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Actemra

Prior Authorization Guideline

Guideline ID	GL-132948
Guideline Name	Actemra
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	01/21/2021 ; 04/21/2021 ; 06/16/2021 ; 09/15/2021 ; 04/20/2022 ; 09/21/2022 ; 01/18/2023 ; 05/25/2023 ; 9/20/2023

1 . Indications

Drug Name: Actemra (tocilizumab), Actemra ACTPen (tocilizumab)
Rheumatoid Arthritis Indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs). **Giant Cell Arteritis** Indicated for giant cell arteritis in adult patients. **Polyarticular Juvenile Idiopathic Arthritis** Indicated for the treatment of active polyarticular juvenile idiopathic arthritis (PJIA) in patients 2 years of age and older. **Active Systemic Juvenile Idiopathic Arthritis** Indicated for the treatment of active systemic juvenile idiopathic arthritis (SJIA) in patients 2 years of age and older. **Systemic Sclerosis-Associated Interstitial Lung Disease** Indicated for slowing the rate of

decline in pulmonary function in adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD).

2 . Criteria

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of giant cell arteritis **AND** **2** - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following: • Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] • Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)] **AND** **3** - Prescribed by or in consultation with a rheumatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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

Approval Criteria

1 - Documentation of positive clinical response to Actemra or Actemra ACTPen therapy

AND

2 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - One of the following:

2.1 History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

3 - One of the following:

3.1 History of failure, contraindication, or intolerance to two of the following preferred products (Document drug, date, and duration of trial):

- Cimzia (certolizumab)
- One of the formulary adalimumab products [b]
- Simponi (golimumab)
- Olumiant (baricitinib)
- Rinvoq (upadacitinib)
- Xeljanz/Xeljanz XR (tofacitinib)

OR

3.2 Both of the following:

3.2.1 Patient is currently on Actemra or Actemra ACTPen therapy as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

3.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Genentech sponsored Actemra Access Solutions program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Actemra or Actemra ACTPen*

AND

4 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	*Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Genentech sponsored Actemra Access Solutions program shall be required to meet initial authorization criteria as if patient were new to therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. [b] For a list of formulary adalimumab products please reference drug coverage tools.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Actemra or Actemra ACTPen therapy **AND** **2** - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following: • Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] • Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of active polyarticular juvenile idiopathic arthritis **AND**	

2 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - One of the following:

3.1 History of failure, contraindication, or intolerance to one of the formulary adalimumab products [b] (Document date and duration of trial)

OR

3.2 Both of the following:

- Patient is currently on Actemra or Actemra ACTPen therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Genentech sponsored Actemra Access Solutions program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Actemra or Actemra ACTPen*

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Genentech sponsored Actemra Access Solutions program shall be required to meet initial authorization criteria as if patient were new to therapy.

	[b] For a list of formulary adalimumab products please reference drug coverage tools.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Actemra or Actemra ACTPen therapy **AND** **2** - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following: • Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] • Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active systemic juvenile idiopathic arthritis

AND

2 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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

Approval Criteria

1 - Documentation of positive clinical response to Actemra or Actemra ACTPen therapy

AND

2 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Systemic sclerosis-associated interstitial lung disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by all of the following criteria:[4]

1.1 One of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 At least two of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)

- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III)

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on HRCT, involving at least 10% of the lungs

AND

2 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actemra or Actemra ACTPen [a]	
Diagnosis	Systemic sclerosis-associated interstitial lung disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Actemra or Actemra ACTPen therapy

AND

2 - Patient is not receiving Actemra or Actemra ACTPen in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Actemra (tocilizumab) or Actemra ACTPen (tocilizumab) is an interleukin-6 (IL-6) receptor antagonist, available in both an intravenous and a subcutaneous formulation. Both formulations of Actemra are indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more disease-modifying anti-rheumatic drugs (DMARDs). [1,2] Examples of DMARDs commonly used in the treatment of rheumatoid arthritis include methotrexate, leflunomide, and sulfasalazine. [3,4] Both formulations are also indicated for giant cell arteritis in adult patients. Both formulations are also indicated for the treatment of active polyarticular juvenile idiopathic arthritis (PJIA) and active systemic juvenile idiopathic arthritis (SJIA), in patients 2 years of age and older. The intravenous formulation is also indicated for the treatment of adults and pediatric patients 2 years of age and older with chimeric

antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome. The subcutaneous formulation is also indicated for slowing the rate of decline in pulmonary function in adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD). [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Actemra [package insert]. South San Francisco, CA: Genentech, Inc.; February 2022.
2. Actemra ACTPen [package insert]. South San Francisco, CA: Genentech, Inc.; February 2022.
3. Pavy S. Constantin A, Pham T, et al. Methotrexate therapy for rheumatoid arthritis: clinical practice guidelines based on published evidence and expert opinions. Joint Bone Spine 2006;73(4):388-95.
4. Singh JA, Saag KG, Bridges SL, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. Arthritis Rheum. 2016;68(1):1-26.
5. van den Hoogen F, Khanna D, Fransen J, et al. 2013 Classification criteria for systemic sclerosis: an American College of Rheumatology/European League against Rheumatism collaborative initiative. Ann Rheum Dis 2013;72:1747-1755.

5 . Revision History

Date	Notes
9/20/2023	Updated step therapy requirement to match adalimumab policy langu age in selecting formulary agent.

Actimmune

Prior Authorization Guideline

Guideline ID	GL-148538
Guideline Name	Actimmune
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	06/17/2020 ; 02/19/2021 ; 06/16/2021 ; 06/15/2022 ; 06/21/2023 ; 6/17/2024

1 . Indications

Drug Name: Actimmune (interferon gamma-1b)
Chronic granulomatous disease Indicated for the treatment of chronic granulomatous disease to reduce the frequency and severity of serious infections. **Osteopetrosis** Indicated in the treatment of severe, malignant osteopetrosis to delay the time to progression. **Other Uses:** The National Cancer Comprehensive Network (NCCN) recommends use of Actimmune in mycosis fungoides (MF) and Sezary syndrome (SS). [2]

2 . Criteria

Product Name: Actimmune [a]	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic granulomatous disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Actimmune [a]	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Actimmune	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Actimmune [a]	
Diagnosis	Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of severe, malignant osteopetrosis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actimmune [a]	
Diagnosis	Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Actimmune	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actimmune [a]	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has ONE of the following diagnoses:	

• Mycosis fungoides (MF) • Sezary syndrome (SS)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actimmune [a]	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Actimmune	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Actimmune [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Actimmune will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Actimmune [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Actimmune therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Actimmune (interferon gamma-1b) is indicated for reducing the frequency and severity of serious infections associated with chronic granulomatous disease (CGD). It is also indicated for delaying time to disease progression in patients with severe, malignant osteopetrosis (SMO). [1] The National Cancer Comprehensive Network (NCCN) recommends use of Actimmune in mycosis fungoides (MF) and Sézary syndrome (SS). [2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

- Supply limits may apply.

4 . References

1. Actimmune [Package Insert]. Deerfield, IL: Horizon Therapeutics USA Inc.; March 2021.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed April 29, 2024.

5 . Revision History

Date	Notes
6/14/2024	Annual review. No changes to coverage criteria.

Adalimumab

Prior Authorization Guideline

Guideline ID	GL-147801
Guideline Name	Adalimumab
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 05/20/2022 ; 09/21/2022 ; 01/18/2023 ; 06/21/2023 ; 08/18/2023 ; 12/13/2023 ; 04/17/2024

1 . Indications

Drug Name: Adalimumab
Rheumatoid Arthritis Indicated for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active rheumatoid arthritis. [1] **Polyarticular Juvenile Idiopathic Arthritis** Indicated for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 2 years of age and older. [1] **Psoriatic Arthritis** Indicated for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active psoriatic arthritis. [1] **Ankylosing Spondylitis** Indicated for reducing signs and symptoms in adult patients with active ankylosing spondylitis. [1]

Crohn's Disease Indicated for the treatment of moderately to severely active Crohn's disease in adults and pediatric patients 6 years and older. [1]

Ulcerative Colitis Indicated for the treatment of moderately to severely active ulcerative colitis in adults and pediatric patients 5 years and older. [1]

Plaque Psoriasis Indicated for the treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate. [1]

Hidradenitis Suppurativa Indicated for the treatment of moderate to severe hidradenitis suppurativa in patients 12 years of age and older. [1]

Uveitis Indicated for the treatment of non-infectious intermediate, posterior and panuveitis in adult and pediatric patients 2 years of age and older. [1]

2 . Criteria

Product Name: Adalimumab [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - ONE of the following:

2.1 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at the maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator. [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply. * Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer spo nsored program SHALL BE REQUIRED to meet initial authorization cr iteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to adalimumab therapy **AND** **2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator. [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Adalimumab [a]	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

3 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to adalimumab therapy

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Adalimumab [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - ONE of the following:

2.1 History of failure to a 3 month trial of methotrexate at the maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

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

- Dermatologist
- Rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to adalimumab therapy **AND** **2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Adalimumab [a]	
Diagnosis	Plaque Psoriasis

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

Approval Criteria

1 - Diagnosis of moderate to severe chronic plaque psoriasis

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

2.1.2 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Coal tar

AND

2.1.3 History of failure to a 3 month trial of methotrexate at the maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

OR

2.3 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

	* Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools

Product Name: Adalimumab [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to adalimumab therapy **AND** **2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Adalimumab [a]	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - ONE of the following:

2.1 History of failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trials)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to adalimumab therapy

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Adalimumab [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following:

2.1 History of failure to ONE of the following conventional therapies at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.2 Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of Crohn's disease as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Stelara (ustekinumab)]

OR

2.3 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

	[b] For a list of preferred adalimumab products please reference drug coverage tools

Product Name: Adalimumab [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to adalimumab therapy **AND** **2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Adalimumab [a]	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active ulcerative colitis	

AND

2 - ONE of the following:

2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission medical records (Document drug, date, and duration of therapy) [e.g., Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND **5** - Prescribed by or in consultation with a gastroenterologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to adalimumab therapy **AND** **2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Adalimumab [a]	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - ONE of the following:

2.1 History of failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)

OR

2.2 BOTH of the following:

- Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab*

AND

3 - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b]

AND

4 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer sponsored program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to adalimumab therapy

AND

2 - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Adalimumab [a]	
Diagnosis	Uveitis (UV)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-infectious uveitis

AND

2 - Uveitis is classified as ONE of the following:

- intermediate
- posterior
- panuveitis

AND

3 - ONE of the following:

3.1 BOTH of the following:

- History of failure to at least ONE corticosteroid (e.g., prednisolone, prednisone) at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)
- History of failure to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at up to a maximally

indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial) **OR** **3.2** BOTH of the following: • Patient is currently on adalimumab therapy as documented by claims history or submission of medical records (Document date and duration of therapy) • Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from a manufacturer sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of adalimumab* **AND** **4** - If the request is for a non-formulary adalimumab product, the patient has a history of failure to all formulary adalimumab products unless the prescriber has given a clinical reason or special circumstance why the patient is unable to use a formulary adalimumab product (please document reason/special circumstances) [b] **AND** **5** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)] **AND** **6** - Prescribed by or in consultation with ONE of the following: • Rheumatologist • Ophthalmologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. * Patients requesting initial authorization who were established on ther

	apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from a manufacturer spo nsored program SHALL BE REQUIRED to meet initial authorization cr iteria as if patient were new to therapy. [b] For a list of preferred adalimumab products please reference drug coverage tools.

Product Name: Adalimumab [a]	
Diagnosis	Uveitis (UV)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to adalimumab therapy **AND** **2** - Patient is not receiving adalimumab in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Clinical Practice Guidelines
Medication: Adalimumab: Humira® (adalimumab), Abrilada™ (adalimumab-afzb), Adalimumab-aacf (unbranded Idacio), Adalimumab-adaz (unbranded Hyrimoz), Adalimumab-adbm (unbranded

Cyltezo), Adalimumab-fkjp (unbranded Hulio), Amjevita™ (adalimumab-atto), Cyltezo®, (adalimumab-adbm), Hadlima™ (adalimumab-bwwd), Hulio® (adalimumab-fkjp), Hyrimoz® (adalimumab-adaz), Idacio® (adalimumab-aacf), Simlandi® (adalimumab-ryvk), Yuflyma® (adalimumab-aaty), Yusimry™ (adalimumab-aqvh)

Benefit/Coverage/Program Information

Background:

Adalimumab is a tumor necrosis factor (TNF) blocker indicated for:

• Rheumatoid Arthritis (RA): reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active RA. Adalimumab can be used alone or in combination with methotrexate or other non-biologic disease-modifying anti-rheumatic drugs (DMARDs).

• Juvenile Idiopathic Arthritis (JIA): reducing signs and symptoms of moderately to severely active polyarticular JIA in patients 2 years of age and older. Adalimumab can be used alone or in combination with methotrexate.

• Psoriatic Arthritis (PsA): reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active PsA.

• Ankylosing Spondylitis (AS): reducing signs and symptoms in adult patients with active AS. Adalimumab can be used alone or in combination with non-biologic DMARDs.

• Crohn's Disease (CD): treatment of moderately to severely active Crohn's disease in adults and pediatric patients 6 years of age and older.

• Ulcerative Colitis (UC): treatment of moderately to severely active ulcerative colitis in adults and pediatric patients 5 years of age and older.

• Plaque Psoriasis (Ps): treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate.

• Hidradenitis Suppurativa (HS): treatment of moderate to severe hidradenitis suppurativa in patients 12 years of age and older.

• Uveitis (UV): treatment of non-infectious intermediate, posterior, and panuveitis in adults and pediatric patients 2 years of age and older.

In ulcerative colitis, effectiveness has not been established in patients who have lost response to or were intolerant to TNF blockers.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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20. Hyrimoz [package insert]. Princeton, NJ: Sandoz, Inc.; April 2023.
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5 . Revision History

Date	Notes
6/19/2024	Annual review. Added Adalimumab-aacf (unbranded Idacio), Adalimumab-adaz (unbranded Hyrimoz), Adalimumab-adbm (unbranded Cyltezo), and Adalimumab-fkjp (unbranded Hulio) to the program. Updated references.

Adbry

Prior Authorization Guideline

Guideline ID	GL-144127
Guideline Name	Adbry
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	2/18/2022
P&T Revision Date:	03/16/2022 ; 07/20/2022 ; 03/15/2023 ; 3/20/2024

1 . Indications

Drug Name: Adbry
Atopic Dermatitis Indicated for the treatment of moderate to severe atopic dermatitis in patients aged 12 years and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

2 . Criteria

Product Name: Adbry [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 History of failure, contraindication, or intolerance to BOTH of the following therapeutic classes of topical therapies (document drug, date of trial, and/ or contraindication to medication)^:

- Medium, high, or very-high potency topical corticosteroids [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- Topical calcineurin inhibitor [e.g., tacrolimus (generic Protopic)]

OR

2.2 BOTH of the following:

2.2.1 Patient is currently on Adbry therapy as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Leo Pharma dermatology patient access program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Adbry*

AND

3 - Patient is NOT receiving Adbry in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Leo Pharma dermatology patient access program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Adbry [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Adbry therapy

AND

2 - Patient is NOT receiving Adbry in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Adbry (tralokinumab-ldrm) is an interleukin-13 antagonist indicated for the treatment of moderate to severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Adbry can be used with or without topical corticosteroids.

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05

	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2

	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

4 . References

1. Adbry [package insert]. Madison, NJ: Leo Pharma Inc.; December 2023.
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5 . Revision History

Date	Notes

3/10/2024	Annual review. Clarified topical steroid potency in atopic dermatitis wi th no change to clinical intent or coverage criteria. Updated backgrou nd and reference.

Afinitor

Prior Authorization Guideline

Guideline ID	GL-150614
Guideline Name	Afinitor
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 05/20/2022 ; 10/19/2022 ; 05/25/2023 ; 08/18/2023 ; 05/17/2024 ; 8/16/2024

1 . Indications

Drug Name: Afinitor (everolimus)
Advanced renal cell carcinoma Indicated for adults with advanced renal cell carcinoma (RCC) after failure of treatment with Sutent (sunitinib) or Nexavar (sorafenib). [1] **Subependymal giant cell astrocytoma (SEGA)** Indicated for treatment of adult and pediatric patients aged 1 year and older with TSC who have subependymal giant cell astrocytoma (SEGA) that requires therapeutic intervention but cannot be curatively resected. [1] **Progressive neuroendocrine tumors of pancreatic origin (PNET)** Indicated for adults with progressive neuroendocrine tumors of pancreatic origin (PNET) and adults with progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin that are unresectable, locally advanced or metastatic. [1] **Renal angiomyolipoma and tuberous sclerosis complex (TSC)** Indicated for adults with renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate

surgery. [1]

Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer (Advanced HR+ BC) Indicated for postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer in combination with Aromasin (exemestane) after failure of treatment with Femara (letrozole) or Arimidex (anastrozole).

Tuberous Sclerosis Complex (TSC) Indicated for the adjunctive treatment of adult and pediatric patients aged 2 years and older with TSC associated partial-onset seizures.

Drug Name: Torpenz (everolimus)

Hormone Receptor-Positive, HER2-Negative Breast Cancer Indicated for postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer in combination with exemestane after failure of treatment with letrozole or anastrozole

Tuberous Sclerosis Complex (TSC)-Associated Renal Angiomyolipoma Indicated for adults with renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery

Tuberous Sclerosis Complex (TSC)-Associated Subependymal Giant Cell Astrocytoma (SEGA) Indicated in adult and pediatric patients aged 1 year and older with TSC for the treatment of SEGA that requires therapeutic intervention but cannot be curatively resected.

2 . Criteria

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Neuroendocrine Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Neuroendocrine tumors of gastrointestinal origin
- Neuroendocrine tumors of lung origin

- Neuroendocrine tumors of thymic origin

AND

1.2 Disease is progressive

AND

1.3 ONE of the following:

- Disease is unresectable
- Disease is locally advanced
- Disease is metastatic

OR

2 - BOTH of the following:

2.1 Diagnosis of neuroendocrine tumors of pancreatic origin

AND

2.2 ONE of the following:

- Used for the management of recurrent, locoregional advanced disease and/or metastatic disease
- Used as preoperative therapy of locoregional insulinoma with or without diazoxide

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Neuroendocrine Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Advanced Renal Cell Carcinoma/Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of advanced renal cell cancer/kidney cancer **AND** **2** - Disease is ONE of the following: • Relapsed • Stage IV disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Advanced Renal Cell Carcinoma/Kidney Cancer

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Tuberous Sclerosis Complex- Associated Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of tuberous sclerosis complex (TSC)- associated renal cell carcinoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Tuberous Sclerosis Complex- Associated Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Subependymal Giant Cell Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of subependymal giant cell astrocytoma (SEGA) **AND** **2** - Used as adjuvant treatment	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Subependymal Giant Cell Astrocytoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Waldenstroms Macroglobulinemia or Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Waldenstroms macroglobulinemia • Lymphoplasmacytic lymphoma **AND** **2** - ONE of the following: • Disease is non-responsive to primary treatment • Disease is progressive • Disease has relapsed	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Waldenstroms Macroglobulinemia or Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - ONE of the following:

- Disease is recurrent
- Disease is metastatic

AND

3 - Disease is hormone receptor (HR)-positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - ONE of the following:

5.1 Patient is a postmenopausal woman

OR

5.2 BOTH of the following

- Patient is a premenopausal woman
- Patient is being treated with ovarian ablation/suppression

OR

5.3 Patient is male

AND

6 - Used in combination with one of the following:

- Exemestane if progressed within 12 months or on a non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Fulvestrant
- Tamoxifen

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Breast Cancer

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of classical Hodgkin lymphoma **AND** **2** - Disease is refractory to at least 3 prior lines of therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following soft tissue sarcoma subtypes: • Locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa) • Recurrent angiomyolipoma • Lymphangioleiomyomatosis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Thymomas and Thymic Carcinomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: • Diagnosis of thymic carcinoma • Diagnosis of thymoma **AND** **2** - ONE of the following: • First-line therapy as a single agent for those who cannot tolerate first-line combination regimens • Second-line therapy as a single agent	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Thymomas and Thymic Carcinomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Follicular carcinoma • Oncocytic carcinoma • Papillary carcinoma **AND** **2** - ONE of the following: • Unresectable locoregional recurrent disease • Persistent disease	

- Metastatic disease

AND

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine treatment

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of meningioma **AND** **2** - Disease is recurrent or progressive **AND** **3** - Surgery and/or radiation is not possible **AND** **4** - ONE of the following^: • Used in combination with bevacizumab (Avastin, Mvasi, etc.) • Used in combination with octreotide acetate LAR	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NC CN guidelines.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of endometrial carcinoma **AND** **2** - Used in combination with letrozole	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Tuberous Sclerosis Complex associated Partial-onset Seizures
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of tuberous sclerosis complex associated partial-onset seizures **AND** **2** - Used as adjunctive therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Tuberous Sclerosis Complex associated Partial-onset Seizures
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Bone Cancer - Osteosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of osteosarcoma

AND

2 - Disease is ONE of the following:

- Relapsed/Refractory
- Metastatic

AND

3 - Used as second-line therapy

AND

4 - Used in combination with Nexavar (sorafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Bone Cancer - Osteosarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Rosai-Dorfman Disease • Langerhans Cell Histiocytosis • Erdheim-Chester Disease **AND**	

2 - Presence of phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Gastrointestingal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Gastrointestinal Stromal Tumor (GIST) **AND**	

2 - Disease is ONE of the following:

- Unresectable
- Progressive
- Metastatic
- Gross residual (R2 resection)
- Tumor rupture

AND

3 - Disease has progressed after single agent therapy with ALL of the following^:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

AND

4 - Used in combination with ONE of the following:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	Gastrointestingal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Afinitor, generic everolimus, generic torpenz [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Afinitor® (everolimus) is a kinase inhibitor indicated for the treatment of postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer in combination with Aromasin® (exemestane) after failure of treatment with Femara® (letrozole) or Arimidex® (anastrozole); in adults with progressive neuroendocrine tumors of pancreatic origin (PNET) and adults with progressive, well-differentiated, non-functional neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin that are unresectable, locally advanced or metastatic; adults with advanced renal cell carcinoma (RCC) after failure of treatment with Sutent® (sunitinib) or Nexavar® (sorafenib); adults with renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery; treatment of adult and pediatric patients aged 1 year and older with TSC who have subependymal giant cell astrocytoma (SEGA) that requires therapeutic intervention but cannot be curatively resected; and for the adjunctive treatment of adult and pediatric patients aged 2 years and older with TSC associated partial-onset seizures.[1] Torpenz is indicated for postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer in combination with exemestane after failure of treatment with letrozole or anastrozole, for adults with renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery, and for adult and pediatric patients aged 1 year and older with TSC who have subependymal giant cell astrocytoma (SEGA) that requires therapeutic intervention but cannot be curatively resected. Afinitor is not indicated for the treatment of patients with functional carcinoid tumors. The National Cancer Comprehensive Network (NCCN) also recommends use of Afinitor in invasive and inflammatory breast cancer, Waldenström's macroglobulinemia / lymphoplasmacytic lymphoma, neuroendocrine tumors, kidney cancer, soft tissue sarcomas, osteosarcomas, gastrointestinal stromal tumors, thymomas and thymic carcinomas, Hodgkin lymphoma, follicular, oncocytic, and papillary thyroid carcinomas, subependymal giant cell astrocytoma (SEGA), meningioma, histiocytic neoplasms, and endometrial carcinoma.[2]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Afinitor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; February 2022.
2. Torpenz [package insert]. Maple Grove, MN: Upsher-Smith Laboratories, LLC.; June 2024.
3. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. March 16, 2023.

5 . Revision History

Date	Notes
8/2/2024	Added Torpenz to the policy, updated reference.

Agamree

Prior Authorization Guideline

Guideline ID	GL-149796
Guideline Name	Agamree
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Agamree (vamorolone)
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older

2 . Criteria

Product Name: Agamree [a]	
Diagnosis	Duchenne Muscular Dystrophy (DMD)
Guideline Type	Non Formulary

Approval Criteria **1** - Published clinical evidence shows Agamree is likely to produce equivalent therapeutic results as other available corticosteroids (e.g., prednisone); therefore, Agamree is not medically necessary for treatment of Duchenne muscular dystrophy.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Agamree (vamorolone) is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older. [1] The UnitedHealthcare Pharmacy and Therapeutics Committee has determined that Agamree is Therapeutically Equivalent to prednisone in the treatment of DMD. Data for FDA approval from relatively short-term randomized controlled trials were limited; and while adverse effect profiles may differ among glucocorticoids, vamorolone does not offer a clear advantage over other glucocorticoids for DMD with respect to efficacy and overall safety. [2-5] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Agamree [package insert]. Coral Gables, FL: Catalyst Pharmaceuticals, Inc.; March 2024.
2. Dang UJ, Damsker JM, Guglieri M, et al. Efficacy and Safety of Vamorolone Over 48 Weeks in Boys With Duchenne Muscular Dystrophy: A Randomized Controlled Trial. Neurology. 2024;102(5):e208112.
3. Guglieri M, Clemens PR, Perlman SJ, et al. Efficacy and Safety of Vamorolone vs Placebo and Prednisone Among Boys With Duchenne Muscular Dystrophy: A Randomized Clinical Trial. JAMA Neurol. 2022;79(10):1005-1014.
4. Griggs RC, Miller JP, Greenberg CR, et al. Efficacy and safety of deflazacort vs prednisone and placebo for Duchenne muscular dystrophy. Neurology. 2016;87(20):2123-2131.
5. Gloss D, Moxley III R, Ashwal S, et. al. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology 2016; 86;465-472.

5 . Revision History

Date	Notes
7/11/2024	New program.

Albendazole

Prior Authorization Guideline

Guideline ID	GL-150659
Guideline Name	Albendazole
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 05/20/2022 ; 06/21/2023 ; 8/16/2024

1 . Indications

Drug Name: Albendazole
Parenchymal neurocysticercosis Indicated for the treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, Taenia solium. **Cystic hydatid disease** Indicated for the treatment of cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, Echinococcus granulosus.

2 . Criteria

Product Name: generic albendazole [a]

Diagnosis	Enterobius vermicularis (pinworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Enterobius vermicularis (pinworm)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Taenia solium and Taenia saginata (Taeniasis or Cysticercosis/Neurocysticercosis)
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Taeniasis or Cysticercosis/ Neurocysticercosis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Echinococcosis (Tapeworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Ancylostoma/Necatoriasis (Hookworm)
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Ascariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Ascariasis (Roundworm)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]

Diagnosis	Toxocariasis (Roundworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Toxocariasis (Roundworm)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Trichinellosis
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Trichinellosis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Trichuriasis (Whipworm)
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Trichuriasis (Whipworm)	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Capillariasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Capillariasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Baylisascaris
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Baylisascaris	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Clonorchiasis (Liver flukes)
Approval Length	1 month(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Clonorchiasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Gnathostomiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Gnathostomiasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Strongyloidiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Strongyloidiasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: generic albendazole [a]	
Diagnosis	Loiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Loiasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: generic albendazole [a]	
Diagnosis	Opisthorchiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Opisthorchiasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: generic albendazole [a]	
Diagnosis	Anisakiasis
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of Anisakiasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic albendazole [a]	
Diagnosis	Microsporidiosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Microsporidiosis not caused by Enterocytozoon bieneusi or Vittaforma corneae.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Albendazole is indicated for the treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, Taenia solium. Albendazole is also indicated for the treatment of cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, Echinococcus granulosus.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Albendazole [package insert]. Piscataway, NJ: Camber Pharmaceuticals Inc; November 2022.
2. CDC treatment guidelines. http://www.cdc.gov./parasites (accessed 5/4/2023).
3. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/microsporidiosis. Accessed May 4, 2023.

5 . Revision History

Date	Notes
7/30/2024	Renamed policy to generic name; Albenza no longer available. Annu al review. Clarified spelling of Opisthorchiasis

Alecensa

Prior Authorization Guideline

Guideline ID	GL-147895
Guideline Name	Alecensa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	6/17/2024

1 . Indications

Drug Name: Alecensa (alectinib)
Non-small cell lung cancer (NSCLC) Alecensa (alectinib) is a kinase inhibitor indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. **Erdheim-Chester Disease** The NCCN also recommends Alecensa for anaplastic lymphoma kinase (ALK)-fusion targeted relapsed/refractory, symptomatic Erdheim-Chester Disease. **Anaplastic large cell lymphoma (ALCL)** The NCCN also recommends Alecensa as second-line or initial palliative intent therapy and subsequent therapy for relapsed/refractory ALK+ anaplastic large cell lymphoma (ALCL). **B-cell lymphoma** The NCCN also recommends Alecensa for relapsed or refractory ALK-positive large B-Cell lymphoma. **Metastatic brain cancer from NSCLC** The NCCN also recommends Alecensa for ALK-

positive metastatic brain cancer from NSCLC.

Inflammatory myofibroblastic tumor The NCCN also recommends Alecensa for inflammatory myofibroblastic tumors with ALK translocation.

2 . Criteria

Product Name: Alecensa [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is anaplastic lymphoma kinase (ALK)-positive

AND

3 - ONE of the following:

3.1 Disease is ONE of the following:

- Recurrent
- Advanced
- Metastatic

OR

3.2 Used as adjuvant treatment following tumor resection	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of symptomatic Erdheim-Chester Disease

AND

2 - Used as targeted therapy ALK-fusion

AND

3 - Disease is ONE of the following:

- Relapsed
- Refractory

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	T-Cell Lymphomas

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

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma (ALCL)

AND

2 - Used as second-line or initial palliative intent therapy and subsequent therapy

AND

3 - Disease is ONE of the following:

- Relapsed
- Refractory

AND

4 - Anaplastic lymphoma kinase (ALK)-positive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of large B-Cell lymphoma

AND

2 - Disease is ONE of the following:

- Relapsed
- Refractory

AND

3 - Anaplastic lymphoma kinase (ALK)-positive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic brain cancer from NSCLC

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of inflammatory myofibroblastic tumor (IMT) **AND** **2** - Presence of ALK translocation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC), Histiocytic Neoplasms, T-Cell Lymphomas, B-Cell Lymphomas, CNS Cancers, Soft Tissue Sarcoma/Uterine Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Alecensa therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Alecensa will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Alecensa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Alecensa (alectinib) is a kinase inhibitor indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test and for adjuvant treatment in patients following tumor resection of ALK-positive NSCLC (tumors ≥ 4 cm or node positive) as detected by an FDA-approved test. The NCCN also recommends Alecensa for (ALK)-fusion targeted relapsed/refractory, symptomatic Erdheim-Chester Disease, as second-line or initial palliative intent therapy and subsequent therapy for relapsed/refractory ALK+ anaplastic large cell lymphoma (ALCL), relapsed or refractory ALK-positive large B-Cell lymphoma, ALK-positive metastatic brain cancer from NSCLC, and inflammatory myofibroblastic tumors with ALK translocation. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Alecensa [package insert]. South San Francisco, CA: Genentech USA, Inc.; April 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed May 9, 2024.

5 . Revision History

Date	Notes

6/10/2024	Added criteria for adjuvant treatment following tumor resection of ALK-positive NSCLC per FDA label. Updated references.

Ampyra

Prior Authorization Guideline

Guideline ID	GL-136026
Guideline Name	Ampyra
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	9/16/2020
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 05/20/2022 ; 05/25/2023 ; 11/17/2023

1 . Indications

Drug Name: Ampyra (dalfampridine)
Multiple sclerosis (MS) Indicated to improve walking in patients with multiple sclerosis (MS).

2 . Criteria

Product Name: Brand Ampyra, generic dalfampridine [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of multiple sclerosis **AND** **2** - Physician confirmation that patient has difficulty walking (e.g., timed 25-foot walk)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Ampyra, generic dalfampridine [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Physician confirmation that the patient's walking improved with therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

Background

Ampyra (dalfampridine) is a potassium channel blocker indicated to improve walking in patients with multiple sclerosis (MS). This was demonstrated by an increase in walking speed.[1]

4 . References

1. Ampyra [package insert]. Acorda Therapeutics: Ardsley, NY. June 2022

5 . Revision History

Date	Notes
11/7/2023	Updated initial authorization period from 6 months to 12 months and added SML.

Prior Authorization Guideline

Guideline ID	GL-150615
Guideline Name	Anticonvulsants
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/15/2020
P&T Revision Date:	07/21/2021 ; 09/15/2021 ; 08/19/2022 ; 08/18/2023 ; 11/17/2023 ; 12/13/2023 ; 02/16/2024 ; 8/16/2024

1 . Indications

Drug Name: Aptiom (eslicarbazepine acetate)
Partial-onset seizures Indicated in the treatment of partial-onset seizures.
Drug Name: Vimpat (lacosamide)
Partial-onset seizures Indicated in the treatment of partial-onset seizures. **Primary Generalized Tonic-Clonic Seizures** Indicated as adjunctive therapy in the treatment of primary generalized tonic-clonic seizures.
Drug Name: Banzel (rufinamide), Onfi (clobazam)
Seizures associated with Lennox-Gastaut syndrome (LGS) Indicated for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS). There is some clinical evidence to support the use of Onfi for refractory partial onset seizures.

Drug Name: Diacomit (stripentol)
Seizures Indicated for seizures associated with Dravet syndrome in patients taking clobazam.
Drug Name: Epidiolex (cannabadiol)
Seizures Indicated for seizures associated with Lennox-Gastaut syndrome, Dravet syndrome or tuberous sclerosis complex.
Drug Name: Fycompa (perampanel)
Partial-onset seizures Indicated for the treatment of partial-onset seizures with or without secondarily generalized seizures **Primary generalized tonic-clonic seizures** Indicated as adjunctive therapy for the treatment of primary generalized tonic-clonic seizures.
Drug Name: Lamictal ODT, Lamictal ODT Kit (lamotrigine)
Seizures Indicated as adjunctive therapy in patients with partial-onset seizures, primary generalized tonic-clonic seizures, and generalized seizures of Lennox-Gastaut syndrome, and as conversion to monotherapy in patients with partial-onset seizures who are receiving treatment with carbamazepine, phenytoin, phenobarbital, primidone, or valproate as the single antiepileptic drug.
Drug Name: Sabril (vigabatrin), Vigadrone (vigabatrin), Vigpoder (vigabatrin)
Refractory complex partial seizures Indicated as adjunctive therapy for refractory complex partial seizures in patients who have inadequately responded to several alternative treatments and for infantile spasms for whom the potential benefits outweigh the risk of vision loss.
Drug Name: Motpoly XR (lacosamide)
Partial-onset seizures Indicated for the treatment of partial-onset seizures in adults and in pediatric patients weighing at least 50 kg. **Primary Generalized Tonic-Clonic Seizures** Indicated as adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in adults and in pediatric patients weighing at least 50 kg.

2 . Criteria

Product Name: Aptiom [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

- Diagnosis of partial-onset seizures
- For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Banzel, generic rufinamide [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

AND

1.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.3 Not used as primary treatment

OR

2 - For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Fycompa [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of partial-onset seizures with or without secondarily generalized seizures

OR

1.2 ALL of the following:

1.2.1 Diagnosis of primary generalized tonic-clonic seizures

AND

1.2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.2.3 Not used as primary treatment

OR

2 - For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Onfi, generic clobazam [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

OR

1.1.2 Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)

OR

1.1.3 Diagnosis of Dravet syndrome

AND

1.2 BOTH of the following:

1.2.1 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.2.2 Not used as primary treatment

OR

2 - For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sabril, generic vigabatrin, Vigadrone, Vigpoder [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of partial-onset seizures

AND

1.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.3 Not used as primary treatment

AND

1.4 Patient has had inadequate response to several (at least three) alternative anticonvulsants

OR

2 - Diagnosis of infantile spasms

OR

3 - For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Diacomit [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Dravet syndrome and currently taking clobazam

OR

2 - For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Epidiolex [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex **OR** **2** - For continuation of prior therapy for a seizure disorder	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Lamictal ODT, generic lamotrigine ODT, Brand Lamictal ODT Kit, generic lamotrigine ODT kit [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - History of greater than or equal to 4 week trial of lamotrigine immediate-release or lamotrigine chewable tablet **OR** **2** - Documented history of an intolerance to the corresponding release product which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., change timing of dosing, divide daily dose out for more frequent but smaller doses)	

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Vimpat oral soln/tabs, generic lacosamide oral soln/tabs [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of partial-onset seizures

OR

2 - ALL of the following:

2.1 Diagnosis of primary generalized tonic-clonic seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

OR

3 - For continuation of prior therapy for a seizure disorder

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Motpoly XR	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ALL of the following: • Diagnosis of partial-onset seizures • Patient weighs at least 50 kg or more **OR** **2** - ALL of the following: • Diagnosis of primary generalized tonic-clonic seizures • Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment.) • Not used as primary treatment **OR** **3** - For continuation of prior therapy for a seizure disorder	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Aptiom, Brand Banzel, generic rufinamide, Diacomit, Epidiolex, Fycompa, Brand Lamictal ODT, generic lamotrigine ODT, Brand Lamictal ODT Kit, generic lamotrigine ODT kit, Motpoly XR, Brand Onfi, generic clobazam, Brand Sabril, generic vigabatrin, Vigadrone, Vigpoder, Brand Vimpat oral soln/tabs, generic lacosamide oral soln/tabs [a]	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Aptiom (eslicarbazepine acetate) and Vimpat (lacosamide) are indicated in the treatment of partial-onset seizures. Vimpat is also indicated as adjunctive therapy in the treatment of primary generalized tonic-clonic seizures. Banzel (rufinamide) and Onfi (clobazam) are indicated for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS). There is some clinical evidence to support the use of clobazam for refractory partial onset seizures. Epidiolex (cannabidiol solution) is indicated for seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex. Diacomit (stiripentol) is indicated for seizures associated with Dravet syndrome in patients taking clobazam. Fycompa (perampanel) is indicated for the treatment of partial-onset seizures with or without secondarily generalized seizures and as adjunctive therapy for the treatment of primary generalized tonic-clonic seizures.

Lamictal ODT and Lamictal ODT Kit (lamotrigine) are indicated as adjunctive therapy in patients with partial-onset seizures, primary generalized tonic-clonic seizures, and generalized seizures of Lennox-Gastaut syndrome; as conversion to monotherapy in patients with partial-onset seizures who are receiving treatment with carbamazepine, phenytoin, phenobarbital primidone, or valproate as the single antiepileptic drug; and as maintenance treatment of bipolar I disorder.

Motpoly XR is indicated for the treatment of partial-onset seizures and as adjunctive therapy in the treatment of primary generalized tonic-clonic seizures in adults and in pediatric patients weighing at least 50 kg.

Sabril (vigabatrin), Vigadone (vigabatrin), Vigpoder (vigabatrin) are indicated as adjunctive therapy for refractory complex partial seizures in patients who have inadequately responded to several alternative treatments and for infantile spasms for whom the potential benefits outweigh the risk of vision loss.

Adjunctive therapy is defined as treatment administered in addition to another therapy. Coverage will not be provided for Banzel as primary treatment.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Banzel [package insert]. Nutley, NJ: Eisai, Inc; December 2022.
2. Vimpat [package insert]. Smyma, GA: UCB, Inc; October 2023.
3. Fycompa [package insert]. Coral Gables, FL: Catalyst Pharmaceuticals, Inc. ; June 2023.
4. Aptiom [package insert]. Marlborough, MA; Sunovion Pharmaceuticals Inc; March 2019.
5. Onfi [package insert]. Deerfield, IL: Lundbeck; January 2023.
6. Sabril [package insert]. Deerfield, IL: Lundbeck; October 2021.

7. Koeppen, D. et al. Clobazam in therapy-resistant patients with partial epilepsy: A double-blind placebo-controlled crossover study. Epilepsia 28(5);495-506. October 1987.
8. Micahel, B. Clobazam as an add-on in the management of refractory epilepsy. Cochrane Database of Systemic Reviews 2008.
9. Diacomit [package insert]. San Mateo, CA: Biocodex Inc; July 2022.
10. Epidiolex [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc. ; January 2023.
11. Lamictal ODT [package insert]. Research Triangle Park, GlaxoSmithKline; February 2023.
12. Vigadrone [package insert]. Maple Grove, MN: Upsher-Smith Laboratories, LLC; March 2023.
13. Motpoly XR [package insert]. Piscataway, NJ: Aucta Pharmaceuticals, Inc.; June 2024.
14. Vigoder [package insert]. Parsippany, NJ: Pyros Pharmaceuticals, Inc.; July 2023.

5 . Revision History

Date	Notes
7/30/2024	Added new indication for Motpoly XR for adjunctive therapy in the tre atment of primary generalized tonic-clonic seizures.

Arikayce

Prior Authorization Guideline

Guideline ID	GL-141138
Guideline Name	Arikayce
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 02/18/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Arikayce (amikacin liposome inhalation suspension)
Mycobacterium avium complex (MAC) lung disease Indicated in adults who have limited or no alternative treatment options, for the treatment of Mycobacterium avium complex (MAC) lung disease as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy.

2 . Criteria

Product Name: Arikayce [a]

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of refractory Mycobacterium avium complex (MAC) lung disease

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting respiratory cultures positive for MAC within the previous 6 months.

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

3.1 Patient has been receiving a multidrug background regimen containing at least two of the following agents for a minimum of 6 consecutive months within the past 12 months:

- Macrolide antibiotic [e.g., azithromycin, clarithromycin]
- Ethambutol
- Rifamycin antibiotic [e.g., rifampin, rifabutin]

AND

4 - Patient will continue to receive a multidrug background regimen

AND

5 - Documentation that the patient has not achieved negative sputum cultures after receipt of a multidrug background regimen for a minimum of 6 consecutive months

AND

6 - In vitro susceptibility testing of recent (within 6 months) positive culture documents that the MAC isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than or equal to 64 mcg/mL

AND

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

- Infectious disease specialist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Arikayce [a]	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Documentation that the patient has achieved negative respiratory cultures

OR

1.2 All of the following:

1.2.1 Patient has not achieved negative respiratory cultures while on Arikayce

AND

1.2.2 Physician attestation that patient has demonstrated clinical benefit while on Arikayce

AND

1.2.3 In vitro susceptibility testing of most recent (within 6 months) positive culture with available susceptibility testing documents that the MAC isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of < 64 mcg/mL

AND

1.2.4 Patient has not received greater than 12 months of Arikayce therapy with continued positive respiratory cultures

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient continues to receive a multidrug background regimen containing at least two of the following agents [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

- Macrolide antibiotic [e.g., azithromycin, clarithromycin]
- Ethambutol
- Rifamycin antibiotic [e.g., rifampin, rifabutin]

AND

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

- Infectious disease specialist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Arikayce is an aminoglycoside antibacterial indicated in adults who have limited or no alternative treatment options, for the treatment of *Mycobacterium avium* complex (MAC) lung disease as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy. As only limited clinical safety and effectiveness data for Arikayce are currently available, reserve Arikayce for use in adults who have limited or no alternative treatment options. This drug is indicated for use in a limited and specific population of patients. [1] This indication is approved under accelerated approval based on achieving sputum culture conversion (defined as 3 consecutive negative monthly sputum cultures) by Month 6. Clinical benefit has not yet been established. [1] Arikayce has only been studied in patients with refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy. The use of Arikayce is not recommended for patients with non-refractory MAC lung disease. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Arikayce [package insert]. Bridgewater, NJ: Insmed; October 2020.

2. Griffith DE, Aksamit T, Brown-Elliot BA, et al. An official ATS/IDSA statement: diagnosis, treatment, and prevention of nontuberculous mycobacterial diseases. Am J Respir Crit Care Med. 2007;175:367-416.
3. Haworth CS, Banks J, Capstick T, et al. British thoracic society guidelines for the management of non-tuberculous mycobacterial pulmonary disease. Thorax. 2017;72:ii1-ii64.
4. Griffith DE, Eagle G, Thomson R, et al. Amikacin liposome inhalation suspension for treatment-refractory lung disease caused by mycobacterium avium complex (CONVERT): a prospective, open-label, randomized study. Am J Respir Crit Care Med. 2018; Sep 14. doi: 10.1164/rccm.201807-1318OC. [Epub ahead of print]
5. Kasperbauer S, Daley CL. Treatment of Mycobacterium avium complex lung infection in adults. Bloom A (Ed). UpToDate . Waltham MA: UpToDate Inc. http://www.uptodate.com. Accessed December 28, 2023.
6. Winthrop KL, Morimoto K, Castellotti PK, et al. An open-label extension study of amikacin liposome inhalation suspension (ALIS) for treatment-refractory lung disease caused by mycobacterium avium complex (MAC). Slides presented at: American College of Chest Physicians Annual Meeting; October 19-23, 2019; New Orleans, Louisiana.
7. Daley CL, Iaccarino Jr JM, Lange C, et al. Treatment of Nontuberculous Mycobacterial Pulmonary Disease: An Official ATS/ERS/ESCMID/IDSA Clinical Practice Guideline. Clinical Infectious Diseases. 2020; 71(11):3023.

5 . Revision History

Date	Notes
2/6/2024	Annual review with no change to coverage criteria.

Austedo, Austedo XR

Prior Authorization Guideline

Guideline ID	GL-154488
Guideline Name	Austedo, Austedo XR
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/15/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 02/18/2022 ; 02/17/2023 ; 06/21/2023 ; 04/17/2024

1 . Indications

Drug Name: Austedo (deutetrabenazine) or Austedo® XR (deutetrabenazine)
Chorea associated with Huntington's disease Indicated for the treatment of chorea associated with Huntington's disease. **Tardive dyskinesia** Indicated for the treatment of adults with tardive dyskinesia.

2 . Criteria

Product Name: Austedo, Austedo XR [a]	
Diagnosis	Tardive Dyskinesia

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

Approval Criteria

1 - Diagnosis of moderate to severe tardive dyskinesia

AND

2 - ONE of the following:

- Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication
- Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

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

- Neurologist
- Psychiatrist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Austedo, Austedo XR [a]	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Austedo, Austedo XR [a]	
Diagnosis	Chorea associated with Huntington's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chorea associated with Huntington's disease **AND** **2** - Prescribed by or in consultation with ONE of the following: • Neurologist • Psychiatrist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Austedo, Austedo XR [a]	
Diagnosis	Chorea associated with Huntington's disease
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Austedo and Austedo XR are a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated in adults for the treatment of chorea associated with Huntington's disease and for the treatment of tardive dyskinesia. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Austedo – Austedo XR [package insert]. Parsippany, NJ: Teva Pharmaceuticals Inc.September 2023.
2. Armstrong MJ, Miyasaki JM. Evidence-based guideline: Pharmacologic treatment of chorea in Huntington disease: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2012 August.
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5 . Revision History

Date	Notes
9/6/2024	Added products

Belbuca_Butrans

Prior Authorization Guideline

Guideline ID	GL-133848
Guideline Name	Belbuca_Butrans
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	12/16/2020
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 12/14/2022 ; 10/18/2023

1 . Indications

Drug Name: Belbuca (buprenorphine) buccal film, Butrans (buprenorphine) transdermal patch
Pain Indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate.

2 . Criteria

Product Name: Belbuca, Brand Butrans, generic buprenorphine [a]	
Diagnosis	Cancer/Hospice/End of Life related pain
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - The patient is being treated for cancer, hospice or end of life related pain	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: Belbuca, Brand Butrans, generic buprenorphine [a]	
Diagnosis	Non-cancer pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to BOTH of the following:

- Patient has been screened for substance abuse/opioid dependence
- Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - Patient has been screened for underlying depression and/or anxiety. If applicable, any underlying conditions have been or will be addressed

AND

4 - ONE of the following:

- The patient has a history of failure, contraindication or intolerance to a trial of tramadol IR, unless the patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time
- Patient is new to plan and currently established on Belbuca or Butrans for at least the past 30 days

AND

5 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias or neuropathies), BOTH of the following:

- Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose. (Document date of trial)
- Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose. (Document drug and date of trial).

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name: Belbuca, Brand Butrans, generic buprenorphine [a]	
Diagnosis	Non-cancer pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documented meaningful improvement in pain and function when assessed against treatment goals (Document improvement in function or pain score improvement). **AND** **2** - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met **AND** **3** - Prescriber attest to BOTH of the following: • Patient has been screened for substance abuse/opioid dependence • Pain is moderate to severe and expected to persist for an extended period of time (chronic)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Supply limits may be in place.

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

Background:

Buprenorphine is a partial opioid agonist. Belbuca and Butrans are buprenorphine products indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate. Similar to other long-acting opioids, the use of Butrans and Belbuca should be reserved for use in patients for whom alternative treatment options (e.g. non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or inadequate to provide sufficient management of pain. Belbuca and Butrans are not indicated as as-needed (prn) analgesics.

UnitedHealthcare employs opioid safety edits at point-of-sale (POS) to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the member's opioid use is appropriate and medically necessary. Development of opioid safety edit specifications, to include cumulative MME thresholds, are determined by the plan taking into consideration clinical guidelines, regulatory/state requirements, utilization and P&T Committee feedback.

4 . References

1. Belbuca [package insert]. Raleigh, NC: BioDelivery Sciences International, Inc.; June 2022.
2. Butrans [package insert]. Stamford, CT: Purdue Pharma L.P.; June 2022.
3. Franklin GM. Opioids for chronic noncancer pain. A position paper of the American Academy of Neurology. Neurology. 2014;83:1277-1284.
4. Rosenquist EWK. Overview of the treatment of chronic pain. UptoDate. October 2014. http://www.uptodate.com/contents/overview-of-the-treatment-of-chronic-pain?source=search_result&search=long+acting+opioids&selectedTitle=1%7E150#H1
5. Argoff CE, Silvershein DI. A Comparison of Long- and Short-Acting Opioids for the Treatment of Chronic Noncancer Pain: Tailoring Therapy to Meet Patient Needs. Mayo Clin Proc. 2009;84(7):602-612.
6. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. JAMA. Published online March 15, 2016.
7. Spatar, SB. Standardizing the use of mental health screening instruments in patients with pain. Fed Pract. 2019 Oct; 36 (Suppl 6): S28-S30.
8. Sullivan MD. Depression effects on long-term prescription opioid use, abuse, and addiction. Clin J Pain. 2018 Sep;34(9):878-884.

5 . Revision History

Date	Notes
9/27/2023	Annual review. Updated background to align with LAO/SAO. Audit la nguage removed throughout policy.

Benlysta

Prior Authorization Guideline

Guideline ID	GL-149902
Guideline Name	Benlysta
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	2/18/2022
P&T Revision Date:	04/20/2022 ; 07/20/2022 ; 07/19/2023 ; 08/18/2023 ; 7/17/2024

Note:

*This program applies to the subcutaneous formulation of belimumab

1 . Indications

Drug Name: Benlysta (belimumab)
Systemic Lupus Erythematosus (SLE) Indicated for the treatment of patients aged 5 years and older with active systemic lupus erythematosus (SLE) who are receiving standard therapy. **Lupus Nephritis** Indicated for the treatment of patients aged 5 years and older with active lupus nephritis who are receiving standard therapy.

2 . Criteria

Product Name: Benlysta [a]	
Diagnosis	Systemic Lupus Erythematosus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of systemic lupus erythematosus

AND

2 - Patient is currently receiving standard immunosuppressive therapy [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

3 - Patient does NOT have severe active central nervous system lupus

AND

4 - Patient is not receiving Benlysta in combination with ANY of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Benlysta [a]	
Diagnosis	Systemic Lupus Erythematosus
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Benlysta therapy

AND

2 - Patient is not receiving Benlysta in combination with ANY of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Benlysta [a]	
Diagnosis	Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Patient is currently receiving standard immunosuppressive therapy for systemic lupus erythematosus [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

3 - Patient does NOT have severe active central nervous system lupus

AND

4 - Patient is not receiving Benlysta in combination with ANY of the following:

- Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]
- Lupkynis (voclosporin)
- Saphnelo (anifrolumab-fnia)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Benlysta [a]	
Diagnosis	Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Benlysta therapy

AND **2** - Patient is not receiving Benlysta in combination with ANY of the following: • Targeted Immunomodulator [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)] • Lupkynis (voclosporin) • Saphnelo (anifrolumab-fnia)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Benlysta is a B-lymphocyte stimulator (BLyS)-specific inhibitor indicated for the treatment of patients aged 5 years and older with active systemic lupus erythematosus (SLE) who are receiving standard therapy and in patients aged 5 years and older with active lupus nephritis who are receiving standard therapy. Limitations of Use: The efficacy of Benlysta has not been evaluated in patients with severe active central nervous system lupus. Use of Benlysta is not recommended in this situation. This program applies to the subcutaneous formulation of belimumab. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

1. Benlysta [package insert]. Durham, NC: GlaxoSmithKline; May 2024.

5 . Revision History

Date	Notes
7/16/2024	Annual review with no changes to coverage criteria. Updated referen ce.

Benznidazole

Prior Authorization Guideline

Guideline ID	GL-122916
Guideline Name	Benznidazole
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 03/16/2022 ; 3/15/2023

1 . Indications

Drug Name: Benznidazole
Chagas disease (American trypanosomiasis) Indicated in pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis), caused by Trypanosoma cruzi. [1]

2 . Criteria

Product Name: Benznidazole [a]	
Diagnosis	Chagas disease (American trypanosomiasis)
Approval Length	60 Day(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Benznidazole, a nitroimidazole antimicrobial, is indicated in pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis), caused by *Trypanosoma cruzi*. [1] This indication is approved under accelerated approval based on the number of treated patients who became Immunoglobulin G (IgG) antibody negative against the recombinant antigens of T. cruzi. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. Antiparasitic treatment is indicated for all cases of acute or reactivated Chagas disease and for chronic *Trypanosoma cruzi (T. cruzi)* infection in children up to 18 years old. Congenital infections are considered acute disease. Treatment is strongly recommended for adults up to 50 years old with chronic infection who do not already have advanced Chagas cardiomyopathy. For adults older than 50 years with chronic *T. cruzi* infection, the decision to treat with antiparasitic drugs should be individualized, weighing the potential benefits and risks for the patient. Physicians should consider factors such as the patient's age, clinical status, preference, and overall health. [2] **Additional clinical Rules** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Benznidazole [package insert]. Florham Park, NJ: Exeltis USA, Inc.; September 2021.
2. CDC Guidelines. Parasites – American Trypanosomiasis (also known as Chagas Disease). https://www.cdc.gov/parasites/chagas/. Accessed January 2022.

5 . Revision History

Date	Notes
3/22/2023	Annual review. Added state mandate language.

Berinert

Prior Authorization Guideline

Guideline ID	GL-144850
Guideline Name	Berinert
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 07/21/2021 ; 09/15/2021 ; 04/20/2022 ; 08/19/2022 ; 04/19/2023 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Berinert (C1 esterase inhibitor, human)
Hereditary angioedema (HAE) Indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients. The safety and efficacy of Berinert for prophylactic therapy have not been established. [1]

2 . Criteria

Product Name: Berinert [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - BOTH of the following:

- Prescribed for the acute treatment of HAE attacks
- Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Firazyr, Ruconest)

AND

3 - Submission of medical records documenting a history of failure, contraindication, or intolerance to ONE of the following:

- icatibant acetate (generic Firazyr)

- Sajazir (icatibant acetate)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Berinert [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Berinert therapy

AND

2 - BOTH of the following:

- Prescribed for the acute treatment of HAE attacks
- Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Firazyr, Ruconest)

AND

3 - Prescribed by ONE of the following:

- Immunologist

• Allergist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Berinert is a plasma-derived C1 esterase inhibitor (human) indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients. The safety and efficacy of Berinert for prophylactic therapy has not been established. [1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Berinert [package insert]. Kankakee, IL: CSL Behring LLC; September 2021.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2024.
4. Busse, P., Christiansen, S., Riedl, M., et. al. “US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.” The Journal of Allergy and Clinical Immunology. 2020 September 05.

5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. Allergy. 2022;77(7):1961-1990. doi:10.1111/all.15214

5 . Revision History

Date	Notes
3/26/2024	Annual review with update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria.

Besremi

Prior Authorization Guideline

Guideline ID	GL-133659
Guideline Name	Besremi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Besremi (ropeginterferon alfa-2b-njft)
Polycythemia Vera Besremi (ropeginterferon alfa-2b-njft) is an interferon alfa-2b indicated for the treatment of adults with polycythemia vera. [2]

2 . Criteria

Product Name: Besremi	
Diagnosis	Polycythemia Vera [a]
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of polycythemia vera	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Besremi	
Diagnosis	NCCN Recommended Regimens [a]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Besremi will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Besremi	
Diagnosis	NCCN Recommended Regimens [a]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Besremi (ropeginterferon alfa-2b-njft) is an interferon alfa-2b indicated for the treatment of adults with polycythemia vera.[2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits and/or Step Therapy may be in place.

4 . References

1. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Accessed August 31, 2023 at http://www.nccn.org/professionals/drug_compendium/content/contents.asp
2. Besremi [package insert]. Burlington, MA: PharmaEssentia; November 2021.

5 . Revision History

Date	Notes

9/21/2023	New guideline.

Bosulif

Prior Authorization Guideline

Guideline ID	GL-141301
Guideline Name	Bosulif
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 02/18/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Bosulif (bosutinib)
Philadelphia-positive chronic myelogenous leukemia (Ph+CML) Inhibitor indicated for the treatment of adult and pediatric patients 1 year of age and older with chronic phase Philadelphia-positive chronic myelogenous leukemia (Ph+ CML), newly diagnosed or resistant or intolerant to prior therapy. Bosulif is also indicated for the treatment of adult patients with accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy.

2 . Criteria

Product Name: Bosulif [a]

Diagnosis	Chronic Myelogenous/Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic myeloid leukemia

AND

2 - ONE of the following:

2.1 Patient is not a candidate for imatinib as attested by physician

OR

2.2 Patient is currently on Bosulif therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]	
Diagnosis	Chronic Myelogenous/Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Bosulif therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]

Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis myeloid/lymphoid neoplasms with eosinophilia **AND** **2** - Presence of ABL1 rearrangement	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Bosulif therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Bosulif will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bosulif [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Bosulif therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Bosulif (bosutinib) is a kinase inhibitor indicated for the treatment of adult and pediatric patients 1 year of age and older with chronic phase Philadelphia-positive chronic myelogenous leukemia (Ph+ CML), newly diagnosed or resistant or intolerant to prior therapy. Bosulif is also indicated for the treatment of adult patients with accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy. [1]

The National Comprehensive Cancer Network (NCCN) recommends use of Bosulif in follow-up therapy in CML after primary treatment with imatinib, dasatinib, or nilotinib. NCCN also recommends Bosulif as primary treatment of CML in accelerated phase, in combination with induction chemotherapy for lymphoid blast phase or myeloid blast phase, in combination with steroids for CML in lymphoid blast phase, for CML in myeloid blast phase as a single agent if not a candidate for induction chemotherapy, as maintenance therapy with consolidation chemotherapy for non-candidates for allogeneic hematopoietic stem cell transplant (HCT) in remission for BP-CML, or for CML patients that are post-transplant experiencing a cytogenic or molecular relapse, for Philadelphia-positive acute lymphoblastic leukemia, and for treatment of myeloid/lymphoid neoplasms with eosinophilia and tyrosine kinase fusion genes. [2]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Bosulif [package insert]. New York, NY: Pfizer, Inc. September 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org. Accessed on December 26, 2023.

5 . Revision History

Date	Notes
2/7/2024	Annual review with no changes to coverage criteria. Updated backgr ound and references.

Brexafemme

Prior Authorization Guideline

Guideline ID	GL-121105
Guideline Name	Brexafemme
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	8/19/2022
P&T Revision Date:	2/17/2023

1 . Indications

Drug Name: Brexafemme (ibrexafungerp)
Vulvovaginal candidiasis Indicated for the treatment of adult and post-menarchal pediatric females with vulvovaginal candidiasis (VVC).

2 . Criteria

Product Name: Brexafemme [a]	
Diagnosis	Treatment of Vulvovaginal candidiasis (VVC)
Approval Length	3 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of vulvovaginal candidiasis (VVC)

AND

2 - One of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 Both of the following:

- Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out
- Failure of a 7-day course of oral fluconazole therapy defined as 100-mg, 150-mg, or 200-mg taken orally every third day for a total of 3 doses [days 1, 4, and 7] for the current episode of VVC

AND

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

- Infectious disease physician
- Obstetrician/Gynecologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brexafemme [a]	
Diagnosis	Recurrent vulvovaginal candidiasis (RVVC)
Approval Length	6 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis (RVVC)

AND

2 - One of the following:

2.1 Confirmed azole resistance demonstrated by culture and susceptibility testing

OR

2.2 Both of the following:

- Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out
- Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months

AND

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

- Infectious disease physician
- Obstetrician/Gynecologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Brexafemme (ibrexafungerp) is indicated for the treatment of adult and post-menarchal pediatric females with vulvovaginal candidiasis (VVC).

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Brexafemme [package insert]. Jersey City, NJ: Scynexis, Inc; November 2022.
2. Sexually Transmitted Infections Treatment Guidelines, 2021. Vulvovaginal Candidiasis (VVC). Centers for Disease Control and Prevention. https://www.cdc.gov/std/treatment-guidelines/candidiasis.htm. Accessed September 2021.

5 . Revision History

Date	Notes
2/22/2023	Annual review. Added the new indication for RVVC.

Buphenyl, Olpruva, Pheburane

Prior Authorization Guideline

Guideline ID	GL-139858
Guideline Name	Buphenyl, Olpruva, Pheburane
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	09/15/2021 ; 10/19/2022 ; 12/14/2022 ; 12/13/2023 ; 2/16/2024

1 . Indications

Drug Name: Sodium Phenylbutyrate
Urea cycle disorders Indicated as adjunctive therapy in the chronic management of patients with urea cycle disorders involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS). **Neonatal-onset deficiency** Indicated in all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). **Late-onset disease (partial enzymatic deficiency, presenting after the first month of life)** Indicated in patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy.

2 . Criteria

Product Name: Buphenyl, generic sodium phenylbutyrate, Olpruva, Pheburane [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of urea cycle disorders (UCDs) **AND** **2** - Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Buphenyl, generic sodium phenylbutyrate, Olpruva, Pheburane [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to sodium phenylbutyrate therapy **AND** **2** - Patient is actively on dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Sodium phenylbutyrate (Buphenyl) is indicated as adjunctive therapy in the chronic management of patients with urea cycle disorders involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS). It is indicated in all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). It is also indicated in patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy. Sodium phenylbutyrate must be used with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place

4 . References

1. Buphenyl [package insert], Lake Forest, IL: Horizon Therapeutics, Inc.; March 2023.
2. Pheburane [package insert]. Bryn Mawr, PA: Medunik USA, Inc.; August 2023.
3. Olpruva™ [package insert]. Newton, MA: Acer Therapeutics, Inc.; December 2022.

5 . Revision History

Date	Notes
1/26/2024	Added Olpruva. Updated references.

Bylvay

Prior Authorization Guideline

Guideline ID	GL-150794
Guideline Name	Bylvay
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	6/15/2022
P&T Revision Date:	08/19/2022 ; 12/14/2022 ; 08/18/2023 ; 10/18/2023 ; 8/16/2024

1 . Indications

Drug Name: Bylvay (odevixibat)
Progressive Familial Intrahepatic Cholestasis (PFIC) Indicated for the treatment of pruritus in patients aged 3 months or older with progressive familial intrahepatic cholestasis (PFIC). **Alagille syndrome (ALGS)** Indicated for the treatment of pruritis in patients 12 months of age and older with Alagille syndrome (ALGS).

2 . Criteria

Product Name: Bylvay [a]

Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Confirmed molecular diagnosis of progressive familial intrahepatic cholestasis (PFIC)

AND

2 - Patient does not have an ABCB11 variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3)

AND

3 - Patient is experiencing moderate to severe pruritus associated with PFIC

AND

4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory

AND

5 - Patient has had an inadequate response to at least two other conventional treatments for the symptomatic relief of pruritus (e.g., uroseoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, and sertraline)

AND

6 - Prescribed by a gastroenterologist or hepatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Bylvay [a]	
Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritus and less sleep disturbance) **AND** **2** - Prescribed by a gastroenterologist or hepatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Bylvay [a]	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of Alagille syndrome (ALGS)	

AND

2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation

AND

3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory.

AND

4 - Patient is experiencing moderate to severe pruritis associated with ALGS

AND

5 - Patient has had an inadequate response to at least two other conventional treatments for the symptomatic relief of pruritus (e.g., uroseoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, and sertraline).

AND

6 - Prescribed by a gastroenterologist or hepatologist.

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Bylvay [a]	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response to Bylvay therapy (e.g., reduced serum bile acids, improved pruritis) **AND** **2** - Prescribed by a gastroenterologist or hepatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. **Background:** Bylvay® (odevixibat) is an ileal bile acid transporter inhibitor indicated for the treatment of pruritis in patients aged 3 months or older with progressive familial intrahepatic cholestasis (PFIC). Bylvay is also indicated for the treatment of pruritis in patients 12 months of age and older with Alagille syndrome (ALGS). PFIC is a heterogeneous group of liver disorders of autosomal recessive inheritance, characterized by an early onset of cholestasis (usually during infancy) with pruritus and malabsorption, which rapidly progresses and ends up as liver failure. Pruritus is the most obvious and the most unbearable symptom in cholestasis. It has been proposed that it is

induced by the stimulation of nonmyelinated subepidermal free nerve ends because of increased serum bile acids.

ALGS is a rare genetic disorder caused by a mutation in the JAG1 or Notch2 genes which are involved in embryonic development in utero. In ALGS patients, multiple organ systems may be affected by the mutation. In the liver, the mutation causes the bile ducts to abnormally narrow, malform and reduce in number, leading to bile acid accumulation, cholestasis, and ultimately progressive liver disease. The cholestatic pruritus experienced by patients with ALGS is among the most severe in any chronic liver disease and is present in most affected children by the third year of life.

Conventional treatments for pruritis associated with PFIC or Alagille syndrome include uroseoxycholic acid (UCDA), antihistamines (e,g., diphenhydramine), bile acid sequestrants (e.g., cholestyramine), rifampin, naltrexone and sertraline.

Limitation of Use:

Bylvay may not be effective in a subgroup of PFIC type 2 patients with specific ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3).

4 . References

1. Bylvay [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc.; February 2024.
2. Thompson RJ, Arnell H, Artan R, et al. Odevixibat treatment in progressive familial intrahepatic cholestasis: a randomised, placebo-controlled, phase 3 trial. Lancet Gastroenterol Hepatol. 2022;7(9):830-842.
3. Ovchinsky N, Aumar M, Baker A, et al. Efficacy and safety of odevixibat in patients with Alagille syndrome (ASSERT): a phase 3, double-blind, randomised, placebo-controlled trial. Lancet Gastroenterol Hepatol. 2024;9(7):632-645.
4. Chowdhury JR, Chowdhury NR. Inherited disorders associated with conjugated hyperbilirubinemia in adults. In: Post TW, ed. UpToDate. UpToDate, 2024. Accessed July 9, 2024. Inherited disorders associated with conjugated hyperbilirubinemia in adults - UpToDate
5. Kohut TJ, Loomes KM. Alaglle syndrome. In: Post TW, ed. UpToDate. UpToDate, 2024. Accessed July 9, 2024. Alagille syndrome - UpToDate

5 . Revision History

Date	Notes
8/2/2024	Annual review. Updated examples of conventional treatment and initial authorization durations. Updated background and references.

Cablivi

Prior Authorization Guideline

Guideline ID	GL-149027
Guideline Name	Cablivi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/17/2024
P&T Revision Date:	

1 . Indications

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

2 . Criteria

Product Name: Cablivi [a]	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)

AND

2 - Cablivi was initiated as a bolus intravenous injection administered by a healthcare provider in combination with plasma exchange therapy.

AND

3 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids)

AND

4 - Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cablivi [a]	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 months for a new episode of aTTP
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Request is for a new (different) episode requiring the re-initiation of plasma exchange for the treatment of aTTP. (Documentation of date of prior episode & documentation date of new episode required)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cablivi (caplacizumab-yhdp) is a von Willebrand factor (vWF)-directed antibody fragment indicated for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Cablivi [package insert]. Cambridge, MA: Genzyme Corporation; April 2023.

5 . Revision History

Date	Notes
7/16/2024	Policy reviewed and approved for application to UnitedHealthcare Value & Balance Exchange for 1/2021 implementation.

Cabometyx

Prior Authorization Guideline

Guideline ID	GL-135610
Guideline Name	Cabometyx
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 11/19/2021 ; 08/19/2022 ; 11/18/2022 ; 08/18/2023 ; 11/17/2023

1 . Indications

Drug Name: Cabometyx (cabozantinib)
Renal cell carcinoma (RCC) Indicated for the treatment of patients with advanced renal cell carcinoma. Cabometyx is also indicated for the treatment of patients with advanced renal cell carcinoma as a first-line treatment in combination with Opdivo (nivolumab). [1] **Hepatocellular carcinoma (HCC)** Indicated for the treatment of patients with hepatocellular carcinoma who have been previously treated with Nexavar (sorafenib). **Differentiated Thyroid Cancer** Indicated for the treatment of adult and pediatric patients 12 years of age and older with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible. **Other Uses:** The National Cancer Comprehensive Network (NCCN) recommends Cabometyx for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement and

HCC as a single agent for progressive disease. Cabometyx is also recommended in NCCN as second line therapy in both osteosarcoma and Ewing sarcoma, as well as gastrointestinal stromal tumors (GIST), kidney cancer, and endometrial carcinoma.

2 . Criteria

Product Name: Cabometyx [a]	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of advanced renal cell carcinoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of non-small cell lung cancer (NSCLC) **AND** **2** - Positive for RET gene rearrangements **AND** **3** - Disease is ONE of the following: • Recurrent • Advanced • Metastatic	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hepatocellular carcinoma

AND

2 - ONE of the following:

2.1 History of failure or intolerance to sorafenib (generic Nexavar)^

OR

2.2 BOTH of the following:

- Disease is Child-Pugh class A
- Patient has unresectable disease and is not a transplant candidate

OR

2.3 BOTH of the following:

- Disease is Child-Pugh class A
- Patient has metastatic disease or extensive liver tumor burden

OR

2.4 BOTH of the following:

- Disease is Child-Pugh class A
- Patient has liver-confined disease and is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Cabometyx [a]	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Osteosarcoma

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

Approval Criteria

1 - Diagnosis of osteosarcoma

AND

2 - Patient's disease has progressed on prior treatment

AND

3 - One of the following:

3.1 Patient has relapsed/refractory disease

OR

3.2 Patient has metastatic disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Osteosarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Ewing Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Ewing sarcoma (including mesenchymal chondrosarcoma) **AND** **2** - Patient has relapsed, progressive, or metastatic disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Ewing Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of GIST

AND

2 - Patient has ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Recurrent/metastatic disease

AND

3 - (3) Disease has progressed on ALL of the following:

- imatinib (generic Gleevec)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Standard dose Qinlock (ripretinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	Gastrointestinal Stromal Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of kidney cancer **AND** **2** - One of the following: **2.1** Patient has relapsed disease	

OR **2.2** Patient has metastatic disease
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of endometrial carcinoma	

AND **2** - Disease is recurrent, high-risk, or metastatic **AND** **3** - Used as second-line treatment
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of differentiated thyroid cancer (DTC)

AND

2 - Disease is locally advanced or metastatic

AND

3 - Disease has progressed following prior VEGFR-targeted therapy

AND

4 - Disease is radioactive iodine-refractory or ineligible

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cabometyx [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Cabometyx will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cabometyx [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cabometyx therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Cabometyx® (cabozantinib) is a kinase inhibitor indicated for the treatment of patients with advanced renal cell carcinoma (RCC), patients with advanced RCC as a first-line treatment in combination with Opdivo (nivolumab), patients with hepatocellular carcinoma (HCC) who have been previously treated with Nexavar® (sorafenib tosylate), and in adult and pediatric patients 12 years of age and older with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible. [1] The National Cancer Comprehensive Network (NCCN) recommends Cabometyx for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement and HCC as a single agent for progressive disease. Cabometyx is also recommended in NCCN as second line therapy in both osteosarcoma and Ewing sarcoma, as well as gastrointestinal stromal tumors (GIST), kidney cancer, and endometrial carcinoma. [2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Cabometyx [package insert]. South San Francisco, CA: Exelixis, Inc.; September 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed October 9, 2023.

5 . Revision History

Date	Notes

11/6/2023	Annual review. Updated trial language to indicate generic Nexavar. U pdated NSCLC, hepatocellular carcinoma, and GIST criteria per NC CN recommendation. Updated background. Updated references.

Calquence

Prior Authorization Guideline

Guideline ID	GL-147488
Guideline Name	Calquence
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	05/20/2022 ; 05/25/2023 ; 5/17/2024

1 . Indications

Drug Name: Calquence (acalabrutinib)
Mantle cell lymphoma Indicated for the treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy. **Chronic Lymphocytic Leukemia or Small Lymphocytic Lymphoma** Indicated for the treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).

2 . Criteria

Product Name: Calquence [a]

Diagnosis	Mantle Cell Lymphoma (MCL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of mantle cell lymphoma (MCL) **AND** **2** - Patient has received at least one prior therapy for MCL [e.g., Rituxan (rituximab)]^	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NC CN guidelines.

Product Name: Calquence [a]	
Diagnosis	Mantle Cell Lymphoma (MCL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Calquence therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Calquence [a]

Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic lymphocytic leukemia/small lymphocytic lymphoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Calquence [a]	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Calquence therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Calquence [a]	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Nodal Marginal Zone Lymphoma
- Extranodal Marginal Zone Lymphoma (EMZL) of the stomach
- Splenic Marginal Zone Lymphoma
- Extranodal Marginal Zone Lymphoma of Nongastric Sites (Non-cutaneous)

AND

2 - Disease is recurrent, relapsed, refractory, or progressive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Calquence [a]	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Calquence [a]	
Diagnosis	Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma

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

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma

AND

1.2 ONE of the following:

- Patient did not respond to primary therapy
- Disease is relapsed or progressive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Calquence [a]	
Diagnosis	Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Calquence [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Calquence will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Calquence [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Calquence therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background

Calquence® (acalabrutinib) is a kinase inhibitor indicated for the treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy. This indication is approved under accelerated approval based on overall response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. It is also approved for the treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). [1]

The National Comprehensive Cancer Network (NCCN) recommends the use of Calquence for the treatment of B-cell lymphomas, including splenic and nodal marginal zone lymphoma, extranodal marginal zone lymphoma (EMZL) of the stomach, extranodal marginal zone lymphoma of nongastric sites (noncutaneous), and Waldenström macroglobulinemia/lymphoplasmacytic lymphoma. [2]

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Calquence [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP. August 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed March 21, 2024.

5 . Revision History

Date	Notes
5/17/2024	Annual review with no change to clinical criteria. Updated reference.

Camzyos

Prior Authorization Guideline

Guideline ID	GL-150891
Guideline Name	Camzyos
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	7/20/2022
P&T Revision Date:	11/18/2022 ; 08/18/2023 ; 8/16/2024

1 . Indications

Drug Name: Camyzos (mavacamten)
Obstructive hypertrophic cardiomyopathy (HCM) Indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms.

2 . Criteria

Product Name: Camyzos [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

AND

2 - Heart failure is classified as ONE of the following:

- New York Heart Association (NYHA) class II heart failure
- New York Heart Association (NYHA) class III heart failure

AND

3 - Patient has a left ventricular ejection fraction of greater than or equal to 55%

AND

4 - Patient has a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

5 - History of inadequate response, intolerance, failure, or contraindication to two of the following at a maximally tolerated dose [2,3]:

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, nadolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)
- Disopyramide

AND

6 - Prescribed by or in consultation with a cardiologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Camyzos [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to therapy as supported by ONE of the following: • Reduction in NYHA class • No worsening in NYHA class **AND** **2** - Patient has a left ventricular ejection fraction of greater than or equal to 50% **AND** **3** - Prescribed by or in consultation with a cardiologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Camzyos (mavacamten) is a cardiac myosin inhibitor indicated for the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Camzyos [package insert]. Brisbane, CA: Bristol Myers Squibb; April 2024.
2. Wasfy JH, Walton SM, Beinfeld M, Nhan E, Sarker J, Whittington MD, Pearson SD, Rind DM. Mavacamten for Hypertrophic Cardiomyopathy: Effectiveness and Value; Final Evidence Report and Meeting Summary. Institute for Clinical and Economic Review, November 16, 2021. https://icer.org/hypertrophic-cardiomyopathy-2021/.
3. Ommen SR, Mital S, Burke MA, et al. 2020 AHA/ACC Guideline for the Diagnosis and Treatment of Patients With Hypertrophic Cardiomyopathy: Executive Summary. Circulation. 2020;142(25):e533-e557.

5 . Revision History

Date	Notes
8/2/2024	Annual review. Updated references.

Caprelsa

Prior Authorization Guideline

Guideline ID	GL-134437
Guideline Name	Caprelsa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	09/18/2019 ; 02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Caprelsa (vandetanib)
Medullary thyroid cancer Indicated for the treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease. [1] Caprelsa may be used in patients with indolent, asymptomatic or slowly progressing disease after careful consideration of the treatment related risks. [1] **Off Label Uses: Follicular, Hurthle cell, Papillary carcinoma** The National Cancer Comprehensive Network (NCCN) recommends use of Caprelsa for the treatment of follicular, oncocytic, and papillary carcinomas.

2 . Criteria

Product Name: Caprelsa [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following criteria:

1.1 Diagnosis of medullary thyroid cancer (MTC)

AND

1.2 ONE of the following

- Unresectable locally advanced disease
- Metastatic disease

AND

1.3 ONE of the following

- Patient has symptomatic disease
- Patient has progressive disease

OR

2 - ALL of the following criteria:

2.1 ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

2.2 ONE of the following:

- Unresectable recurrent
- Persistent locoregional disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Caprelsa [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Caprelsa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Caprelsa will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Caprelsa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Caprelsa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Caprelsa (vandetanib) is a kinase inhibitor indicated for the treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease.[1] The National Cancer Comprehensive Network (NCCN) recommends use of Caprelsa for the treatment of medullary, follicular, oncocytic, and papillary carcinomas. Caprelsa may be used in patients with indolent, asymptomatic or slowly progressing disease after careful consideration of the treatment related risks. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Caprelsa [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed August 22, 2023.

5 . Revision History

Date	Notes
10/6/2023	Annual review. Updated hürthle cell carcinoma to oncocytic carcinom a. Updated references.

Carbaglu

Prior Authorization Guideline

Guideline ID	GL-149903
Guideline Name	Carbaglu
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 07/21/2021 ; 07/20/2022 ; 07/14/2023 ; 7/17/2024

1 . Indications

Drug Name: Carbaglu (carglumic acid)
Chronic Hyperammonemia Indicated for maintenance therapy in pediatric and adult patients for the treatment of chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency. **Acute Hyperammonemia** Indicated as an adjunctive therapy to standard of care in pediatric and adult patients for the treatment of acute hyperammonemia due to NAGS deficiency, and adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).

2 . Criteria

Product Name: Brand Carbaglu, carglumic (generic Carbaglu) [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hyperammonemia due to ONE of the following: • N-acetylglutamate synthase (NAGS) deficiency • Propionic acidemia (PA) • Methylmalonic acidemia (MMA)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Carbaglu, carglumic (generic Carbaglu) [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Carbaglu therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information

Background:

Carbaglu (carglumic acid) is a Carbamoyl Phosphate Synthetase 1 (CPS 1) activator indicated in pediatric and adult patients as maintenance therapy for the treatment of chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency, adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to NAGS deficiency, and adjunctive therapy to standard of care for the treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA).

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Carbaglu® [package insert]. Lebanon, NJ: Recordati Rare Diseases Inc.; January 2024.

5 . Revision History

Date	Notes
7/16/2024	Annual review with no changes to coverage criteria. Updated referen ce.

Cholbam

Prior Authorization Guideline

Guideline ID	GL-147489
Guideline Name	Cholbam
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 03/16/2022 ; 05/20/2022 ; 05/25/2023 ; 08/18/2023 ; 5/17/2024

1 . Indications

Drug Name: Cholbam (cholic acid)
Bile acid synthesis disorders (BASDs) Indicated for treatment of bile acid synthesis disorders (BASDs) due to single enzyme defects (SEDs). Limitation of use: The safety and effectiveness of Cholbam on extrahepatic manifestations of bile acid synthesis disorders due to SEDs have not been established. **Peroxisomal disorders (PDs) including Zellweger spectrum disorders** Indicated as an adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat soluble vitamin absorption. Limitation of use: The safety and effectiveness of Cholbam on extrahepatic manifestations of bile acid synthesis disorders due PDs including Zellweger spectrum disorders have not been established.

