*	1*	NR	NR

balsalazide disodium (generic Colazal) oral cap	750 mg	Colon	270/30	$104	6.75	3-6*	ID	ID	NR	NR
mesalamine (generic SFRowasa) rectal enema	4 G/60 mL	Sigmoid colon, rectum	1680/28	$353	4	2-4*	4*	ID	NR	NR
mesalamine (generic Rowasa) rectal enema kit	4 G/60 mL	Sigmoid colon, rectum	4/28	$479	4	2-4*	4*	ID	NR	NR
mesalamine (generic Canasa) rectal supp	1000 mg	Rectum	30/30	$750	1	1*	ID	ID	NR	NR

**Off-label indication*

Maint: maintenance; ID: insufficient data; NR: not recommended.

Doses shown are total grams per day and must be divided in 3 or 4 equally divided doses for certain formulations. For details, see Lexi-Comp drug information included with UpToDate and the official prescribing information.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/30/2022
- **Last Updated Date:** 3/30/2022

Calcitonin Gene-Related Peptide (CGRP) Antagonists

Policy Number: Rx051

I. MEDICATION NAME(S):

- Vyepti (eptinezumab)
- Aimovig (erenumab)
- Ajovy (fremanezumab)
- Emgality (galcanezumab)
- Nurtec (rimegepant)
- Ubrelvy (ubrogenpant)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for an FDA-approved indication AND is the appropriate dose and duration being prescribed consistent with the FDA approved prescribing information? (Refer to Table 1. Indications and Dosing in 'Additional Information' section.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member age 18 or older?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the medication prescribed by or in consultation with a neurologist or headache specialist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Have medication overuse headaches been ruled out (i.e. member is not frequently using opioids, butalbital-containing products, triptans, acetaminophen, aspirin or NSAIDS)?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Is the request for migraine prophylaxis/prevention with Nurtec (rimagepant), Vyepti (eptinezumab), Aimovig (erenumab), Ajovy (fremanezumab), or Emgality (galcanezumab)?
    a. Yes (go to #8)
    b. No (go to #6)
6. Is the request for acute migraine treatment with Nurtec (rimegepant) or Ubrelvy (ubrogenpant)?
    a. Yes (go to #10)

b. No (go to #7)

7. Is the request for Emgality (galcanezumab) for cluster headache prophylaxis?
    a. Yes (go to #11)
    b. No (forward to pharmacist for review [deny 8a])
8. Does the member have episodic migraines (4 - 14 headaches per month) or chronic migraines (at least 15 headaches per month)?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review [deny 5a])
9. Has the member had an adequate trial and failure of, contraindication to, or intolerance to at least one drug in each of the following classes: (1) Beta-blockers (e.g. propranolol, atenolol, metoprolol, nadolol, timolol); (2) Anticonvulsants (e.g. topiramate, valproate); AND (3) Antidepressants (e.g. amitriptyline, nortriptyline, venlafaxine)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 7a])
10. Has the member had an adequate trial and failure of, contraindication to, or intolerance to simple analgesics such as NSAIDS (e.g. ibuprofen, naproxen) or acetaminophen, AND at least three different triptans (e.g. naratriptan, rizatriptan, sumatriptan, zolmitriptan)? (Note: members who have more than four headaches per month also require current use of a prophylactic medication such as a beta-blocker, anticonvulsant, and antidepressant.)
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 7a])
11. Does the member have any of the following exclusions: (1) ECG abnormalities compatible with an acute CV event or condition delay; (2) History of unstable angina, percutaneous coronary intervention, coronary artery bypass grafting, deep vein thrombosis, or pulmonary embolism within the past 6 months; OR (3) Any history of stroke, intracranial or carotid aneurysm, intracranial hemorrhage, or vasospastic angina, clinical evidence of peripheral vascular disease, or diagnosis of Raynaud's disease?
    a. Yes (forward to pharmacist for review [deny 5a])
    b. No (go to #12)
12. Has the member had an adequate trial and failure of, contraindication to, or intolerance to verapamil and at least one anticonvulsant (e.g. topiramate, valproate)? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #13)
    b. No (forward to pharmacist for review [deny 7a])
13. If applicable, has the member tried and failed other less costly CGRP Antagonists for the indication being treated? (Refer to Table 1. Indications and Dosing in 'Additional Information' section.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Is the request for Nurtec (rimegepant), Vyepti (eptinezumab), Aimovig (erenumab), Ajovy (fremanezumab), or Emgality (galcanezumab) for migraine prophylaxis?
    a. Yes (go to #4)
    b. No (go to #2)
2. Is the request for Nurtec (rimegepant) or Ubrelvy (ubrogenpant) for acute migraine treatment?
    a. Yes (go to #5)
    b. No (go to #3)
3. Is the request for Emgality (galcanezumab) for cluster headache prophylaxis?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 8a])
4. Has the member had an objective response to therapy defined as a reduction of at least two headache days per month for episodic migraines; OR a reduction of at least 50% headache days per month for chronic migraines; OR reduction in ED or urgent care utilization?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
5. Has the member had an objective response to therapy as indicated by a reduction in headache frequency and/or intensity?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])
6. Has the member had an objective response to therapy defined as a reduction of at least eight cluster headaches per month?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