2 . Criteria

Product Name: Cholbam [a]	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary
Approval Criteria **1** - BOTH of the following: • Diagnosis of a bile acid synthesis disorder • Bile acid synthesis disorder is due to single enzyme defects (SEDs) **OR** **2** - ALL of the following: • Diagnosis of a peroxisomal disorder including Zellweger spectrum disorders • Patient exhibits manifestations of liver disease, steatorrhea or complications from decreased fat soluble vitamin absorption • Cholbam is being used as adjunctive treatment	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cholbam [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria	

1 - Documentation of positive clinical response to Cholbam therapy as evidenced by BOTH of the following: • Improvement in liver function (e.g., aspartate aminotransferase [AST], alanine aminotransferase [ALT]) • Absence of complete biliary obstruction	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Cholbam (cholic acid) is a bile acid indicated for the treatment of bile acid synthesis disorders (BASDs) due to single enzyme defects (SEDs) and as an adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat soluble vitamin absorption. Cholbam should be discontinued if liver function does not improve within 3 months of starting treatment, if complete biliary obstruction develops, or if there are persistent clinical or laboratory indicators of worsening liver function or cholestasis. Limitation of use: The safety and effectiveness of Cholbam on extrahepatic manifestations of bile acid synthesis disorders due to SEDs or PDs including Zellweger spectrum disorders have not been established. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program. • Supply limitations may be in place

4 . References

1. Cholbam [package insert]. San Diego, CA: Manchester Pharmaceuticals, Inc. A wholly owned subsidiary of Travere Therapeutics, Inc.; March 2023.

5 . Revision History

Date	Notes
5/17/2024	Annual review with no change to coverage criteria. Updated referenc e.

Cibinqo

Prior Authorization Guideline

Guideline ID	GL-144089
Guideline Name	Cibinqo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	4/20/2022
P&T Revision Date:	07/20/2022 ; 10/19/2022 ; 03/15/2023 ; 09/20/2023 ; 3/20/2024

1 . Indications

Drug Name: Cibinqo (abrocitinib)
Atopic Dermatitis Indicated for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

2 . Criteria

Product Name: Cibinqo [a]	
Diagnosis	Atopic Dermatitis

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

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 History of failure, contraindication, or intolerance to BOTH of the following therapeutic classes of topical therapies (document drug, date of trial, and/or contraindication to medication)

- Medium, high, or very-high potency topical corticosteroids [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- Topical calcineurin inhibitor [e.g., tacrolimus (generic Protopic)]

AND

2.1.2 ONE of the following^:

2.1.2.1 BOTH of the following:

- Submission of medical records (e.g., chart notes, laboratory values) documenting a 3 month trial of a systemic drug product for the treatment of atopic dermatitis (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration)
- Physician attests that the patient was not adequately controlled with the documented systemic drug product

OR

2.1.2.2 Physician attests that systemic treatment with BOTH of the following, FDA-

approved chronic atopic dermatitis therapies is inadvisable (Document drug and contraindication rationale)^

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria) [5]

OR

2.2 BOTH of the following:

2.2.1 Patient is currently on Cibinqo therapy as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

2.2.2 Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer dermatology patient access program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Cibinqo*

AND

3 - Patient is NOT receiving Cibinqo in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer dermatology patient access program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Cibinqo [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Cibinqo therapy

AND

2 - Patient is not receiving Cibinqo in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND **3** - Prescribed by or in consultation with ONE of the following: • Dermatologist • Allergist • Immunologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Cibinqo is a Janus kinase (JAK) inhibitor indicated for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

Limitation of Use: Cibinqo is not recommended in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05

High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
	Alclometasone dipropionate	Cream, ointment	0.05

Low potency	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
3/8/2024	Annual review. Clarified topical steroid potency in atopic dermatitis wi th no change to clinical intent or coverage criteria. Updated reference .

Cimzia

Prior Authorization Guideline

Guideline ID	GL-148643
Guideline Name	Cimzia
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/21/2021 ; 05/20/2022 ; 09/21/2022 ; 05/25/2023 ; 6/17/2024

1 . Indications

Drug Name: Cimzia (certolizumab)
Crohn's disease (CD) Indicated for reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy. **Rheumatoid Arthritis (RA)** Indicated for the treatment of adults with moderately to severely active rheumatoid arthritis. **Active Psoriatic Arthritis (PsA)** Indicated for the treatment of adult patients with active psoriatic arthritis. **Active Ankylosing Spondylitis (SpA)** Indicated for the treatment of adults with active ankylosing spondylitis. **Plaque Psoriasis (PS)** Indicated for the treatment of adults with moderate-to-severe plaque

psoriasis who are candidates for systemic therapy or phototherapy.

Non-Radiographic Axial Spondyloarthritis (nr-axSpA) Indicated for the treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation.

2 . Criteria

Product Name: Cimzia [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following^:

2.1 History of failure to ONE of the following conventional therapies at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.2 Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of Crohn's disease as documented by claims history or submission of medical

records (Document drug, date, and duration of therapy) [e.g., adalimumab, Stelara (ustekinumab)]

OR

2.3 BOTH of the following:

- Patient is currently on Cimzia therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the UCB sponsored CIMplicity® program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Cimzia*

AND

3 - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the UCB sponsored CIMplicity® program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy. ^ Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Cimzia [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cimzia therapy **AND** **2** - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cimzia [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active rheumatoid arthritis **AND** **2** - ONE of the following: **2.1** History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)	

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Cimzia therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the UCB sponsored CIMplicity® program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Cimzia*

AND

3 - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the UCB sponsored CIMplicity® program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Cimzia [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cimzia therapy **AND** **2** - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cimzia [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of active psoriatic arthritis **AND** **2** - ONE of the following:	

2.1 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Cimzia therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the UCB sponsored CIMplicity® program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Cimzia*

AND

3 - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

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

- Rheumatologist
- Dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the UCB sponsored CIMplicity® program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Cimzia [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cimzia therapy **AND** **2** - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cimzia [a]	
Diagnosis	Ankylosing Spondylitis (AS) and non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis

AND

2 - ONE of the following:

2.1 History of failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trials)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Cimzia therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the UCB sponsored CIMplicity® program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Cimzia*

AND

3 - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND **4** - Prescribed by or in consultation with a rheumatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the UCB sponsored CIMplicity® program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Cimzia [a]	
Diagnosis	Ankylosing Spondylitis (AS) and non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cimzia therapy **AND** **2** - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cimzia [a]

Diagnosis	Plaque Psoriasis (PS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

2.1.2 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Coal tar

AND

2.1.3 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Tremfya (guselkumab)]

OR

2.3 BOTH of the following:

2.3.1 Patient is currently on Cimzia therapy as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

2.3.2 Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the UCB sponsored CIMplicity® program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Cimzia*

AND

3 - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

4 - Prescribed by or in consultation with a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the UCB sponsored CIMplicity® program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Cimzia [a]	
Diagnosis	Plaque Psoriasis (PS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cimzia therapy **AND** **2** - Patient is not receiving Cimzia in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cimzia (certolizumab) is a tumor necrosis factor (TNF) blocker indicated for reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy. Cimzia is also indicated for the treatment of adults with moderately to severely active rheumatoid arthritis (RA), treatment of adult patients with active psoriatic arthritis (PsA), treatment of adults with active ankylosing spondylitis (SpA), treatment of adults with moderate

to severe plaque psoriasis (PS) who are candidates for systemic therapy or phototherapy, and for the treatment of adults with active non-radiographic axial spondyloarthritis (nr-axSpA), with objective signs of inflammation.[1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
6/19/2024	Annual review, updated safety language to match commercial.

Cinryze

Prior Authorization Guideline

Guideline ID	GL-143789
Guideline Name	Cinryze
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	3/20/2024

1 . Indications

Drug Name: Cinryze
Hereditary angioedema (HAE) Cinryze is a plasma-derived C1 esterase inhibitor (human) indicated for routine prophylaxis against angioedema attacks in adults, adolescents, and pediatric patients (6 years of age and older) with hereditary angioedema (HAE).

2 . Criteria

Product Name: Cinryze [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - ALL of the following:

- Prescribed for the prophylaxis of HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Haegarda, Orladeyo, Takhzyro)
- Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Cinryze

AND

3 - Submission of medical records documenting a history of failure, contraindication, or intolerance to Haegarda (C1 esterase inhibitor, human)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cinryze [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Cinryze therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Cinryze therapy

AND

3 - BOTH of the following:

- Prescribed for the prophylaxis of HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Haegarda, Orladeyo, Takhzyro)

AND **4** - Prescribed by ONE of the following: • Immunologist • Allergist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cinryze is a plasma-derived C1 esterase inhibitor (human) indicated for routine prophylaxis against angioedema attacks in adults, adolescents, and pediatric patients (6 years of age and older) with hereditary angioedema (HAE).[1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
3/1/2024	Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Simplified reauthorization criteria. Updated refere nce.

Clomid

Prior Authorization Guideline

Guideline ID	GL-144760
Guideline Name	Clomid
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/17/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	10/20/2021 ; 08/19/2022 ; 12/14/2022 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Clomid (clomiphene citrate)
Ovulatory dysfunction Indicated for the treatment of ovulatory dysfunction in women desiring pregnancy. Impediments to achieving pregnancy must be excluded or adequately treated before beginning clomiphene therapy. Those patients most likely to achieve success with clomiphene therapy include patients with polycystic ovary syndrome, amenorrhea-galactorrhea syndrome, psychogenic amenorrhea, certain cases of secondary amenorrhea of undetermined etiology, and post-oral contraceptive amenorrhea.

2 . Criteria

Product Name: Clomid, clomiphene tabs [a]

Diagnosis	Ovulation Induction
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ovulatory dysfunction

AND

2 - ONE of the following exists:

- Anovulation
- Oligo-ovulation
- Amenorrhea

AND

3 - Other specific causative factors (e.g., thyroid disease, hyperprolactinemia) have been excluded or treated

AND

4 - Infertility is not due to primary ovarian failure

AND

5 - For induction of ovulation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Clomid, clomiphene tabs [a]	
Diagnosis	Controlled Ovarian Stimulation**

Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of infertility

AND

2 - ONE of the following exists:

- Unexplained infertility
- Endometriosis
- Male factor infertility
- Diminished ovarian reserve
- Unilateral tubal factor infertility

AND

3 - For the development of one or more follicles (controlled ovarian stimulation)

AND

4 - Will be used in conjunction with intrauterine insemination (IUI)

Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Clomid, clomiphene tabs [a]	
Diagnosis	Clomiphene Challenge Test**
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - To be used to conduct a clomiphene challenge test

Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Clomid, clomiphene tabs [a]	
Diagnosis	Male Factor Infertility/Oligospermia [off-label]**
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Mild, moderate, or severe male factor infertility
- Oligospermia

AND

2 - At least ONE of the following exists on at least 2 separate semen analyses obtained at least 4 weeks apart:

- Sperm concentration is < 15 million/mL (milliliter)
- Progressive motility < 40%
- Sperm preparation techniques result in a sperm concentration of < 1 million motile sperm/mL

AND

3 - Patient condition has not improved despite an adequate trial (two to three months) of

positive lifestyle changes (e.g., weight loss, healthy diet, smoking cessation, reduction of alcohol intake)	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: This program is designed to provide coverage for these medications to be used in conjunction with Assisted Reproductive Technologies (ART, i.e., in vitro fertilization). Clomiphene citrate is a nonsteroidal fertility agent used to induce ovulation in infrequently ovulating or anovulatory women, including patients with polycystic ovary syndrome (PCOS). It is also used for controlled ovarian stimulation in ovulatory women. The drug is effective at producing ovulation in patients with an intact hypothalamic-pituitary-ovarian axis and with ovaries that are capable of functioning normally. Clomiphene therapy is not effective in patients with primary pituitary or ovarian failure. Dosage should generally not exceed 100 mg daily for 5 days. If ovulation has not occurred after 3 courses of therapy, the patient should be reevaluated. If pregnancy does not occur within a total of 6 cycles, clomiphene should be discontinued as prolonged administration is not recommended. [1-5] Clomiphene citrate is indicated for the treatment of ovulatory dysfunction in women desiring pregnancy. Impediments to achieving pregnancy must be excluded or adequately treated before beginning CLOMIPHENE therapy. Those patients most likely to achieve success with clomiphene therapy include patients with polycystic ovary syndrome, amenorrhea-galactorrhea syndrome, psychogenic amenorrhea, certain cases of secondary amenorrhea of undetermined etiology, and post-oral contraceptive amenorrhea. [6] Clomiphene may be used to evaluate a woman's ovulation and egg quality in what is referred to as the Clomiphene Challenge Test. [8,9] When given early in a woman's

menstrual cycle for 5 days, clomiphene elevates a woman's follicle-stimulating hormone (FSH) level. On the next day, an FSH blood level that has dropped back to normal is a sign of a normal ovarian reserve and ovulation. An elevated FSH is a sign of low ovarian reserve. Women who have a diminished ovarian reserve can use donor eggs, which greatly improves their chances of giving birth to a healthy child.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
3/25/2024	Texas added to ovulation induction operation note.

Prior Authorization Guideline

Guideline ID	GL-141342
Guideline Name	CNS Stimulants
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/15/2020
P&T Revision Date:	02/19/2021 ; 10/06/2021 ; 10/20/2021 ; 10/20/2021 ; 05/20/2022 ; 12/14/2022 ; 2/16/2024

1 . Indications

Drug Name: CNS stimulants
Attention Deficit Hyperactivity Disorder (ADHD) FDA approved indication for Attention Deficit Hyperactivity Disorder (ADHD) **Attention Deficit Disorder (ADD)** FDA approved indication for Attention Deficit Disorder (ADD) **Narcolepsy** FDA approved indication for narcolepsy **Off Label Uses: Idiopathic hypersomnolence** There is evidence for off label use for idiopathic hypersomnolence. **Fatigue associated with multiple sclerosis** There is evidence for off label use for fatigue associated with multiple sclerosis. **Mental fatigue secondary to traumatic brain injury** There is evidence for off label use for

mental fatigue secondary to traumatic brain injury.

Depression There is evidence for off label use for depression.

Weight Loss (Not Covered Benefit) The potential use of these agents for weight loss is not a covered benefit.

Drug Name: Vyvanse

Moderate to Severe Binge Eating Disorder (BED) Indicated for Moderate to Severe Binge Eating Disorder (BED).

Attention Deficit Hyperactivity Disorder (ADHD) Indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults and pediatric patients 6 years and older.

2 . Criteria

Product Name: (Includes both brand and generic versions of the listed products unless otherwise noted: Products containing amphetamine, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate, serdexmethylphenidate or any combinations of the mentioned products) [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 The patient is less than 18 years of age

OR

1.2 BOTH of the following:

1.2.1 The patient is 18 years of age or older

AND

1.2.2 The patient has ONE of the following diagnoses:

- Attention-deficit hyperactivity disorder (ADHD) or attention-deficit disorder (ADD)
- Depression
- Narcolepsy
- Other hypersomnia of central origin
- Autism Spectrum Disorder
- Mental fatigue secondary to traumatic brain injury (e.g. post-concussion syndrome)
- Fatigue associated with medical illness in patients in palliative or end of life care
- Fatigue associated with multiple sclerosis

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Vyvanse, generic lisdexamfetamine [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 The patient is less than 18 years of age

OR

1.2 BOTH of the following:

1.2.1 The patient is 18 years of age or older

AND

1.2.2 The patient has ONE of the following diagnoses:

- Attention-deficit hyperactivity disorder (ADHD) or attention-deficit disorder (ADD)
- Depression
- Narcolepsy
- Other hypersomnia of central origin
- Autism Spectrum Disorder
- Mental fatigue secondary to traumatic brain injury (e.g. post-concussion syndrome)
- Fatigue associated with medical illness in patients in palliative or end of life care
- Fatigue associated with multiple sclerosis
- The patient has Moderate to Severe Binge Eating Disorder (BED)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: This program will allow coverage for diagnoses supported by FDA labeling and clinical evidence. The CNS stimulants have a variety of FDA approved labeled indications, such as Attention Deficit Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), and narcolepsy. There is evidence for off label use for the stimulants in idiopathic hypersomnolence, fatigue associated with multiple sclerosis, mental fatigue secondary to traumatic brain injury, and depression. The potential use of these agents for weight loss is not a covered benefit. Because of the high abuse potential for this class of medications, their use should be closely monitored in certain age groups. In addition, if the member is less than 18 years of age, the prescription will automatically process without a coverage review. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply Limits may also be in place

4 . References

1. Adderall [package insert]. Parsippany, NJ: Teva Pharmaceuticals; September 2023.
2. Adderall XR [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc; October 2023.
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21. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: 2013.
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5 . Revision History

Date	Notes
2/8/2024	Annual review. Updated references.

Prior Authorization Guideline

Guideline ID	GL-133876
Guideline Name	COC Oncology Hepatitis C Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	1/20/2022
P&T Revision Date:	

1 . Criteria

Product Name: Hepatitis C Medications*	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - Member is new to plan (within first 120 days of eligibility with the plan)	

AND

2 - Diagnosis of hepatitis C**

AND

3 - Previous use of the requested medication within the past 120 days

AND

4 - The patient requires continuation of therapy to complete the course of treatment

Notes	*Applicable drugs will have a Clinical Program of Continuity of Care. **This policy applies to requests for hepatitis C only. Requests for dia gnoses other than hepatitis C should not reviewed using this policy. Policy is to be applied if drug specific criteria are not met.

Product Name: Drugs and Biological Used in An Anti-Cancer Chemotherapeutic Regimen*	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Member is new to plan (within first 120 days of eligibility with the plan)

AND

2 - Meets Off-Label Administrative guideline criteria

AND

3 - Previous use of the requested medication within the past 120 days

AND **4** - The patient requires continuation of therapy to complete the course of treatment	
Notes	*Applicable drugs will have a Clinical Program of Continuity of Care. Policy is to be applied if drug specific criteria are not met.

2 . Background

Benefit/Coverage/Program Information
Background: This program is to be administered to members who are new to plan (within the past 120 days) and who have started an oncology or hepatitis C regimen prior to starting with the plan to allow continuation of therapy. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

3 . Revision History

Date	Notes
9/27/2023	New guideline.

Cometriq

Prior Authorization Guideline

Guideline ID	GL-148644
Guideline Name	Cometriq
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 06/16/2021 ; 09/15/2021 ; 06/15/2022 ; 06/21/2023 ; 08/18/2023 ; 6/17/2024

1 . Indications

Drug Name: Cometriq (cabozantinib)
Medullary thyroid cancer (MTC) Indicated for the treatment of patients with progressive, metastatic medullary thyroid cancer (MTC). [1]

2 . Criteria

Product Name: Cometriq [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of medullary carcinoma

OR

1.2 ALL of the following:

1.2.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic cell carcinoma
- Papillary carcinoma

AND

1.2.2 Disease is progressive after treatment with ONE of the following^:

- Lenvima (lenvatinib)
- sorafenib (generic Nexavar)

AND

1.2.3 Disease is at least ONE of the following:

- Symptomatic iodine-refractory
- Unresectable locoregional recurrent or persistent disease
- Distant metastatic disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

	^Tried/failed alternative(s) are supported by FDA labeling and/or treat ment guidelines.

Product Name: Cometriq [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cometriq therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cometriq [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of non-small cell lung cancer (NSCLC) **AND** **2** - Positive for RET gene rearrangements	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cometriq [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cometriq therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cometriq [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Cometriq will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cometriq [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cometriq therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cometriq (cabozantinib) is a kinase inhibitor indicated for the treatment of patients with progressive, metastatic medullary thyroid cancer (MTC).[1] In addition, the National Cancer Comprehensive Network (NCCN) recommends Cometriq for the treatment of medullary, follicular, oncocytic, and papillary thyroid carcinomas. NCCN also recommends Cometriq for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement.[2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
6/19/2024	Annual review. Updated references.

Prior Authorization Guideline

Guideline ID	GL-134204
Guideline Name	Compounded Drugs Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	10/20/2021

1 . Criteria

Product Name: Compound Drugs	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - The compound route of administration is NOT an intravenous injectable	

AND

2 - One of the following:

2.1 Each active ingredient in the compound is/are FDA-approved for the requested indication

OR

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

AND

3 - If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

AND

4 - If the drug component is no longer available commercially it must not have been withdrawn for safety reasons

AND

5 - One of the following:

5.1 A unique vehicle is required

OR

5.2 A unique dosage form is required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form

OR

5.3 A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

OR

5.4 There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP Current Drug Shortages tracking log

AND

6 - Coverage for compounds and bulk powders will NOT be approved for any of the following:

6.1 For topical compound preparations (e.g., creams, ointments, lotions, or gels to be applied to the skin for transdermal, transcutaneous, or any other topical route), if the requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use

OR

6.2 Requested compound contains topical fluticasone. Topical fluticasone will NOT be approved unless:

6.2.1 Topical fluticasone is intended to treat a dermatologic condition. Scar treatments are considered cosmetic and will not be covered

AND

6.2.2 Patient has a contraindication to all commercially available topically fluticasone formulations

OR

6.3 Requested compound is for cosmetic use or contains any ingredients when used for cosmetic purposes (see Appendix for examples)

OR

6.4 Requested compound does NOT contain any ingredients which are on the FDA's Do Not Compound List (https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=216.24) **AND** **7** - The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note in Background for the Exclusions and Limitations Grid URL) **AND** **8** - One of the following: **8.1** If the request has one or more ACA/HCR ingredients, ACA/HCR criteria within the ACA/HCR Administrative guideline are met for ALL ingredients* **OR** **8.2** The request does not contain any ACA/HCR ingredients^	
Notes	Only ingredients that are available on formulary in one of the formular y tiers, or has a non-formulary status are approvable and should be in cluded in the effectuation. If an approved compound contains an exclu ded drug such as OTC products, excipients, inactive ingredient that is a BULK chemical, injectable drugs covered under the medical benefit, etc. these ingredients should not be included in the effectuation. If the compound request includes an active ingredient that is a BULK chemi cal, the request should be denied as benefit exclusion. Injectable prod ucts (such as IV antibiotics, infusions, etc.) may be covered under the medical benefit and are excluded from the pharmacy benefit. These s hould be denied as benefit exclusion. *If compound and ACA/HCR criteria are met, approve the compound at $0 cost share. If only compound criteria are met and not ACA/HCR criteria, deny the request for not meeting ACA/HCR and approve the c ompound at regular cost share. ^If all compound criteria are met, approve the compound at regular co st share.

2 . Background

Benefit/Coverage/Program Information
Background: Compounded drugs that exceed $50 in cost or contain an ingredient that is commercially available but is never supported by the standard references to be compounded will reject at point of sale as product service not covered. These compounds may be approved if criteria are met. **Appendix:** Example topical compound preparations (e.g., creams, ointments, lotions or gels to be applied to the skin for transdermal, transcutaneous or any other topical route) that contain any FDA approved ingredient that are not FDA approved for TOPICAL use, including but NOT LIMITED TO the following: (1) Ketamine (2) Gabapentin (3) Flurbiprofen (topical ophthalmic use not included) (4) Ketoprofen (5) Morphine (6) Nabumetone (7) Oxycodone (8) Cyclobenzaprine (9) Baclofen (10) Tramadol (11) Hydrocodone (12) Meloxicam (13) Amitriptyline (14) Pentoxifylline (15) Orphenadrine (16) Piroxicam

(17) Levocetirizine

(18) Amantadine

(19) Oxytocin

(20) Sumatriptan

(21) Chorionic gonadotropin (human)

(22) Clomipramine

(23) Dexamethasone

(24) Hydromorphone

(25) Methadone

(26) Papaverine

(27) Mefenamic acid

(28) Promethazine

(29) Succimer DMSA

(30) Tizanidine

(31) Apomorphine

(32) Carbamazepine

(33) Ketorolac

(34) Dimercaptopropane-sulfonate

(35) Dimercaptosuccinic acid

(36) Duloxetine

(37) Fluoxetine

(38) Bromfenac (topical ophthalmic use not included)

(39) Nepafenac (topical ophthalmic use not included)

Example compounds that contain ingredients for cosmetic purposes:

(1) Hydroquinone

(2) Acetyl hexapeptide-8

(3) Tocopheryl Acid Succinate

(4) PracaSil TM-Plus

(5) Chrysaderm Day Cream

(6) Chrysaderm Night Cream

(7) PCCA Spira-Wash

(8) Lipopen Ultra

(9) Versapro

(10) Fluticasone

(11) Mometasone

(12) Halobetasol

(13) Betamethasone

(14) Clobetasol

(15) Triamcinolone

(16) Minoxidil

(17) Tretinoin

(18) Dexamethasone

(19) Spironolactone

(20) Cycloserine

(21) Tamoxifen

(22) Sermorelin

(23) Mederma Cream

(24) PCCA Cosmetic HRT Base

(25) Sanare Scar Therapy Cream

(26) Scarcin Cream

(27) Apothederm

(28) Stera Cream

(29) Copasil

(30) Collagenase

(31) Arbutin Alpha

(32) Nourisil

(33) Freedom Cepapro

(34) Freedom Silomac Andydrous

(35) Retinaldehyde

(36) Apothederm

Example ingredients on the FDA's Do Not Compound List:

(1) 3,3′,4′,5-tetrachlorosalicylanilide

(2) Adenosine phosphate

(3) Adrenal cortex

(4) Alatrofloxacin mesylate

(5) Aminopyrine

(6) Astemizole

(7) Azaribine

(8) Benoxaprofen

(9) Bithionol

(10) Camphorated oil

(11) Carbetapentane citrate

(12) Casein, iodinated

(13) Cerivastatin sodium

(14) Chlormadinone acetate

(15) Chloroform

(16) Cisapride

(17) Defenfluramine hydrochloride

(18) Diamthazole dihydrochloride

(19) Dibromsalan

(20) Dihydrostreptomycin sulfate

(21) Dipyrone

(22) Encainide hydrochloride

(23) Etretinate

(24) Fenfluramine hydrochloride

(25) Flosequinan

(26) Glycerol, iodinated

(27) Grepafloxacin

(28) Mepazine

(29) Metabromsalan

(30) Methapyrilene

(31) Methopholine

(32) Methoxyflurane

(33) Mibefradil dihydrochloride

(34) Nomifensine maleate

(35) Novobiocin sodium

(36) Oxyphenisatin acetate

(37) Oxyphenisatin

(38) Pemoline

(39) Pergolide mesylate

(40) Phenacetin

(41) Phenformin hydrochloride

(42) Phenylpropanolamine

(43) Pipamazine

(44) Potassium arsenite

(45) Propoxyphene

(46) Rapacuronium bromide

(47) Rofecoxib

(48) Sibutramine hydrochloride

(49) Sparteine sulfate

(50) Sulfadimethoxine

(51) Sweet spirits of nitre

(52) Tegaserod maleate

(53) Temafloxacin hydrochloride

(54) Terfenadine

(55) Ticrynafen

(56) Tribromsalan

(57) Trichloroethane

(58) Troglitazone

(59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

Technician Note:

Link of Exclusions and Limitations Grid:
https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange

3 . References

1. Food and Drug Administration (2014, July 02). Additions and Modifications to the List of Drug Products That Have Been Withdrawn or Removed From the Market for Reasons of Safety and Effectiveness. Retrieved from http://federalregister.gov/a/2014-15371. Accessed July 23, 2023.
2. FDA Drug Shortages. Current and Resolved Drug Shortages and Discontinuations Reported to the FDA. Available at: https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm
3. Current Drug Shortages. Available at: https://www.ashp.org/Drug-Shortages/Current-Shortages
4. CFR - code of federal Regulations Title 21. accessdata.fda.gov. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=216.24. Published November 10, 2020. Accessed July 23, 2023.

4 . Revision History

Date	Notes
10/3/2023	Updated all criteria and notes.

Corlanor

Prior Authorization Guideline

Guideline ID	GL-154420
Guideline Name	Corlanor
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/18/2020
P&T Revision Date:	02/19/2021 ; 11/19/2021 ; 08/19/2022 ; 10/19/2022 ; 08/18/2023 ; 9/18/2024

1 . Indications

Drug Name: Corlanor (ivabradine)
Heart failure in adult patients Indicated to reduce the risk of hospitalization for worsening of heart failure in adult patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use. **Heart failure in pediatric patients** Indicated for the treatment of stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older, who are in sinus rhythm with an elevated heart rate.

2 . Criteria

Product Name: Brand Corlanor, generic ivabradine [a]	
Diagnosis	Symptomatic Chronic Heart Failure
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Worsening heart failure in a diagnosis of stable, symptomatic chronic [e.g. New York Heart Association (NYHA) class II, III or IV] heart failure

AND

1.2 Patient has a left ventricular ejection fraction (EF) less than or equal to 35%

AND

1.3 The patient is in sinus rhythm

AND

1.4 Patient has a resting heart rate greater than or equal to 70 beats per minute

AND

1.5 ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a maximum tolerated beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)
- Patient has a contraindication or intolerance to beta-blocker therapy

AND

1.6 ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with Jardiance or Farxiga (includes combination products containing empagliflozin and dapagliflozin)
- Patient has a contraindication or intolerance to SGLT2 inhibitor therapy

AND

1.7 ONE of the following:

1.7.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following:

- angiotensin-converting enzyme (ACE) inhibitor (e.g. captopril, enalapril)
- angiotensin II receptor blocker (ARB) (e.g. candesartan, valsartan)
- angiotensin receptor-neprilysin inhibitor (ARNI) (e.g. Entresto)

OR

1.7.2 Patient has a contraindication or intolerance to ACE inhibitors, ARBs, and ARNIs

AND

1.8 ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a maximally tolerated aldosterone antagonist (e.g. eplerenone, spironolactone)
- Patient has a contraindication or intolerance to aldosterone antagonist therapy

OR

1.9 Prescribed by or in consultation with a cardiologist

OR

2 - ALL of the following:

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

AND

2.2 Patient is in sinus rhythm

AND

2.3 Patient has an elevated heart rate

AND

2.4 Prescribed by or in consultation with a cardiologist

OR

3 - ALL of the following:

3.1 Diagnosis of inappropriate sinus tachycardia (IST)

AND

3.2 Patient is in sinus rhythm

AND

3.3 ONE of the following:

- Patient has tried and failed or had an inadequate response to a beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol)
- Patient has a contraindication or intolerance to beta-blocker therapy

AND **3.4** Prescribed by or in consultation with a cardiologist **OR** **4** - Patient is currently established on Corlanor therapy
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Corlanor, generic ivabradine [a]	
Diagnosis	Symptomatic Chronic Heart Failure
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Corlanor therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Corlanor (ivabradine) is a hyperpolarization-activated cycle nucleotide-gated channel blocker indicated to reduce the risk of hospitalization for worsening of heart failure in patients

with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤ 35%, who are in sinus rhythm with resting heart rate ≥ 70 beats per minute and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use. It is also indicated to treat stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older, who are in sinus rhythm with an elevated heart rate. Also, although not an FDA-approved indication, Corlanor has also shown to have efficacy in treating inappropriate sinus tachycardia (IST).

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply Limits may be in place.

4 . References

1. Corlanor [package insert]. Thousand Oaks, CA: Amgen Inc.; August 2021.
2. Heidenreich, P. A., Bozkurt, B., Aguilar, D., et al. 2022 ACC/AHA/HFSA guideline for the management of heart failure. Journal of Cardiac Failure, 2022 28(5), e1-e167.
3. Sheldon, R.S., Grubb, B.P., et al. 2015 Heart Rhythm Society Expert Consensus Statement on the Diagnosis and Treatment of Postural Tachycardia Syndrome, Inappropriate Sinus Tachycardia, and Vasovagal Syncope. Heart Rhythm, 2015, 12(6), e41-e63.

5 . Revision History

Date	Notes
9/5/2024	Added generic and updated criteria

Cotellic

Prior Authorization Guideline

Guideline ID	GL-135552
Guideline Name	Cotellic
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/17/2023
P&T Revision Date:	02/19/2021 ; 11/19/2021 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Cotellic (cobimetinib)
Melanoma Indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with Zelboraf (vemurafenib) and as a single agent for the treatment of patients with histiocytic neoplasms. [1] **NCCN recommendations** Indicated in combination with Zelboraf (vemurafenib) as treatment for Central Nervous System (CNS) Cancers.

2 . Criteria

Product Name: Cotellic [a]

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

Approval Criteria

1 - Diagnosis of melanoma

AND

2 - Disease is one of the following:

- Unresectable
- Metastatic

AND

3 - Disease is positive for one of the following mutations:

- BRAF V600E
- BRAF V600K

AND

4 - Used in combination with Zelboraf (vemurafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cotellic [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cotellic therapy **AND** **2** - Used in combination with Zelboraf (vemurafenib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cotellic [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of CNS Cancer **AND** **2** - Disease is BRAF V600E positive **AND** **3** - Used in combination with Zelboraf (vemurafenib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cotellic [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cotellic therapy **AND** **2** - Used in combination with Zelboraf (vemurafenib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cotellic [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of histiocytic neoplasms	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Cotellic [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Cotellic therapy.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cotellic [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Cotellic will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cotellic [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Cotellic therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cotellic (cobimetinib) is a kinase inhibitor indicated for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with Zelboraf (vemurafenib) and as a single agent for the treatment of patients with histiocytic neoplasms. [1] The National Cancer Comprehensive Network (NCCN) also recommends the use of Cotellic in combination with Zelboraf® (vemurafenib) as treatment for Central Nervous System (CNS) Cancers. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Cotellic [package insert]. Genentech USA, Inc.: South San Francisco, CA; May 2023.

2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org. Accessed September 25, 2023.

5 . Revision History

Date	Notes
10/27/2023	Annual review. Updated histiocytic neoplasms criteria based on label ed indication and CNS cancer based on NCCN recommendations. U pdated background and references.

Prior Authorization Guideline

Guideline ID	GL-144128
Guideline Name	Cough and Cold
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	12/16/2020
P&T Revision Date:	02/19/2021 ; 08/20/2021 ; 09/15/2021 ; 03/15/2023 ; 3/20/2024

1 . Criteria

Product Name: Opioid Containing Cough and Cold Products for Patients Younger than 18 Years* [a]	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Prescriber attests they are aware of FDA labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use).	

AND

2 - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)

AND

3 - Patient has tried and failed at least one non-opioid containing cough and cold remedy

Notes	*Includes both brand and generic versions of the listed products unless otherwise noted: Products containing codeine or hydrocodone in combinations with one or more of the following: homatropine, chlorpheniramine, guaifenesin, pyrilamine, brompheniramine, phenylephrine, triprolidine, dexchlorpheniramine, promethazine, pseudoephedrine. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Opioid Containing Cough and Cold Products*	
Diagnosis	Requests Exceeding the Plan's Quantity Limit
Approval Length	Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.
Guideline Type	Administrative

Approval Criteria

1 - Requests exceeding the quantity limit will be approved based on BOTH of the following:

1.1 Doses exceeding the quantity limit will be approved up to the requested amount if the prescriber attests that a larger quantity is medically necessary

AND

1.2 The requested dose is within FDA maximum dose per day, where an FDA maximum dose per day exists	
Notes	*Includes both brand and generic versions of the listed products unles s otherwise noted: Products containing codeine or hydrocodone in combinations with one or more of the following: homatropine, chlorpheniramine, guaifenesin, pyrilamine, brompheniramine, phenylephrine, triprolidine, dexchlorph eniramine, promethazine, pseudoephedrine.

2 . Background

Benefit/Coverage/Program Information
Background Opioid (codeine or hydrocodone) containing cough and cold products are FDA labeled for use in adults 18 years of age and older. Use of prescription opioid cough and cold medicines containing codeine or hydrocodone should be limited in children younger than 18 years old due to serious risks associated with use. Coverage for patients age 18 or greater will process automatically. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

3 . References

1. Approach to Cough in Children. UpToDate. October 2022. Accessed January 24, 2024.
2. FDA Drug Safety Communication (2018a). FDA requires labeling changes for prescription opioid cough and cold medicines to limit their use to adults 18 years and older. US Food and Drug Administration website. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-requires-labeling-changes-prescription-opioid-cough-and-cold. Published January 11, 2018. Accessed January 24, 20224.

4 . Revision History

Date	Notes
3/10/2024	Annual review, updated references.

Cuvrior

Prior Authorization Guideline

Guideline ID	GL-124706
Guideline Name	Cuvrior
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2023
P&T Approval Date:	1/1/2023
P&T Revision Date:	

1 . Indications

Drug Name: Cuvrior (trientine tetrahydrochloride)
Wilson's Disease Indicated for the treatment of adult patients with Wilson's disease who are de-coppered and tolerant to penicillamine.

2 . Criteria

Product Name: Cuvrior	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Wilson's disease

AND

2 - Patient is de-coppered [i.e., serum non-ceruloplasmin copper (NCC) level greater than or equal to 25 and less than or equal to 150 mcg/L]

AND

3 - Patient is tolerant to penicillamine

AND

4 - Prescriber provides a reason or special circumstance why the patient cannot use penicillamine

AND

5 - Patient will not use penicillamine in conjunction with Cuvrior

Product Name: Cuvrior	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Cuvrior therapy

3 . Background

Benefit/Coverage/Program Information
Background: Cuvrior (trientine tetrahydrochloride) is a copper chelator indicated for the treatment of adult patients with Wilson's disease who are de-coppered and tolerant to penicillamine. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place

4 . References

1. Cuvrior [package insert]. Chicago, IL: Orphalan; April 2022.

5 . Revision History

Date	Notes
4/17/2023	New Program

Cystaran

Prior Authorization Guideline

Guideline ID	GL-116148
Guideline Name	Cystaran
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	11/18/2022

1 . Indications

Drug Name: Cystaran (cysteamine) ophthalmic solution
Cystinosis Indicated for the treatment of corneal cystine crystal accumulation in patients with cystinosis.

2 . Criteria

Product Name: Cystaran	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystinosis **AND** **2** - Treatment of corneal cystine crystal accumulation	

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

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Cystaran [package insert]. Gaithersburg, MD: Leadiant Biosciences, Inc.; February 2022.

5 . Revision History

Date	Notes
11/2/2022	Annual review, updated reference.

Daliresp

Prior Authorization Guideline

Guideline ID	GL-136042
Guideline Name	Daliresp
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 11/19/2021 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Daliresp (roflumilast)
Chronic obstructive pulmonary disease (COPD) Indicated for reducing the risk of chronic obstructive pulmonary disease (COPD) exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations

2 . Criteria

Product Name: Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of severe to very severe COPD (i.e., FEV1 less than or equal to 50 percent of predicted) **AND** **2** - COPD is associated with chronic bronchitis **AND** **3** - History COPD exacerbation(s)	

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

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

Background:

Daliresp (roflumilast) is a phosphodiesterase-4 inhibitor indicated for reducing the risk of chronic obstructive pulmonary disease (COPD) exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations.

4 . References

1. Daliresp [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; March 2019.
2. Global strategy for the diagnosis, management and prevention of COPD. Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2023.

5 . Revision History

Date	Notes
11/7/2023	Annual review. Updated reference.

Daraprim

Prior Authorization Guideline

Guideline ID	GL-147490
Guideline Name	Daraprim
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 05/20/2022 ; 05/25/2023 ; 5/17/2024

1 . Indications

Drug Name: Daraprim (pyrimethamine)
Treatment of toxoplasmosis Indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide, since synergism exists with this combination. [1]

2 . Criteria

Product Name: Brand Daraprim, generic pyrimethamine [a]	
Approval Length	12 months*
Guideline Type	Prior Authorization

Approval Criteria

1 - Daraprim will be approved based on submission of medical record (e.g., chart notes) documenting ONE of the following criteria:

1.1 Treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis

OR

1.2 Treatment of congenital toxoplasmosis

OR

1.3 Secondary prophylaxis of toxoplasmic encephalitis

OR

1.4 ALL of the following:

1.4.1 Primary Pneumocystis pneumonia (PCP) prophylaxis in HIV-infected patients or as secondary prophylaxis in HIV-infected patients who have been treated for an acute episode of Pneumocystis pneumonia

AND

1.4.2 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.4.3 ONE of the following:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

- Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)

OR

1.5 ALL of the following:

1.5.1 Primary prophylaxis of toxoplasmic encephalitis

AND

1.5.2 Toxoplasma IgG positive

AND

1.5.3 CD4 is less than or equal to 100 cells/mm3 if initiating prophylaxis or CD4 is less than 100-200 cells/mm3 if reinstituting prophylaxis

AND

1.5.4 Will be used in combination with dapsone or atovaquone

AND

1.5.5 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.5.6 ONE of the following:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

• Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g., toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)	
Notes	* Consider discontinuation of primary prophylaxis if CD4 is greater than 200 cells/mm3 for greater than 3 months after institution of combination antiretroviral therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Daraprim (pyrimethamine) is indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide, since synergism exists with this combination. [1] The use of pyrimethamine for the treatment or prophylaxis of malaria is no longer recommended in the CDC Guidelines for the Treatment of Malaria in the United States. For the treatment of malaria, contact the CDC Malaria Hotline: (770) 488-7788 or (855) 856-4713 toll-free Monday-Friday 9 am to 5 pm EST - (770) 488-7100 after hours, weekends and federal holiday [2-3] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place **Limitations of Use:** Outpatient medication access to Daraprim is available exclusively through the Daraprim Direct program in partnership with Optime Care, Inc. [4]

4 . References

1. Daraprim [Package Insert]. Jersey City, NJ: Tilde Sciences LLC: October 2023.
2. Centers for Disease Control and Prevention. Treatment of Malaria (Guidelines For Clinicians). Accessed March 21, 2024: CDC - Malaria - Diagnosis & Treatment (United States) - Treatment (U.S.) - Guidelines for Clinicians
3. Centers for Disease Control and Prevention. CDC Yellow Book: Health Information for International Travel 2020. New York: Oxford University Press; 2024. Accessed March 21, 2024: https://wwwnc.cdc.gov/travel/yellowbook/2024/infections-diseases/malariahttps
4. Daraprim Accessing Daraprim. Accessed April 3, 2023: https://www.daraprimdirect.com/home/hcp#PO
5. Department of Health and Human Services. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. Accessed March 21, 2024: Clinicalinfo | Information on HIV/AIDS Treatment, Prevention and Research
6. Department of Health and Human Services. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Accessed March 21, 2024: Toxoplasmosis | Pediatric Opportunistic Infection | ClinicalInfo (hiv.gov)

5 . Revision History

Date	Notes
5/17/2024	Annual review without change to coverage criteria. Updated referenc es.

Daybue

Prior Authorization Guideline

Guideline ID	GL-145646
Guideline Name	Daybue
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	5/25/2023
P&T Revision Date:	4/17/2024

1 . Indications

Drug Name: Daybue (trofinetide)
Rett syndrome (RTT) Indicated for the treatment of Rett syndrome (RTT) in adults and pediatric patients aged 2 years and older.

2 . Criteria

Product Name: Daybue [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Rett Syndrome (RTT) confirmed by ONE of the following:

1.1 ALL of the following clinical signs and symptoms:

- A pattern of development, regression, then recovery or stabilization
- Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose
- Partial or complete loss of spoken language
- Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing
- Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait

OR

1.2 Confirmed genetic mutation in the MECP2 gene

AND

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

- Geneticist
- Pediatrician who specializes in childhood neurological or developmental disorders
- Neurologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Daybue [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Daybue therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Daybue is a synthetic analog of the amino-terminal tripeptide of insulin-like growth factor-1 (IGF-1) indicated for the treatment of Rett syndrome (RTT) in adults and pediatric patients aged 2 years and older. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

1. Daybue [package insert]. San Diego, CA: Acadia Pharmaceuticals, Inc.; March 2023.

5 . Revision History

Date	Notes

4/12/2024	Changed initial authorization from 6 months to 12, added SML and u pdated policy to convert from non-formulary to prior authorization.

Prior Authorization Guideline

Guideline ID	GL-114586
Guideline Name	Diabetic Meters and Test Strips - PA, NF, QL
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2023
P&T Approval Date:	1/20/2021
P&T Revision Date:	09/15/2021

Note:

NOTE: Continuous Glucose Monitoring (CGM) devices and Glucose Sensors (GPI: 97202012******) are a medical benefit. They are not the same as Glucose Meters and Test Strips and should not be reviewed using this guideline.

1 . Criteria

Product Name: Test Strips and Glucose Meters (preferred and non-preferred)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization, Non Formulary

Approval Criteria

1 - One of the following reasons that a preferred Test Strip/Glucometer (Accu-Chek or OneTouch strip/meter) cannot be used:

- The member has a vision problem/blindness that requires the use of a special glucometer/test strip
- The member is currently on an insulin pump or an insulin delivery device (e.g., OmniPod) that requires a specific glucometer/test strip
- There is a medically necessary justification (e.g., an impairment of manual dexterity) requiring use of a special monitoring system and/or test strip

Notes	NOTE: a) Before approving/denying a product, please check for a pre vious approval on file for the member for a non-preferred product. If a n approval is on file, an automatic approval is appropriate. b) If a non-preferred test strip/meter is approved for a member, future requests fo r non-preferred test strip/meter products should also be approved. NOTE: Continuous Glucose Monitoring (CGM) devices and Glucose S ensors (GPI: 97202012******) are a medical benefit. They are not the same as Glucose Meters and Test Strips and should not be reviewed using this guideline.

Product Name: Test Strips (preferred and non-preferred)	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Quantities exceeding the plan's limit of 100 test strips per 30 days are approved for one of the following:

- The patient is insulin dependent or pregnant and the physician confirms the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)
- The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control
- The patient’s physician is adjusting medications and the patient requires additional blood glucose testing during this time
- The patient’s physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time
- The patient requires additional testing due to fluctuations in blood glucose due to physical activity/exercise

• Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by UnitedHealthcare reviewing pharmacist and/or medical director)	
Notes	NOTE: Effectuate approvals with quantity limit that corresponds to the approved MDD (max daily dose) for test strips to the requested quantity.

2 . Background

Benefit/Coverage/Program Information
Background: Preferred test strips and meters are Accu-Chek and OneTouch. All other brands are non-preferred. All preferred and non-preferred test strips have a quantity limit of 100 strips per 30 days. In addition, all preferred and non-preferred meters have a quantity limit of one per 365 days.

3 . Revision History

Date	Notes
9/29/2022	Annual review. Administrative change to background information.

Dojolvi

Prior Authorization Guideline

Guideline ID	GL-120451
Guideline Name	Dojolvi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2023
P&T Approval Date:	12/16/2020
P&T Revision Date:	02/19/2021 ; 05/20/2022

1 . Indications

Drug Name: Dojolvi (triheptanoin)
Long-chain fatty acid oxidation disorders (LC-FAOD) Dojolvi (triheptanoin) is a medium-chain triglyceride indicated as a source of calories and fatty acids for the treatment of pediatric and adult patients with molecularly confirmed long-chain fatty acid oxidation disorders (LC-FAOD).

2 . Criteria

Product Name: Dojolvi	
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records confirming the diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) with at least two of the following diagnostic criteria:

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

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products

AND

3 - Prescribed by a board certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

AND

6 - If not diagnosed by newborn screening, patient has a history of clinical manifestations of long-chain fatty acid oxidation disorders LC-FAOD (e.g., rhabdomyolysis)

Product Name: Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Dojolvi therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products

AND

3 - Prescribed by a board certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

3 . Background

Benefit/Coverage/Program Information
Background Dojolvi (triheptanoin) is a medium-chain triglyceride indicated as a source of calories and fatty acids for the treatment of pediatric and adult patients with molecularly confirmed long-chain fatty acid oxidation disorders (LC-FAOD). **Additional Clinical Rules:** • Supply limits may be in place • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Dojolvi [package insert]. Novato, CA: Ultragenyx Pharmaceutical, Inc.; November 2021.

5 . Revision History

Date	Notes
1/24/2023	Move from non-specialty to specialty formulary.

Prior Authorization Guideline

Guideline ID	GL-149897
Guideline Name	Dry Eye Disease
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	03/20/2024 ; 7/17/2024

1 . Indications

Drug Name: Cequa (cyclosporine 0.09% ophthalmic solution), Restasis (cyclosporine 0.05% ophthalmic emulsion), Restasis Multidose (cyclosporine 0.05% ophthalmic emulsion)
Keratoconjunctivitis sicca Indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca.
Drug Name: Miebo (perfluorohexyloctane ophthalmic solution), Tyrvaya (varenicline nasal spray), Vevye (cyclosporine 0.1%) , Xiidra (lifitegrast 5% ophthalmic solution)
Dry eye disease Indicated for the treatment of the signs and symptoms of dry eye disease.

2 . Criteria

Product Name: Cequa, Restasis Multidose, Brand Restasis, Xiidra, Miebo, Tyrvaya, Vevye [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Not prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK)

AND

3 - The patient has a history of failure, contraindication, or intolerance to a trial of at least one OTC (over-the-counter) artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP)

AND

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

- Ophthalmologist
- Optometrist
- Rheumatologist

AND

5 - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)

AND **6** - The patient has a history of failure, contraindication, or intolerance to a trial of cyclosporine 0.05% ophthalmic emulsion (generic Restasis or generic Restasis Multidose)
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Cequa, Restasis Multidose, Brand Restasis, Xiidra, Miebo, Tyrvaya, Vevye [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has demonstrated clinically significant improvement with therapy **AND** **2** - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Miebo, Restasis single dose-vials, Tyrvaya, Xiidra)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: cyclosporine 0.05% ophthalmic emulsion (generic Restasis and generic Restasis Multidose) [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to ONE of the following:

- Moderate to severe keratoconjunctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Not prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK)

AND

3 - The patient has a history of failure, contraindication, or intolerance to a trial of at least one OTC (over-the-counter) artificial tear product (e.g., Systane Ultra, Akwa Tears, Refresh Optive, Soothe XP)

AND

4 - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Cequa, Miebo, Restasis, Vevye, Xiidra)

AND

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

- Ophthalmologist
- Optometrist
- Rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: cyclosporine 0.05% ophthalmic emulsion (generic Restasis and generic Restasis Multidose) [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has demonstrated clinically significant improvement with therapy **AND** **2** - Medication will not be used in combination with another prescription product for dry eye disease or keratoconjunctivitis sicca (e.g., Cequa, Miebo, Restasis, Vevye Xiidra)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cequa™ (cyclosporine 0.09% ophthalmic solution), Restasis® (cyclosporine 0.05% ophthalmic emulsion) and Restasis Multidose (cyclosporine 0.05% ophthalmic emulsion) are indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Miebo (perfluorohexyloctane ophthalmic solution), Tyrvaya (varenicline nasal spray), Vevye (cyclosporine 0.1%) and Xiidra™ (lifitegrast 5% ophthalmic solution) are indicated for the treatment of the signs and symptoms of dry eye disease.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Cequa [package insert]. Cranbury, NJ: Sun Pharmaceutical Industries, Inc; December 2022.
2. Restasis [package insert]. Irvine, CA: Allergan, Inc.; July 2017.
3. Restasis MultiDose [package insert]. Irvine, CA: Allergan, Inc.; October 2016.
4. Tyrvaya [package insert]. Princeton NJ: Oyster Point Pharma, Inc; February 2024.
5. Xiidra [package insert]. Bridgewater, NJ: Bausch & Lomb Americas Inc;: December 2023.
6. Miebo [package insert]. Bridgewater, NJ: Bausch & Lomb Americas Inc; June 2023.
7. American Academy of Ophthalmology. Dry Eye Syndrome Preferred Practice Pattern 2023.
8. Vevye [package insert]. Nashville, TN: Harrow Eye, LLC; November 2023

5 . Revision History

Date	Notes
7/16/2024	Added language on concomitant therapy. Updated references.

Duopa

Prior Authorization Guideline

Guideline ID	GL-129928
Guideline Name	Duopa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/21/2022 ; 8/18/2023

1 . Indications

Drug Name: Duopa (carbidopa/levodopa)
Advanced Parkinson's disease Indicated for the treatment of motor fluctuations in patients with advanced Parkinson's disease.

2 . Criteria

Product Name: Duopa [a]	
Approval Length	12 Months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of advanced Parkinson's Disease **AND** **2** - Patient experiences a wearing "off" phenomenon that cannot be managed by increasing the dose of oral levodopa **AND** **3** - Has undergone or has planned placement of a procedurally-placed tube	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Duopa [a]	
Approval Length	12 Months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Duopa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Duopa (carbidopa/levodopa) enteral suspension is indicated for the treatment of motor fluctuations in patients with advanced Parkinson's disease. Duopa should be administered continuously via an infusion pump over 16 hours through a procedurally-placed tube. Duopa may be administered through a naso-jejunal (NJ) tube for a short period of time until a gastrostomy tube can be placed.[1,2,3] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Duopa [package insert]. North Chicago, IL: AbbVie, Inc.; March 2022.
2. Sara Varanese, Zoe Birnbaum, Roger Rossi, and Alessandro Di Rocco, "Treatment of Advanced Parkinson's Disease," Parkinson's Disease, vol. 2010, Article ID 480260, 9 pages, 2010. doi:10.4061/2010/480260.
3. International Parkinson and Movement Disorder Society Evidence-Based Medicine Review: Update on Treatments for the Motor Symptoms of Parkinson's Disease. Movement Disorders. 2018.

5 . Revision History

Date	Notes
8/21/2023	Annual review. Updated references.
8/21/2023	Annual review. Added SML.

Dupixent

Prior Authorization Guideline

Guideline ID	GL-143795
Guideline Name	Dupixent
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	06/16/2021 ; 08/20/2021 ; 10/20/2021 ; 12/15/2021 ; 01/19/2022 ; 02/18/2022 ; 04/20/2022 ; 07/20/2022 ; 11/18/2022 ; 03/15/2023 ; 07/19/2023 ; 08/18/2023 ; 3/20/2024

1 . Indications

Drug Name: Dupixent (dupilumab)
Moderate to Severe Atopic Dermatitis Indicated for treatment of patients aged 6 years and older with moderate to severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. **Moderate-to-Severe Asthma** Indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 6 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma. **Chronic Rhinosinusitis with Nasal Polyposis** Indicated as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP). **Eosinophilic Esophagitis** Indicated for treatment of adult and pediatric patients aged 1 year

and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE).

Prurigo nodularis (PN) Indicated for the treatment of adult patients with prurigo nodularis (PN).

2 . Criteria

Product Name: Dupixent [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 History of failure, contraindication, or intolerance to BOTH of the following therapeutic classes of topical therapies (document drug, date of trial, and/or contraindication to medication)^:

- Medium, high, or very-high potency topical corticosteroids [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- Topical calcineurin inhibitor [e.g., tacrolimus (generic Protopic)]

OR

2.2 BOTH of the following:

2.2.1 Patient is currently on Dupixent therapy as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Sanofi and Regeneron Pharmaceuticals sponsored Dupixent MyWay program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Dupixent*

AND

3 - Patient is not receiving Dupixent in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Sanofi and Regeneron Pharmaceuticals sponsored Dupixent MyWay program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Dupixent [a]	
Diagnosis	Atopic Dermatitis

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

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient is not receiving Dupixent in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Dupixent [a]	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate-to-severe asthma

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

- Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

2.1.2 Dupixent will be used in combination with one of the following:

2.1.2.1 ONE maximally dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., fluticasone propionate/salmeterol, Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.1.2.2 Combination therapy including BOTH of the following:

- ONE maximally dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]

- ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or salmeterol (Serevent); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

2.1.3 ONE of the following:

2.1.3.1 Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/uL (microliter)

OR

2.1.3.2 Patient is currently dependent on oral corticosteroids for the treatment of asthma

OR

2.2 BOTH of the following:

2.2.1 Patient is currently on Dupixent therapy

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in prescriber office, or any form of assistance from the Sanofi and Regeneron Pharmaceuticals sponsored Dupixent MyWay program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Dupixent*

AND

3 - Patient is not receiving Dupixent in combination with ANY of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Sanofi and Regeneron Pharmaceuticals sponsored Dupixent MyWay program shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Dupixent [a]	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Dupixent is being used in combination with an ICS-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Dupixent [a]	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

1.1.1 TWO OR MORE of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

1.1.2 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

1.1.3 ONE of the following:

- Presence of bilateral nasal polyposis
- Patient has previously required surgical removal of bilateral nasal polyps

AND

1.1.4 ONE of the following:

1.1.4.1 Patient has required prior sinus surgery

OR

1.1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

1.1.4.3 Patient has been unable to obtain symptom relief after trial of TWO of the following classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

OR

1.2 ALL of the following:

1.2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

AND

1.2.2 Patient is currently on Dupixent therapy

AND

1.2.3 Patient has not received a manufacturer supplied sample at no cost in prescriber office, or any form of assistance from the Sanofi and Regeneron Pharmaceuticals sponsored Dupixent MyWay program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Dupixent*

AND

2 - Patient will receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Sanofi and Regeneron Pharmaceuticals sponsored Dupixent MyWay program shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Dupixent [a]	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is NOT receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

4 - Prescribed by or in consultation with ONE of the following

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Dupixent [a]	
Diagnosis	Eosinophilic Esophagitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis

AND

2 - Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of greater than or equal to 15 intraepithelial eosinophils per high power field (HPF) (or 60 eosinophils per mm^2)

AND

4 - Secondary causes of esophageal eosinophilia have been ruled out

AND

5 - Mucosal eosinophilia is isolated to the esophagus and symptoms have persisted after an 8-week trial of at least one of the following:

- Proton pump inhibitors (e.g., pantoprazole, omeprazole)
- Topical (esophageal) corticosteroids (e.g., budesonide, fluticasone)

AND

6 - Patient is not receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

7 - Prescribed by ONE of the following:

- Allergist
- Gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Dupixent [a]	
Diagnosis	Eosinophilic Esophagitis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy as evidenced by improvement of at least one of the following from baseline:

- Symptoms (e.g., dysphagia, chest pain, heartburn)
- Histologic measures (e.g., esophageal intraepithelial eosinophil count)
- Endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)

AND

2 - Patient is not receiving Dupixent in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Dupixent [a]	
Diagnosis	Prurigo Nodularis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of prurigo nodularis

AND

2 - Patient has greater than or equal to 20 nodular lesions

AND

3 - History of failure, contraindication, or intolerance to at least ONE previous prurigo nodularis treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors, topical capsaicin)

AND

4 - Patient is not receiving Dupixent in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

5 - Prescribed by ONE of the following:

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Dupixent [a]	
Diagnosis	Prurigo Nodularis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Dupixent therapy

AND

2 - Patient is not receiving Dupixent in combination with EITHER of the following:

- Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]

AND

3 - Prescribed by one of the following:

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Clinical Practice Guidelines			
Table 1: Relative potencies of topical corticosteroids			
Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5

Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

Table 2: Low, medium and high daily doses of inhaled corticosteroids

Adults and adolescents (12 years of age and older)

Drug	Daily dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (CFC)	200-500	>500-1000	>1000
Beclometasone dipropionate (HFA)	100-200	>200-400	>400

Budesonide DPI	200-400	>400-800	>800
Ciclesonide (HFA)	80-160	>160-320	>320
Fluticasone furoate (DPI)	100	n.a	200
Fluticasone propionate (DPI)	100-250	>250-500	>500
Fluticasone propionate (HFA)	100-250	>250-500	>500
Mometasone furoate	110-220	>220-440	>440
Triamcinolone acetonide	400-1000	>1000-2000	>2000

Benefit/Coverage/Program Information

Background:

Dupixent (dupilumab) is an interleukin-4 receptor alpha antagonist indicated for treatment of patients aged 6 months and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Dupixent can be used with or without topical corticosteroids. Dupixent is also indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 6 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma, as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP), for the treatment of adult and pediatric patients aged 1 year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE), and for adult patients with prurigo nodularis (PN).

Limitation of Use: Dupixent is not for the relief of acute bronchospasm or status asthmaticus.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limitations may be in place.

4 . References

1. Simpson EL, Bieber T, Guttman-Yassky E, et al. Two phase 3 trials of dupilumab versus placebo in atopic dermatitis. N Engl J Med. 2016 Sep 30.

2. Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014; 71(1):116-32.
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5 . Revision History

Date	Notes
3/6/2024	Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Removed weight requirement fro m Eosinophilic Esophagitis criteria. Updated background and referen ce.

Duvyzat

Prior Authorization Guideline

Guideline ID	GL-149898
Guideline Name	Duvyzat
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Duvyzat (givinostat) oral suspension
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 6 years of age and older.

2 . Criteria

Product Name: Duvyzat [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Duchenne muscular dystrophy (DMD)

AND

2 - Diagnosis confirmed by the presence of a mutation in the DMD gene

AND

3 - Patient is 6 years of age or older

AND

4 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.)

AND

5 - Patient has been or will be established on a stable corticosteroid regimen

AND

6 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD

AND

7 - Patient has not received gene therapy for DMD [e.g., Elevidys (delandistrogene moxparvovec-rokl)]

AND

8 - Patient will not receive Duvyzat in combination with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Duvyzat [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Physician attestation that patient would benefit from continued administration.

AND

2 - Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory WITHOUT needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.)

AND

3 - Patient continues to receive concomitant corticosteroid regimen

AND

4 - Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD

AND **5** - Patient has not received gene therapy for DMD [e.g., Elevidys (delandistrogene moxparvovec-rokl)] **AND** **6** - Patient will not receive Duvyzat in combination with exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Duvyzat (givinostat) is a histone deacetylase inhibitor indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 6 years of age and older. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Duvyzat [package insert]. Concord, MA: ITF Therapeutics, LLC; March 2024.
2. Mercuri E, Vilchez JJ, Boespflug-Tanguy O, et al. Safety and efficacy of givinostat in boys with Duchenne muscular dystrophy (EPIDYS): a multicentre, randomised, double-

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5 . Revision History

Date	Notes
7/16/2024	New program.

Egaten

Prior Authorization Guideline

Guideline ID	GL-154209
Guideline Name	Egaten
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	09/21/2022 ; 09/20/2023 ; 9/18/2024

1 . Indications

Drug Name: Egaten (triclabendazole)
Fascioliasis Indicated for the treatment of fascioliasis in patients over the age of 6 years.

2 . Criteria

Product Name: Egaten [a]	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of fascioliasis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place **Background** Egaten (triclabendazole) is an anthelmintic, indicated in the treatment of fascioliasis in patients over the age of 6 years.

4 . References

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5 . Revision History

Date	Notes
9/3/2024	Annual review, updated reference.

Egrifta SV

Prior Authorization Guideline

Guideline ID	GL-121412
Guideline Name	Egrifta SV
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	9/15/2021
P&T Revision Date:	2/17/2023

1 . Indications

Drug Name: Egrifta SV (tesamorelin)
Reduction of excess abdominal fat in HIV-infected patients with lipodystrophy Indicated for the reduction of excess abdominal fat in HIV-infected patients with lipodystrophy.

2 . Criteria

Product Name: Egrifta SV [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of HIV-associated lipodystrophy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Egrifta SV [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response (e.g., improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance) while on Egrifta SV therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

Background

Egrifta SV (tesamorelin) is a growth hormone releasing factor (GHRF) analog indicated for the reduction of excess abdominal fat in HIV-infected patients with lipodystrophy.

Limitations of Use:

- Long-term cardiovascular safety of Egrifta SV has not been established.
- Not indicated for weight loss management.
- There are no data to support improved compliance with anti-retroviral therapies in HIV-positive patients taking Egrifta SV.

4 . References

1. Egrifta SV [prescribing information]. Montreal, Quebec, Canada. Theratechnologies, Inc. October 2019.

5 . Revision History

Date	Notes
2/22/2023	Annual review with no changes to coverage criteria. Updated backgr ound, references and added state mandate footnote. Removed Egrift a and updated guideline name since Egrifta is obsolete.

Emflaza

Prior Authorization Guideline

Guideline ID	GL-148732
Guideline Name	Emflaza
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	10/18/2023

1 . Indications

Drug Name: Emflaza (deflazacort)
Duchenne muscular dystrophy (DMD) Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.

2 . Criteria

Product Name: Brand Emflaza, generic deflazacort [a]	
Diagnosis	Duchenne Muscular Dystrophy
Guideline Type	Prior Authorization

Approval Criteria **1** - Published clinical evidence shows Emflaza is likely to produce equivalent therapeutic results as other available corticosteroids (e.g., prednisone); therefore, Emflaza is NOT MEDICALLY NECESSARY for treatment of Duchenne muscular dystrophy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Emflaza (deflazacort) is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older. [1] In a report from the Guideline Development Subcommittee of the American Academy of Neurology, regarding selection of prednisone versus deflazacort in the treatment of DMD, the following statement is made: “prednisone and deflazacort are possibly equally effective for improving motor function in patients with DMD (2 Class III studies). There is insufficient evidence to directly compare the effectiveness of prednisone vs deflazacort in cardiac function in patients with DMD (1 Class III study of a combined cohort).[2] The UnitedHealthcare Pharmacy and Therapeutics Committee has determined that Emflaza is Therapeutically Equivalent to prednisone in the treatment of DMD. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Emflaza [package insert]. South Plainfield, NJ: PTC Therapeutics Inc.; June 2021.
2. Gloss D, Moxley III R, Ashwal S, et. al. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology 2016;86;465-472.

5 . Revision History

Date	Notes
6/20/2024	Added generic Emflaza

Empaveli

Prior Authorization Guideline

Guideline ID	GL-144851
Guideline Name	Empaveli
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	2/18/2022
P&T Revision Date:	08/18/2023 ; 02/16/2024 ; 4/17/2024

1 . Indications

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

2 . Criteria

Product Name: Empaveli [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:

- Flow cytometry analysis confirming presence of PNH clones
- Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

2 - ONE of the following:

2.1 Patient will not be prescribed Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Fabhalta, Soliris, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Fabhalta, Soliris, Ultomiris) which will be discontinued and Empaveli will be initiated in accordance with the United States Food and Drug Administration approved labeling

AND

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

- Hematologist
- Oncologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Empaveli [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Empaveli therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.) **AND** **2** - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Fabhalta, Soliris, Ultomiris) **AND** **3** - Prescribed by, or in consultation with, one of the following: • Hematologist • Oncologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Empaveli (pegcetacoplan) is a complement inhibitor indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

4 . References

1. Empaveli [package insert], Waltham, MA: Apellis Pharmaceuticals, Inc.; September 2023.
2. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. Blood. 2005 Dec 1; 106(12): 3699–3709.
3. Devalet B, Mullier F, Chatelain B, et al. Pathophysiology, diagnosis, and treatment of paroxysmal nocturnal hemoglobinuria: a review. Eur J Haematol. 2015 Sep;95(3):190-8.
4. Sutherland DR, Keeney M, Illingworth A. Practical guidelines for the high-sensitivity detection and monitoring of paroxysmal nocturnal hemoglobinuria clones by flow cytometry. Cytometry B Clin Cytom. 2012 Jul;82(4):195-208.
5. Röth A, Maciejewski J, Nishimura JI, et al. Screening and diagnostic clinical algorithm for paroxysmal nocturnal hemoglobinuria: Expert consensus. Eur J Haematol. 2018 Jul;101(1):3-11.

5 . Revision History

Date	Notes
3/26/2024	Simplified criteria language for converting to new complement inhibit or therapy.

Entresto

Prior Authorization Guideline

Guideline ID	GL-150616
Guideline Name	Entresto
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 04/21/2021 ; 08/19/2022 ; 10/19/2022 ; 11/17/2023 ; 8/16/2024

1 . Indications

Drug Name: Entresto (valsartan-sacubitril), Entresto sprinkles (valsartan-sacubitril)
Heart Failure Indicated to reduce the risk of cardiovascular death and hospitalization for heart failure. Benefits are most clearly evident in patients with left ventricular ejection fraction (LVEF) below normal. It is also indicated for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients aged one year and older.

2 . Criteria

Product Name: Entresto [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - As continuation of therapy initiated during an inpatient stay

OR

2 - ALL of the following:

- Diagnosis of pediatric heart failure with systemic left ventricular systolic dysfunction which is symptomatic
- Prescribed by or in consultation with a cardiologist
- If the request is for Entresto Sprinkles, the prescriber has given a clinical reason or special circumstance why the patient is unable to use regular Entresto tablets

OR

3 - ALL of the following:

3.1 Diagnosis of heart failure (with or without hypertension)

AND

3.2 ONE of the following:

3.2.1 Ejection fraction is less than or equal to 40 percent

OR

3.2.2 BOTH of the following:

- Ejection fraction greater than 40 percent
- Patient has structural heart disease (i.e. left atrial enlargement (LAE) or left ventricular hypertrophy (LVH)

AND

3.3 Heart failure is classified as ONE of the following:

- New York Heart Association Class II
- New York Heart Association Class III
- New York Heart Association Class IV

AND

3.4 Patient does not have a history of angioedema

AND

3.5 Patient will discontinue any use of concomitant ACE Inhibitor or ARB before initiating treatment with Entresto. ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto

AND

3.6 Patient is not concomitantly on aliskiren therapy

AND

3.7 Entresto is prescribed by, or in consultation with, a cardiologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Entresto [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - The Entresto dose has been titrated to a dose of 97 mg/103 mg twice daily or the maximum labeled dose for pediatric patients, or to a maximum dose as tolerated by the patient **AND** **2** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply Limits may be in place. **Background:** Entresto (valsartan-sacubitril) is indicated to reduce the risk of cardiovascular death and hospitalization for heart failure. Benefits are most clearly evident in patients with left ventricular ejection fraction (LVEF) below normal. It is also indicated for the treatment of symptomatic heart failure with systemic left ventricular systolic dysfunction in pediatric patients aged one year and older.

4 . References

1. Entresto [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2024.
2. McMurray JJ, Desai AS, Gong J. Dual angiotensin receptor and neprilysin inhibition as an alternative to angiotensin-converting enzyme inhibition in patients with chronic systolic heart failure: rationale for and design of the prospective comparison of ARNI with ACEI to determine impact on global mortality and morbidity in heart failure trial (PARADIGM-HF). European Journal of Heart Failure 2013; 15: 1062-1073.
3. McMurray JJ, Packer M, Desai AS, et al. Angio-tensin-neprilysin inhibition versus enalapril in heart failure. N Engl J Med 2014;371:993-1004.
4. Heidenreich PA, Bozkurt, B, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiolgy/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2022;145(18):e895-e1032.

5 . Revision History

Date	Notes
8/2/2024	Added Entresto sprinkles to the policy. Update reference.

Entyvio

Prior Authorization Guideline

Guideline ID	GL-147897
Guideline Name	Entyvio
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	6/17/2024

1 . Indications

Drug Name: Entyvio® (vedolizumab) subcutaneous formulation
Ulcerative Colitis Indicated in adults for the treatment of moderately to severely active ulcerative colitis (UC) and moderately to severely active Crohn's disease (CD) in adults

2 . Criteria

Product Name: Entyvio (subcutaneous formulation) [a]	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records documenting clinical rationale for need of subcutaneous Entyvio in place of Entyvio administered intravenously (covered under the medical benefit)

AND

2 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

3 - ONE of the following:

- Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)].

AND

4 - Patient is not receiving Entyvio in combination with a targeted immunomodulator [e.g., Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Entyvio (subcutaneous formulation) [a]	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Entyvio therapy **AND** **2** - Patient is not receiving Entyvio in combination with a targeted immunomodulator [e.g., Simponi (golimumab), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Entyvio (subcutaneous formulation) [a]	
Diagnosis	Crohn's disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary
Approval Criteria **1** - Submission of medical records documenting clinical rationale for need of subcutaneous Entyvio in place of Entyvio administered intravenously (covered under the medical benefit) **AND**	

2 - Diagnosis of moderately to severely active Crohn's disease (CD)

AND

3 - ONE of the following:

- Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine, methotrexate)
- Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of Crohn's disease as confirmed by claims history or submission of medical records [e.g., Cimzia (certolizumab), adalimumab]

AND

4 - Patient is not receiving Entyvio in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Entyvio (subcutaneous formulation) [a]	
Diagnosis	Crohn's disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Entyvio therapy **AND** **2** - Patient is not receiving Entyvio in combination with a targeted immunomodulator [e.g., adalimumab, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Entyvio (vedolizumab) for subcutaneous use is an integrin receptor antagonist indicated in adults for the treatment of moderately to severely active ulcerative colitis (UC) and moderately to severely active Crohn's disease (CD) in adults. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place

4 . References

1. Entyvio [package insert]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; April 2024.
2. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology. 2020; 158(5):1450-61.

3. Lichtenstein GR, Loftus EV, Isaacs KL, et al ACG clinical guideline: management of Crohn's disease in adults. Am J Gastroenterol. 2018; 113:481-517.

5 . Revision History

Date	Notes
6/10/2024	Added criteria for Crohn's Disease.

Eohilia

Prior Authorization Guideline

Guideline ID	GL-147190
Guideline Name	Eohilia
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	5/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Eohilia (budesonide oral suspension)
Eosinophilic esophagitis (EoE) Indicated for 12 weeks of treatment in adult and pediatric patients 11 years of age and older with eosinophilic esophagitis (EoE).

2 . Criteria

Product Name: Eohilia [a]	
Approval Length	12 Week(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis (EoE)

AND

2 - Patient is experiencing symptoms related to esophageal dysfunction (e.g., dysphagia, food impaction, chest pain that is often centrally located and may not respond to antacids, gastroesophageal reflux disease-like symptoms/refractory heartburn, upper abdominal pain)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting eosinophil-predominant inflammation on esophageal biopsy, consisting of a peak value of ≥15 intraepithelial eosinophils per high power field (HPF)

AND

4 - Secondary causes of esophageal eosinophilia have been ruled out

AND

5 - Failure, contraindication or intolerance to an 8-week trial of BOTH of the following (document name and date tried):

- Proton pump inhibitor (e.g., pantoprazole, omeprazole)
- Inhalational corticosteroid administered orally [e.g., budesonide nebulized solution (Pulmicort respules), Fluticasone HFA (Flovent HFA authorized generic)]

AND

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

- Allergist/Immunologist

• Gastroenterologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

3 . References

1. Eohilia [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc; February 2024.
2. Hirano, I, Chan, ES, Rank MA, et. al. AGA Institute and the Joint Task Force on Allergy-Immunology Practice Parameters Clinical Guidelines for the Management of Eosinophilic Esophagitis. Gastroenterology. 2020; 158: 1776-86.
3. Delton, ES, Gonsalves, N, Hirano, I, et al. ACG Clinical Guideline: Evidenced Based Approach to the Diagnosis and Management of Esophageal Eosinophilia and Eosinophilic Esophagitis (EoE). Am J Gastroenterol. 2013; 108: 679-92.

4 . Revision History

Date	Notes
5/9/2024	New program.

Erleada

Prior Authorization Guideline

Guideline ID	GL-136043
Guideline Name	Erleada
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 11/19/2021 ; 08/19/2022 ; 11/18/2022 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Erleada (apalutamide)
Prostate cancer Indicated for the treatment of patients with non-metastatic castration-resistant prostate cancer. It is also indicated for the treatment of metastatic castration-sensitive prostate cancer.

2 . Criteria

Product Name: Erleada [a]	
Diagnosis	Prostate Cancer

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

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - One of the following:

2.1 Both of the following:

- Disease is castration-resistant or recurrent
- Disease is non-metastatic

OR

2.2 Both of the following:

- Disease is castration-sensitive or naive
- Disease is metastatic

AND

3 - One of the following:

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had bilateral orchiectomy

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Erleada [a]	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Erleada therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Erleada [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Erleada will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Erleada [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Erleada therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Erleada (apalutamide) is an androgen receptor inhibitor indicated for the treatment of patients with non-metastatic castration-resistant prostate cancer. It is also indicated for the treatment of metastatic castration-sensitive prostate cancer. Patients should also receive a gonadotropin-releasing hormone (GnRH) analog concurrently while taking Erleada or should have had bilateral orchiectomy. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Erleada [package insert]. Horsham, PA: Janssen Products LP. February 2023.

2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 27, 2023.

5 . Revision History

Date	Notes
11/7/2023	Annual review with no change to coverage criteria. Updated referenc es.

Esbriet, Ofev

Prior Authorization Guideline

Guideline ID	GL-144130
Guideline Name	Esbriet, Ofev
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	04/21/2021 ; 09/15/2021 ; 04/20/2022 ; 09/21/2022 ; 03/15/2023 ; 08/18/2023 ; 3/20/2024

1 . Indications

Drug Name: Esbriet (pirfenidone)
Idiopathic Pulmonary Fibrosis (IPF) Indicated for the treatment of idiopathic pulmonary fibrosis (IPF).
Drug Name: Ofev (nintedanib)
Idiopathic Pulmonary Fibrosis (IPF) Indicated for in the treatment of idiopathic pulmonary fibrosis (IPF). **Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)** Indicated for slowing the rate of decline in pulmonary function in patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD). **Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype**

Indicated for the treatment of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype

2 . Criteria

Product Name: Brand Esbriet, Ofev, generic pirfenidone [a]	
Diagnosis	Idiopathic pulmonary fibrosis [a]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) as documented by ALL of the following criteria:

1.1 Exclusion of other known causes of interstitial lung disease (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), as documented by the following:

- ICD-10 Code J84.112 (Idiopathic pulmonary fibrosis)

AND

1.2 ONE of the following:

1.2.1 In patients NOT subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF [5]

OR

1.2.2 In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF [5]

AND

2 - ONE of the following:

- If request is for Esbriet, Esbriet is not being used in combination with Ofev
- If the request is for Ofev, Ofev is not being used in combination with Esbriet.

AND

3 - The prescriber is a pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Esbriet, Ofev, generic pirfenidone, [a]	
Diagnosis	Idiopathic pulmonary fibrosis [a]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

- If request is for Esbriet, Esbriet is not being used in combination with Ofev
- If the request is for Ofev, Ofev is not being used in combination with Esbriet

AND

3 - The prescriber is a pulmonologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Ofev [a]	
Diagnosis	Systemic sclerosis-associated interstitial lung disease [a]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by all of the following criteria:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 At least TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III)

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on HRCT, involving at least 10% of the lungs

AND

2 - Ofev is not being used in combination with Esbriet or pirfenidone

AND

3 - The prescriber is a pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ofev [a]	
Diagnosis	Systemic sclerosis-associated interstitial lung disease [a]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ofev therapy

AND

2 - Ofev is not being used in combination with Esbriet or pirfenidone

AND

3 - The prescriber is a pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ofev [a]	
Diagnosis	Chronic fibrosing interstitial lung disease with a progressive phenotype [a]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following criteria:

1.1 Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT, involving at least 10% of the lungs

AND

1.2 Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

1.2.1 Forced vital capacity (FVC) decline of greater than 10%

OR

1.2.2 TWO of the following:

- FVC decline of greater than or equal to 5%, but less than 10%
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

AND

2 - Ofev is not being used in combination with Esbriet or pirfenidone

AND

3 - The prescriber is a pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ofev [a]	
Diagnosis	Chronic fibrosing interstitial lung disease with a progressive phenotype [a]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ofev therapy

AND

2 - Ofev is not being used in combination with Esbriet or pirfenidone

AND

3 - The prescriber is a pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Esbriet (pirfenidone) is a pyridone inhibitor and Ofev (nintedanib) is a kinase inhibitor that are indicated for the treatment of idiopathic pulmonary fibrosis (IPF). Ofev is also indicated for slowing the rate of decline in pulmonary function in patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD) and for the treatment of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Esbriet [Prescribing Information]. South San Francisco, CA. Genentech USA, Inc. February 2023.
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5. Richeldi L, du Boise RM, Raghu G, et al. Efficacy and safety of nintedanib in idiopathic pulmonary fibrosis. N Engl J Med. 2014 May 29;370(22):2071-82.
6. Richeldi L, Cottin V, Flaherty KR, et al. Design of the INPULSIS trials: two phase 3 trials of nintedanib in patients with idiopathic pulmonary fibrosis. Resp Med. 2014;108:1023-1030.
7. Raghu G, Remy-Jardin M, Richeldi L, et al. Idiopathic Pulmonary Fibrosis (an Update) and Progressive Pulmonary Fibrosis in Adults: An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline. Am J Respir Crit Care Med. 2022;205(9):e18-e47. doi:10.1164/rccm.202202-0399ST

5 . Revision History

Date	Notes
3/10/2024	Annual review. No change in coverage criteria. Updated references.

Evrysdi

Prior Authorization Guideline

Guideline ID	GL-149799
Guideline Name	Evrysdi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/20/2022
P&T Revision Date:	08/19/2022 ; 08/18/2023 ; 7/17/2024

1 . Indications

Drug Name: Evrysdi (risdiplam)
Spinal muscular atrophy (SMA) Indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.

2 . Criteria

Product Name: Evrysdi [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of spinal muscular atrophy (SMA)

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

- Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)
- Compound heterozygous mutation ONE of SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

3 - Patient is not dependent on either of the following:

- Invasive ventilation or tracheostomy
- Use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

4 - Patient is not receiving concomitant chronic survival motor neuron (SMN) modifying therapy [e.g., Spinraza (nusinersen)]

AND

5 - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) documenting the

baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Revised Upper Limb Module (RULM) Test
- Motor Function Measure 32 (MFM-32) Scale

AND

7 - Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA

Notes	* Baseline assessments for patients less than 2 months of age reques ting Evrysdi are not necessary in order to not delay access to initial th erapy in recently diagnosed infants. Initial assessments shortly post-th erapy can serve as baseline with respect to efficacy reauthorization as sessment. [a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Evrysdi [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) with the most recent results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status (inclusive of baseline assessments prior to receipt of previous chronic SMN modifying therapy) as demonstrated by at least one of the following exams:

1.1 CHOP INTEND: ONE of the following:

- Improvement or maintenance of previous improvement of at least a 4 point increase in score from pretreatment baseline

- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.2 HINE-2: ONE of the following:

- Improvement or maintenance of previous improvement of at least 2 point (or maximal score) increase in ability to kick
- Improvement or maintenance of previous improvement of at least 1 point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp
- The patient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
- Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

OR

1.3 HFMSE: ONE of the following

- Improvement or maintenance of previous improvement of at least a 3 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.4 RULM: ONE of the following:

- Improvement or maintenance of previous improvement of at least a 2 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.5 MFM-32: ONE of the following:

- Improvement or maintenance of previous improvement of at least a 3 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

2 - Patient is not dependent on either of the following:

- Invasive ventilation or tracheostomy
- Use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

3 - Patient is not receiving concomitant chronic survival motor neuron (SMN) modifying therapy [e.g., Spinraza (nusinersen)]

AND

4 - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

5 - Prescribed by or in consultation with a neurologist with expertise in the treatment of SMA

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Evrysdi is a survival of motor neuron 2 (SMN2) splicing modifier indicated for the treatment of spinal muscular atrophy (SMA) in pediatric and adult patients.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Evrysdi [package insert]. South San Francisco, CA: Genentech, Inc; February 2024.
2. Mercuri E, Darras BT, Chiriboga CA, et al. Nusinersen versus Sham Control in Later-Onset Spinal Muscular Atrophy. N Engl J Med. 2018 Feb 15;378(7):625-635.
3. Finkel RS, Mercuri E, Darras BT, et al. Nusinersen versus Sham Control in Infantile-Onset Spinal Muscular Atrophy. N Engl J Med. 2017 Nov 2;377(18):1723-1732.
4. Markowitz JA, Singh P, Darras BT. Spinal Muscular Atrophy: A Clinical and Research Update. Pediatric Neurology 46 (2012) 1-12.
5. Mendell JR, Al-Zaidy S, Shell R, et al. Single-dose gene-replacement therapy for spinal muscular atrophy. N Engl J Med. 2017;377:1713-22
6. Chiriboga C, Mercuri E, Fischer D, et al. JEWELFISH: Risdiplam (RG7916) increased survival of motor neuron (SMN) protein levels in non-naïve patients with spinal muscular atrophy (SMA). Presented at the 6th International Congress of Myology in Bordeux, France; March 25-28, 2019. Poster.
7. Chiriboga C, Bruno C, Duong T, et al. JEWELFISH: Safety and pharmacodynamic data in non-naïve patients with spinal muscular atrophy receiving treatment with risdiplam. Presented at the 2020 Virtual SMA Research & Clinical Care Meeting. June 12, 2020.
8. Day JW, Annoussamy M, Baranello G, et al. SUNFISH Part 1: 24-month safety and exploratory outcomes of risdiplam (RG7916) treatment in patients with Type 2 or 3 spinal muscular atrophy (SMA). Presented at the 2020 Virtual SMA Research & Clinical Care Meeting. June 12, 2020.
9. Servais L, Baranello G, Masson R, et al. FIREFISH Part 2: Efficacy and safety of risdiplam (RG7916) in infants with Type 1 spinal muscular atrophy (SMA). Presented at the 2020 Virtual SMA Research & Clinical Care Meeting. June 12, 2020.
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muscular atrophy: 12 month changes. Muscle Nerve. 2019 Apr;59(4):426-430. doi: 10.1002/mus.26419. Epub 2019 Feb 7. PMID: 30677148.12. Pera MC, Coratti G, Mazzone ES, Montes J, Scoto M, De Sanctis R, Main M, Mayhew A, Muni Lofra R, Dunaway Young S, Glanzman AM, Duong T, Pasternak A, Ramsey D, Darras B, Day JW, Finkel RS, De Vivo DC, Sormani MP, Bovis F, Straub V, Muntoni F, Pane M, Mercuri E; iSMAC Consortium Group. Revised upper limb module for spinal muscular atrophy: 12 month changes. Muscle Nerve. 2019 Apr;59(4):426-430. doi: 10.1002/mus.26419. Epub 2019 Feb 7. PMID: 30677148.

13. Stolte B, Bois JM, Bolz S, Kizina K, Totzeck A, Schlag M, Kleinschnitz C, Hagenacker T. Minimal clinically important differences in functional motor scores in adults with spinal muscular atrophy. Eur J Neurol. 2020 Dec;27(12):2586-2594. doi: 10.1111/ene.14472. Epub 2020 Sep 6. PMID: 32781490.

5 . Revision History

Date	Notes
7/16/2024	Annual review. Revised prescriber requirement and updated Upper Limb Module to Revised Upper Limb Module test. Updated references.

Fabhalta

Prior Authorization Guideline

Guideline ID	GL-144852
Guideline Name	Fabhalta
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	2/16/2024
P&T Revision Date:	4/17/2024

1 . Indications

Drug Name: Fabhalta (iptacopan)
Paroxysmal Nocturnal Hemoglobinuria Indicated for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH)

2 . Criteria

Product Name: Fabhalta [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following [2,3,4,5]:

- Flow cytometry analysis confirming presence of PNH clones
- Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

2 - ONE of the following:

2.1 Patient will not be prescribed Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, Soliris, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Empaveli, Soliris, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the United States Food and Drug Administration approved labeling

AND

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

- Hematologist
- Oncologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Fabhalta [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Fabhalta therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.) **AND** **2** - Patient is not receiving Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, Soliris, Ultomiris) **AND** **3** - Prescribed by, or in consultation with one of the following: • Hematologist • Oncologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Fabhalta (iptacopan) a complement factor B inhibitor, indicated for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH). [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place

4 . References

1. Fabhalta [package insert]. East Hanover, New Jersey: Novartis Pharmaceuticals Corporation; December 2023.
2. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. Blood. 2005 Dec 1; 106(12): 3699–3709.
3. Devalet B, Mullier F, Chatelain B, et al. Pathophysiology, diagnosis, and treatment of paroxysmal nocturnal hemoglobinuria: a review. Eur J Haematol. 2015 Sep;95(3):190-8.
4. Sutherland DR, Keeney M, Illingworth A. Practical guidelines for the high-sensitivity detection and monitoring of paroxysmal nocturnal hemoglobinuria clones by flow cytometry. Cytometry B Clin Cytom. 2012 Jul;82(4):195-208.
5. Röth A, Maciejewski J, Nishimura JI, et al. Screening and diagnostic clinical algorithm for paroxysmal nocturnal hemoglobinuria: Expert consensus. Eur J Haematol. 2018 Jul;101(1):3-11.

5 . Revision History

Date	Notes
3/26/2024	Simplified criteria language for converting to new complement inhibit or therapy.

Fasenra

Prior Authorization Guideline

Guideline ID	GL-149904
Guideline Name	Fasenra
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/21/2021
P&T Revision Date:	11/19/2021 ; 12/15/2021 ; 02/18/2022 ; 02/17/2023 ; 07/19/2023 ; 7/17/2024

Note:

This program applies to the prefilled autoinjector formulation.

1 . Indications

Drug Name: Fasenra (benralizumab) prefilled auto-injector
Severe Asthma Indicated for the add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype.

2 . Criteria

Product Name: Fasenra (benralizumab) prefilled auto-injector [a]	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Fasenra under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma

AND

1.2 Documentation of positive clinical response to Fasenra therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

1.3 Fasenra is being used in combination with an inhaled corticosteroin (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

1.4 Patient is not receiving Fasenra in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.5 Prescribed by ONE of the following:

- Pulmonologist
- Allergist
- Immunologist

OR

2 - ALL of the following:

2.1 Diagnosis of severe asthma

AND

2.2 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

- Poor symptom control ((e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

2.3 Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level ≥ 150 cells/μL

AND

2.4 Fasenra will be used in combination with ONE of the following:

2.4.1 ONE maximally dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.4.2 Combination therapy including BOTH of the following:

- ONE maximally dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]
- ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

2.5 Patient is not receiving Fasenra in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

2.6 Prescribed by ONE of the following:

- Pulmonologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Fasenra (benralizumab) prefilled auto-injector [a]	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Fasenra therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Fasenra is being used in combination with an ICS-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Fasenra in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Fasenra (benralizumab) is an interleukin-5 receptor alpha-directed cytolytic monoclonal antibody indicated for the add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype. Fasenra is not used for treatment of other eosinophilic conditions or for relief of acute bronchospasm or status asthmaticus. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. • The prefilled syringe is typically covered under the medical benefit. Please refer to the United Healthcare Medical Benefit Drug Policy: “Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®)”.

4 . References

1. Fasenra [prescribing information]. Wilmington, DE;: AstraZeneca Pharmaceuticals LP; April 2024.
2. Chung KF, Wenzel SE, Brozek JL, et al. International ERS/ATS guidelines on definition, evaluation and treatment of severe asthma. Eur Respir J. 2014 Feb:43(2):343-73.
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4. Centers for Disease Control and Prevention. Asthma. Available at http://www.cdc.gov. Accessed December 2022.
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6. FitzGerald JM, Bleecker ER, Menzies-Gow A, et al. Predictors of enhanced response with benralizumab for patients with severe asthma: pooled analysis of the SIROCCO and CALIMA studies. Lancet Respir Med. 2017 Sep 8.
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5 . Revision History

Date	Notes
7/24/2024	Annual review. Modified criteria for existing prior authorization for und er the medical benefit. Updated background for expanded indication f or ages 6 years and older. Updated references.

Fentanyl Transmucosal

Prior Authorization Guideline

Guideline ID	GL-145569
Guideline Name	Fentanyl Transmucosal
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 02/18/2022 ; 04/19/2023 ; 4/17/2024

1 . Indications

Drug Name: Actiq (fentanyl lozenge), Fentora (fentanyl buccal tablet), fentanyl buccal tablet (authorized generic of Fentora), Lazanda (fentanyl nasal spray), Subsys (fentanyl sublingual spray)
Breakthrough cancer pain Indicated for the management of breakthrough cancer pain in patients who are already receiving and have developed tolerance to around-the-clock opioid therapy for their underlying persistent cancer pain.

2 . Criteria

Product Name: Brand Actiq, generic fentanyl lozenge, brand Fentora, fentanyl buccal tablet (AG of Fentora), Lazanda, or Subsys [a]

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Submission of medical records demonstrating ALL of the following:

1.1.1 Use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented in the medical record).

AND

1.1.2 Patient must have at least a ONE week history of ONE of the following medications to demonstrate tolerance to opioids:

- Morphine sulfate at a dose of greater than or equal to 60 mg/day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 mcg/hr
- Oral oxycodone at a dose of greater than or equal to 30 mg/day
- Oral hydromorphone at a dose of greater than or equal to 8 mg/day
- Oral oxymorphone at a dose of greater than or equal to 25 mg/day
- Oral hydrocodone at a dose of greater than or equal to 60 mg/day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)

AND

1.1.3 The patient is currently taking a long-acting opioid around the clock for cancer pain.

AND

1.1.4 ONE of the following:

1.1.4.1 The patient is not concurrently receiving an alternative transmucosal fentanyl product.

OR

1.1.4.2 The patient is currently receiving an alternative transmucosal fentanyl product AND the prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication. Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied. **OR** **1.2** The patient is currently taking Actiq, fentanyl lozenge (generic Actiq), Fentora, fentanyl buccal tablet (AG of Fentora), Lazanda or Subsys and does not meet the prior authorization criteria requirements based on the FDA-approved indication for breakthrough cancer pain (a one-time fill may be approved for transition to an alternative treatment).

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Actiq, Fentora, Lazanda, and Subsys, are rapid-acting opioid analgesics indicated for the management of breakthrough cancer pain in patients who are already receiving and have developed tolerance to around-the-clock opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking at least 60 mg of oral morphine daily, at least 25 mcg/hour of transdermal fentanyl, at least 30 mg of oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg of oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer. Patients must remain on around-the-clock opioids while taking a rapid-acting fentanyl product. Actiq, Fentora, Lazanda, and Subsys must not be used in opioid non-tolerant patients because life-threatening hypoventilation could occur at any dose in patients not on a chronic regimen of opiates. **Additional Clinical Programs:** • Supply limits may be in place.

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Lazanda [package insert]. Parsippany, NJ: West Therapeutic Development LLC; December 2023.
2. Actiq [package insert]. Parsippany, NJ: Cephalon; December 2023.
3. Fentora [package insert]. North Wales, PA: Cephalon; November 2022.
4. Subsys [package insert]. Chandler, AZ: Insys Therapeutics; May 2021.
5. Fentanyl buccal [package insert]. Raleigh, NC: Mayne Pharma; January 2024.

5 . Revision History

Date	Notes
4/10/2024	Added opioid tolerate dose for oral hydrocodone. Updated reference s.

Filspari

Prior Authorization Guideline

Guideline ID	GL-124150
Guideline Name	Filspari
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

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

1 . Indications

Drug Name: Filspari
immunoglobulin A nephropathy (IgAN) Indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g.

2 . Criteria

Product Name: Filspari [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - Estimated glomerular filtration rate (eGFR) ≥ 30 mL/min/1.73 m2

AND

5 - Both of the following:

5.1 Patient is on a maximized stable dose with one of the following prior to initiating therapy:

- maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

5.2 Use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs), endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer)], and Tekturna will be discontinued prior to initiating treatment

AND **6** - History of failure, contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) **AND** **7** - Prescribed by or in consultation with a nephrologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Filspari [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response demonstrated by a reduction in proteinuria

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background

Filspari (sparsentan) is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g.

This indication is approved under accelerated approval based on a reduction in proteinuria. It has not been established whether Filspari slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program.
- Supply limitations may be in place

4 . References

1. Filspari [package insert]. San Diego, CA: Traverse Therapeutics, Inc; February 2023.
2. KDIGO 2021 Glomerular Diseases Guideline. October 2021; 100 (4S).

5 . Revision History

Date	Notes
4/5/2023	New Program.

Filsuvez

Prior Authorization Guideline

Guideline ID	GL-145534
Guideline Name	Filsuvez
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Filsuvez (birch triterpenes)
Epidermolysis bullosa Indicated for the treatment of wounds associated with dystrophic and junctional epidermolysis bullosa in adult and pediatric patients 6 months of age and older.

2 . Criteria

Product Name: Filsuvez [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Patient is at least 6 months of age and older

AND

2 - ONE of the following diagnoses:

- Dystrophic epidermolysis bullosa (DEB)
- Junctional epidermolysis bullosa (JEB)

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) confirming a genetic mutation associated with DEB or JEB (i.e., COL7A1, LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4, ITGA3)

AND

4 - Patient has at least one partial thickness wound that meets ALL of the following criteria:

- 10-50 cm2 in size
- Present for at least 3 weeks
- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

5 - Prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

6 - Patient is NOT receiving Filsuvez in combination with Vyjuvek (beremagene geperpavec-svdt) on the same wound(s)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Filsuvez [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Filsuvez therapy (e.g., complete wound closure, reduction in wound size, decrease in procedural pain, less frequent dressing changes, decreased total body wound burden)

AND

2 - Wound(s) being treated meet all of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection
- No evidence or history of basal or squamous cell carcinomas (SCC)

AND

3 - Filsuvez is prescribed by, or in consultation with, a dermatologist with expertise in the treatment of epidermolysis bullosa (EB)

AND

4 - Patient is NOT receiving Filsuvez in combination with Vyjuvek (beremagene geperpavec-svdt) on the same wound(s)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Filsuvez (birch triterpenes) topical gel is indicated for the treatment of wounds associated with dystrophic and junctional epidermolysis bullosa in adult and pediatric patients 6 months of age and older. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Filsuvez [package insert]. Boston, MA: Chiesi Global Rare Diseases; January 2024.
2. Kern JS, Sprecher E, Fernandez MF, et al. Efficacy and safety of Oleogel-S10 (birch triterpenes) for epidermolysis bullosa: results from the phase III randomized double-blind phase of the EASE study. Br J Dermatol. 2023;188(1):12-21. doi:10.1093/bjd/ljac001
3. Varki R, Sadowski S, Pfendner E, Uitto J. Epidermolysis bullosa. I. Molecular genetics of the junctional and hemidesmosomal variants. J Med Genet. 2006;43(8):641-652. doi:10.1136/jmg.2005.039685

5 . Revision History

Date	Notes
4/15/2024	New program

Firazyr, Sajazir

Prior Authorization Guideline

Guideline ID	GL-144853
Guideline Name	Firazyr, Sajazir
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	8/19/2022
P&T Revision Date:	04/19/2023 ; 02/16/2024 ; 4/17/2024

1 . Indications

Drug Name: Firazyr (icatibant)
Hereditary angioedema (HAE) Indicated for the treatment of acute attacks of HAE in adults 18 years of age and older.
Drug Name: Sajazir (icatibant)
Hereditary angioedema (HAE) Indicated for the treatment of acute attacks of HAE in adults 18 years of age and older.

2 . Criteria

Product Name: Brand Firazyr, generic icatibant, Sajazir [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - BOTH of the following:

2.1 Prescribed for the acute treatment of HAE attacks

AND

2.2 Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

AND

3 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Firazyr, generic icatibant, Sajazir [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - BOTH of the following:

2.1 Prescribed for the acute treatment of HAE attacks

AND

2.2 Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Kalbitor, or Ruconest)

AND

3 - Prescribed by ONE of the following: • Immunologist • Allergist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Firazyr (icatibant) is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older. [1] Sajazir (icatibant) injection is a bradykinin B2 receptor antagonist indicated for treatment of acute attacks of HAE in adults 18 years of age and older.[6] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Firazyr [package insert]. Lexington, MA: Shire Orphan Therapies, LLC; January 2024.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2024.

4. Busse, P., Christiansen, S., Riedl., M., et. al. “US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.” The Journal of Allergy and Clinical Immunology. 2020 September 05.
5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. Allergy. 2022;77(7):1961-1990. doi:10.1111/all.15214
6. Sajazir [package insert]. Cambridge, CB3 0FA, United Kingdom: Cycle Pharmaceuticals Ltd; May 2022.

5 . Revision History

Date	Notes
3/26/2024	Annual review with update to examples of genetic variant(s) and diag nostic criteria with normal C1 inhibitor levels. Updated language for r eauthorization criteria. Updated references. Added SML.

Forteo

Prior Authorization Guideline

Guideline ID	GL-136318
Guideline Name	Forteo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	03/17/2021 ; 03/17/2021 ; 10/20/2021 ; 01/19/2022 ; 01/18/2023 ; 02/17/2023 ; 10/18/2023 ; 11/17/2023

1 . Indications

Drug Name: Forteo (teriparatide) and Teriparatide Injection (teriparatide)
Postmenopausal patients with osteoporosis at high risk of fracture Indicated for the treatment of postmenopausal patients with osteoporosis who are at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. **Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture** Indicated to increase bone mass in patients with primary or hypogonadal osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. **Glucocorticoid-induced osteoporosis at high risk for fracture** Indicated for the treatment of patients with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) at high risk for fracture, defined as a

history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.

2 . Criteria

Product Name: Forteo or Teriparatide Injection [a]	
Diagnosis	Osteoporosis
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - One of the following diagnoses:

1.1 Both of the following:

- Patient is female
- Diagnosis of postmenopausal osteoporosis

OR

1.2 Both of the following:

- Patient is male
- Diagnosis of osteoporosis

AND

2 - One of the following:

- Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than −3.0), high risk for falls or history of injurious falls, and very high fracture

probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture >30%, hip fracture >4.5%)]
- Patient has a history of failure, intolerance or contraindication to other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate)

AND

3 - One of the following:

3.1 Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos)

OR

3.2 Both of the following:

- Patient is currently or has previously been treated with parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos)
- The prescriber attests that the patient remains at or has returned to having a high risk for fracture

AND

4 - Patient has a history of failure, intolerance or contraindication to Tymlos

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Forteo or Teriparatide Injection [a]	
Diagnosis	Osteoporosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Treatment duration of parathyroid hormones (e.g., teriparatide injection, Forteo, Tymlos) has not exceeded a total of 24 months during the patient's lifetime **OR** **2** - Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones (e.g., teriparatide injection, Forteo, Tymlos)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Forteo or Teriparatide Injection [a]	
Diagnosis	Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of glucocorticoid-induced osteoporosis

AND

2 - History of prednisone or its equivalent at a dose greater than or equal to 5 mg/day

AND

3 - One of the following:

- Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g.,

less than −3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture >30%, hip fracture >4.5%)]
- Patient has a history of failure, intolerance or contraindication to other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate)

AND

4 - One of the following:

4.1 Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos)

OR

4.2 Both of the following:

- Patient is currently or has previously been treated with parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos)
- The prescriber attests that the patient remains at or has returned to having a high risk for fracture

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Forteo or Teriparatide Injection [a]	
Diagnosis	Osteoporosis Associated with Sustained Systemic Glucocorticoid Therapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Treatment duration of parathyroid hormones (e.g., teriparatide injection, Forteo, Tymlos) has not exceeded a total of 24 months during the patient's lifetime **OR** **2** - Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones (e.g., teriparatide injection, Forteo, Tymlos)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Forteo (teriparatide) and Teriparatide Injection (teriparatide) are recombinant human parathyroid hormone with three FDA approved indications:[1] **Treatment of postmenopausal patients with osteoporosis at high risk of fracture :** Forteo and Teriparatide Injection are indicated for the treatment of postmenopausal patients with osteoporosis who are at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. **Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture:** Forteo and Teriparatide Injection are indicated to increase bone mass in patients with primary or hypogonadal osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. **Treatment of patients with glucocorticoid-induced osteoporosis at high risk for fracture:** Forteo and Teriparatide Injection are indicated for the treatment of patients with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg

or greater of prednisone) at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.

The American Association of Clinical Endocrinologists/American College of Endocrinology recommend the use of Tymlos in patients unable to sue oral therapy and as initial therapy for patients at very high fracture risk defined as the following: patients with a recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than −3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture >30%, hip fracture >4.5%) or other validated fracture risk algorithm to be at very high fracture risk.[2]

Because of the unknown relevance of the rodent osteosarcoma findings to humans, cumulative use of Forteo for more than 2 years during a patient's lifetime should only be considered if a patient remains at or has returned to having a high risk for fracture.

The safety and efficacy of Teriparatide Injection and Tymlos have not been evaluated beyond 2 years of treatment. Cumulative use of Forteo and other parathyroid hormone analogs (e.g., Forteo, Teriparatide) for more than 2 years during a patient's lifetime is not recommended. [5-6]

Coverage will be provided for members who meet the above criteria.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Forteo [package insert]. Indianapolis, IN: Eli Lilly, Inc.; November 2020.
2. American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis – 2020 Update. Endocr Pract. 2020;26(Supp1): 1-46. doi:10.4158/GL-2020-0524SUPPL
3. Tymlos [package insert]. Boston, MA: Radius Health, Inc.; June 2023.
4. Teriparatide Injection [package insert]. Morristown, NJ: Alvogen, Inc.; November 2019.

5 . Revision History

Date	Notes
11/14/2023	Added step through Tymlos for osteoporosis for 2024

FSH

Prior Authorization Guideline

Guideline ID	GL-144788
Guideline Name	FSH
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/17/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	10/20/2021 ; 06/15/2022 ; 09/21/2022 ; 12/14/2022 ; 08/18/2023 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Follistim AQ (follitropin beta)
Induction of ovulation and pregnancy in anovulatory infertile women Indicated for induction of ovulation and pregnancy in anovulatory infertile women in whom the cause of infertility is functional and not due to primary ovarian failure. **Pregnancy in normal ovulatory women** Indicated for pregnancy in normal ovulatory women undergoing controlled ovarian stimulation as part of an in vitro fertilization (IVF) or intracytoplasmic sperm injection (ICSI) cycle. **Induction of spermatogenesis in men** Indicated in males for induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism (HH) in whom the cause of infertility is not due to primary testicular failure. [3]
Drug Name: Gonal-f (follitropin alfa)

Induction of ovulation and pregnancy in oligo-anovulatory infertile women Indicated for the induction of ovulation and pregnancy in the oligo-anovulatory infertile patient in whom the cause of infertility is functional and not due to primary ovarian failure. **Development of multiple follicles** Indicated for the development of multiple follicles in ovulatory women participating in an Assisted Reproductive Technology (ART) program. **Induction of spermatogenesis in men** Indicated for the induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. [4,5]
Drug Name: Gonal-f RFF (follitropin alfa), Gonal-F RFF Redi-Ject (follitropin alfa)
Induction of ovulation and pregnancy in oligo-anovulatory infertile women Indicated for the induction of ovulation and pregnancy in the oligo-anovulatory infertile patient in whom the cause of infertility is functional and not due to primary ovarian failure. **Development of multiple follicles** Indicated for the development of multiple follicles in ovulatory women participating in an Assisted Reproductive Technology (ART) program.

2 . Criteria

Product Name: Follistim AQ, Gonal-F, Gonal-F RFF, Gonal-F RFF Rediject [a]	
Diagnosis	Ovulation Induction
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ovulatory dysfunction

AND

2 - ONE of the following exists:

- Anovulation
- Oligo-ovulation

- Amenorrhea

AND

3 - Other specific causative factors (e.g., thyroid disease, hyperprolactinemia) have been excluded or treated

AND

4 - Infertility is not due to primary ovarian failure

AND

5 - For induction of ovulation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Follistim AQ, Gonal-F, Gonal-F RFF, Gonal-F RFF Rediject [a]	
Diagnosis	Controlled Ovarian Stimulation**
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of infertility

AND

2 - For the development of multiple follicles (controlled ovarian stimulation)

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 ONE of the following exists:

- Diminished ovarian reserve
- Endometriosis
- Male factor infertility
- Tubal factor infertility
- Unexplained infertility
- Uterine factor infertility
- Ovulatory dysfunction
- Recurrent pregnancy loss
- Failure to achieve conception with other treatment modalities

AND

3.1.2 Will be used in conjunction with assisted reproductive technology (ART)

OR

3.2 BOTH of the following:

3.2.1 ONE of the following exists:

- Diminished ovarian reserve
- Mild to moderate male factor infertility
- Minimal to mild endometriosis
- Unilateral tubal factor infertility
- Unexplained infertility

AND

3.2.2 Will be used in conjunction with intrauterine insemination (IUI)

Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas, and Texas

	should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Follistim AQ, Gonal-F [a]	
Diagnosis	Male Hypogonadotropic Hypogonadism**
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: **1.1** Diagnosis of male primary hypogonadotropic hypogonadism **OR** **1.2** Diagnosis of male secondary hypogonadotropic hypogonadism **AND** **2** - For induction of spermatogenesis **AND** **3** - Infertility is not due to primary testicular failure	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: The body produces two types of gonadotropins, follicle-stimulating hormone (FSH) and luteinizing hormone (LH), both of which play a role in fertility and human reproduction. After they are produced by the pituitary gland, gonadotropins trigger production of other sex hormones which then promote production of egg and sperm. Gonadotropins are used in the treatment of infertility, a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse or therapeutic donor insemination. [1,2,14] Follistim AQ (follitropin beta) is indicated for induction of ovulation and pregnancy in anovulatory infertile women in whom the cause of infertility is functional and not due to primary ovarian failure. It is also indicated for pregnancy in normal ovulatory women undergoing controlled ovarian stimulation as part of an in vitro fertilization (IVF) or intracytoplasmic sperm injection (ICSI) cycle. In males, Follistim AQ is indicated for induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism (HH) in whom the cause of infertility is not due to primary testicular failure. [3] Gonal-f, Gonal-f RFF and Gonal-f RFF Redi-Ject (follitropin alfa) are indicated for the induction of ovulation and pregnancy in oligo-anovulatory infertile women in whom the cause of infertility is functional and not due to primary ovarian failure. Gonal-f, Gonal-f RFF, and Gonal-f RFF Redi-ject are also indicated for the development of multiple follicles in ovulatory women participating in an Assisted Reproductive Technology (ART) program. Gonal-f is indicated for the induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism for whom the cause of infertility is not due to primary testicular failure. [4,5] The clinically appropriate dosing for FSH agents is 450 IU/day or less when used for an ART cycle, or 225 IU/day or less when used for ovulation induction or controlled ovarian stimulation, for not more than 14 days of treatment. Exceeding this daily dose and duration of treatment has not been proven to be efficacious in terms of pregnancy outcome. [9,13]

Additional Clinical Programs:

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. World Health Organization web site. https://www.who.int/health-topics/infertility#tab=tab. Accessed July 16, 2023.
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4. Gonal-f [package insert]. Rockland, MA: EMD Serono, Inc.; December 2020.
5. Gonal-f RFF [package insert]. Rockland, MA: EMD Serono, Inc.; December 2020.
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8. Andoh K, Mizunuma H, Liu X, et al. A comparative study of fixed-dose, stepdown, and low-dose step-up regimens of human menopausal gonadotropin for patients with polycystic ovary syndrome. Fertil Steril m1998: 70; 840-846.
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5 . Revision History

Date	Notes
3/25/2024	Texas added to ovulation induction operation note.

Furoscix

Prior Authorization Guideline

Guideline ID	GL-144131
Guideline Name	Furoscix
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	3/15/2023
P&T Revision Date:	3/20/2024

1 . Indications

Drug Name: Furoscix (furosemide injection)
Chronic Heart Failure Indicated for the treatment of congestion due to fluid overload in adults with NYHA Class II/III chronic heart failure.

2 . Criteria

Product Name: Furoscix	
Approval Length	1 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of chronic heart failure

AND

2 - Heart failure is classified as ONE of the following:

- New York Heart Association (NYHA) class II heart failure
- New York Heart Association (NYHA) class III heart failure

AND

3 - Patient has signs or symptoms of congestion due to fluid overload

AND

4 - Patient is established on background loop diuretic therapy (e.g., furosemide, torsemide, bumetanide)

AND

5 - BOTH of the following:

- Patient does not require ongoing emergency care or hospitalization for heart failure, acute pulmonary edema, or other conditions
- Patient is currently a candidate for parenteral diuresis outside of the hospital

AND

6 - Patient has an estimated creatine clearance greater than 30ml/min

AND

7 - Furoscix is prescribed by or in consultation with a cardiologist

3 . Background

Benefit/Coverage/Program Information
Background: Furoscix (furosemide injection) is indicated for the treatment of congestion due to fluid overload in adults with NYHA Class II/III chronic heart failure. [1] Limitations of use: Furoscix is not indicated for emergency situations or in patients with acute pulmonary edema. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Furoscix [package insert]. Burlington, MA: scPharmaceuticals, Inc.; November 2022.
2. Heidenreich PA, Bozkurt, B, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2022;145(18):e895-e1032.

5 . Revision History

Date	Notes
3/10/2024	Annual review. Updated background to include limitations of use. Up dated reference.

Prior Authorization Guideline

Guideline ID	GL-144759
Guideline Name	Gender Affirming Treatment
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/15/2024
P&T Approval Date:	12/15/2021
P&T Revision Date:	01/18/2023 ; 01/17/2024

1 . Indications

Drug Name: Vaniqa (eflornithine 13.9%) , Propecia (finasteride 1 mg)
Gender Affirming Treatment Gender affirming treatment is defined as a service or product that a health care provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Vaniqa (eflornithine 13.9%) and Propecia (finasteride 1mg) are considered standards of care for gender affirming treatment. [1]

2 . Criteria

Product Name: Vaniqa, Brand Propecia, finasteride (generic Propecia)	
Approval Length	12 month(s)

Guideline Type	Non Formulary
Approval Criteria **1** - Medication is being prescribed for medically necessary gender affirming treatment* **AND** **2** - Medication is not being requested solely for cosmetic purposes	
Notes	*Any submission with a diagnosis other than the above should be denied as a benefit exclusion.

3 . Background

Benefit/Coverage/Program Information
Background: This program is designed to comply with state mandates which prohibit health carriers from denying or limiting coverage for gender affirming treatment when that treatment is medically necessary. Gender affirming treatment is defined as a service or product that a health care provider prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Vaniqa (eflornithine 13.9%) and Propecia (finasteride 1mg) are considered standards of care for gender affirming treatment. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. The World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 8th Version.

5 . Revision History

Date	Notes
3/22/2024	Updated guideline name and background to clarify that policy is applicable to any market where medications in scope are non-formulary as determined by state mandate.

Prior Authorization Guideline

Guideline ID	GL-133975
Guideline Name	Gleevec
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Gleevec (Imatinib mesylate)
Philadelphia positive chronic myeloid leukemia (Ph+ CML) Indicated for the treatment of Philadelphia positive chronic myeloid leukemia (Ph+ CML) in chronic phase, blast crisis, or accelerated phase after failure of interferon-alpha therapy and for newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase **Philadelphia positive acute lymphoblastic leukemia (Ph+ ALL)** Indicated for the treatment of relapsed or refractory Philadelphia positive acute lymphoblastic leukemia (Ph+ ALL) and for newly diagnosed Ph+ ALL in combination with chemotherapy **Myelodysplastic/myeloproliferative (MDS/MPD) disease** Indicated for the treatment of myelodysplastic/myeloproliferative (MDS/MPD) disease associated with platelet-derived growth factor receptor (PDGFR) gene re-arrangements **Aggressive systemic mastocytosis (ASM)** Indicated for the treatment of aggressive

systemic mastocytosis (ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown

Hypereosinophilic syndrome (HES)/chronic eosinophilic leukemia (CEL) Indicated for the treatment of patients with hypereosinophilic syndrome (HES)/chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown

Dermatofibrosarcoma protuberans (DFSP) Indicated for the treatment of unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP)

Gastrointestinal stromal tumors (GIST) Indicated for the treatment of Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST) or adjuvant treatment of patients following resection of Kit (CD117) positive GIST.

Off Label Uses: Other indications The National Cancer Comprehensive Network (NCCN) also recommends the use of imatinib mesylate (Gleevec) for AIDS-related Kasposi sarcoma, desmoid tumors, chordomas, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), C-KIT mutated melanoma, primary and follow-up chronic myelogenous/myeloid leukemia (CML) in all phases, steroid-refractory graft-versus-host disease (GVHD), and myeloid/lymphoid neoplasms. [2]

2 . Criteria

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic myelogenous / myeloid leukemia (CML)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Myelodysplastic Disease (MDS) / Myeloproliferative Disease (MPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of myelodysplastic/myeloproliferative disease (MDS/MPD) **AND** **2** - Platelet-derived growth factor receptor (PDGFR) gene re-arrangements	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Myelodysplastic Disease (MDS) / Myeloproliferative Disease (MPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Aggressive Systemic Mastocytosis (ASM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of aggressive systemic mastocytosis (ASM) **AND** **2** - One of the following: • KIT D816V mutation negative or unknown • Well-differentiated SM [WDSM] • Eosinophilia is present with FIP1L1-PDGFRA fusion gene	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Aggressive Systemic Mastocytosis (ASM)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Hypereosinophilic Syndrome (HES) / Chronic Eosinophilic Leukemia (CEL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of at least one of the following: • Hypereosinophilic syndrome (HES) • Chronic eosinophilic leukemia (CEL)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Hypereosinophilic Syndrome (HES) / Chronic Eosinophilic Leukemia (CEL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Dermatofibrosarcoma Protuberans (DFSP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of dermatofibrosarcoma protuberans (DFSP)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Dermatofibrosarcoma Protuberans (DFSP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of one of the following: • Gastrointestinal stromal tumors (GIST) • Desmoid tumors / aggressive fibromatosis • Pigmented villonodular synovitis (PVNS) / tenosynovial giant cell tumor (TGCT)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chordoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of melanoma **AND** **2** - Patient has C-KIT mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	AIDS-Related Kaposi Sarcoma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of AIDS-related Kaposi Sarcoma **AND** **2** - Not used as first line therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	AIDS-Related Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Steroid-Refractory Chronic Graft-Versus-Host Disease (GVHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic graft-versus-host disease **AND** **2** - Patient is being treated with systemic corticosteroids **AND** **3** - Patient had no response to first-line therapy options	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Steroid-Refractory Chronic Graft-Versus-Host Disease (GVHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]

Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

AND

2 - One of the following:

- FIP1L1-PDGFRA rearrangement
- PDGFRB rearrangement
- ABL1 rearrangement

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Gleevec or imatinib will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Gleevec, generic imatinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Gleevec therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Imatinib mesylate (Gleevec) is a kinase inhibitor indicated for the treatment of: [1] • Newly diagnosed adult and pediatric patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase • Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase, blast crisis, or accelerated phase after failure of interferon-alpha therapy • Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) • Newly diagnosed Ph+ ALL in combination with chemotherapy • Myelodysplastic / myeloproliferative (MDS/MPD) diseases associated with platelet-derived growth factor receptor (PDGFR) gene re-arrangements • Aggressive systemic mastocytosis (ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown • Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown • Unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP) • Kit (CD117) positive unresectable and/or metastatic malignant gastrointestinal stromal tumors (GIST) • Adjuvant treatment of patients following resection of Kit (CD117) positive GIST The National Cancer Comprehensive Network (NCCN) also recommends the use of imatinib mesylate (Gleevec) for AIDS-related Kasposi sarcoma, desmoid tumors, chordomas, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), C-KIT mutated melanoma, primary and follow-up chronic myelogenous/myeloid leukemia (CML) in all phases, steroid-refractory graft-versus-host disease (GVHD), and myeloid/lymphoid neoplasms.[2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Gleevec [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed on September 5, 2023.

5 . Revision History

Date	Notes
9/29/2023	Annual review. Updates made to MDS/MPD, ASM, and AIDS-Related Kaposi Sarcoma per NCCN guidelines. Updated reference.

Prior Authorization Guideline

Guideline ID	GL-148013
Guideline Name	GLP1 Receptor Agonists
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	12/14/2022
P&T Revision Date:	08/18/2023 ; 05/17/2024 ; 6/17/2024

1 . Indications

Drug Name: Mounjaro (tirzepatide), Ozempic (semaglutide), Rybelsus (semaglutide), and Trulicity (dulaglutide)
Type 2 Diabetes Mellitus Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.
Drug Name: Bydureon BCise (exenatide extended-release), and Victoza (liraglutide)
Type 2 Diabetes Mellitus Indicated as an adjunct to diet and exercise to improve glycemic control in patients 10 years of age and older with type 2 diabetes mellitus.
Drug Name: Ozempic (semaglutide), Trulicity (dulaglutide), and Victoza (liraglutide)
Type 2 Diabetes Mellitus Indicated to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease.

2 . Criteria

Product Name: Bydureon BCise, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by ONE of the following laboratory values • A1C greater than or equal to 6.5% • Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL • 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during oral glucose tolerance test • Random plasma glucose greater than or equal to 200 mg/dL in patient with classic symptoms of hyperglycemia or hyperglycemic crisis **OR** **2** - For patients requiring ongoing treatment for type 2 diabetes mellitus (i.e., diagnosed greater than 2 years ago), submission of medical records (e.g., chart notes) confirming diagnosis of type 2 diabetes mellitus	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Medications used for the purposes of weight loss are typically excluded from benefit coverage. Coverage is determined by the member's prescription drug benefit plan.

3 . Background

Benefit/Coverage/Program Information

Background:

Ozempic (semaglutide), Rybelsus (semaglutide), and Trulicity (dulaglutide), are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Bydureon BCise (exenatide extended-release) and Victoza (liraglutide) are indicated as an adjunct to diet and exercise to improve glycemic control in patients 10 years of age and older with type 2 diabetes mellitus. Ozempic, Trulicity, and Victoza are also indicated to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease.

Mounjaro (tirzepatide) is a glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Bydureon BCise [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; May 2023.
2. Mounjaro [package insert] Indianapolis, IN: Eli Lilly and Company; July 2023.
3. Ozempic [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; September 2023.
4. Rybelsus [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; January 2024.
5. Trulicity [package insert]. Indianapolis, IN: Eli Lilly and Company; April 2021.
6. Victoza [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; December 2021.
7. American Diabetes Association. Standard of Medical Care in Diabetes - 2024. Diabetes Care 2022;47 (Supplement 1).
8. Consensus Statement by The American Association Of Clinical Endocrinologists and American College Of Endocrinology On The Comprehensive Type 2 Diabetes Management Algorithm – 2020 Executive Summary. AACE/ACE Consensus Statement. Endocr Pract. 2020;26: 107-39.

5 . Revision History

Date	Notes
6/3/2024	Added requirement to match commercial for submission of medical r ecords to confirm type 2 diabetes diagnosis. Updated references.

Prior Authorization Guideline

Guideline ID	GL-144789
Guideline Name	GnRH Antagonists
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/17/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	12/15/2021 ; 09/21/2022 ; 12/14/2022 ; 08/18/2023 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Cetrotide (cetrorelix acetate), Fyremadel (ganirelix acetate)
Ovulation induction, controlled stimulation Indicated to inhibit premature luteinizing hormone (LH) surges in women undergoing controlled ovarian stimulation followed by insemination or assisted reproductive technology (ART). [1-3,5]

2 . Criteria

Product Name: Brand Cetrotide, generic cetrorelix, generic fyremadel, generic ganirelix acetate

Diagnosis	Controlled Ovarian Stimulation** [a]
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of infertility

AND

2 - ONE of the following exists:

- Unexplained infertility
- Endometriosis
- Male factor infertility
- Tubal factor infertility
- Diminished ovarian reserve
- Uterine factor infertility
- Ovulatory dysfunction
- Recurrent pregnancy loss
- Failure to achieve conception with other treatment modalities

AND

3 - For the development of one or more follicles (controlled ovarian stimulation)

AND

4 - Documentation of an approved assisted reproductive technology (ART) protocol

Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cetrotide (cetrorelix acetate) and ganirelix acetate are synthetic decapeptides with gonadotropin-releasing hormone (GnRH) antagonist activity. These agents are indicated to inhibit premature luteinizing hormone (LH) surges in women undergoing controlled ovarian stimulation followed by insemination or assisted reproductive technology (ART) [1-3,5] **Additional Clinical Programs:** • Supply limits may be in place. • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Cetrotide [package insert]. Rockland, MA: EMD Serono, Inc.; September 2018.
2. Ganirelix acetate [package insert]. Whitehouse Station, NJ: Merck and Co., Inc.; June 2021.
3. Ganirelix acetate [package insert]. Parsippany, NJ: Ferring Pharmaceuticals Inc.; June 2021.
4. Sahakyan M, Harlow BL, Hornstein MD. Influence of age, diagnosis, and cycle number on pregnancy rates with gonadotropin-induced controlled ovarian hyperstimulation and intrauterine insemination. Fertil Steril 1999; 72: 500-504.
5. Ganirelix acetate [package insert]. Jersey City, NJ: Organon Global Inc.; June 2021.

5 . Revision History

Date	Notes
3/25/2024	Texas added to ovulation induction operation note.

Prior Authorization Guideline

Guideline ID	GL-154783
Guideline Name	Growth hormone
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	2/19/2021
P&T Revision Date:	07/21/2021 ; 09/15/2021 ; 01/19/2022 ; 07/19/2023 ; 09/20/2023 ; 09/20/2023 ; 12/13/2023 ; 9/18/2024

1 . Indications

Drug Name: Somatropin
Growth hormone deficiency Indicated for the treatment of growth hormone deficiency. **Turner syndrome or Noonan syndrome** Indicated for short stature associated with Turner syndrome or Noonan syndrome **Short-stature homeobox (SHOX) gene deficiency** Indicated for short-stature homeobox (SHOX) gene deficiency **Prader-Willi syndrome** Indicated for growth failure due to Prader-Willi syndrome. **Short stature in children small for gestational age** Indicated for short stature in children born small for gestational age. **Growth failure in children with chronic renal insufficiency** Indicated for growth failure in

children with chronic renal insufficiency up to the time of transplant. **Short bowel syndrome** Indicated for short bowel syndrome in patients receiving specialized nutritional support. **HIV-associated wasting** Indicated for HIV-associated wasting. **Replacement of endogenous growth hormone in adults** Indicated for replacement of endogenous growth hormone in adults with confirmed growth hormone deficiency.
Drug Name: Mecasermin (Increlex)
Severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion Indicated for the treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with GH gene deletion who have developed neutralizing antibodies to GH.
Drug Name: Skytrofa (lonapegsomatropin-tcgd)
Pediatric Growth Hormone Deficiency (GHD) Indicated for the treatment of pediatric patients 1 year and older who weigh at least 11.5 kg and have growth failure due to inadequate secretion of endogenous growth hormone (GH).
Drug Name: Ngenla (somatrogon)
Pediatric Growth Hormone Deficiency (GHD) Indicated for treatment of pediatric patients aged 3 years and older who have growth failure due to inadequate secretion of endogenous GH.
Drug Name: Sogroya (somapacitan)
Pediatric Growth Hormone Deficiency (GHD) Indicated for the treatment of pediatric patients aged 2.5 years and older who have growth failure due to inadequate secretion of endogenous growth hormone. **Adult Growth Hormone Deficiency** Indicated for the replacement of endogenous GH in adults with growth hormone deficiency (GHD).

2 . Criteria

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)

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

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

- Infant is less than 4 months of age
- Infant has growth deficiency
- Prescribed by an endocrinologist

OR

1.2 BOTH of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Prescribed by an endocrinologist

OR

1.3 BOTH of the following:

- Diagnosis of panhypopituitarism
- Prescribed by an endocrinologist

OR

2 - ALL of the following:

2.1 Diagnosis of pediatric GH deficiency as confirmed by ONE of the following:

- Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height
- Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

- Growth velocity is greater than 2 SD below mean for age and gender
- Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

2.2 ONE of the following:

2.2.1 Patient is male and ONE of the following:

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

2.2.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

2.3.1 BOTH of the following:

2.3.1.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

2.3.1.2 Both GH response values are less than 10 mcg/L

OR

2.3.2 BOTH of the following:

2.3.2.1 Patient is less than 1 year of age

AND

2.3.2.2 ONE of the following is below the age and gender adjusted normal range as provided by the physician's lab:

- Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
- Insulin Growth Factor Binding Protein-3 (IGFBP-3)

AND

2.4 ONE of the following:

2.4.1 Request does not exceed a maximum supply limit of 0.3 mg/kg/week

OR

2.4.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 mg/kg/week

AND

2.5 Prescribed by an endocrinologist

Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. Note: Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset G H deficiency, utilize criteria for Transition Phase Adolescent or Adult G H Deficiency.

	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 cm/year over the previous year documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

2 - BOTH of the following:

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Calculated height (growth) velocity over the past 12 months

AND

4 - Documentation of ONE of the following :

4.1 Patient is male and ONE of the following::

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

4.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

5 - ONE of the following:

5.1 Request does not exceed a maximum supply limit of 0.3 mg/kg/week

OR

5.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 mg/kg/week

AND

6 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy.

	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ngenla, Skytrofa, Sogroya **[a]	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Prescribed by an endocrinologist

OR

1.2 BOTH of the following:

- Diagnosis of panhypopituitarism
- Prescribed by an endocrinologist

OR

2 - ALL of the following:

2.1 Diagnosis of pediatric GH deficiency as confirmed by ONE of the following:

- Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height
- Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

- Growth velocity is greater than 2 SD below mean for age and gender
- Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

2.2 ONE of the following:

2.2.1 Patient is male and ONE of the following:

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

2.2.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting BOTH of the following:

2.3.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

2.3.2 BOTH GH response values are less than 10 mcg/L

AND

2.4 Prescribed by an endocrinologist	
Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. Note: Includes children who have undergone brain radiation. If patient is a Transition Phase A dolescent or Adult who had childhood onset GH deficiency, utilize crit eria for Transition Phase Adolescent or Adult GH Deficiency. **Please Note: The request for growth hormone (GH) injections to trea t idiopathic short stature (ISS) is not authorized. There is no consensu s in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Ngenla, Skytrofa, Sogroya **[a]	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 cm/year over the previous year documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

2 - BOTH of the following:

- Expected adult height not obtained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Calculated height (growth) velocity over the past 12 months

AND

4 - Documentation of ONE of the following:

4.1 Patient is male and ONE of the following:

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

4.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

5 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Prader-Willi Syndrome

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Prader-Willi Syndrome **AND** **2** - Prescribed by an endocrinologist	
Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following: • Evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)	

- Prescribed by an endocrinologist

OR

2 - ALL of the following:

2.1 Height increase of at least 2 cm/year over the previous year of treatment as documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

2.2 BOTH of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

AND

2.3 Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of SGA based on demonstration of catch up growth failure in the first 24 months of life using a birth to 36 month growth chart as confirmed by the following criterion: **1.1** Documentation that ONE of the following is below the 3rd percentile for gestational age (≥ 2 SD below population mean): • Birth weight • Birth length **AND** **1.2** Patient has demonstrated failure of catch up growth in the first 24 months of life **AND** **2** - Documentation that height remains less than or equal to 3rd percentile (≥ 2 SD below population mean) **AND** **3** - Prescribed by an endocrinologist	
Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. **Please Note: The request for growth hormone (GH) injections to trea t idiopathic short stature (ISS) is not authorized. There is no consensu s in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 cm/year over the previous year documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pediatric growth failure associated with ONE of the following:

1.1 BOTH of the following:

1.1.1 Turner Syndrome (Gonadal Dysgenesis)

AND

1.1.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age < 14 years measured in the past 12 months

OR

1.2 BOTH of the following:

1.2.1 Noonan Syndrome

AND

1.2.2 Documentation of ONE of the following:

1.2.2.1 Patient is male and ONE of the following:

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

1.2.2.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

2 - Height is below the 5th percentile on growth charts for age and gender

AND

3 - Prescribed by an endocrinologist

Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. **Please Note: The request for growth hormone (GH) injections to trea t idiopathic short stature (ISS) is not authorized. There is no consensu s in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Height increase of at least 2 cm/year over the previous year documented by BOTH of the following: • Previous height and date obtained • Current height and date obtained **AND** **2** - Documentation of BOTH of the following: • Expected adult height not attained • Expected adult height goal **AND** **3** - Prescribed by an endocrinologist	
Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency as confirmed by genetic testing

AND

2 - ONE of the following:

2.1 Patient is male and ONE of the following:

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

2.2 Patient is female and ONE of the following:

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

3 - Prescribed by an endocrinologist

Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. **Please Note: The request for growth hormone (GH) injections to trea t idiopathic short stature (ISS) is not authorized. There is no consensu s in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency

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

Approval Criteria

1 - Height increase of at least 2 cm/year over the previous year documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pediatric growth failure associated with chronic renal insufficiency

AND

2 - Documentation of ONE of the following:

2.1 Patient is male and ONE of the following:

- Tanner stage less than IV
- Bone age less than 16 years measured in the past 12 months

OR

2.2 Patient is female and ONE of the following

- Tanner stage less than IV
- Bone age less than 14 years measured in the past 12 months

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. **Please Note: The request for growth hormone (GH) injections to trea t idiopathic short stature (ISS) is not authorized. There is no consensu s in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy.

	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Height increase of at least 2 cm/year over the previous year documented by BOTH of the following: • Previous height and date obtained • Current height and date obtained **AND** **2** - Documentation of BOTH of the following: • Expected adult height not attained • Expected adult height goal **AND** **3** - Prescribed by ONE of the following: • Endocrinologist • Nephrologist	
Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications,

	efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Sogroya, Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of adult GH deficiency as a result of ONE of the following:

1.1 Clinical records supporting a diagnosis of childhood-onset GHD

OR

1.2 BOTH of the following

- Adult-onset GHD
- Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

AND

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

2.1 BOTH of the following:

2.1.1 Patient has undergone ONE of the following GH stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- Arginine & GHRH (GHRH+ARG)
- Glucagon
- Arginine (ARG)
- Macrilen (macimorelin)

AND

2.1.2 ONE of the following peak GH values:

- ITT less than or equal to 5 microgram/L
- GHRH+ARG (less than or equal to 11 microgram/L if body mass index [BMI] less than 25 kg/m^2; less than or equal to 8 microgram/L if BMI greater than or equal to 25 and less than 30 kg/m^2; less than or equal to 4 microgram/L if BMI greater than or equal to 30 kg/m^2)
- Glucagon less than or equal to 3 microgram/L
- ARG less than or equal to 0.4 microgram/L
- Macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 minutes following macimorelin administration

OR

2.2 BOTH of the following:

2.2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH
- TSH
- FSH/LH

AND

2.2.2 IGF-1/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

AND

3 - ONE of the following:

3.1 Diagnosis of panhypopituitarism

OR

3.2 Other diagnosis AND not used in combination with the following:

- Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]
- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

4 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Sogroya, Somatropin** [a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of IGF-1/Somatomedin C level within the past 12 months

AND

2 - ONE of the following:

2.1 Diagnosis of panhypopituitarism

OR

2.2 Other diagnosis AND not used in combination with the following

- Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]
- Androgens [e.g., Delatestryl (testoseterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

3 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Request does not exceed a maximum supply limit of 0.3 mg/kg/week

AND

2 - Documentation of ONE of the following:

- Attained expected adult height
- Closed epiphyses on bone radiograph

AND

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

3.1 BOTH of the following:

3.1.1 Documentation of high risk of GH deficiency due to GH deficiency in childhood from ONE of the following:

3.1.1.1 Embryopathic/congenital defects

OR

3.1.1.2 Genetic mutations

OR

3.1.1.3 Irreversible structural hypothalamic-pituitary disease

OR

3.1.1.4 Panhypopituitarism

OR

3.1.1.5 Deficiency of THREE of the following anterior pituitary hormones:

- ACTH
- TSH
- Prolactin
- FSH/LH

AND

3.1.2 ONE of the following:

3.1.2.1 IGF-1/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

OR

3.1.2.2 ALL of the following:

3.1.2.2.1 Patient does not have a low IGF-1/Somatomedin C level

AND

3.1.2.2.2 Discontinued GH therapy for at least 1 month

AND

3.1.2.2.3 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- ITT
- GHRH+ARG
- ARG
- Glucagon

AND

3.1.2.2.4 ONE of the following peak GH values:

- ITT less than or equal to 5 microgram/L
- GHRH+ARG (less than or equal to 11 microgram/L if body mass index [BMI] less than 25 kg/m^2; less than or equal to 8 microgram/L if BMI greater than or equal to 25 and less than 30 kg/m^2; less than or equal to 4 microgram/L if BMI greater than or equal to 30 kg/m^2)
- Glucagon less than or equal to 3 microgram/L
- ARG less than or equal to 0.4 microgram/L

OR

3.2 ALL of the following:

3.2.1 At low risk of severe GH deficiency (e.g, due to isolated and/or idiopathic GH deficiency)

AND

3.2.2 Discontinued GH therapy for at least 1 month

AND

3.2.3 BOTH of the following:

3.2.3.1 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- ITT
- GHRH+ARG
- ARG
- Glucagon

AND

3.2.3.2 ONE of the following peak GH values:

- ITT less than or equal to 5 microgram/L
- GHRH+ARG (less than or equal to 11 microgram/L if body mass index [BMI] less than 25 kg/m^2; less than or equal to 8 microgram/L if BMI greater than or equal to 25 and less than 30 kg/m^2; less than or equal to 4 microgram/L if BMI greater than or equal to 30 kg/m^2)
- Glucagon less than or equal to 3 microgram/L
- ARG less than or equal to 0.4 microgram/L

AND

4 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Somatropin**[a] (Genotropin, Genotropin Miniquick, Humatrope, Norditropin, Norditropin Flexpro, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive, and Serostim)	
Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 and IGFBP-3 levels)

AND

2 - Request does not exceed a maximum supply limit of 0.3 mg/kg/week

AND

3 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Serostim**[a]	
Diagnosis	Human Immunodeficiency Virus (HIV)-Associated Cachexia (Serostim only)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of HIV-associated wasting syndrome or cachexia

AND

2 - Documentation of ONE of the following:

2.1 Unintentional weight loss of greater than 10% over the last 12 months

OR

2.2 Unintentional weight loss of greater than 7.5% over the last 6 months

OR

2.3 Loss of 5% body cell mass (BCM) within 6 months

OR

2.4 Body mass index (BMI) less than 20 kg/m^2

OR

2.5 ONE of the following:

2.5.1 ALL of the following

- Patient is male
- BCM less than 35% of total body weight
- BMI less than 27 kg/m^2

OR

2.5.2 ALL of the following:

- Patient is female
- BCM less than 23% of total body weight
- BMI less than 27 kg/m^2

AND

3 - A nutritional evaluation has been completed since onset of wasting first occurred

AND

4 - Patient has not had weight loss as a result of other underlying treatable conditions (e.g.,

depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)

AND

5 - Patient's anti-retroviral therapy has been optimized to decrease the viral load

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Serostim** [a]	
Diagnosis	Human Immunodeficiency Virus (HIV)-Associated Cachexia (Serostim only)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Evidence of positive response to therapy (i.e., greater than or equal to 2% increase in body weight and/or BCM)

AND

2 - ONE of the following targets or goals has not been achieved:

- Weight
- BCM
- BMI

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zorbtive**[a]	
Diagnosis	Short Bowel Syndrome (Zorbtive only)
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome

AND

2 - Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements

AND

3 - Patient has not previously received 4 weeks of treatment with Zorbtive

Notes	Note: Treatment with Zorbtive will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied. **Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements an

	d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Increlex**[a]	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion (Increlex only)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of ALL of the following:

- Diagnosis of severe primary IGF-1 deficiency
- Height standard deviation score less than or equal to -3.0
- Basal IGF-1 standard deviation score less than or equal to -3.0
- Normal or elevated growth hormone levels
- Documentation of open epiphyses on last bone radiograph
- The patient will not be treated with concurrent growth hormone therapy
- Prescribed by an endocrinologist

OR

2 - ALL of the following:

- Diagnosis of growth hormone gene deletion and has developed neutralizing antibodies to growth hormone
- Documentation of open epiphyses on last bone radiograph
- The patient will not be treated with concurrent growth hormone therapy
- Prescribed by an endocrinologist

Notes	Note: Documentation of previous height, current height and goal expe cted adult height will be required for renewal. **Please Note: The request for growth hormone (GH) injections to trea t idiopathic short stature (ISS) is not authorized. There is no consensu s in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children

	with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Increlex**[a]	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion (Increlex only)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 cm/year over the previous year of treatment as documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:

- Expected adult height not obtained
- Expected adult height goal

AND

3 - Patient is not treated with concurrent growth hormone therapy

AND

4 - Prescribed by an endocrinologist

Notes	**Please Note: The request for growth hormone (GH) injections to treat idiopathic short stature (ISS) is not authorized. There is no consensus in current peer-reviewed medical literature regarding the indications, efficacy, safety, or long-term consequences of GH therapy in children with ISS who are otherwise healthy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Somatropin is indicated for the treatment of growth hormone deficiency (GHD), short stature associated with Turner syndrome or Noonan syndrome, short-stature homeobox (SHOX) gene deficiency, growth failure due to Prader-Willi syndrome, short stature in children born small for gestational age, growth failure in children with chronic renal insufficiency up to the time of transplant, short bowel syndrome in patients receiving specialized nutritional support, and HIV-associated wasting. Somatropin is also indicated for replacement of endogenous growth hormone (GH) in adults with confirmed GHD. Skytrofa (lonapegsomatropin-tcgd) is indicated for the treatment of pediatric patients 1 year and older who weigh at least 11.5 kg and have growth failure due to inadequate secretion of endogenous growth hormone (GH). Sogroya is indicated for the treatment of pediatric patients aged 2.5 years and older who have growth failure due to inadequate secretion of endogenous GH. It is also indicated for the replacement of endogenous GD in adults with GHD. Ngenla™ is indicated for treatment of pediatric patients aged 3 years and older who have growth failure due to inadequate secretion of endogenous GH.

Mecasermin is indicated for the treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency or with GH gene deletion who have developed neutralizing antibodies to GH.

***Educational Statement**

Documentation of previous height, current height and goal expected adult height will be required for renewal.

Additional Clinical Rules

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

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5 . Revision History

Date	Notes
9/11/2024	Updated clinical criteria to align with commercial line of business. Co mbined Ngenla, and Sogroya into the Skytrofa pediatric GHD section s. Combined Sogroya with somatotropin in the adult GHD sections a s the criteria is the same.

Haegarda

Prior Authorization Guideline

Guideline ID	GL-143801
Guideline Name	Haegarda
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	3/20/2024

1 . Indications

Drug Name: Haegarda
Prophylaxis of HAE attacks Haegarda is a plasma-derived concentrate of C1 Esterase Inhibitor (Human) (C1-INH) indicated for routine prophylaxis to prevent hereditary angioedema (HAE) attacks in patients 6 years of age and older.

2 . Criteria

Product Name: Haegarda [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - ALL of the following:

- Prescribed for the prophylaxis of HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Orladeyo, Takhzyro)
- Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Haegarda

AND

3 - Prescribed by ONE of the following:

- Immunologist

• Allergist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Haegarda [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Haegarda therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Haegarda therapy

AND

3 - BOTH of the following:

- Prescribed for the prophylaxis of HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Orladeyo, Takhzyro)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Haegarda is a plasma-derived concentrate of C1 Esterase Inhibitor (Human) (C1-INH) indicated for routine prophylaxis to prevent hereditary angioedema (HAE) attacks in patients 6 years of age and older.[1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Haegarda [package insert]. Kankakee, IL: CSL Behring, LLC; January 2022.
2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2023.
4. Busse, P., Christiansen, S., Riedl, M., et. al. “US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.” The Journal of Allergy and Clinical Immunology. 2020 September 05.
5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. Allergy. 2022;77(7):1961-1990. doi:10.1111/all.15214

5 . Revision History

Date	Notes
3/1/2024	Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated language for reauthorization criteria.

HCG

Prior Authorization Guideline

Guideline ID	GL-144790
Guideline Name	HCG
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/17/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	10/20/2021 ; 11/19/2021 ; 09/21/2022 ; 08/18/2023 ; 11/17/2023 ; 4/17/2024

1 . Indications

Drug Name: Novarel (chorionic gonadotropin), Pregnyl (chorionic gonadotropin)
Ovulation Induction Novarel (chorionic gonadotropin) and Pregnyl (chorionic gonadotropin) are indicated for induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure, and who has been appropriately pretreated with human menotropins. They are also indicated for prepubertal cryptorchidism not due to anatomic obstruction and selected cases of hypogonadotropic hypogonadism (hypogonadism secondary to a pituitary deficiency) in males. [4-5]
Drug Name: Ovidrel (choriogonadotropin alfa)
Ovulation Induction Ovidrel (choriogonadotropin alfa) is indicated for the induction of final follicular maturation and early luteinization in infertile women who have undergone pituitary desensitization and who have been appropriately pretreated with follicle stimulating hormones as part of an Assisted Reproductive Technology (ART) program such as in vitro fertilization

and embryo transfer. It is also indicated for the induction of ovulation and pregnancy in anovulatory infertile patients in whom the cause of infertility is functional and not due to primary ovarian failure. [6]
Drug Name: Novarel (chorionic gonadotropin), Pregnyl (chorionic gonadotropin), Ovidrel (choriogonadotropin alfa)
Prepubertal Cryptorchidism hCG may also be used to treat cryptorchidism in boys because hCG is thought to induce testicular descent in situations when descent would have occurred at puberty. hCG thus may help to predict whether or not orchiopexy will be needed in the future. Although, in some cases, descent following hCG administration is permanent, in most cases the response is temporary. [1-3] **Hypogonadotropic Hypogonadism** hCG is also used to induce puberty in boys and to treat androgen deficiency in hypogonadotropic hypogonadism. However, the major use of hCG preparations in males is in the initiation and maintenance of spermatogenesis in hypogonadotropic men who desire fertility. [1-3]

2 . Criteria

Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Ovulation Induction [a]
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anovulatory infertility

AND

2 - Infertility is not due to primary ovarian failure

AND

3 - For induction of ovulation

AND **4** - Patient has been pre-treated with a follicular stimulating agent (e.g., gonadotropin, clomiphene citrate, letrozole)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Controlled Ovarian Hyperstimulation** [a]
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of infertility **AND** **2** - For the development of multiple follicles (controlled ovarian hyperstimulation) **AND** **3** - Patient has been or will be pre-treated with a follicular stimulating agent (e.g., gonadotropin, clomiphene citrate, letrozole)	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Prepubertal Cryptorchidism** [a]
Approval Length	6 Week(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Hypogonadotropic Hypogonadism** [a]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hypogonadism secondary to pituitary deficiency **AND** **2** - Low testosterone (below normal reference level provided by the physician's laboratory) **AND** **3** - ONE of the following:	

• Low LH (below normal reference level provided by the physician's laboratory) • Low FSH (below normal reference level provided by the physician's laboratory)	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
Diagnosis	Hypogonadotropic Hypogonadism** [a]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: The body produces two types of gonadotropins, follicle-stimulating hormone (FSH) and luteinizing hormone (LH), both of which play a role in fertility and human reproduction. After they are produced by the pituitary gland, gonadotropins trigger production of other sex

hormones which then promote production of egg and sperm. Produced in pregnant women by the placenta and extracted from the urine, human chorionic gonadotropin (hCG) is similar in chemical structure and function to LH. [1-3]

hCG is routinely used to trigger ovulation in the treatment of infertility, a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse or therapeutic donor insemination.[1-3]

hCG may also be used to treat cryptorchidism in boys because hCG is thought to induce testicular descent in situations when descent would have occurred at puberty. hCG thus may help to predict whether or not orchiopexy will be needed in the future. Although, in some cases, descent following hCG administration is permanent, in most cases the response is temporary. hCG is also used to induce puberty in boys and to treat androgen deficiency in hypogonadotropic hypogonadism. However, the major use of hCG preparations in males is in the initiation and maintenance of spermatogenesis in hypogonadotropic men who desire fertility.[1-3]

Novarel (chorionic gonadotropin) and Pregnyl (chorionic gonadotropin) are indicated for induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure, and who has been appropriately pretreated with human menotropins. They are also indicated for prepubertal cryptorchidism not due to anatomic obstruction and selected cases of hypogonadotropic hypogonadism (hypogonadism secondary to a pituitary deficiency) in males.[4-5]

Ovidrel (choriogonadotropin alfa) is indicated for the induction of final follicular maturation and early luteinization in infertile women who have undergone pituitary desensitization and who have been appropriately pretreated with follicle stimulating hormones as part of an Assisted Reproductive Technology (ART) program such as *in vitro* fertilization and embryo transfer. It is also indicated for the induction of ovulation and pregnancy in anovulatory infertile patients in whom the cause of infertility is functional and not due to primary ovarian failure.[6]

Additional Clinical Rules:

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. World Health Organization web site. http://www.who.int/reproductivehealth/topics/infertility/definitions/en/index.html. Accessed September 29, 2023.
2. American Society for Reproductive Medicine. Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertil Steril 2013;Jan;99(1):63
3. Petak SM, Nankin HR, Spark RF, Swerdloff RS, Rodriguez-Rigau LJ. American Association of Clinical Endocrinologists Medical Guidelines for clinical practice for the evaluation and treatment of hypogonadism in adult male patients – 2002 update. Endocr Pract. 2002;8:440-456.
4. Novarel [package insert]. Parsippany, NJ: Ferring Pharmaceuticals Inc.; May 2023.
5. Pregnyl [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; June 2022.
6. Ovidrel [package insert]. Rockland, MA: EMD Serono, Inc.; February 2022.

5 . Revision History

Date	Notes
3/25/2024	Texas added to ovulation induction operation note.

Prior Authorization Guideline

Guideline ID	GL-136023
Guideline Name	HCR Contraceptives Zero Dollar Cost Share Review Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	

Note:

Technician Note: Non-Formulary Alternatives Table link:
https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange%2FNF%20Alt%20Tables

1 . Criteria

Product Name: OTC and Prescription Non-Formulary and Formulary Contraceptives	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Requests to waive cost-sharing for a medication not included on a zero-cost-sharing coverage list must meet ALL of the following:

1.1 Patient is using the prescribed drug for contraception

AND

1.2 If the request is for a prescription product that is non-formulary, one of the following:

1.2.1 There must be an appropriate clinical reason why the patient cannot take two (2) products that are covered at the $0 ACA/HCR preventative cost share+ (i.e., the patient has had an allergic reaction or intolerance to an inactive ingredient or has experienced an inadequate response)

OR

1.2.2 Provider attests the non-formulary contraceptive drug is the preferred product for this patient (e.g., provider attestation that the non-formulary contraceptive is medically necessary, patient is stable on the requested non-formulary contraceptive, patient requires continuation of therapy to complete the course of treatment, transition to another agent could result in destabilization)

Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs. +Products covered at the $0 ACA/HCR preventative cost share can b e identified under the Status column of the Formulary Lookup Tool as having a status of “HCR $0 copay”.

2 . Background

Benefit/Coverage/Program Information
Background: The Patient Protection and Affordable Care Act (PPACA) provides for $0 cost share conditional coverage for contraceptives when used for contraception. Examples of

covered products include: OTC contraceptive products (with prescription) including male and female condoms, spermicides, or sponges; OTC emergency contraceptive (with prescription) or prescription emergency contraceptive drug; Contraceptive patch; Contraceptive ring; Injectable contraceptives; Diaphragm or cervical caps; Contraceptive implant; Non-emergency oral contraceptives.

This policy applies to formulary drugs that process at a non-$0 cost share or are non-formulary.

3 . References

1. U.S. Preventive Services Task Force http://www.uspreventiveservicestaskforce.org/ Accessed August 8, 2023.

4 . Revision History

Date	Notes
11/6/2023	Moved coverage criteria from IFP Preventative Medications Guidelin e to separate guideline. No change in coverage criteria.

Prior Authorization Guideline

Guideline ID	GL-136022
Guideline Name	HCR Preventative Medications Zero Dollar Cost Share Review Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	12/15/2021 ; 08/18/2023

Note:

Technician Note: Non-Formulary Alternatives Table link:
https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange%2FNF%20Alt%20Tables

1 . Criteria

Product Name: Formulary HIV Pre-Exposure Prophylaxis Medications: generic emtricitabine/tenofovir 200-300 mg, tenofovir 300 mg; Applies to Florida and Illinois only: Descovy 200/25 mg, Brand Viread; Applies to Florida only: Brand Truvada 200/300 mg	
Approval Length	12 month(s)

Guideline Type	Administrative
Approval Criteria **1** - Patient is at high risk for HIV infection and needs this medication as pre-exposure prophylaxis (PrEP)	
Notes	This program is designed to meet Health Care Reform requirements which require coverage of effective HIV PrEP regimens at zero-dollar cost share if being used for preexposure prophylaxis (PrEP) and criter ia are met. If approved, authorizations should have overrides to allow f or $0 cost share for formulary drugs.

Product Name: OTC Aspirin 81 mg	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - Pregnancy at greater than 12 weeks with high risk of preeclampsia	
Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs.

Product Name: Tamoxifen 20 mg, Soltamox, generic raloxifene, Brand Evista, generic anastrozole, Brand Arimidex, generic exemestane, Brand Aromasin, generic letrozole, Brand Femara	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - Patient is greater than or equal to 35 years of age **AND**	

2 - Patient is at increased risk for breast cancer

AND

3 - Patient is at low risk for adverse medication effects

AND

4 - One of the following:

4.1 Request is for a FORMULARY drug

OR

4.2 Both of the following:

4.2.1 Request is for a NON-FORMULARY drug

AND

4.2.2 The patient must try and fail, or have specific medical reason(s) why the number of alternatives specified by the Non-Formulary Alternatives Table is not appropriate (see technician note for NF Alts Table URL)

Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs.

Product Name: Immunizations	
Approval Length	Authorization will be issued for one time
Guideline Type	Administrative

Approval Criteria

1 - Preventative immunizations as a single-entity or combination vaccination will be approved

when used for an Advisory Committee on Immunization Practices (ACIP) recommended vaccine regimen*	
Notes	*https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html https://www.cdc.gov/vaccines/acip/recommendations.html If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs.

Product Name: Non-Formulary and Formulary HMG-CoA Reductase Inhibitors (statins)	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Patient is 40 to 75 years old

AND

2 - Patient has one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension, smoking, etc.)

AND

3 - Patient has a calculated 10-year risk of a cardiovascular event of 10% or greater

AND

4 - Patient has no history of cardiovascular disease (i.e., symptomatic coronary artery disease or ischemic stroke)

AND

5 - One of the following:

5.1 The request is for a FORMULARY medication

OR

5.2 Both of the following:

5.2.1 The request is for a NON-FORMULARY medication

AND

5.2.2 The patient must try and fail, or have specific medical reason(s) why the number of alternatives specified by the Non-Formulary Alternatives Table is not appropriate (see technician note for NF Alts Table URL)

Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs.

Product Name: Bowel preparation agents for colorectal cancer screening	
Approval Length	Authorization will be issued for one time
Guideline Type	Administrative

Approval Criteria

1 - OTC oral generic - bisacodyl EC 5 mg tablet, magnesium citrate solution, and polyethylene glycol 3350 powder will be approved if the requested product is being prescribed for bowel preparation prior to colon cancer screening

OR

2 - Formulary combination Prep Kits will be approved if both of the following are met:

2.1 Requested product is being prescribed for bowel preparation prior to colon cancer screening

AND

2.2 Appropriate clinical reason provided as to why the patient cannot use two individual

generic products (such as separate bisacodyl tablets and polyethylene glycol 3350 powder taken together) that are covered at the $0 ACA/HCR preventative cost share+ concurrently (i.e., the patient has had an allergic reaction or intolerance to an inactive ingredient or has experienced an inadequate response)

OR

3 - Non-formulary combination Prep Kits will be approved if all of the following are met:

3.1 Requested product is being prescribed for bowel preparation prior to colon cancer screening

AND

3.2 Appropriate clinical reason provided as to why the patient cannot use two individual generic products (such as separate bisacodyl tablets and polyethylene glycol 3350 powder taken together) that are covered at the $0 ACA/HCR preventative cost share+ concurrently (i.e., the patient has had an allergic reaction or intolerance to an inactive ingredient or has experienced an inadequate response)

AND

3.3 Appropriate clinical reason provided as to why the patient cannot use two formulary combination bowel prep kits

Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs. +Products covered at the $0 ACA/HCR preventative cost share can b e identified under the Status column of the Formulary Lookup Tool as having a status of “HCR $0 copay”.

Product Name: Fluoride supplementation products	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Patient is between 6 months of age to 16 years of age

AND

2 - The use is for prophylaxis of dental carries

AND

3 - Requested product is a prescription oral fluoride supplementation product (e.g., sodium fluoride tablets, chewable tablets, and drops)

Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs.

Product Name: Folic acid supplementation products	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Patient is pregnant, planning pregnancy, or could become pregnant

AND

2 - Requested product is a prescription or OTC folic acid product (with prescription), including prenatal vitamins containing folic acid

AND

3 - Requested product contains between 0.4 mg to 0.8 mg of folic acid

Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs.

Product Name: Erythromycin 0.5% ophthalmic ointment	
Approval Length	12 month(s)

Guideline Type	Administrative
Approval Criteria **1** - Member or health care provider intends to administer medication to newborn for the prophylaxis of gonococcal ophthalmia neonatorum* **OR** **2** - Newborn is 0-1 month of age	
Notes	If approved, authorizations should have overrides to allow for $0 cost share for non-formulary or formulary drugs. This program is designed to meet Health Care Reform requirements which require coverage of erythromycin 0.5% ophthalmic ointment at zero dollar cost share if bei ng used for primary prevention of gonococcal ophthalmia neonatorum (GON) and criteria are met. *Requests may be submitted before the infant's birth and could be req uested under the mother's account.

2 . Background

Benefit/Coverage/Program Information
Background: The Patient Protection and Affordable Care Act (PPACA) provides for $0 cost share conditional coverage of preventative medications in the following drug categories:

Drug Category of Prevention*	Example Medications
HIV Pre-Exposure Prophylaxis	Truvada (emtricitabine-tenofovir disoproxil fumarate), emtricitabine-tenofovir disoproxil fumarate (generic Truvada), Viread (tenofovir disoproxil fumarate), tenofovir disoproxil fumarate 300mg (generic Viread), Descovy (emtricitabine-tenofovir alafenamide fumarate)
Aspirin Use for Pregnancy at High Risk of Preeclampsia	OTC aspirin 81 mg

Breast Cancer: Medication Use to Reduce Risk	tamoxifen citrate, tamoxifen citrate solution (generic Soltamox), raloxifene (generic Evista), Aromatase inhibitors [anastrozole (generic Arimidex), exemestane (generic Aromasin), letrozole (generic Femara)]
Immunizations	Diphtheria, tetanus, acellular pertussis (Daptacel, Infanrix, Adacel, Boostrix); Hepatitis B (Engerix-B, Recombivax HB); Human papillomavirus (Gardasil); Influenza (Fluzone, Fluad, FluMist Quadrivalent); Zoster (Zostavax, Shingrix)
Cardiovascular Disease in Adults (Statin Use)	atorvastatin 10 & 20 mg (generic Lipitor), lovastatin all strengths (generic Mevacor), and simvastatin 5, 10, 20, 40 mg (generic Zocor)
Bowel preparations for colonoscopy needed for preventive colon cancer screening	OTC oral generic - bisacodyl EC 5mg tablet (Dulcolax), magnesium citrate solution (Citroma), and polyethylene glycol 3350 powder (Miralax)
Fluoride Supplements to Prevent Dental Caries in Children	oral sodium fluoride tablets, chewable tablets, solution, and drops (Ludent, Nafrinse, Floriva)
Folic Acid for the Prevention of Neural Tube Defects	folic acid 400 & 800 mcg, or Prenatal vitamins with 400 - 800 mcg folic acid
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum	Erythromycin 0.5% ophthalmic ointment

* The Patient Protection and Affordable Care Act (PPACA) also provides for $0 cost share for smoking cessation and contraceptive products. Refer to the Tobacco Cessation Health Care Reform Zero Dollar Cost Share Review guideline for reviews of smoking cessation related products. Refer to the Contraceptives Zero Dollar Cost Share Review guideline for reviews for contraceptive related products.

This policy applies to formulary drugs that process at a non-$0 cost share or are non-formulary.

3 . References

1. U.S. Preventive Services Task Force http://www.uspreventiveservicestaskforce.org/ Accessed August 8, 2023.

4 . Revision History

Date	Notes
11/6/2023	Removed criteria for formulary and non-formulary contraceptives; cre ated new Contraceptives Zero Dollar Cost Share Guideline with no c hange to coverage criteria.

Prior Authorization Guideline

Guideline ID	GL-136217
Guideline Name	Hepatitis C Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 08/20/2021 ; 09/15/2021 ; 02/18/2022 ; 06/15/2022 ; 07/20/2022 ; 11/17/2023

1 . Indications

Drug Name: Epclusa (sofobuvir/velpatasvir)
Hepatitis C Indicated for the treatment of adult and pediatric patients 3 years of age and older with chronic hepatitis C virus (HCV) genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis, or with decompensated cirrhosis in combination with ribavirin.
Drug Name: Harvoni (ledipasvir/sofosbuvir) and Harvoni Pak
Hepatitis C Indicated for the treatment of HCV in adults and pediatric patients 3 years of age and older for genotype 1, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis, genotype 1 infection with decompensated cirrhosis, in combination with ribavirin, or with genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or with compensated cirrhosis, in combination with ribavirin.
Drug Name: Mavyret (glecaprevir/pibrentasvir)

Hepatitis C Indicated for the treatment of adult and pediatric patients 3 years and older with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A). **Hepatitis C** Indicated for the treatment of adult and pediatric patients 3 years and older with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.
Drug Name: Sovaldi (sofosbuvir) and Sovaldi Pak
Hepatitis C Indicated for the treatment of adult patients with genotype 1, 2, 3, or 4 chronic HCV infection without cirrhosis or with compensated cirrhosis as a component of a combination antiviral treatment regimen and pediatric patients 3 years of age and older with genotype 2 or 3 chronic HCV without cirrhosis or with compensated cirrhosis in combination with ribavirin.
Drug Name: Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir)
Hepatitis C Indicated for the treatment of chronic HCV genotype 1a without cirrhosis or with compensated cirrhosis in combination with ribavirin or genotype 1b in patients without cirrhosis or with compensated cirrhosis.
Drug Name: Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
Hepatitis C Indicated for the treatment of adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.
Drug Name: Zepatier (elbasvir/grazoprevir)
Hepatitis C Indicated for treatment of chronic HCV genotype 1 or 4 infection in adult and pediatric patients 12 years of age and older or weighing at least 30 kg. **Hepatitis C** Indicated for use with ribavirin in certain patient populations.