- Table 1. Indications and Dosing

Drug	Indication	Dose	Price per 30 Days*
Vyepti (eptinezumab)	Migraine Prophylaxis	100 mg IV every 3 months; some patients may benefit from 300 mg IV every 3 months	$1,642 for 100mg; $4,926 for 300 mg
Aimovig (erenumab)	Migraine Prophylaxis	70 mg SC monthly; some patients may benefit from 140 mg SC monthly	$656
Ajovy (fremanezumab)	Migraine Prophylaxis	225 mg SC monthly or 675 mg SC every 3 months	$656
Emgality (galcanezumab)	Migraine Prophylaxis, Cluster Headache Prophylaxis	Migraine: 240 mg SC as a single loading dose, then 120 mg SC monthly Cluster HA: 300 mg SC at onset, then monthly until the end of the cluster period	$1,267for first month, then $633 - $1583
Nurtec (rimegepant)	Acute Migraine Treatment Migraine Prophylaxis	Acute: 75 mg orally as needed for acute migraine attack Prophylaxis: 75 mg every other day	$892/8 tablets $1,672/15 tablets
Ubrelvy (ubrogepant)	Acute Migraine Treatment	50 mg, 100 mg orally as needed for acute migraine attack	$909/10 tablets

**Price quotes completed on 06-16-2022*

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/22/2022
- **Last Updated Date:** 6/22/2022

Sacubitril-Valsartan

Policy Number: Rx052

I. MEDICATION NAME(S):

- Entresto (sacubitril-valsartan)

II. LENGTH OF AUTHORIZATION:

- Initial: 6 months
- Renewal: 12 months

III. QUANTITY LIMITS:

- Adult: 60 tablets per 30 days

IV. INITIAL CRITERIA:

1. Is the drug prescribed for chronic heart failure with New York Heart Association (NYHA) Class II,III,IV (Refer to Table 1. Heart Failure Classifications in 'Additional Information' section.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member a child age 1 to 18 with a reduced ejection fraction (LVEF) of ≤40, or is the member age 18 or older?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed at the FDA-approved dose to treat the covered condition? (Refer to Table 2. Indications and Dosing in 'Additional Information' section.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the drug prescribed by or in consulation with a cardiologist or cardiac care specialist?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review)
5. Does the member have a history of angioedema or will they be continuing use of an ACE inhibitor or aliskiren?
    a. Yes (forward to pharmacist for review)
    b. No (go to #6)
6. Has the member had an adequate trial and failure of an ACE-inhibitor or ARB or was sacubitril-valsartan initiated during heart failure related hospitalization? (Adequate trial is defined as adherent to therapy for at least 30 days at or above the recommended target dose of an agent with clinical evidence for use in heart failure.) Refer to Table 2. Doses of ACE/ARBs in 'Additional Information' section.
    a. Yes (go to #7)

b. No (forward to pharmacist for review)

7. Has the member had an adequate trial and failure of, contraindication to, or intolerance to carvedilol, sustained-release metoprolol succinate, or bisoprolol? (Clinical guidelines recommend concurrent use of a beta blocker at the highest tolerated dose.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member adherent to therapy? (Adherence defined as MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- Table 1. New York Heart Association Functional Classifications

NYHA Functional Classifications	
I	No limitation of physical activity. Ordinary physical activity does not cause symptoms of heart failure.
II	Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in symptoms of heart failure.
III	Marked limitation of physical activity. Comfortable at rest but less than ordinary physical activity causes symptoms of heart failure.
IV	Unable to carry on any physical activity without symptoms of HF. Experiences symptoms of heart failure at rest.

- Table 2. Minimum Daily Doses of ACEI/ARB Required

ACE	**TARGET DOSE**	**ARB**	**TARGET DOSE**
Captopril	50mg Three times daily	Candesartan	32 mg Once daily
Enalapril	10 mg Twice daily	Losartan	150 mg Once daily
Lisinopril	20 mg Once daily	Valsartan	160 mg Once daily
Ramipril	5mg Two times daily		
Trandalopril	4 mg Once daily		

Patients much achieve a minimum daily dose of one of the drugs listed for at least 30 days to improve changes of tolerability to the target maintenance dose of sacubitril/valsartan (97/103 mg BID). Target daily doses of other ACE-I and ARBS for heart failure have not been established. The agents listed have demonstrated efficacy in heart failure.

- Table 3. FDA Approved Dosing for Entresto®

Indication	**Starting step (BID)**	**Second Step (BID)**	**Final Step (BID)**
Adult Heart Failure	49/51 mg	97/103**	-
Pediatric HF (less than 40 kg)	1.6 mg/kg*	2.3 mg/kg	3.1 mg/kg
Pediatric HF (40kg-50 KG)	24/26 mg	49/51 mg	72/78
Pediatric HF (>50 kg)	49/51 mg	72/78	97/103

The clinical trial dose of Entresto was 97/103 mg twice daily. To prevent occurrence of angioedema and hypotension, ARNI is available in 3 doses use for initiation and titration.
**The 49/51 mg tablets may be used to compound an oral suspension*
***The valsartan in Entresto is more bioavailable vs valsartan in other marketed tables.*