2 . Criteria

Product Name: Mavyret, Mavyret Pak	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 1 - Mavyret
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine
- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following:

4.1 The request is for Mavyret

AND

4.2 The patient is without cirrhosis or has compensated cirrhosis (Child-Pugh A)

AND

4.3 One of the following:

4.3.1 Both of the following:

- Patient is genotype 1, 2, 3, 4, 5, or 6

- Patient is treatment naïve

OR

4.3.2 All of the following:

4.3.2.1 Patient is treatment-experienced

AND

4.3.2.2 Patient is genotype 1

AND

4.3.2.3 One of the following:

- Patient previously treated with an NS5A inhibitor [e.g., Daklinza (daclatasvir), Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir)] without prior treatment with an NS3/4A protease inhibitor
- Patient previously treated with an NS3/4 protease inhibitor [e.g., Incivek (teleprevir), Victrelis (boceprevir)] without prior treatment with an NS5A inhibitor

OR

4.3.3 All of the following:

- Patient is treatment-experienced
- Patient is genotype 1, 2, 3, 4, 5, or 6
- Patient has not been previously treated with any of the following regimens: HCV NS3/4A protease inhibitor [e.g., Incivek (teleprevir), Victrelis (boceprevir), Viekira (dasabuvir/ombitasvir/paritaprevir/ritonavir), Zepatier (elbasvir/grazoprevir)] or NS5A inhibitor [e.g., Daklinza (daclatasvir), Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Viekira (dasabuvir/ombitasvir/ paritaprevir/ritonavir), Zepatier (elbasvir/grazoprevir)]

AND

4.4 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral

agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

4.5 The requested regimen is an approvable regimen, as outlined in Chart 1 - Mavyret, based on patient genotype and characteristics

Product Name: Epclusa, sofosbuvir/velpatasvir (AG of Epclusa), Epclusa Pak	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 2 -Epclusa
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine
- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following:

4.1 The request is for Epclusa or sofosbuvir/velpatasvir (AG of Epclusa)

AND

4.2 Patient is genotype 1, 2, 3, 4, 5, or 6

AND

4.3 One of the following:

4.3.1 Patient does not have decompensated liver disease

OR

4.3.2 Both of the following

- Patient has decompensated liver disease (Child-Pugh B or C)
- Will be used in combination with ribavirin

AND

4.4 Patient is not receiving Epclusa or sofosbuvir/velpatasvir (AG of Epclusa) in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

4.5 The requested regimen is an approvable regimen, as outlined in Chart 2 - Epclusa, based on patient genotype and characteristics

Product Name: Harvoni, ledipasvir/sofosbuvir (AG of Harvoni), or Harvoni Pak	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 3 - Harvoni
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine
- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following:

4.1 The request is for Harvoni, ledipasvir/sofosbuvir (AG of Harvoni), or Harvoni Pak

AND

4.2 Patient is genotype 1, 4, 5, or 6

AND

4.3 Patient is not receiving Harvoni or ledipasvir/sofosbuvir (AG of Harvoni) in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

4.4 The requested regimen is an approvable regimen, as outlined in Chart 3 - Harvoni, based on patient genotype and characteristics

Product Name: Sovaldi or Sovaldi Pak	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 4 - Sovaldi
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine
- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following

4.1 The request is for Sovaldi or Sovaldi Pak

AND

4.2 Patient is not receiving Sovaldi in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Zepatier (elbasvir/grazoprevir)]

AND

4.3 The requested regimen is an approvable regimen, as outlined in Chart 4 - Sovaldi, based on patient genotype and characteristics

Product Name: Viekira Pak	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 5 - Viekira Pak
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine
- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following

4.1 The request is for Viekira Pak

AND

4.2 Patient is not receiving Viekira Pak in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

4.3 The requested regimen is an approvable regimen, as outlined in Chart 5 - Viekira Pak, based on patient genotype and characteristics

Product Name: Vosevi	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 6 - Vosevi
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine

- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following

4.1 The request is for Vosevi

AND

4.2 The patient is without cirrhosis or has compensated cirrhosis (Child-Pugh A)

AND

4.3 One of the following

4.3.1 Patient is genotype 1, 2, 3, 4, 5, or 6 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor

OR

4.3.2 Patient is genotype 1a or 3 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofobuvir without an NS5A inhibitor

AND

4.4 Patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

4.5 The requested regimen is an approvable regimen, as outlined in Chart 6 - Vosevi, based on patient genotype and characteristics

Product Name: Zepatier	
Diagnosis	Chronic Hepatitis C
Approval Length	refer to Chart 7 - Zepatier
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

AND

2 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the American Academy of HIV Medicine
- Transplant physician

AND

3 - Physician/provider asserts patient demonstrates treatment readiness, including the ability to adhere to the treatment regimen

AND

4 - All of the following

4.1 The request is for Zepatier

AND

4.2 Patient is genotype 1 or 4

AND

4.3 Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent [e.g., Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir)]

AND

4.4 The requested regimen is an approvable regimen, as outlined in Chart 7 - Zepatier, based on patient genotype and characteristics

3 . Background

Benefit/Coverage/Program Information

Chart 1 - Mavyret

Treatment Naïve Patients

HCV Genotype	**Treatment Duration**	
	No cirrhosis	Compensated cirrhosis (Child-Pugh A)
1, 2, 3, 4, 5, or 6	8 weeks	8 weeks

Treatment Experienced Patients

		Treatment Duration

HCV Genotype	Patients previously treated with a regimen containing:	No cirrhosis	Compensated cirrhosis (Child-Pugh A)
1	An NS5A inhibitor[1] without prior treatment with an NS3/4A protease inhibitor	16 weeks	16 weeks
	An NS3/4A PI[2] without prior treatment with an NS5A inhibitor	12 weeks	12 weeks
1, 2, 4, 5, or 6	PRS[3]	8 weeks	12 weeks
3	PRS[3]	16 weeks	16 weeks

Kidney or LiverTransplant Recipients

HCV Genotype	Treatment Duration	
	No cirrhosis	Compensated cirrhosis (Child-Pugh A)
1, 2, 3, 4, 5, or 6	12 week	12 weeks

1. In clinical trials, subjects were treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.

2. In clinical trials, subjects were treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.

3. PRS = prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor.

Chart 2 - Epclusa

Patient Population	Recommended Treatment Regimen
Patients without cirrhosis and patients with compensated cirrhosis (Child-Pugh A)	EPCLUSA for 12 weeks

Patients with decompensated cirrhosis (Child-Pugh B and C)	EPCLUSA + ribavirin for 12 weeks

Chart 3 - Harvoni

Recommended treatment regimen and duration:

Genotype	Patient Population	Regimen and Duration
Genotype 1	Treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	HARVONI 12 weeks*
	Treatment-experienced without cirrhosis	HARVONI 12 weeks
	Treatment-experienced with compensated cirrhosis (Child-Pugh A)	HARVONI 24 weeks**
	Treatment-naïve and treatment-experienced with decompensated cirrhosis (Child-Pugh B or C)	HARVONI + ribavirin 12 weeks
Genotype 1 or 4	Treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A)	HARVONI + ribavirin 12 weeks
Genotype 4, 5, or 6	Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)	HARVONI 12 weeks

*HARVONI for 8 weeks can be considered in treatment-naïve genotype 1 patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL

**HARVONI + ribavirin for 12 weeks can be considered in treatment-experienced genotype 1 patients with cirrhosis who are eligible for ribavirin

Chart 4 - Sovaldi

Recommended Adult Treatment Regimen and Duration

	Adult Patient Population	Regimen and Duration
Genotype 1 or 4	Treatment naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + peginterferon alfa + ribavirin 12 weeks
Genotype 2	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 12 weeks
Genotype 3	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 24 weeks

SOVALDI in combination with ribavirin for 24 weeks can be considered for adult patients with genotype 1 infection who are interferon ineligible.

SOVALDI should be used in combination with ribavirin for treatment of HCV in adult patients with hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first.

Recommended Treatment Regimen and Duration for Pediatric Patients 3 Years of Age and Older

	Pediatric Patient Population 3 Years of Age and Older	Regimen and Duration
Genotype 2	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 12 weeks

Genotype 3	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)	SOVALDI + ribavirin 24 weeks

Chart 5 - Viekira Pak

Patient Population	Treatment*	Duration
Genotype 1a, without cirrhosis	VIEKIRA PAK + ribavirin	12 weeks
Genotype 1a, with compensated cirrhosis	VIEKIRA PAK + ribavirin	24 weeks**
Genotype 1b, with or without compensated cirrhosis	VIEKIRA PAK	12 weeks

*Note: Follow the genotype 1a dosing recommendations in patients with an unknown genotype 1 subtype or with mixed genotype 1 infection

**VIEKIRA PAK administered with ribavirin for 12 weeks may be considered in some patients based on prior treatment history

Chart 6- Vosevi

Genotype	Patients previously treated with an HCV regimen containing:	VOSEVI Duration
1, 2, 3, 4, 5, or 6	An NS5A inhibitor[1]	12 weeks
1a or 3	Sofosbuvir without an NS5A inhibitor[2]	12 weeks

1. In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir.

2. In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir).

Chart 7 - Zepatier

Dosage Regimens and Durations for ZEPATIER in Patients with Genotype 1 or 4 HCV with or without Cirrhosis

Patient Population	Treatment	Duration
Genotype 1a: treatment naïve or PegIFN/RBV experienced* without baseline NS5A polymorphisms+	ZEPATIER	12 weeks
Genotype 1a: treatment naïve or PegIFN/RBV experienced* with baseline NS5A polymorphisms+	ZEPATIER + ribavirin	16 weeks
Genotype 1b: treatment naïve or PegIFN/RBV experienced*	ZEPATIER	12 weeks
Genotype 1a or 1b: PegIFN/RBV/PI experienced++	ZEPATIER + ribavirin	12 weeks
Genotype 4: treatment naïve	ZEPATIER	12 weeks
Genotype 4: PegIFN/RBV experienced*	ZEPATIER + ribavirin	16 weeks

*Peginterferon alfa + ribavirin

+Polymorphisms at amino acid positions 28, 30, 31, or 93

++Peginterferon alfa + ribavirin + HCV NS3/4 A protease inhibitor

***Comparison of Scoring Systems for Histological Stage (Fibrosis)**

METAVIR	Batts-Ludwig	Knodell	Ishak
0	0	0	0
1	1	1	1
1	1	1	2
2	2	--	3
3	3	3	4
4	4	4	5
4	4	4	6

Background

Epclusa (sofosbuvir/velpatasvir) is indicated for the treatment of adult and pediatric patients 3 years of age and older with chronic hepatitis C virus (HCV) genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis, or with decompensated cirrhosis in combination with ribavirin.

Harvoni and Harvoni Pak (ledipasvir/sofosbuvir) are indicated for the treatment of HCV in adults and pediatric patients 3 years of age and older for genotype 1, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis, genotype 1 infection with decompensated cirrhosis, in combination with ribavirin, or with genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or with compensated cirrhosis, in combination with ribavirin.

Mavyret (glecaprevir/pibrentasvir) is indicated for the treatment of adult and pediatric patients 3 years and older with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A). Mavyret is also indicated for the treatment of adult and pediatric patients 3 years and older or with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

Sovaldi and Solvandi Pak (sofosbuvir) are indicated for the treatment of adult patients with genotype 1, 2, 3, or 4 chronic HCV infection without cirrhosis or with compensated cirrhosis as a component of a combination antiviral treatment regimen and pediatric patients 3 years of age and older with genotype 2 or 3 chronic HCV without cirrhosis or with compensated cirrhosis in combination with ribavirin.

Viekira Pak (ombitasvir/paritaprevir/ritonavir tablets/dasabuvir) is indicated for the treatment of chronic HCV genotype 1a without cirrhosis or with compensated cirrhosis in combination with ribavirin or genotype 1b in patients without cirrhosis or with compensated cirrhosis.

Vosevi (sofosbuvir/velpatasvir/voxilaprevir) is indicated for the treatment of adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.

Zepatier (elbasvir/grazoprevir) is indicated for treatment of chronic HCV genotype 1 or 4 infection in adult and pediatric patients 12 years of age and older or weighing at least 30 kg. Zepatier is indicated for use with ribavirin in certain patient populations.

Additional Clinical Rules

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and reauthorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply Limits may be in place.

4 . References

1. Epclusa [package insert]. Foster City, CA: Gilead Sciences, Inc.; April 2022.
2. Harvoni [package insert]. Foster City, CA: Gilead Sciences, Inc.; March 2020.
3. Mavyret [package insert]. North Chicago, IL: AbbVie, Inc.; June 2021.
4. Sovaldi [package insert]. Foster City, CA: Gilead Sciences, Inc.; March 2020.
5. Viekira Pak [package insert]. North Chicago, IL: AbbVie, Inc.; December 2019.
6. Vosevi [package insert]. Foster City, CA: Gilead Sciences, Inc.; November 2019.
7. Zepatier [package insert]. Whitehouse Station, NJ: Merck & Co.; May 2022.

5 . Revision History

Date	Notes
11/10/2023	Annual review with no change to coverage criteria. Updated referenc es.

Prior Authorization Guideline

Guideline ID	GL-138730
Guideline Name	Hetlioz
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 12/15/2021 ; 12/14/2022 ; 12/14/2022 ; 1/17/2024

1 . Indications

Drug Name: Hetlioz (tasimelteon)
Non-24-hour sleep-wake disorder Indicated for the treatment of non-24-hour sleep-wake disorder in adults and nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older. Hetlioz LQ is an oral suspension and is indicated for the treatment of nighttime sleep disturbances in SMS in pediatric patients 3 years to 15 years of age.

2 . Criteria

Product Name: Hetlioz, generic tasimelteon, Hetlioz LQ [a]

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Diagnosis of non-24-hour sleep wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome)
- Patient is totally blind (has no light perception)
- Prescribed by or in consultation with a specialist in sleep disorders

OR

2 - BOTH of the following:

- Diagnosis of nighttime sleep disturbances in Smith-Magenis-Syndrome (SMS)
- Prescribed by or in consultation with a specialist in sleep disorders

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Hetlioz, generic tasimelteon, Hetlioz LQ [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Hetlioz or Hetlioz LQ therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply

3 . Background

Benefit/Coverage/Program Information
Background: Hetlioz is a melatonin receptor agonist indicated for the treatment of non-24-hour sleep-wake disorder in adults and nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) in patients 16 years of age and older. Hetlioz LQ is an oral suspension and is indicated for the treatment of nighttime sleep disturbances in SMS in pediatric patients 3 years to 15 years of age. Non-24-hour sleep wake disorder is also called free-running disorder, circadian rhythm sleep disorder - free running (or non-entrained) type, and hypernychthemeral syndrome. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Hetlioz [package insert]. Washington, D.C.: Vanda Pharmaceuticals Inc.; February 2021.
2. International Classification of Sleep Disorders: Diagnostic & Coding Manual. 3rd ed. Westchester, IL: American Academy of Sleep Medicine; 2014.
3. Auger RR, Burgess HJ, Emens JS, et al. Clinical Practice Guidelines for the Treatment of Intrinsic Circadian Rhythm Sleep-Wake Phase Disorder (DSWPD), Non-24-Hour Sleep-Wak Rhythm Disorder (N24SWD), and Irregular Sleep-Wake Rhythm Disorder (ISWRD) J Clin Sleep Med 2015;11(10):1199 –1236.
4. Rajaratnam SM, Polymeropoulos MH, Fisher DM, et al. Melatonin agonist tasimelteon (VEC-162) for transient insomnia after sleep-time shift: two randomised controlled multicentre trials. Lancet. 2009 Feb 7;373(9662):482-91.

5 . Revision History

Date	Notes
1/8/2024	Annual review. Added state mandate note and updated references.

Hycamtin

Prior Authorization Guideline

Guideline ID	GL-135665
Guideline Name	Hycamtin
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 08/19/2022 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Hycamtin (topotecan hydrochloride)
Relapsed small cell lung cancer Indicated for the treatment of patients with relapsed small cell lung cancer.

2 . Criteria

Product Name: Hycamtin [a]	
Diagnosis	Small cell lung cancer (SCLC)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of small cell lung cancer (SCLC) **AND** **2** - Patient has experienced a relapse of disease after initial first-line chemotherapy (e.g., cisplatin with etoposide)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Hycamtin [a]	
Diagnosis	Small cell lung cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Hycamtin therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Hycamtin [a]	
Diagnosis	Merkel cell carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Merkel cell carcinoma **AND** **2** - Disease is M1 disseminated **AND** **3** - Patient has a contraindication to or disease has progressed on anti-PD-L1 or anti-PD-1 therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Hycamtin [a]	
Diagnosis	Merkel cell carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Hycamtin therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Hycamtin [a]

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Hycamtin will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Hycamtin [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Hycamtin (topotecan hydrochloride) is a topoisomerase inhibitor indicated for the treatment of patients with relapsed small cell lung cancer. [1] The National Cancer Comprehensive Network (NCCN) also recommends Hycamtin may be considered as single-agent treatment (useful in certain circumstances) for M1 disseminated disease with or without surgery and/or radiation therapy if anti-PD-L1 or anti-PD-1 therapy is contraindicated or disease has progressed on anti-PD-L1 or anti-PD-1 therapy. [2]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Hycamtin [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; September 2018.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 22, 2023.

5 . Revision History

Date	Notes
11/6/2023	Annual review. Updated Merkel cell carcinoma criteria based on curr ent NCCN recommendations. Updated background and reference.

Ibrance

Prior Authorization Guideline

Guideline ID	GL-140169
Guideline Name	Ibrance
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	2/16/2024
P&T Revision Date:	05/21/2021 ; 05/20/2022 ; 08/19/2022 ; 02/17/2023

1 . Indications

Drug Name: Ibrance (palbociclib)
Breast cancer Indicated for the treatment of hormone receptor (HR)-positive human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine-based therapy, or in combination with Faslodex (fulvestrant) in patients with disease progression following endocrine therapy. **Other Uses:** The use of an aromatase inhibitor in men with breast cancer is ineffective without concomitant suppression of testicular steroidogenesis. The National Comprehensive Cancer Network (NCCN) recommends the use of Ibrance as single-agent therapy for unresectable retroperitoneal well-differentiated/dedifferentiated liposarcoma (WD-DDLS).

2 . Criteria

Product Name: Ibrance [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced, recurrent, or metastatic breast cancer

AND

2 - Disease is hormone-receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

4 - One of the following:

4.1 Used in combination with an aromatase inhibitor (e.g. anastrozole, letrozole, exemestane)

OR

4.2 Used in combination with Faslodex (fulvestrant)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ibrance [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Ibrance therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ibrance [a]	
Diagnosis	Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of unresectable retroperitoneal WD-DDLS	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ibrance [a]	
Diagnosis	Well-Differentiated/Dedifferentiated Liposarcoma (WD-DDLS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Ibrance therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ibrance [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Ibrance will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ibrance [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Ibrance therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Ibrance® (palbociclib) is a kinase inhibitor indicated for the treatment of hormone receptor (HR)-positive human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor as initial endocrine-based therapy, or in combination with Faslodex® (fulvestrant) in patients with disease progression following endocrine therapy. The use of an aromatase inhibitor in men with breast cancer is ineffective without concomitant suppression of testicular steroidogenesis. The National Comprehensive Cancer Network (NCCN) recommends the use of Ibrance as single-agent therapy for unresectable retroperitoneal well-differentiated/dedifferentiated liposarcoma (WD-DDLS). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Ibrance capsule [package insert]. New York, NY: Pfizer Labs; September 2023.
2. Ibrance tablets [package insert]. New York, NY: Pfizer Labs; September 2023.
3. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed December 22, 2023.

5 . Revision History

Date	Notes
1/30/2024	Annual review. Specified type of unresectable WD-DDLS to be retroperitoneal per NCCN recommendation. Updated references to separate out package insert references for Ibrance capsules and tablets.

Iclusig

Prior Authorization Guideline

Guideline ID	GL-135666
Guideline Name	Iclusig
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/19/2021
P&T Revision Date:	08/19/2022 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Iclusig (ponatinib)
Chronic Myeloid Leukemia (CML) Indicated for treatment of patients with chronic phase, accelerated phase, or blast phase chronic myeloid leukemia or Ph+ ALL for whom no other tyrosine kinase inhibitor (TKI) therapy is indicated. [1] **Acute Lymphoblastic Leukemia (Ph+ ALL)** Indicated for treatment of patients with T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL). **Myeloid/Lymphoid Neoplasms** Indicated for the treatment of myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or ABL1 rearrangements.

2 . Criteria

Product Name: Iclusig [a]	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia (CML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic myelogenous/ myeloid leukemia (CML)

AND

2 - One of the following:

2.1 Both of the following:

- Disease is in the chronic phase
- Patient with resistance or intolerance to two or more tyrosine kinase inhibitor (TKI) therapies [e.g., imatinib mesylate, Sprycel (dasatinib), or Tasigna (nilotinib)]^

OR

2.2 Confirmed documentation of T315I mutation

OR

2.3 Both of the following:

- Disease is in the accelerated or blast phase
- No other kinase inhibitors are indicated

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

	^ Tried/failed alternative(s) are supported by FDA labeling and/or NC CN guidelines.

Product Name: Iclusig [a]	
Diagnosis	Chronic Myelogenous / Myeloid Leukemia (CML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Iclusig therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Iclusig [a]	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Iclusig [a]

Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Iclusig therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Iclusig [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia **AND** **2** - One of the following: • Patient has a FGFR1 rearrangement • Patient has an ABL1 rearrangement	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Iclusig [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Iclusig therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Iclusig [a]	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Recurrent/metastatic disease after progression on approved therapies (e.g. imatinib, sunitinib, regorafenib, and standard dose ripretinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Iclusig [a]	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Iclusig therapy.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Iclusig [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Iclusig will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Iclusig [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Iclusig therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Iclusig (ponatinib) is a kinase inhibitor indicated for the treatment of patients with T315I-positive chronic myeloid leukemia (CML) (chronic phase, accelerated phase, or blast phase) or T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL). It is also indicated for treatment of patients with chronic phase CML with resistance or intolerance to at least two prior kinase inhibitors and accelerated phase or blast phase CML or Ph+ ALL for whom no other tyrosine kinase inhibitors (TKI) are indicated. The National Comprehensive Cancer Network (NCCN) also recommends Iclusig for the treatment of myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or ABL1 rearrangements. **Additional Clinical Programs:** • Supply limits may be in place. • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Iclusig [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc; February 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 25, 2023.

5 . Revision History

Date	Notes
10/31/2023	Annual review. Updated ALL criteria based on NCCN recommendations. Added criteria for GIST based on NCCN recommendations. Updated background and references.

Idhifa

Prior Authorization Guideline

Guideline ID	GL-152733
Guideline Name	Idhifa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	09/21/2022 ; 09/20/2023 ; 9/18/2024

1 . Indications

Drug Name: Idhifa (enasidenib)
Relapsed or refractory acute myeloid leukemia (AML) Indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test.

2 . Criteria

Product Name: Idhifa [a]	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - AML is IDH2 mutation-positive

AND

3 - ONE of the following:

- Disease is relapsed or refractory
- Used as low-intensity treatment induction when not a candidate for intensive induction therapy
- Used for consolidation therapy as continuation of low-intensity regimen used for induction
- Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Idhifa [a]	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Idhifa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Idhifa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Idhifa will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Idhifa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Idhifa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Idhifa (enasidenib) is an isocitrate dehydrogenase-2 inhibitor indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test. The National Cancer Comprehensive Network (NCCN) also recommends the use of Idhifa as a single agent, or in combination with azacitidine, in patients with IDH2-mutated AML for treatment induction when not a candidate for intensive induction therapy, as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen, or as consolidation therapy as continuation of low-intensity regimen used for induction. Idhifa has a black box warning for differentiation syndrome with or without concomitant hyperleukocytosis. Please see full prescribing information for additional details. **Additional Clinical Programs:** • Supply limits may be in place. • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Idhifa [package insert]. Summit, NJ: Celgene Corporation; December 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed July 26, 2024.

5 . Revision History

Date	Notes
8/27/2024	Annual review. Updated AML criteria based on NCCN recommendations.

Imbruvica

Prior Authorization Guideline

Guideline ID	GL-134131
Guideline Name	Imbruvica
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Imbruvica (ibrutinib)
Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Indicated for the treatment of adult patients with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL). **Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma with 17p deletion** Indicated for the treatment of adult patients with chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL) with 17p deletion **Waldenström's Macroglobulinemia** Indicated for the treatment of adult patients with Waldenström's macroglobulinemia. **Chronic Graft versus Host Disease** Indicated for the treatment of patients with chronic graft-versus-host disease after failure of one or more lines of systemic therapy. [1] **Other Uses** The National Cancer Comprehensive Network (NCCN) also recommends the use

of Imbruvica for the B-cell lymphoma types: extranodal marginal zone lymphoma (EMZL) of the stomach and of nongastric sites (noncutaneous), mantle cell lymphoma (MCL),gastric and nongastric MALT, diffuse large B-cell, AIDSHIV-related B-cell, high grade B-cell lymphoma, and post-transplant lymphoproliferative disorders. NCCN also recommends its use for primary CNS lymphoma and hairy cell leukemia.

2 . Criteria

Product Name: Imbruvica [a]	
Diagnosis	B-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of mantle cell lymphoma (MCL)

AND

1.2 ONE of the following:

- Patient has received at least one prior therapy for MCL
- Used in pre-treatment therapy in combination with Rituxan (rituximab) to limit the number of cycles with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen

OR

2 - Diagnosis of ONE of the following:

- Chronic Lymphocytic Leukemia (CLL)

- Small Lymphocytic Lymphoma (SLL)

OR

3 - BOTH of the following:

3.1 Diagnosis of ONE of the following:

- Histologic transformation to diffuse large B-cell lymphoma
- Post-transplant lymphoproliferative disorders
- Extranodal marginal zone lymphoma (EMZL) of the stomach
- Extranodal Marginal Zone Lymphoma of Nongastric Sites (Noncutaneous)
- Diffuse large B-cell lymphoma (non-GCB DLBCL and non-candidate for transplant)
- HIV-related B-cell lymphoma
- High grade B-cell lymphoma
- Hairy cell leukemia
- Nodal or splenic marginal zone lymphoma (MZL)

AND

3.2 Used as second-line or a subsequent therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Imbruvica [a]	
Diagnosis	B-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Imbruvica [a]	
Diagnosis	Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Imbruvica [a]	
Diagnosis	Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Imbruvica therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Imbruvica [a]	
Diagnosis	Chronic Graft Versus Host Disease

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic graft versus host disease **AND** **2** - History of failure of at least one other systemic therapy [e.g. corticosteroids, mycophenolate, etc.]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Imbruvica [a]	
Diagnosis	Chronic Graft Versus Host Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient shows evidence of positive clinical response while on Imbruvica therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Imbruvica [a]	
Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary CNS lymphoma

AND

2 - One of the following:

- Used as second-line or a subsequent therapy
- Used as induction therapy if patient is unsuitable or intolerant to high-dose methotrexate

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Imbruvica [a]	
Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Imbruvica [a]

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Imbruvica will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Imbruvica [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Imbruvica therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Imbruvica (ibrutinib) is a kinase inhibitor indicated for the treatment of adult patients with the following: chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL); chronic lymphocytic leukemia (CLL)/SLL with 17p deletion; and Waldenström's macroglobulinemia (WM). Imbruvica is also FDA approved for the treatment of adult and pediatric patients age 1 year and older with chronic graft versus host disease (cGVHD) after failure of one or more lines of systemic therapy.[1]

The National Cancer Comprehensive Network (NCCN) also recommends the use of Imbruvica for the B-cell lymphoma types: extranodal marginal zone lymphoma (EMZL) of the stomach and of nongastric sites (noncutaneous), mantle cell lymphoma (MCL),, diffuse large B-cell, HIV-related B-cell, high grade B-cell lymphoma, and post-transplant lymphoproliferative disorders. NCCN also recommends its use for primary CNS lymphoma and hairy cell leukemia.[2]

Additional Clinical Rules:

Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

Supply limits may be in place.

4 . References

1. Imbruvica [package insert]. South San Francisco, CA: Pharmacyclics, LLC. May 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia. Accessed August 31, 2023

5 . Revision History

Date	Notes
10/4/2023	Annual review. Updated background with withdrawal of MCL and MZ L indications from FDA label as well as NCCN recommendations. Up

	dated B-Cell lymphomas with terminology changes. Updated referen ces.

Ingrezza

Prior Authorization Guideline

Guideline ID	GL-148734
Guideline Name	Ingrezza
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	11/16/2018 ; 02/19/2021 ; 06/16/2021 ; 06/21/2023 ; 07/19/2023 ; 10/18/2023

1 . Indications

Drug Name: Ingrezza (valbenazine)
Tardive dyskinesia Indicated for the treatment of adults with tardive dyskinesia.

2 . Criteria

Product Name: Ingrezza [a]	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe tardive dyskinesia

AND

2 - One of the following:

- Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication
- Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

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

- Neurologist
- Psychiatrist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ingrezza [a]	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ingrezza therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ingrezza [a]	
Diagnosis	Chorea associated with Huntington's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chorea associated with Huntington's disease **AND** **2** - ii. Prescribed by or in consultation with ONE of the following: • Neurologist • Psychiatrist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ingrezza [a]	
Diagnosis	Chorea associated with Huntington's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Ingrezza therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Ingrezza is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of adults with tardive dyskinesia. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Ingrezza [package insert]. San Diego, CA: Neurocrine Biosciences, Inc. August 2023.
2. Hauser RA, Factor SA, Marder SR, et al. Kinect 3: A phase 3 randomized, double-blind, placebo-controlled trial of valbenazine for tardive dyskinesia. American Journal of Psychiatry. May 2017. 174:5.
3. Waln O, Jankovic J: An update on tardive dyskinesia: from phenomenology treatment. Tremor Other Hyperkinet Mov (N Y) 2013; 3: tre-03-161-4138-1.

5 . Revision History

Date	Notes
6/20/2024	Added new Ingrezza products

Inlyta

Prior Authorization Guideline

Guideline ID	GL-154483
Guideline Name	Inlyta
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	09/21/2022 ; 09/20/2023 ; 9/18/2024

1 . Indications

Drug Name: Inlyta (axitinib)
Advanced renal cell carcinoma (RCC) Indicated for the treatment of advanced renal cell carcinoma (RCC) after failure of one prior systemic therapy. Indicated in combination with either avelumab or pembrolizumab for the first-line treatment of patients with advanced RCC. **Off Label Uses: Other indications** The NCCN (National Comprehensive Cancer Network) recommends the use of Inlyta for treatment of unresectable, metastatic, or recurrent salivary gland tumors and follicular, oncocytic, and papillary carcinomas. The NCCN also recommends Inlyta as preferred therapy in combination with pembrolizumab for treatment of alveolar soft part sarcoma (ASPS) and as first-line treatment of relapsed or stage IV renal cell carcinoma.

2 . Criteria

Product Name: Inlyta [a]	
Diagnosis	Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following **1.1** Diagnosis of advanced renal cell carcinoma **AND** **1.2** ONE of the following: **1.2.1** Patient has failed one prior systemic therapy **OR** **1.2.2** Inlyta will be used in combination with Bavencio (avelumab) or Keytruda (pembrolizumab) **OR** **2** - Diagnosis of relapsed or stage IV renal cell carcinoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Renal Cell Carcinoma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Inlyta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable
- Persistent
- Metastatic

AND **3** - Disease is not amenable to radioactive iodine treatment	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Inlyta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of salivary gland tumor	

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable
- Metastatic

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of alveolar soft part sarcoma (ASPS) **AND** **2** - Inlyta will be used in combination with Keytruda (pembrolizumab)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Inlyta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Inlyta will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Inlyta [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Inlyta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Inlyta (axitinib) is a kinase inhibitor indicated for the treatment of advanced renal cell carcinoma (RCC) after failure of one prior systemic therapy. It is also indicated in combination with either avelumab or pembrolizumab for the first-line treatment of patients with advanced RCC. [1] The NCCN (National Comprehensive Cancer Network) recommends the use of Inlyta for treatment of unresectable, metastatic, or recurrent salivary gland tumors and follicular, oncocytic and papillary carcinomas. The NCCN also recommends Inlyta as preferred therapy in combination with pembrolizumab for treatment of alveolar soft part sarcoma (ASPS) and as first-line treatment of relapsed or stage IV renal cell carcinoma. [2]

Additional Clinical Programs:

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Inlyta [package insert]. New York, NY: Pfizer, Inc.; July 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed July 30, 2024.

5 . Revision History

Date	Notes
9/6/2024	Annual review. Updated criteria for renal cell carcinoma per NCCN g uidelines. Updated references.

Prior Authorization Guideline

Guideline ID	GL-141358
Guideline Name	Interferon
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 11/19/2021 ; 08/19/2022 ; 10/19/2022 ; 12/13/2023 ; 2/16/2024

1 . Indications

Drug Name: Intron A (Interferon alfa-2b)
Chronic hepatitis C Indicated for the treatment of chronic hepatitis C in patients 18 years of age or older with compensated liver disease who have a history of blood or blood-product exposure and/or are HCV antibody positive. **Chronic hepatitis C with compensated liver disease** Indicated for the treatment of chronic hepatitis C in patients 3 years of age and older previously untreated with alpha interferon therapy and in patients 18 years of age and older who have relapsed following alpha interferon therapy. **Chronic hepatitis B** Indicated for the treatment of chronic hepatitis B in patients 1 year of age or older with compensated liver disease. Patients who have been serum HBsAg positive for at least 6 months and have evidence of HBV replication (serum HBeAg positive) with elevated serum ALT are candidates for treatment.

Hairy cell leukemia Indicated for the treatment of patients 18 years of age or older with hairy cell leukemia.

Malignant Melanoma Indicated as adjuvant to surgical treatment in patients 18 years of age or older with malignant melanoma who are free of disease but a high risk for systemic recurrence, within 56 days of surgery.

Follicular Non-Hodgkin's lymphoma Indicated for the initial treatment of clinically aggressive follicular Non-Hodgkin's lymphoma in conjunction with anthracycline-containing combination chemotherapy in patients 18 years of age or older.

Condylomata Acuminata Indicated for intralesional treatment of selected patients 18 years of age or older with condylomata acuminata involving external surfaces of the genital and perianal areas.

AIDS-Related Kaposi's Sarcoma Indicated for the treatment of selected patients 18 years of age or older with AIDS-Related Kaposi's Sarcoma.

The National Comprehensive Cancer Network (NCCN) Recommends use of Intron A for myeloproliferative neoplasms (MPNs) such as essential thrombocytopenia (ET), polycythemia vera (PV), and primary myelofibrosis (PM), adult T-cell leukemia / lymphoma, mycosis fungoides / Sézary syndrome, and systemic mastocytosis.

Drug Name: Pegasys (peginterferon alfa-2a)

Chronic hepatitis C Indicated for the treatment of chronic hepatitis C (CHC) as part of a combination regimen with other hepatitis C virus (HCV) antiviral drugs in patients 5 years of age and older with compensated liver disease. Pegasys monotherapy is indicated for CHC only if patient has contraindication to or significant intolerance to other HCV antiviral drugs.

HBeAg positive and HBeAg negative chronic hepatitis B Indicated in the treatment of adult patients with HBeAg positive and HBeAg negative chronic hepatitis B infection who have compensated liver disease and evidence of viral replication and liver inflammation.

2 . Criteria

Product Name: Intron A, Pegasys, Pegasys Proclick [a]	
Diagnosis	Treatment of Chronic Hepatitis B
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic Hepatitis B infection

AND

2 - Patient does not have decompensated liver disease*

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Defined as Child-Pugh Class B or C

Product Name: Intron A, Pegasys, Pegasys Proclick [a]	
Diagnosis	Treatment of Chronic Hepatitis C
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - Patient does not have decompensated liver disease*

AND

3 - Will be used as part of a combination antiviral treatment regimen

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may ap

	ply. *Defined as Child-Pugh Class B or C

Product Name: Intron A [a]	
Diagnosis	For Diagnoses Other Than Hepatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following diagnoses: • Hairy cell leukemia • Malignant melanoma • Follicular Lymphoma • Condylomata acuminata (genital or perianal) • AIDS-related Kaposi's sarcoma • Giant cell tumors of the bone • Mycosis fungoides / Sézary syndrome • Primary cutaneous CD30+ T-cell lymphoproliferative disorders • Adult T-cell leukemia/lymphoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Pegasys and Pegasys Proclick [a]	
Diagnosis	For Diagnoses Other Than Hepatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following diagnoses: • Chronic myeloid leukemia (CML)	

• Hairy cell leukemia • Erdheim-Chester disease (ECD) • Myeloproliferative neoplasms (MPNs) such as essential thrombocythemia (ET), polycythemia vera (PV), or myelofibrosis (MF) • Mycosis fungoides/Sezary syndrome • Primary cutaneous CD30+ T-cell lymphoproliferative disorders • Systemic mastocytosis • Adult T-cell leukemia/lymphoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Intron A, Pegasys, Pegasys Proclick [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The drug will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Intron A (interferon alfa-2b) is indicated for the treatment of chronic hepatitis C in patients 18 years of age or older with compensated liver disease who have a history of blood or blood-product exposure and/or are HCV antibody positive. Intron A has additional FDA labeling for the treatment of chronic hepatitis C in patients 3 years of age and older with compensated

liver disease previously untreated with alpha interferon therapy and in patients 18 years of age and older who have relapsed following alpha interferon therapy. Intron A is also indicated for the treatment of chronic hepatitis B in patients 1 year of age or older with compensated liver disease. Patients who have been serum HBsAg positive for at least 6 months and have evidence of HBV replication (serum HBeAg positive) with elevated serum ALT are candidates for treatment. Intron A is indicated for the treatment of patients 18 years of age or older with hairy cell leukemia. Intron A is indicated as adjuvant to surgical treatment in patients 18 years of age or older with malignant melanoma who are free of disease but a high risk for systemic recurrence, within 56 days of surgery. It is also indicated for the initial treatment of clinically aggressive follicular Non-Hodgkin's lymphoma in conjunction with anthracycline-containing combination chemotherapy in patients 18 years of age or older. Intron A is indicated for intralesional treatment of selected patients 18 years of age or older with condylomata acuminata involving external surfaces of the genital and perianal areas. It is also indicated for the treatment of selected patients 18 years of age or older with AIDS-Related Kaposi's Sarcoma. [1]

The National Comprehensive Cancer Network (NCCN) also recommends use of Intron A (interferon alfa-2b) for giant cell tumors of the bone, mycosis fungoides / Sézary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, and adult T-cell leukemia/lymphoma [2]

Pegasys (peginterferon alfa-2a) is an inducer of the innate immune response indicated for the treatment of chronic hepatitis C (CHC) as part of a combination regimen with other hepatitis C virus (HCV) antiviral drugs in patients 5 years of age and older with compensated liver disease. Pegasys monotherapy is indicated for CHC only if patient has contraindication to or significant intolerance to other HCV antiviral drugs. Pegasys is indicated in the treatment of adult patients with HBeAg positive and HBeAg negative chronic hepatitis B (CHB) infection who have compensated liver disease and evidence of viral replication and liver inflammation. It is also indicated for the treatment of non-cirrhotic pediatric patients 3 years of age and older with HBeAg-positive CHB and evidence of viral replication and elevations in serum alanine aminotransferase (ALT). [3]

The National Comprehensive Cancer Network (NCCN) also recommends the use of Pegasys (peginterferon alfa-2a) in patients with chronic myeloid leukemia (CML), Erdheim-Chester disease (ECD), myeloproliferative neoplasms (MPNs) such as essential thrombocytopenia (ET), polycythemia vera (PV), and myelofibrosis (PM), and systemic mastocytosis, as well as mycosis fungoides/Sezary syndrome, hairy cell leukemia, primary cutaneous CD30+ T-cell lymphoproliferative disorders, and adult T-cell leukemia/lymphoma. [2,6-9]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

4 . References

1. Intron A [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; March 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendiu). Accessed September 6, 2023 at https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia
3. Pegasys [package insert]. South San Francisco, CA: Genetech USA, Inc.; March 2021.

5 . Revision History

Date	Notes
2/9/2024	Removed Pegintron as it is discontinued and added SML.

Iqirvo

Prior Authorization Guideline

Guideline ID	GL-154206
Guideline Name	Iqirvo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/18/2024
P&T Revision Date:	

1 . Indications

Drug Name: Iqirvo (elafibranor)
Primary biliary cholangitis Indicated for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA.

2 . Criteria

Product Name: Iqirvo [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of primary biliary cholangitis

AND

2 - Patient does not have decompensated cirrhosis

AND

3 - ONE of the following^:

3.1 BOTH of the following:

- Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol)
- Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 consecutive months of treatment with ursodeoxycholic acid (e.g., Urso, ursodiol)

OR

3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol)

AND

4 - Patient is not receiving Iqirvo in combination with Livdelzi (seladelpar) or Ocaliva (obeticholic acid)

AND

5 - Prescribed by one of the following:

- Hepatologist

• Gastroenterologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Iqirvo [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., laboratory values) documenting a reduction in ALP level from pre-treatment baseline (i.e., prior to Iqirvo therapy)

AND

2 - Patient does not have decompensated cirrhosis

AND

3 - Patient is not receiving Iqirvo in combination with Livdelzi (seladelpar) or Ocaliva (obeticholic acid)

AND

4 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Iqirvo (elafibranor) is a peroxisome proliferator-activated receptor (PPAR) agonist indicated for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. This indication is approved under accelerated approval based on reduction of alkaline phosphatase (ALP). Improvement in survival or prevention of liver decompensation events have not been demonstrated. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). Use of Iqirvo is not recommended in patients who have or develop decompensated cirrhosis (e.g., ascites, variceal bleeding, hepatic encephalopathy). [1] **Additional Clinical Rules:** • Supply limits may be in place. • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Iqirvo [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc.; June 2024.

5 . Revision History

Date	Notes

9/3/2024	New program

Iressa

Prior Authorization Guideline

Guideline ID	GL-134439
Guideline Name	Iressa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	9/15/2021
P&T Revision Date:	10/20/2021 ; 10/19/2022 ; 06/21/2023 ; 10/18/2023

1 . Indications

Drug Name: Iressa (gefitinib)
Non-small cell lung cancer (NSCLC) Indicated as first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations. **Off Label Uses: National Cancer Comprehensive Network (NCCN)** The National Cancer Comprehensive Network (NCCN) also recommends the use of Iressa in patients with NSCLC with EGFR S768I, L861Q, and/or G719X mutation positive tumors as well as patients with NSCLC with a known sensitizing EGFR mutation and associated brain metastases.

2 . Criteria

Product Name: Brand Iressa, generic gefitinib [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of metastatic non-small cell lung cancer (NSCLC) **AND** **2** - ONE of the following: • Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions • Tumors are positive for exon 21 (L858R) substitution mutations • Tumors are positive for a known sensitizing EGFR mutation (e.g, exon 20 S768I mutation, exon 18 G719X mutation, exon 21 L861Q mutation)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Iressa, generic gefitinib [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Iressa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Iressa, generic gefitinib [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of central nervous system (CNS) cancer with metastatic lesions **AND** **2** - Iressa is active against primary (NSCLC) tumor with a known EGFR sensitizing mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Iressa, generic gefitinib [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Iressa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Iressa, generic gefitinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Iressa will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Iressa, generic gefitinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Iressa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Iressa (gefitinib) is a tyrosine kinase inhibitor indicated as first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations [1] The National Cancer Comprehensive Network (NCCN) also recommends the use of Iressa in patients with NSCLC with EGFR S768I, L861Q, and/or G719X mutation positive tumors as well as patients with NSCLC with a known sensitizing EGFR mutation and associated brain metastases.[2] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Iressa [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia . Accessed September 1, 2023.

5 . Revision History

Date	Notes
10/6/2023	Annual review. Updated background and list of examples of sensitizi ng EGFR mutations per NCCN recommendations. Updated referenc es.

Prior Authorization Guideline

Guideline ID	GL-126557
Guideline Name	Iron Chelators
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 06/16/2021 ; 09/15/2021 ; 06/15/2022 ; 6/21/2023

1 . Indications

Drug Name: Exjade (deferasirox), Jadenu (deferasirox)
Chronic iron overload due to blood transfusions (transfusional iron overload) Indicated for the treatment of chronic iron overload due to blood transfusions in patients 2 years of age and older. The safety and efficacy of Exjade and Jadenu, when administered with other iron chelation therapy, have not been established. **Chronic iron overload due to non-transfusion dependent thalassemia syndromes** Indicated for the treatment of chronic iron overload in patients 10 years of age and older with non-transfusion dependent thalassemia syndromes and with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight (dw) and a serum ferritin greater than 300 mcg/L.

2 . Criteria

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox [a]	
Diagnosis	Chronic Iron Overload Due to Blood Transfusions (i.e., Transfusional Iron Overload)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox [a]	
Diagnosis	Chronic Iron Overload Due to Blood Transfusions (i.e., Transfusional Iron Overload)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox [a]

Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndromes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndrome

AND

2 - Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with Exjade or Jadenu

AND

3 - Patient has serum ferritin levels consistently greater than 300 mcg/L prior to initiation of treatment with Exjade or Jadenu

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Exjade, Brand Jadenu, generic deferasirox [a]	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndromes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Exjade (deferasirox) and Jadenu (deferasirox) are iron chelating agents indicated for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) in patients 2 years of age and older. The safety and efficacy of deferasirox, when administered with other iron chelation therapy, have not been established. It is recommended that therapy with deferasirox be started when a patient has evidence of chronic transfusional iron overload, such as the transfusion of approximately 100 mL/kg of packed red blood cells (approximately 20 units for a 40-kg patient) and a serum ferritin consistently >1000 mcg/L. Deferasirox is also indicated for the treatment of chronic iron overload in patients 10 years of age and older with non-transfusion dependent thalassemia (NTDT) syndromes and with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight (mg Fe/g dw) and a serum ferritin greater than 300 mcg/L. This indication is based on achievement of an LIC less than 5 mg Fe/g dw. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Step therapy may be in place.

4 . References

1. Exjade [Package Insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020.

2. Jadenu [Package Insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2020.

5 . Revision History

Date	Notes
6/21/2023	Updated references. Removed formulation notations because policy applies to all formulations of targeted drugs.
6/21/2023	Annual review. Added state mandate language.

Jakafi

Prior Authorization Guideline

Guideline ID	GL-137003
Guideline Name	Jakafi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Jakafi (ruxolitinib)
Myelofibrosis Indicated for treatment of patients with intermediate or high-risk myelofibrosis, including primary myelofibrosis (PMF), post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis. **Polycythemia vera** Indicated in patients with polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea. **Graft versus host disease (GVHD)** Indicated for the treatment of steroid-refractory acute graft-versus-host disease and chronic graft-versus-host disease after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older.

2 . Criteria

Product Name: Jakafi [a]	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following diagnoses: • Primary myelofibrosis • Post-polycythemia vera myelofibrosis • Post-essential thrombocythemia myelofibrosis	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi	
Notes	NOTE: If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of therapy.

	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Polycythemia vera
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of polycythemia vera **AND** **2** - History of failure, inadequate response, contraindication, or intolerance to one of the following: • Hydroxyurea • Interferon therapy (e.g., Intron A, Pegays, Pegintron)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Polycythemia vera
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi	
Notes	NOTE: If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Essential thrombocythemia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of essential thrombocythemia

AND

2 - Inadequate response or loss of response to ONE of the following:

- Hydroxyurea
- Pegasys (peginterferon alfa-2a)
- Agrylin (Anagrelide)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]

Diagnosis	Essential thrombocythemia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation that patient has evidence of symptom improvement or reduction in spleen volume while on Jakafi	
Notes	NOTE: If documentation does not provide evidence of symptom improvement or reduction in spleen volume while on Jakafi, authorization will be issued for 2 months to allow for dose titration with discontinuation of therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Graft versus host disease (GVHD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following: • Diagnosis of acute GVHD • Disease is steroid refractory **OR** **2** - BOTH of the following:	

• Diagnosis of chronic GVHD • Failure of one or two lines of systemic therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Graft versus host disease (GVHD)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation that patient has symptom improvement while on Jakafi	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia	

AND **2** - Patient has a JAK2 rearrangement	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Jakafi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Myelodysplastic Syndromes
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Both of the following: **1.1** Diagnosis of chronic myelomonocytic leukemia (CMML)-2	

AND **1.2** Use in combination with a hypomethylating agent (e.g., azacitidine, decitabine) **OR** **2** - Diagnosis of BCR-ABL negative atypical chronic myeloid leukemia (aCML)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Myelodysplastic Syndromes
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Jakafi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Pediatric Acute Lymphoblastic Leukemia
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of pediatric acute lymphoblastic leukemia **AND** **2** - Used as a component of induction therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	Immunotherapy-Related Toxicities
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of CAR-T induced G4 cytokine release syndrome **AND** **2** - Disease is refractory to high-dose corticosteroids and anti-IL-6 therapy (e.g., Actemra [tocilizumab])	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	T-Cell Lymphomas
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Peripheral T-Cell Lymphoma not otherwise specified (PTCL-NOS)
- Enteropathy-associated T-cell lymphoma (EATL)
- Monomorphic epitheliotropic intestinal T-cell lymphoma (MEITL)
- Angioimmunoblastic T-cell lymphoma (AITL)
- Nodal peripheral T-cell lymphoma with T-follicular helper phenotype (PTCL, TFH)
- Follicular T-cell lymphoma (FTCL)
- Anaplastic large cell lymphoma (ALCL)
- Hepatosplenic T-cell lymphoma

AND

2 - Used as initial palliative intent therapy or second-line and subsequent therapy for relapsed/refractory disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	T-Cell Lymphomas
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Jakafi will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jakafi [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Jakafi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Benefit/Coverage/Program Information

Jakafi (ruxolitinib) is a kinase inhibitor indicated for treatment of patients with intermediate or high-risk myelofibrosis, including primary myelofibrosis (PMF), post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis. It is also indicated in patients with polycythemia vera who have had an inadequate response to or are intolerant of hydroxyurea. It is also indicated for the treatment of steroid-refractory acute graft-versus-host disease and chronic graft-versus-host disease after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older.

The National Cancer Comprehensive Network (NCCN) also recommends Jakafi for the treatment of patients with polycythemia vera who have had an inadequate response to interferon therapy, essential thrombocythemia, lymphoid, myeloid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement and myelodysplastic syndromes, pediatric acute lymphoblastic leukemia, T-Cell Lymphomas, and management of CAR-T-cell related toxicities.

Additional Clinical Rules:

Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and reauthorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

Supply limits may be in place.

4 . References

1. Jakafi [package insert]. Wilmington, DE: Incyte Corporation; January 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 27, 2023.
3. Ayalew Tefferi and Animesh Pardanani. Brief Report: Serious Adverse Events During Ruxolitinib Treatment Discontinuation in Patients With Myelofibrosis. Mayo Clin Proc. December 2011 86(12):1188-1191.
4. Hill, J, Alousi A, Kebriaei P, et al. New and emerging therapies for acute and chronic graft versus host disease. Ther Adv Hematol. 2018; 9(1):21-46.
5. Zeiser R, Burchert A, Lengerke C, et al. Ruxolitinib in corticosteroid-refractory graft versus host disease after allogeneic stem cell transplantation: a multicenter survey. Leukemia. 2015; 29(10):2062-8.
6. Zeiser R, Blazar BR. Pathophysiology of chronic graft versus host disease and therapeutic target. N Engl J Med. 2017; 377:2565-79.

7. Arber DA, Orazi A, Hasserjian RP, et al. International Consensus Classification of myeloid neoplasms and acute leukemia: Integrating morphological, clinical and genomic data. Blood 2022. Epub ahead of print.

5 . Revision History

Date	Notes
11/28/2023	Annual review. Added criteria for T-cell lymphomas and essential thrombocythemia per NCCN recommendations. Updated criteria for pediatric ALL. Updated criteria for GVHD per FDA label. Updated background. Updated references.

Jesduvroq

Prior Authorization Guideline

Guideline ID	GL-137872
Guideline Name	Jesduvroq
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	1/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Jesduvroq (daprodustat)
Anemia due to chronic kidney disease (CKD) Indicated for the treatment of anemia due to chronic kidney disease in adults who have been receiving dialysis for at least four months.

2 . Criteria

Product Name: Jesduvroq [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of anemia due to chronic kidney disease (CKD)

AND

2 - Patient has been receiving dialysis for at least four months

AND

3 - BOTH of the following:

- Ferritin greater than 100 mcg/L
- Transferrin saturation (TSAT) greater than 20%

AND

4 - Hemoglobin level less than 11 g/dL

AND

5 - Trial and failure, contraindication or intolerance to an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

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

- Hematologist
- Nephrologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Jesduvroq [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Jesduvroq therapy (e.g., clinically meaningful increase in hemoglobin level)

AND

2 - Adequate iron stores confirmed by BOTH of the following:

- Ferritin greater than 100 mcg/L
- Transferrin saturation (TSAT) greater than 20%

AND

3 - Hemoglobin level does not exceed 12 g/dL

AND

4 - Patient is not on concurrent treatment with an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

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

• Hematologist • Nephrologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Jesduvroq (daprodustat) is a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor indicated for the treatment of anemia due to chronic kidney disease in adults who have been receiving dialysis for at least four months. The treatment of anemia includes intravenous (IV) iron and/or treatment with either an erythropoiesis-stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] or a hypoxia-inducible factor prolyl hydroxylase inhibitor (HIF PHI) [e.g., Jesduvroq (daprodustat)]. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limit may be in place.

4 . References

1. Jesduvroq [package insert]. Durham, NC: GlaxoSmithKline; August 2023.
2. Akizawa T, Nangaku M, Yonekawa T, et al. Efficacy and Safety of Daprodustat Compared with Darbepoetin Alfa in Japanese Hemodialysis Patients with Anemia: A Randomized, Double-Blind, Phase 3 Trial. Clin J Am Soc Nephrol. 2020;15(8):1155-1165. doi:10.2215/CJN.16011219

3. Ketteler M, Block GA, Evenepoel P, Fukagawa M, Herzog CA, McCann L, Moe SM, Shroff R, Tonelli MA, Toussaint ND, Vervloet MG, Leonard MB. KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (CKD-MBD). Ann Intern Med. 2018 Mar 20;168(6):422-430.

5 . Revision History

Date	Notes
12/20/2023	New program.

Joenja

Prior Authorization Guideline

Guideline ID	GL-147292
Guideline Name	Joenja
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	5/25/2023
P&T Revision Date:	5/17/2024

1 . Indications

Drug Name: Joenja (leniolisib)
Activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) Indicated for the treatment of activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) in adult and pediatric patients 12 years of age and older.

2 . Criteria

Product Name: Joenja [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS)

AND

2 - Diagnosis has been confirmed by the presence of an APDS-associated genetic variant in either PIK3CD or PIK3R1.

AND

3 - Documentation of other clinical findings and manifestations consistent with APDS (e.g., recurrent respiratory tract infections, recurrent herpesvirus infections, lymphadenopathy, hepatosplenomegaly, autoimmune cytopenia)

AND

4 - Patient has a history of trial and failure, intolerance or contraindication to current standard of care for APDS (e.g., antimicrobial prophylaxis, immunoglobulin replacement therapy, immunosuppressive therapy)

AND

5 - Prescribed by ONE of the following:

- Hematologist
- Immunologist

AND

6 - BOTH of the following:

- Patient is 12 years of age or older

• Patient weighs greater than or equal to 45 kg	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Joenja [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Joenja therapy (e.g., reduced lymph node size, increased naïve B-cell percentage, decreased frequency or severity of infections, decreased frequency of hospitalizations) **AND** **2** - Prescribed by ONE of the following: • Hematologist • Immunologist **AND** **3** - Patient weighs greater than or equal to 45 kg	
Notes	a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Joenja (leniolisib) is a kinase inhibitor indicated for the treatment of activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) in adult and pediatric patients 12 years of age and older.[1] APDS is a rare primary immunodeficiency caused by variations in the genes encoding subunits of the PI3Kδ enzyme complex and PI3Kδ hyperactivity. PI3Kδ hyperactivity results in altered development of B and T-cell which can lead to severe lymphoproliferation, recurrent infections, autoimmune disorders, and malignancies. APDS can be characterized by a variety of symptoms, including recurrent respiratory tract infections (e.g., pneumonia, otitis media, rhinosinusitis), recurrent herpesvirus infections (e.g., Epstein Barr virus, cytomegalovirus, herpes simplex virus), lymphoproliferation (e.g., lymphadenopathy, hepatosplenomegaly), autoimmune cytopenia and glomerulonephritis, and neurodevelopmental delay. A definitive diagnosis can be made through genetic testing. Current standard of care includes antimicrobial prophylaxis (e.g., trimethoprim/ sulfamethoxazole, azithromycin), immunoglobulin replacement therapy (IRT), immunosuppressive therapy (e.g., glucocorticoids, rituximab), and hematopoietic stem cell transplant (HSCT).[4] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

1. Joenja [package insert]. Foster City, CA: Pharming Technologies, Inc.; March 2023.
2. Rao VK, Webster S, Šedivá A, et al. Study of Efficacy of CDZ173 in Patients With APDS/PASLI. ClinicalTrials.gov identifier: NCT02435173. Updated August 10, 2022. Accessed March 28, 2023. https://clinicaltrials.gov/ct2/show/study/NCT02435173.
3. Rao VK, Webster S, Šedivá A, et al. A randomized, placebo-controlled phase 3 trial of the PI3Kδ inhibitor leniolisib for activated PI3Kδ syndrome. Blood. 2023;141(9):971-983. doi:10.1182/blood.2022018546
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5. Vanselow S, Wahn V, Schuetz C. Activated PI3Kδ syndrome - reviewing challenges in diagnosis and treatment. Front Immunol. 2023 Jul 20;14:1208567. doi: 10.3389/fimmu.2023.1208567. PMID: 37600808; PMCID: PMC10432830.

5 . Revision History

Date	Notes
5/13/2024	Annual review. Updated initial authorization duration to 12 months. U pdated references.

Juxtapid

Prior Authorization Guideline

Guideline ID	GL-140171
Guideline Name	Juxtapid
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	7/20/2022
P&T Revision Date:	07/19/2023 ; 10/18/2023 ; 2/16/2024

1 . Indications

Drug Name: Juxtapid (lomitapide)
Homozygous familial hypercholesterolemia (HoFH) Indicated as an adjunct to a low-fat diet and other lipid lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH).

2 . Criteria

Product Name: Juxtapid [a]

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

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment LDL-C greater than 400 mg/dL

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diet

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - History of intolerance, failure or contraindication to Repatha (evolocumab) (document date of trial and list reason for therapeutic failure, contraindication, or intolerance)

AND

6 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Juxtapid [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Patient continues to receive comprehensive counseling regarding appropriate diet

AND

2 - Patient continues to receive other lipid-lowering therapy (e.g., statin, LDL apheresis)

AND

3 - Documentation of a positive clinical response to therapy from pre-treatment baseline **AND** **4** - Prescribed by ONE of the following: • Cardiologist • Endocrinologist • Lipid specialist **AND** **5** - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab), Repatha (evolocumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Juxtapid (lomitapide) is a microsomal triglyceride transfer protein inhibitor indicated as an adjunct to a low-fat diet and other lipid lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH). The safety and efficacy of Juxtapid have not been established in patients with hypercholesterolemia who do not have HoFH including those with heterozygous familial hypercholesterolemia (HeFH). The effect of Juxtapid on cardiovascular morbidity and mortality has not been determined. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Juxtapid [package insert]. Cambridge, MA: Amryt Pharmaceuticals; September 2020.
2. Cuchel M, Bruckert E, Ginsberg HN, et al. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. Eur Heart J. 2014; 35:2146-57.
3. Cuchel M, Raal FJ, Hegele RA, et al. 2023 Update on European Atherosclerosis Society Consensus Statement on Homozygous Familial Hypercholesterolaemia: new treatments and clinical guidance. Eur Heart J. 2023;44(25):2277-2291. doi:10.1093/eurheartj/ehad197

5 . Revision History

Date	Notes
1/30/2024	Updated diagnostic criteria per European Atherosclerosis Society gui dance. Updated references.

Kerendia

Prior Authorization Guideline

Guideline ID	GL-132887
Guideline Name	Kerendia
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	9/21/2022
P&T Revision Date:	12/14/2022 ; 9/20/2023

1 . Indications

Drug Name: Kerendia
Chronic kidney disease associated with type 2 diabetes Indicated to reduce the risk of sustained estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes (T2D).

2 . Criteria

Product Name: Kerendia [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of chronic kidney disease

AND

2 - Both of the following:

- Urinary albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g
- An eGFR greater than or equal to 25 mL/min/1.73 m2

AND

3 - History of type 2 diabetes

AND

4 - Used to reduce the risk of any of the following:

- Sustained eGFR decline
- End-stage kidney disease
- Cardiovascular death
- Non-fatal myocardial infarction
- Hospitalization for heart failure

AND

5 - Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment

AND

6 - One of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs

AND

7 - One of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT2 inhibitor (e.g., Jardiance, Farxiga)
- History of failure, contraindication, or intolerance to a SGLT2 inhibitor (e.g., Jardiance, Farxiga)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Kerendia [a]	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Kerendia (finerenone) is indicated to reduce the risk of sustained estimated glomerular filtration rate (eGFR) decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes (T2D). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Kerendia [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc. September 2022.
2. Bakris, GL, Agarwal R, Anker SD, Effect of Finerenone on Chronic Kidney Disease Outcomes in Type 2 Diabetes. NEJM. 2020; 383:2219-29.
3. American Diabetes Association. Standard of Medical Care in Diabetes- 2022. Diabetes Care 2022;45 (Supplement 1)
4. de Boer, IH, Khunti, K, Sadusky, T, et al. Diabetes Management in Chronic Kidney Disease: A Consensus Report by the American Diabetes Association (ADA) and Kidney Disease: Improving Global Outcomes (KDIGO). Diabetes Care 2022.
5. KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease. 2022. 102 (5S).

5 . Revision History

Date	Notes
9/11/2023	Updated to allow concomitant therapy with a SGLT.

Kisqali Femara Co-Pack

Prior Authorization Guideline

Guideline ID	GL-140205
Guideline Name	Kisqali Femara Co-Pack
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	02/18/2022 ; 08/19/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Kisqali Femara Co-Pack (ribociclib/letrozole)
Breast Cancer Indicated as initial endocrine-based therapy for the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

2 . Criteria

Product Name: Kisqali Femara Co-Pack [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced, recurrent, or metastatic breast cancer

AND

2 - Disease is hormone receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Kisqali Femara Co-Pack [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Kisqali Femara Co-Pack therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Kisqali Femara Co-Pack [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of recurrent or metastatic endometrial cancer **AND** **2** - Tumor is estrogen receptor (ER)-positive	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Kisqali Femara Co-Pack [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Kisqali Femara Co-Pack therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Kisqali Femara Co-Pack [a]

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Kisqali Femara Co-Pack will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Kisqali Femara Co-Pack [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Kisqali Femara Co-Pack therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Kisqali Femara Co-Pack is a co-packaged product containing ribociclib, a kinase inhibitor, and letrozole, an aromatase inhibitor, and is indicated as initial endocrine-based therapy for the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

The National Comprehensive Cancer Network (NCCN) recommends the use of Kisqali similarly for men and premenopausal women receiving ovarian ablation/suppression with recurrent unresectable (local or regional) or metastatic HR-positive HER2-negative breast cancer disease in combination with an aromatase inhibitor or fulvestrant. The use of an aromatase inhibitor in men with breast cancer is ineffective without concomitant suppression of testicular steroidogenesis. The NCCN also recommends Kisqali for estrogen receptor (ER)-positive recurrent or metastatic endometrial carcinoma in combination with letrozole.

Additional Clinical Programs:

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Kisqali Femara Co-Pack [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp. August 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed December 27, 2023.

5 . Revision History

Date	Notes
1/31/2024	Annual review. Updated background and added clinical criteria for en dometrial carcinoma per NCCN. Updated reference.

Lenvima

Prior Authorization Guideline

Guideline ID	GL-140207
Guideline Name	Lenvima
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 11/19/2021 ; 02/18/2022 ; 08/19/2022 ; 02/17/2023 ; 08/18/2023 ; 2/16/2024

1 . Indications

Drug Name: Lenvima (lenvatinib)
Thyroid Carcinoma Indicated for the treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. **Renal Cell Cancer** Indicated in combination with everolimus for the treatment of patients with advanced renal cell carcinoma (RCC) following one prior anti-angiogenic therapy. Indicated in combination with pembrolizumab for the first-line treatment of adult patients with advanced RCC. **Hepatocellular Carcinoma** Indicated for the first-line treatment of patients with unresectable hepatocellular carcinoma. **Endometrial Carcinoma** Indicated in combination with pembrolizumab, for the treatment of patients with advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior

systemic therapy and are not candidates for curative surgery or radiation.

Other Uses: The National Cancer Comprehensive Network (NCCN) also recommends Lenvima for the treatment of medullary thyroid carcinoma in patients who have experienced disease progression while on Caprelsa (vandetanib) or Cometriq (cabozantinib), as a systemic therapy for recurrent adenoid cystic carcinoma, and for the treatment of metatstatic hepatocellular carcinoma, thymic carcinoma, biliary tract carcinoma and cutaneous melanoma.

2 . Criteria

Product Name: Lenvima [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of differentiated thyroid cancer (DTC) **AND** **2** - Disease is locally recurrent, metastatic, progressive, or symptomatic **AND** **3** - Disease is radioactive iodine-refractory or ineligible	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lenvima therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Renal Cell Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of advanced renal cell carcinoma **AND** **2** - ONE of the following: **2.1** BOTH of the following: **2.1.1** History of failure, contraindication, or intolerance to prior anti-angiogenic therapy [e.g., Avastin (bevacizumab), Votrient (pazopanib), Sutent (sunitinib), Nexavar (sorafenib)]	

AND **2.1.2** Used in combination with everolimus (generic Afinitor) **OR** **2.2** Used in combination with Keytruda (pembrolizumab)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Renal Cell Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lenvima therapy **AND** **2** - Used in combination with everolimus (generic Afinitor) or Keytruda (pembrolizumab)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Hepatobiliary Cancer

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

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of hepatocellular carcinoma

AND

1.2 Disease is ONE of the following:

- Unresectable
- Metastatic

OR

2 - ALL of the following:

2.1 Diagnosis of biliary tract cancer

AND

2.2 Disease is ONE of the following:

- Unresectable or resected gross residual (R2) disease
- Metastatic

AND

2.3 Disease has progressed on or after systemic treatment

AND

2.4 Used in combination with Keytruda (pembrolizumab)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Hepatobiliary Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lenvima therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of endometrial carcinoma **AND** **2** - Used in combination with Keytruda (pembrolizumab)	

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lenvima [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lenvima therapy **AND** **2** - Used in combination with Keytruda (pembrolizumab)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lenvima [a]	
Diagnosis	Adenoid Cystic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of recurrent adenoid cystic carcinoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lenvima [a]	
Diagnosis	Adenoid Cystic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lenvima therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lenvima [a]	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of thymic carcinoma **AND** **2** - ONE of the following: • Used as a single agent for those who cannot tolerate first-line combination regimens	

• Used as a second line therapy in unresectable locally advanced disease, solitary metastasis or ipsilateral pleural metastasis, or extrathoracic metastatic disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lenvima therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cutaneous melanoma **AND**	

2 - ONE of the following:

- Disease is unresectable
- Disease is metastatic

AND

3 - Used in combination with Keytruda (pembrolizumab)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - Used in combination with Keytruda (pembrolizumab)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Lenvima will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lenvima [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Lenvima therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Lenvima (lenvatinib) is a kinase inhibitor indicated for the treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer in combination with Afinitor (everolimus), for the treatment of patients with advanced

renal cell carcinoma (RCC) following one prior anti-angiogenic therapy, in combination with Keytruda (pembrolizumab), for the first-line treatment of patients with advanced RCC, for the first-line treatment of patients with unresectable hepatocellular carcinoma, and in combination with pembrolizumab, for the treatment of patients with advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior systemic therapy in any setting and are not candidates for curative surgery or radiation. [1]

In addition, the National Cancer Comprehensive Network (NCCN) also recommends Lenvima for the treatment of medullary thyroid carcinoma in patients who have experienced disease progression while on Caprelsa (vandetanib) or Cometriq (cabozantinib), as a systemic therapy for recurrent adenoid cystic carcinoma, and for the treatment of metastatic hepatocellular carcinoma, thymic carcinoma, biliary tract carcinoma and cutaneous melanoma [2].

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Lenvima [package insert]. Woodcliff Lake, NJ: Eisai Inc.; October 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at NCCN Drugs and Biologics Compendium®. Accessed December 28, 2023.

5 . Revision History

Date	Notes
1/31/2024	Annual review. Updated thyroid cancer criteria based on label and N CCN. Updated hepatobiliary and thymic cancer based on NCCN reco mmendations. Updated references.

Prior Authorization Guideline

Guideline ID	GL-147899
Guideline Name	Leuprolide
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/20/2021 ; 10/19/2022 ; 12/14/2022 ; 08/18/2023 ; 04/17/2024 ; 6/17/2024

1 . Indications

Drug Name: Subcutaneously (SC) administered leuprolide acetate (Camcevi, Eligard, and generics)
Advanced prostate cancer Indicated for the palliative treatment of advanced prostate cancer. **Central precocious puberty (CPP)** While a depot formulation of leuprolide (Lupron Depot-Ped) is FDA labeled for the treatment of central precocious puberty (CPP), clinical evidence supports the use of daily SC administered leuprolide acetate for the same indication. CPP is defined as early onset of secondary sexual characteristics, generally earlier than 8 years of age in girls and 9 years of age in boys, associated with pubertal pituitary gonadotropin activation. Leuprolide prescribing information states that prior to initiation of treatment, a clinical diagnosis of CPP should be confirmed by blood concentration of luteinizing hormone (LH) (basal or stimulated with a GnRH analog) and assessment of bone age versus chronological age. Once therapy is initiated, CPP patients should be evaluated every 3 to 6 months for pubertal development and growth, and bone age should be measured

radiographically every 6 to 12 months.

Gender dysphoria Clinical evidence supporting the use of GnRH analogs for the treatment of gender dysphoria is limited and lacks long-term safety data. Statistically robust randomized controlled trials are needed to address the issue of whether the benefits outweigh the clinical risk in its use.

Salivary gland tumors and uterine sarcoma The National Cancer Comprehensive Network (NCCN) recommends leuprolide acetate for the treatment of salivary gland tumors and uterine sarcoma

Drug Name: Intramuscular (IM) administered leuprolide acetate 22.5 mg injection
Advanced prostate cancer Indicated for the treatment of advanced prostate cancer.

2 . Criteria

Product Name: Camcevi, Eligard, leuprolide inj kit 1 mg/0.2 mL, leuprolide acetate 22.5 mg injection [a]	
Diagnosis	Treatment of Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of prostate cancer **AND** **2** - Disease is ONE of the following: • Advanced • Metastatic	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Camcevi, Eligard, leuprolide inj kit 1 mg/0.2 mL, leuprolide acetate 22.5 mg injection [a]	
Diagnosis	Treatment of Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: leuprolide acetate inj kit 1 mg/0.2 mL [a]	
Diagnosis	Treatment of Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of central precocious puberty (idiopathic or neurogenic) **AND** **2** - Onset of secondary sexual characteristics in ONE of the following: • Females at birth less than or equal to 8 years of age	

- Males at birth less than or equal to 9 years of age

AND

3 - Confirmation of diagnosis as defined by ONE of the following:

- A pubertal luteinizing hormone response to a GnRH stimulation test
- Bone age advanced one year beyond the chronological age

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: leuprolide acetate inj kit 1 mg/0.2 mL [a]	
Diagnosis	Treatment of Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response (e.g., decrease in height velocity, cessation of menses, arrest pubertal progression, reduction in bone age advancement)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: leuprolide acetate inj kit 1 mg/0.2 mL [a]	
Diagnosis	Infertility**
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of infertility **AND** **2** - Used as part of an assisted reproductive technology (ART) protocol	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. **Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion.

Product Name: Eligard, leuprolide acetate inj kit 1 mg/0.2 mL [a]	
Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of salivary gland tumor

AND

2 - Disease is ONE of the following:

- Recurrent
- Unresectable
- Metastatic

AND

3 - Disease is androgen receptor positive (AR+)

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Eligard, leuprolide acetate inj kit 1 mg/0.2 mL [a]	
Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Camcevi, Eligard, leuprolide inj kit 1 mg/0.2 mL, leuprolide acetate 22.5 mg injection [a]	
Diagnosis	Gender dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Using hormones to change physical characteristics **AND** **2** - The covered person must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Camcevi, Eligard, leuprolide inj kit 1 mg/0.2 mL, leuprolide acetate 22.5 mg injection [a]	
Diagnosis	Gender dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient continues to use hormone therapy to change physical characteristics **AND** **2** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Camcevi, Eligard, leuprolide inj kit 1 mg/0.2 mL, leuprolide acetate 22.5 mg injection [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following:	

• Low-grade endometrial stromal sarcoma (ESS) • Adenosarcoma without sarcomatous overgrowth • Estrogen receptor/progesterone receptor positive (ER/PR+) uterine sarcoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Camcevi, Eligard, leuprolide inj kit 1 mg/0.2 mL, leuprolide acetate 22.5 mg injection [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Coverage Criteria: These criteria provides parameters for coverage of oncology indications based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium. The Compendium lists the appropriate drugs and biologics for specific cancers using US Food and Drug Administration (FDA)-approved disease indications and specific NCCN panel recommendations. Each recommendation is supported by a level of evidence category.

UnitedHealthcare recognizes indications and uses of leuprolide acetate listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B as proven and Categories of Evidence and Consensus of 3 as unproven.

Clinical evidence supporting the use of GnRH analogs for the treatment of gender dysphoria is limited and lacks long-term safety data. Statistically robust randomized controlled trials are needed to address the issue of whether the benefits outweigh the clinical risk in its use.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

Additional Clinical Rules:

Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

Supply limitations may be in place.

Background:

Leuprolide acetate is a synthetic nonapeptide analog of naturally occurring gonadotropin releasing hormone (GnRH) or luteinizing hormone-releasing hormone (LH-RH) which acts as a potent inhibitor of gonadotropin secretion when given continuously in therapeutic doses. Leuprolide aetate is indicated in the palliative treatment of advanced prostatic cancer

Subcutaneously (SC) administered leuprolide acetate (Eligard and generics) is FDA-labeled for the palliative treatment of advanced prostate cancer.[1,2]

Intramuscular (IM) administered leuprolide acetate 22.5 mg injection is FDA-labeled for the treatment of advanced prostate cancer.[18]

In addition to prostate cancer, the National Cancer Comprehensive Network (NCCN) recommends leuprolide acetate for the treatment of salivary gland tumors and uterine sarcoma. [2]

While a depot formulation of leuprolide (Lupron Depot-Ped) is FDA labeled for the treatment of central precocious puberty (CPP),[4] clinical evidence supports the use of daily SC administered leuprolide acetate for the same indication.[5] CPP is defined as early onset of secondary sexual characteristics, generally earlier than 8 years of age in girls and 9 years of

age in boys, associated with pubertal pituitary gonadotropin activation. Leuprolide prescribing information states that prior to initiation of treatment, a clinical diagnosis of CPP should be confirmed by blood concentration of luteinizing hormone (LH) (basal or stimulated with a GnRH analog) and assessment of bone age versus chronological age. [4] Once therapy is initiated, CPP patients should be evaluated every 3 to 6 months for pubertal development and growth, and bone age should be measured radiographically every 6 to 12 months.[5] Fensolvi is a gonadotropin releasing hormone (GnRH) agonist indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty.

4 . References

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2. Leuprolide acetate [package insert]. Princeton, NJ: Sandoz Inc; June 2020.
3. Camcevi [package insert]. Durham, NC: Accord BioPharma Inc.; November 2022.
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13. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2013. Washington, DC. Pages 451-459.
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15. de Vries AL, McGuire JK, Steensma TD, et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014 Oct;134(4):696-704.
16. Leuprolide acetate depot [package insert]. Warren, NJ: Cipla USA, Inc. November 2023.

5 . Revision History

Date	Notes
6/10/2024	Annual review. Simplified criteria for prostate and salivary gland canc er. Added criteria for uterine sarcoma. Updated reauthorization criteri a for CPP. Updated background and references.

Lidocaine Patch

Prior Authorization Guideline

Guideline ID	GL-141359
Guideline Name	Lidocaine Patch
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	06/16/2021 ; 10/20/2021 ; 09/21/2022 ; 08/18/2023 ; 11/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Lidoderm (lidocaine patch), ZTlido (lidocaine patch), Lidocan (lidocaine patch), Lidocan II (lidocaine patch), Lidocan III (lidocaine patch)
Pain associated with post-herpetic neuralgia (PHN) Indicated for the relief of pain associated with post-herpetic neuralgia (PHN). The American Academy of Neurology recommends the use of lidocaine patch as an option for the management of PHN. Evidence also exists in support of using lidocaine patch for non-PHN neuropathies.

2 . Criteria

Product Name: Brand Lidoderm patch, generic lidocaine patch, ZTLido patch, Lidocan, Lidocan II, Lidocan III [a] [a]

Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: • Diagnosis of post-herpetic neuralgia • Diagnosis of neuropathic pain	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Lidoderm is indicated for the relief of pain associated with post-herpetic neuralgia (PHN). The American Academy of Neurology recommends the use of lidocaine patch as an option for the management of PHN. Evidence also exists in support of using lidocaine patch for non-PHN neuropathies. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

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2. Bril V, England J, Franklin GM, et al. Evidence-based guideline: Treatment of Painful Diabetic Neuropathy. Report of the American Academy of Neurology, the American Association of Neuromuscular and Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation. Neurology. 2011 May 17; 76(20):1758-65.
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5. Gilron, Ian et al. Neuropathic Pain: Principles of Diagnosis and Treatment. Mayo Clinic Proceedings, Volume 90, Issue 4, 532 - 545.
6. Hooten M, Thorson D, Bianco J, et al. Institute for Clinical Systems Improvement. Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management. Updated August 2017. https://www.icsi.org/_asset/f8rj09/Pain.pdf. Accessed September 13, 2023.
7. Lidoderm [package insert]. San Jose, CA: TPU Pharma; December 2022.
8. ZTlido [package insert]. Palo Alto, CA: Scilex Pharmaceuticals Inc; April 2021.

5 . Revision History

Date	Notes
2/9/2024	Added Lidocan, Lidocan II, and Lidocan III

Linzess_Symproic_Zelnorm

Prior Authorization Guideline

Guideline ID	GL-128044
Guideline Name	Linzess_Symproic_Zelnorm
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	9/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 03/17/2021 ; 06/16/2021 ; 09/15/2021 ; 11/18/2022 ; 03/15/2023 ; 04/19/2023 ; 7/19/2023

1 . Indications

Drug Name: Linzess (linaclotide)
Chronic idiopathic constipation Indicated for the treatment of chronic idiopathic constipation in adults aged 18 years and older. **Irritable bowel syndrome** Indicated for the treatment of irritable bowel syndrome with constipation in adults aged 18 years and older. **Functional constipation (FC)** Indicated for treatment of functional constipation (FC) in pediatric patients 6 to 17 years of age.
Drug Name: Symproic (naldemedine)
Opioid-induced constipation Indicated for the treatment of opioid-induced constipation in adult patients with chronic non-cancer pain including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation

Drug Name: Zelnorm (tegaserod)
Irritable bowel syndrome Indicated for the treatment of irritable bowel syndrome with constipation in adult women less than 65 years of age.

2 . Criteria

Product Name: Linzess [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following: • Diagnosis of chronic idiopathic constipation • Diagnosis of irritable bowel syndrome with constipation • Diagnosis of functional constipation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Symproic [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following:	

• Diagnosis of opioid-induced constipation in patients being treated for chronic, non-cancer pain • Diagnosis of opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelnorm [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of irritable bowel syndrome with constipation **AND** **2** - Patient was female at birth **AND** **3** - History of failure, contraindication or intolerance to lactulose **AND** **4** - History of failure, contraindication, or intolerance to Linzess	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Symproic, or Zelnorm [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. NOTE: Linzess will continue to go through initial authorization for a dia gnosis check only.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place **Background** Zelnorm (tegaserod) is indicated for treatment of irritable bowel syndrome with constipation (IBS-C) in adults; however, Zelnorm is only indicated in adult women less than 65 years. Linzess (linaclotide) is indicated for the treatment of chronic idiopathic constipation and irritable bowel syndrome with constipation in adults aged 18 years and older and for the treatment of functional constipation (FC) in pediatric patients 6 to 17 years of age. Symproic (naldemedine) is an opioid antagonist indicated for the treatment of opioid-induced constipation in adult patients with chronic non-cancer pain including patients with chronic

pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation. Physicians and patients should periodically assess the need for continued treatment with these agents.

4 . References

1. Linzess [package insert]. North Chicago, IL: AbbVie; June 2023.
2. Symproic [package insert]. Raleigh, NC: BioDelivery Services International, Inc.; May 2020.
3. Zelnorm [package insert]. Louisville, KY: US WorldMeds, LLC; June 2020.

5 . Revision History

Date	Notes
7/20/2023	Removed Amitiza from policy as clinical prior auth has been removed .
7/20/2023	Added new indication for Linzess for functional constipation. Removed Linzess from reauthorization section, will be transitioning to Dx2Rx which will continue to go through the initial authorization criteria for a diagnosis check only. Updated reference.

Litfulo (Ritlecitinib)

Prior Authorization Guideline

Guideline ID	GL-137113
Guideline Name	Litfulo (Ritlecitinib)
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	9/20/2023
P&T Revision Date:	09/20/2023 ; 12/13/2023

1 . Indications

Drug Name: Litfulo (ritlecitinib)
Alopecia Areata Indicated for the treatment of severe alopecia areata in adults and adolescents 12 years and older.

2 . Criteria

Product Name: Litfulo [a]	
Diagnosis	Alopecia Areata
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient has a current episode of alopecia areata with at least 50% scalp hair loss

AND

4 - Patient is not receiving Litfulo in combination with ANY of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine) [1]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib), Olumiant (baricitinib)]

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Litfulo [a]

Diagnosis	Alopecia Areata
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Litfulo therapy

AND

2 - Patient is not receiving Litfulo in combination with ANY of the following:

- Biologic DMARD [e.g., Enbrel (etanercept), adalimumab, Cimzia (certolizumab), Simponi (golimumab)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine) [1]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Janus kinase inhibitor [e.g., Xeljanz/Xeljanz XR (tofacitinib), Rinvoq (upadacitinib), Olumiant (baricitinib)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Litfulo® (ritlecitinib) is an oral kinase inhibitor indicated for the treatment of severe alopecia areata in adults and adolescents 12 years and older. Use of Litfulo in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Litfulo [package insert]. New York, NY: Pfizer Inc; June 2023.
2. Messenger AG, McKillop J, Farrant P, et al. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. Br J Dermatol. 2012;166(5):916-926.
3. King BA, Mesinkovska NA, Craiglow B, et al. Development of the alopecia areata scale for clinical use: results of an academic-industry collaborative effort. J Am Acad Dermatol. 2022;86(2):359-364.
4. Meah N, Wall D, York K, et al. The Alopecia Areata Consensus of Experts (ACE) study: Results of an international expert opinion on treatments for alopecia areata. J Am Acad Dermatol. 2020;83(1):123-130.
5. King BA, Senna MM, Ohyama M, et al. Defining Severity in Alopecia Areata: Current Perspectives and a Multidimensional Framework. Dermatol Ther (Heidelb). 2022 Apr;12(4):825-834.

5 . Revision History

Date	Notes
11/29/2023	Removed age requirement and prescriber requirement in reauthoriza tion; aligned with commercial medical necessity.

Livmarli

Prior Authorization Guideline

Guideline ID	GL-154210
Guideline Name	Livmarli
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	11/19/2021
P&T Revision Date:	01/19/2022 ; 08/19/2022 ; 01/18/2023 ; 05/25/2023 ; 05/17/2024 ; 9/18/2024

1 . Indications

Drug Name: Livmarli (maralixibat)
Alagille Syndrome Indicated for the treatment of cholestatic pruritis in patients 3 months of age and older with Alagille syndrome (ALGS). **Progressive Familial Intrahepatic Cholestasis** Indicated for the treatment of cholestatic pruritis in patients 12 months of age and older with progressive familial intrahepatic cholestasis (PFIC).

2 . Criteria

Product Name: Livmarli [a]	
Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of progressive familial intrahepatic cholestasis (PFIC)

AND

2 - Patient does not have a ABCB11 variant resulting in non-functional or complete absence of bile salt export pump (BSEP) protein

AND

3 - Patient is experiencing moderate to severe pruritus associated with PFIC.

AND

4 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory.

AND

5 - Patient has had an inadequate response to at least TWO conventional treatments for the symptomatic relief of pruritus (e.g., uroseoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, and sertraline).

AND

6 - Prescribed by a gastroenterologist or hepatologist.

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Livmarli [a]	
Diagnosis	Progressive Familial Intrahepatic Cholestasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, improved pruritis and less sleep disturbance) **AND** **2** - Prescribed by a gastroenterologist or hepatologist.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Livmarli [a]	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of Alagille syndrome (ALGS)	

AND

2 - Confirmation of diagnosis by presence of the JAG1 or Notch2 gene mutation

AND

3 - Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory.

AND

4 - Patient is experiencing moderate to severe pruritis associated with ALGS

AND

5 - Patient has had an inadequate response to at least TWO conventional treatments for the symptomatic relief of pruritus (e.g., uroseoxycholic acid, diphenhydramine, cholestyramine, rifampin, naltrexone, and sertraline).

AND

6 - Prescribed by a gastroenterologist or hepatologist.

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Livmarli [a]	
Diagnosis	Alagille Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response to Livmarli therapy (e.g., reduced serum bile acids, improved pruritis) **AND** **2** - Prescribed by a gastroenterologist or hepatologist.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Livmarli (maralixibat) is an ileal bile acid transporter inhibitor indicated for the treatment of cholestatic pruritis in patients 12 months of age and older with progressive familial intrahepatic cholestasis (PFIC). Livmarli is also indicated for the treatment of cholestatic pruritis in patients 3 months of age and older with Alagille syndrome (ALGS). PFIC is a heterogeneous group of liver disorders of autosomal recessive inheritance, characterized by an early onset of cholestasis (usually during infancy) with pruritus and malabsorption, which rapidly progresses and ends up as liver failure. Pruritus is the most obvious and the most unbearable symptom in cholestasis. It has been proposed that it is induced by the stimulation of nonmyelinated subepidermal free nerve ends because of increased serum bile acids. ALGS is a rare genetic disorder caused by a mutation in the JAG1 or Notch2 genes which are involved in embryonic development in utero. In ALGS patients, multiple organ systems

may be affected by the mutation. In the liver, the mutation causes the bile ducts to abnormally narrow, malform and reduce in number, leading to bile acid accumulation, cholestasis, and ultimately progressive liver disease. The cholestatic pruritus experienced by patients with ALGS is among the most severe in any chronic liver disease and is present in most affected children by the third year of life.

Conventional treatments for pruritis associated with PFIC or Alagille syndrome include uroseoxycholic acid (UCDA), antihistamines (e,g., diphenhydramine), bile acid sequestrants (e.g., cholestyramine), rifampin, naltrexone and sertraline.

Limitation of Use:

Livmarli is not recommended in a subgroup of PFIC type 2 patients with specific ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

4 . References

1. Livmarli [package insert]. Foster City, CA: Mirum Pharmaceuticals, Inc.; July 2024.
2. Gonzales E, Hardikar W, Stormon M, et al. Efficacy and safety of maralixibat treatment in patients with Alagille syndrome and cholestatic pruritus (ICONIC): a randomised phase 2 study. Lancet. 2021;398(10311):1581-1592.
3. Miethke AG, Moukarzel A, Porta G, et al. Maralixibat in progressive familial intrahepatic cholestasis (MARCH-PFIC): a multicentre, randomised, double-blind, placebo-controlled, phase 3 trial [published correction appears in Lancet Gastroenterol Hepatol. 2024 Jul;9(7):e10.
4. Chowdhury JR, Chowdhury NR. Inherited disorders associated with conjugated hyperbilirubinemia in adults. In: Post TW, ed. UpToDate. UpToDate, 2024. Accessed July 9, 2024. Inherited disorders associated with conjugated hyperbilirubinemia in adults - UpToDate
5. Kohut TJ, Loomes KM. Alagille syndrome. In: Post TW, ed. UpToDate. UpToDate, 2024. Accessed July 9, 2024. Alagille syndrome - UpToDate

5 . Revision History

Date	Notes
9/3/2024	Updated background with expanded PFIC indication in patients 12 m onths to 4 years of age. Updated examples of conventional treatment within initial authorization criteria for both PFIC and ALGS. Updated references.

Lokelma, Veltassa

Prior Authorization Guideline

Guideline ID	GL-155311
Guideline Name	Lokelma, Veltassa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	06/16/2021 ; 06/15/2022 ; 06/21/2023 ; 06/17/2024 ; 07/17/2024

1 . Indications

Drug Name: Lokelma (sodium zirconium cyclosilicate), Veltassa (patiromer)
Hyperkalemia Indicated for the treatment of hyperkalemia.

2 . Criteria

Product Name: Lokelma, Veltassa [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-life threatening hyperkalemia

AND

2 - Where clinically appropriate, loop or thiazide diuretic therapy for potassium removal has failed

AND

3 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Lokelma, Veltassa [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a positive clinical response to Lokelma or Veltassa therapy and continues to require treatment for hyperkalemia

AND

2 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place **Background:** Lokelma and Veltassa are indicated for the treatment of hyperkalemia. Lokelma and Veltassa should not be used as an emergency treatment for life threatening hyperkalemia because of its delayed onset of action. Non-emergent hyperkalemia is generally treated by addressing the reversible causes, such as removing drugs that may be causing impaired renal function, removing or adjusting medications that directly cause hyperkalemia, and initiating therapies for potassium removal.

4 . References

1. Veltassa [package insert]. Redwood City, CA: Vifor Pharma, Inc.; October 2023..
2. Weir MR, Bakris GL, Bushinsky DA, et al. Patiromer in patients with kidney disease and hyperkalemia receiving RAAS inhibitors. N Engl J Med 2015; 372:211.
3. Palmer BF. Managing hyperkalemia caused by inhibitors of the renin-angiotensin-aldosterone system. N Engl J Med 2004; 351:585.
4. Khanna A, White WB. The management of hyperkalemia in patients with cardiovascular disease. Am J Med. 2009 Mar. 122(3):215-21
5. Lokelma [package insert]. Wilmington, DE: AstraZeneca; February 2024.
6. Mount D. Treatment and prevention of hyperkalemia in adults. Sterns, R (Ed). UpToDate. Waltham, MA: UpToDate Inc. February 2024. Accessed May 1, 2024.
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8. KDIGO 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Int. 2024;105(4S): S117–S314. Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group.

5 . Revision History

Date	Notes
9/19/2024	Added new Veltassa strength

Prior Authorization Guideline

Guideline ID	GL-144132
Guideline Name	Long-Acting Opioids
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	12/16/2020
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 05/20/2022 ; 10/19/2022 ; 12/14/2022 ; 03/15/2023 ; 04/19/2023 ; 08/18/2023 ; 3/20/2024

1 . Indications

Drug Name: MS Contin (morphine sulfate controlled-release tablets), Duragesic (fentanyl transdermal), Zohydro ER (hydrocodone extended- release), oxymorphone extended-release tablets, morphine sulfate extended-release capsules
Management of moderate to severe pain Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid is needed for an extended period of time and for which alternative treatment options are not appropriate. They are not intended for use as an as needed analgesic.
Drug Name: Hydromorphone extended-release tablets (generic Exalgo), Hysingla ER (hydrocodone extended-release), Kadian (morphine sulfate sustained-release capsules), Nucynta ER (tapentadol extended-release)
Management of moderate to severe pain Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid is needed for an extended period of

time and for which alternative treatment options are not appropriate. They are not intended for use as an as needed analgesic.
Drug Name: OxyContin (oxycodone controlled-release, includes authorized generic), Xtampza ER (oxycodone extended-release), Dolophine (methadone), tramadol extended release tablets
Management of moderate to severe pain Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid is needed for an extended period of time and for which alternative treatment options are not appropriate. They are not intended for use as an as needed analgesic.
Drug Name: Conzip (tramadol extended release capsules), levorphanol, methadone 5mg/5mL and 10mg/5mL solution, Methadose (methadone)
Management of moderate to severe pain Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid is needed for an extended period of time and for which alternative treatment options are not appropriate. They are not intended for use as an as needed analgesic.

2 . Criteria

Product Name: Brand Hysingla ER, Oxycodone ER tabs, Xtampza ER, generic fentanyl patches, generic methadone tabs/tbso, generic methadone 5mg/5mL and 10mg/5mL soln, Brand Methadose tbso, generic morphine sulfate ER caps/tabs, generic oxymorphone ER, Conzip, Brand Tramadol ER caps, generic tramadol ER tabs, generic hydrocodone ER tabs, generic hydromorphone ER, generic hydrocodone ER caps, Brand MS Contin, Oxycontin, Nucynta ER, generic methadone intensol, generic methadone conc, Brand Methadose conc, generic morphine sulfate CR, generic levorphanol tartrate [a]	
Diagnosis	Cancer, Hospice, or End of Life Related Pain [a]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer related pain

OR

1.2 Patient is in hospice or is receiving end of life care

AND

2 - If the request is for fentanyl transdermal, hydrocodone extended-release capsules, hydromorphone extended-release tablets (generic Exalgo), morphine sulfate sustained-release capsules (generic Kadian), Nucynta ER (tapentadol extended-release), methadone (generic Dolophine), levorphanol tablets, methadone 5mg/5mL and 10mg/5mL solution, or Methadose (methadone), ONE of the following:

2.1 The patient has a history of failure, contraindication, or intolerance to a trial of morphine sulfate ER (generic MS Contin)*

OR

2.2 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, or end of life care related pain, and the medication is not a new regimen for treatment of cancer-related pain, hospice, or end of life care pain (document date regimen was started)

AND

3 - If the request is for oxymorphone extended-release tablets, Hysingla ER (hydrocodone extended-release), OxyContin (oxycodone controlled-release), oxycodone ER (Oxycontin authorized generic), or Xtampza ER (oxycodone extended-release), ONE of the following:

3.1 The patient has a history of failure, contraindication, or intolerance to a trial of morphine sulfate ER (generic MS Contin)*

OR

3.2 The physician attests the patient has risk factors for substance abuse

OR

3.3 Patient is established on pain therapy with the requested medication for cancer-related pain, hospice related pain, or end of life care related pain, and the medication is not a new regimen for treatment of cancer-related pain, hospice, or end of life care pain (document date regimen was started)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for long-acting opioids, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *morphine sulfate ER (generic MS Contin) may require prior authorization.

Product Name: Brand Hysingla ER, Oxycodone ER tabs, Xtampza ER, generic fentanyl patches, generic methadone tabs/tbso, generic methadone 5mg/5mL and 10mg/5mL soln, Brand Methadose tbso, generic morphine sulfate ER caps/tabs, generic oxymorphone ER, Conzip, Brand Tramadol ER caps, generic tramadol ER tabs, generic hydrocodone ER tabs, generic hydromorphone ER, generic hydrocodone ER caps, Brand MS Contin, Oxycontin, Nucynta ER, generic methadone intensol, generic methadone conc, Brand Methadose conc, generic morphine sulfate CR, generic levorphanol tartrate [a]	
Diagnosis	Non-Cancer, Non-Hospice or Non-End of Life pain [a]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The prescriber attests to BOTH of the following:

- Patient has been screened for substance abuse/opioid dependence
- Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

2 - Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

3 - Patient has been screened for underlying depression and/or anxiety. If applicable, any underlying conditions have been or will be addressed

AND

4 - One of the following:

4.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days (document drug(s), and date of trial), unless the patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or in the postoperative pain is expected to be moderate to severe and persist for an extended period of time

OR

4.2 Patient is new to plan and currently established on long-acting opioid therapy for at least the past 30 days

AND

5 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias and neuropathies), one of the following:

5.1 Both of the following:

5.1.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (document date of trial)

AND

5.1.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and duration of trial)

OR

5.2 The patient is new to the plan and is currently established on the requested long-acting opioid therapy for at least the past 30 days

AND

6 - If the request is for fentanyl transdermal, hydrocodone extended-release capsules, hydromorphone extended-release tablets (generic Exalgo), morphine sulfate sustained-release capsules (generic Kadian), Nucynta ER (tapentadol extended-release), methadone (generic Dolophine), levorphanol, methadone 5mg/5mL and 10mg/5mL solution, or Methadose (methadone), the patient has a history of failure, contraindication, or intolerance to a trial of morphine sulfate ER (generic MS Contin)*

AND

7 - If the request is for oxymorphone extended-release tablets, Hysingla ER (hydrocodone extended-release), OxyContin (oxycodone controlled-release), oxycodone ER (Oxycontin authorized generic), Xtampza ER (oxycodone extended-release), ONE of the following:

7.1 The patient has a history of failure, contraindication, or intolerance to a trial of morphine sulfate ER (generic MS Contin)*

OR

7.2 The physician attests the patient has risk factors for substance abuse

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for long-acting opioids, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *morphine sulfate ER (generic MS Contin) may require prior authorization.

Product Name: Brand Hysingla ER, Oxycodone ER tabs, Xtampza ER, generic fentanyl patches, generic methadone tabs/tbso, generic methadone 5mg/5mL and 10mg/5mL soln, Brand Methadose tbso, generic morphine sulfate ER caps/tabs, generic oxymorphone ER, Conzip, Brand Tramadol ER caps, generic tramadol ER tabs, generic hydrocodone ER tabs, generic hydromorphone ER, generic hydrocodone ER caps, Brand MS Contin, Oxycontin, Nucynta ER, generic methadone intensol, generic methadone conc, Brand Methadose conc, generic morphine sulfate CR, generic levorphanol tartrate [a]	
Diagnosis	Non-Cancer, Non-Hospice or Non-End of Life pain [a]
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documented meaningful improvement in pain and function when assessed against treatment goals (document improvement in function or pain score improvement)

AND

2 - Document rationale for not tapering or discontinuing opioid if treatment goals are not being met

AND

3 - Prescriber attests to BOTH of the following:

- Patient has been screened for substance abuse/opioid dependence
- Pain is moderate to severe and expected to persist for an extended period of time (chronic)

AND

4 - If the request is for fentanyl transdermal, hydrocodone extended-release capsules, hydromorphone extended-release tablets (generic Exalgo), morphine sulfate sustained-release capsules (generic Kadian), Nucynta ER (tapentadol extended-release), methadone (generic Dolophine), levorphanol, methadone 5mg/5mL and 10mg/5mL solution, or Methadose (methadone), the patient has a history of failure, contraindication, or intolerance to a trial of morphine sulfate ER (generic MS Contin)*

AND **5** - If the request is for oxymorphone extended-release tablets, Hysingla ER (hydrocodone extended-release), OxyContin (oxycodone controlled-release), oxycodone ER (Oxycontin authorized generic), or Xtampza ER (oxycodone extended-release), ONE of the following: **5.1** The patient has a history of failure, contraindication, or intolerance to a trial of morphine sulfate ER (generic MS Contin)* **OR** **5.2** The physician attests the patient has risk factors for substance abuse	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. If the patient is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for long-acting opioids, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *morphine sulfate ER (generic MS Contin) may require prior authorization.

3 . Background

Benefit/Coverage/Program Information
Background: Long-acting opioid analgesics are indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid is needed for an extended period of time and for which alternative treatment options are not appropriate. They are not intended for use as an as needed analgesic Long-acting opioids are not indicated for pain in the immediate postoperative period (the first 12-24 hours following surgery), or if the pain is mild, or not expected to persist for an

extended period of time. They are only indicated for postoperative use if the patient is already receiving the drug prior to surgery or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time. Physicians should individualize treatment, moving from parenteral to oral analgesics as appropriate.

Long-acting opioids should not be used in treatment naïve patients. Physicians should individualize treatment in every case, initiating therapy at the appropriate point along a progression from non-opioid analgesics, such as non-steroidal anti-inflammatory drugs and acetaminophen to opioids in a plan of pain management.

UnitedHealthcare employs opioid safety edits at point-of-sale (POS) to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the member's opioid use is appropriate and medically necessary. Development of opioid safety edit specifications, to include cumulative MME thresholds, are determined by the plan taking into consideration clinical guidelines, regulatory/state requirements, utilization and P&T Committee feedback.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and reauthorization based solely on prevoius claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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5. MS Contin [package insert]. Stanford, CT. Purdue Pharma; March 2021.
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7. Oxymorphone Extended Release [package insert]. Brookhaven, NY. Amneal Pharmaceuticals of NY; June 2022.
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5 . Revision History

Date	Notes
3/11/2024	Removed references to brand Duragesic and Zohydro ER as they ar e off the market.

Lonsurf

Prior Authorization Guideline

Guideline ID	GL-144901
Guideline Name	Lonsurf
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	04/20/2022 ; 08/19/2022 ; 04/19/2023 ; 4/17/2024

1 . Indications

Drug Name: Lonsurf (trifluridine/tipiracil)
Colorectal cancer Indicated for the treatment of patients with metastatic colorectal cancer as a single agent or in combination with bevacizumab who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and if RAS wild-type, an anti-EGFR therapy. **Gastric cancer** Indicated for the treatment of patients with metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.

2 . Criteria

Product Name: Lonsurf [a]	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced or metastatic colorectal cancer (mCRC)

AND

2 - History of failure, contraindication, or intolerance to treatment with ALL of the following^:

- Fluoropyrimidine-based chemotherapy
- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy
- Anti-VEGF biological therapy

AND

3 - ONE of the following:

3.1 Tumor is RAS mutant-type

OR

3.2 BOTH of the following:

- Tumor is RAS wild-type
- History of failure, contraindication, or intolerance to anti-EGFR therapy^

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may ap

	ply. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Lonsurf [a]	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lonsurf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lonsurf [a]	
Diagnosis	Gastric/Gastroesophageal Junction Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Unresectable locally advanced, recurrent, or metastatic gastric cancer
- Unresectable locally advanced, recurrent, or metastatic gastroesophageal junction adenocarcinoma

AND

2 - History of failure, contraindication, or intolerance to treatment with at least TWO prior lines of chemotherapy that consisted of the following agents^:

- Fluoropyrimidine (e.g, fluorouracil)
- Platnium (e.g., carboplatin, cisplatin, oxaliplatin)
- Taxane (e.g, docetaxel, paclitaxel) or irinotecan
- HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Lonsurf [a]	
Diagnosis	Gastric/Gastroesophageal Junction Adenocarcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lonsurf [a]	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Lonsurf will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lonsurf [a]	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Lonsurf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Lonsurf (trifluridine/tipiracil) is a combination of trifluridine, a nucleoside metabolic inhibitor, and tipiracil, a thymidine phosphorylase inhibitor, indicated for the treatment of adult patients with: • Metastatic colorectal cancer as a single agent or in combination with bevacizumab who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and if RAS wild-type, an anti-EGFR therapy. • Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a

platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy.

In addition, the National Cancer Comprehensive Network (NCCN) also recommends the use of colon, appendiceal, or rectal cancer as second-line and subsequent therapy as a single agent, or in combination with bevacizumab (preferred), for advanced or metastatic disease (proficient mismatch repair/microsatellite-stable [pMMR/MSS], or ineligible for, or progressed on, checkpoint inhibitor immunotherapy for deficient mismatch repair/microsatellite instability-high [dMMR/MSI-H] or polymerase epsilon/delta [POLE/POLD1] mutation not previously treated with Lonsurf in patients who have progressed through all available regimens besides Fruzaqla, Stivarga, or Lonsurf with or without bevacizumab.

Additional Clinical Programs:

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Lonsurf [package insert]. Cambridge, MA: ARIAD Pharmaceuticals, Inc.; August 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org. Accessed February 19, 2024.

5 . Revision History

Date	Notes
3/27/2024	Annual review. Updated background for FDA indications and NCCN r ecommendations. Updated diagnostic criteria for colorectal cancer. U pdated gastric/gastroesophageal junction adenocarcinoma diagnosti c criteria. Updated references.

Lorbrena

Prior Authorization Guideline

Guideline ID	GL-141052
Guideline Name	Lorbrena
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 02/18/2022 ; 08/19/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Lorbrena (lorlatinib)
Non-small cell lung cancer (NSCLC) Indicated for the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC).

2 . Criteria

Product Name: Lorbrena [a]	
Diagnosis	Non-small cell lung cancer (NSCLC)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of NSCLC

AND

2 - ONE of the following:

2.1 Disease is BOTH of the following:

- Advanced, metastatic, or recurrent
- Anaplastic lymphoma kinase (ALK) - positive

OR

2.2 BOTH of the following:

2.2.1 Disease is BOTH of the following:

- Recurrent, advanced, or metastatic
- ROS proto-oncogene 1 (ROS1) - positive

AND

2.2.2 Disease has progressed on at least ONE of the following therapies^:

- Rozlytrek (entrectinib)
- Xalkori (crizotinib)
- Zykadia (ceritinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines

Product Name: Lorbrena [a]	
Diagnosis	Non-small cell lung cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lorbrena therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lorbrena [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Erdheim-Chester Disease (ECD) **AND** **2** - Disease is BOTH of the following: • Symptomatic, relapsed, or refractory • ALK-positive	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lorbrena [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lorbrena therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lorbrena [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of inflammatory myofibroblastic tumor (IMT) with ALK translocation	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Lorbrena [a]	
Diagnosis	Soft Tissue Sarcoma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lorbrena therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lorbrena [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of uterine sarcoma

AND

2 - Disease is ONE of the following:

- Advanced
- Recurrent/metastatic
- Inoperable

AND

3 - Disease is ALK-positive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lorbrena [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lorbrena therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lorbrena [a]	
Diagnosis	Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Anaplastic large cell lymphoma (ALCL)
- Large B-Cell lymphoma

AND

2 - Disease is relapsed or refractory **AND** **3** - Disease is ALK-positive
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lorbrena [a]	
Diagnosis	Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Lorbrena therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lorbrena [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Lorbrena will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lorbrena [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Lorbrena therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Lorbrena (lorlatinib) is a kinase inhibitor indicated for the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC). In addition, the National Cancer Comprehensive Network (NCCN) recommends Lorbrena for the treatment of patients with ALK-positive recurrent and advanced NSCLC and in patients with ROS1 rearrangement positive recurrent, advanced, or metastatic NSCLC.

The use of Lorbrena is also recommended by the NCCN for the treatment of Erdheim-Chester Disease (ECD) with symptomatic or relapsed/refractory disease, treatment of advanced, recurrent/metastatic, or inoperable uterine sarcoma, treatment of limited and extensive brain metastases in patients with ALK rearrangement-positive NSCLC, treatment of inflammatory myofibroblastic tumor (IMT) with ALK translocation, and treatment of relapsed or refractory ALK-positive peripheral T-Cell and large B-Cell lymphoma.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Lorbrena [package insert]. New York, NY: Pfizer Labs, April 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed December 26, 2023.

5 . Revision History

Date	Notes
2/2/2024	Annual review. Updated NSCLC section to include Xalkori per NCCN recommendations. Added criteria for NCCN recommended use of Lorbrena in uterine sarcoma, peripheral T-Cell lymphoma and large B-cell lymphoma. Updated background and references.

Lotronex

Prior Authorization Guideline

Guideline ID	GL-107956
Guideline Name	Lotronex
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	8/1/2022
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 6/15/2022

1 . Indications

Drug Name: Lotronex (alosetron)
Severe diarrhea-predominant irritable bowel syndrome (IBS) Indicated only for use in women with severe diarrhea-predominant irritable bowel syndrome (IBS) who have chronic IBS, had anatomical or biochemical abnormalities of the gastrointestinal tract excluded and have not responded to conventional therapy.

2 . Criteria

Product Name: Brand Lotronex, alosetron (generic Lotronex) [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) with symptoms for at least six months **AND** **2** - Patient was female at birth **AND** **3** - Has not responded adequately to conventional therapy (e.g., loperamide, antispasmodics) **AND** **4** - Anatomic or biochemical abnormalities of the GI tract have been excluded	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Lotronex, alosetron (generic Lotronex) [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. Supply limits may be in place. **Background** Lotronex (alosteron) is indicated only for use in women with severe diarrhea-predominant irritable bowel syndrome (IBS) who have chronic IBS, had anatomical or biochemical abnormalities of the gastrointestinal tract excluded and have not responded to conventional therapy. [1]

4 . References

1. Lotronex [package insert]. San Diego, CA: Promethus Therapeutics and Diagnostics; April 2019.

5 . Revision History

Date	Notes
6/8/2022	Off-cycle review to align with commercial line of business. Added req uirements for exclusion of anatomic or biochemical abnormalities of GI tract. Updated references.

Lovaza, Vascepa

Prior Authorization Guideline

Guideline ID	GL-144145
Guideline Name	Lovaza, Vascepa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/14/2021
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 03/16/2022 ; 03/15/2023 ; 01/17/2024 ; 3/20/2024

1 . Indications

Drug Name: Lovaza (omega-3-acid ethyl esters), Vascepa (icosapent ethyl)
Severe Hypertriglyceridemia Indicated as adjunctive therapy to diet and exercise to reduce triglyceride (TG) levels in adult patients with severe (≥ 500 mg/dL) hypertriglyceridemia.
Drug Name: Vascepa (icosapent ethyl)
Cardiovascular Risk Reduction Indicated as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated triglyceride (TG) levels (≥ 150 mg/dL) and either established cardiovascular disease or diabetes mellitus and 2 or more additional risk factors for cardiovascular disease.

2 . Criteria

Product Name: Brand Vascepa, generic icosapent ethyl, Brand Lovaza, generic omega-3-acid ethyl esters [a]	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of severe hypertriglyceridemia (pre-treatment triglyceride level of greater than or equal to 500 mg/dL) **AND** **2** - Patient is on an appropriate lipid-lowering diet and exercise regimen	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Vascepa, generic icosapent ethyl, Brand Lovaza, generic omega-3-acid ethyl esters [a]	
Diagnosis	Severe Hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

AND

2 - Patient is on an appropriate lipid-lowering diet and exercise regimen

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Vascepa, generic icosapent ethyl [a]	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypertriglyceridemia (pre-treatment triglyceride level of greater than or equal to 150 mg/dL)

AND

2 - Patient is receiving maximally tolerated statin therapy

AND

3 - Used to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization

AND

4 - ONE of the following:

4.1 Established cardiovascular disease (CVD)

OR

4.2 BOTH of the following:

4.2.1 Diagnosis of diabetes mellitus

AND

4.2.2 TWO additional risk factors for cardiovascular disease, for example:

- Men greater than or equal to 55 years and women greater than or equal to 65 years
- Cigarette smoker or stopped smoking within the past 3 months
- Hypertension (pretreatment blood pressure greater than or equal to 140 mmHg systolic or greater than or equal to 90 mmHg diastolic)
- HDL-C less than or equal to 40 mg/dL for men or less than or equal to 50 mg/dL for women
- High-sensitivity C-reactive protein greater than 3.0 mg/L
- Creatinine clearance greater than 30 and less than 60 mL/min
- Retinopathy
- Micro- or macro-albuminuria
- Ankle-brachial index (ABI) less than 0.9 without symptoms of intermittent claudication

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Vascepa, generic icosapent ethyl [a]	
Diagnosis	Cardiovascular Risk Reduction
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND **2** - Patient is receiving maximally tolerated statin therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

3 . Background

Benefit/Coverage/Program Information
Background: Lovaza (omega-3-acid ethyl esters) and Vascepa are indicated as adjunctive therapy to diet and exercise to reduce triglyceride (TG) levels in adult patients with severe (greater than or equal to 500 mg/dL) hypertriglyceridemia. Vascepa is also indicated as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated triglyceride (TG) levels (greater than or equal to 150 mg/dL) and either established cardiovascular disease or diabetes mellitus and 2 or more additional risk factors for cardiovascular disease. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Vascepa [package insert]. Bridgewater, NJ : Amarin Pharma Inc.; September 2021.
2. Lovaza [package insert]. Wixom, MI: Woodward Pharma Services LLC; February 2021.

3. Orringer, CE, Jacobson, TA, Maki, KC. National Lipid Association Scientific Statement on the use of icosapent ethyl in statin-treated patients with elevated triglycerides and high or very-high ASCVD risk. J Clin Lipidol. 2019;13(6):860-72.

5 . Revision History

Date	Notes
3/11/2024	Annual review. Updated references.

Prior Authorization Guideline

Guideline ID	GL-154481
Guideline Name	Medical Foods, Nutritional Supplements, Enteral Nutrition
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 04/19/2023 ; 08/18/2023 ; 9/18/2024

1 . Criteria

Product Name: RCF, Calcilo XD, Phenex Chews, Cyclinex-1, Cyclinex-2, Elecare, Elecare DHA/ARA Infant, Elecare JR, Elecare/DHA/ARA, Glutarex-1, Glutarex-2, Hominex-1, Hominex-2, I-Valex-1, I-Valex-2, Ketonex-1, Ketonex-2, Phenex-1, Phenex-2, Propimex-1, Propimex-2, Provimin, Tyrex-1, Tyrex-2, Puramino DHA/ARA, Alfamino Infant, Neocate Syneo Infant, Neocate Nutra, Neocate Infant DHA/ARA [a]	
Approval Length	12 month(s)
Guideline Type	Non Formulary
Approval Criteria	

1 - Being used as part of disease or disorder specific treatment

AND

2 - Requested product has been proven effective for the patient's specific disease or disorder. This includes, but is not limited to:

2.1 Inherited diseases of amino acid and/or organic acid metabolism (e.g., glutaric aciduria type I, vitamin B6-nonresponsive homocystinuria or hypermethioninemia, disorder of leucine catabolism, PKU, MSUD, propionic or methylmalonic acidemia, tyrosinemia types I, II, or III)

OR

2.2 Patients who require a formula modified in carbohydrate, fat, and/or increased protein: abetalipoproteinemia; cholestasis; chylothorax; fatty acid oxidation defects; glutaric aciduria type II; hyperlipoproteinemia type I (fasting chylomicronemia); hypobetalipoproteinemia; lymphangiectasis, intestinal malabsorption of carbohydrate and/or fat; supplement for any patient who requires increased protein, minerals, and vitamins; X-linked adrenoleukodystrophy

OR

2.3 Hypercalcemia, as may occur in infants with Williams syndrome, osteopetrosis, and primary neonatal hyperparathyroidism

OR

2.4 Urea cycle disorder, gyrate atrophy of the choroid and retina, or HHH syndrome

OR

2.5 ONE of the following:

2.5.1 Infants or children who cannot tolerate intact or hydrolyzed protein, or unable to tolerate the type or amount of carbohydrate in milk or infant formulas

OR **2.5.2** The child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk **OR** **2.6** Infants or children with multiple, severe food allergies **OR** **2.7** Immunoglobulin E and non-immunoglobulin E-mediated allergies to multiple food proteins **OR** **2.8** Severe food protein induced enterocolitis syndrome **OR** **2.9** Eosinophilic disorders **OR** **2.10** Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: The intent of this program is to provide coverage for specialized foods (including nutritional supplements), for specific medical conditions, including, but not limited to, inherited enzymatic disorders, inherited metabolic diseases, severe protein allergic conditions, severe protein induced enterocolitis, eosinophilic disorders, impaired absorption disorders, conditions requiring amino acid-based modified elemental formulas, and formulas necessary for phenylketonuria. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

3 . References

1. Abbott Nutrition [package inserts]. 100 Abbott Park Road, Abbott Park, Ill. 60064; August 2020

4 . Revision History

Date	Notes
9/6/2024	Updated background

Prior Authorization Guideline

Guideline ID	GL-147304
Guideline Name	Mekinist
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	03/16/2022 ; 08/19/2022 ; 05/25/2023 ; 06/21/2023 ; 5/17/2024

1 . Indications

Drug Name: Mekinist
Melanoma Indicated, as a single agent in BRAF-inhibitor treatment-naïve patients or in combination with dabrafenib, for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations. Mekinist is also indicated, in combination with dabrafenib, for the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations and involvement of lymph node(s) following complete resection. **Non-small cell lung cancer** Indicated, in combination with dabrafenib, for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation. **Anaplastic thyroid cancer** Indicated, in combination with dabrafenib, for the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options. **Solid Tumors** Indicated for the treatment of adult and pediatric patients 6 years of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have

progressed following prior treatment and have no satisfactory alternative treatment options.

BRAF V600E Mutation-Positive Low-Grade Glioma Indicated, in combination with Tafinlar, for the treatment of pediatric patients 1 year of age and older with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy

Other Uses: The National Comprehensive Cancer Network (NCCN) also recommends use of Mekinist in combination with Tafinlar for the adjuvant treatment of anaplastic thyroid cancer with BRAF V600E mutations following resection; for the treatment of follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation; for the treatment of central nervous system (CNS) cancer in patients with melanoma or infiltrative supratentorial astrocytoma/oligodendroglioma; distant metastatic uveal melanoma; epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer with persistent disease, recurrence in BRAF V600E positive tumors, or recurrence of low-grade serous carcinoma; pancreatic and ampullary adenocarcinomas if BRAF V600E mutation positive; and BRAF V600E mutation positive histiocytic neoplasms and hepatobiliary cancers.

2 . Criteria

Product Name: Mekinist [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 ONE of the following:

1.1.1 Unresectable melanoma

OR

1.1.2 Metastatic melanoma

OR

1.1.3 BOTH of the following:

- Prescribed as adjuvant therapy for melanoma involving the lymph node(s)
- Used in combination with Tafinlar (dabrafenib)

AND

1.2 Cancer is positive for BRAF V600 mutation

OR

2 - Distant metastatic uveal melanoma

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Tafinlar (dabrafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of anaplastic thyroid cancer (ATC)

AND

1.2 Cancer is positive for BRAF V600E mutation

AND

1.3 Used in combination with Tafinlar (dabrafenib)

AND

1.4 ONE of the following:

1.4.1 Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

OR

1.4.2 Prescribed as adjuvant therapy following resection

OR

2 - ALL of the following:

2.1 ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

AND **2.5** Cancer is positive for BRAF V600 mutation **AND** **2.6** Used in combination with Tafinlar (dabrafenib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient has metastatic brain lesions
- Mekinist is active against primary tumor (melanoma)

OR

1.2 Patient has a glioma

AND

2 - Cancer is positive for BRAF V600E mutation

AND

3 - Used in combination with Tafinlar (dabrafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial Ovarian Cancer
- Fallopian Tube Cancer
- Primary Peritoneal Cancer

AND

2 - ONE of the following:

- Persistent disease
- Recurrence in BRAF V600E positive tumors
- Recurrence of low-grade serous carcinoma

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic Cholangiocarcinoma
- Intrahepatic Cholangiocarcinoma

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND **4** - Cancer is positive for BRAF V600E mutation **AND** **5** - Used in combination with Tafinlar (dabrafenib)
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Langerhans Cell Histiocytosis
- Erdheim-Chester Disease
- Rosai-Dorfman Disease

AND

2 - Mitogen-activated protein (MAP) kinase pathway mutation, no detectable mutation, or testing not available

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Presence of solid tumor

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E mutation

AND

5 - Used in combination with Tafinlar (dabrafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Pancreatic Cancer / Ampullary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Pancreatic adenocarcinoma
- Ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

AND

3 - Cancer is positive for BRAF V600E mutation

AND **4** - Used in combination with Tafinlar (dabrafenib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Pancreatic Cancer / Ampullary Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following:	

• Diagnosis of hairy cell leukemia • Used in combination with Tafinlar (dabrafenib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of salivary gland tumor	

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable
- Metastatic

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Tafinlar (dabrafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of BRAF V600E-mutated GIST

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Progressive
- Recurrent
- Metastatic

AND

3 - Used in combination with Tafinlar (dabrafenib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Mekinist therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Mekinist will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mekinist [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Mekinist therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Mekinist (trametinib) is a kinase inhibitor indicated as a single agent or in combination with Tafinlar (dabrafenib) for treatment of patients with unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutations as detected by an FDA-approved test. It is also indicated in combination with Tafinlar for the treatment of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA approved test, for the adjuvant treatment of melanoma with BRAF V600E or BRAF V600K mutations, as detected by an FDA-approved test, involving the lymph nodes following resection, and for the treatment of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation with no satisfactory locoregional treatment options, and for the treatment of adult and pediatric patients 6 years of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options. The latter indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s). [1] Mekinist, in combination with Tafinlar, is also indicated for the treatment of pediatric patients 1 year of age and older with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy. The National Comprehensive Cancer Network (NCCN) also recommends use of Mekinist in combination with Tafinlar for the adjuvant treatment of anaplastic thyroid cancer with BRAF V600E mutations following resection; for the treatment of follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation; for the treatment of central nervous system (CNS) cancer in patients with melanoma or infiltrative supratentorial astrocytoma/oligodendroglioma; distant metastatic uveal melanoma; epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer with persistent disease, recurrence in BRAF V600E positive tumors, or recurrence of low-grade serous carcinoma; pancreatic and

ampullary adenocarcinomas if BRAF V600E mutation positive; and BRAF V600E mutation positive histiocytic neoplasms and hepatobiliary cancers. [2]

Information on FDA-approved tests for the detection of BRAFV600 mutations in melanoma may be found at: http://www.fda.gov/CompanionDiagnostics. [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Mekinist [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available atwww.nccn.org. Accessed April 16, 2024.

5 . Revision History

Date	Notes
5/15/2024	Added coverage criteria for hairy cell leukemia, salivary gland tumor, and GIST per NCCN. Updated background and references.

Menopur

Prior Authorization Guideline

Guideline ID	GL-148646
Guideline Name	Menopur
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	06/15/2022 ; 09/21/2022 ; 12/14/2022 ; 06/21/2023 ; 08/18/2023 ; 04/17/2024 ; 6/17/2024

1 . Indications

Drug Name: Menopur (menotropins)
Development of multiple follicles and pregnancy in ovulatory women Indicated for the development of multiple follicles and pregnancy in ovulatory women participating in an assisted reproductive technology (ART) program. **Induction of spermatogenesis** Used for induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. **Off Label Uses:** **Ovulation induction** Used for the treatment of ovulation induction in women with ovulatory dysfunction including polycystic ovary syndrome (PCOS) who failed on clomiphene as well as for ovulation induction in the setting of hypogonadotropic hypogonadism.

2 . Criteria

Product Name: Menopur [a]	
Diagnosis	Ovulation Induction
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ovulatory dysfunction

AND

2 - ONE of the following exists:

- Anovulation
- Oligo-ovulation
- Amenorrhea

AND

3 - Other specific causative factors (e.g., thyroid disease, hyperprolactinemia) have been excluded or treated

AND

4 - Infertility is not due to primary ovarian failure

AND

5 - For induction of ovulation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Menopur [a]	
Diagnosis	Controlled Ovarian Stimulation**
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of infertility **AND** **2** - Documentation of an approved assisted reproductive technology (ART) protocol	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Menopur [a]	
Diagnosis	Male Hypogonadotropic Hypogonadism**
Approval Length	2 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of male primary hypogonadotropic hypogonadism	

OR **2** - Diagnosis of male secondary hypogonadotropic hypogonadism	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina, Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: This program is designed to provide coverage for these medications to be used in conjunction with Assisted Reproductive Technologies (ART, i.e., in vitro fertilization). Menopur (menotropins) is indicated for the development of multiple follicles and pregnancy in ovulatory women participating in an assisted reproductive technology (ART) program. [3] hMG is used for the treatment of ovulation induction in women with ovulatory dysfunction including polycystic ovary syndrome (PCOS) who failed on clomiphene as well as for ovulation induction in the setting of hypogonadotropic hypogonadism. hMG is also used for induction of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. [4-13] The clinically appropriate dosing for hMG agents when used in an ART cycle without an FSH product is 450 IU/day or less for not more than 14 days of treatment. When used as part of a mixed stimulation protocol (hMG + FSH) or when used alone for ovulation induction or controlled ovarian stimulation the clinically appropriate maximum dosing for hMG agents is 225 IU/day and 150 IU/day respectively. Exceeding this daily dose and duration of treatment has not been proven to be efficacious in terms of pregnancy outcome. [9,13] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. World Health Organization web site. https://www.who.int/health-topics/infertility#tab=tab. Accessed May 3, 2024.
2. American Society for Reproductive Medicine. Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertil Steril 2013; Jan 99(1):63.
3. Menopur [package insert]. Parsippany, NJ: Ferring Pharmaceuticals, Inc.; May 2018.
4. Platteau P, Andersen AN, Balen A, et al. Similar ovulation rates, but different follicular development with highly purified menotrophin compared with recombinant FSH in WHO Group II anovulatory infertility: a randomized controlled study. Hum. Reprod. 2006;21:1798-1804.
5. Kelly AC, Jewlewicz R. Alternate regimens for ovulation induction in polycystic ovarian disease. Fertil Steril. 1990;54;195-202.
6. Muasher SJ. Use of gonadotrophin-releasing hormone agonists in controlled ovarian hyperstimulation for in vitro fertilization. Clin Ther 1992;14(Suppl A):74-86.
7. Ferraretti A, Marca A, Fauser B, et al. ESHRE consensus on the definition of 'poor response' to ovarian stimulation for in vitro fertilization: the Bologna criteria. Human Reprod 2011; 26: 1616-24.
8. Andoh K, Mizunuma H, Liu X, et al. A comparative study of fixed-dose, stepdown, and low-dose step-up regimens of human menopausal gonadotropin for patients with polycystic ovary syndrome. Fertil Steril m1998: 70; 840-846.
9. Pal L, Jindal S, Witt B, Santoro N. Less is more: increased gonadotropin use for ovarian stimulation adversely influences clinical pregnancy and live birth after in vitro fertilization. Fertil Steril 2008;89:1694-701.
10. Fauser B, Nargund G, Anderson A, et al. Mild ovarian stimulation for IVF: 10 years later. Human Reprod 2010; 25: 2678-84.
11. Baart E, Martini E, Eijkemans M, et al. Milder ovarian stimulation for in-vitro fertilization reduces aneuploidy in the human preimplantation embryo: a randomized controlled trial. Human Reprod 2007; 22: 980-8.
12. Sunkara S, Rittenberg V, Raine-Fenning N, et al. Association between the number of eggs and live birth in IVF treatment: an analysis of 400,135 treatment cycles. Human Reprod 2011; 26: 1768-74.
13. The Practice Committee of the American Society for Reproductive Medicine. Use of exogenous gonadotropins in anovulatory women: a technical bulletin. Fertil Steril 2008;90:S7–.
14. Practice Committees of the American Society for Reproductive Medicine and Society for Reproductive Endocrinology and Infertility. Electronic address: asrm@asrm.org. Use of exogenous gonadotropins for ovulation induction in anovulatory women: a committee opinion. Fertil Steril. 2020;113(1):66-70. doi:10.1016/j.fertnstert.2019.09.020

5 . Revision History

Date	Notes
6/19/2024	Annual review, updated reference.

Motofen

Prior Authorization Guideline

Guideline ID	GL-154212
Guideline Name	Motofen
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	09/21/2022 ; 9/18/2024

1 . Indications

Drug Name: Motofen (difenoxin/atropine)
Diarrhea Indicated as adjunctive therapy in management of acute nonspecific diarrhea and acute exacerbations of chronic functional diarrhea.

2 . Criteria

Product Name: Motofen [a]	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used as adjunctive therapy

AND

2 - Used for the management of acute nonspecific diarrhea or acute exacerbations of chronic functional diarrhea

AND

3 - History of failure, contraindication, or intolerance to both of the following:

- diphenoxylate/atropine (generic Lomotil)
- loperamide

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Motofen is indicated as adjunctive therapy in management of acute nonspecific diarrhea and acute exacerbations of chronic functional diarrhea. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Motofen [package insert]. Roswell, GA: Sebela Pharmaceuticals Inc;December 2018.

5 . Revision History

Date	Notes
9/3/2024	Annual review, updated reference.

Prior Authorization Guideline

Guideline ID	GL-147497
Guideline Name	MS Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	12/16/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 05/20/2022 ; 09/21/2022 ; 12/14/2022 ; 02/17/2023 ; 02/17/2023 ; 01/17/2024 ; 5/17/2024

1 . Indications

Drug Name: Avonex and Rebif(interferon β-1a), Betaseron and Extavia(interferon β-1b), Plegridy(peginterferon β-1a), Copaxone and Glatopa(glatiramer acetate), Aubagio(teriflunomide)
Relasping forms of multiple sclerosis Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.
Drug Name: Mayzent (siponimod), Tecfidera (dimethyl fumarate), Bafiertam (monomethyl fumarate), Kesimpta (ofatumumab), Ponvory (Ponesimod), Vumerity (diroximel fumarate)
Relasping Forms of Multiple Sclerosis Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

Drug Name: Gilenya (fingolimod)
Relapsing forms of multiple sclerosis Indicated for the treatment of patients 10 years of age and older with relapsing forms of multiple sclerosis.
Drug Name: Mavenclad (cladribine)
Relapsing forms of multiple sclerosis Indicated for the treatment of relapsing forms of multiple sclerosis, including relapsing-remitting (RRMS) and active secondary progressive disease in adults who have had inadequate response or are intolerant to other therapies for multiple sclerosis.
Drug Name: Tascenso ODT (fingolimod)
Relapsing forms of multiple sclerosis Indicated for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in pediatric patients 10 years of age and older.

2 . Criteria

Product Name: Brand Aubagio, generic teriflunomide, Avonex, Avonex Pen, Bafiertam, Betaseron, Brand Copaxone, generic glatiramer, Extavia, Brand Gilenya, generic fingolimod, Glatopa, Kesimpta, Mavenclad, Mayzent, Plegridy, Plegridy Pen, Ponvory, Rebif, Tascenso ODT, Brand Tecfidera, generic dimethyl fumerate, Vumerity [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of multiple sclerosis (MS)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. **Background:** Aubagio (teriflunomide), Avonex (interferon β-1a), Bafiertam (monomethyl fumarate), Betaseron (interferon β-1b), Copaxone (glatiramer acetate), Extavia (interferon β-1b), Glatopa (glatiramer acetate), Kesimpta (ofatumamab), Mayzent (siponimod), Plegridy (Peginterferon Beta-1a), Ponvory (ponesimod), Rebif (interferon β-1a), Tecfidera (dimethyl fumarate), and Vumerity (diroximel fumarate) are indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. [1-3, 5, 6] Mavenclad (cladribine) is indicated for the treatment of relapsing forms of multiple sclerosis, including relapsing-remitting (RRMS) and active secondary progressive disease in adults who have had inadequate response or are intolerant to other therapies for multiple sclerosis. Mavenclad is also indicated for the treatment of active hairy cell leukemia as defined by clinically significant anemia, neutropenia, thrombocytopenia, or disease-related symptoms. Gilenya (fingolimod) is indicated for the treatment of patients with relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in patients 10 years of age and older. [4] Tascenso ODT™ (fingolimod) is indicated for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in pediatric patients 10 years of age and older. [16] Due to the risk of a decrease in heart rate and/or atrioventricular conduction after the first dose of Gilenya, all patients should be observed for signs and symptoms of bradycardia for at least 6 hours after their first dose. First-dose monitoring should also be performed when restarting Gilenya after discontinuation for more than 14 days and with dose increases. Novartis, the manufacturer of Gilenya, provides a First-Dose Observation program at no cost to the patient through the GILENYA Go Program. To find a first-dose observation center, visit http://www.gilenya.com/c/ms-pill/first-day or http://maps.concentra.com/gilenya-fdo/.

4 . References

1. Avonex [package insert]. Cambridge, MA: Biogen Inc.; July 2023.
2. Rebif [package insert]. Rockland, MA: EMD Serono Inc; July 2023.
3. Betaseron [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; July 2023.
4. Copaxone [package insert]. Parsippany, NJ: Teva Pharmaceuticals USA, Inc.; November 2023.
5. Extavia [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; July 2023.
6. Gilenya [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp.; August 2023.
7. Aubagio [package insert]. Cambridge, MA: Genzyme Corporation; December 2022.
8. Tecfidera [package insert]. Cambridge, MA: Biogen Inc.; March 2024.
9. Plegridy [package insert]. Cambridge, MA: Biogen Inc; July 2023.
10. Glatopa [package insert]. Princeton, NJ: Sandoz Inc.; December 2023.
11. Mayzent [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; August 2023.
12. Mavenclad [package insert]. Rockland, MA: EMD Serono Inc; August 2023.
13. Vumerity [package insert]. Cambridge, MA: Biogen Inc.; March 2024.
14. Bafiertam [package insert]. High Point, NC: Banner Life Sciences LLC; December 2023.
15. Kesimpta [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; January 2024.
16. Ponvory [package insert]. Titusville, NJ: Janssen Pharmaceuticals Inc; August 2023.
17. Tascenso ODT [package insert]. San Jose, CA: Handa Neuroscience, LLC; August 2023.

5 . Revision History

Date	Notes
5/17/2024	Annual review, added SML and updated references.

Mulpleta

Prior Authorization Guideline

Guideline ID	GL-120452
Guideline Name	Mulpleta
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021

1 . Indications

Drug Name: Mulpleta
Thrombocytopenia Indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure.

2 . Criteria

Product Name: Mulpleta	
Diagnosis	Thrombocytopenia
Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of thrombocytopenia

AND

2 - Patient has chronic liver disease

AND

3 - Patient is scheduled to undergo a procedure

3 . Background

Benefit/Coverage/Program Information
Background: Mulpleta (lusutrombopag) is a thrombopoietin receptor agonist indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Mulpleta [Package Insert]. Florham Park, NJ: Shionogi, Inc.; April 2019.

5 . Revision History

Date	Notes
1/25/2023	No criteria changes. Moved from non-specialty to specialty formulary.

Multaq

Prior Authorization Guideline

Guideline ID	GL-113387
Guideline Name	Multaq
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2022
P&T Approval Date:	8/14/2020
P&T Revision Date:	07/21/2021 ; 9/21/2022

1 . Indications

Drug Name: Multaq (dronedarone)
Atrial fibrillation Indicated to reduce the risk of hospitalization for atrial fibrillation in patients in sinus rhythm with a history of paroxysmal or persistent atrial fibrillation.

2 . Criteria

Product Name: Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following criteria:

1.1.1 Diagnosis of a history of one of the following:

- Paroxysmal atrial fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

AND

1.1.2 One of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.1.3 Patient has none of the following:

- NYHA Class IV heart failure
- Symptomatic heart failure with recent decompensation requiring hospitalization

OR

1.2 For continuation of current therapy

3 . Background

Benefit/Coverage/Program Information
Background:

Multaq is an antiarrhythmic drug indicated to reduce the risk of hospitalization for atrial fibrillation in patients in sinus rhythm with a history of paroxysmal or persistent atrial fibrillation.

Multaq carries a black box warning for increased risk of death, stroke, and heart failure in patients with decompensated heart failure or permanent atrial fibrillation. It is contraindicated in patients with symptomatic heart failure with recent decompensation requiring hospitalization or NYHA Class IV heart failure, as Multaq doubles the risk of death in these patients. Multaq is also contraindicated in patients in atrial fibrillation who will not or cannot be cardioverted into normal sinus rhythm. In patients with permanent atrial fibrillation, Multaq doubles the risk of death, stroke and hospitalization for heart failure.

Patients currently on Multaq therapy will be allowed to remain on therapy.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place

4 . References

1. Multaq [package insert]. Bridgewater, NJ: Sanofi-Aventis U.S LLC; November 2020.
2. ACC/AHA/ESC Guidelines for the Management of Patients with Atrial Fibrillation: Executive Summary: A Repot of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and the Heart Rhythm Society. Circulation 2014; 130:e199.
3. American College of Cardiology. 2019 AHA/ACC/HRS Focused Update of the 2014 AHA/ACC/HRS Guideline for the Management of Patients with Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Rhythm Society. J Am Coll Cardiol. 2019 Jul 9;74(1):104-132.

5 . Revision History

Date	Notes
9/14/2022	Annual review, updated references.

Myalept

Prior Authorization Guideline

Guideline ID	GL-148647
Guideline Name	Myalept
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 05/20/2022 ; 06/21/2023 ; 6/17/2024

1 . Indications

Drug Name: Myalept (metreleptin)
Generalized lipodystrophy Indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. [1]

2 . Criteria

Product Name: Myalept [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency

AND

2 - Myalept is being used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

AND

4 - Patient has at least ONE of the following:

4.1 Diabetes mellitus or insulin resistance with persistent hyperglycemia (HgbA1C greater than 7.0) despite BOTH of the following:

- Dietary intervention
- Optimized insulin therapy at maximum tolerated doses

OR

4.2 Persistent hypertriglyceridemia (TG greater than 250) despite BOTH of the following:

- Dietary intervention
- Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Myalept [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Myalept therapy **AND** **2** - Myalept is being used as an adjunct to diet modification **AND** **3** - Prescribed by an endocrinologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

Background:

Myalept (metreleptin) is a leptin analog indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. [1]

Limitations of Use:

- The safety and effectiveness of Myalept for the treatment of complications of partial lipodystrophy have not been established.
- The safety and effectiveness of Myalept for the treatment of liver disease, including nonalcoholic steatohepatitis (NASH), have not been established.
- Myalept is not indicated for use in patients with HIV-related lipodystrophy.
- Myalept is not indicated for use in patients with metabolic disease, without concurrent evidence of generalized lipodystrophy.

Myalept is available only through a restricted distribution program under a Risk Evaluation and Mitigation Strategy (REMS), called the Myalept REMS program, because of the risks associated with the development of anti-metreleptin antibodies that neutralize endogenous leptin and the risk of lymphoma.

4 . References

1. Myalept [package insert]. Amryt Pharmaceuticals, Inc. Cambridge, MA. February 2022.
2. Handelsman Y, Oral EA, Bloomgarden ZT, et al. The clinical approach to the detection of lipodystrophy - an AACE consensus statement. Endocrine Practice 2013;19(1):107-116.
3. Garg A. Acquired and inherited lipodystrophies. N Engl J Med 2004;350:1220-1234.
4. Garg A. Lipodystrophies: genetic and acquired body fat disorders. J Clin Endocrinol and Metab 2011;96(11):3313-3325.
5. Chan JL, Lutz K, Cochran E, et al. Clinical effects of long-term metreleptin treatment in patients with lipodystrophy. Endocr Pract. 2011;17(6):922-932.

5 . Revision History

Date	Notes
6/19/2024	Annual review with no changes to coverage criteria. Updated backgr ound.

Mytesi

Prior Authorization Guideline

Guideline ID	GL-133820
Guideline Name	Mytesi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	10/18/2023
P&T Revision Date:	

1 . Indications

Drug Name: Mytesi (crofelemer)
HIV/AIDS associated diarrhea Mytesi (crofelemer) is an anti-diarrheal indicated for the symptomatic relief of non-infectious diarrhea in adult patients with HIV/AIDS on anti-retroviral therapy. Ruling out infectious etiologies of diarrhea is required for the appropriate use of Mytesi. [1]

2 . Criteria

Product Name: Mytesi [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of HIV/AIDS associated diarrhea **AND** **2** - Patient is on antiretroviral therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Mytesi [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Mytesi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Mytesi (crofelemer) is an anti-diarrheal indicated for the symptomatic relief of non-infectious diarrhea in adult patients with HIV/AIDS on anti-retroviral therapy. Ruling out infectious etiologies of diarrhea is required for the appropriate use of Myesi.[1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Mytesi [package insert]. San Francisco, CA: Napo Pharmaceuticals, Inc; November 2020.

5 . Revision History

Date	Notes
9/26/2023	New guideline.

Natpara

Prior Authorization Guideline

Guideline ID	GL-154484
Guideline Name	Natpara
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 08/19/2022 ; 09/20/2023 ; 9/18/2024

1 . Indications

Drug Name: Natpara (parathyroid hormone analog)
Hypocalcemia associated with hypoparathyroidism Indicated as an adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism.

2 . Criteria

Product Name: Natpara [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism **AND** **2** - Patient is currently on adequate supplemental calcium and active vitamin D (e.g., calcitriol) therapy as evidenced by serum calcium (albumin corrected) greater than 7.5 mg/dL **AND** **3** - Prescribed by ONE of the following: • Endocrinologist • Nephrologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Natpara [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response [e.g., total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 8.5 mg/dL)] **AND**	

2 - Patient continues to take concomitant calcium supplementation that is sufficient to meet daily requirements **AND** **3** - Prescribed by ONE of the following: • Endocrinologist • Nephrologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Natpara is a parathyroid hormone indicated as an adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism.[1] Limitations of Use: • Because of the potential risk of osteosarcoma, Natpara is recommended only for patients who cannot be well-controlled on calcium supplements and active forms of vitamin D alone. It is available only through a restricted program called the Natpara REMS Program. • Natpara was not studied in patients with hypoparathyroidism caused by calcium-sensing receptor mutations. • Natpara was not studied in patients with acute post-surgical hypoparathyroidism **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

4 . References

1. Natpara [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; February 2023..
2. Goltzman, David. Hypoparathyroidism. In: Post TW, ed. UpToDate. UpToDate; 2023. Accessed July 26, 2024.
3. Mannstadt, M, Clarke, BL, Vokes, T, et al. Efficacy and safety of recombinant human parathyroid hormone (1-84) in hypoparathyroidism (REPLACE): a double-blind, placebo-controlled, randomized, phase 3 study. The lancet Diabetes & endocrinology. 2013 Dec;1(4):275-83. PMID: 24622413

5 . Revision History

Date	Notes
9/6/2024	Annual review. Updated initial authorization criteria and initial authori zation duration to 12 months. Updated references.

Prior Authorization Guideline

Guideline ID	GL-134428
Guideline Name	New to Therapy (NTT) and Morphine Milligram Equivalents (MME)
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	9/15/2021
P&T Revision Date:	09/21/2022 ; 10/18/2023

1 . Criteria

Product Name: Requested opioid pain medication (Formulary and non-formulary)	
Diagnosis	New to Therapy: Criteria for Opioid Naïve Members. An opioid-naïve member is defined as not having filled an opioid in the past 60 days. Patients will be limited to a 7 day supply for their initial opioid fill
Approval Length	Authorization for cancer, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will be issued for the requested duration, not to exceed one month.
Guideline Type	Administrative

Approval Criteria

1 - Opioid naïve members (defined as not having filled an opioid in the past 60 days) may receive greater than the supply limit based on the following:

1.1 If the request is for greater than the supply limit ONE of the following:

- Cancer diagnosis
- End of life care, including hospice care
- Palliative care
- Sickle cell anemia
- Long term care
- A written or verbal statement is received from the requesting prescriber saying that it is medically necessary for the patient to take the opioid drug for more than 7 days

Notes	NOTE: This section applies to all formulary and non-formulary medications

Product Name: Morphine Milligram Equivalents (MME) Reviews: For Requests Exceeding the 90MME Cumulative Threshold^ (Formulary and non-formulary)	
Diagnosis	Cancer, Hospice, End of Life, Long-Term Care, Palliative Care, or Sickle Cell related pain
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Doses exceeding the cumulative morphine mg equivalent (MME) of 90 mg will be approved up to the requested amount for all opioid products if one of the following conditions is met:

- Cancer diagnosis
- End of life diagnosis, including hospice
- Sickle cell anemia diagnosis
- Long-term care
- Palliative care

Notes	^The authorization should be entered for an MME of 99999.99 so as to prevent future disruptions in therapy if the patient's dose is increased. NOTE: This section applies to all formulary and non-formulary medications

Product Name: Morphine Milligram Equivalents (MME) Reviews: For Requests Exceeding the 90MME Cumulative Threshold^ (Formulary and non-formulary)	
Diagnosis	Non-cancer, non-hospice, non-end of life, non-long-term care, non-palliative care, non-sickle cell related pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	MEDcDUR

Approval Criteria

1 - If the dose exceeds the maximum cumulative MME of 90mg, must meet ALL of the following:

1.1 Prescriber attest the patient has been screened for substance abuse/opioid dependence

AND

1.2 Treatment goals are defined and include estimated duration of treatment (must document treatment goals)

AND

1.3 Patient has been screened for underlying depression and/or anxiety. If applicable, any underlying conditions have been or will be addressed

AND

1.4 ONE of the following:

- Opioid medication doses of less than 90MME have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)
- Patient is new to plan and currently established on the requested MME for at least the past 30 days

Notes	^Authorization will be issued for 6 months for non-cancer/non-hospice /non-end of life/non-long-term care/non-palliative care/non-sickle cell r

	elated pain up to the current requested MME plus 90 MME. NOTE: If the member has been established on the requested MME do se for at least 30 days and does not meet the medical necessity autho rization criteria requirements, a denial should be issued and a maximu m 60-day authorization may be authorized one time for the requested MME dose. NOTE: This section applies to all formulary and non-formulary medica tions.

Product Name: Morphine Milligram Equivalents (MME) Reviews: For Requests Exceeding the 90MME Cumulative Threshold^ (Formulary and non-formulary)	
Diagnosis	Non-cancer, non-hospice, non-end of life, non-long-term care, non-palliative care, non-sickle cell related pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Administrative
Approval Criteria **1** - If the dose exceeds the maximum cumulative MME of 90mg, must meet ALL of the following: **1.1** Prescriber attest the patient has been screened for substance abuse/opioid dependence **AND** **1.2** Document rationale for not tapering or discontinuing opioid if treatment goals are not being met **AND** **1.3** Documented meaningful improvement in pain and function when assessed against treatment goals (Document improvement in function or pain score improvement)	
Notes	^Authorization will be issued for 6 months for non-cancer/non-hospice /non-end of life/non-long-term care/non-palliative care/non-sickle cell r elated pain up to the current requested MME plus 90 MME. NOTE: If the member has been established on the requested MME do se for at least 30 days and does not meet the medical necessity autho rization criteria requirements, a denial should be issued and a maximu

	m 60-day authorization may be authorized one time for the requested MME dose. NOTE: This section applies to all formulary and non-formulary medica tions.

2 . Background

Benefit/Coverage/Program Information
Background: UnitedHealthcare employs opioid safety edits at point-of-sale (POS) to prompt prescribers and pharmacists to conduct additional safety reviews to determine if the member's opioid use is appropriate and medically necessary. Development of opioid safety edit specifications, to include cumulative MME thresholds, are determined by the plan taking into consideration clinical guidelines, regulatory/state requirements, utilization and P&T Committee feedback. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and reauthorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

3 . References

1. Franklin GM. Opioids for chronic noncancer pain. A position paper of the American Academy of Neurology. Neurology. 2014;83:1277-1284.
2. Rosenquist EWK. Overview of the treatment of chronic pain. UptoDate. October 2014. http://www.uptodate.com/contents/overview-of-the-treatment-of-chronic-pain?source=search_result&search=long+acting+opioids&selectedTitle=1%7E150#H1
3. Argoff CE, Silvershein DI. A Comparison of Long- and Short-Acting Opioids for the Treatment of Chronic Noncancer Pain: Tailoring Therapy to Meet Patient Needs. Mayo Clin Proc. 2009;84(7):602-612.
4. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA. Published online March 15, 2016.
5. Spatar, SB. Standardizing the use of mental health screening instruments in patients with pain. Fed Pract. 2019 Oct; 36 (Suppl 6): S28-S30
6. Sullivan MD. Depression effects on long-term prescription opioid use, abuse, and addiction. Clin J Pain. 2018 Sep;34(9):878-884.

4 . Revision History

Date	Notes
10/6/2023	Updated background information and removed audit language.

Nexavar

Prior Authorization Guideline

Guideline ID	GL-154213
Guideline Name	Nexavar
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 09/21/2022 ; 09/20/2023 ; 9/18/2024

1 . Indications

Drug Name: Nexavar (sorafenib tosylate)
Renal cell carcinoma Indicated for the treatment of advanced renal cell carcinoma. **Hepatocellular carcinoma** Indicated for the treatment of unresectable hepatocellular carcinoma. **Thyroid carcinoma** Indicated for the treatment of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment.

2 . Criteria

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of renal cell carcinoma (RCC)

AND

2 - ONE of the following:

2.1 Disease has relapsed

OR

2.2 BOTH of the following:

- Medically or surgically unresectable tumor
- Diagnosis of Stage IV Disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hepatocellular carcinoma

AND

2 - ONE of the following:

2.1 Patient has metastatic disease

OR

2.2 Patient has extensive liver tumor burden

OR

2.3 Patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only)

OR

2.4 BOTH of the following:

- Patient is not a transplant candidate
- Disease is unresectable

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Hepatocellular Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.1.2 ONE of the following:

- Unresectable recurrent disease
- Persistent locoregional disease
- Metastatic disease

AND

1.1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.1.4 Disease is refractory to radioactive iodine treatment

OR

1.2 ALL of the following:

1.2.1 Diagnosis of medullary thyroid carcinoma

AND

1.2.2 ONE of the following:

- Disease is progressive
- Disease is symptomatic with distant metastases

AND

1.2.3 History of failure, contraindication, or intolerance to ONE of the following^:

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of angiosarcoma

OR

1.2 Diagnosis of desmoid tumors / aggressive fibromatosis

OR

1.3 BOTH of the following:

1.3.1 Diagnosis of progressive gastrointestinal stromal tumors (GIST)

AND

1.3.2 History of failure, contraindication, or intolerance to ONE of the following^:

- Imatinib (generic Gleevec)
- Sunitinib (generic Sutent)
- Stivarga (regorafenib)
- Qinlock (ripretinib)

OR

1.4 Diagnosis of solitary fibrous tumor/hemangiopericytoma

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following: • Diagnosis of chordoma • Disease is recurrent **OR** **2** - BOTH of the following: **2.1** ONE of the following: • Diagnosis of osteosarcoma	

- Diagnosis of dedifferentiated chondrosarcoma
- Diagnosis of high-grade undifferentiated pleomorphic sarcoma (UPS)

AND

2.2 NOT used as first-line therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - Patient has FLT3-ITD mutation-positive disease

AND

3 - ONE of the following:

- Patient has relapsed disease
- Patient has refractory disease

AND

4 - Used in combination with ONE of the following:

- Vidaza (azacitidine)
- Dacogen (decitabine)

AND

5 - Patient is unable to tolerate more aggressive treatment regimens

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Acute Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Ovarian cancer
- Fallopian tube cancer
- Primary peritoneal cancer

AND

2 - ONE of the following:

- Patient has persistent disease
- Patient has recurrent disease

AND

3 - Disease is platinum-resistant

AND

4 - Used in combination with topotecan

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of salivary gland tumor **AND** **2** - Disease is ONE of the following: • Recurrent and unresectable	

• Metastatic	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and FLT3 rearrangement	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Nexavar or sorafenib will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Nexavar, generic sorafenib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Nexavar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limit may be in place. **Background** Nexavar® (sorafenib tosylate) is a kinase inhibitor indicated for the treatment of unresectable hepatocellular carcinoma, advanced renal cell carcinoma and locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment. The National Comprehensive Cancer Network also recommends the use of Nexavar for the treatment of gastrointestinal stromal tumor (GIST), chordoma, osteosarcoma, acute myeloid leukemia (AML), soft tissue sarcoma, salivary gland tumors, ovarian/fallopian tube cancer/primary peritoneal cancer, and myeloid/lymphoid neoplasms with tyrosine kinase gene fusions.

4 . References

1. Nexavar [package insert]. Wayne, NJ: Bayer HealthCare Pharmaceuticals Inc.; August 2023.

2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at www.nccn.org. Accessed July 28, 2024.

5 . Revision History

Date	Notes
9/3/2024	Annual review with no changes. Updated background and references .

Nocdurna

Prior Authorization Guideline

Guideline ID	GL-141053
Guideline Name	Nocdurna
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 02/18/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Nocdurna (desmopressin acetate)
nocturia due to nocturnal polyuria Indicated for the treatment of nocturia due to nocturnal polyuria in adults who awaken at least 2 times per night to void.

2 . Criteria

Product Name: Nocdurna [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)

AND

2 - Patient wakes at least twice per night on a reoccurring basis to void

AND

3 - Documented serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months.

AND

4 - The patient has been evaluated for other medical causes and has either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes (e.g., overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure)

AND

5 - Prescriber attests that the risks have been assessed and benefits outweigh the risks

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nocdurna [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Nocdurna therapy **AND** **2** - Patient has routine monitoring for serum sodium levels **AND** **3** - Prescriber attests that the risks of hyponatremia have been assessed and benefits outweigh the risks	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Nocdurna (desmopressin acetate) sublingual tablets are indicated for the treatment of nocturia due to nocturnal polyuria in adults who awaken at least 2 times per night to void. In clinical trials, nocturnal polyuria was defined as nighttime urine production exceeding one-third of the 24-hour urine production. Prior to initiating treatment with Nocdurna, patients should be evaluated for possible causes of nocturia and to optimize the treatment of underlying conditions that may be contributing to the nocturia. Desmopressin should be avoided in older adults (those 65 or older) due to the risk of hyponatremia. This medication is included in the American Geriatrics Society Beers Criteria. Nocdurna have a Black Box Warning for hyponatremia listed in the FDA prescribing

information. Nocdurna use is contraindicated in patients with hyponatremia or a history of hyponatremia, SIADH, eGFR <50 mL/min/1.7m^2, uncontrolled hypertension, and New York Heart Association Class II – IV congestive heart failure. See package insert for full listing of contraindications and safety warnings.

Nocdurna has not been studied in patients less than 18 years of age.

This prior authorization program is intended to ensure appropriate prescribing of Nocdurna prior to initiating therapy.

Additional Clinical Rules

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Johnson, TM. Nocturia: Clinical presentation, evaluation and management in adults. O'Leary, MP, ed. UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com (Accessed on December 23, 2019.)
2. Nocdurna (desmopressin) sublingual tablets [package insert]. Parsippany, NJ: Ewing, NJ: Antares Pharma, Inc; November 2020.
3. American Geriatrics Society 2023 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults J Am Geriatr Soc. 942023; 71: 2052-81

5 . Revision History

Date	Notes
2/2/2024	Annual review. Increased initial authorization to 12 months. Updated references. Added state mandate language.

Non-Formulary Administrative

Prior Authorization Guideline

Guideline ID	GL-148672
Guideline Name	Non-Formulary Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	10/20/2021 ; 6/17/2024

Note:

Technician Note: UHCGP Exchange Non-Formulary Alternatives Tables link: https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange%2FNF%20Alt%20Tables Link to Exclusions and Limitations Grid: https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange

1 . Criteria

Product Name: Non-Formulary Medications (other than contraceptive products) [a]	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - In the absence of a drug-specific non-formulary guideline that has been approved by the P&T Committee to guide the non-formulary exceptions process, the following guideline will be used to establish medical necessity:

1.1 One of the following:

1.1.1 Both of the following:

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

AND

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

OR

1.1.2 Meets Off-Label Administrative guideline criteria

AND

1.2 One of the following:

1.2.1 If the target drug is NOT listed on the Non-Formulary Alternatives table, then the patient must try and fail, or have specific medical reason(s) why a maximum of five (5) equivalent formulary drugs, as determined by the PA pharmacist are not appropriate

OR

1.2.2 If the target drug is listed on the Non-Formulary Alternatives table, then the patient

must try and fail, or have specific medical reason(s) why the number of alternatives* specified by the Non-Formulary Alternatives Table is not appropriate (see technician note for NF Alts Table URL)

OR

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

AND

1.3 The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note for the Exclusions and Limitations Grid URL)

Notes	[a] Formulary: 2024 UnitedHealthcare Government Programs Exchange Formulary. If approved, the non-formulary drug will be covered at tier 5 for 6-tiered formularies, at tier 4 for 5-tiered formularies, or tier 3 for 4-tiered formularies. *If an alternative is the generic equivalent of the non-formulary target drug, then it must be one of the required alternatives the patient must try and fail or have a specific medical reason why the alternative is not appropriate. ** For Virginia, if the provider indicates that changing drug therapy presents a significant health risk (e.g., provider states the patient is stable on the requested medication, transition to another medication may result in destabilization) and there is a paid claim for the requested drug in the prior plan year, the member does not have to T/F the alternatives, unless the alternative is the generic of the requested brand drug.

Product Name: Non-Formulary Contraceptive Medications	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - In the absence of a drug-specific non-formulary guideline that has been approved by the P&T Committee to guide the non-formulary exceptions process, the following guideline will be used to establish medical necessity:

1.1 One of the following:

1.1.1 Both of the following [a]:

1.1.1.1 Diagnosis of contraception

AND

1.1.1.2 One of the following:

- If the contraceptive drug is NOT listed on the Non-Formulary Alternatives table, then the patient must try and fail, or have specific medical reason(s) why a maximum of two (2) equivalent formulary drugs, as determined by the PA pharmacist are not appropriate
- If the contraceptive drug is listed on the Non-Formulary Alternatives table, then the patient must try and fail, or have specific medical reason(s) why two (2) alternatives* specified by the Non-Formulary Alternatives Table is not appropriate (see technician note for NF Alts Table URL)
- Provider attests the non-formulary contraceptive drug is the preferred product for this patient (e.g., provider attestation that the non-formulary contraceptive is medically necessary, patient is stable on the requested non-formulary contraceptive, patient requires continuation of therapy to complete the course of treatment, transition to another agent could result in destabilization)

OR

1.1.2 All of the following [b]:

1.1.2.1 Drug is requested for a non-contraception use

AND

1.1.2.2 One of the following:

- Requested drug is FDA-approved for the condition being treated
- Meets Off-Label Administrative guideline criteria

AND

1.1.2.3 One of the following:

- If the target drug is NOT listed on the Non-Formulary Alternatives table, then the patient must try and fail, or have specific medical reason(s) why a maximum of five (5) equivalent formulary drugs, as determined by the PA pharmacist are not appropriate

• If the target drug is listed on the Non-Formulary Alternatives table, then the patient must try and fail, or have specific medical reason(s) why the number of alternatives* specified by the Non-Formulary Alternatives Table is not appropriate (see technician note for NF Alts Table URL) • No formulary drug is appropriate to treat the patient's condition **AND** **1.1.2.4** The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note for the Exclusions and Limitations Grid URL)	
Notes	[a] If used for contraceptive purpose and approved, authorizations sho uld have overrides to allow for $0 cost share for non-formulary drugs. [b] Formulary: 2024 UnitedHealthcare Government Programs Exchan ge Formulary. If used for non-contraceptive purpose and approved, th e non-formulary drug will be covered at tier 5 for 6-tiered formularies, at tier 4 for 5-tiered formularies, or tier 3 for 4-tiered formularies. *If an alternative is the generic equivalent of the non-formulary target drug, then it must be one of the required alternatives the patient must try and fail or have a specific medical reason why the alternative is not appropriate.

2 . Background

Benefit/Coverage/Program Information
Background: Non-formulary medications will have a Tier 8/non-formulary status on the RxWeb Formulary Lookup tool. This guideline applies to these Tier 8 medications. If a medication has a non-formulary status and a PA flag of yes, apply the criteria within the drug-specific guideline as well as the non-formulary alternatives grid in the link in the technician note. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

Formulary Note:

Termination date of non-formulary exception authorizations approved pursuant to this guideline is 12 months from date of approval

3 . Revision History

Date	Notes
6/19/2024	Added administrative note for Virginia.

Prior Authorization Guideline

Guideline ID	GL-133268
Guideline Name	Non-Solid Oral Dosage Forms
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 08/20/2021 ; 09/15/2021 ; 09/15/2021 ; 10/19/2022 ; 8/18/2023

1 . Criteria

Product Name: Sotylize, Tiglutik, generic naproxen susp, Tirosint-Sol, Thyquidity, generic sucralfate susp [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following:	

• age • oral/motor difficulties • dysphagia **OR** **2** - Patient utilizes a feeding tube for medication administration

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Coverage criteria outlined below are for patients unable to ingest a solid oral dosage form. Claims for patients under the age of 6 will process automatically for Naproxen (generic for Naprosyn) suspension, Sotylize, sucralfate suspension, Tiglutik, Thyquidity, and Tirosint-Sol. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

3 . References

1. Naprosyn [package insert]. Atlanta, GA: Athena Bioscience LLC.; July 2019.
2. Sotylize [package insert]. Atlanta, GA: Arbor Pharmaceuticals, LLC.; July 2015
3. Tiglutik [package insert]. Berwyn, PA: ITF Pharma, Inc.; March 2020.
4. Thyquidity [package insert]. New Providence, NJ: VistaPharm, Inc.; December 2020.
5. Tirosint-Sol [package insert]. Pambio-Noranco, Switzerland: IBSA Institute Biochimique SA; January 2021.