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/20/2023
- **Last Updated Date:** 9/20/2023

Acne Agents

Policy Number: Rx053

I. MEDICATION NAME(S):

- adapalene gel
- benzoyl peroxide
- clindamycin solution
- isotretinoin
- Accutane (isotretinoin)
- Amnesteem (isotretinoin)
- Clavaris (isotretinoin)
- Myorisan (isotretinoin)
- Zenatane (isotretinoin)
- tretinoin cream
- multiple non-formulary acne topical agents (must try and fail formulary alternatives if applicable)

II. LENGTH OF AUTHORIZATION:

- Initial: 3 months
- Renewal: 6 months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the member under age 21?
    a. Yes (go to #2)
    b. No (go to #3)
2. Is there documentation that treating the condition is medically appropriate and necessary in which it will enhance the member's ability to grow, develop, or participate in school per the EPSDT Medicaid benefit?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the drug prescribed for a condition funded by the Oregon Health Plan (OHP) in a manner consistent with the Health Evidence Review Commission (HERC) Prioritized List of Health Services? (Mild acne is not covered. Refer to Guideline Note 65 for coverage of severe cystic acne or Guideline Note 132 for acne conglobata and acne fulminans: persistent or recurrent inflammatory nodules and cysts AND ongoing scarring OR acne conglobata with recurrent abscesses or communicating sinuses.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a GLN65 and/or GLN132])
4. Is the drug prescribed for an FDA approved indication or a medically appropriate off-label use with strong evidence supporting safety and efficacy?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 8a])

5. Is the request for oral isotretinoin?
    a. Yes (go to #6)
    b. No (go to #8)
6. Has the member tried and failed three months of oral doxycyline or minocycline?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review [deny 7a])
7. Has the member tried and failed a topical antibiotic (such as clindamycin 1%)?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review [deny 7a])
8. Is the request for adapalene gel, tretinoin cream, clindamycin solution, or benzyoyl peroxide?
    a. Yes (approve for 3 months)
    b. No (go to #9)
9. Has the member had an adequate trial and failure of, condraindication to, or intolerance to adapalene gel, tretinoin cream, clindamycin solution, or benzoyl peroxide?
    a. Yes (approve for three months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 12/7/2022
- **Last Updated Date:** 12/7/2022

Cystic Fibrosis Modulators

Policy Number: Rx054

I. MEDICATION NAME(S):

- Kalydeco (ivacaftor)
- Orkambi (lumacaftor/ivacaftor)
- Symdeko (tezacaftor/ivacaftor)
- Trikafta (elexacaftor/tezacaftor/ivacaftor)

II. LENGTH OF AUTHORIZATION:

- Initial: three months
- Renewal: twelve months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for Cystic Fibrosis with confirmed genetic testing and for an FDA approved age and CFTR gene mutation?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the drug prescribed by or in consultation with a pulmonologist or practitioner at an accredited Cystic Fibrosis center?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is there documentation of pulmonary function testing completed in the last 90 days with percent forced expiratory volume in 1 second (ppFEV1) between 40-90%?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a)
4. Has the member had an adequate trial and failure of, contraindication to, or intolerance to dornase alpha AND hypertonic saline AND inhaled antibiotic therapy, if appropriate for age and condition? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for 3 months)
    b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Has the member had an objective response to therapy as defined by lack of decline in FEV1, reduction in incidence of pulmonary exacerbations, significant improvement in BMI by 10% from baseline, or reduction in cystic fibrosis exacerbations?

    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is there evidence of adherence and tolerance to therapy?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is there ongoing oversite by prescriber including annual liver function tests?
    a. Yes (approve for 12 months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 3/31/2021
- **Last Updated Date:** 3/31/2021

Varenicline

Policy Number: Rx055

I. MEDICATION NAME(S):

- Chantix (varenicline)

II. LENGTH OF AUTHORIZATION:

- Initial and renewal: up to 12 weeks

III. QUANTITY LIMITS:

- 0.5 (11)-1 ORAL TAB DS PK: 53 tablets per 28 days, 106 tablets per year
- 0.5 mg: 11 tablets per 7 days, 22 tablets per year
- 1 mg: 2 tablets per day, 12 weeks per 180 days

IV. INITIAL CRITERIA:

1. Has the member completed two quit attempts in the past year?
    a. Yes (forward to pharmacist for review [deny 5q])
    b. No (go to #2)
2. Has the provider submitted documentation that the member has stopped using tobacco?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Is the member enrolled in a tobacco cessation support program, such as Quit 4 Life?
    a. Yes (approve up to 12 weeks)
    b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

See Initial Criteria

VI. ADDITIONAL INFORMATION:

- For tobacco cessation support, UHA recommends using Quit 4 Life. Quit 4 Life has a team of trained experts to help members develop a quit plan and provides tools for tobacco cessation. Expert support and assistance is available from coaches who specialize in tobacco cessation. For additonal details or for enrollment, call 1-866-QUIT-4-LIFE (1-866-784-8454), or visit www.quitnow.net.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/23/2021
- **Last Updated Date:** 6/23/2021