6. Sucralfate suspension [package insert]. Chestnut Ridge, NY. Par Pharmaceutical; June 2018.

4 . Revision History

Date	Notes
9/19/2023	Updated GPI and product name lists, cleaned up criteria and notes, u pdated Background and References.

Nubeqa

Prior Authorization Guideline

Guideline ID	GL-154215
Guideline Name	Nubeqa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	9/18/2024

1 . Indications

Drug Name: Nubeqa (darolutamide)
Prostate cancer Indicated for the treatment of patients with non-metastatic castration-resistant prostate cancer and metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel. Patients should also receive a gonadotropin-releasing hormone (GnRH) analog concurrently while taking Nubeqa or should have had bilateral orchiectomy.

2 . Criteria

Product Name: Nubeqa [a]	
Diagnosis	Prostate Cancer

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

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Disease is non-metastatic
- Disease is castration-resistant or recurrent

OR

2.2 ALL of the following:

- Disease is metastatic
- Disease is hormone-sensitive
- Nubeqa will be used in combination with docetaxel

AND

3 - ONE of the following:

3.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

OR

3.2 Patient has had bilateral orchiectomy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nubeqa [a]	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Nubeqa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nubeqa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nubeqa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Nubeqa (darolutamide) is an androgen receptor inhibitor indicated for the treatment of patients with non-metastatic castration-resistant prostate cancer and metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel. Patients should also receive a gonadotropin-releasing hormone (GnRH) analog concurrently while taking Nubeqa or should have had bilateral orchiectomy. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Nubeqa [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; October 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed July 26, 2024.

5 . Revision History

Date	Notes
9/3/2024	Annual review with no changes. Updated references.

Nucala

Prior Authorization Guideline

Guideline ID	GL-149906
Guideline Name	Nucala
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/21/2021
P&T Revision Date:	09/15/2021 ; 11/19/2021 ; 12/15/2021 ; 01/19/2022 ; 02/18/2022 ; 06/21/2023 ; 07/19/2023 ; 7/17/2024

Note:

This program applies to the prefilled autoinjector and prefilled syringe formulations.

1 . Indications

Drug Name: Nucala (mepolizumab) prefilled autoinjector and prefilled syringe
Severe Asthma Indicated for the add-on maintenance treatment of patients with severe asthma 6 years and older, and with an eosinophilic phenotype. **Eosinophilic Granulomatosis with Polyangiitis** Indicated for the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA). **Hypereosinophilic Syndrome** Indicated for the treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) for ≥6 months without an

identifiable non-hematologic secondary cause.

Maintenance Treatment of Chronic Rhinosinusitis with Nasal Polyps Indicated for add-on maintenance treatment of adult patients 18 years and older with chronic rhinosinusitis with nasal polyps (CRSwNP)

2 . Criteria

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Eosinophilic granulomatosis with polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of EGPA

AND

1.2 Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency and/or severity of relapses
- Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant
- Disease remission
- Reduction in severity or frequency of EGPA-related symptoms

AND

1.3 Patient is not receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.4 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

OR

2 - ALL of the following:

2.1 Diagnosis of relapsing or refractory EGPA as defined by ALL of the following:

2.1.1 Diagnosis of EGPA

AND

2.1.2 Past medical history or presence of asthma

AND

2.1.3 Presence of at least TWO of the following characteristics typical of EGPA:

- Histopathological evidence of: Eosinophilic vasculitis, Perivascular eosinophilic infiltration, Eosinophil-rich granulomatous inflammation
- Neuropathy, mono or poly (motor deficit or nerve conduction abnormality)
- Pulmonary infiltrates, non-fixed
- Sino-nasal abnormality
- Cardiomyopathy (established by echocardiography or MRI)
- Glomerulonephritis (hematuria, red cell casts, proteinuria)
- Alveolar hemorrhage
- Palpable purpura

- Anti-neutrophil cytoplasmic antibody (ANCA) positive

AND

2.1.4 History of relapsing or refractory disease defined as ONE of the following:

- Relapsing disease as defined as a past history (within the past 2 years) of at least one EGPA relapse (requiring additional or dose escalation of corticosteroids or immunosuppressant, or hospitalization)
- Refractory disease as defined as failure to attain remission within the prior 6 months following induction treatment with standard therapy regimens

AND

2.2 Patient is currently taking standard therapy [i.e., systemic glucocorticoids (e.g., prednisone, methylprednisolone)] with or without immunosuppressive therapy (e.g., cyclophosphamide, rituximab)]

AND

2.3 Patient is not receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

2.4 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Eosinophilic granulomatosis with polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following: • Reduction in the frequency and/or severity of relapses • Reduction or discontinuation of doses of corticosteroids and/or immunosuppressant • Disease remission • Reduction in severity or frequency of EGPA-related symptoms **AND** **2** - Patient is not receiving Nucala in combination with ANY of the following: • Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma

AND

1.2 Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

1.3 Nucala is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

1.4 Patient is not receiving Nucala in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.5 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

OR

2 - ALL of the following:

2.1 Diagnosis of severe asthma

AND

2.2 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

- Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

2.3 Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level ≥ 150 cells/μL

AND

2.4 Nucala will be used in combination with ONE of the following:

2.4.1 ONE maximally dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.4.2 Combination therapy including BOTH of the following:

- ONE maximally dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]
- ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

2.5 Patient is not receiving Nucala in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

2.6 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Nucala is being used in combination with an ICS-containing controller maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Nucala in combination with any of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of HES

AND

1.2 Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

- Reduction in frequency of HES flares
- Maintenance or reduction in background HES therapy requirements

AND

1.3 Patient is not receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.4 Prescribed by ONE of the following:

- Allergist
- Cardiologist
- Hematologist
- Immunologist
- Pulmonologist

OR

2 - ALL of the following:

2.1 Diagnosis of HES greater than or equal to 6 months ago

AND

2.2 BOTH of the following:

- There is no identifiable non-hematologic secondary cause of the patient's HES (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)
- HES is not FIP1L1-PDGFRα kinase-positive

AND

2.3 Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting BOTH of the following:

- Baseline (pre-mepolizumab treatment) blood eosinophil level greater than or equal to 1000 cells/μL within the past 4 weeks
- Patient is currently receiving a stable dose of background HES therapy (e.g., oral corticosteroid, immunosuppressor, or cytotoxic therapy)

AND

2.4 Patient is not receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

2.5 Prescribed by ONE of the following:

- Allergist
- Cardiologist
- Hematologist
- Immunologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Nucala therapy as demonstrated by at least ONE of the following:

- Reduction in frequency of HES flares
- Maintenance or reduction in background HES therapy requirements

AND

2 - Patient is not receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Nucala under an active UnitedHealthcare medical benefit prior authorization for the treatment of CRSwNP

AND

1.2 Documentation of positive clinical response to Nucala therapy

AND

1.3 Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

1.4 Patient is NOT receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.5 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

OR

2 - ALL of the following:

2.1 Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by ALL of the following:

2.1.1 TWO OR MORE of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

2.1.2 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

2.1.3 ONE of the following:

- Presence of bilateral nasal polyposis
- Patient has previously required surgical removal of bilateral nasal polyps

AND

2.1.4 ONE of the following:

2.1.4.1 Patient has required prior sinus surgery

OR

2.1.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years

OR

2.1.4.3 Patient has been unable to obtain symptom relief after trial of two of the following classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)
- Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)

AND

2.2 Patient will receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

2.3 Patient is NOT receiving Nucala in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

2.4 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nucala prefilled autoinjector and prefilled syringe [a]	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Nucala therapy **AND** **2** - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) **AND** **3** - Patient is NOT receiving Nucala in combination with ANY of the following: • Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Nucala (mepolizumab) is an interleukin-5 receptor antagonist indicated for add-on maintenance treatment of patients aged 6 years and older with severe asthma and with an eosinophilic phenotype, for add-on maintenance treatment of adult patients 18 years and older with chronic rhinosinusitis with nasal polyps (CRSwNP), the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA), and the treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) for ≥6 months without an identifiable non-hematologic secondary cause[1].

Limitations of use:

Nucala is not for relief of acute bronchospasm of status asthmaticus.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
- The single-dose vial is typically covered under the medical benefit. Please refer to the United Healthcare Medical Benefit Drug Policy: “Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®)”.

4 . References

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5 . Revision History

Date	Notes
7/18/2024	Annual review. Updated background with modified indication for CRS wNP. Specified existing prior authorization for under the medical ben efit. Updated references.

Nuedexta

Prior Authorization Guideline

Guideline ID	GL-149932
Guideline Name	Nuedexta
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	07/21/2021 ; 09/15/2021 ; 07/20/2022 ; 7/17/2024

1 . Indications

Drug Name: Nuedexta (dextromethorphan/quinidine)
Pseudobulbar affect (PBA) Indicated for the treatment of pseudobulbar affect (PBA). PBA occurs secondary to a variety of neurologic conditions, and is characterized by involuntary, sudden, and frequent episodes of laughing and/or crying.

2 . Criteria

Product Name: Nuedexta [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of pseudobulbar affect

AND

2 - ONE of the following

- Amyotrophic lateral sclerosis (ALS)
- Alzheimer's disease
- Multiple sclerosis (MS)
- Parkinson's disease
- Stroke
- Traumatic brain injury

AND

3 - Documented absence of cardiac rhythm disorders

AND

4 - Prescribed by or in consultation with a neurologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nuedexta [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Nuedexta, a combination product containing dextromethorphan hydrobromide and quinidine sulfate, is indicated for the treatment of pseudobulbar affect (PBA). PBA occurs secondary to a variety of neurologic conditions, and is characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. PBA episodes typically occur out of proportion or are inappropriate to the underlying emotional state. PBA is a specific condition, distinct from other types of emotional lability that may occur in patients with neurological disease or injury. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Nuedexta [package insert]. Aliso Viejo, CA: Avanir Pharmaceuticals, Inc.; June 2019.
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5 . Revision History

Date	Notes
7/17/2024	Annual review. Updated initial authorization to 12 months. Added stat e mandate criteria

Nurtec, Qulipta, Ubrelvy, Zavzpret

Prior Authorization Guideline

Guideline ID	GL-150897
Guideline Name	Nurtec, Qulipta, Ubrelvy, Zavzpret
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	8/16/2024

1 . Indications

Drug Name: Nurtec ODT (rimegepant)
Migraine Indicated for the acute treatment of migraine with or without aura in adults **Episodic Migraine** Indicated for the preventive treatment of episodic migraine in adults.
Drug Name: Ubrelvy (ubrogepant), Zavzpret (zavegepant)
Migraine Indicated for the acute treatment of migraine with or without aura in adults
Drug Name: Qulipta (atogepant)
Episodic Migraine Indicated for the preventive treatment of migraine in adults

2 . Criteria

Product Name: Ubrelvy [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - History of therapeutic failure (after at least 3 migraine episodes and a minimum of a 30-day trial), contraindication or intolerance to TWO of the following (document name and date tried):

- naratriptan (Amerge)
- rizatriptan (Maxalt/Maxalt MLT)
- sumatriptan (Imitrex)

AND

3 - ONE of the following:

3.1 Patient is currently treated with one of the following prophylactic therapies:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ONE of the following prophylactic therapies:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Nurtec ODT, Zavzpret)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zavzpret [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - History of therapeutic failure (after at least 3 migraine episodes and a minimum of a 30-day trial), contraindication or intolerance to BOTH of the following (document name and date tried):

- TWO formulary 5-HT1 receptor agonist (triptan) alternatives (e.g., sumatriptan, rizatriptan, or naratriptan with step therapy), one of which must be sumatriptan nasal spray
- Ubrelvy

AND

3 - ONE of the following:

3.1 Patient is currently treated with one of the following prophylactic therapies:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

3.2 Patient has less than 4 migraine days per month

OR

3.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ONE of the following prophylactic therapies:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Nurtec ODT, Ubrelvy)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ubrelvy or Zavzpret [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Nurtec ODT)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Nurtec ODT [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Used for acute treatment of migraine

AND

1.2 History of a therapeutic failure (after at least 3 migraine episodes and a minimum of a 30-day trial) contraindication or intolerance to TWO of the following (document name and date tried):

- naratriptan (Amerge)
- rizatriptan (Maxalt/Maxalt MLT)
- sumatriptan (Imitrex)

AND

1.3 History of failure (after at least 3 migraine episodes and a minimum of a 30-day trial), contraindication, or intolerance to Ubrelvy (document date tried).

AND

1.4 ONE of the following:

1.4.1 Patient is currently treated with one of the following prophylactic therapies:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)

- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

OR

1.4.2 Patient has less than 4 migraine days per month

OR

1.4.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to one of the following prophylactic therapies:

- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist or inhibitor for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

1.5 Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonists (e.g., Ubrelvy, Zavzpret)

OR

2 - ALL of the following:

2.1 Diagnosis of episodic migraines with greater than or equal to 4 migraine days per month

AND

2.2 Used for preventive treatment of migraines

AND

2.3 Failure (after a trial of at least three months), contraindication or intolerance to Aimovig (document name and date tried)

AND

2.4 History of failure (after a trial of at least two months), contraindication or intolerance to TWO of the following prophylactic therapies (document name and date tried):

- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol
- Divalproex sodium (Depakote/Depakote ER)
- Topiramate (Topamax)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

2.5 Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Qulipta, Vyepti)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Nurtec ODT [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Use is for the acute treatment of migraine
- Medication will not be used in combination with another acute calcitonin gene-related peptide receptor (CGRP) antagonist (e.g., Ubrelvy, Zavzpret)

OR

2.2 BOTH of the following:

- Use is for the preventive treatment of migraines
- Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Qulipta, Vyepti)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Qulipta [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of migraine consistent with The International Classification of Headache Disorders, 3rd edition

AND

2 - ONE of the following:

2.1 4 to 7 migraine days per month and at least ONE of the following:

- Less than 15 headache days per month
- Provider attests this is the member's predominant headache diagnosis (i.e., primary driver of headaches is not a different, non-migrainous condition)

OR

2.2 Greater than or equal to 8 migraine days per month

AND

3 - Failure (after a trial of at least two months), contraindication or intolerance to TWO of the following prophylactic therapies (document name and date tried):

- One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol
- Divalproex sodium (Depakote/Depakote ER)
- A serotonin-norepinephrine reuptake inhibitor [i.e., duloxetine (Cymbalta), venlafaxine (Effexor/Effexor XR)]
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- A tricyclic antidepressant [i.e., amitriptyline (Elavil), nortriptyline (Pamelor)]

AND

4 - Failure (after a trial of at least three months), contraindication or intolerance to Aimovig (document name and date tried)

AND

5 - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Qulipta [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy **AND** **2** - Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines (e.g., Aimovig, Ajovy, Emgality, Nurtec ODT, Vyepti)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Nurtec ODT (rimegepant), Ubrelvy (ubrogepant) and Zavzpret (zavegepant) are calcitonin gene-related peptide receptor antagonists indicated for the acute treatment of migraine with or without aura in adults. Nurtec ODT is also indicated for the preventive treatment of

episodic migraine in adults and Qulipta (atogepant) is indicated for the preventive treatment of migraine in adults.

The American Headache Society recommends the use of NSAIDs (including aspirin), non-opioid analgesics, acetaminophen, or caffeinated analgesic combinations (e.g., aspirin/acetaminophen/caffeine) for mild-to-moderate attacks and migraine-specific agents (i.e., triptans, dihydroergotamine [DHE]) for moderate or severe attacks and mild-to-moderate attacks that respond poorly to NSAIDs or caffeinated combinations.

Preventive treatment selection is based on evidence of efficacy, tolerability, patient preference, headache subtype, and comorbidities. The American Academy of Neurology guidelines note that antiepileptic drugs (divalproex sodium, valproate sodium, topiramate) and beta-blockers (metoprolol, propranolol, timolol) have established efficacy and that antidepressants (amitriptyline, venlafaxine) and beta-blockers (atenolol, nadolol) are probably effective for the preventive treatment of migraine headache.

This program requires a member to try lower cost options prior to receiving coverage for Nurtec ODT, Qulipta, Ubrelvy or Zavzpret.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Nurtec ODT [package insert]. New York, NY: Pfizer Inc; April 2023.
2. Qulipta [package insert]. Dublin, Ireland: Forest Laboratories Ireland, Ltd. June 2023.
3. Ubrelvy [package insert]. North Chicago, IL: AbbVie Inc: June 2023.
4. Zavzpret [package insert]. New York, NY: Pfizer Inc.; March 2023
5. The American Headache Society Position Statement on Integrating New Migraine Treatments Into Clinical Practice. AHS Consensus Statement. Headache. 2021; 61:1021-39.
6. International Headache Society (HIS); Headache Classification Committee. The International Classification of Headache Disorders, 3rd edition. Cephalalgia 2018; 38:1-211.

5 . Revision History

Date	Notes
8/2/2024	Updated list of potential prophylactic therapies.

Prior Authorization Guideline

Guideline ID	GL-154217
Guideline Name	Nuvigil, Provigil
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	10/06/2021 ; 10/20/2021 ; 03/16/2022 ; 06/21/2023 ; 08/18/2023 ; 08/18/2023 ; 9/18/2024

1 . Indications

Drug Name: Provigil (modafinil) and Nuvigil (armodafinil)
Narcolepsy, obstructive sleep apnea/hypopnea syndrome, shift work sleep disorder. To improve wakefulness in patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea/hypopnea syndrome, and shift work sleep disorder
Drug Name: Provigil (modafinil)
Off Label Uses: Idiopathic hypersomnia, fatigue associated with multiple sclerosis, depression augmentation Has been shown to be beneficial in the treatment of excessive sleepiness in patients with idiopathic hypersomnia, treatment of fatigue associated with multiple sclerosis, and in the augmentation therapy for the treatment of depression.

2 . Criteria

Product Name: Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: • Diagnosis of narcolepsy • Diagnosis of idiopathic hypersomnia • Diagnosis of excessive sleepiness due to obstructive sleep apnea • Diagnosis of excessive sleepiness due to shift work disorder • Diagnosis of fatigue associated with multiple sclerosis • Diagnosis of major depressive disorder or bipolar depression **AND** **2** - If the request is for armodafinil (generic Nuvigil), the patient has a history of failure, contraindication, or intolerance to modafinil (generic Provigil)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Modafinil (Provigil) and armodafinil (Nuvigil) are wakefulness-promoting agents for oral administration. Both products are approved by the Food and Drug Administration (FDA) to improve wakefulness in patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea and shift work disorder. Modafinil has been shown to be beneficial in the treatment of excessive sleepiness in patients with idiopathic hypersomnia, treatment of

fatigue associated with multiple sclerosis, and in the augmentation therapy for the treatment of depression.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

4 . References

1. Provigil [package insert]. Parsippany, NJ: Teva Pharmaceuticals; December 2022.
2. Nuvigil [package insert]. Parsippany, NJ: Teva Pharmaceuticals; December 2022.
3. Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: an American Academy of Sleep Medicine clinical practice guideline. Journal of Clinical Sleep Medicine. 2021;17(9):1881–1893
4. Rammohan KW, Rosenberg JH, Lynn DJ, et al. Efficacy and safety of modafinil (Provigil) for the treatment of fatigue in multiple sclerosis: a two center phase 2 study. J Neurol Neurosurg Psychiatry 2002;72:179-183.
5. Zifko UA, Rupp M, Schwarz S, et al. Modafinil in treatment of fatigue in multiple sclerosis. Results of an open-label study. J Neurol 2002;249:983-987.
6. Goss AJ, Kaser M, Costafreda SG, Sahakian BJ, Fu CH. Modafinil Augmentation Therapy in Unipolar and Bipolar Depression: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. J Clin Psychiatry 74:11, November 2013.
7. APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts. American Psychiatric Association. Arlington, VA. February 2019.

5 . Revision History

Date	Notes
9/3/2024	Annual review, updated references.

Ocaliva

Prior Authorization Guideline

Guideline ID	GL-148648
Guideline Name	Ocaliva
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	06/15/2022 ; 06/21/2023 ; 6/17/2024

1 . Indications

Drug Name: Ocaliva (obeticholic acid)
Primary biliary cholangitis Indicated for the treatment of primary biliary cholangitis (PBC), without cirrhosis or with compensated cirrhosis without evidence of portal hypertension, in combination with ursodeoxycholic acid.

2 . Criteria

Product Name: Ocaliva [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary biliary cholangitis

AND

2 - ONE of the following:

- Patient does not have cirrhosis
- Patient has compensated cirrhosis without evidence of portal hypertension

AND

3 - ONE of the following:

3.1 BOTH of the following^:

- Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol)
- Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 consecutive months of treatment with ursodeoxycholic acid (e.g., Urso, ursodiol)

OR

3.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol)

AND

4 - Prescribed by one of the following:

- Hepatologist
- Gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply. ^Tried/failed alternative(s) are supported by FDA labeling and/or treat ment guidelines.

Product Name: Ocaliva [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., laboratory values) documenting a reduction in ALP level from pre-treatment baseline (i.e., prior to Ocaliva therapy) while on Ocaliva therapy

AND

2 - ONE of the following:

- Patient does not have cirrhosis
- Patient has compensated cirrhosis without evidence of portal hypertension

AND

3 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Ocaliva (obeticholic acid), a farnesoid X receptor (FXR) agonist, is indicated for the treatment of primary biliary cholangitis (PBC), without cirrhosis or with compensated cirrhosis without evidence of portal hypertension, in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA. This indication is approved under accelerated approval based on a reduction in alkaline phosphatase (ALP). An improvement in survival or disease-related symptoms has not been established. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Ocaliva [package insert]. Morristown, NJ: Intercept Pharmaceuticals, Inc.; May 2022.

5 . Revision History

Date	Notes
6/19/2024	Annual review. Updated initial authorization to 12 months.

Off-Label Administrative

Prior Authorization Guideline

Guideline ID	GL-125813
Guideline Name	Off-Label Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	7/1/2023
P&T Approval Date:	1/1/2023
P&T Revision Date:	10/20/2021 ; 5/25/2023

Note:

Technician Note: ***Link to Exclusions and Limitations Grid:
https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange

1 . Criteria

Product Name: All medications requested for off-label indications	
Approval Length	12 month(s)
Guideline Type	Administrative Off-Label

Approval Criteria

1 - A request for an off-label indication will be approved based on one of the following:

1.1 The diagnosis is supported in DRUGDEX and one of the following:

1.1.1 The drug has a Strength of Recommendation in the FDA Uses/Non-FDA Uses section rating of Class I, Class IIa, or Class IIb (see DRUGDEX Strength of Recommendation table in Background section)

OR

1.1.2 Both of the following:

- The drug has a Strength of Recommendation of III or Class Indeterminate (see DRUGDEX Strength of Recommendation table in Background section)
- Efficacy is rated as "Effective" or "Evidence Favors Efficacy" (see DRUGDEX Efficacy Rating and Prior Authorization Approval Status table in Background section)

OR

1.1.3 The diagnosis is supported in any other section in DRUGDEX. (Note: Supported use is considered to mean positive language in any section of the compendia that clearly indicates the drug has efficacy or is beneficial for an off-label use. If there is conflicting evidence, [e.g., use is not supported in the FDA Uses/Non-FDA Uses sections of DRUGDEX but has favorable support elsewhere within DRUGDEX] the favorable support would take precedence and the use would be accepted as a supported use)

OR

1.2 The diagnosis is supported as a use in Clinical Pharmacology

OR

1.3 The diagnosis is supported as a use in American Hospital Formulary Service Drug Information (AHFS DI)

OR

1.4 The diagnosis is supported as a use in the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B (see NCCN Categories of Evidence and Consensus table in Background section)

OR

1.5 The diagnosis is supported as a use in United States Pharmacopoeia-National Formulary (USP-NF)

OR

1.6 The diagnosis is supported as a use in Drug Facts and Comparisons

OR

1.7 The diagnosis is supported as a use in Wolters Kluwer Lexi-Drugs

OR

1.8 The diagnosis is supported in published practice guidelines and treatment protocols

OR

1.9 The diagnosis is supported in peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

AND

2 - The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note for the Exclusions and Limitations Grid URL).

Notes	Off-label use may be reviewed for medical necessity and denied as such if the off-label criteria are not met. Please refer to drug specific PA guideline for off-label criteria if available.

2 . Background

Clinical Practice Guidelines

DRUGDEX Strength of Recommendation [1]

Class	Recommendation	Description
Class I	Recommended	The given test or treatment has been proven 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	

DRUGDEX Efficacy Rating and Prior Authorization Approval Status [1]

Efficacy Rating	Prior Authorization Status
Effective	Approvable
Evidence favors Efficacy	Approvable
Evidence is inconclusive	Not approvable
Ineffective	Not approvable

NCCN Categories of Evidence and Consensus [2]

Category	Level of Consensus
1	Based upon high-level evidence, there is uniform NCCN consensus tha intervention is appropriate.
2A	Based upon lower-level evidence, there is uniform NCCN consensus th intervention is appropriate.
2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
3	Based upon any level of evidence, there is major NCCN disagreement t intervention is appropriate.

Benefit/Coverage/Program Information

BACKGROUND:

This program is to be administered to medications of various formulary statuses where the requested use is not FDA approved. This policy is intended to ensure that medications subject to prior authorization, including those not listed on the Plan Formulary/PDL, are utilized in accordance with FDA indications and uses found in the compendia of current literature. This policy aims to foster cost-effective, first-line use of available formulary/PDL medications.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

3 . References

1. Micromedex Healthcare Series. Recommendation, Evidence and Efficacy Ratings. https://www.micromedexsolutions.com/home/dispatch/CS/F09729/PFActionId/pf.HomePage. Accessed July 12, 2022.
2. National Comprehensive Cancer Network Categories of Evidence and Consensus. Available at: https://www.nccn.org/guidelines/guidelines-process/development-and-update-of-guidelines. Accessed July 12, 2022.

4 . Revision History

Date	Notes
5/18/2023	Removed chart detailing state specific acceptable compendia. Modified criteria to include standard list of compendia and levels of evidence applicable to all states. Added level/strength of evidence background for DrugDex and NCCN.
5/18/2023	Added criteria to confirm that use is not excluded.

Ohtuvayre

Prior Authorization Guideline

Guideline ID	GL-154843
Guideline Name	Ohtuvayre
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/18/2024
P&T Revision Date:	

1 . Indications

Drug Name: Ohtuvayre (ensifentrine)
Chronic obstructive pulmonary disease (COPD) in adult patients. Indicated for the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients.

2 . Criteria

Product Name: Ohtuvayre [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease

AND

2 - Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than 80%
- Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following (document name):

- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- An ISC/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

AND

3.1.2 ONE of the following:

3.1.2.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)]

OR

3.1.2.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.2 BOTH of the following:

3.2.1 Patient has a failure, contraindication, or intolerance to ALL of the following (document name and date tried):

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat),
- An ISC/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

AND

3.2.2 ONE of the following:

3.2.2.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)]

OR

3.2.2.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.3 ALL of the following:

3.3.1 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Spiriva Respimat) to control their COPD due to ONE of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is <60 L/min)

AND

3.3.2 Patient requires the use of BOTH of the following (document date)

- A nebulized LABA [i.e., arformoterol (generic Brovana), formoterol (generic Perforomist)]
- A nebulized long-acting antimuscarinic agent [LAMA (i.e.,Yupelri)]

AND

3.3.3 ONE of the following:

3.3.3.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitors [i.e., roflumilast (Daliresp)]

OR

3.3.3.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

AND

4 - Patient experiences dyspnea during everyday activities (e.g., short of breath when walking up a slight hill)

AND

5 - Prescribed by or in consultation with a Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ohtuvayre [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Ohtuvayre therapy demonstrated by BOTH of the following: • Improved COPD symptoms (e.g., dyspnea) • Improved FEV1	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Ohtuvayre™ (ensifentrine) is a phosphodiesterase 3 (PDE3) inhibitor and phosphodiesterase 4 (PDE4) inhibitor indicated for the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients. **Additional Clinical Rules:** • Supply limits may be in place. • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis

codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Ohtuvayre [package insert]. Raleigh, NC: Verona Pharma; June 2024.
2. Global strategy for the diagnosis, management and prevention of COPD. Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2024.
3. Anzueto, A, Barjaktarevic, IZ, Siler, TM, et.al. Ensifentrine, a Novel Phosphodiesterase 3 and 4 Inhibitor for the Treatment of Chronic Obstructive Pulmonary Disease: Randomized, Double-Blind, Placebo-controlled, Multicenter Phase III Trials (the ENHANCE Trials. Am J Respir Crit Care Med. 2023; 208: 406-16.

5 . Revision History

Date	Notes
9/12/2024	New Program

Ojjaara

Prior Authorization Guideline

Guideline ID	GL-135691
Guideline Name	Ojjaara
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/17/2023
P&T Revision Date:	

1 . Indications

Drug Name: Ojjaara (momelotinib)
Myelofibrosis (MF) Indicated for the treatment of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [postpolycythemia vera (PV) and post-essential thrombocythemia (ET)] with anemia.

2 . Criteria

Product Name: Ojjaara [a]	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Disease is considered intermediate or high-risk based on ONE of the following diagnosis:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

2 - Patient has anemia

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ojjaara [a]	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ojjaara [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary
Approval Criteria **1** - Ojjaara will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ojjaara [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Ojjaara therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Ojjaara (momelotinib) is a kinase inhibitor indicated for the treatment of intermediate or

high-risk myelofibrosis (MF), including primary MF or secondary MF [postpolycythemia vera (PV) and post-essential thrombocythemia (ET)] with anemia.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limit may be in place.

4 . References

1. Ojjaara [package insert]. Durham, NC: GlaxoSmithKline; September 2023.

5 . Revision History

Date	Notes
11/1/2023	New program

Olumiant

Prior Authorization Guideline

Guideline ID	GL-137673
Guideline Name	Olumiant
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/21/2021 ; 02/18/2022 ; 08/19/2022 ; 09/21/2022 ; 09/20/2023 ; 12/13/2023

1 . Indications

Drug Name: Olumiant
Rheumatoid Arthritis Indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies. Use of Olumiant in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended. [1] **Alopecia Areata** Indicated for the treatment of adult patients with severe alopecia areata.

2 . Criteria

Product Name: Olumiant [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active RA

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 One of the following:

- History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 One of the following:

- History of failure, contraindication, or intolerance to at least one TNF antagonist therapy ^
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [3])

OR

2.2 Both of the following:

2.2.1 Patient is currently on Olumiant therapy as documented by claims history or submission of medical records (Document date and duration of therapy)

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Eli Lilly sponsored Olumiant Together program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Olumiant*

AND

3 - Patient is not receiving Olumiant in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Eli Lilly sponsored Olumiant Together program shall be required to meet initial authorization criteria as if patient were new to therapy. ^ Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Olumiant [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Olumiant therapy

AND

2 - Patient is not receiving Olumiant in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Olumiant [a]	
Diagnosis	Alopecia Areata*
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecias, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient has a current episode of alopecia areata lasting more than 6 months and at least 50% scalp hair loss

AND

4 - History of failure, contraindication, or intolerance to previous alopecia areata treatments (e.g., topical, intralesional, or systemic corticosteroids, topical immunotherapy, anthralin)

AND

5 - Patient is not receiving Olumiant in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib), Litfulo (ritlecitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

6 - Prescribed by a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Alopecia areata is not considered cosmetic use.

Product Name: Olumiant [a]

Diagnosis	Alopecia Areata*
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Olumiant therapy

AND

2 - Patient is not receiving Olumiant in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib), Litfulo (ritlecitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Alopecia areata is not considered cosmetic use.

3 . Background

Benefit/Coverage/Program Information
Background: Olumiant (baricitinib) is a Janus Kinase (JAK) inhibitor indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies and for the treatment of adult patients with severe alopecia areata. Use of Olumiant in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended. Olumiant is also indicated for the

treatment of COVID-19 in hospitalized adults requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or ECMO. [1]

Additional Clinical Rules

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Olumiant [package insert]. Indianapolis, IN: Lilly USA, LLC; June 2022.
2. Fraenkel L, Bathon JM, England BR, et al 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. Arthritis Rheum. 2021;73(7):924-939
3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA: American Psychiatric Publishing. 2013.
4. Messenger AG, McKillop J, Farrant P, et al. British Association of Dermatologists' guidelines for the management of alopecia areata 2012. Br J Dermatol. 2012;166(5):916-926.
5. King B, Ohyama M, Kwon O, et al. BRAVE-AA Investigators. Two Phase 3 Trials of Baricitinib for Alopecia Areata. N Engl J Med. 2022 May 5;386(18):1687-1699.
6. King BA, Mesinkovska NA, Craiglow B, et al. Development of the alopecia areata scale for clinical use: results of an academic-industry collaborative effort. J Am Acad Dermatol. 2022;86(2):359-364.
7. Meah N, Wall D, York K, et al. The Alopecia Areata Consensus of Experts (ACE) study: Results of an international expert opinion on treatments for alopecia areata. J Am Acad Dermatol. 2020;83(1):123-130.

5 . Revision History

Date	Notes
12/12/2023	Added Litfulo as an example not to be used in combination. Remove d prescriber requirement for reauthorization.

Omnipod 5 (PA, QL)

Prior Authorization Guideline

Guideline ID	GL-144146
Guideline Name	Omnipod 5 (PA, QL)
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	5/20/2022
P&T Revision Date:	09/21/2022 ; 11/18/2022 ; 04/19/2023 ; 11/17/2023 ; 3/20/2024

1 . Criteria

Product Name: Omnipod 5*	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of diabetes	

AND

2 - ALL of the following:

- Patient regularly tests blood glucose greater than or equal to 4 times/day or utilizes a continuous glucose monitor (CGM) for greater than or equal to 8 weeks
- Patient has completed a diabetes management program
- Patient injects insulin greater than or equal to 3 times/day

AND

3 - ONE of the following:

- Unexplained, nocturnal, or severe hypoglycemia
- Hypoglycemia unawareness
- Dawn phenomenon blood glucose greater than 200 mg/dL
- Wide and unpredictable (erratic) swings in blood glucose levels
- Glycemic targets within individualized range but lifestyle requires increased flexibility of insulin pump use
- HbA1C greater than 7% or outside individualized targets

AND

4 - BOTH of the following:

- Patient or caregiver is motivated to assume responsibility for self-care and insulin management
- Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning

Notes	*If patient meets criteria above, approve using NDC List OMNIPOD5

Product Name: Omnipod 5*	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response	
Notes	*If patient meets criteria above, approve using NDC List OMNIPOD5

Product Name: Omnipod 5 G6 or G7 Pods*	
Approval Length	12 month(s)
Guideline Type	Quantity Limit Exceptions
Approval Criteria **1** - Quantity requests for Omnipod 5 G6 or G7 pods exceeding the limited amount will be approved based on physician confirmation that the patient requires a greater quantity	
Notes	*Note: Authorization for quantity limit overrides should be entered at th e NDC level for the requested Omnipod 5 G6 or G7 pods, for the requ ested quantity.

2 . Background

Benefit/Coverage/Program Information
Background: External insulin pumps are used for managing individuals with type 1 or type 2 diabetes and deliver insulin by continuous subcutaneous infusion. Members will be required to meet the following coverage criteria. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place • Coverage is not provided for indications unproven per medical benefit drug policy.

3 . References

1. American Diabetes Association. Diabetes Technology: Standards of Care in Diabetes - 2023. Diabetes Care December 2022, Vol.46, S111-S127
2. Blonde L, Umpierrez G, Reddy S, et al.; American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan-2022 Update. Endocrine Practice 28(2022)923-1049.

4 . Revision History

Date	Notes
3/11/2024	Updated note to account for new G7 agent

Omvoh

Prior Authorization Guideline

Guideline ID	GL-148733
Guideline Name	Omvoh
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	1/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Subcutaneous formulation of Omvoh (mirikizumab-mrkz)
Ulcerative colitis (Moderate to Severe) Indicated for the treatment of moderately to severely active ulcerative colitis in adults.

2 . Criteria

Product Name: Omvoh [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization for Maintenance Dosing

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - ONE of the following:

2.1 Patient has been established on therapy with Omvoh for moderately to severely active ulcerative colitis under an active UnitedHealthcare prior authorization

OR

2.2 BOTH of the following:

- Patient is currently on Omvoh therapy for moderately to severely active ulcerative colitis as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from an Eli Lilly sponsored program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Omvoh*

AND

3 - Patient is not receiving Omvoh in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may ap

	ply. *Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from an Eli Lilly sponsore d program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Omvoh [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization for Maintenance Dosing
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Omvoh therapy **AND** **2** - Patient is not receiving Omvoh in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Omvoh (mirikizumab-mrkz) is an interleukin-23 antagonist indicated for the treatment of moderately to severely active ulcerative colitis in adults.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limit may be in place.

4 . References

1. Omvoh [package insert]. Indianapolis, IN: Eli Lilly and Company; October 2023.
2. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. Gastroenterology. 2020 Jan 13.
3. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG Clinical Guideline: Ulcerative Colitis in Adults. Am J Gastroenterol. 2019 Mar;114(3):384-413.Yese.

5 . Revision History

Date	Notes
6/20/2024	Added new Omvoh prefill syringe

Opfolda

Prior Authorization Guideline

Guideline ID	GL-135749
Guideline Name	Opfolda
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/17/2023
P&T Revision Date:	

1 . Indications

Drug Name: Opfolda (miglustat)
Pompe disease Indicated, in combination with Pombiliti, a hydrolytic lysosomal glycogen-specific enzyme, for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy (ERT).

2 . Criteria

Product Name: Opfolda [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of late-onset Pompe disease **AND** **2** - Patient has an active UnitedHealthcare prior authorization for Pombiliti (cipaglucosidase alfa-atga) for late-onset Pompe disease.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Opfolda [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Opfolda plus Pombiliti **AND** **2** - Opfolda continues to be prescribed in combination with Pombiliti	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Opfolda (miglustat) is an enzyme stabilizer indicated, in combination with Pombiliti, a hydrolytic lysosomal glycogen-specific enzyme, for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy (ERT). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limit may be in place.

4 . References

1. Opfolda [prescribing information]. Philadelphia, PA: Amicus Therapeutics US, LLC; September 2023.
2. Pombiliti [prescribing information]. Philadelphia, PA: Amicus Therapeutics US, LLC; September 2023.

5 . Revision History

Date	Notes
11/1/2023	New program

Opzelura

Prior Authorization Guideline

Guideline ID	GL-132953
Guideline Name	Opzelura
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	4/20/2022
P&T Revision Date:	07/20/2022 ; 09/21/2022 ; 9/20/2023

1 . Indications

Drug Name: Opzelura (ruxolitinib)
Atopic Dermatitis (Mild to Moderate) Indicated for the topical short term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. **Nonsegmental Vitiligo** Indicated for the topical treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older.

2 . Criteria

Product Name: Opzelura [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis

AND

2 - One of the following:

2.1 History of failure, contraindication, or intolerance to both of the following therapeutic classes of topical therapies^:

2.1.1 One of the following:

- For mild atopic dermatitis: a topical corticosteroid [e.g., desonide (generic DesOwen), hydrocortisone] (any potency)
- For moderate atopic dermatitis: a topical corticosteroid of at least a medium- to high-potency (e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]

AND

2.1.2 One topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]

OR

2.2 Both of the following:

- Patient is currently on Opzelura therapy
- Patient has not received a manufacturer supplied sample at no cost in prescriber office, or any form of assistance from the Incyte sponsored Opzelura IncyteCARES

program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Opzelura¥

AND

3 - Patient is not receiving Opzelura in combination with another biologic medication [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] or JAK inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

4 - Patient is not receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ¥ Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Incyte sponsored Opzelura IncyteCARES program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Opzelura [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Opzelura in combination with another biologic medication [e.g.,Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] or JAK inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

3 - Patient is not receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Opzelura [a]	
Diagnosis	Nonsegmental Vitiligo
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of nonsegmental vitiligo

AND

2 - Other causes of depigmentation have been ruled out (e.g., nevus depigmentosus, pityriasis alba, idiopathic guttate hypomelanosis, tinea (pityriasis) versicolor, halo nevus, piebaldism, progressive macular hypomelanosis, lichen sclerosus, chemical leukoderma, drug-induced leukoderma, hypopigmented mycosis fungoides)

AND

3 - Affected areas not to exceed 10% body surface area

AND

4 - History of failure, contraindication, or intolerance to previous nonsegmental vitiligo treatment(s) (e.g., topical corticosteroids, topical calcineurin inhibitors)

AND

5 - Patient is not receiving Opzelura in combination with another biologic medication [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] or JAK inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]

AND

6 - Patient is not receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Opzelura [a]	
Diagnosis	Nonsegmental Vitiligo
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Opzelura in combination with another biologic medication [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] or JAK inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)])] **AND** **3** - Patient is not receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Opzelura (ruxolitinib) is a Janus kinase (JAK) inhibitor indicated for the topical short term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 12 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Opzelura is also indicated for the topical treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older. Use of Opzelura in combination with therapeutic biologics, other JAK inhibitors or potent immunosuppressants such as azathioprine or cyclosporine is not recommended. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Opzelura [package insert]. Wilmington, DE: Incyte Corporation; January 2023.
2. Frazier W, Bhardwaj N. Atopic Dermatitis: Diagnosis and Treatment. Am Fam Physician. 2020;101(10):590-598.
3. Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014;71(1):116-132.
4. Taieb A, Alomar A, Böhm M, et al. Guidelines for the management of vitiligo: the European Dermatology Forum consensus. Br J Dermatol. 2013;168(1):5-19.
5. Grimes PE. Vitiligo: Management and prognosis. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com. Accessed on August 15, 2022.
6. Bergqvist C, Ezzedine K. Vitiligo: A Review. Dermatology. 2020;236(6):571-592.

5 . Revision History

Date	Notes
9/20/2023	Annual review. Updated Humira language in safety check to match other policies. Updated safety language in Vitiligo section so reauth matches initial. Updated references.

Orilissa

Prior Authorization Guideline

Guideline ID	GL-141054
Guideline Name	Orilissa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 09/21/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Orilissa (elagolix)
Endometriosis Indicated for the management of moderate to severe pain associated with endometriosis.

2 . Criteria

Product Name: Orilissa 150 mg [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - Failure after a three month trial (e.g., inadequate pain relief), contraindication or intolerance of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen)

AND

3 - Failure after a three month trial, contraindication, or intolerance to ONE of the following:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

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

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Orilissa 150 mg [a]	
Approval Length	Authorization will be issued for 12 months up to a maximum treatment duration of 24 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months

Notes	NOTE: Orilissa 150 mg once daily is indicated for a maximum treatment duration of 24 months; [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Orilissa 200 mg [a]	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - Failure after a three month trial (e.g., inadequate pain relief), contraindication or intolerance of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen)

AND

3 - Failure after a three month trial, contraindication, or intolerance to ONE of the following: • Hormonal contraceptives • Progestins [e.g., norethindrone (generic Aygestin)] **AND** **4** - Prescribed by or in consultation with ONE of the following: • Obstetrics/Gynecologist (OB/GYN) • Reproductive endocrinologist	
Notes	NOTE: Orilissa 200 mg twice daily is indicated for a maximum treatme nt duration of 6 months; [a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Orilissa (elagolix) is a gonadotropin-releasing hormone (GnRH) receptor antagonist indicated for the management of moderate to severe pain associated with endometriosis. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Orilissa [package insert]. AbbVie Inc. North Chicago, IL. June 2023.
2. Taylor H, Giudice L, Lessey B, et al. Treatment of endometriosis-associated pain with elagolix, an oral GnRH antagonist. N Engl J Med 2017; 377:28-40.
3. The American College of Obstetricians and Gynecologists. Management of endometriosis. Practice Bulletin 114. July 2010 (Reaffirmed 2018).

5 . Revision History

Date	Notes
2/2/2024	Annual review. Updated failure language. Updated authorization duration. Updated references.

Orkambi

Prior Authorization Guideline

Guideline ID	GL-148083
Guideline Name	Orkambi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 06/21/2023 ; 6/17/2024

1 . Indications

Drug Name: Orkambi (lumacaftor/ivacaftor)
Cystic fibrosis (CF) Indicated for the treatment of cystic fibrosis (CF) in patients aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene.

2 . Criteria

Product Name: Orkambi [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the CFTR gene

AND

3 - The patient is greater than or equal to 1 year of age

AND

4 - Prescribed by or in consultation with a provider who specializes in the treatment of CF

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Orkambi [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Orkambi therapy (e.g., improved lung function, stable lung function)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Orkambi is a combination of lumacaftor and ivacaftor, a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator, indicated for the treatment of cystic fibrosis (CF) in patients aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. [1] Limitations of Use: The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Orkambi [Package Insert]. Cambridge, MA: Vertex Pharmaceuticals, Inc.; August 2023.

5 . Revision History

Date	Notes

6/4/2024	Annual review. Increased initial authorization approval duration to 12 months. Removed prescriber requirement from reauthorization criteria. Updated reference.

Orladeyo

Prior Authorization Guideline

Guideline ID	GL-143806
Guideline Name	Orladeyo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	3/30/2024

1 . Indications

Drug Name: Orladeyo
Prophylaxis of HAE attacks Orladeyo is a plasma kallikrein inhibitor indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years and older. Orladeyo should not be used for the treatment of acute HAE attacks.

2 . Criteria

Product Name: Orladeyo [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - ALL of the following:

- Prescribed for the prophylaxis of HAE attacks
- Not used in combination with other approved products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro)
- Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Orladeyo

AND

3 - Prescribed by ONE of the following:

- Immunologist

- Allergist

AND

4 - Submission of medical records documenting a history of failure, contraindication, or intolerance to Haegarda (C1 esterase inhibitor, human)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Orladeyo [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Orladeyo therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest), as confirmed by claims history or submission of medical records, while on Orladeyo therapy

AND

3 - BOTH of the following:

- Prescribed for the prophylaxis of HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro)

AND

4 - Prescribed by ONE of the following: • Immunologist • Allergist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Orladeyo is a plasma kallikrein inhibitor indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years and older. Orladeyo should not be used for the treatment of acute HAE attacks.[1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Orladeyo [package insert]. Durham, NC: BioCryst Pharmaceuticals Inc.; March 2022.
2. Busse, P., Christiansen, S., Riedl, M., et. al. “US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.” The Journal of Allergy and Clinical Immunology. 2020 September 05.
3. Maurer, M., Magerl, M., et. al. “The international WAO/EAACI guideline for the management of hereditary angioedema – the 2017 revision and update.” World Allergy Organization Journal. 2018 February 27.

5 . Revision History

Date	Notes
3/1/2024	Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated reauth criteria to match other drugs in th e class.

Osphena

Prior Authorization Guideline

Guideline ID	GL-144147
Guideline Name	Osphena
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	09/15/2021 ; 03/16/2022 ; 3/20/2024

1 . Indications

Drug Name: Osphena (ospemifene)
Moderate to severe dyspareunia Indicated for the treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy due to menopause. **Moderate to severe vaginal dryness** Indicated for the treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy due to menopause.

2 . Criteria

Product Name: Osphena	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA) due to menopause*	
Notes	*Note: Medications for the treatment of moderate to severe dyspareunia are excluded and are to be denied as a benefit exclusion.

Product Name: Osphena	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy*	
Notes	*Note: Medications for the treatment of moderate to severe dyspareunia are excluded and are to be denied as a benefit exclusion.

3 . Background

Benefit/Coverage/Program Information
Background: Osphena (ospemifene) is indicated for the treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy due to menopause and for the treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA) due to menopause. **Additional Clinical Rules:**

- Supply limits may be in place
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Osphena [package insert]. Princeton, NJ: Duchesnay USA, Inc; May 2023.

5 . Revision History

Date	Notes
3/11/2024	Annual review. Updated references.

Otezla

Prior Authorization Guideline

Guideline ID	GL-154698
Guideline Name	Otezla
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/15/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/18/2020 ; 03/17/2021 ; 02/18/2022 ; 02/17/2023 ; 06/17/2024

1 . Indications

Drug Name: Otezla (apremilast)
Active psoriatic arthritis Indicated for the treatment of adult patients with active psoriatic arthritis. **Plaque psoriasis** Indicated for the treatment of patients with plaque psoriasis who are candidates for phototherapy or systemic therapy. **Behcet's disease** Indicated for the treatment of adult patients with oral ulcers associated with Behcet's disease.

2 . Criteria

Product Name: Otezla [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of active psoriatic arthritis **AND** **2** - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Otezla [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Otezla therapy **AND**	

2 - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Otezla [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of plaque psoriasis who are candidates for phototherapy or systemic therapy **AND** **2** - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Otezla [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Otezla therapy **AND** **2** - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Otezla [a]	
Diagnosis	Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Behcet's disease **AND** **2** - Patient has oral ulcers attributed to Behcet's disease **AND**	

3 - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Otezla [a]	
Diagnosis	Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Otezla therapy **AND** **2** - Patient is not receiving Otezla in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Otezla® (apremilast) is a phosphodiesterase 4 (PDE4) inhibitor indicated for the treatment of adult patients with active psoriatic arthritis, for the treatment of adult patients with plaque psoriasis who are candidates for phototherapy or systemic therapy, for the treatment of pediatric patients 6 years of age and older and weighing at least 20 kg with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy, and for the treatment of adult patients with oral ulcers associated with Behçet's disease. [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Otezla [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.

5 . Revision History

Date	Notes
9/10/2024	Added new strength

Oxervate

Prior Authorization Guideline

Guideline ID	GL-149802
Guideline Name	Oxervate
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Oxervate TM (cenegermin-bkbj) ophthalmic solution
Neurotrophic keratitis Indicated for the treatment of neurotrophic keratitis.

2 . Criteria

Product Name: Oxervate [a]	
Diagnosis	Neurotrophic Keratitis
Approval Length	8 Week(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Stage 2 or 3 neurotrophic keratitis

AND

2 - History of failure to at least ONE OTC ocular artificial tear product (e.g., Systane® Ultra, Akwa® Tears, Refresh Optive®, Soothe® XP)

AND

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

- Ophthalmologist
- Optometrist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Oxervate (cenegermin-bkbj) ophthalmic solution is a recombinant human nerve growth factor indicated for the treatment of neurotrophic keratitis. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

• Supply limits may be in place

4 . References

1. Oxervate [prescribing information]. Boston, MA: Dompé U.S. Inc..; October 2023.
2. Sacchetti, M., Lambiase, A. Diagnosis and management of neurotrophic keratitis. Clinical Ophthalmology 2014;8: 571-9.

5 . Revision History

Date	Notes
7/16/2024	Policy reviewed and approved for application to UnitedHealthcare Value & Balance Exchange for 9/2024 implementation.

Prior Authorization Guideline

Guideline ID	GL-147326
Guideline Name	PAH Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 06/16/2021 ; 09/15/2021 ; 06/15/2022 ; 07/20/2022 ; 11/18/2022 ; 03/15/2023 ; 08/18/2023 ; 02/16/2024 ; 5/17/2024

1 . Indications

Drug Name: Adcirca (tadalafil)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to improve exercise ability. [5]

Drug Name: Adempas (riociguat)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of adults with PAH (WHO Group 1) to improve exercise capacity, improve WHO functional class and to delay clinical worsening. **Chronic thromboembolic pulmonary hypertension (CTEPH)** Indicated for the treatment of adults with persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH to improve exercise capacity and WHO functional class. [10]

Drug Name: Alyq (tadalafil)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to improve exercise ability. [13]
Drug Name: Letairis (ambrisentan)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to improve exercise ability and delay clinical worsening. It is also indicated in combination with tadalafil to reduce the risk of disease progression and hospitalization for worsening PAH, and to improve exercise ability. [2]
Drug Name: Opsumit (macitentan)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to reduce the risks of disease progression and hospitalization for PAH. [8]
Drug Name: Orenitram (treprostinil)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to delay disease progression and to improve exercise capacity. [9]
Drug Name: Revatio (sildenafil), Liqrev (tadalafil)
Pulmonary arterial hypertension (PAH) Indicated in pediatric patients 1 to 17 years old for the treatment of PAH (WHO Group I) to improve exercise ability and, in pediatric patients too young to perform standardized exercise testing, pulmonary hemodynamics thought to underly improvements in exercise. Revatio is also indicated in adult patients for the treatment of PAH (WHO Group 1) to improve exercise ability and delay clinical worsening. [4]
Drug Name: Tracleer (bosentan)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to improve exercise ability and to decrease clinical worsening in adult patients, and improve pulmonary vascular resistance, which is expected to result in an improvement in exercise ability in pediatric patients aged 3 years and older. [3]
Drug Name: Tyvaso (treprostinil), Tyvaso DPI (treprostinil)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to improve exercise ability. [7] **Pulmonary hypertension associated with interstitial lung disease** Indicated for the treatment of pulmonary hypertension associated with interstitial lung disease (WHO Group 3) to improve exercise ability. [7, 13]
Drug Name: Ventavis (iloprost)

Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration. [6]
Drug Name: Uptravi (selexipag)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of PAH (WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH. [12]
Drug Name: Tadliq (tadalafil)
Pulmonary arterial hypertension (PAH) Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise ability.
Drug Name: Opsynvi (macitentan/tadalafil),
Pulmonary Arterial Hypertension Indicated for the chronic treatment of adults with pulmonary arterial hypertension (PAH, WHO Group I and WHO Functional Class (FC) II–III).

2 . Criteria

Product Name: Brand Adcirca, Adempas, Brand Letairis, Opsumit, Brand Tracleer, Ventavis, Orenitram, Tracleer tbso, Tyvaso, Alyq, generic tadalafil 20 mg (PAH) tabs, generic ambrisentan, generic bosentan, Brand Revatio tabs, generic sildenafil 20 mg tabs, Orenitram titration kit, Tyvaso DPI	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

- The medication is prescribed by or in consultation with a cardiologist, pulmonologist or rheumatologist.

OR

2 - BOTH of the following:

- Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension
- The medication is prescribed by or in consultation with a cardiologist, pulmonologist or rheumatologist.

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Adcirca, Adempas, Brand Letairis, Opsumit, Brand Tracleer, Ventavis, Orenitram, Tracleer tbso, Tyvaso, Alyq, generic tadalafil 20 mg (PAH) tabs, generic ambrisentan, generic bosentan, Brand Revatio tabs, generic sildenafil 20 mg tabs, Orenitram titration kit, Tyvaso DPI	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Revatio susp, generic sildenafil susp [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- age
- oral-motor difficulties
- dysphagia

AND

3 - Prescribed by or in consultation with a cardiologist, pulmonologist or rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Revatio susp, generic sildenafil susp [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation the patient is receiving clinical benefit to Revatio oral suspension or generic sildenafil suspension **AND** **2** - Patient remains unable to ingest a solid dosage form (e.g., an oral tablet) due to ONE of the following: • age • oral-motor difficulties • dysphagia	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Liqrev, Tadliq [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: **1.1** ALL of the following • Pulmonary arterial hypertension is symptomatic • Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization	

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- age
- oral-motor difficulties
- dysphagia

AND

3 - History of failure, contraindication, or intolerance to sildenafil citrate suspension (generic Revatio suspension)

AND

4 - Prescribed by or in consultation with a cardiologist, pulmonologist or rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Liqrev, Tadliq [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to Liqrev oral suspension or Tadliq therapy

AND

2 - Patient remains unable to ingest a solid dosage form (e.g., an oral tablet) due to ONE of the following:

- age
- oral-motor difficulties
- dysphagia

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Uptravi, Uptravi titration pack [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 As continuation of therapy

AND

1.2 Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the manufacturer sponsored support program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Orenitram or Uptravi

AND

1.3 Patient is not taking Uptravi in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

AND

1.4 Prescribed by or in consultation with a cardiologist, pulmonologist or rheumatologist

OR

2 - ALL of the following:

2.1 ONE of the following:

2.1.1 ALL of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

2.1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2.2 History of failure, contraindication, or intolerance to BOTH of the following:

2.2.1 ONE of the following:

- A PDE-5 inhibitor [e.g., sildenafil citrate (generic Revatio), tadalafil (generic Adcirca)]
- Adempas

AND

2.2.2 An ERA [e.g., ambrisentan (generic Letairis), Opsumit, or bosentan (generic Tracleer)]

AND

2.3 Patient is not taking Uptravi in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

AND

2.4 Prescribed by or in consultation with a cardiologist, pulmonologist or rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Uptravi, Uptravi titration pack [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to Uptravi therapy

AND

2 - Patient is not taking Uptravi in combination with a prostanoid/prostacyclin analogue (e.g., epoprostenol, iloprost, treprostinil)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Opsynvi [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Pulmonary arterial hypertension is symptomatic
- Diagnosis of pulmonary arterial hypertension that is confirmed by right heart catheterization

OR

1.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

2 - Failure to BOTH of the following TAKEN TOGETHER as confirmed by claims history or submission of medical records:

- A formulary PDE-5 inhibitor
- A formulary ERA

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Opsynvi [a]	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation the patient is receiving clinical benefit to therapy.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Adempas [a]	
Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)
- CTEPH is symptomatic
- Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist

OR

2 - BOTH of the following:

2.1 Patient is currently on any therapy for the diagnosis of CTEPH

AND

2.2 Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Adempas [a]	
Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation the patient is receiving clinical benefit to Adempas therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Tyvaso, Tyvaso DPI [a]	
Diagnosis	Pulmonary Hypertension Associated with Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ALL of the following: • Diagnosis of pulmonary hypertension associated with interstitial lung disease (WHO group 3) confirmed by right heart catheterization • Interstitial lung disease is diagnosed based on evidence of diffuse parenchymal lung disease on computed tomography of the chest • Pulmonary hypertension is symptomatic	

AND **2** - Prescribed by or in consultation with a cardiologist, pulmonologist, or rheumatologist.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Tyvaso, Tyvaso DPI [a]	
Diagnosis	Pulmonary Hypertension Associated with Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Tyvaso therapy (e.g., improved exercise ability)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

3 . Background

Benefit/Coverage/Program Information
Background: Pulmonary arterial hypertension (PAH) is often a progressive disease characterized by elevated pressure in the vessels that carry blood between the heart and the lungs. This results in ventricular dysfunction, reduced exercise capacity, the potential for right sided heart failure, and even death.

Several mechanisms have been identified in the pathogenesis of PAH, leading to the development of four classes of medications to treat the disorder. Endothelin receptor antagonists (ERAs), phosphodiesterase-5 (PDE-5) inhibitors, prostacyclin analogs, and soluble guanylate cyclase (sGC) stimulators may be used as monotherapy, sequential combination therapy, or simultaneous combination therapy to treat PAH. [1]

Letairis (ambrisentan), Tracleer (bosentan), and Opsumit (macitentan) are oral endothelin receptor antagonists (ERA). Letairis is indicated for the treatment of PAH (WHO Group 1) to improve exercise ability and delay clinical worsening. It is also indicated in combination with tadalafil to reduce the risk of disease progression and hospitalization for worsening PAH, and to improve exercise ability. [2] Tracleer is indicated for the treatment of PAH (WHO Group 1) to improve exercise ability and to decrease clinical worsening in adult patients, and improve pulmonary vascular resistance, which is expected to result in an improvement in exercise ability in pediatric patients aged 3 years and older. [3] Opsumit is indicated for the treatment of PAH (WHO Group 1) to reduce the risks of disease progression and hospitalization for PAH. [8]

Revatio (sildenafil), Liqrev (tadalafil), Adcirca (tadalafil), Tadliq (tadalafil), and Alyq (tadalafil) are oral PDE-5 inhibitors. Revatio and Liqrev is indicated in pediatric patients 1 to 17 years old for the treatment of PAH (WHO Group 1) to improve exercise ability, in pediatric patients too young to perform standardized exercise testing, pulmonary hemodynamics thought to underly improvements in exercise. Revatio is also indicated in adult patients for the treatment of PAH (WHO Group 1) to improve exercise ability and delay clinical worsening. [4]
Adcirca and Alyq are indicated for the treatment of PAH (WHO Group 1) to improve exercise ability. [5, 13]

Ventavis (iloprost) and Tyvaso (treprostinil) are prostacyclin analogs administered as inhalation solutions. Tyvaso DPI (treprostinil) is a prostacyclin analog administered as a powder for inhalation. Ventavis is indicated for the treatment of PAH (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration. [6] Tyvaso and Tyvaso DPI are indicated for the treatment of PAH (WHO Group 1) to improve exercise ability. Theyare also indicated for the treatment of pulmonary hypertension associated with interstitial lung disease (WHO Group 3) to improve exercise ability. [7,13]

Orenitram (treprostinil) is an orally administered prostacyclin analog indicated for the treatment of PAH (WHO Group 1) to delay disease progression and to improve exercise capacity. [9]

Adempas (riociguat) is a soluble guanylate cyclase (sGC) stimulator indicated for the treatment of adults with PAH (WHO Group 1) to improve exercise capacity, improve WHO functional class and to delay clinical worsening. Adempas is also indicated for the treatment of adults with persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH to improve exercise capacity and WHO functional class. [10]

Uptravi (selexipag) is a prostacyclin receptor agonist indicated for the treatment of PAH (WHO Group 1) to delay disease progression and reduce the risk of hospitalization for PAH. [12]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limitations may be in place.

Additional Information regarding the endothelin receptor antagonists (Letairis, Opsumit, and Tracleer):

These agents should be used with caution in patients with liver disease. Use is not recommended in moderate to severe hepatic impairment. Tracleer product labeling includes a black box warning regarding the risk of liver injury. Prescribers are cautioned to consider whether benefits of use offset the risk of liver injury in WHO Class II patients. Early liver injury may preclude future use as disease progresses. [3]

Additional Information regarding the oral PDE-5 inhibitors (Revatio, Adcirca, Tadliq, Liqrev and Alyq):

Administration of the oral PDE-5 inhibitors to patients taking any form of organic nitrate, either regularly or intermittently, is contraindicated. [4,5] In addition, the concomitant administration of oral PDE-5 inhibitors with Adempas is contraindicated. [9]

4 . References

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4. Revatio [package insert]. New York, NY: Pfizer Labs; January 2023.
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6. Ventavis [package insert]. Titusville, NJ: Actelion Pharmaceuticals US, Inc.; March 2022.
7. Tyvaso [package insert]. Research Triangle Park, NC: United Therapeutics Corp.; March 2021.
8. Opsumit [package insert]. Titusville, NJ: Actelion Pharmaceuticals US Inc.; June 2023.
9. Orenitram [package insert]. Research Triangle Park, NC: United Therapeutics Corp.; August 2023.
10. Adempas [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; September 2021.
11. Taichman D, Ornelas J, Chung L, et al. Pharmacologic Therapy for Pulmonary Arterial Hypertension in Adults. CHEST 2014;146(2):449-475.
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13. Alyq [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc.; January 2019.
14. Uptravi [package insert]. South Titusville, NJ: Actelion Pharmaceuticals US, Inc; July 2022.
15. Tyvaso DPI [package insert]. Research Triangle Park, NC: United Therapeutics Corp.; June 2023.
16. Tadliq [package insert]. Farmville, NC: CMP Pharma, Inc.; October 2023.
17. Liqrev [package insert]. Farmville, NC: CMP Pharma, Inc.; April 2023.
18. Opsynvi [package insert]. Titusville, NJ: Janssen Pharmaceutical Company; March 2024.

5 . Revision History

Date	Notes
5/15/2024	Added Opsynvi to criteria

Piqray

Prior Authorization Guideline

Guideline ID	GL-143809
Guideline Name	Piqray
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 08/20/2021 ; 09/15/2021 ; 08/19/2022 ; 08/18/2023 ; 3/20/2024

1 . Indications

Drug Name: Piqray (alpelisib)
Breast Cancer Indicated for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer following progression on or after an endocrine-based regimen.

2 . Criteria

Product Name: Piqray (alpelisib) [a]	
Diagnosis	Breast Cancer

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

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - ONE of the following:

- Advanced
- Metastatic

AND

3 - Disease is hormone receptor (HR)-positive

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - Presence of one or more PIK3CA mutations

AND

6 - Used in combination with fulvestrant

AND

7 - Disease has progressed on or after an endocrine-based regimen	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Piqray (alpelisib) [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Piqray therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Piqray (alpelisib) [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Piqray will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Piqray (alpelisib) [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Piqray therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Piqray (alpelisib) is a kinase inhibitor indicated in combination with fulvestrant for the treatment of adults with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer following progression on or after an endocrine-based regimen. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Piqray [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation. January 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed February 7, 2024.

5 . Revision History

Date	Notes
3/1/2024	Updated criteria reflecting new indication for use is adults removing c riteria for postmenopausal, premenopausal with ovarian ablation/sup pression and male. Updated background and references.

Pomalyst

Prior Authorization Guideline

Guideline ID	GL-147334
Guideline Name	Pomalyst
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	05/20/2022 ; 05/25/2023 ; 5/17/2024

1 . Indications

Drug Name: Pomalyst
Multiple myeloma Indicated for the treatment of adult patients, in combination with dexamethasone, for patients with multiple myeloma (MM) who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or within 60 days of completion of the last therapy. **Kaposi sarcoma** Indicated for patients with AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative. **Other Uses:** The National Comprehensive Cancer Network (NCCN) also recommends use of Pomalyst for the treatment of relapsed/refractory systemic light chain amyloidosis in combination with dexamethasone and, for the treatment of relapsed or refractory primary central nervous system (CNS) lymphoma. Additionally, Pomalyst is recommended in NCCN for treatment of multiple myeloma in combination of dexamethasone after receiving only one prior line of therapy or for induction therapy for the management of POEMS

2 . Criteria

Product Name: Pomalyst [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple myeloma

AND

2 - ONE of the following:

2.1 History of failure, contraindication, or intolerance to ONE of the following:

- Immunomodulatory agent [e.g., Revlimid (lenalidomide)]
- Proteasome inhibitor [e.g.,Velcade (bortezomib)]

OR

2.2 Induction therapy for the management of POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Pomalyst [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Pomalyst therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of systemic light chain amyloidosis **AND** **2** - Used in combination with dexamethasone	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Pomalyst therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of HIV-negative Kaposi Sarcoma **OR** **2** - BOTH of the following: • Diagnosis of AIDS-related Kaposi Sarcoma • Patient is currently being treated with antiretroviral therapy (ART)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	Kaposi Sarcoma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Pomalyst therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	Primary CNS Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Both of the following: **1.1** Diagnosis of primary CNS lymphoma **AND** **1.2** Used as second-line or a subsequent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	Primary CNS Lymphoma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Pomalyst therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Pomalyst will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pomalyst [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Pomalyst therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Pomalyst (pomalidomide) is a thalidomide analogue indicated for the treatment of adult patients, in combination with dexamethasone, for patients with multiple myeloma who have received at least two prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor [e.g., Velcade® (bortezomib)] and have demonstrated disease progression on or within 60 days of completion of the last therapy. Pomalyst is also indicated for adult patients with AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative.[1] The National Comprehensive Cancer Network (NCCN) also recommends use of Pomalyst for the treatment of systemic light chain amyloidosis in combination with dexamethasone and, for the treatment of relapsed or refractory primary central nervous system (CNS) lymphoma. Additionally, Pomalyst is recommended in NCCN for treatment of multiple myeloma in combination of dexamethasone after receiving only one prior line of therapy or for induction therapy for the management of POEMS. [2] Due to embryo-fetal risk (pregnancy category X) associated with Pomalyst; it is available only through the Pomalyst Risk Evaluation and Mitigation Strategy (REMS) Program. Prescribers and pharmacies must be certified with the Pomalyst REMS Program by enrolling and complying with the REMS requirements. Patients must sign a Patient-Physician agreement form and comply with the REMS requirements. Specifically, female patients who are not pregnant but can become pregnant must comply with the pregnancy testing and contraception requirements and males must comply with contraception requirements. Pharmacies must only dispense to patients who are authorized to receive the drug and must

comply with REMS requirements. Additional information may be found at: https://www.pomalystrems.com/.[3].

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed March 25, 2024
3. Pomalyst REMS®. Available at https://www.pomalystrems.com/. Accessed March 25, 2024.

5 . Revision History

Date	Notes
5/13/2024	Annual review. Updated criteria for multiple myeloma and kaposi sarc oma. Updated background and references.

Praluent

Prior Authorization Guideline

Guideline ID	GL-147336
Guideline Name	Praluent
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	06/15/2022 ; 01/18/2023 ; 06/21/2023 ; 10/18/2023 ; 02/16/2024 ; 5/17/2024

1 . Indications

Drug Name: Praluent
Primary hyperlipidemia Indicated as adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C)-lowering therapies (e.g., statins, ezetimibe, LDL apheresis), for the treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce LDL-C **Cardiovascular Disease** Indicated to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease. **Homozygous Familial Hypercholesterolemia** Indicated as an adjunct to other LDL-C-lowering therapies in adult patients with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C. Indicated as an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 8 years and older with HeFH to reduce LDL-C.

2 . Criteria

Product Name: Praluent [a]	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - ONE of the following diagnoses:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following: [14-16]

1.1.1.1 Pre-treatment LDL-C greater than or equal to 190 mg/dL (greater than or equal to 155 mg/dL if less than 16 years of age)

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 BOTH of the following: [14-16]

1.1.2.1 Pre-treatment LDL-C greater than or equal to 190 mg/dL (greater than or equal to 155 mg/dL if less than 16 years of age)

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL, apoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

OR

1.3 Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

2.1 Patient has been receiving at least 12 consecutive weeks OF HIGH INTENSITY STATIN THERAPY [i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a high-intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e. atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin ≥ 10 mg, pravastatin ≥ 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40mg twice daily or Livalo (pitavastatin) ≥ 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate LOW OR MODERATE-, AND HIGH-INTENSITY STATINS as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical records (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

- Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy
- Patient has a history of contraindication, or intolerance to ezetimibe

AND

4 - ONE of the following:

- Patient is less than 10 years of age

- History of failure, contraindication, or intolerance to Repatha (evolocumab) (document date of trial and list reason for therapeutic failure, contraindication, or intolerance)

AND

5 - Patient has received comprehensive counseling regarding appropriate diet

AND

6 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

7 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

8 - Not used in combination with Leqvio (inclisiran)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Praluent [a]	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C reduction while on Praluent therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Praluent [a]	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 Both of the following:

1.2.1 Pre-Treatment LDL-C greater than 400 mg/dL

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diet

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)]

AND

6 - Not used in combination with Juxtapid (lomitapide)

AND

7 - History of failure, contraindication, or intolerance to Repatha (evolocumab) (document date of trial and list reason for therapeutic failure, contraindication, or intolerance)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Praluent [a]	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting LDL-C reduction while on Praluent therapy

AND

2 - Prescribed by ONE of the following:

- Cardiologist

• Endocrinologist • Lipid specialist **AND** **3** - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Repatha (evolocumab)] **AND** **4** - Not used in combination with Juxtapid (lomitapide)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Praluent (alirocumab) is a PCSK9 (Proprotein Convertase Subtilisin Kexin Type 9) inhibitor indicated: [1] • To reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease. • As adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C) lowering therapies (e.g., statins, ezetimibe, LDL apheresis), for the treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce LDL-C. • As an adjunct to other LDL-C-lowering therapies in adult patients with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C. • As an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 8 years and older with HeFH to reduce LDL-C. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Praluent [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals; March 2024.
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20. Writing Committee, Lloyd-Jones DM, Morris PB, et al. 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2022;80(14):1366-1418. doi:10.1016/j.jacc.2022.07.006
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5 . Revision History

Date	Notes
5/17/2024	Added criterion for patients less than 10 years of age to align with new label for pediatric patients aged 8 years and older with HeFH. Updated background and reference.

Prior Authorization Guideline

Guideline ID	GL-133919
Guideline Name	Prior Authorization Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	1/21/2021
P&T Revision Date:	01/21/2021

Note:

Technician Note Link to Exclusions and Limitations Grid:
https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange

1 . Criteria

Product Name: Medications with a Prior Authorization Requirement without a Drug Specific Guideline, Medications with New FDA-Approved Indications	
Diagnosis	Prior Authorization Required Medications Used for Non-Cancer Indications [a]

Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - For formulary drugs with a prior authorization requirement, for which a guideline is unavailable, the requested drug will be approved based on BOTH of the following criteria:

1.1 One of the following:

1.1.1 Both of the following:

1.1.1.1 Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert)

AND

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

OR

1.1.2 Off-label criteria are met*

AND

1.2 The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note for the Exclusions and Limitations Grid URL)

OR

2 - For new FDA-approved indications, which are not addressed in the existing drug-specific prior authorization guideline, the requested drug will be approved based on all of the following criteria:

2.1 Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert)

AND

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

AND

2.3 The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note for the Exclusions and Limitations Grid URL)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. Authorization will be issued for 12 months. *Reference the Off-label Administrative Guideline.

Product Name: Medications with a Prior Authorization Requirement without a Drug Specific Guideline, Medications with New FDA-Approved Indications	
Diagnosis	Prior Authorization Required Medications Used for Cancer Indications [a]
Approval Length	12 month(s)
Guideline Type	Administrative Prior Authorization

Approval Criteria

1 - For formulary drugs with a prior authorization requirement, for which a guideline is unavailable, the requested drug will be approved based on ONE of the following criteria:

1.1 Both of the following:

1.1.1 Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert)

AND **1.1.2** Additional requirements listed in the "Indications and Usage" and "Dosage and Administration" sections of the prescribing information (or package insert) have been met (e.g.: first line therapies have been tried and failed, any testing requirements have been met, etc.) **OR** **1.2** Off-label criteria are met* **OR** **2** - For new FDA-approved indications, which are not addressed in the existing drug-specific prior authorization guideline, the requested drug will be approved based on both of the following criteria: **2.1** Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert) **AND** **2.2** Additional requirements listed in the "Indications and Usage" and "Dosage and Administration" sections of the prescribing information (or package insert) have been met (e.g.: first line therapies have been tried and failed, any testing requirements have been met, etc.)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. Authorization will be issued for 12 months. *Reference the Off-label Administrative Guideline.

2 . Background

Benefit/Coverage/Program Information
Background: This program is to be administered to medications that have a prior authorization requirement but do not have a drug specific guideline. The program is also to be administered when new FDA-approved indications are not addressed in an existing drug-specific prior authorization guideline. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

3 . Revision History

Date	Notes
9/28/2023	Updated guideline name, cleaned up criteria, indications, and notes, updated background, and removed references.

Progesterone

Prior Authorization Guideline

Guideline ID	GL-144793
Guideline Name	Progesterone
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/17/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	09/21/2022 ; 12/14/2022 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Endometrin (progesterone vaginal insert)
Infertility Indicated to support embryo implantation and early pregnancy by supplementation of corpus luteal function as part of an ART treatment program for infertile women.
Drug Name: Crinone (progesterone vaginal gel)
Infertility Indicated for progesterone supplementation or replacement as part of an Assisted Reproductive Technology (ART) treatment for infertile women with progesterone deficiency. **Secondary amenorrhea** Crinone is also indicated for the treatment of secondary amenorrhea.

2 . Criteria

Product Name: Endometrin, Crinone	
Diagnosis	Infertility** [a]
Approval Length	2 month(s)
Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of infertility **AND** **2** - Documentation of an approved assisted reproductive technology (ART) protocol	
Notes	**Requests for an infertility related diagnosis other than ovulation induction for members in New Jersey, North Carolina Kansas and Texas should be denied as a benefit exclusion. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Endometrin, Crinone	
Diagnosis	Non-Infertility [a]
Approval Length	6 month(s)
Guideline Type	Non Formulary
Approval Criteria **1** - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: This program is designed to provide coverage for these medications to be used in conjunction with Assisted Reproductive Technologies (ART, i.e., in vitro fertilization). Endometrin® (progesterone inserts) is indicated to support embryo implantation and early pregnancy by supplementation of corpus luteal function as part of an ART treatment program for infertile women. Crinone (progesterone gel) is indicated for progesterone supplementation or replacement as part of an Assisted Reproductive Technology (ART) treatment for infertile women with progesterone deficiency. Crinone is also indicated for the treatment of secondary amenorrhea. **Additional Clinical Rules** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Endometrin [package insert]. Parsippany, NJ: Ferring Pharmaceuticals Inc; January 2018.
2. Crinone [package insert]. Parsippany, NJ: Actavis Pharma; June 2017.

5 . Revision History

Date	Notes
3/25/2024	Texas added to ovulation induction operation note.

Promacta, Alvaiz

Prior Authorization Guideline

Guideline ID	GL-150905
Guideline Name	Promacta, Alvaiz
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 11/19/2021 ; 01/19/2022 ; 01/18/2023 ; 01/17/2024 ; 06/17/2024 ; 8/16/2024

1 . Indications

Drug Name: Promacta (eltrombopag), Alvaiz (eltrombopag)
Chronic immune thrombocytopenia (ITP) Indicated for the treatment of thrombocytopenia in adult and pediatric patients (1 year and older for Promacta and 6 years and older for Alvaiz) with persistent or chronic immune thrombocytopenia (ITP) who have experienced an insufficient response to corticosteroids, immunoglobulins, or splenectomy. **Chronic hepatitis C-associated thrombocytopenia** Indicated for the treatment of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy. **Aplastic Anemia** Indicated for the treatment of patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.

2 . Criteria

Product Name: Promacta, Alvaiz [a]	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic immune thrombocytopenia (ITP) **AND** **2** - History of failure, contraindication, or intolerance to at least ONE of the following: • Corticosteroids • Immunoglobulins • Splenectomy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Promacta, Alvaiz [a]	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Promacta or Alvaiz therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Promacta, Alvaiz [a]	
Diagnosis	Chronic hepatitis C-associated thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic hepatitis C-associated thrombocytopenia **AND** **2** - ONE of the following: • Planning to initiate and maintain interferon-based treatment • Currently receiving interferon-based treatment	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Promacta, Alvaiz [a]	
Diagnosis	Chronic hepatitis C-associated thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Promacta or Alvaiz therapy

AND

2 - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Promacta, Alvaiz [a]	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe aplastic anemia

AND

2 - ONE of the following:

- Used in combination with standard immunosuppressive therapy (e.g., Atgam [antithymocyte globulin equine], Thymoglobulin [antithymocyte globulin rabbit], cyclosporine)
- History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy (e.g., Atgam [antithymocyte globulin equine], Thymoglobulin [antithymocyte globulin rabbit], cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Promacta, Alvaiz [a]	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Promacta or Alvaiz therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Promacta and Alvaiz (eltrombopag) are thrombopoietin receptor agonists indicated for the treatment of thrombocytopenia in adult and pediatric patients (1 year and older for Promacta and 6 years and older for Alvaiz) with persistent or chronic immune thrombocytopenia (ITP) who have experienced an insufficient response to corticosteroids, immunoglobulins, or splenectomy, for the treatment of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy, and for the treatment of patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy. [1] Promacta is also approved in combination with standard immunosuppressive therapy for the first line treatment of adult and pediatric patients 2 years and older with severe aplastic anemia. Promacta and Alvaiz should be used only in patients with ITP whose degree of thrombocytopenia and clinical condition increase the risk for bleeding. [1]

Promacta and Alvaiz should be used only in patients with chronic hepatitis C whose degree of thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. Safety and efficacy have not been established in combination with direct-acting antiviral agents used without interferon for treatment of chronic hepatitis C infection. [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Promacta [Package Insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2023.
2. Alvaiz [Package Insert]. Parsippany, NJ: Teva Pharmaceuticals; November 2023.

5 . Revision History

Date	Notes
8/2/2024	Updated authorization durations throughout to 12 months.

Prudoxin and Zonalon

Prior Authorization Guideline

Guideline ID	GL-122959
Guideline Name	Prudoxin and Zonalon
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	01/15/2020 ; 03/17/2021 ; 09/15/2021 ; 03/16/2022 ; 3/15/2023

1 . Indications

Drug Name: Prudoxin and Zonalon cream
Atopic dermatitis or lichen simplex chronicus Indicated for the short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus.

2 . Criteria

Product Name: Brand Prudoxin, Brand Zonalon cream, generic doxepin cream [a]	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderate pruritus due to one of the following: **1.1** Atopic dermatitis **OR** **1.2** Lichen simplex chronicus	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Brand Prudoxin, Brand Zonalon cream, generic doxepin cream [a]	
Approval Length	1 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy **AND** **2** - Diagnosis of moderate pruritis due to either atopic dermatitis or lichen simplex chronicus	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

3 . Background

Benefit/Coverage/Program Information
Background: Prudoxin and Zonalon cream are indicated for the short-term (up to 8 days) management of moderate pruritus in adult patients with atopic dermatitis or lichen simplex chronicus. **Additional Clinical Rules** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place

4 . References

1. Prudoxin [package insert]. Morgantown, WV: Mylan Pharmaceuticals; June 2017.
2. Zonalon [package insert]. San Antonio, TX: DPT Laboratories, Ltd.; June 2017.

5 . Revision History

Date	Notes
3/22/2023	Annual review. Added state mandate language.

Pulmozyme

Prior Authorization Guideline

Guideline ID	GL-121441
Guideline Name	Pulmozyme
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/18/2022 ; 2/17/2023

1 . Indications

Drug Name: Pulmozyme (dornase alfa)
Cystic fibrosis Indicated in conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function.

2 . Criteria

Product Name: Pulmozyme [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis **AND** **2** - Used in conjunction with standard CF therapies [e.g., chest physiotherapy, bronchodilators, antibiotics, anti-inflammatory therapy (e.g., ibuprofen, oral/inhaled corticosteroids)] [2]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pulmozyme [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Pulmozyme therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background

Pulmozyme (dornase alfa) is a recombinant deoxyribonuclease (DNase) enzyme indicated in conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function.

In CF patients with a forced vital capacity (FVC) ≥ 40% of predicted, daily administration of Pulmozyme has also been shown to reduce the risk of respiratory tract infections requiring parenteral antibiotics.[1]

Additional Clinical Rules

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Pulmozyme [package insert]. South San Francisco, CA: Genentech, Inc.; July 2021.
2. Mogayzel P, Naureckas E, Robinson K, Mueller G, Hadjiliadis D, Hoag J, Lubsch L, Hazle L, Sabadosa K, Marshall B; Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. American Journal of Respiratory and Critical Care Medicine 2013;187:680-689.

5 . Revision History

Date	Notes
2/22/2023	Annual review. No changes to coverage criteria. Added state mandat e footnote.

Pyrukynd

Prior Authorization Guideline

Guideline ID	GL-147338
Guideline Name	Pyrukynd
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	5/20/2022
P&T Revision Date:	5/17/2024

1 . Indications

Drug Name: Pyrukynd (mitapivat)
Hemolytic anemia Indicated for the treatment of hemolytic anemia in adults with pyruvate kinase (PK) deficiency.

2 . Criteria

Product Name: Pyrukynd [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of pyruvate kinase (PK) deficiency based on ALL of the following:

- Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 is a missense variant
- Patient is not homozygous for the c.1436G>A (p.R479H) variant
- Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

2 - Used for the treatment of hemolytic anemia

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Baseline hemoglobin less than or equal to 10 g/dL
- Patient has had no more than 4 transfusions in the previous 52 weeks and no transfusions in the preceding 3-month period

OR

3.2 Patient has had a minimum of 6 transfusion episodes in the preceding 52 weeks

AND

4 - Prescribed by a nephrologist or hematologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pyrukynd	
Diagnosis	Documentation of positive clinical response to Pyrukynd therapy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Pyrukynd therapy **AND** **2** - Prescribed by, or in consultation with, a nephrologist or hematologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Pyrukynd	
Diagnosis	Documentation does not provide evidence of positive clinical response to Pyrukynd therapy
Approval Length	4 Week(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation does not provide evidence of positive clinical response to Pyrukynd therapy, allow for dose titration with discontinuation of therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program. • Supply limitations may be in place **Background** Pyrukynd® (mitapivat) is a pyruvate kinase activator indicated for the treatment of hemolytic anemia in adults with pyruvate kinase (PK) deficiency.

4 . References

1. Pyrukynd [package insert]. Cambridge, MA: Agios Pharmaceuticals, Inc.; February 2022.

5 . Revision History

Date	Notes
5/13/2024	Updated initial approval duration from 6 months to 12 months. Simplified reauthorization criteria. Added state mandate note.

Qlosi, Vuity

Prior Authorization Guideline

Guideline ID	GL-138097
Guideline Name	Qlosi, Vuity
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	4/20/2022
P&T Revision Date:	03/15/2023 ; 1/17/2024

1 . Indications

Drug Name: Vuity (pilocarpine), Qlosi (pilocarpine)
Presbyopia FDA approved indication for the treatment of presbyopia in adults.

2 . Criteria

Product Name: Vuity, Qlosi [a]	
Diagnosis	Treatment of Presbyopia
Guideline Type	Non Formulary

Approval Criteria **1** - Qlosi or Vuity are not considered medically necessary for the treatment of presbyopia based on the definition of medically necessary health care services in the certificate of coverage. All requests for authorization will be denied.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

3 . Background

Benefit/Coverage/Program Information
Background: Qlosi (pilocarpine) 0.4% ophthalmic solution and Vuity (pilocarpine) 1.25% ophthalmic solution are indicated for the treatment of presbyopia in adults. The efficacy of Qlosi was established in clinical trials with patients aged 45 to 64 years of age with presbyopia and for Vuity in patients aged 40 to 55 years of age with presbyopia. The standard of therapy for the treatment of presbyopia is use of corrective lenses, such as glasses and contact lenses, or refractive surgery. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Qlosi [package insert]. Ponte Vedra, FL: Orasis Pharmaceuticals, Ltd.; October 2023.
2. Vuity [package insert]. North Chicago, IL: AbbVie Inc.; March 2023.
3. Mian, SI. Visual impairment in adults: Refractive disorders and presbyopia. In: UpToDate, Gardiner, MF, UpToDate, Waltham, MA, 2023.

5 . Revision History

Date	Notes
12/20/2023	Annual review. Added Qlosi. Updated references.

Prior Authorization Guideline

Guideline ID	GL-144849
Guideline Name	Quantity Limits Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	05/21/2021 ; 10/20/2021 ; 10/20/2021

Note:

Technician Note: Link to Exclusions and Limitations Grid:
https://uhgazure.sharepoint.com/sites/CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&viewid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2Fsites%2FCST%2FCSDM%2FShared%20Documents%2FUHCGP%20Exchange

1 . Criteria

Product Name: Opioid containing medications for malignant pain	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - In the absence of an opioid-specific quantity limit override guideline, the following approval criteria will be used:

1.1 Diagnosis of malignant (cancer) pain

AND

1.2 For opioid containing combination products, the total daily dose of the non-opioid component is supported by one of the following references:

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX Information System
- National Comprehensive Cancer Network (NCCN)
- Clinical pharmacology
- Wolters Kluwer Lexi-Drugs
- United States Pharmacopoeia-National Formulary (USP-NF)
- Drug Facts and Comparisons

Product Name: Opioid containing medications for non-malignant pain	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - One of the following:

1.1 Quantity limit override requests must involve an FDA-approved indication

OR

1.2 Quantity limit override requests involving off-label indications must meet off-label guideline requirements*

AND

2 - One of the following:

2.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

2.2 Higher dose or quantity is supported by one of the following references:

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX Information System
- Clinical pharmacology
- Wolters Kluwer Lexi-Drugs
- United States Pharmacopoeia-National Formulary (USP-NF)
- Drug Facts and Comparisons

AND

3 - Quantity requests exceeding the plan's quantity limits will be approved if one of the following criteria are met:

3.1 The prescriber maintains and provides chart documentation of the patient's evaluation, including all of the following:

- An appropriate patient medical history and physical examination
- A description of the nature and intensity of the pain
- Documentation of appropriate dose escalation
- Documentation of ongoing, periodic review of the course of opioid therapy
- An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- Verification that the risks and benefits of the use of the controlled substance have been discussed with the patient, significant other(s), and/or guardian

OR

3.2 All of the following:

3.2.1 Medication is being used to treat postoperative pain

AND

3.2.2 Medication is not being prescribed for pain related to a dental procedure

AND

3.2.3 The dose being prescribed is the dose that the patient was stable on prior to discharge

AND

4 - For opioid combination products, the total daily dose of the non-opioid component must be supported by one of the following references:

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX Information System
- Clinical pharmacology
- Wolters Kluwer Lexi-Drugs
- United States Pharmacopoeia-National Formulary (USP-NF)
- Drug Facts and Comparisons

Notes	*Reference the Off-label Administrative Guideline.

Product Name: Opioid containing medications for non-pain uses	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - One of the following:

1.1 Quantity limit override requests must involve an FDA-approved indication

OR

1.2 Quantity limit override requests involving off-label indications must meet off-label guideline requirements*

AND

2 - One of the following:

2.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

2.2 Higher dose or quantity is supported by one of the following resources:

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX Information System
- Clinical pharmacology
- Wolters Kluwer Lexi-Drugs
- United States Pharmacopoeia-National Formulary (USP-NF)
- Drug Facts and Comparisons

AND

3 - The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (see technician note for the Exclusions and Limitations Grid URL)

Notes	*Reference the Off-label Administrative Guideline.

Product Name: Non-opioid medications (except eye drops, topical applications, condoms, spermicides, emergency contraceptive products, non-hormonal vaginal contraceptives, and contraceptive implants) (in the absence of a drug-specific guideline)*	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - One of the following:

1.1 Quantity limit override requests must involve an FDA-approved indication

OR

1.2 Quantity limit override requests involving off-label indications must meet off-label guideline approval criteria*

AND

2 - One of the following:

2.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

2.2 Higher dose or quantity is supported by one of the following resources:

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX Information System
- Clinical pharmacology
- Wolters Kluwer Lexi-Drugs
- United States Pharmacopoeia-National Formulary (USP-NF)
- Drug Facts and Comparisons
- National Comprehensive Cancer Network (NCCN)

AND

3 - One of the following:

3.1 The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation (for example, for titration or loading-dose purposes, dose-alternating schedule)

OR

3.2 For glycemic agents prescribed for hypoglycemia treatment (e.g., glucagon), the patient is experiencing or is prone to hypoglycemia

OR

3.3 For diabetic testing products (e.g., glucose control solution), the patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control

OR

3.4 For antiemetics (e.g., ondansetron), the patient requires a larger quantity due to chemotherapy cycle or surgery

OR

3.5 One of the following:

3.5.1 Requested strength/dose is commercially unavailable

OR

3.5.2 There is a medically necessary justification why patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency

AND

4 - The use is not excluded as documented in the limitations and exclusions section of the certificate of coverage (refer to the Exclusions and Limitations Grid found in the link in the Background section)

Notes	*Reference the Off-label Administrative Guideline. For requested drugs containing acetaminophen where the cumulative

	acetaminophen dose exceeds 4 grams per day, apply the Therdose g uideline.

Product Name: Eye Drops	
Approval Length	12 months. Authorization will be for one additional bottle of eye drops per 30 days.
Guideline Type	Administrative

Approval Criteria

1 - One additional bottle of eye drops may be approved based on BOTH of the following:

1.1 One of the following:

- Quantity limit override requests must involve an FDA-approved indication
- Quantity limit override requests involving off-label indications must meet off-label guideline approval criteria*

AND

1.2 The patient requires a larger quantity due to a medical condition making it difficult to accurately administer a single drop**

Notes	**Examples of medical conditions making it difficult to accurately admi nister a single drop include: arthritis, tremor, Parkinson disease, neuro logical condition, musculoskeletal condition, etc. The request may als o be approved if the provider states an additional bottle is needed by t he insured for use in a day care center, school, or adult day program. *Reference the Off-label Administrative Guideline.

Product Name: Condoms, Spermicides (e.g., Encare), Emergency Contraceptive Products (e.g., Ella), Non-Hormonal Vaginal Contraceptives (e.g., Phexxi), and Contraceptive Implants (e.g., Nexplanon)	
Approval Length	12 months. Authorization will be for the requested quantity.
Guideline Type	Administrative

Approval Criteria

1 - Physician attests that the patient requires a larger quantity

Product Name: Topical Applications	
Approval Length	12 months. Authorization will be for the requested quantity.
Guideline Type	Administrative
Approval Criteria **1** - One of the following: **1.1** Quantity limit override requests must involve an FDA-approved **OR** **1.2** Quantity limit override requests involving off-label indications must meet off-label guideline approval criteria* **AND** **2** - Physician attests that the patient requires a larger quantity to cover a larger surface area	
Notes	*Reference the Off-label Administrative Guideline.

2 . Revision History

Date	Notes
3/26/2024	Removed operational note for albuterol inhalers.

Radicava ORS

Prior Authorization Guideline

Guideline ID	GL-149929
Guideline Name	Radicava ORS
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/20/2022
P&T Revision Date:	7/17/2024

1 . Indications

Drug Name: Radicava ORS (edaravone)
Amyotrophic lateral sclerosis (ALS) Indicated for the treatment of amyotrophic lateral sclerosis (ALS).

2 . Criteria

Product Name: Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - BOTH of the following:

1.1 Patient has been established on therapy with Radicava for amyotrophic lateral sclerosis under an active UnitedHealthcare medical benefit prior authorization

AND

1.2 ALL of the following:

- Diagnosis of “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria
- Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS
- Patient is currently receiving Radicava therapy
- Patient is not dependent on invasive ventilation or tracheostomy

OR

2 - ALL of the following:

2.1 Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria [2]

AND

2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

2.3 Submission of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score

confirming that the patient has scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment [3]

AND

2.4 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment [3]

Product Name: Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of “definite” or “probable” ALS per the El Escorial/revised Airlie House diagnostic criteria

AND

2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient is currently receiving Radicava ORS therapy

AND

4 - Patient is not dependent on invasive ventilation or tracheostomy

3 . Background

Benefit/Coverage/Program Information
Background: Radicava ORS is indicated for the treatment of amyotrophic lateral sclerosis (ALS). [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Radicava ORS [package insert]. Jersey City, NJ: Mitsubishi Tanabe Pharma Corporation. May 2022.
2. Subcommittee on Motor Neuron Diseases of World Federation of Neurology Research Group on Neuromuscular Diseases, El Escorial “Clinical Limits of ALS” Workshop Contributors. El Escorial World Federation of Neurology criteria for the diagnosis of amyotrophic lateral sclerosis. J Neurol Sci 1994; 124: 96–107.
3. Takahashi F, Takei K, Tsuda K, Palumbo J. Post-hoc analysis of MCI186-17, the extension study to MCI186-16, the confirmatory double-blind, parallel-group, placebo-control006Ced study of edaravone in amyotrophic lateral sclerosis. Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration. 2017;18(sup1):32-39.

5 . Revision History

Date	Notes
7/17/2024	Annual review. Clarified criteria for existing prior authorization for und er the medical benefit. Updated initial authorization and reauthorizati on to 12 months.

Regranex

Prior Authorization Guideline

Guideline ID	GL-130143
Guideline Name	Regranex
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 12/15/2021 ; 11/18/2022 ; 8/18/2023

1 . Indications

Drug Name: Regranex (becaplermin gel)
Lower extremity diabetic neuropathic ulcers Indicated for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue, or beyond, and have an adequate blood supply.

2 . Criteria

Product Name: Regranex [a]	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient has a lower extremity diabetic neuropathic ulcer	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Regranex is indicated for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue, or beyond, and have an adequate blood supply. Regranex should be used as an adjunct to, and not a substitute for, good ulcer care practices including initial sharp debridement, pressure relief and infection control. The efficacy of Regranex gel has not been established for the treatment of pressure ulcers or venous stasis ulcers. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Regranex [package insert]. Fort Worth, TX: Smith & Nephew, Inc; August 2019.

5 . Revision History

Date	Notes
8/21/2023	Annual review.
8/21/2023	Received approved from Lesley for TSK005167914 _Eff: 10.1.23. BA 8.21.23

Relistor

Prior Authorization Guideline

Guideline ID	GL-149935
Guideline Name	Relistor
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 07/21/2021 ; 07/20/2022 ; 07/19/2023 ; 7/17/2024

1 . Indications

Drug Name: Relistor (methylnaltrexone bromide)
Opioid-induced constipation Indicated for the treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation. Relistor injection is also indicated for the treatment of opioid-induced constipation in patients with advanced illness or pain caused by active cancer who require opioid dosage escalation for palliative care.

2 . Criteria

Product Name: Relistor injection [a]

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

Approval Criteria

1 - Relistor injection will be approved based on documentation (e.g. chart notes) demonstrating ONE of the following:

1.1 Diagnosis of opioid induced constipation in patients with advanced illness receiving palliative care

OR

1.2 BOTH of the following:

1.2.1 ONE of the following:

- Diagnosis of opioid induced constipation with chronic, non-cancer pain
- Diagnosis of opioid induced constipation in patients with chronic pain related to prior cancer diagnosis or cancer treatment who do not require frequent (e.g., weekly) opioid dosage escalation.

AND

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

- lubiprostone (generic Amitiza)
- Symproic

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Relistor injection [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Relistor injection therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Relistor (methylnaltrexone bromide) is an opioid antagonists indicated for the treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation. Relistor injection is also indicated for the treatment of opioid-induced constipation in patients with advanced illness or pain caused by active cancer who require opioid dosage escalation for palliative care. Physicians and patients should periodically assess the need for continued treatment with Relistor. This prior authorization program is intended to encourage the use of lower cost alternatives. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Relistor [package insert]. Bridgewater, NJ: Bausch Health US, LLC; May 2024.
2. Amitiza [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc.; November 2020.
3. Symproic [package insert]. Raleigh, NC: BioDelivery Sciences International; July 2021.
4. Chang, L, Sultan, S, et al. AGA Clinical Practice Guideline on the Pharmacological Management of Irritable Bowel Syndrome with Constipation. Gastroenterology: 2022; 162:118-36.

5 . Revision History

Date	Notes
7/17/2024	Annual review. Updated references.

Relyvrio

Prior Authorization Guideline

Guideline ID	GL-118086
Guideline Name	Relyvrio
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2023
P&T Approval Date:	12/14/2022
P&T Revision Date:	

1 . Indications

Drug Name: Relyvrio
Amyotrophic lateral sclerosis (ALS) Indicated for the treatment of amyotrophic lateral sclerosis (ALS) in adults. [1]

2 . Criteria

Product Name: Relyvrio	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of amyotrophic lateral sclerosis (ALS) [2,3]

AND

2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

3 - Provider attestation that the patient's baseline functional ability has been documented prior to initiating treatment (e.g., speech, walking, climbing stairs, etc.)

AND

4 - Patient is not dependent on invasive ventilation or tracheostomy

Product Name: Relyvrio	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of ALS

AND

2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient is currently receiving Relyvrio therapy

AND

4 - Provider attestation that the patient has slowed disease progression from baseline

AND

5 - Patient is not dependent on invasive ventilation or tracheostomy

3 . Background

Benefit/Coverage/Program Information
Background: Relyvrio™ is indicated for the treatment of amyotrophic lateral sclerosis (ALS) in adults. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Relyvrio [package insert]. Cambridge, MA: Amylyx Pharmaceuticals, Inc. September 2022.

2. Subcommittee on Motor Neuron Diseases of World Federation of Neurology Research Group on Neuromuscular Diseases, El Escorial “Clinical Limits of ALS” Workshop Contributors. El Escorial World Federation of Neurology criteria for the diagnosis of amyotrophic lateral sclerosis. J Neurol Sci 1994; 124: 96–107.
3. Brooks BR, Miller RG, Swash M, Munsat TL; World Federation of Neurology Research Group on Motor Neuron Diseases. El Escorial revisited: revised criteria for the diagnosis of amyotrophic lateral sclerosis. Amyotroph Lateral Scler Other Motor Neuron Disord. 2000;1(5):293-299. doi:10.1080/146608200300079536
4. Paganoni S, Macklin EA, Hendrix S, et al. Trial of Sodium Phenylbutyrate-Taurursodiol for Amyotrophic Lateral Sclerosis. N Engl J Med. 2020;383(10):919-930. doi:10.1056/NEJMoa1916945

5 . Revision History

Date	Notes
12/14/2022	New Program

Repatha

Prior Authorization Guideline

Guideline ID	GL-146958
Guideline Name	Repatha
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/2/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	06/16/2021 ; 10/20/2021 ; 06/15/2022 ; 01/18/2023 ; 06/21/2023 ; 10/18/2023 ; 02/16/2024

1 . Indications

Drug Name: Repatha (evolocumab)
Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD Indicated as an adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-c) lowering therapies (e.g., statins, ezetimibe), for treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce (LDL-C).¥ **Homozygous familial hypercholesterolemia (HoFH)** Indicated as an adjunct to other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in patients with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C. [1] **Heterozygous familial hypercholesterolemia (HeFH)** Indicated as an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH) to reduce LDL-C.

Cardiovascular disease Indicated to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease.

2 . Criteria

Product Name: Repatha [a]	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by ONE of the following:

1.1.1 BOTH of the following: [14-16]

1.1.1.1 Pre-treatment LDL-C greater than or equal to 190 mg/dL (greater than or equal to 155 mg/dL if less than 16 years of age)

AND

1.1.1.2 ONE of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of heterozygous or homozygous familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 BOTH of the following: [14-16]

1.1.2.1 Pre-treatment LDL-C greater than or equal to 190 mg/dL (greater than or equal to 155 mg/dL if less than 16 years of age)

AND

1.1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

- Functional mutation in LDL, apoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by ONE of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization
- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

OR

1.3 Primary hyperlipidemia with pre-treatment LDL-C greater than or equal to 190 mg/dL

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

2.1 Patient has been receiving at least 12 consecutive weeks of HIGH-INTENSITY STATIN

THERAPY [i.e. atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a high-intensity statin at maximally tolerated dose

OR

2.2 BOTH of the following:

2.2.1 Patient is unable to tolerate high-intensity statin as evidenced by ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms:

- Myalgia [muscle symptoms without creatine kinase (CK) elevations]
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

2.2.2 Patient has been receiving at least 12 consecutive weeks of low-intensity or moderate-intensity statin therapy [i.e. atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin ≥ 10 mg, pravastatin ≥ 10 mg, lovastatin 20-40 mg, fluvastatin XL 80 mg, fluvastatin 20-40 mg up to 40mg twice daily or Livalo (pitavastatin) ≥ 1 mg] and will continue to receive a low-intensity or moderate-intensity statin at maximally tolerated dose

OR

2.3 Patient is unable to tolerate LOW OR MODERATE-, AND HIGH-INTENSITY STATINS as evidenced by ONE of the following:

2.3.1 ONE of the following intolerable and persistent (i.e. more than 2 weeks) symptoms for low or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

OR

2.3.2 Patient has a labeled contraindication to all statins as documented in medical records

OR

2.3.3 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3 - ONE of the following:

3.1 Submission of medical record (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C greater than or equal to 100 mg/dL with ASCVD
- LDL-C greater than or equal to 130 mg/dL without ASCVD

OR

3.2 BOTH of the following:

3.2.1 Submission of medical record (e.g., laboratory values) documenting ONE of the following LDL-C values while on maximally tolerated lipid lowering therapy for a minimum of at least 12 weeks within the last 120 days or 120 days prior to starting PCSK9 inhibitor therapy:

- LDL-C between 55 mg/dL and 99 mg/dL with ASCVD
- LDL-C between 100 mg/dL and 129 mg/dL without ASCVD

AND

3.2.2 Submission of medical record (e.g., chart notes, laboratory values) documenting ONE of the following [prescription claims history may be used in conjunction as documentation of medication use, dose, and duration]:

- Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy
- Patient has a history of contraindication, or intolerance to ezetimibe

AND

4 - Patient has received comprehensive counseling regarding appropriate diet

AND

5 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

6 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

7 - Not used in combination with Leqvio (inclisiran)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Repatha [a]	
Diagnosis	Primary Hyperlipidemia (including heterozygous familial hypercholesterolemia) and ASCVD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist

- Lipid specialist

AND

2 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C reduction while on Repatha therapy

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Leqvio (inclisiran)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Repatha [a]	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.1 Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

1.2 BOTH of the following:

1.2.1 Pre-treatment LDL-C greater than 400 mg/dL

AND

1.2.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Patient has received comprehensive counseling regarding appropriate diet

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

6 - Not used in combination with Juxtapid (lomitapide)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Repatha [a]	
Diagnosis	Homozygous Familial Hypercholesterolemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g. chart notes, laboratory values) documenting LDL-C reduction while on Repatha therapy

AND

2 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

3 - Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor [e.g., Praluent (alirocumab)]

AND

4 - Not used in combination with Juxtapid (lomitapide)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Repatha (evolocumab) is a PCSK9 (proprotein convertase subtilisin kexin type 9) inhibitor indicated: • To reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease • As an adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-c)lowering therapies (e.g., statins, ezetimibe), for treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce LDL-C • As an adjunct to other LDL-C-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in adults and pediatric patients aged 10 years and older with homozygous familial hypercholesterolemia (HoFH) to reduce LDL-C [1] • As an adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH) to reduce LDL-C **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
5/1/2024	Updating numbering

Prior Authorization Guideline

Guideline ID	GL-144149
Guideline Name	Repository Corticotropins
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	5/20/2022
P&T Revision Date:	08/19/2022 ; 03/15/2023 ; 3/20/2024

1 . Criteria

Product Name: Acthar Gel, Purified Cortrophin Gel [a]	
Diagnosis	Infantile Spasm
Approval Length	12 month(s)
Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of infantile spasms (i.e., West Syndrome)	

AND

2 - Patient is less than 2 years old

AND

3 - Dosing for infantile spasm is as follows:

- Initial dose: 75 U/m2 intramuscular (IM) twice daily for 2 weeks
- After 2 weeks, dose should be tapered according to the following schedule: 30 U/m2 IM in the morning for 3 days; 15 U/m2 IM in the morning for 3 days; 10 U/m2 IM in the morning for 3 days; and 10 U/m2 IM every other morning for 6 days (3 doses)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Acthar Gel, Purified Cortrophin Gel [a]	
Diagnosis	Opsoclonus-Myoclonus Syndrome
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Opsoclonus-Myoclonus Syndrome (i.e., OMS, Kinsbourne Syndrome)

AND

2 - If the request is for Acthar Gel, provider provides a reason or special circumstance patient cannot use Purified Cortrophin Gel

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Acthar Gel, Purified Cortrophin Gel [a]	
Diagnosis	Other Diagnoses
Guideline Type	Non Formulary
Approval Criteria **1** - Acthar Gel and Purified Cortrophin Gel are unproven and/or not medically necessary for treatment of the following disorders and diseases: • Allergic States: Serum sickness, atopic dermatitis • Collagen Diseases: systemic lupus erythematosus, systemic dermatomyositis (polymyositis) • Dermatologic Diseases: Severe erythema multiforme, Stevens-Johnson syndrome, severe psoriasis • Edematous State: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus • Ophthalmic Diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation • Multiple sclerosis: for treatment of acute exacerbations • Respiratory Diseases: Symptomatic sarcoidosis • Rheumatic Disorders: psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, ankylosing spondylitis, acute gouty arthritis • Any indication outside of the proven indications listed in the coverage criteria	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

2 . Background

Benefit/Coverage/Program Information
Background: Acthar Gel (repository corticotropin injection) and Purified Cortrophin Gel (repository corticotropin injection USP) are adrenocorticotropic hormone (ACTH) analogues. Repository corticotropin injection and ACTH stimulate the adrenal cortex to secrete cortisol,

corticosterone, aldosterone, and a number of weakly androgenic substances. Prolonged administration of large doses of repository corticotropin injection induces hyperplasia and hypertrophy of the adrenal cortex and continuous high output of cortisol, corticosterone and weak androgens. The release of endogenous ACTH is influenced by the nervous system via the regulatory hormone released from the hypothalamus and by a negative corticosteroid feedback mechanism. Elevated plasma cortisol suppresses ACTH release. Repository corticotropin injection also binds to melanocortin receptor. Both endogenous ACTH and repository corticotropin injection have a trophic effect on the adrenal cortex which is mediated by cyclic adenosine monophosphate (cyclic AMP).

The Acthar Gel and Purified Cortrophin Gel package inserts have listed other conditions in which it may be used. UHCP has determined that use of Acthar Gel and Purified Cortrophin Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

3 . References

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4 . Revision History

Date	Notes
3/11/2024	Annual review, updated references.

Revlimid

Prior Authorization Guideline

Guideline ID	GL-149795
Guideline Name	Revlimid
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/12/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 10/20/2021 ; 05/20/2022 ; 05/25/2023 ; 05/17/2024

1 . Indications

Drug Name: Revlimid (lenalidomide)
Multiple Myeloma (MM) Indicated for the treatment of adult patients with multiple myeloma (MM), in combination with dexamethasone. Revlimid is indicated as maintenance therapy in adult patients with MM following autologous hematopoietic stem cell transplantation (auto-HSCT). **Myelodysplastic syndromes (MDS)** Indicated for the treatment of adult patients with transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities. **Mantle cell lymphoma (MCL)** Indicated for the treatment of adult patients with mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. **Follicular Lymphoma (FL)** Indicated for the treatment of adult patients with previously

treated follicular lymphoma (FL), in combination with a rituximab product. **Marginal Zone Lymphoma (MZL)** Indicated for the treatment of adult patients with previously treated marginal zone lymphoma (MZL), in combination with a rituximab product.

2 . Criteria

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of multiple myeloma	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Myelodysplastic Syndromes (MDS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) associated WITH a deletion 5q

OR

2 - BOTH of the following:

2.1 Diagnosis of symptomatic anemia due to myelodysplastic syndrome (MDS) without deletion 5q

AND

2.2 ONE of the following:

2.2.1 All of the following:

2.2.1.1 Serum erythropoetin levels less than or equal to 500 mU/mL

AND

2.2.1.2 ONE of the following:

- Ring sideroblasts less than 15%
- Ring sideroblasts less than 5% with an SF3B1 mutation

AND

2.2.1.3 History of failure, contraindication, or intolerance to ONE of the following^:

- Erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa
- Reblozyl (luspatercept-aamt)

AND

2.2.1.4 Used in combination with an erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa

OR

2.2.2 ALL of the following:

2.2.2.1 Serum erythropoetin levels less than or equal to 500 mU/mL

AND

2.2.2.2 ONE of the following:

- Ring sideroblasts greater than or equal to 15%
- Ring sideroblasts greater than or equal to 5% with an SF3B1 mutation

AND

2.2.2.3 History of failure, contraindication, or intolerance to BOTH of the following^:

- Erythropoietin stimulating agent (ESA) [e.g., Epogen, Procrit, Retacrit (epoetin alfa)] or darbepoetin alfa
- Reblozyl (luspatercept-aamt)

OR

2.2.3 ALL of the following:

2.2.3.1 Serum erythropoetin levels greater than 500 mU/mL

AND

2.2.3.2 ONE of the following:

- Ring sideroblasts less than 15%
- Ring sideroblasts less than 5% with an SF3B1 mutation

AND

2.2.3.3 ONE of the following:

- Poor probability to respond to immunosuppressive therapy (e.g., azacitidine, decitabine)
- History of failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azacitidine, decitabine)

OR

2.2.4 ALL of the following:

2.2.4.1 Serum erythropoetin levels greater than 500 mU/mL

AND

2.2.4.2 ONE of the following:

- Ring sideroblasts greater than or equal to 15%
- Ring sideroblasts greater than or equal to 5% with an SF3B1 mutation

AND

2.2.4.3 History of failure, contraindication, or intolerance to Reblozyl (luspatercept-aamt)^

OR

3 - BOTH of the following:

3.1 Diagnosis of MDS/MPN overlap neoplasm

AND

3.2 ONE of the following:

- Patient has SF3B1 mutation and thrombocytosis
- Patient has ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Myelodysplastic Syndromes (MDS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]

Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following criteria:

1.1 Diagnosis of ONE of the following:

- Mantle cell lymphoma (MCL)
- Extranodal marginal zone lymphoma of nongastric sites (noncutaneous)
- Extranodal marginal zone lymphoma (EMZL) of the stomach
- Classic follicular lymphoma
- Nodal marginal zone lymphoma
- Splenic marginal zone lymphoma

OR

1.2 BOTH of the following:

1.2.1 ONE of the following diagnoses:

- HIV-related B-cell lymphoma
- Diffuse large B-cell lymphoma
- High-grade B-cell lymphoma
- Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
- Post-transplant lymphoproliferative disorders

AND

1.2.2 Used as second line or subsequent therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]

Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of myelofibrosis-associated anemia **AND** **2** - Presence of del(5q) mutation **AND** **3** - No symptomatic splenomegaly and/or constitutional symptoms	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response while on Revlimid	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Hodgkin lymphoma **AND** **2** - Disease is refractory to at least 3 prior lines of therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of systemic light chain amyloidosis **AND** **2** - Used in combination with ONE of the following: • Dexamethasone • Dexamethasone and cyclophosphamide • Dexamethasone and Ninlaro (ixazomib)	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic lymphocytic leukemia (CLL) / small lymphocytic lymphoma (SLL) **AND** **2** - Disease is relapsed or refractory	

AND **3** - Used after prior therapy with Bruton Tyrosine Kinase (BTK) inhibitor- and venetoclax-based regimens
Notes | [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	T-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following:	

1.1 ONE of the following diagnoses:

- Peripheral T-cell lymphoma
- T-cell leukemia / lymphoma
- Hepatosplenic gamma-delta T-cell lymphoma

AND

1.2 Used as second-line or subsequent therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	T-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Central Nervous System Cancers-Primary CNS Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of primary central nervous system lymphoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Central Nervous System Cancers-Primary CNS Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following:	

1.1 Diagnosis of HIV-negative Kaposi Sarcoma

OR

1.2 BOTH of the following:

- Diagnosis of HIV-related Kaposi Sarcoma
- Patient is currently being treated with antiretroviral therapy (ART)

AND

2 - Disease has progressed or not responded to two different systemic first-line systemic therapies (e.g., liposomal doxorubicin, sirolimus, paclitaxel)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Histiocytic Neoplasms

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of one of the following histiocytic neoplasms: • Langerhans cell histiocytosis • Rosai-Dorfman disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Castleman Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of multicentric castleman disease **AND** **2** - ONE of the following: • Progressed following treatment of relapsed/refractory disease • Considered progressive disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	Castleman Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Revlimid will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Revlimid, generic lenalidomide [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Revlimid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Revlimid® (lenalidomide) is a thalidomide analogue indicated for the treatment of adult patients with the following: multiple myeloma (MM), in combination with dexamethasone; MM, as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT); transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities; mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib; previously treated follicular lymphoma (FL), in combination with a rituximab product; and previously treated marginal zone lymphoma (MZL), in combination with a rituximab product. [1]

The National Cancer Comprehensive Network (NCCN) also recommends use of Revlimid for treatment of the following B-Cell lymphomas: histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, classic follicular lymphoma (grade 1-2), extranodal marginal zone lymphoma of nongastric sites (noncutaneous), extranodal marginal zone lymphoma (EMZL) of the stomach, high-grade B-cell lymphoma, splenic marginal zone lymphoma, post-transplant lymphoproliferative disorders, diffuse large B-cell lymphoma, and HIV-related B-cell lymphomas. Additionally, NCCN recommends the use of Revlimid for Kaposi Sarcoma, primary CNS lymphoma, castleman disease, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), MDS/MPN overlap neoplasms, myelofibrosis-associated anemia, systemic light chain amyloidosis, classic hodgkin lymphoma, Langerhans cell histiocytosis, Rosai-Dorfman disease, and the following T-cell lymphomas: hepatosplenic gamma-delta T-cell lymphoma, peripheral T-cell lymphoma, and adult T-cell leukemia/lymphoma.

Because of the risk of serious malformations if given during pregnancy, there is an extensive risk management program requiring registration by patients, prescribers and dispensing pharmacies. Additional information about the lenalidomide Risk Evaluation and Mitigation Strategy (REMS) [Lenalidomide REMS] program may be found at **Error! Hyperlink reference not valid.**. [4]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Revlimid [package insert]. Summit, NJ: Celgene Corporation; March 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed March 16, 2024.
3. Lenalidomide REMS®. Available at http://www.revlimidrems.com/. Accessed March 26, 2024.

5 . Revision History

Date	Notes
7/11/2024	Annual review. Updated background to reflect current NCCN guidance and updated the lenalidomide REMS program information. Updated criteria per NCCN for myelodysplastic syndrome, b-cell lymphomas, myelofibrosis-associated anemia, Hodgkin lymphoma, systemic light chain amyloidosis, chronic lymphocytic leukemia/small lymphocytic lymphoma, t-cell lymphoma, and kaposi sarcoma. Renamed and updated criteria for histiocytic neoplasms. Moved castleman disease from b-cell lymphoma into its own criteria. Updated references.

Reyvow

Prior Authorization Guideline

Guideline ID	GL-144917
Guideline Name	Reyvow
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Reyvow (lasmiditan)
Migraine with or without aura Indicated for the acute treatment of migraine with or without aura in adults. Limitations of Use: Reyvow is not indicated for the preventive treatment of migraine.

2 . Criteria

Product Name: Reyvow [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Used for acute treatment of migraine

AND

2 - Patient is 18 years of age or older

AND

3 - History of a therapeutic failure (after at least 3 migraine episodes and a minimum of a 30-day trial), contraindication or intolerance to BOTH of the following (document name and date tried):

3.1 TWO of the following:

- naratriptan (Amerge)
- rizatriptan (Maxalt/Maxalt MLT)
- sumatriptan (Imitrex)

AND

3.2 Ubrelvy

AND

4 - Prescribed by or in consultation with ONE of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist [b]

AND

5 - Prescriber attests to BOTH of the following:

- Patient has been informed the use of Reyvow may result in significant CNS impairment, and may impact the patient's ability to drive or operate machinery for 8 hours after each dose
- If used concurrently with a benzodiazepine or other drugs that could potentially cause central nervous system (CNS) depression, the prescriber has acknowledged that they have completed an assessment of increased risk for sedation and other cognitive and/or neuropsychiatric adverse events

AND

6 - ONE of the following:

6.1 Patient is currently treated with ONE of the following prophylactic therapies:

- Amitriptyline (Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Nurtec ODT, Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)
- OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements]
- Topiramate (Topamax)
- Venlafaxine (Effexor/Effexor XR)

OR

6.2 Patient has less than 4 migraine days per month

OR

6.3 Patient has greater than or equal to 4 migraine days per month and has contraindication or intolerance to ONE of the following prophylactic therapies:

- Amitriptyline (Elavil)
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)
- A calcitonin gene-related peptide receptor (CGRP) antagonist for preventive treatment of migraine [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab), Nurtec ODT, Qulipta, Vyepti (eptinezumab-jjmr)]
- Divalproex sodium (Depakote/Depakote ER)

• OnabotulinumtoxinA (Botox) [Note: Coverage of onabotulinumtoxinA (Botox) may be subject to additional benefit and coverage review requirements] • Topiramate (Topamax) • Venlafaxine (Effexor/Effexor XR)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. [b] Headache specialists are physicians certified by the United Council for Neurologic Subspecialties (UCNS).

Product Name: Reyvow [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Reyvow (lasmiditan) is a serotonin 5-HT_{1F} receptor agonist indicated for the acute treatment of migraine with or without aura in adults. Sedation was reported up to 8 hours after a single dose of Reyvow. Patients should be advised to not engage in activities requiring complete mental alertness, such as driving a motor vehicle or operating machinery, for at least 8 hours after each dose of Reyvow.

The American Headache Society recommends use of NSAIDs (including aspirin), non-opioid analgesics, acetaminophen, or caffeinated analgesic combinations (e.g., aspirin/acetaminophen/caffeine) for mild-to-moderate attacks and migraine-specific agents (i.e., triptans, dihydroergotamine [DHE]) for moderate or severe attacks and mild-to-moderate attacks that respond poorly to NSAIDs or caffeinated combinations.

4 . References

1. Reyvow [package insert]. Indianapolis, IN: Lilly USA, LLC,; September 2022.
2. The American Headache Society Position Statement on Integrating New Migraine Treatments Into Clinical Practice. AHS Consensus Statement. Headache. 2021; 61:1021-39.

5 . Revision History

Date	Notes
3/27/2024	Policy reviewed and approved for application to UnitedHealthcare Value & Balance Exchange for 6/2024 implementation.

Rezdiffra

Prior Authorization Guideline

Guideline ID	GL-145536
Guideline Name	Rezdiffra
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Rezdiffra (resmetirom)
Noncirrhotic nonalcoholic steatohepatitis (NASH) Indicated in conjunction with diet and exercise for the treatment of adults with noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis)

2 . Criteria

Product Name: Rezdiffra [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) [formerly known as nonalcoholic steatohepatitis (NASH)] **AND** **2** - Disease is fibrosis stage F2 or F3 as confirmed by one of the following [4,5]: • FAST [FibroScan-aspartate aminotransferase (AST)] • MAST [derived from magnetic resonance imaging–proton density fat fraction, magnetic resonance elastography (MRE), and AST] • MEFIB [MRE combined with fibrosis-4 index (FIB-4)] • Liver biopsy **AND** **3** - Patient has received comprehensive counseling regarding lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program) **AND** **4** - Prescribed by or in consultation with a gastroenterologist or hepatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rezdiffra [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response to Rezdiffra therapy (e.g., improvement in or stabilization of fibrosis) **AND** **2** - Prescribed by or in consultation with a gastroenterologist or hepatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Rezdiffra™ (resmetirom) is a thyroid hormone receptor-beta (THR-beta) agonist indicated in conjunction with diet and exercise for the treatment of adults with noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis). This indication is approved under accelerated approval based on improvement of NASH and fibrosis. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Rezdiffra [package insert]. West Conshohocken, PA: Madrigal Pharmaceuticals, Inc.; March 2024.
2. Harrison SA, Bedossa P, Guy CD, Schattenberg JM, Loomba R, Taub R, Labriola D, Moussa SE, Neff GW, Rinella ME, Anstee QM, Abdelmalek MF, Younossi Z, Baum SJ, Francque S, Charlton MR, Newsome PN, Lanthier N, Schiefke I, Mangia A, Pericàs JM, Patil R, Sanyal AJ, Noureddin M, Bansal MB, Alkhouri N, Castera L, Rudraraju M, Ratziu V; MAESTRO-NASH Investigators. A Phase 3, Randomized, Controlled Trial of Resmetirom in NASH with Liver Fibrosis. N Engl J Med. 2024 Feb 8;390(6):497-509. doi: 10.1056/NEJMoa2309000. PMID: 38324483.
3. Rinella ME, Lazarus JV, Ratziu V, et al. A multisociety Delphi consensus statement on new fatty liver disease nomenclature. Hepatology. 2023;78(6):1966-1986. doi:10.1097/HEP.0000000000000520
4. Rinella ME, Neuschwander-Tetri BA, Siddiqui MS, et al. AASLD Practice Guidance on the clinical assessment and management of nonalcoholic fatty liver disease. Hepatology. 2023;77(5):1797-1835. doi:10.1097/HEP.0000000000000323
5. Wattacheril JJ, Abdelmalek MF, Lim JK, Sanyal AJ. AGA Clinical Practice Update on the Role of Noninvasive Biomarkers in the Evaluation and Management of Nonalcoholic Fatty Liver Disease: Expert Review. Gastroenterology. 2023;165(4):1080-1088. doi:10.1053/j.gastro.2023.06.013

5 . Revision History

Date	Notes
4/9/2024	New program

Rhofade

Prior Authorization Guideline

Guideline ID	GL-130272
Guideline Name	Rhofade
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 05/20/2022 ; 04/19/2023 ; 8/18/2023

1 . Indications

Drug Name: Rhofade (oxymetazoline cream)
Rosacea Indicated for the topical treatment of persistent (nontransient) erythema of rosacea in adults.

2 . Criteria

Product Name: Rhofade [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of rosacea	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Rhofade® (oxymetazoline) 1% topical cream is an alpha-adrenergic agonist indicated for the topical treatment of persistent (nontransient) erythema of rosacea in adults **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

4 . References

1. Rhofade [package insert]. Wayne, PA: Aclaris Therapeutics, Inc.; August 2021.

5 . Revision History

Date	Notes
8/21/2023	Annual review. Removed requirement of persistent facial erythema.

8/21/2023	Removed reauthorization criteria to allow for automation. State mandate language added.

Rinvoq, Rinvoq LQ

Prior Authorization Guideline

Guideline ID	GL-148147
Guideline Name	Rinvoq, Rinvoq LQ
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/21/2021 ; 02/18/2022 ; 03/16/2022 ; 05/20/2022 ; 06/15/2022 ; 07/20/2022 ; 09/21/2022 ; 10/19/2022 ; 12/14/2022 ; 07/19/2023 ; 09/20/2023 ; 6/17/2024

1 . Indications

Drug Name: Rinvoq (upadacitinib)
Rheumatoid Arthritis Indicated for the treatment of adults with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers. **Atopic Dermatitis** Indicated for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies are inadvisable. **Ulcerative Colitis** Indicated for the treatment of adults with moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to one or more TNF blockers.

Ankylosing Spondylitis Indicated for the treatment of adults with active ankylosing spondylitis who have had an inadequate response or intolerance to one or more TNF blockers.

Non-radiographic axial spondyloarthritis Indicated for the treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation who have had an inadequate response or intolerance to TNF blocker therapy.

Crohn's Disease Indicated in adults with moderately to severely active Crohn's disease who have had an inadequate response or intolerance to one or more TNF blockers.

Drug Name: Rinvoq (upadacitinib), Rinvoq LQ (upadacitinib) oral solution

Polyarticular juvenile idiopathic arthritis Indicated in patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis who have an inadequate response or intolerance to one or more TNF blockers.

Psoriatic Arthritis Indicated for the treatment of adults and pediatric patients 2 years of age and older with active psoriatic arthritis who have an inadequate response or intolerance to one or more TNF blockers.

2 . Criteria

Product Name: Rinvoq [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active RA

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

- History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Olumiant (baricitinib), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 ONE of the following:

- History of failure, contraindication, or intolerance to at least ONE TNF inhibitor^
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [6])

OR

2.2 BOTH of the following:

- Patient is currently on Rinvoq therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq*

AND

3 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]

• Potent immunosuppressant (e.g., azathioprine or cyclosporine) **AND** **4** - Prescribed by or in consultation with a rheumatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the AbbVie sponsored Rinvoq Complete program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Rinvoq [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Rinvoq therapy **AND** **2** - Patient is not receiving Rinvoq in combination with ANY of the following: • Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)] • Potent immunosuppressant (e.g., azathioprine or cyclosporine)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Rinvoq, Rinvoq LQ [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

- History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Olumiant (baricitinib), Otezla (apremilast)Cimzia (certolizumab), adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 ONE of the following:

- History of failure, contraindication, or intolerance to at least ONE TNF inhibitor^

- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [6])

OR

2.2 BOTH of the following:

- Patient is currently on Rinvoq or Rinvoq LQ therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq or Rinvoq LQ*

AND

3 - Patient is not receiving Rinvoq or Rinvoq LQ in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

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

- Rheumatologist
- Dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. *Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the AbbVie sponsor ed Rinvoq Complete program shall be required to meet initial authoriz

	ation criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Rinvoq, Rinvoq LQ [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Rinvoq therapy **AND** **2** - Patient is not receiving Rinvoq or Rinvoq LQ in combination with ANY of the following: • Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Otezla (apremilast)] • Potent immunosuppressant (e.g., azathioprine or cyclosporine)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Rinvoq [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate-to-severe chronic atopic dermatitis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 History of failure, contraindication, or intolerance to BOTH of the following therapeutic classes of topical therapies (document drug, date of trial, and/ or contraindication to medication)

- Medium to very-high potency topical corticosteroids [e.g., mometasone furoate (generic Elocon), fluocinolone acetonide (generic Synalar), fluocinonide (generic Lidex)]
- Topical calcineurin inhibitor [e.g., tacrolimus (Protopic)]

AND

2.1.2 ONE of the following:

2.1.2.1 BOTH of the following^:

- Submission of medical records (e.g., chart notes, laboratory values) documenting a 3 month trial of a systemic drug product for the treatment of atopic dermatitis (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration)
- Physician attests that the patient was not adequately controlled with the documented systemic drug product

OR

2.1.2.2 Physician attests that systemic treatment with BOTH of the following, FDA-approved chronic atopic dermatitis therapies is inadvisable. (Document drug and contraindication rationale)^

- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

OR

2.1.2.3 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [6]).

OR

2.2 BOTH of the following:

- Patient is currently on Rinvoq therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq*

AND

3 - Patient is NOT receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the

	prescriber's office or any form of assistance from the AbbVie sponsor ed Rinvoq Complete program shall be required to meet initial authoriz ation criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Rinvoq [a]	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is not receiving Rinvoq in combination with any of the following:

- Targeted immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Cibinqo (abrocitinib), Xeljanz/XR (tofacitinib), Olumiant (baricitinib), Opzelura (topical ruxolitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Rinvoq [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active UC

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

- Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz/XR (tofacitinib)]

AND

2.1.2 ONE of the following:

- History of failure, contraindication, or intolerance to at least one TNF inhibitor^
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [6])

OR

2.2 BOTH of the following:

- Patient is currently on Rinvoq therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq*

AND

3 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the AbbVie sponsored Rinvoq Complete program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Rinvoq [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rinvoq [a]	
Diagnosis	Ankylosing Spondylitis or non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

- History of failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis or non-radiographic axial spondyloarthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Xeljanz/Xeljanz XR (tofacitinib)]

AND

2.1.2 ONE of the following:

- History of failure, contraindication, or intolerance to at least ONE TNF inhibitor^
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [5])

OR

2.2 BOTH of the following:

- Patient is currently on Rinvoq therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq*

AND

3 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a rheumatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the AbbVie sponsored Rinvoq Complete program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Rinvoq [a]	
Diagnosis	Ankylosing Spondylitis or non-radiographic Axial Spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rinvoq [a]	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 History of failure to ONE of the following conventional therapies at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.1.1.2 Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of Crohn's disease as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Cimzia (certolizumab)]

AND

2.1.2 ONE of the following:

- History of failure, contraindication, or intolerance to at least one TNF inhibitor^
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria5).

OR

2.2 BOTH of the following:

- Patient is currently on Rinvoq therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq*

AND

3 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the AbbVie sponsored Rinvoq Complete program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Rinvoq [a]

Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Rinvoq therapy

AND

2 - Patient is not receiving Rinvoq in combination with ANY of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rinvoq, Rinvoq LQ [a]	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active polyarticular juvenile idiopathic arthritis

AND

2 - ONE of the following:

2.1 History of failure, contraindication, or intolerance to at least ONE TNF inhibitor^

OR

2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [5]).

OR

2.3 BOTH of the following:

- Patient is currently on Rinvoq or Rinvoq LQ therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy):
- Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the AbbVie sponsored Rinvoq Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Rinvoq or Rinvoq LQ*

AND

3 - Patient is not receiving Rinvoq or Rinvoq LQ in combination with either of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Xeljanz (tofacitinib)]
- Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. * Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the

	prescriber's office or any form of assistance from the AbbVie sponsor ed Rinvoq Complete program shall be required to meet initial authoriz ation criteria as if patient were new to therapy. ^ Tried/failed alternative(s) are supported by FDA labeling

Product Name: Rinvoq, Rinvoq LQ [a]	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (pJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Rinvoq or Rinvoq LQ therapy **AND** **2** - Patient is not receiving Rinvoq or Rinvoq LQ in combination with ANY of the following: • Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Olumiant (baricitinib), Xeljanz (tofacitinib)] • Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. * Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the AbbVie sponsor ed Rinvoq Complete program shall be required to meet initial authoriz ation criteria as if patient were new to therapy.

3 . Background

Benefit/Coverage/Program Information
Background: Rinvoq is a Janus kinase (JAK) inhibitor, Rinvoq and/or Rinvoq LQ is indicated for the treatment of: • Adults with moderately to severely active rheumatoid arthritis (RA) who have had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blocker. Limitation of Use: The use of Rinvoq in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended. • Adults and pediatric patients 2 years of age and older with active psoriatic arthritis who have an inadequate response or intolerance to one or more TNF blockers. Limitation of Use: Rinvoq/Rinvoq LQ is not recommended for use in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine. • Adults and pediatric patients 12 years of age and older with refractory, moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies are inadvisable. Limitation of Use: Rinvoq is not recommended in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants. • Adults with moderately to severely active ulcerative colitis who have had an inadequate response or intolerance to one or more TNF blockers. Limitations of Use: Rinvoq is not recommended for use in combination with other JAK inhibitors, biological therapies for ulcerative colitis, or with other potent immunosuppressants such as azathioprine and cyclosporine. Rinvoq should be discontinued if adequate therapeutic response is not achieved with the 30 mg dosage. Use the lowest effective dosage needed to maintain response. • Adults with active ankylosing spondylitis who have had an inadequate response or intolerance to one or more TNF blockers. Limitations of Use: Rinvoq is not recommended for use in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine.

- Adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation who have had an inadequate response or intolerance to TNF blocker therapy.

Limitations of Use: Rinvoq is not recommended for use in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine.

- Adults with moderately to severely active Crohn's disease who have had an inadequate response or intolerance to one or more TNF blockers.

Limitations of Use: Rinvoq is not recommended for use in combination with other JAK inhibitors, biological therapies for Crohn's disease, or with potent immunosuppressants such as azathioprine and cyclosporine

- Patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis who have an inadequate response or intolerance to one or more TNF blockers.

Limitation of Use: Rinvoq/Rinvoq LQ is not recommended for use in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine.

Table 1: Relative potencies of topical corticosteroids[8]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05

	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1

Hydrocortisone acetate	Cream, ointment	0.5-1

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Rinvoq [package insert]. North Chicago, IL: AbbVie Inc.; April 2024.
2. Fraenkel L, Bathon JM, England BR , et al. 2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. Arthritis Rheum. 2021;73(7):924-939.
3. Cohen S, Mikuls TR. Initial treatment of rheumatoid arthritis in adults. In: Post TW, ed. UpToDate. UpToDate; 2021. Accessed on December 17th, 2021.
4. Sing JA, Guyatt G, Ogie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis.
5. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. UpToDate; 2021. Accessed on December 17th, 2021.
6. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA: American Psychiatric Publishing. 2013.
7. Eichenfield LF, Tom WL, Chamlin SL et al. Guidelines of care for the management of atopic dermatitis: section 1. Diagnosis and assessment of atopic dermatitis. J Am Acad Dermatol. 2014; 70(1):338-51.
8. Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014; 71(1):116-32.
9. Sidbury R, Davis DM, Cohen DE, et al. Guidelines of care for the management of atopic dermatitis: Section 3. Management and treatment with phototherapy and systemic agents. J Am Acad Dermatol. 2014 Aug;71(2):327-49.

5 . Revision History

Date	Notes
6/11/2024	Added Rinvoq LQ to the program. Updated criteria with pediatric indi cation for PsA. Added criteria for new indication for pJIA. Updated ba ckground, reference and safety language.

Rivfloza

Prior Authorization Guideline

Guideline ID	GL-147353
Guideline Name	Rivfloza
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	5/17/2024

1 . Indications

Drug Name: Rivfloza (nedosiran)
Primary hyperoxaluria type 1 (PH1) Indicated to lower urinary oxalate levels in children 9 years of age and older and adults with primary hyperoxaluria type 1 (PH1) and relatively preserved kidney function, e.g., eGFR ≥ 30 mL/min/1.73 m2

2 . Criteria

Product Name: Rivfloza [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

- Patient has been established on therapy with Rivfloza under an active UnitedHealthcare prior authorization for the treatment of primary hyperoxaluria type 1 (PH1)
- Submission of medical records (e.g., chart notes, laboratory values) documenting a positive clinical response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate: creatinine ratio, decreased plasma oxalate concentrations)
- Patient has not received a liver transplant
- Patient has relatively preserved kidney function (e.g., eGFR ≥ 30 mL/min/1.73 m2)
- Patient is not receiving Rivfloza in combination with Oxlumo (lumasiran)
- Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

OR

2 - ALL of the following:

2.1 Diagnosis of primary hyperoxaluria type 1 (PH1)

AND

2.2 Confirmation of diagnosis based on BOTH of the following:

2.2.1 Metabolic testing demonstrating ONE of the following:

- Increased urinary oxalate excretion (e.g. greater than 1 mmol/1.73 m2 per day [90 mg/1.73 m2 per day], increased urinary oxalate: creatinine ratio relative to normative values for age)
- Increased plasma oxalate and glyoxylate concentrations

AND

2.2.2 Genetic testing has confirmed a mutation in the alanine: glyoxylate aminotransferase (AGT or AGXT) gene

AND

2.3 Patient has not received a liver transplant

AND

2.4 Patient is at least 9 years of age and older

AND

2.5 Patient has relatively preserved kidney function (e.g., eGFR ≥ 30 mL/min/1.73 m2)

AND

2.6 Patient is not receiving Rivfloza in combination with Oxlumo (lumasiran)

AND

2.7 Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rivfloza [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a positive clinical response to therapy from pre-treatment baseline (e.g., decreased urinary oxalate concentrations, decreased urinary oxalate: creatinine ratio, decreased plasma oxalate concentrations) **AND** **2** - Patient has not received a liver transplant **AND** **3** - Patient has relatively preserved kidney function (e.g., eGFR ≥ 30 mL/min/1.73 m2) **AND** **4** - Patient is not receiving Rivfloza in combination with Oxlumo (lumasiran) **AND** **5** - Prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Rivfloza (nedosiran) is an LDHA-directed small interfering RNA indicated to lower urinary oxalate levels in children 9 years of age and older and adults with primary hyperoxaluria type 1 (PH1) and relatively preserved kidney function, e.g., eGFR ≥ 30 mL/min/1.73 m2.

Oxlumo (lumasiran) is an HAO1-directed small interfering ribonucleic acid (siRNA) indicated for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary and plasma oxalate levels in pediatric and adult patients.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place

4 . References

1. Rivfloza [package insert]. Plainsboro, NJ: Novo Nordisk, Inc.; September 2023.
2. Baum MA, Langman C, Cochat P, et al. PHYOX2: a pivotal randomized study of nedosiran in primary hyperoxaluria type 1 or 2. Kidney Int. 2023;103(1):207-217. doi:10.1016/j.kint.2022.07.025
3. Long term extension study in patients with primary hyperoxaluria (PHYOX3). ClinicalTrials.gov website Study Details | Long Term Extension Study in Patients With Primary Hyperoxaluria | ClinicalTrials.gov Accessed March 6, 2024.
4. Oxlumo [package insert]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; September 2023.
5. Cochat P, Hulton SA, Acquaviva C, et al. Primary Hyperoxaluria Type 1: Indications For Screening And Guidance For Diagnosis And Treatment. Nephrol Dial Transplant 2012; 27:1729.
6. Niaudet P. Primary Hyperoxaluria. In: UpToDate, Mattoo TK, Kim MS, (Ed), UpToDate, Waltham, MA, 2024.

5 . Revision History

Date	Notes
5/14/2024	Removed step through Oxlumo

Rozlytrek

Prior Authorization Guideline

Guideline ID	GL-138759
Guideline Name	Rozlytrek
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 01/18/2023 ; 1/17/2024

1 . Indications

Drug Name: Rozlytrek™ (entrectinib)
Non-small cell lung cancer (NSCLC) Indicated for the treatment of adult patients with ROS1- positive metastatic non-small cell lung cancer (NSCLC). **Solid Tumors** Indicated for the treatment of adult and pediatric patients 1 month of age and older with solid tumors that: have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have progressed following treatment or have no satisfactory alternative therapy

2 . Criteria

Product Name: Rozlytrek [a]	
Diagnosis	Non-small cell lung cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of metastatic non-small cell lung cancer (NSCLC) **AND** **2** - Disease is ROS1-positive	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rozlytrek [a]	
Diagnosis	Non-small cell lung cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Rozlytrek therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rozlytrek [a]

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

Approval Criteria

1 - Presence of solid tumors (e.g., sarcoma, NSCLC, salivary, breast, thyroid, colorectal, neuroendocrine, pancreatic, gynecological, cholangiocarcinoma, etc.)

AND

2 - Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]

AND

4 - Disease is one of the following:

- Metastatic
- Unresectable

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rozlytrek [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Rozlytrek therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rozlytrek [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Rozlytrek will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Rozlytrek [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Rozlytrek therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Additional Clinical Rules:
 	
• Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
 	
• Supply limits may be in place.
 	
Background:
 	
Rozlytrek™ (entrectinib) is a kinase inhibitor indicated for the treatment of:
 	
• Adult patients with ROS1-positive metastatic non-small cell lung cancer (NSCLC).
• Adult and pediatric patients 1 month of age and older with solid tumors that:
  ○ have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation,
  ○ are metastatic or where surgical resection is likely to result in severe morbidity, and
  ○ have progressed following treatment or have no satisfactory alternative therapy
 	
This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.[1]

4 . References

1. Rozlytrek [package insert]. Genentech USA, Inc.: South San Francisco, CA; October 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed November 27, 2023.

5 . Revision History

Date	Notes
1/9/2024	Annual review with update to background. No changes to clinical crit eria. Updated references.

Ruconest

Prior Authorization Guideline

Guideline ID	GL-145515
Guideline Name	Ruconest
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	07/21/2021 ; 09/15/2021 ; 04/20/2022 ; 04/19/2023 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Ruconest
Hereditary angioedema (HAE) Indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE).

2 . Criteria

Product Name: Ruconest [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - BOTH of the following:

2.1 Prescribed for the acute treatment of HAE attacks

AND

2.2 Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr)

AND

3 - Submission of medical records documenting a history of failure, contraindication, or intolerance to ONE of the following:

- Icatibant (generic Firazyr)
- Sajazir (icatibant)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ruconest [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Ruconest therapy

AND

2 - BOTH of the following:

2.1 Prescribed for the acute treatment of HAE attacks

AND

2.2 Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr) **AND** **3** - Prescribed by ONE of the following: • Immunologist • Allergist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Ruconest (C1 esterase inhibitor [recombinant]) is indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE). Effectiveness was not established in HAE patients with laryngeal attacks. [1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Ruconest [package insert]. Warren, NJ: Pharming Healthcare, Inc.; April 2020.

2. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.
3. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2024.
4. Busse, P., Christiansen, S., Riedl, M., et. al. “US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.” The Journal of Allergy and Clinical Immunology. 2020 September 05
5. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. Allergy. 2022;77(7):1961-1990. doi:10.1111/all.15214

5 . Revision History

Date	Notes
4/8/2024	Annual review with update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria.

Prior Authorization Guideline

Guideline ID	GL-139057
Guideline Name	Sandostatin
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 01/19/2022 ; 08/19/2022 ; 01/18/2023 ; 1/17/2024

1 . Indications

Drug Name: Sandostatin (octreotide acetate)
Acromegaly Indicated to reduce blood levels of growth hormone and IGF-I (somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation and bromocriptine mesylate at maximally tolerated doses. **Metastatic carcinoid tumors** Indicated for the symptomatic treatment of patients with metastatic carcinoid tumors, where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease, and for the treatment of profuse watery diarrhea associated with VIP-secreting tumors. [1,2]

2 . Criteria

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Radiotherapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

2.2 Not a candidate for any of the following:

- Surgery
- Radiotherapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]

Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of meningioma **AND** **2** - Disease is surgically inaccessible **AND** **3** - One of the following: • Disease is recurrent • Disease is progressive	

AND **4** - Additional radiation is not possible	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Neuroendocrine and Adrenal Tumors [2]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following diagnoses: **1.1** Neuroendocrine tumors [e.g., carcinoid tumors, Islet cell tumors, gastrinomas,	

glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI tract, lung, thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]

OR

1.2 All of the following:

1.2.1 Diagnosis of Pheochromocytoma or Paraganglioma

AND

1.2.2 Disease is locally unresectable or distant metastases

AND

1.2.3 Disease is somatostatin receptor positive

AND

1.2.4 Presence of symptomatic disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

OR

2 - Documentation of positive clinical response (e.g., suppression of severe diarrhea, flushing, etc.) to therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Sandostatin will be approved based on both of the following criteria:

1.1 Diagnosis of thymoma or thymic carcinoma

AND

1.2 One of the following:

1.2.1 Used as a second-line therapy for one of the following:

- Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis.
- Extrathoracic metastatic disease.

OR

1.2.2 Both of the following:

1.2.2.1 Used as first line therapy for one of the following:

- Unresectable locally advanced disease in combination with radiation therapy
- Potentially resectable locally advanced disease
- Potentially resectable solitary metastasis or ipsilateral pleural metastasis
- Consideration following surgery for solitary metastasis or ipsilateral pleural metastasis
- Extrathoracic metastatic disease
- Postoperative treatment for thymoma after R2 resection

AND

1.2.2.2 Patient is unable to tolerate first-line combination regimens

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Malignant Bowel Obstruction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Sandostatin will be approved based on both of the following criterion: **1.1** Diagnosis of malignant bowel obstruction **AND** **1.2** Gut function cannot be maintained	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Malignant Bowel Obstruction
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Chemotherapy- and/or Radiation-Induced Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Sandostatin will be approved based on both of the following criterion: **1.1** Diagnosis of diarrhea due to concurrent cancer chemotherapy and/or radiation **AND** **1.2** One of the following: **1.2.1** Presence of Grade 3 or 4 severe diarrhea **OR** **1.2.2** Patients in palliative or end of life care	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Chemotherapy- and/or Radiation-Induced Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	HIV/AIDS-Related Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of HIV/AIDS-related diarrhea	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	HIV/AIDS-Related Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Bleeding Gastroesophageal Varices
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of bleeding gastroesophageal varices associated with liver disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sandostatin, octreotide acetate (generic Sandostatin) [a]	
Diagnosis	Bleeding Gastroesophageal Varices
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Sandostatin (octreotide acetate) is indicated to reduce blood levels of growth hormone and IGF-I (somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation and bromocriptine mesylate at maximally tolerated doses. It is also indicated for the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing

episodes associated with the disease and for the treatment of profuse watery diarrhea associated with vasoactive intestinal peptide (VIP)-secreting tumors.[1,2]

The National Comprehensive Cancer Network (NCCN) recommends the use of octreotide acetate for the treatment of thyomas and thymic carcinomas as well as meningiomas. The NCCN also recommends octreotide acetate for the treatment of several types of neuroendocrine and adrenal tumors, including neuroendocrine tumors of the gastrointestinal tract, lung and thymus, neuroendocrine tumors of the pancreas, pheochromocytoma/paraganglioma. The NCCN Palliative Care Guidelines recommend octreotide for the treatment of chemotherapy and/or radiation-induced diarrhea and malignant bowel obstruction.[3]

Clinical evidence supports the use of octreotide acetate for the treatment of refractory HIV/AIDS-related diarrhea that does not respond to first-line anti-diarrheal therapy,[8-16] and as an adjunct to endoscopic therapy for bleeding gastroesophageal varices associated with liver disease.[17-22]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
1/16/2024	Annual review with no changes to coverage criteria. Updated backgr ound and references.

Sensipar

Prior Authorization Guideline

Guideline ID	GL-154482
Guideline Name	Sensipar
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 08/20/2021 ; 10/20/2021 ; 08/19/2022 ; 9/18/2024

1 . Indications

Drug Name: Sensipar (cinacalcet)
Secondary hyperparathyroidism Indicated for the treatment of secondary hyperparathyroidism (HPT) in adult patients with chronic kidney disease on dialysis. **Parathyroid carcinoma** Indicated for the treatment of hypercalcemia in patients with parathyroid carcinoma. **Primary hyperparathyroidism** Indicated for the treatment of hypercalcemia in patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.

2 . Criteria

Product Name: Brand Sensipar, generic cinacalcet [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Diagnosis of secondary hyperparathyroidism with chronic kidney disease

AND

2.1.2 Patient is on dialysis

AND

2.1.3 BOTH of the following:

- Patient has therapeutic failure, contraindication or intolerance to one phosphate binder (e.g., PhosLo, Fosrenol, sevelamer, Renagel, etc.)
- Patient has therapeutic failure, contraindication or intolerance to one vitamin D analog (e.g., calcitriol, Hectorol, paricalcitriol, Zemplar, etc.)

OR

2.2 Diagnosis of hypercalcemia with parathyroid carcinoma

OR **2.3** ALL of the following: • Diagnosis of primary hyperparathyroidism (HPT) • Severe hypercalcemia (serum calcium level greater than 12.5 mg/dL) due to primary HPT • Patient is unable to undergo parathyroidectomy
Notes: [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sensipar, generic cinacalcet [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has experienced a reduction in serum calcium from baseline	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Cinacalcet is a calcium-sensing receptor agonist indicated for the treatment of secondary hyperparathyroidism (HPT) in patients with chronic kidney disease (CKD) on dialysis,

hypercalcemia in adult patients with parathyroid carcinoma (PC), and for hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.

Cinacalcet is not indicated for use in patients with CKD who are not on dialysis.[1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Sensipar [package insert]. Thousand Oaks, CA: Amgen Inc.; December 2019.
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5 . Revision History

Date	Notes
9/6/2024	updated generic product

Signifor

Prior Authorization Guideline

Guideline ID	GL-115209
Guideline Name	Signifor
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2022
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 10/19/2022

1 . Indications

Drug Name: Signifor (pasireotide diaspartate)
Cushing's disease Indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative. [1]

2 . Criteria

Product Name: Signifor [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Both of the following: **1.1** Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids) **AND** **1.2** One of the following: • Pituitary surgery has not been curative for the patient • Patient is not a candidate for pituitary surgery	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Signifor [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Signifor therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Signifor (pasireotide diaspartate) is a somatostatin analog indicated for the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Signifor [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2020.

5 . Revision History

Date	Notes
10/18/2022	Annual review with no changes to coverage criteria. Added state man date footnote.

Simponi

Prior Authorization Guideline

Guideline ID	GL-148650
Guideline Name	Simponi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 03/17/2021 ; 05/21/2021 ; 05/20/2022 ; 09/21/2022 ; 05/25/2023 ; 6/17/2024

1 . Indications

Drug Name: Simponi (golimumab)
Rheumatoid Arthritis Indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate (MTX). [1] **Psoriatic Arthritis** Indicated alone or in combination with methotrexate for the treatment of adult patients with active psoriatic arthritis (PsA). [1] **Ankylosing Spondylitis** Indicated for the treatment of adult patients with active ankylosing spondylitis (AS). [1] **Ulcerative Colitis** Indicated in adult patients with moderate to severe ulcerative colitis who require continuous steroid therapy or who have had an inadequate response to or intolerance to prior treatment. It is indicated for inducing and maintaining clinical response, improving

endoscopic appearance of the mucosa during induction, inducing clinical remission, and achieving and sustaining clinical remission in induction responders. [1]

2 . Criteria

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - ONE of the following:

2.1 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Humira (adalimumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Simponi therapy as documented by claims history or submission of medical records (Document date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Jannsen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Simponi*

AND

3 - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Jannsen sponsored CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Simponi therapy

AND

2 - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - ONE of the following:

2.1 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date, and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia

(certolizumab), Humira (adalimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Simponi therapy as documented by claims history or submission of medical records (Document date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Jannsen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Simponi*

AND

3 - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

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

- Rheumatologist
- Dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Jannsen sponsored CarePath Savings program shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)

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

Approval Criteria

1 - Documentation of positive clinical response to Simponi therapy

AND

2 - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - ONE of the following:

2.1 History of failure to TWO NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated

doses, each used for at least 4 weeks, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trials)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Xeljanz/Xeljanz XR (tofacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Simponi therapy as documented by claims history or submission of medical records (Document date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Jannsen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Simponi*

AND

3 - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz/Xeljanz XR (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Jannsen sponsored CarePath Savings program shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Simponi therapy

AND

2 - Patient is not receiving Simponi in combination with with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - ONE of the following:

2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine^

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Simponi therapy as documented by claims history or submission of medical records (Document date, and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Jannsen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Simponi*

AND

3 - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. *Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Jannsen sponso red CarePath Savings program SHALL BE REQUIRED to meet initial

	authorization criteria as if patient were new to therapy. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Simponi (subcutaneous formulations) [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Simponi therapy **AND** **2** - Patient is not receiving Simponi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Simponi (golimumab) is a tumor necrosis factor (TNF) blocker, indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate (MTX). [1] Simponi, alone or in combination with methotrexate, is indicated for the treatment of adult patients with active psoriatic arthritis (PsA). [1] It is also indicated for the treatment of adult patients with active ankylosing spondylitis (AS).[1] Simponi is also indicated in adult patients with moderate to severe ulcerative colitis who require continuous

steroid therapy or who have had an inadequate response to or intolerance to prior treatment. For ulcerative colitis, it is indicated for inducing and maintaining clinical response, improving endoscopic appearance of the mucosa during induction, inducing clinical remission, and achieving and sustaining clinical remission in induction responders. [1]

An intravenous formulation of golimumab, Simponi Aria, is also available. Simponi Aria is indicated for adult patients with moderately to severely active rheumatoid arthritis in combination with methotrexate, active psoriatic arthritis in patients 2 years of age and older, adult patients with active ankylosing spondylitis, and active polyarticular Juvenile Idiopathic Arthritis (pJIA) in patients 2 years of age and older.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Simponi [package insert]. Horsham, PA: Janssen Biotech Inc.; September 2019.
2. Simponi Aria [package insert]. Horsham, PA: Janssen Biotech, Inc.; July 2023.
3. Singh JA, Saag KG, Bridges SL, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. Arthritis Care & Research. Arthritis Rheum. 2016;68(1):1-26.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis -- Section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: Case-based presentations and evidence-based conclusions. J Am Acad Dermatol. 2011;65:137-174.
5. Yu D, van Tubergen A. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. Sieper, J (Ed). UpToDate. Accessed January 14, 2019.
6. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology. 2020; 158(5):1450-61.

5 . Revision History

Date	Notes
6/19/2024	Annual review, updated safety language to match commercial and up dated references.

Sirturo

Prior Authorization Guideline

Guideline ID	GL-135751
Guideline Name	Sirturo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/17/2023
P&T Revision Date:	

1 . Indications

Drug Name: Sirturo (bedaquiline fumarate)
Pulmonary multi-drug resistant tuberculosis Indicated as part of combination therapy in adult and pediatric patients (5 years and older and weighing at least 15 kg) with pulmonary multi-drug resistant tuberculosis.

2 . Criteria

Product Name: Sirturo [a]	
Diagnosis	Pulmonary multi-drug resistant tuberculosis
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - Sirturo will be approved as continuation of therapy upon hospital discharge **OR** **2** - ALL of the following: • Diagnosis of pulmonary multi-drug resistant tuberculosis • Prescribed as part of a combination regimen with other anti-tuberculosis agents • Prescribed by an infectious disease specialist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Sirturo is a diarylquinoline antimycobacterial drug indicated as part of combination therapy in adult and pediatric patients (5 years and older and weighing at least 15 kg) with pulmonary multi-drug resistant tuberculosis. Sirturo should be reserved for use when an effective treatment regimen cannot otherwise be provided. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Sirturo [package insert]. Titusville, NJ: Janssen Therapeutics. September 2021.

5 . Revision History

Date	Notes
11/1/2023	New program

Skyclarys

Prior Authorization Guideline

Guideline ID	GL-147498
Guideline Name	Skyclarys
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	5/25/2023
P&T Revision Date:	5/17/2024

1 . Indications

Drug Name: Skyclarys (omaveloxolone)
Friedreich's ataxia Indicated for the treatment of Friedreich's ataxia in adults and adolescents aged 16 years and older

2 . Criteria

Product Name: Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of Friedreich's ataxia

AND

2 - Confirmed presence of a mutation in the frataxin (FXN) gene

AND

3 - Prescribed by, or in consultation with, ONE of the following

- Neurologist
- Neurogeneticist
- Physical Medicine and Rehabilitation physician (i.e., physiatrist)

Product Name: Skyclarys	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Skyclarys therapy

AND

2 - Prescribed by, or in consultation with, ONE of the following

- Neurologist
- Neurogeneticist

- Physical Medicine and Rehabilitation physician (i.e., physiatrist)

3 . Background

Benefit/Coverage/Program Information
Background Skyclarys (omaveloxolone) is indicated for the treatment of Friedreich's ataxia in adults and adolescents aged 16 years and older. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

1. Skyclarys™ [package insert]. Plano, TX: Reata Pharmaceuticals, Inc.; January 2024.

5 . Revision History

Date	Notes
5/17/2024	Annual review with no updates to coverage criteria. Updated referenc es.

Skyrizi

Prior Authorization Guideline

Guideline ID	GL-149895
Guideline Name	Skyrizi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/21/2021 ; 06/16/2021 ; 09/15/2021 ; 03/16/2022 ; 08/19/2022 ; 09/21/2022 ; 12/13/2023 ; 05/17/2024 ; 7/17/2024

1 . Indications

Drug Name: Skyrizi (risankizumab-rzaa)
Plaque Psoriasis Indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy. **Psoriatic Arthritis** Indicated for the treatment of active psoriatic arthritis in adults. **Crohn's Disease** Indicated for the treatment of moderately to severely active Crohn's disease in adults. **Ulcerative Colitis** Indicated for the treatment of moderately to severely active ulcerative colitis in adults.

2 . Criteria

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

2.1.2 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Coal tar

AND

2.1.3 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless

contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), Humira (adalimumab), Stelara (ustekinumab), Tremfya (guselkumab)]

OR

2.3 BOTH of the following:

- Patient is currently on Skyrizi therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Abbvie sponsored Skyrizi Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Skyrizi*

AND

3 - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

4 - Prescribed by or in consultation with a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. *Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Abbvie sponsor

	ed Skyrizi Complete program shall be required to meet initial authoriz ation criteria as if patient were new to therapy.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Skyrizi therapy **AND** **2** - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of active psoriatic arthritis	

AND

2 - ONE of the following:

2.1 History of failure to a 3 month trial of methotrexate at the maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Humira (adalimumab), Cimzia (certolizumab), Rinvoq (upadacitinib), Simponi (golimumab), Stelara (ustekinumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast)]

OR

2.3 BOTH of the following:

- Patient is currently on Skyrizi therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Abbvie sponsored Skyrizi Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Skyrizi*

AND

3 - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

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

• Rheumatologist • Dermatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Abbvie sponsored Skyrizi Complete program shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Skyrizi therapy **AND** **2** - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Crohn's Disease (CD)

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

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following:

2.1 Patient has been established on therapy with Skyrizi under an active UnitedHealthcare prior authorization for the treatment of moderately to severely active Crohn's disease

OR

2.2 BOTH of the following:

- Patient is currently on Skyrizi therapy for moderately to severely active Crohn's disease as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Abbvie sponsored Skyrizi Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Skyrizi*

AND

3 - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Abbvie sponsored Skyrizi Complete program shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Skyrizi therapy **AND** **2** - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - ONE of the following:

2.1 Patient has been established on therapy with Skyrizi under an active UnitedHealthcare medical benefit prior authorization for the treatment of moderately to severely active ulcerative colitis

OR

2.2 BOTH of the following:

- Patient is currently on Skyrizi therapy for moderately to severely active ulcerative colitis as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Abbvie sponsored Skyrizi Complete program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Skyrizi*

AND

3 - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), adalimumab]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap

	ply. * Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Abbvie sponsor ed Skyrizi Complete program SHALL BE REQUIRED to meet initial au thorization criteria as if patient were new to therapy.

Product Name: Skyrizi (subcutaneous formulations) [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Skyrizi therapy **AND** **2** - Patient is not receiving Skyrizi in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), adalimumab]	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Skyrizi is an interleukin-23 antagonist indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy and

active psoriatic arthritis in adults, and moderately to severely active Crohn's disease in adults, and moderately to severely active ulcerative colitis in adults.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Skyrizi [package insert]. North Chicago, IL: AbbVie Inc.; June 2024.
2. Menter A, Gottlieb A, Feldman SR, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol 2008; 58(5):826-50.
3. Gottlieb A, Korman NJ, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Psoriatic arthritis: Overview and guidelines of care for treatment with an emphasis on the biologics. J Am Acad Dermatol 2008;58(5):851-64.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies. J Am Acad Dermatol 2009;60(4):643-59.
5. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Guidelines of care for the treatment of psoriasis with phototherapy and photochemotherapy. J Am Acad Dermatol 2010;62(1):114-35.
6. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol 2009;61(3):451-85.
7. Nast A, et al; European S3-Guidelines on the systemic treatment of psoriasis vulgaris – update 2015 – short version – EFF in cooperation with EADV and IPC, J Eur Acad Derm Venereol 2015;29:2277-94.
8. Menter A, Korman NJ, Elmets CA, Feldman SR, Gelfand JM, Gordon KB, Guidelines of care for the management of psoriasis and psoriatic arthritis: section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. J Am Acad Dermatol. 2011 Jul;65(1):137-74.
9. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019;80:1029-72.
10. Lichtenstein GR, Loftus EV, Isaacs KL, et al ACG clinical guideline: management of Crohn’s disease in adults. Am J Gastroenterol. 2018; 113:481-517.

5 . Revision History

Date	Notes
7/16/2024	Updated clinical coverage criteria and background to add ulcerative c olitis. Updated active prior authorization verbiage under Crohn's dise ase with no change to clinical intent. Updated safety language and re ference.