Insulin Delivery Devices

Policy Number: Rx056

I. MEDICATION NAME(S)

- Omnipod DASH Insulin Management System

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: one year

III. QUANTITY LIMITS:

- Personal Diabetes Manager (PDM): one every four years
- Pods: 10 per 30 days

IV. INITIAL CRITERIA:

1. Does the member have a diagnosis of type 1 or type 2 diabetes mellitus?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the member's C-peptide level ≤ 110% below the lower limit of normal; OR does the member have a creatine clearance of ≤ 50 ml/minutes, a fasting C-peptide level ≤ 110% the lower limit of normal, and a fasting blood sugar obtained at the same time as the C-peptide level ≤ 225mg/dl; OR is there a positive beta cell antibody test?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 5a])
3. Has the member been on a program of multiple daily injections (at least three per day) with frequent self-adjustments for insulin dose for at least the past six months?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the member or caregiver completed a comprehensive diabetes education program?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Is the device prescribed by or in consultation with an endocrinologist?
    a. Yes (got to #6)
    b. No (forward to pharmacist for review [deny 5a])
6. Has the member had suboptimal blood sugar in the past two months despite appropriate management demonstrated by any of the following: (1) A1C > 7%; (2) Recurring hypoglycemia; (3) Wide fluctuations in blood glucose before mealtime; (4) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl; OR (5) History of severe glycemic excursions?

a. Yes (go to #7)
b. No (forward to pharmacist for review [deny 5a])

7. Has the member tried and failed Omnipod, or is there a documented reason why Omnipod is not prescribed? (See 'Additional Information' section for details on billing Omnipod via the medical benefit.)
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review [deny 7a])

IV. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No ((forward to pharmacist for review [deny 5u])
2. Is the member adherent to provider follow up and diabetes education? (Prescriber should follow up with member at least every three months.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
3. Has the member had a positive clinical response to therapy such as at least a 10% reduction in A1c or A1c is at goal (at or below 7%), or has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for one year)
    b. No (forward to pharmacist for review [deny 5a])

V. ADDITIONAL INFORMATION:

- All other external insulin infusion pumps, including Omnipod, are considered durable medical equipment (DME):
    - Prior authorization requirements for durable medical equipment can be found on the UHA website at: https://www.umpquahealth.com/prior_authorizations/
    - The Oregon Health Authority rules governing external insulin infusion pumps can be found on the OHA website at: https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=JCDopJXq6rWEhPNDYybKLZvmyKzqi_G2xCUUqpHW10mnXktZ0f5!849948759?ruleVrsnRsn=84246

VI. REVISION HISTORY:

- **Last Reviewed Date:** 12/22/2021
- **Last Updated Date:** 12/22/2021

C1 Esterase Inhibitors

Policy Number: Rx057

I. MEDICATION NAME(S):

- Haegarda (C1 esterase inhibitor)

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: up to one year

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Does the member have a diagnosis of hereditary angioedema (HAE) confirmed by genetic testing or normal C1q lab levels with levels below the lab's normal reference range for both C4 and C1INH?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Is the drug prescribed at the FDA-approved dose based on patient age and weight?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Does the member have a history of at least two attacks per month which are considered severe with swelling of the face, throat or gastrointestinal tract that significantly interrupts usual daily activity despite short-term symptomatic treatment or treatment required in the emergency department? (Note: Prophylactic use has only been evaluated in patients with more than 2 attacks per month)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Has the member been evaluated for triggers of HAE attacks and is maximally managed for avoidance of those triggers (such as stress, hormonal changes, dental surgery, trauma, medications including ACE inhibitors and estrogen)?
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5a])
5. Has the provider documented discussion with the patient of risks (including thrombotic events and/or anaphylaxis) versus benefits of therapy?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review [deny 5a])
6. Is the patient prescribed concurrent epinephrine or do they have epinephrine on hand?
    a. Yes (approve for 6 months)

b. No (forward to pharmacist for review [deny 5a])

V. RENEWAL CRITERIA:

1. Has there been at least a 50% reduction in the number of angioedema attacks, significant improvement in the severity and duration of attacks, and clinical documentation of functional improvement?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 5a])
2. Has the patient been attack free for at least 6 months?
    a. Yes (go to #3)
    b. No (approve for up to 12 months)
3. Is there documentation from the prescriber that they have evaluated continued necessity of long-term prophylactic treatment at the current dose?
    a. Yes (approve for up to six months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **P&T Review Date:** 6/22/2022
- **Implementation Date:** 6/22/2022

Finerenone

Policy Number: Rx058

I. MEDICATION NAME(S):

- Kerendia (finerenone)

II. LENGTH OF AUTHORIZATION:

- Initial: three months
- Renewal: twelve months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the drug prescribed for an adult with a diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)? (CKD is defined as the presence of kidney damage or decreased kidney function for three or more months with an estimated glomerular filtration rate [eGFR] <60 ml/min/1.73 m2 or an albumin-to-creatinine ration [ACR] >30 mg/g.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Is the medication being prescribed in a manner that is supported by the FDA approved indication and dosing recommendations based on estimated glomerular filtration rates (eGFR) and serum potassium levels? (Refer to Table 1 in 'Additional Information' for recommended initial dosing.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review [deny 8a])
3. Is the medication prescribed by or in consultation with a nephrologist or kidney care specialist?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review [deny 5a])
4. Is the member currently using a maximally tolerated ACE or ARB, OR have a documented contraindication, or intolerance to both? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review [deny 5k/5a])
5. Is the member currently using a maximally tolerated dose of an SGLT2 inhibitor with renal benefit (e.g., Farxiga, Invokana) OR have a documented contraindication to or intolerance? (Adequate trial is defined as adherent to therapy for at least three

consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)

a. Yes (approve for three months)
b. No (forward to pharmacist for review [deny 7a])

V. RENEWAL CRITERIA:

1. Is the medication being prescribed in a manner that is supported by the FDA approved indication and dosing recommendations based on estimated glomerular filtration rates (eGFR) and serum potassium levels? (Refer to Table 2 in 'Additional Information' for recommended maintenance dosing.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review [deny 8a])
2. Has the member had a positive clinical response to therapy OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for 12 months)
    b. No (forward to pharmacist for review [deny 5a])

VI. ADDITIONAL INFORMATION:

- Table 1. Recommended Starting Dose

eGFR (mL/min/1.73^2)	Starting Dose
≥ 60	20 mg once daily
≥ 25 to < 60	10mg once daily
< 25	Not Recommended

Measure serum potassium levels and estimated glomerular filtration rate (eGFR) before initiation. Do not initiate treatment if serum potassium is > 5.0 mEq/L. If serum potassium is >4.8 to 5 mEq/L, may consider initiation with increased serum potassium monitoring during the first 4 weeks.

- Table 2. Recommended Maintenance Dose

		Current Kerendia Dose	
		10 mg once daily	**20mg once daily**
Current Serum Potassium (mEq/L)	**≤ 4.8**	Increase the dose to 20 mg once daily.*	Maintain 20 mg once daily.
	> 4.8-5.5	Maintain 10 mg once daily.	Maintain 20 mg once daily.
	> 5.5	Withhold Kerendia. Consider restarting at 10 mg once daily when serum potassium ≤ 5.0 mEq/L.	Withhold Kerendia. Restart at 10 mg once daily when serum potassium ≤ 5.0 mEq/L.

If eGFR had decreased by more than 30% compared to previous, maintain 10 mg dose.

VII. REVISION HISTORY:

- **Last Reviewed Date:** 9/14/2022
- **Last Updated Date:** 9/14/2022

Buprenorphine & Opioid Concurrent Use

Policy Number: Rx059

I. MEDICATION NAME(S):

- buprenorphine HCl sublingual tablet
- buprenorphine HCl/naloxone sublingual HCl film
- buprenorphine HCl/naloxone HCl sublingual tablet

II. LENGTH OF AUTHORIZATION:

- Initial: varies

III. QUANTITY LIMITS:

- Total daily dose of 24 mg buprenorphine

IV. INITIAL CRITERIA:

1. Is the medication being used to transition from a prescribed chronic opiate with planned short term continued use of the opiate to minimize symptoms of opioid withdrawal/cravings?
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is there documentaton of an opiod tapering plan?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Is the request for less than or equal to an average daily dose of 24 mg of buprenorphine?
    a. Yes (approve)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

- Formulary buprenorphine and buprenorphine/naloxone products do not require prior authorization review unless prescribed concurrently with an opioid medication.

VII. REVISION HISTORY:

- **P&T Review Date:** 3/15/2023
- **Implementation Date:** 3/15/2023

Vesicular Monoamine Transporter 2 (VMAT2) Inhibitors

Policy Number: Rx061

I. MEDICATION NAME(S):

- Austedo (deutetrabenazine)
- Ingrezza (valbenazine tosylate)
- tetrabenazine

II. LENGTH OF AUTHORIZATION:

- Initial: 2 months
- Renewal: 12 months

III. QUANTITY LIMITS:

- Deutetrabenazine maximum dose: 48 mg/day
- Valbenazine maximum dose: 80 mg/day
- Tetrabenazine maximum dose: 50 mg/day (chorea as a result of Huntington's disease)

IV. INITIAL CRITERIA:

1. Is the drug prescribed for chorea as a result of Huntington's disease in a patient 18 years or older?
    a. Yes (go to #2)
    b. No (go to #5)
2. Is the request for tetrabenazine or deutetrabenazine?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Does the patient have a baseline total maximal chorea score of 8 or higher?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Has it been determined that the patient does not have uncontrolled depression or is at risk of violent or suicidal behavior?
    a. Yes (go to #13)
    b. No (forward to pharmacist for review)
5. Is the drug prescribed for moderate to severe tardive dyskinesia in a patient 18 years or older?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the request for valbenazine or deutetrabenazine?
    a. Yes (go to #7)
    b. No (forward to pharmacist for review)

7. Is the patient's documented baseline Abnormal Voluntary Movement Scale (AIMS) score 10 or greater on scale of 0-20?
    a. Yes (go to #8)
    b. No (forward to pharmacist for review)
8. Is the medication prescribed by or in consultation with a neurologist or psychiatrist?
    a. Yes (go to #9)
    b. No (forward to pharmacist for review)
9. Does the patient have persistent dyskinesia despite cessation of offending agent, or is there a documented inability to discontinue the offending agent?
    a. Yes (go to #10)
    b. No (forward to pharmacist for review)
10. Does the patient have a localized form of dystonia?
    a. Yes (go to #11)
    b. No (go to #12)
11. Has the patient tried and failed or have a contraindication to botulinum toxin injections?
    a. Yes (go to #12)
    b. No (forward to pharmacist for review)
12. Has the requesting provider performed a urine drug screen to rule out non-prescribed drug causes of tardive dyskinesia? (Appropriate results would include the absence of THC, cocaine, benzodiazepines, opiates, or other non-prescribed substances.)
    a. Yes (go to #13)
    b. No (forward to pharmacist for review)
13. Is the drug prescribed at an FDA-approved dose?
    a. Yes (go to #14)
    b. No (forward to pharmacist for review)
14. Has the patient recently been evaluated and determined not to be at risk for a prolonged QT interval?
    a. Yes (go to #15)
    b. No (forward to pharmacist for review)
15. Is the request for the least costly VMAT2 inhibitor approved for the indication?
    a. Yes (approve for 2 months)
    b. No (go to #16)
16. Has the member had an adequate trial and failure of, contraindication to, or intolerance to the less costly alternative agent? (Adequate trial is defined as adherent to therapy for at least three consecutive months, MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (approve for 2 months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the request for renewal of tetrabenazine or deutetrabenazine in a patient with chorea as a result of Huntington's disease?
    a. Yes (go to #2)
    b. No (go to #3)
2. Has there been documented evidence of improvement in total maximal chorea score of at least 3 points from baseline?

    a. Yes (approve for 12 months)
    b. No (forward to pharmacist for review)
3. Is the request for renewal of valbenazine or deutetrabenazine in a patient with tardive dyskinesia?
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Has there been documented evidence of improvement in AIMS score by at least 50% from baseline?
    a. Yes (approve for 12 months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/21/2023
- **Last Updated Date:** 6/21/2023

Pharmaceutical Weight Management

Policy Number: Rx060

I. MEDICATION NAME(S):

- All FDA approved medications

II. LENGTH OF AUTHORIZATION:

- Initial: six months
- Renewal: six months

III. QUANTITY LIMITS:

- N/A

IV. INITIAL CRITERIA:

1. Is the request for a drug prescribed for the primary purpose of reducing weight for a member age 20 years or younger? (Note: Medications for weight loss are not a covered condition funded by the Oregon Health Plan (OHP) according to the Health Evidence Review Commission (HERC) Prioritized List of Health Services.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member age 8 or older? (Note: Use of pharmacotherapy is not medically appropriate for children under the age of 8 per the American Academy of Pediatrics Clinical Practice Guidelines.)
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Has the member been engaged in comprehensive, intensive behavioral interventions for at least six months? (Note: Adequate documentation is required.)
    a. Yes (go to #4)
    b. No (forward to pharmacist for review)
4. Is the member, parent, or caregiver, actively participating in a lifestyle or nutrition support program? (Note: UHA requires attestation of participation in a program such as Diabetes Self Management, Food Smart, or a similar clinic based program.)
    a. Yes (go to #5)
    b. No (forward to pharmacist for review and medication therapy management/CM)
5. Is the medication being prescribed in a manner that is supported by the FDA approved indication and dosing recommendations based on age?
    a. Yes (go to #6)
    b. No (forward to pharmacist for review)
6. Is the member's BMI greater than or equal to 30 kg/m^2, or if under 18 is the initial BMI in the 95^{th} percentile or higher for age and sex?
    a. Yes (go to #7)

b. No (forward to pharmacist for review)

7. Has the member tried and failed all appropriate less costly alternative therapies?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

V. RENEWAL CRITERIA:

1. Is the member adherent to therapy? (Adherence defined as a MPR greater than or equal to 80% or no gaps between fills that exceed 5 days.)
    a. Yes (go to #2)
    b. No (forward to pharmacist for review)
2. Is the member actively participating in a lifestyle or nutrition support program? DPP, DSM, FoodSmart, or similar clinic based program?
    a. Yes (go to #3)
    b. No (forward to pharmacist for review)
3. Has the member had a positive clinical response to therapy OR has the prescriber submitted documentation of continued medical necessity in accordance with the initial criteria?
    a. Yes (approve for six months)
    b. No (forward to pharmacist for review)

VI. ADDITIONAL INFORMATION:

VII. REVISION HISTORY:

- **Last Reviewed Date:** 6/21/2023
- **Last Updated Date:** 6/21/2023

UMPQUA HEALTH ALLIANCE

Alternatives for Commonly Requested Non-Preferred Drugs

HOW TO USE THIS DOCUMENT:

- This list is provided to assist with prescribing decisions for select common conditions that have multiple clinically appropriate options.
- Our current complete list of covered medications, also called a preferred drug list or "formulary," and our coverage guidelines for drugs on our formulary that require a prior authorization are included online at https://www.umpquahealth.com/pharmacy-services/
- For the list of CPT codes for medications covered under the medical benefit, refer to the Prior Authorization Grid on the Prior Authorization page.

MEDICATION LIST:

THERAPEUTIC CLASS	NON-PREFERRED DRUG	➲	ALTERNATIVE PREFERRED DRUG
ALLERGY			
ANTIHISTAMINES	• CETIRIZINE CHEW TAB • FEXOFENADINE TABLET • LEVOCETIRIZINE TABLET	➲	• CETIRIZINE 1 MG/ML ORAL SOLUTION • CETIRIZINE TABLET • LORATADINE TABLET
NASAL ANTI-INFLAMMATORY STEROIDS	• FLONASE ALLERGY RELIEF 50 MCG SPRAY	➲	• FLUTICASONE PROPIONATE 50 MCG NASAL SPRAY SUSPENSION • IPRATROPIUM BROMIDE 21 MCG NASAL SPRAY
ANTHELMINITICS			
ANTHELMINITICS	• ALBENDAZOLE 200 MG TABLET	➲	• REESE'S PINWORM 50 MG/ML ORAL SUSPENSION
ASTHMA AND COPD			
ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	• TUDORZA PRESSAIR 400 MCG INHALER	➲	• INCRUSE ELLIPTA 62.5 MCG INHALER
BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	• PROAIR RESPICLICK 90 MCG INHALER	➲	• ALBUTEROL SULFATE HFA 90 MCG INHALER • LEVALBUTEROL TARTRATE HFA 45 MCG INHALER
BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	• ADVAIR HFA INHALER • BREO ELLIPTA INHALER	➲	• FLUTICASONE-SALMETEROL INHALERS (GENERIC AIRDUO, GENERIC ADVAIR DISKUS, AND WIXELA INHUB)
BEHAVIORAL HEALTH - OTHER			
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	• VYVANSE 30 MG CAPSULE	➲	• DEXTROAMPHETAMINE IR TABLET • METHYLPHENIDATE IR TABLET

THERAPEUTIC CLASS	NON-PREFERRED DRUG	➲	ALTERNATIVE PREFERRED DRUG
			• METHYLPHENIDATE ER 10 MG AND 20 MG TABLET • AGE LIMITS FOR ALL ALTERNATIVES, PA REQUIREMENTS MAY APPLY
SEDATIVE-HYPNOTICS,NON-BARBITURATE	• ESZOPICLONE 2 MG TABLETS	➲	• ZOLPIDEM TARTRATE IR TABLET (QUANTITY LIMITS APPLY)
CARDIVASCULAR DISEASE - HYPERTENSION			
BETA-ADRENERGIC BLOCKING AGENTS	• BYSTOLIC 10 MG TABLET	➲	• ACEBUTOLOL CAPSULE • ATENOLOL TABLET • BISOPROLOL FUMARATE TABLET • METOPROLOL SUCCINATE ER TABLET • METOPROLOL TARTRATE TABLET • NADOLOL TABLET • PROPRANOLOL ER CAPSULE • PROPRANOLOL TABLET • SOTALOL TABLET
CONTRACEPTION/OXYTOCICS			
CONTRACEPTIVES,ORAL	• LO LOESTRIN FE 1-10 TABLET	➲	• SPRINTEC TABLET • JUNEL FE TABLET • PORTIA TABLET • NORA-BE TABLET • MANY ADDITIONAL OPTIONS FOR ORAL BIRTH CONTROL IS FOUND ON THE FORMULARY
COUGH AND COLD			
DECONGESTANTS, ORAL	• PSEUDOEPHEDRINE ER 120 MG TAB • SUDOGEST 12 HOUR 120 MG CAPLET	➲	• SUDOGEST 30MG OR 60MG TABLET (QUANTITY LIMITS APPLY)
NON-NARCOTIC ANTITUSSIVE AND EXPECTORANT COMB.	• MUCINEX ER 600 MG TABLET	➲	• MUCUS ER 600MG TABLET • MUCUS ER 1,200MG TABLET • GUAIFENESIN TABLET • QUANTITY LIMITS MAY APPLY TO THESE OPTIONS
DERMATOLOGY – ANTIINFECTIVE			
TOPICAL ANTIBIOTICS	• CLINDAMYCIN PH 1% SOLUTION	➲	• MUPIROCIN 2% TOPICAL OINTMENT • CLINDAMYACIN 1% TOPICAL SOLUTION (PA REQUIRED)
TOPICAL ANTIFUNGALS	• CLOTRIMAZOLE 1% SOLUTION • ECONAZOLE NITRATE 1% CREAM	➲	• CLOTRIMAZOLE 1% CREAM • TERBINAFINE 1% CREAM

THERAPEUTIC CLASS	NON-PREFERRED DRUG	➲	ALTERNATIVE PREFERRED DRUG
	• NYSTATIN-TRIAMCINOLONE CREAM/OINTMENT		• MICONAZOLE NITRATE 2% CREAM • NYSTATIN CREAM/OINTMENT/POWDER • TRIAMCINOLONE CREAM/OINTMENT (AVAILABLE SEPARATELY FROM NYSTATIN)
TOPICAL ANTIFUNGAL/ANTIINFLAMMATORY, STERIOD AGENT	• CLOTRIMAZOLE-BETAMETHASONE CREAM	➲	• CLOTRIMAZOLE 1% CREAM • BETAMETHASONE DP AUGMENTED CREAM • BETAMETHASONE VALERATE CREAM • EACH AVAILABLE SEPARATELY
DERMATOLOGY – ANTIINFLAMMATORY			
TOPICAL ANTI-INFLAMMATORY STEROIDAL	• BETAMETHASONE DP 0.05% CREAM/OINTMENT • FLUOCINONIDE 0.05% SOLUTION	➲	• BETAMETHASONE DP AUGMENTED CREAM/OINTMENT • BETAMETHASONE VALERATE CREAM/OINTMENT • TRIAMCINOLONE CREAM/OINTMENT • HYDROCORTISONE CREAM/OINTMENT
DERMATOLOGY - MISCELLANEOUS			
TOPICAL LOCAL ANESTHETICS	• LIDOCAINE 3% CREAM • LIDOCAINE 5% OINTMENT	➲	• LIDOCAINE-PRILOCAINE 2.5%-2.5% TOPICAL CREAM
DIABETES			
ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	• OZEMPIC PEN • MOUNJARO • VICTOZA PEN	➲	• BYETTA, BYDUREON, RYBELSUS, AND TRULICITY • PA REQUIRED FOR ALL OPTIONS; OTHER ALTERNATIVES MAY APPLY
ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	• FARXIGA TABLET • JARDIANCE TABLET	➲	• STEGLATRO
ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	• JANUVIA TABLET	➲	• ALOGLIPTIN
INSULINS	• BASAGLAR KWIKPEN	➲	• INSULIN GLARGINE-YFGN VIALS/PENS (GENERIC SEMGLEE-YFGN) • INSULIN GLARGINE VIALS (GENERIC LANTUS) • INSULIN GLARGINE SOLOSTAR (GENERIC LANTUS SOLOSTAR)
EAR - GENERAL DISORDERS			

THERAPEUTIC CLASS	NON-PREFERRED DRUG	➲	ALTERNATIVE PREFERRED DRUG
EAR PREPARATIONS,ANTIBIOTICS	• CORTISPORIN-TC EAR SUSPENSION	➲	• NEOMYCIN-POLYMYXIN-HYDROCORTISONE 3.5-10K-1 OTIC SOLUTION • OXFLOXACIN 0.3% OTIC DROPS
HORMONAL DEFICIENCY			
ANDROGENIC AGENTS	• TESTOSTERONE 1.62% GEL PUMP	➲	• TESTOSTERONE CYPIONATE 200 MG/ML (PA REQUIRED)
INFECTIOUS DISEASE - VIRAL			
ANTIVIRALS, GENERAL	• FAMCICLOVIR TABLET	➲	• ACYCLOVIR CAPSULE/TABLET • VALACYCLOVIR TABLET (QUANTITY LIMITS MAY APPLY)
INFLAMMATORY DISEASE			
ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	• HUMIRA PEN/SYRINGE	➲	• AMJEVITA (PA REQUIRED; OTHER ALTERNATIVES MAY APPLY) • INFLECTRA (PA REQUIRED; OTHER ALTERNATIVES MAY APPLY)
GLUCOCORTICOIDS	• BUDESONIDE EC CAPSULE	➲	• BALSALAZIDE 750MG CAPSULE • SULFASALAZINE IR OR ER TABLET • PREDNISONE TABLET • METHYLPREDNISOLONE TABLET • DEXAMETHASONE TABLET • PREDNISLONE SODIUM PHOSPHATE SOLUTION
LOWER GASTROINTESTINAL DISORDERS - BOWEL INFLAMMATORY			
RECTAL PREPARATIONS	• ANUCORT-HC SUPPOSITORY	➲	• LIDOCAINE-PRILOCAINE 2.5%-2.5% TOPICAL CREAM
DRUG TX-CHRONIC INFLAM. COLON DX,5-AMINOSALICYLAT	• PENTASA CAPSULE	➲	• BALSALAZIDE 750MG CAPSULE • SULFASALAZINE IR OR ER TABLET • MESALAMINE (PA REQUIRED)
SKELETAL MUSCLE DISORDER			
SKELETAL MUSCLE RELAXANTS	• CARISOPRODOL TABLET • METAXALONE TABLET	➲	• BACLOFEN TABLET • CYCLOBENZAPRINE TABLET • METHOCARBAMOL TABLET • TIZANIDINE TABLET (QUANTITY LIMITS MAY APPLY)
UPPER GASTROINTESTINAL DISORDERS - ULCER DISEASE			
ANTI-ULCER PREPARATIONS	• SUCRALFATE 1 GM/10 ML SUSPENSION	➲	• SUCRALFATE 1 GM TABLET
PROTON-PUMP INHIBITORS	• ESOMEPRAZOLE MAGNESIUM DR CAPSULE	➲	• OMEPRAZOLE DR CAPSULE/TABLET • PANTOPRAZOLE DR TABLET • LANSOPRAZOLE DR CAPSULE (QUANTITY LIMITS MAY APPLY)

THERAPEUTIC CLASS	NON-PREFERRED DRUG	➲	ALTERNATIVE PREFERRED DRUG
URINARY TRACT - FUNCTIONAL DISORDERS			
OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEP	• MYRBETRIQ ER TABLET	➲	• TROSPIUM • OXYBUTYNIN IR AND ER • TOLTERODINE IR AND ER (STEP THERAPY REQUIRED)