Sohonos

Prior Authorization Guideline

Guideline ID	GL-138100
Guideline Name	Sohonos
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	1/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Sohonos (palovarotene)
Fibrodysplasia ossificans progressiva (FOP) Indicated for reduction in the volume of new heterotopic ossification in adults and children aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressiva (FOP).

2 . Criteria

Product Name: Sohonos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of fibrodysplasia ossificans progressiva (FOP)

AND

2 - Diagnosis has been confirmed by the presence of a mutation in the activin receptor IA (ACVR1) gene

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Patient is female
- Patient is aged 8 years and older

OR

3.2 BOTH of the following:

- Patient is male
- Patient is aged 10 years and older

AND

4 - Sohonos is being used to reduce the volume of new heterotopic ossification (HO)

AND

5 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

Product Name: Sohonos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response (e.g., reduction in new HO volume, improved CAJIS and FOP-PFQ scores, improved quality of life)

AND

2 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

3 . Background

Benefit/Coverage/Program Information
Background: Sohonos (palovarotene) is a retinoid indicated for reduction in the volume of new heterotopic ossification in adults and children aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressiva (FOP). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Sohonos [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc.; August 2023.
2. The International Clinical Council on FOP (ICC) and Consultants. The medical management of fibrodysplasia ossificans progressiva: Current treatment considerations. March 2019. Available at: https://www.ifopa.org/for_medical_professionals (Accessed on November 6, 2023).

5 . Revision History

Date	Notes
12/21/2023	New program

Somavert

Prior Authorization Guideline

Guideline ID	GL-149937
Guideline Name	Somavert
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 07/21/2021 ; 07/20/2022 ; 07/19/2023 ; 7/17/2024

1 . Indications

Drug Name: Somavert (pegvisomant)
Acromegaly Indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery or radiation therapy, or for whom these therapies are not appropriate.

2 . Criteria

Product Name: Somavert [a]	
Diagnosis	Acromegaly
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of acromegaly confirmed by ONE of the following:

- Serum GH level greater than 1 ng/mL after a 2-hour oral glucose tolerance test (OGTT) at time of diagnosis
- Elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis

AND

1.2 ONE of the following:

1.2.1 Inadequate response to ONE of the following:

- Surgery^
- Radiation therapy^
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

1.2.2 Not a candidate for ANY of the following:

- Surgery^
- Radiation therapy^
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

AND

1.3 Inadequate response, intolerance, or contraindication to a long-acting somatostatin analog [e.g., Sandostatin LAR (octreotide), Somatuline Depot (lanreotide)]

OR

2 - Patient is currently on Somavert therapy for acromegaly	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines.

Product Name: Somavert [a]	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Somavert therapy (e.g., age-normalized serum IGF-1 level)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

Background

Somavert (pegvisomant) is a growth hormone receptor antagonist indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery or radiation therapy, or for whom these therapies are not appropriate. The goal of treatment is to normalize serum insulin-like growth factor-I (IGF-I) levels. [1] The American Association of Clinical Endocrinologists (AACE) recommends pegvisomant in patients for whom surgical treatment and somatostatin analogues (SSAs) have proved ineffective or for those who are intolerant of somatostatin analogues. [2,4] The AACE and the Endocrine Society also recommend that dopamine agonists may be considered as first-line medical therapy, particularly in patients with mild biochemical activity, such as in the setting of modestly elevated serum IGF-I levels in the absence or concomitant presence of SSA therapy. [2,4,5]

4 . References

1. Somavert [prescribing information]. New York, NY: Pfizer Inc.; July 2023
2. Katznelson L, Atkinson JL, Cook DM, et al.; American Association of Clinical Endocrinologists. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of acromegaly--2011 update. Endocr Pract. 2011 Jul-Aug;17Suppl 4:1-44.
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5 . Revision History

Date	Notes
7/17/2024	Annual review with no changes to coverage criteria. Updated referen ces.

Spevigo

Prior Authorization Guideline

Guideline ID	GL-147354
Guideline Name	Spevigo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	5/17/2024
P&T Revision Date:	

Note:

This program applies to the subcutaneous formulations of Spevigo

1 . Indications

Drug Name: Spevigo® (spesolimab-sbzo) prefilled syringe
Generalized pustular psoriasis (GPP) Indicated for the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg.

2 . Criteria

Product Name: Spevigo prefilled syringe [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of generalized pustular psoriasis (GPP) based on BOTH of the following: [2,3]

- Presence of primary, sterile, macroscopically visible pustules on non-acral skin
- Pustulation is not restricted to psoriatic plaques

AND

2 - BOTH of the following:

- Used to prevent GPP flares
- Patient is not currently experiencing a GPP flare

AND

3 - ONE of the following:

3.1 Patient has been established on therapy with Spevigo for GPP under an active UnitedHealthcare medical benefit prior authorization

OR

3.2 BOTH of the following:

- Patient is currently on Spevigo therapy for GPP as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or via manufacturer's patient assistance programs (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Spevigo*

AND

4 - Patient is not receiving Spevigo in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or via manufacturer's patient assistance programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name: Spevigo prefilled syringe [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction in the rate and/or number of GPP flares)

AND

2 - Reduction in the utilization of therapy (e.g., intravenous Spevigo) used for GPP flares

AND

3 - Patient is not receiving Spevigo in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)] **AND** **4** - Prescribed by a dermatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Spevigo is an interleukin-36 receptor antagonist indicated for the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Spevigo [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; March 2024.
2. Bachelez H, Choon SE, Marrakchi S, et al. Trial of Spesolimab-sbzo for Generalized Pustular Psoriasis. N Engl J Med. 2021;385(26):2431-2440. doi:10.1056/NEJMoa2111563.

3. Navarini AA, Burden AD, Capon F, et al. European consensus statement on phenotypes of pustular psoriasis. J Eur Acad Dermatol Venereol. 2017;31(11):1792-1799. doi:10.1111/jdv.14386.

5 . Revision History

Date	Notes
5/17/2024	New program

Spravato (PA, QL)

Prior Authorization Guideline

Guideline ID	GL-149028
Guideline Name	Spravato (PA, QL)
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	06/15/2022 ; 12/14/2022 ; 12/13/2023 ; 06/17/2024

1 . Indications

Drug Name: Spravato (esketamine)
Treatment-resistant depression Indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults. **Major depressive disorder with acute suicidal ideation or behavior** Indicated, in conjunction with an oral antidepressant, for the treatment of depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior.

2 . Criteria

Product Name: Spravato [a]

Diagnosis	Major depressive disorder (treatment-resistant)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder (treatment-resistant), according to the current DSM (i.e., DSM-5-TR) criteria, by a mental health professional

AND

2 - Prescribed by or in consultation with a psychiatrist

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline scoring (prior to starting Spravato) on at least ONE of the following clinical assessments has been completed:

- Baseline score on the 17-item Hamilton Rating Scale for Depression (HAMD17)
- Baseline score on the 16-item Quick Inventory of Depressive Symptomatology (QIDS-C16)
- Baseline score on the 10-item Montgomery-Asberg Depression Rating Scale (MADRS)
- Baseline score on the 9-item Patient Health Questionnaire (PHQ-9)

AND

4 - History of a trial, failure, and/or contraindication of THREE different antidepressant medications or treatment regimens at the maximally tolerated dose(s) for at least 8 weeks in the current depressive episode. An antidepressant or treatment regimen would include any of the following classes or combinations (document medication, dose, and duration):

- Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
- Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, etc.)
- Bupropion
- Tricyclic antidepressants (e.g, amitriptyline, clomipramine, nortriptyline, etc.)

- Mirtazapine
- Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine, etc.)
- Serotonin modulators (e.g., nefazodone, trazodone, etc.)
- Augmentation with lithium, Cytomel (liothyronine), antipsychotics, or anticonvulsants

AND

5 - Spravato will be used in combination with an oral antidepressant (one that the patient has not previously failed)

AND

6 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS program

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Spravato [a]	
Diagnosis	Major depressive disorder (treatment-resistant)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of remission or a positive clinical response to Spravato therapy

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) documenting baseline and recent (within the last month) scoring on at least ONE of the following assessments demonstrating remission or clinical response (e.g., score reduction from baseline) as defined by the:

- Hamilton Rating Scale for Depression (HAMD17; remission defined as a score of ≤7)
- Quick Inventory of Depressive Symptomatology (QIDS-C16; remission defined as a score of ≤ 5)
- Montgomery-Asberg Depression Rating Scale (MADRS; remission defined as a score of ≤ 12)
- Baseline score on the 9-item Patient Health Questionnaire (PHQ-9)

AND

3 - Spravato will be used in combination with an oral antidepressant

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS program

AND

5 - Prescribed by or in consultation with a psychiatrist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Spravato* [a]	
Diagnosis	Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder according to the current DSM (i.e., DSM-5-TR) criteria, by a mental health professional

AND

2 - Patient is experiencing an acute suicidal ideation or behavior

AND

3 - Spravato will be used in combination with a newly initiated or optimized oral antidepressant

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS program

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Note: Spravato is hard-coded with a quantity of 0.29 per day for the 56mg strength and 0.43 per day for the 84mg strength. If criteria are met, enter one GPI-12 authorization with an MDD override of 1 and a PQE of 24 per 28 days.

Product Name: Spravato* [a]	
Diagnosis	Depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - The drug is prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in the compendia of current literature

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply. *Note: Spravato is hard-coded with a quantity of 0.29 per day for the 5 6mg strength and 0.43 per day for the 84mg strength. If criteria are m et, enter one GPI-12 authorization with an MDD override of 1 and a P QE of 24 per 28 days.

3 . Background

Benefit/Coverage/Program Information
Background: Spravato (esketamine) is a non-competitive N-methyl D-aspartate (NMDA) receptor antagonist indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults and depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior. Limitations of Use: The effectiveness of Spravato in preventing suicide or in reducing suicidal ideation or behavior has not been demonstrated. Use of Spravato does not preclude the need for hospitalization if clinically warranted, even if patients experience improvement after an initial dose of Spravato. Spravato is not approved as an anesthetic agent. The safety and effectiveness of Spravato as an anesthetic agent have not been established. Because of the risks of serious adverse outcomes resulting from sedation, dissociation, and abuse and misuse, Spravato is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Spravato REMS. For the purposes of this program, a trial and failure of a given antidepressant is defined as the patient unable to achieve a clinical meaningful improvement of the maximally tolerated dose(s) for at least 8 weeks in the current depressive episode. [2,3] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Spravato [prescribing information]. Lakewood, NJ; Janssen Pharmaceuticals, Inc.; October 2023.
2. Gaynes BN, Rush AJ, Trivedi MH, et al. The STAR*D study: treating depression in the real world. Cleve Clin J Med. 2008; 75(1):57-66
3. American Psychiatric Association (APA). Practice guideline for the treatment of patients with major depressive disorder. 3rd ed. Arlington (VA): American Psychiatric Association (APA); 2010 Oct.
4. Psychopharmacologic Drugs Advisory Committee and Drug Safety and Risk Management Advisory Committee Meeting. FDA Briefing Document. February 12, 2019. https://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/PsychopharmacologicDrugsAdvisoryCommittee/UCM630970.pdf. (Accessed on July 21, 2021)
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7. Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–61.
8. Rush AJ, Bernstein IH, Trivedi MH, et al. An evaluation of the Quick Inventory of Depressive Symptomatology and the Hamilton Rating Scale for Depression: a Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial report. Biol Psychiatry 2006; 59:493–501.
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10. Trivedi MH, Rush AJ, Gaynes BN, et al. Maximizing the adequacy of medication treatment in controlled trials and clinical practice: STAR*D measurement-based care. Neuropsychopharmacology. 2007 Dec;32(12):2479-89.
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12. Popova V, Daly EJ, Trivedi M, et al. Efficacy and Safety of Flexibly Dosed Esketamine Nasal Spray Combined with a Newly Initiated Oral Antidepressant in Treatment-Resistant Depression: A Randomized Double-Blind Active-Controlled Study. Am J Psychiatry. 2019 Jun 1;176(6):428-438.
13. Fu DJ, Ionescu DF, Li X, et al. Esketamine Nasal Spray for Rapid Reduction of Major Depressive Disorder Symptoms in Patients Who Have Active Suicidal Ideation with Intent: Double-Blind, Randomized Study (ASPIRE I). J Clin Psychiatry. 2020 May 12;81(3):19m13191.

14. Ionescu DF, Fu DJ, Qiu X, et al. Esketamine Nasal Spray for Rapid Reduction of Depressive Symptoms in Patients with Major Depressive Disorder Who Have Active Suicide Ideation with Intent: Results of a Phase 3, Double-Blind, Randomized Study (ASPIRE II), International Journal of Neuropsychopharmacology, pyaa068.
15. Coley RY, Boggs JM, Beck A, Hartzler AL, Simon GE. Defining Success in Measurement-Based Care for Depression: A Comparison of Common Metrics. Psychiatr Serv. 2020;71(4):312-318. doi:10.1176/appi.ps.201900295

5 . Revision History

Date	Notes
6/27/2024	Updated wording of coverage criteria without change to clinical intent . Updated approval duration, both initial and reauthorization, to 12 m onths. Updated quantity limit override note. Updated GL name

Sprycel

Prior Authorization Guideline

Guideline ID	GL-154705
Guideline Name	Sprycel
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/15/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Sprycel (dasatinib)
Philadelphia Chromosome-Positive Chronic Myeloid Leukemia (Ph+ CML) Indicated for newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase. It is also indicated for the treatment of pediatric patients 1 year of age and older with Ph+ CML in chronic phase. **Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)** FDA-labeled for treatment of adults with Philadelphia chromosome-positive acute lymphoblastic leukemia with resistance or intolerance to prior therapy. It is also indicated for the treatment of pediatric patients 1 year of age and older with newly diagnosed Ph+ ALL in combination with chemotherapy. **Gastrointestinal stromal tumor** National Comprehensive Cancer Network (NCCN) also approves of the use of Sprycel in gastrointestinal stromal tumor in patients with a PDGFRA D842V mutation.

Metastatic chondrosarcoma The National Comprehensive Cancer Network (NCCN) also recommends the use of Sprycel in metastatic chondrosarcoma.

Chordoma The National Comprehensive Cancer Network (NCCN) also recommends the use of Sprycel in recurrent chordoma.

BCR-ABL1-Positive Chronic Myelogenous / Myeloid Leukemia The National Comprehensive Cancer Network (NCCN) also recommends the use of Sprycel in BCR-ABL1 positive CML.

Myeloid/lymphoid neoplasms The National Comprehensive Cancer Network (NCCN) also recommends the use of Sprycel in myeloid/lymphoid neoplasms with eosinophilia and ABL1 rearrangement.

2 . Criteria

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Philadelphia chromosome-positive or BCR-ABL1-Positive chronic myeloid leukemia **AND** **2** - ONE of the following: • Patient is not a candidate for imatinib as attested by physician • Patient is currently on Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Philadelphia Chromosome-Positive or BCR-ABL1-Positive Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Sprycel, generic dasatinib [a]

Diagnosis	Philadelphia Chromosome-Positive Acute Lymphoblastic Leukemia (Ph+ALL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of gastrointestinal stromal tumor (GIST) with PDGFRA D842V mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of metastatic chondrosarcoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sprycel therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of recurrent chordoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]

Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia **AND** **2** - Patient has an ABL1 rearrangement	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Cutaneous Melanoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cutaneous melanoma **AND** **2** - Tumors are metastatic or unresectable **AND** **3** - Contains activating mutations of KIT **AND** **4** - Used as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	Cutaneous Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on Sprycel therapy.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Sprycel will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sprycel, generic dasatinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Sprycel therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Sprycel (dasatinib) is a tyrosine kinase inhibitor indicated for newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase. Sprycel is also indicated for treatment of adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including (imatinib), for the treatment of adults with Ph+ acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy, for the treatment of pediatric patients 1 year of age and older with Ph+ CML in chronic phase, and for the treatment of pediatric patients 1 year of age and older with Ph+ ALL in combination with chemotherapy.[1] The National Comprehensive Cancer Network (NCCN) also recommends the use of Sprycel in BCR-ABL1 positive CML, in gastrointestinal stromal tumor in patients with a PDGFRA D842V mutation, metastatic chondrosarcoma, in recurrent chordoma and in myeloid/lymphoid neoplasms with eosinophilia and ABL1 rearrangement, and in cutaneous melanoma with metastatic or unresectable tumors with activating mutations of KIT as second-line or subsequent therapy for disease progression, intolerance, and/or projected risk of progression with BRAF-targeted therapy **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply Limits may be in place

4 . References

1. Sprycel [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; February 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed August 29, 2023.

5 . Revision History

Date	Notes
9/10/2024	Added generic Sprycel

State Mandates Administrative

Prior Authorization Guideline

Guideline ID	GL-155860
Guideline Name	State Mandates Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	01/21/2021 ; 10/06/2021 ; 10/20/2021 ; 12/15/2021 ; 02/17/2023 ; 09/20/2023 ; 12/13/2023

1 . Criteria

Guideline Type	Administrative
Approval Criteria **1** - Please see background section for criteria	

2 . Background

Benefit/Coverage/Program Information
Background: This document serves as a resource to highlight individual state mandates that may impact existing utilization management programs. Utilization programs include but are not limited to step therapy, prior authorization, supply limits, first-line trial duration limitations and pain therapy/end of life regulations. Select state mandates may require medical records for documentation. New and revised mandates will be reviewed quarterly with the Utilization Management (UM) committee. *This resource only focuses on sections of state mandates that pertain to utilization management programs. This reference document does not cite full state mandates.* **1. Arizona:** **a. Step Therapy Exception, AZ21-18132471 CS EI, ARS §20-3604** (effective 1/1/23) A step therapy exception request shall be granted if sufficient justification to establish that any of the following applies: • The prescription drug required by the step therapy protocol is contraindicated or will likely cause a serious adverse reaction by or physical or mental harm to the patient. • The prescription drug required by the step therapy protocol is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen. • The patient has tried the prescription drug required by the step therapy protocol while under the patient's current or previous health care plan, or another prescription drug in the same pharmacological class with a similar efficacy and side effect profile or with the same mechanism of action, the patient's adherence during the trial was for a period of time sufficient to allow for a positive treatment outcome and the prescription drug was discontinued due to lack of efficacy or effectiveness, an adverse event or contraindication. • The prescription drug required by the step therapy protocol is not in the best interest of the patient based on medical necessity because the patient's use of the prescription drug is expected to cause any of the following: o A barrier to the patient's adherence to or compliance with the patient's plan of care. o A negative impact on the patient's comorbid conditions. o A clinically predictable negative drug interaction. o A decrease in the patient's ability to achieve or maintain a reasonably functional ability in performing daily activities for which the patient has experienced a positive therapeutic

outcome.
- The patient has experienced a positive therapeutic outcome on a prescribed drug selected by the patient's health care provider for the medical condition under consideration while on the patient's current or previous health care plan.

A health care provider may not use a pharmaceutical sample for the purpose of qualifying for an exception to step therapy under this paragraph.

2. Colorado:

a. Step Therapy Exception for Metastatic Cancer, CO22-21309458 C.R.S. §10-16-145.5 (effective 01/01/2023)

A carrier that provides coverage under a health benefit plan for the treatment of stage four advanced metastatic cancer shall not limit or exclude coverage under the health benefit plan for a drug approved by the FDA and that is on the carrier's prescription drug formulary by mandating that a covered person with stage four advanced metastatic cancer undergo STEP THERAPY if the use of the approved drug is consistent with:

- The FDA-approved indication or
- The National Comprehensive Cancer Network Drugs and Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; or
- Peer-reviewed medical literature.

b. Step Therapy Exception, CO22-21309458 CS EI C.R.S. §10-16-145 (effective 1/1/24)

A carrier, a private utilization review organization, or a PBM shall grant an exception to step therapy if the prescribing provider submits justification and supporting clinical documentation, if needed, that states:

- The provider attests that the required prescription drug is contraindicated or will likely cause an adverse reaction or harm to the covered person;
- The required prescription drug is ineffective based on the known clinical characteristics of the covered person and the known characteristics of the prescription drug regimen;
- The covered person has tried, while under the covered person's current or previous health benefit plan, the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the use of the prescription drug by the covered person was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

- The covered person, while on the covered person's current or previous health benefit plan, is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration after undergoing step therapy or after having sought and received a step-therapy exception.

This section does not prohibit a carrier, an organization, or a PBM from requiring a covered person to try a generic equivalent drug, a biosimilar drug, or an interchangeable biological product unless the covered person or covered person's prescribing provider has requested a step-therapy exception and the prescribed drug meets the criteria for a step-therapy section as specified in this section.

3. Florida:

a. Step Therapy Exception §627.42393 F.S. (effective 1/1/2024)

A health insurer issuing a major medical individual or group policy may not require a step-therapy protocol under the policy for a covered prescription drug requested by an insured if:
1. The insured has previously been approved to receive the prescription drug through the completion of a step-therapy protocol required by a separate health coverage plan.

4. Georgia:

a. Step Therapy Exception GA19-12787856 EI O.C.G.A §33-24-59.25 (effective 1/1/2020)

A step therapy exception shall be granted by a health benefit plan if the prescribing provider's submitted justification and supporting clinical documentation, if needed, is completed and determined to support such provider's statement that:
- The required prescription drug is contraindicated or will cause an adverse reaction or physical or mental harm to the patient;
- The required prescription drug is expected to be ineffective based on the known clinical condition of the patient and the known characteristics of the prescription drug regimen;
- The patient has tried the required prescription drug or another prescription drug in the same pharmacological class or with the same mechanism of action as the required drug while on their current or immediately preceding health plan and such drug was discontinued due to lack of efficacy, diminished effect, or an adverse event; or
- The patient is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current or immediately preceding health plan, the patient received coverage for the prescription drug and the practitioner gives documentation in accordance with this subsection that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the

patient based on the known characteristics of the patient and the known characteristics of the required prescription drug.

Drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy required prescription drug. This Code section shall not be construed to prevent:

- A health benefit plan from requiring a patient to try an AB-rated generic equivalent prior to providing coverage for the equivalent-branded prescription drug
- A health benefit plan from requiring a patient to try an interchangeable biological product prior to providing coverage for the biological products

b. Terminal Condition, GA15-1507096 O.C.G.A §33-24-59.18 (effective 7/1/2015)

No health benefit plan shall restrict coverage for treatment of a terminal condition when such treatment has been prescribed by a physician as medically appropriate and such treatment has been agreed to by an insured patient or by a person to whom the insured patient has legally delegated such authority or to whom otherwise has the legal authority to consent on behalf of the insured patient. The health benefit plan shall not refuse to pay or otherwise reimburse for the treatment diagnosed under this subsection, including any drug or device, so long as such end of life care is consistent with best practices for the treatment of the terminal condition and such treatment is supported by peer reviewed medical literature.

'Terminal condition' means any disease, illness, or health condition that a Physician has diagnosed as expected to result in death in 24 months or less.

c. Step Therapy Exception for Metastatic Cancer, GA Code §33-24-59.20 (effective 1/1/20)

No health benefit plan issued, delivered, or renewed in this state that, as a provision of hospital, medical, or surgical services, directly or indirectly covers the treatment of stage four advanced, metastatic cancer shall limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of such drug or drugs; provided, however, that the use of such drug or drugs is consistent with best practices for the treatment of stage four advanced, metastatic cancer and is supported by peer reviewed medical literature. Other mandate provisions define “health benefit plan” and “stage four advanced, metastatic cancer.”

5. Illinois:

a. Step Therapy Exception IL16-3027525 215 ILCS 134/45.1 (effective 1/1/2018)

A step therapy requirement exception request shall be approved if:
- the required prescription drug is contraindicated;
- the patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or
- the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

b. Step Therapy Exception for Stage 4 Advanced, Metastatic Cancer IL18-9299149 215 ILCS 5/356z.29 (effective 1/1/2019)

No individual or group policy of accident and health insurance amended, issued, delivered, or renewed in this State after the effective date of this amendatory Act of the 100th General Assembly that, as a provision of hospital, medical, or surgical services, directly or indirectly covers the treatment of stage 4 advanced, metastatic cancer shall limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or prove history of failure of the drug as long as the use of the drug is consistent with best practices for the treatment of stage 4 advanced, metastatic cancer and is supported by peer-reviewed medical literature

6. Louisiana:

a. Step Therapy Exception for Stage 4 Advanced, Metastatic Cancer LA19-13246769 EI La. R.S. 22:1053 (effective 6/5/2019)

No health coverage plan shall use step therapy or fail first protocols as the basis to restrict any prescription benefit for the treatment of stage-four advanced, metastatic cancer or associated conditions if at least one of the following criteria is met:
- The prescribed drug or drug regimen has the United States Food and Drug Administration approved indication.
- The prescribed drug or drug regimen has the National Comprehensive Cancer Network Drugs and Biologic Compendium indication.
- The prescribed drug or drug regimen is supported by peer-reviewed, evidenced-based medical literature.

The provisions this Section shall not apply if the preferred drug or drug regimen is considered clinically equivalent for therapy, contains the identical active ingredient or ingredients, and is proven to have the same efficacy. For purposes of this Subsection, different salts proven to have the same efficacy shall not be considered as different active ingredients.

b. Exception for Cancer Treatment Targeting A Specific Genetic Mutation, LA 2022000 S 146 EI La. Stat. 22:§1054.1 (A) (effective 8/1/22)

No health coverage plan delivered or issued for delivery in this state shall deny coverage for the treatment of metastatic or unresectable tumors or other advanced cancers with a medically necessary drug prescribed by a physician on the sole basis that the drug is not indicated for the specific tumor type or location in the body of the patient's cancer if the drug is approved by the United States Food and Drug Administration for the treatment of the specific mutation in a different type of cancer. Insurers shall not consider the treatment experimental or outside of their policy scope if the United States Food and Drug Administration has approved the drug for the treatment of cancer with the specific genetic mutation, even if in a different tumor type. This coverage may be denied only if an alternative treatment has proven to be more effective in published randomized clinical trials and is not contraindicated in the patient.

c. Step Therapy Exception, LA20-15951347 CS EI <R.S. 22:1053> (effective 1/1/2021, amended 8/1/2023)

An override of such the restriction shall be expeditiously granted by the insurer under health coverage plan if the prescribing practitioner, using sound clinical evidence, can demonstrate any of the following circumstances:

- The prescribing physician can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol has been ineffective in the treatment of the insured's patient's disease or medical condition. The prescribing practitioner shall demonstrate to the health coverage plan that the patient has tried the required prescription drug while under his current or a previous health insurance or health coverage plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The prescribing physician can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured patient and known characteristics of the drug regimen.
- The prescribing physician can demonstrate to the health coverage plan, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first

protocol is contraindicated or will likely cause an adverse reaction or other physical or mental harm to the insured patient.
- The patient is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on his current health coverage plan or the immediately preceding health coverage plan, the patient received coverage for the prescription drug.
- The required prescription drug is not in the best interest of the patient based on medical necessity as evidenced by valid documentation submitted by the prescriber.
- The provisions of this Section shall not be construed to prohibit the substitution of an AB-rated generic equivalent, biosmimilar, or interchangeable biological product as designated by the federal Food and Drug Administration

d. Off-Label Use Exception, R.S. 22:1060.8 (effective 1/1/23)

No health coverage plan delivered or issued for delivery in this state shall limit or exclude coverage involving a minor for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved by the United States Food and Drug Administration and all of the following apply:

- The drug has been approved by the United States Food and Drug Administration.
- The drug is prescribed by a licensed healthcare provider for the treatment of a life threatening, chronic, or seriously debilitating disease or condition in a minor and the drug has been approved by the United States Food and Drug Administration for the same condition or disease in an adult and the drug is medically necessary to treat the disease or condition.
- The drug has been recognized for the treatment of the disease or condition in pediatric application by one of the following:
  - The American Hospital Formulary Service Drug Information
  - The United States Pharmacopeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"
  - Recognized in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed journal.

e. Cancer Prior Authorization Requirements LA23-23518873 R.S. 22:1060.14 (effective 1/1/2024)

No health coverage plan that is renewed, delivered, or issued for delivery in this state that provides coverage for cancer in accordance with the Louisiana Insurance Code shall deny a request for prior authorization or the payment of a claim for any procedure, pharmaceutical, or diagnostic test typically covered under the plan to be provided or performed for the diagnosis and treatment of cancer if the procedure, pharmaceutical, or diagnostic test is

recommended by nationally recognized clinical practice guidelines for use in the diagnosis or treatment for the insureds particular type of cancer and clinical state.

f. Step Therapy Exception for Menopause and Perimenopause, LA 2024000 H 392 R.S. 22:988 (effective 8/1/2024)

A health insurance issuer offering health coverage plans in this state shall provide coverage for any medically necessary care or treatment for menopause and perimenopause.

A health insurance issuer shall not require a prior authorization or otherwise be subject to a step-therapy or fail-first policy or protocol for the administration or prescription of any medication administered or prescribed for hormone replacement therapy used to treat symptoms of menopause and perimenopause

7. Maryland:

a. Step Therapy Exception MD 23-23313747, MD INS Code Ann. §15-141 (effective 1/1/2024)

An entity subject to this section may not impose a Step Therapy or Fail - First Protocol on an insured or enrollee if:

- The Step Therapy Drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated; or
- A prescriber provides supporting medical information to the entity that a prescription drug covered by the entity:
- Was ordered by a prescriber for the insured or enrollee within the past 180 days; and
- Based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition.

A step therapy exception request shall be granted if, based on the professional judgment of the prescriber and any information and documentation required when:

- The step therapy drug is contraindicated or will likely cause an adverse reaction to the insured or enrollee;
- The step therapy drug is expected to be ineffective based on the known clinical characteristics of the insured or enrollee and the known characteristics of the prescription drug regimen;
- The insured or enrollee is stable on a prescription drug prescribed for the medical condition under consideration while covered under the policy or contract of the entity or under a previous source of coverage; or
- While covered under the policy or contract of the entity or a previous source of coverage, the insured or enrollee has tried a prescription drug that:

o Is in the same pharmacologic class or has the same mechanism of action as the step therapy drug; and
o Was discontinued by the prescriber due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

This subsection may not be construed to prevent:

- An entity subject to this section from requiring an insured or enrollee to try an AB-rated generic equivalent or interchangeable biologic product before providing coverage for the equivalent branded prescription drug; OR
- A health care provider from prescribing a prescription drug that is determined to be medically inappropriate; or
o Require an entity subject to this section to provide coverage for a prescription drug that is not covered by a policy or contract of the entity

b. Step Therapy Exception for Stage 4 Advanced, Metastatic Cancer, MD17-4512688 MD INS Code §15-142 (effective 10/1/2017)

An entity subject to this section may not impose a step therapy or fail-first protocol on an insured or an enrollee for a prescription drug approved by the U.S. Food and Drug Administration if:

- The prescription drug is used to treat the insured's or enrollee's stage four advanced metastatic cancer; and
- Use of the prescription drug is:
o Consistent with the U.S. Food and Drug Administration-approved indication or
o The National Comprehensive Cancer Network Drugs & Biologics Compendium Indication for the treatment of stage four advanced metastatic cancer; and
o Supported by peer-reviewed medical literature.

8.Mississippi:

a. Step Therapy Exception, MS 83-9-36 (effective 1/1/2012)

An override of that restriction shall be expeditiously granted by the insurer under the following circumstances:

- The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in

the treatment of the insured's disease or medical condition; or
- Based on sound clinical evidence or medical and scientific evidence:
  - The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or
  - The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.
- The duration of any step therapy or fail-first protocol shall not be longer than a period of thirty (30) days when the treatment is deemed clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended up to seven (7) additional days.

b. Terminal Condition, § 83-9-22
Health coverage plans prohibited from restricting coverage for medically appropriate treatment prescribed by physician based on insured's diagnosis with terminal condition.;

(1); (a) Notwithstanding any other provision of the law to the contrary, no health coverage plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. Refusing to pay for treatment rendered to an insured near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section;
(b) Violations of this section shall constitute an unfair trade practice and subject the violator to the penalties provided by law;
(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal;
(d) As used in this section, a "health coverage plan" shall mean any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the State Health and Life Insurance Plan.;
(2); (a) Notwithstanding any other provision of the law to the contrary, no health benefit paid directly or indirectly with state funds, specifically Medicaid, shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal

condition.;
(b) Refusing to pay for treatment rendered to an individual near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section;
(c) As used in this section “terminal condition” means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

c. **Step Therapy Exception for Advanced, Metastatic Cancer and Associated Conditions** MS § 83-9-36, HB 2143 (effective 8/1/2024)

A health benefit plan that provides coverage for advanced, metastatic cancer and associated conditions may not require, before the health benefit plan provides coverage of a prescription drug approved by the United States Food and Drug Administration, that the enrollee:

(a) Fail to successfully respond to a different drug; or

(b) Prove a history of failure of a different drug.

This section applies only to a drug the use of which is:

(a) Consistent with best practices for the treatment of advanced, metastatic cancer or an associated condition.

(b) Supported by peer-reviewed, evidence-based literature; and

(c) Approved by the United States Food and Drug Administration.

An override of that restriction shall be expeditiously granted by the insurer under the following circumstances:

(a) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence:

(i) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

(ii) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

"Associated conditions" means the symptoms or side effects associated with advanced, metastatic cancer or its treatment and which, in the judgment of the health care practitioner, further jeopardizes the health of a patient if left untreated.

"Advanced, metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

9. Missouri:

a. **Step Therapy Exception**, MO§ 376.2034 (effective 7/1/2012)

A step therapy override exception determination shall be granted if the patient has tried the step therapy required prescription drugs while under his or her current or previous health insurance or health benefit plan, and such prescription drugs were discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, or if the patient's treating health care provider attests that coverage of the prescribed prescription drug is necessary to save the life of the patient. Pharmacy drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy required prescription drug.

- Upon the granting of a step therapy override exception request, the health carrier, health benefit plan, or utilization review organization shall authorize dispensation of and coverage for the prescription drug prescribed by the patient's treating health care provider, provided such drug is a covered drug under such policy or contract.
- This section shall not be construed to prevent:
  - A health carrier, health benefit plan, or utilization review organization from requiring a patient to try a generic equivalent or other brand name drug prior to providing coverage for the requested prescription drug; or
  - A health care provider from prescribing a prescription drug he or she determines is medically appropriate.

10. New Mexico

a. **Step Therapy Exception**, N.M. § 59A-46-52.2 (effective 1/1/24)

A carrier shall expeditiously grant an exception to the health maintenance organization contract's step therapy protocol, based on medical necessity and a clinically valid explanation from the patient's prescribing practitioner as to why a drug on the health

maintenance organization contract's formulary that is therapeutically equivalent to the prescribed drug should not be substituted for the prescribed drug, if:

- The prescription drug that is the subject of the exception request is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient;
- The prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- While under the enrollee's current health maintenance organization contract, or under the enrollee's previous health coverage, the enrollee has tried the prescription drug that is the subject of the exception request or another prescription drug in the same pharmacologic class or with the same mechanism of action as the prescription drug that is the subject of the exception request and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event; or
- The prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:
- Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
- Worsen a comorbid condition of the patient; or
- Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.

The provisions of this section shall not be construed to prevent a health maintenance organization contract from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug. The provisions of this section shall not be construed to prevent a health maintenance organization contract from requiring a patient to try a generic equivalent of a prescription drug before providing coverage for the equivalent brand-name prescription drug.

11. North Carolina

a. Step Therapy Exception NC20- 16056997 CS EI, Statute § 58-3-221 (effective 1/1/2024)

An insurer shall grant an exception request if the prescribing provider's submitted justification and supporting clinical documentation are sufficient to demonstrate any of the following:

- The enrollee has tried the alternate drug or drugs while covered by the current or the previous health benefit plan.
- The formulary or alternate drug or drugs has been ineffective in the treatment of the enrollee's disease or condition.

- The formulary or alternate drug or drugs causes or is reasonably expected by the prescribing provider to cause a harmful or adverse clinical reaction in the enrollee.
- Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.
- The enrollee's prescribing provider certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the enrollee's health or has been ineffective in treating the same condition and, in the opinion of the prescribing health care provider, is likely to be detrimental to the enrollee's health or ineffective in treating the condition again.

Pharmaceutical drug samples or patient incentive programs, including coupons or debit cards, shall not be considered trial and failure of a preferred prescription drug in lieu of trying the formulary preferred prescription drug.

Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer.

This section shall not be construed to prevent the health benefit plan from requiring an enrollee to try an A-rated generic equivalent drug, or a biosimilar, as defined under 42 U.S.C. § 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

12. Ohio:

a. Step Therapy Exception, OH 3901.832 (effective 1/1/20)

Pursuant to a step therapy exemption request or an appeal, a health plan issuer or utilization review organization shall grant a step therapy exemption if any of the following are met:

- The required prescription drug is contraindicated for that specific patient, pursuant to the drug's United States food and drug administration prescribing information.
- The patient has tried the required prescription drug while under their current, or a previous, health benefit plan, or another United States food and drug administration approved AB-rated prescription drug, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The patient is stable on a prescription drug selected by the patient's health care provider for the medical condition under consideration, regardless of whether or not the drug was prescribed when the patient was covered under the current or a previous health benefit plan, or has already gone through a step therapy protocol. However, a health benefit plan may require a stable patient to try a pharmaceutical alternative, per the federal food and drug

administration's orange book, purple book, or their successors, prior to providing coverage for the prescribed drug.

b. Step Therapy Exception for Stage 4 Advanced, Metastatic Cancer, OH21-16933950, ORC **§ 3902.51** (effective 3/24/2021)

A health benefit plan issued, delivered, or renewed in Ohio on or after 3/24/2021 that directly or indirectly covers the treatment of stage four advanced metastatic cancer is prohibited from making coverage of a drug that is prescribed to treat such cancer or associated conditions dependent upon a covered person demonstrating either of the following:
- Failure to successfully respond to a different drug;
- A history of failing to respond to a different drug or drugs.

This prohibition applies only to uses of such drug or drugs that are consistent with either of the following:
- An indication approved by, or described in, as applicable, either of the following for the treatment of stage four advanced metastatic cancer:
  - The United States Food and Drug Administration;
  - The National Comprehensive Cancer Network drugs and biologics compendium.
- The best practices for the treatment of stage four advanced metastatic cancer, as supported by peer-reviewed medical literature.

A violation of this prohibition is an unfair and deceptive practice in the business of insurance.

13. Oklahoma:

a. Step Therapy Exception, OK19-12431543 OK Stat. §63-7310 (effective 1/1/2020)

A health insurance plan shall grant a requested step therapy exception if the submitted justification of the prescribing provider and supporting clinical documentation, if needed, is completed and supports the statement of the provider that:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient,
- The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug,
- The patient has tried the required prescription drug while under the patient's current or a previous health insurance plan and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event,
- The required prescription drug is not in the best interest of the patient, based on medical

necessity, or
- The patient is stable on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on the patient's current or a previous health insurance plan

Nothing in this section shall be construed to authorize the use of a pharmaceutical sample for the sole purpose of meeting the requirements for a step therapy exception

b. Step Therapy Exception for Stage 4 Advanced, Metastatic Cancer, H-2748, OK23-2329415 (effective 11/1/23)

A health benefit plan that provides coverage for advanced metastatic cancer and associated conditions may not require, before providing coverage of an FDA-approved prescription drug, that the enrollee: (1) fails to successfully respond to a different drug; or (2) proves a history of failure of a different drug. This prohibition applies only to a drug, the use of which is: (1) consistent with best practices for the treatment of advanced metastatic cancer or an associated condition; (2) supported by peer-reviewed, evidence-based literature; and (3) approved by the FDA.

14. Tennessee:

a. Step Therapy Exception, Tenn. Code § 56-7-3502 (effective 1/1/23)

A health carrier, health benefit plan, or utilization review organization shall grant a step therapy exception if one (1) of the following applies:
- The required prescription drug is contraindicated or will likely cause an adverse reaction to, or physical or mental harm to, the patient due to a documented adverse event with a previous use of the required prescription drug or a documented medical condition, including a comorbid condition;
- The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
o The required prescription drug is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the drug is expected to:
o Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
o Worsen a comorbid condition of the patient; or
o Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or
- The patient is currently receiving a positive therapeutic outcome on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan, and the patient's healthcare provider gives documentation to the health insurance, health benefit plan, or

utilization review organization that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

The use of pharmaceutical samples of a required prescription drug is not considered a trial of the required prescription drug as part of a step therapy protocol.

15. Texas:

a. Step Therapy Exception, TX17-4501604 Tex. Ins. Code §1369.0546 (effective 1/1/2018)
A health benefit plan issuer shall grant a written request if the request includes the prescribing provider's written statement, with supporting documentation, stating that:
- The drug required under the step therapy protocol:
  - Is contraindicated;
  - Will likely cause an adverse reaction in or physical or mental harm to the patient; or
  - Is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- The patient previously discontinued taking the drug required under the step therapy protocol, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the health benefit plan currently in force or while covered under another health benefit plan because the drug was not effective or had a diminished effect or because of an adverse event;
- The drug required under the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the drug is expected to:
  - Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
  - Worsen a comorbid condition of the patient; or
  - Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or
- The drug that is subject to the step therapy protocol was prescribed for the patient's condition;
- The patient:
  - Received benefits for the drug under the health benefit plan currently in force or a previous health benefit plan; and
  - Is stable on the drug; and
  - The change in the patient's prescription drug regimen required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known clinical characteristics of the patient and the known characteristics of the required prescription drug regimen

b. Step Therapy Exception for Stage 4 Advanced, Metastatic Cancer, TX19-13305672 Tex. Ins. Code §1369.213 (effective 1/1/2020)

A health benefit plan that provides coverage for stage-four advanced, metastatic cancer and associated conditions may not require, before the health benefit plan provides coverage of a prescription drug approved by the United States Food and Drug Administration (FDA), that the enrollee:

- Fail to successfully respond to a different drug; or
- Prove a history of failure of a different drug.

This section applies only to a drug the use of which is:

- Consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition;
- Supported by peer-reviewed, evidence-based literature; and
- Approved by the United States Food and Drug Administration.

c. **Step Therapy Exception for Serious Mental Illness** TX23-23491650 §1369.0547 (effective 1/1/2024)

This section applies only to a drug prescribed to an enrollee who is 18 years of age or older to treat a diagnosis of a serious mental illness. A health benefit plan that provides coverage for prescription drugs to treat a serious mental illness may not require, before the health benefit plan provides coverage of a prescription drug approved by the United States Food and Drug Administration, that the enrollee:

- fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or
- prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug.

Subject to Section 1369.0546, a health benefit plan issuer may implement a step therapy protocol to require a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

- once in a plan year; and
- if the generic or pharmaceutical equivalent drug is added to the plan's drug formulary.

16. Virginia:

a. Continuity of Care for Treatment of a Mental Disorder, VA21-17387330 VA code §38.2-3407.15:2 (effective 7/1/2021)

Any provider contract between a carrier and a participating health care provider with prescriptive authority, or its contracting agent, shall contain specific provisions that:

- Require that when any carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization shall be required by the carrier, provided that (i) the drug is a covered benefit; (ii) the prescription does not exceed the FDA-labeled dosages; (iii) the prescription has been continuously issued for no fewer than three months; and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. Nothing in this subdivision shall prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription for the drug is issued.

b. Step Therapy Exception, VA19-11741564 VA code §38.2-3407.9:05 (effective 1/1/2020)

A step therapy exception request shall be granted if the prescribing provider's submitted justification and supporting clinical documentation, if needed, are determined to support the prescribing provider's statement that:

- The required prescription drug is contraindicated;
- The required drug would be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- The patient has tried the step therapy-required prescription drug while under their current or a previous health benefit plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or
- The patient is currently receiving a positive therapeutic outcome on a prescription drug recommended by his provider for the medical condition under consideration while on a current or the immediately preceding health benefit plan.

Drug samples shall not be considered trial and failure of a preferred drug.

This section shall not be construed to prevent a carrier or utilization review organization from requiring an enrollee to try an AB-rate generic equivalent or interchangeable biological product prior to providing coverage or substitute a generic for a branded drug.

c. **Non-Formulary Exception Process**, VA Code Ann. § 38.2-3407.9:01 (effective 8/1/2024)

If an insurer, corporation, or health maintenance organization maintains one or more closed drug formularies, each insurer, corporation, or health maintenance organization shall:

Establish a process to allow an enrollee to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the enrollee's covered benefits, a specific, medically necessary nonformulary prescription drug when the enrollee has been receiving the specific nonformulary prescription drug for at least six months previous to the development or revision of the formulary and the prescribing physician has determined that the formulary drug is an inappropriate therapy for the specific patient or that changing drug therapy presents a significant health risk to the specific patient. After reasonable investigation and consultation with the prescribing physician, the insurer, corporation or health maintenance organization shall act on such requests within one business day of receipt of the request. For purposes of this subsection, substituting the generic equivalent drug, which has been approved by the U.S. Food and Drug Administration, for a branded version of such drug shall not constitute a change in drug therapy.

17. Washington

a. Non-Formulary and Step Therapy Exception, WA19-12810894 48.43 RCW (effective 1/1/2021)

An exception request must be granted if the health carrier or prescription drug utilization management entity determines that the evidence submitted by the provider or patient is sufficient to establish that:

- The required prescription drug is contraindicated or will likely cause a clinically predictable adverse reaction by the patient;
- The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- The patient has tried the required prescription drug or another prescription drug in the same pharmacologic class or a drug with the same mechanism of action while under his or her current or a previous health plan, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

- The patient is currently experiencing a positive therapeutic outcome on a prescription drug recommended by the patient's provider for the medical condition under consideration while on his or her current or immediately preceding health plan, and changing to the required prescription drug may cause clinically predictable adverse reactions, or physical or mental harm to, the patient; or
- The required prescription drug is not in the best interest of the patient, based on documentation of medical appropriateness, because the patient's use of the prescription drug is expected to:

a. Create a barrier to the patient's adherence to or compliance with the patient's plan of care;
b. Negatively impact a comorbid condition of the patient;
c. Cause a clinically predictable negative drug interaction; or
d. Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities

- This section does not prevent:

a. A health carrier or prescription drug utilization management entity from requiring a patient to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug;
b. A health carrier or prescription drug utilization management entity from denying an exception for a drug that has been removed from the market due to safety concerns from the federal food and drug administration; or
c. A health care provider from prescribing a prescription drug that is determined to be medically appropriate

b. Continuity of Care, WA21-16859749 WAC 284-43-2021 (effective 1/1/2021)

A carrier must not require the enrollee to submit a new exception request for a refill if the enrollee's prescribing physician or other prescriber continues to prescribe the drug and the drug continues to be approved by the U.S. Food and Drug Administration for treating the enrollee's disease or medical condition, or if the drug was prescribed as part of the enrollee's participation in a clinical trial.

- If the substituted drug is for an off-label drug use, a carrier may require the enrollee to submit a new exception request when a prescription fill and renewal cycle ends.
- A carrier may require an enrollee to try and AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to providing coverage for the equivalent branded prescription drug.
- A carrier must consider exception requests for a U.S. Food and Drug Administration approved drug used for purposes other than what is indicated on the official label if the use is

medically acceptable. A carrier must take into consideration major drug compendia, authoritative medical literature, and accepted standards of practice when making its decision.

18. Wisconsin

a. **Step Therapy Exception**, WI19-13419928 EI Wis. Stat. § 632.866 (effective 1/1/2020)

An insurer, pharmacy benefit manager, or utilization review organization shall grant an exception to the step therapy protocol if the prescribing provider submits complete, clinically relevant written documentation supporting a step therapy exception request and any of the following are satisfied:

- The prescription drug required under the step therapy protocol is contraindicated or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:
  - Cause a serious adverse reaction in the patient.
  - Decrease the ability to achieve or maintain reasonable functional ability in performing daily activities.
  - Cause physical or psychiatric harm to the patient.
- The prescription drug required under the step therapy protocol is expected to be ineffective based on all of the following:
  - Sound clinical evidence or medical and scientific evidence.
  - The known clinical characteristics of the patient.
  - The known characteristics of the prescription drug regimen as described in peer−reviewed literature or the manufacturer's prescribing information for the prescription drug.
- The patient has tried the prescription drug required under the step therapy protocol, or another prescription drug in the same pharmacologic class or with the same mechanism of action, under the policy or plan or a previous policy or plan, the patient was adherent to the prescription drug regimen for a time that allows for a positive treatment outcome, and the patient's use of the prescription drug was discontinued by the patient's provider due to lack of efficacy or effectiveness, diminished effect, or adverse event. This subdivision does not prohibit an insurer, pharmacy benefit manager, or utilization review organization from requiring a patient to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by clinical review criteria
- The patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while covered under the policy or plan or a previous policy or plan.
- Nothing in this subsection shall be construed to allow the use of a pharmaceutical sample to satisfy a criterion for an exception to a step therapy protocol.

Nothing in this subsection shall be construed to prevent any of the following: 1. An insurer, pharmacy benefit manager, or utilization review organization from requiring a patient to try an

A−rated generic equivalent prescription drug, as designated by the federal Food and Drug administration, or a biosimilar, as defined under 42 USC 262 (i) (2), before providing coverage for the equivalent brand name prescription drug

Additional Clinical Rules That Apply to All State Mandates:

- Applicable clinical programs will apply
- Step therapy bypass does NOT apply to FDA approved labeling requirements
- Verbal attestation may be accepted; submission of evidence not required

3 . Revision History

Date	Notes
9/24/2024	Added Louisiana menopause, perimenopause mandate.

Stelara

Prior Authorization Guideline

Guideline ID	GL-148663
Guideline Name	Stelara
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/21/2021 ; 12/15/2021 ; 08/19/2022 ; 09/21/2022 ; 03/15/2023 ; 6/17/2024

1 . Indications

Drug Name: Stelara (ustekinumab)
Plaque Psoriasis Indicated for the treatment of adult and pediatric patients 6 years of age or older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy. **Psoriatic Arthritis** Indicated for the treatment of adult and pediatric patients 6 years of age or older with active psoriatic arthritis. **Crohn's Disease** Indicated in adult patients with moderately to severely active Crohn's disease. **Ulcerative Colitis** Indicated in adults for moderately to severely active ulcerative colitis.

2 . Criteria

Product Name: Stelara 45mg/0.5mL (subcutaneous formulations) [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

2.1 ALL of the following:

2.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

2.1.2 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Coal tar

AND

2.1.3 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless

contraindicated or clinically significant adverse effects are experienced (document date and duration of trial) **OR** **2.2** Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Tremfya (guselkumab)] **OR** **2.3** BOTH of the following: • Patient is currently on Stelara therapy as documented by claims history or submission of medical records (Document date and duration of therapy) • Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Janssen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Stelara* **AND** **3** - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)] **AND** **4** - Prescribed by or in consultation with a dermatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. *Patients requesting initial authorization who were established on ther apy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Janssen sponso

	red CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Stelara 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient's weight is greater than 100 kg (220 lbs)

AND

3 - ONE of the following:

3.1 ALL of the following:

3.1.1 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

3.1.2 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

- Coal tar

AND

3.1.3 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

3.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of plaque psoriasis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Tremfya (guselkumab)]

OR

3.3 BOTH of the following:

- Patient is currently on Stelara therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Janssen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Stelara*

AND

4 - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Janssen sponsored CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Stelara 45mg/0.5mL, 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Stelara therapy **AND** **2** - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stelara 45mg/0.5mL (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - ONE of the following:

2.1 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Tremfya (guselkumab) Xeljanz (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

OR

2.3 BOTH of the following:

- Patient is currently on Stelara therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Janssen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Stelara*

AND

3 - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

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

- Rheumatologist
- Dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Janssen sponsored CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Stelara 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient's weight is greater than 100 kg (220 lbs)

AND

3 - ONE of the following:

3.1 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

3.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib), Otezla (apremilast), Rinvoq (upadacitinib)]

OR

3.3 BOTH of the following:

- Patient is currently on Stelara therapy as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Janssen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Stelara*

AND

4 - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

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

- Rheumatologist
- Dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Janssen sponsored CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Stelara 45mg/0.5mL, 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Stelara therapy **AND** **2** - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stelara 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization for Maintenance Dosing
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following:

2.1 History of failure to ONE of the following conventional therapies at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

OR

2.2 Patient has been previously treated with a biologic DMARD FDA-approved for the treatment of Crohn's disease as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Cimzia (certolizumab), adalimumab]

OR

2.3 Patient has been established on therapy with Stelara for moderately to severely active Crohn's disease under an active UnitedHealthcare prior authorization

OR

2.4 BOTH of the following:

- Patient is currently on Stelara therapy for moderately to severely active Crohn's disease as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Janssen sponsored CarePath

Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Stelara*

AND

3 - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Janssen sponsored CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Stelara 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Stelara therapy

AND

2 - Patient is not receiving Stelara in combination with another targeted immunomodulator

[e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stelara 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - ONE of the following:

2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Xeljanz (tofacitinib)]

OR

2.3 Patient has been established on therapy with Stelara for moderately to severely active ulcerative colitis under an active UnitedHealthcare prior authorization

OR

2.4 BOTH of the following:

- Patient is currently on Stelara therapy for moderately to severely active ulcerative colitis as documented by claims history or submission of medical records (Document date and duration of therapy)
- Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Janssen sponsored CarePath Savings program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Stelara*

AND

3 - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. * Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Janssen sponsored CarePath Savings program SHALL BE REQUIRED to meet initial authorization criteria as if patient were new to therapy.

Product Name: Stelara 90mg/1mL (subcutaneous formulations) [a]	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Stelara therapy **AND** **2** - Patient is not receiving Stelara in combination with another targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Stelara (ustekinumab) is a human interleukin-12 and -23 antagonist indicated for the treatment of adult and pediatric patients 6 years of age or older with active psoriatic arthritis and for moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy. It is also indicated in adult patients with moderately to severely active Crohn's disease and for moderately to severely active ulcerative colitis. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. • The intravenous infusion is typically covered under the medical benefit. Please refer to the UnitedHealthcare Drug Policy for Stelara.

4 . References

1. Stelara [package insert]. Horsham, PA: Janssen Biotech Inc.; March 2024.
2. Menter A, Gottlieb A, Feldman SR, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis: Section 1. Overview of psoriasis and guidelines of care for the treatment of psoriasis with biologics. J Am Acad Dermatol 2008; 58(5):826-50.
3. Gottlieb A, Korman NJ, Gordon KB, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Psoriatic arthritis: Overview and guidelines of care for treatment with an emphasis on the biologics. J Am Acad Dermatol 2008;58(5):851-64.
4. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies. J Am Acad Dermatol 2009;60(4):643-59.
5. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Guidelines of care for the treatment of psoriasis with phototherapy and photochemotherapy. J Am Acad Dermatol 2010;62(1):114-35.
6. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Guidelines of care for the management and treatment of psoriasis with traditional systemic agents. J Am Acad Dermatol 2009;61(3):451-85.
7. Menter A, Korman NJ, Elmets CA, Feldman SR, Gelfand JM, Gordon KB, Guidelines of care for the management of psoriasis and psoriatic arthritis: section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. J Am Acad Dermatol. 2011 Jul;65(1):137-74.
8. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology. 2020; 158(5):1450-61.
9. Lichtenstein GR, Loftus EV, Isaacs KL, et al ACG clinical guideline: management of Crohn's disease in adults. Am J Gastroenterol. 2018; 113:481-517.
10. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019;80:1029-72.

5 . Revision History

Date	Notes
6/19/2024	Annual review, updated safety language to match commercial. Updat ed reference.

Prior Authorization Guideline

Guideline ID	GL-132954
Guideline Name	Step Therapy Antigout Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	10/18/2020
P&T Revision Date:	07/21/2021 ; 09/15/2021 ; 07/20/2022 ; 9/20/2023

1 . Criteria

Product Name: Febuxostat (generic Uloric) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication or intolerance to the following:	

• allopurinol (generic Zyloprim)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Febuxostat (generic Uloric) is an antigout agent indicated for the chronic management of hyperuricemia in patients with gout who have an inadequate response to a maximally titrated dose of allopurinol, who are intolerant to allopurinol, or for whom treatment with allopurinol is not advisable. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try allopurinol before providing coverage for febuxostat (generic Uloric). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may apply

3 . References

1. Uloric [package insert]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; April 2023.

4 . Revision History

Date	Notes
9/20/2023	Annual review updated reference.

Step Therapy Antiparkinson Agents

Prior Authorization Guideline

Guideline ID	GL-98185
Guideline Name	Step Therapy Antiparkinson Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2022
P&T Approval Date:	11/13/2020
P&T Revision Date:	09/15/2021

1 . Criteria

Product Name: Rasagiline (generic Azilect) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to the following (list reason for therapeutic failure, contraindication, or intolerance):	

• selegiline (generic Eldepryl)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Rasagiline (generic Azilect) is an antiparkinson agent indicated for the treatment of Parkinson's disease as monotherapy or as adjunct therapy in patients taking / not taking levodopa, with or without other Parkinson's Disease drugs. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try selegiline before providing coverage for Rasagiline (generic Azilect). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

3 . References

1. Rasagiline [package insert]. Overland Park, KS: Teva Neuroscience; April 2021.

4 . Revision History

Date	Notes
11/8/2021	Updated references. Updated background to remove automation lan guage.

Prior Authorization Guideline

Guideline ID	GL-133385
Guideline Name	Step Therapy Atypical Antipsychotics
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 05/20/2022 ; 05/20/2022 ; 06/21/2023 ; 8/18/2023

1 . Criteria

Product Name: generic asenapine [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy
Approval Criteria	

1 - History of failure, contraindication, or intolerance to TWO of the following (list reason for therapeutic failure, contraindication, or intolerance):

- olanzapine oral or orally disintegrating tablets
- quetiapine oral immediate release or extended-release tablets
- risperidone oral solution, oral disintegrating, or tablets
- ziprasidone oral capsules
- aripiprazole immediate release tablets

OR

2 - Treatment was initiated at a recent behavioral inpatient admission and the member is currently stable on therapy

OR

3 - The member is new to the plan (as evidenced by coverage effective date of less than or equal to 120 days) and currently stabilized on therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic asenapine [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy

Approval Criteria

1 - Documentation of positive clinical response

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Asenapine (generic Saphris) is an atypical antipsychotic indicated for the treatment of Schizophrenia in adults; and Bipolar I disorder as acute monotherapy treatment of manic or mixed episodes in adults and pediatric patients 10 to 17 years of age, adjunctive treatment to lithium or valproate in adults, and maintenance monotherapy treatment in adults. [1,2] Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try generic atypical antipsychotic alternative(s) prior to receiving coverage for asenapine (generic Saphris). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

3 . References

1. Saphris [package insert]. Allergan Pharmaceuticals Inc.; Madison, NJ. October 2021.
2. Asenapine [package insert]. Peapack, NJ: Greenstone, LLC.; February 2017.

4 . Revision History

Date	Notes
9/21/2023	Removed Latuda from GPI list and criteria, updated background and references, cleaned up criteria.

Prior Authorization Guideline

Guideline ID	GL-133051
Guideline Name	Step Therapy Glaucoma Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	10/18/2020
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 03/16/2022 ; 7/19/2023

1 . Indications

Drug Name: Tafluprost (generic Zioptan)
Open-angle glaucoma/ocular hypertension Tafluprost (generic Zioptan) is an ophthalmic prostaglandin analog therapy for the treatment of open-angle glaucoma/ocular hypertension.

2 . Criteria

Product Name: generic tafluprost [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria **1** - History of failure, contraindication, or intolerance to one of the following: • latanoprost (generic Xalatan) • travoprost (generic Travatan Z)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tafluprost (generic Zioptan) is an ophthalmic prostaglandin analog therapy for the treatment of open-angle glaucoma/ocular hypertension. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try one alternative Glaucoma Agent – latanoprost (generic Xalatan) or travoprost (generic Travatan Z) – prior to receiving coverage for tafluprost (generic Zioptan). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. American Academy of Ophthalmology. Preferred Practice Pattern: Primary Open-Angle Glaucoma. September 2020.
2. Zioptan [package insert]. France: Akorn, Inc. November 2018.
3. Travatan Z [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation. May 2020.

5 . Revision History

Date	Notes
9/13/2023	Updated GPI and product name lists, indications, and background.

Step Therapy Hepatitis B

Prior Authorization Guideline

Guideline ID	GL-136220
Guideline Name	Step Therapy Hepatitis B
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	12/16/2020
P&T Revision Date:	09/15/2021 ; 03/16/2022 ; 09/30/2023 ; 11/17/2023

1 . Criteria

Product Name: Vemlidy [a]	
Diagnosis	Treatment-Naive Chronic Hepatitis B Infection
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - Patient has a contraindication to entecavir therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vemlidy [a]	
Diagnosis	Treatment-Experienced Chronic Hepatitis B Infection
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Patient has a history of failure, intolerance or contraindication to entecavir therapy

OR

2 - Both of the following:

2.1 Patient is currently on tenofovir disoproxil fumarate 300mg therapy

AND

2.2 One of the following:

- Patient has an estimated glomerular filtration rate below 90 mL/minute
- Patient has a diagnosis of osteoporosis

OR

3 - Patient is currently on Vemlidy therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background Entecavir is a hepatitis B virus (HBV) nucleoside analogue reverse transcriptase inhibitor indicated for the treatment of chronic hepatitis B virus infection in adults and children at least 2 years of age with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease. [1] Vemlidy (tenofovir alafenamide) is an HBV nucleoside analogue reverse transcriptase inhibitor and is indicated for the treatment of chronic hepatitis B virus infection in adults and pediatric patients 12 years of age and older with compensated liver disease. [2] Viread (tenofovir disoproxil fumarate) is an HBV nucleoside analogue reverse transcriptase inhibitor and is indicated for the treatment of chronic hepatitis B in adults and pediatric patients 2 years of age and older weighing at least 10 kg. [3] Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try entecavir oral tablets or tenofovir disoproxil fumarate 300mg before providing coverage for Vemlidy (tenofovir alafenamide). **Additional Clinical Rules:** • Supply limits may be in place • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

3 . References

1. Baraclude [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; November 2019
2. Vemlidy [package insert]. Foster City, CA: Gilead Sciences, Inc.; October 2022.
3. Viread [package insert]. Foster City, CA: Gilead Sciences, Inc.; April 2019.

4 . Revision History

Date	Notes
11/10/2023	Annual review with no changes to clinical coverage criteria. Updated background and references.

Prior Authorization Guideline

Guideline ID	GL-145602
Guideline Name	Step Therapy Leukotriene Modifiers
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 03/16/2022 ; 03/15/2023 ; 4/17/2024

1 . Indications

Drug Name: Zileuton extended-release
Asthma Indicated for the prophylaxis and chronic treatment of asthma in adults and children 12 years of age and older.

2 . Criteria

Product Name: generic zileuton extended-release [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - One of the following:

1.1 History of therapeutic failure to one of the following:

- montelukast 10 mg tablets or chewable (generic Singulair)
- zafirlukast (generic Accolate)

OR

1.2 Contraindication or intolerance to both of the following:

- montelukast 10 mg tablets or chewable (generic Singulair)
- zafirlukast (generic Accolate)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Zileuton extended-release is a leukotriene modifier indicated for the prophylaxis and chronic treatment of asthma in adults and children 12 years of age and older. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try one of two alternative leukotriene modifiers - montelukast 10 mg tablets or chewable (generic Singulair) or zafirlukast (generic Accolate) - prior to receiving coverage for zileuton extended-release (generic Zyflo CR).

Additional Clinical Rules:

Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

4 . References

1. Zileuton extended-release [package insert]. East Brunswick, NJ: Lupin Pharmaceuticals, Inc.; March 2023.
2. Global Initiative for Asthma: Global Strategy for Asthma Management and prevention. 2023. Available from: www.ginasthma.org.

5 . Revision History

Date	Notes
4/10/2024	Annual review. Updated references.

Prior Authorization Guideline

Guideline ID	GL-116158
Guideline Name	Step Therapy Ophthalmic Anti-allergy Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	2/1/2023
P&T Approval Date:	12/16/2020
P&T Revision Date:	09/15/2021 ; 11/18/2022

1 . Indications

Drug Name: Epinastine Ophthalmic Solution
Allergic conjunctivitis Indicated for the treatment of itching of the eye associated with allergic conjunctivitis.

2 . Criteria

Product Name: Epinastine Ophthalmic Solution (generic Elestat) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria **1** - History of failure, contraindication, or intolerance to the following: • Azelastine (generic Optivar)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Epinastine (generic Elestat) is an ophthalmic anti-allergy agent indicated for the treatment of itching of the eye associated with allergic conjunctivitis. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try one alternative ophthalmic anti-allergy alternative – Azelastine (generic Optivar) – prior to receiving coverage for Epinastine (generic Elestat). **Additional Clinical Programs:** Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. Supply limits may also be in place.

4 . References

1. Epinastine Ophthalmic Solution [package insert]. Defender SD Manufacturing, LLC: San Diego, CA; November 2021.
2. Azelastine Ophthalmic Solution [package insert]. Alembic Pharmaceuticals, Bridgewater, NJ. May 2022.

5 . Revision History

Date	Notes
11/2/2022	Annual review, updated references.

Prior Authorization Guideline

Guideline ID	GL-154839
Guideline Name	Step Therapy Oral NSAID Combinations
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	08/19/2022 ; 08/18/2023 ; 9/18/2024

1 . Criteria

Product Name: ibuprofen/famotidine (generic Duexis) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to both of the following taken concurrently: • Ibuprofen 800 mg (milligrams)	

• Famotidine at a minimum dose of 20 mg	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: naproxen/esomeprazole magnesium (generic Vimovo) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to both of the following taken concurrently: • Naproxen at a minimum dose of 375 mg • Esomeprazole at a minimum dose of 20 mg	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Duexis (ibuprofen/famotidine), a combination of a nonsteroidal anti-inflammatory drug (NSAID) ibuprofen and the histamine H2-receptor antagonist famotidine, is indicated for the relief of signs and symptoms of rheumatoid arthritis and osteoarthritis and to decrease the risk of developing upper gastrointestinal ulcers.

Vimovo (naproxen/esomeprazole), a combination of an NSAID naproxen and the proton pump inhibitor (PPI) esomeprazole magnesium, is indicated in adult and adolescent patients 12 years of age and older weighing at least 38 kg requiring naproxen for symptomatic relief of arthritis and esomeprazole magnesium to decrease the risk of developing naproxen associated gastric ulcers.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

3 . References

1. Duexis [package insert]. Deerfield, IL: Horizon Medicines LLC; April 2023.
2. Vimovo [package insert]. Deerfield, IL: Horizon Medicines, LLC.; July 2023.
3. Lanza FL, Chan FK, Quigley EM, et al. Guidelines for prevention of NSAID-related ulcer complications. Am J Gastroenterol. 2009; 104(3):728-38.

4 . Revision History

Date	Notes
9/12/2024	Annual review, updated reference.

Prior Authorization Guideline

Guideline ID	GL-134440
Guideline Name	Step Therapy Oral NSAIDs
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	11/13/2020
P&T Revision Date:	06/16/2021 ; 09/15/2021 ; 06/15/2022 ; 10/18/2023

1 . Indications

Drug Name: Ketoprofen
Rheumatoid Arthritis and Osteoarthritis: Indicated for the management of the signs and symptoms of rheumatoid arthritis and osteoarthritis **Pain:** Indicated for the management of pain **Primary Dysmenorrhea:** Indicated for the treatment of primary dysmenorrhea
Drug Name: Ketoprofen Extended-Release (ER)
Rheumatoid Arthritis and Osteoarthritis: Indicated for the management of the signs and symptoms of rheumatoid arthritis and osteoarthritis

2 . Criteria

Product Name: Generic ketoprofen, generic ketoprofen extended-release [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to three of the following solid oral formulary products: • diclofenac IR or ER • flurbiprofen • ibuprofen (prescription strength) • naproxen (prescription strength) • indomethacin or indomethacin ER • meloxicam • nabumetone • piroxicam • sulindac	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Ketoprofen is a non-steroidal anti-inflammatory (NSAID) for the management of the signs and symptoms of rheumatoid arthritis and osteoarthritis, for the management of pain, and for treatment of primary dysmenorrhea. Ketoprofen extended-release is indicated for the management of the signs and symptoms of rheumatoid arthritis and osteoarthritis. Extended-release ketoprofen is not indicated for acute pain. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try three alternative solid oral

NSAIDs – diclofenac, flurbiprofen, prescription strength ibuprofen, or prescription strength naproxen – prior to receiving coverage for ketoprofen or ketoprofen extended-release.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may also be in place.

4 . References

1. Ketoprofen [package insert]. Ripley, MS: Misemer Pharmaceutical, Inc. September 2022.
2. Ketoprofen extended-release [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; March 2021.

5 . Revision History

Date	Notes
10/6/2023	Annual review. Updated reference.

Prior Authorization Guideline

Guideline ID	GL-136221
Guideline Name	Step Therapy Otic Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 11/18/2022 ; 11/17/2023

1 . Criteria

Product Name: Ciprofloxacin/dexamethasone (generic Ciprodex) Otic [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - History of failure, contraindication, or intolerance to ONE of the following (list reason for therapeutic failure, contraindication, or intolerance):

- generic ofloxacin otic or generic ophthalmic formulation administered in the ear

• generic ciprofloxacin otic or generic ophthalmic formulation administered in the ear	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

2 . Background

Benefit/Coverage/Program Information
Background: Ciprofloxacin/dexamethasone (generic Ciprodex) is an otic agent indicated for the treatment of acute otitis externa due to susceptible organisms. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try one alternative fluoroquinolone otic or ophthalmic agent administered in the ear prior to receiving coverage for ciprofloxacin/dexamethasone (generic Ciprodex). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place

3 . References

1. Ciprodex [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp.; November 2020.

4 . Revision History

Date	Notes
11/10/2023	Annual review, no changes to clinical criteria. Updated reference.

Prior Authorization Guideline

Guideline ID	GL-135752
Guideline Name	Step Therapy Overactive Bladder Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	09/15/2021 ; 11/18/2022 ; 11/17/2023

1 . Criteria

Product Name: generic darifenacin [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to oxybutynin (generic Ditropan) or oxybutynin ER (generic Ditropan XL).	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Darifenacin is indicated for the treatment of an overactive bladder (OAB) with symptoms of urinary frequency, urinary urgency, or urge-related urinary incontinence. Oxybutynin is indicated for the treatment of OAB with symptoms of urinary frequency, urinary urgency, or urinary incontinence due to involuntary detrusor muscle contractions (includes neurogenic bladder), and for the relief of symptoms of bladder instability associated with voiding in patients with uninhibited neurogenic or reflex neurogenic bladder (i.e., urgency, frequency, urinary leakage, urge incontinence, dysuria). Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try oxybutynin (generic Ditropan) prior to receiving coverage for darifenacin. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

3 . References

1. Ditropan XL [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; March 2021.
2. Darifenacin [package insert]. Florham Park, NJ: Xiromed, LLC; April 2021.
3. Oxybutynin chloride syrup [package insert]. Philadelphia, PA: Lannett Company, Inc.; February 2020.
4. Oxybutynin chloride tablet [package insert]. Princeton, NJ: Eywa Pharma Inc.; July 2019.

4 . Revision History

Date	Notes
11/1/2023	Removed generic Vesicare and Detrol as step removed due to down-tiering

Prior Authorization Guideline

Guideline ID	GL-139061
Guideline Name	Step Therapy Sedative Hypnotic Agents
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	09/15/2021 ; 05/20/2022 ; 07/19/2023 ; 1/17/2024

1 . Criteria

Product Name: Belsomra [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of trial and failure, contraindication, or intolerance to TWO of the following sedative-hypnotic alternatives: • Zolpidem immediate release tablets (generic Ambien)	

• Zaleplon (generic Sonata) • Eszopiclone (generic Lunesta)	
Notes	[a]State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Ramelteon (generic Rozerem) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - ONE of the following criteria: **1.1** History of trial and failure, contraindication, or intolerance to TWO of the following sedative-hypnotic alternatives: • Zolpidem immediate release oral tablets (generic Ambien) • Zaleplon (generic Sonata) • Eszopiclone (generic Lunesta) **OR** **1.2** History of or potential for a substance abuse disorder	
Notes	[a]State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background:

Ramelteon (generic Rozerem) is a sedative hypnotic agent indicated for the treatment of sleep-onset insomnia. Belsomra (suvorexant) is a sedative hypnotic agent indicated for treatment of both sleep-onset and sleep-maintenance insomnia.

Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try alternative sedative hypnotic agents prior to receiving coverage for Ramelteon (generic Rozerem) or Belsomra (suvorexant).

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

3 . References

1. Belsomra [package insert]. Whitehouse Station, NJ: Merck & Co; March 2023
2. Rozerem [package insert]. Deerfield, IL: Takeda Global; January 2023.

4 . Revision History

Date	Notes
1/16/2024	Updated references.

Prior Authorization Guideline

Guideline ID	GL-116161
Guideline Name	Step Therapy Serotonin (5-HT) Receptor Agonists
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	2/1/2023
P&T Approval Date:	11/13/2020
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 11/18/2022

1 . Criteria

Product Name: Zolmitriptan nasal spray (generic Zomig nasal spray) [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - Both of the following criteria:

1.1 History of failure, contraindication, or intolerance to two of the following oral triptans:

• almotriptan (generic Axert) • eletriptan (generic Relpax) • naratriptan (generic Amerge) • rizatriptan (generic Maxalt/Maxalt MLT) • sumatriptan (generic Imitrex) • zolmitriptan (generic Zomig) tablets or ODT **AND** **1.2** History of failure, contraindication, or intolerance to sumatriptan nasal spray (generic Imitrex nasal spray)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Zolmitriptan nasal spray (generic Zomig nasal spray) is indicated for the acute treatment of migraine with or without aura in adults and pediatric patients 12 years of age and older. Zolmitriptan nasal spray (generic Zomig nasal spray) is not intended for the prophylactic therapy of migraine attacks or for the treatment of cluster headache. Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try two oral generic triptans and sumatriptan nasal spray before providing coverage for Zolmitriptan nasal spray (generic Zomig nasal spray). **Additional Clinical Programs:** Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10)

and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

3 . References

1. Zomig [package insert]. Bridgewater, NJ: Amneal Pharmaceuticals; May 2019.

4 . Revision History

Date	Notes
11/2/2022	Annual review, updated brand/generic language to previously approv ed standardized format.

Prior Authorization Guideline

Guideline ID	GL-136223
Guideline Name	Step Therapy SNRIs
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/13/2020
P&T Revision Date:	06/16/2021 ; 08/19/2022 ; 03/15/2023 ; 11/17/2023

1 . Criteria

Product Name: Fetzima [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - ONE of the following:

1.1 History of failure, contraindication, or intolerance to at least THREE of the following generic formulations (document drug and date of trials):

- bupropion (non-smoking deterrent)
- citalopram
- duloxetine
- escitalopram
- fluoxetine
- fluvoxamine immediate release
- paroxetine
- sertraline tablets
- venlafaxine IR tablets
- venlafaxine ER capsules
- desvenlafaxine (generic Pristiq only)

OR

1.2 The requested medication was initiated during a recent inpatient mental health hospitalization, and the member is stabilized on the requested medication

OR

1.3 Member is new to the plan and currently stabilized on the requested medication (as evidenced by coverage effective date of less than or equal to 120 days)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information
Background: Fetzima (levomilnacipran) is a serotonin norepinephrine reuptake inhibitor [SNRI] indicated for major depressive disorder [MDD].

Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a trial of at least three step one medications before providing coverage for Fetzima.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may also be in place.

3 . References

1. Fetzima [Package Insert]. St. Louis, MO: Forest Pharmaceuticals, Inc.; August 2023.
2. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder, third edition. Oct. 2010.

4 . Revision History

Date	Notes
11/11/2023	Annual review, updated reference.

Prior Authorization Guideline

Guideline ID	GL-103436
Guideline Name	Step Therapy Topical Calcineurin Inhibitors
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2022
P&T Approval Date:	11/13/2020
P&T Revision Date:	09/15/2021 ; 2/18/2022

1 . Indications

Drug Name: Pimecrolimus (generic Elidel)
Mild to moderate atopic dermatitis Indicated as second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.
Drug Name: Tacrolimus (generic Protopic)
Moderate to severe atopic dermatitis Indicated as second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children, who have failed to respond adequately to other topical prescription treatments for atopic dermatitis or when those treatments are not advisable.

2 . Criteria

Product Name: Pimecrolimus (generic Elidel) [a], Tacrolimus (generic Protopic)[a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - One of the following: **1.1** History of failure, contraindication, or intolerance to one of the following topical corticosteroids: • mometasone furoate cream, ointment, or solution (generic Elocon) • fluocinolone acetonide cream, ointment, or solution (generic Synalar) • fluocinonide cream, gel, ointment, or solution (generic Lidex) **OR** **1.2** Drug is being prescribed for the facial or groin area	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Programs: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may also be in place.

Background:

Pimecrolimus (generic Elidel) is indicated as second-line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable.

Tacrolimus (generic Protopic) is indicated as second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children, who have failed to respond adequately to other topical prescription treatments for atopic dermatitis or when those treatments are not advisable.

4 . References

1. Elidel [package insert]. Bridgewater, NJ: Bausch Health; September 2020.
2. Protopic [package insert]. Madison, NJ: LEO Pharma Inc; February 2019.

5 . Revision History

Date	Notes
2/11/2022	Updated background and references.

Prior Authorization Guideline

Guideline ID	GL-134462
Guideline Name	Step Therapy Topical Steroids
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	2/19/2021
P&T Revision Date:	06/16/2021 ; 09/15/2021 ; 06/15/2022 ; 08/18/2023 ; 10/18/2023

1 . Criteria

Product Name: generic flurandrenolide 0.05% lotion, Nolix 0.05% lotion [a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to TWO generic alternative medications in the lower-mid potency class (Class 5 and 6): • betamethasone dipropionate lotion 0.05%	

• betamethasone valerate lotion 0.1% • desonide cream 0.05% • desonide lotion 0.05% • desonide ointment 0.05% • fluticasone propionate cream 0.05% • hydrocortisone valerate 0.2% cream • prednicarbate 0.1% cream • prednicarbate 0.1% ointment • triamcinolone acetonide cream 0.025% • triamcinolone acetonide 0.1% lotion • triamcinolone acetonide 0.025% ointment	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: flurandrenolide 0.05% ointment, generic clocortolone pivalate 0.1% cream[a]	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication, or intolerance to ONE generic alternative medication in the medium potency class (Class 4): • betamethasone diproprionate cream 0.05% • desoximetasone cream, gel, ointment 0.05% • fluocinolone acetonide 0.025% ointment • fluocinonide emulsified base cream 0.05% • hydrocortisone valerate 0.2% ointment • mometasone furoate cream 0.1% • mometasone furoate solution 0.1% • triamcinolone acetonide cream 0.1% • triamcinolone acetonide ointment 0.1%	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic halcinonide 0.1% cream [a]

Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - History of failure, contraindication, or intolerance to TWO alternative medications in the high potency class (Class 2):

- Apexicon E cream 0.05%
- betamethasone dipropionate ointment 0.05%
- betamethasone dipropionate augmented cream 0.05%
- desoximetasone spray 0.25%
- desoximetasone cream, ointment 0.25%
- diflorasone diacetate emollient base cream 0.05%
- fluocinonide cream, gel, ointment, solution 0.05%

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

2 . Background

Benefit/Coverage/Program Information

Background:

Topical steroids are commonly prescribed for the treatment of rash, eczema, and dermatitis. Topical steroids have anti-inflammatory properties, and are classified into different potency classes based on their vasoconstriction abilities. A vasoconstriction bioassay provides potency measurements that correlate with clinical potency. There are numerous topical steroid products.

Class 1: Super Potent	Class 5: Lower Mid-Strength
Class 2: Potent	Class 6: Mild
Class 3: Upper Mid-Strength	Class 7: Least Potent

Class 4: Mid-Strength	

Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try one or two lower cost alternative topical steroids before providing coverage for higher cost topical steroids.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

3 . References

1. Psoriasis.org. 2019. Topical steroid potency chart - National Psoriasis Foundation. [online] Available at: https://www.psoriasis.org/potency-chart/ [Accessed: May 5, 2022].
2. Uptodate.com. 2020. Topical corticosteroids. [online] Available at: https://www.uptodate.com/contents/image?imageKey=DERM%2F62402&topicKey=DERM%2F5565&search=topical%20corticosteroid%20potency&rank=1~150&source=see_link [Accessed: May 5, 2022].
3. Menter, Alan, et al. "Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 3. Guidelines of care for the management and treatment of psoriasis with topical therapies." Journal of the American Academy of Dermatology 60.4 (2009):643-659.
4. Elmets, C. A., Korman, N. J., Prater, E. F., Wong, E. B., Rupani, R. N., Kivelevitch, D., ... & Menter, A. (2021). Joint AAD–NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. Journal of the American Academy of Dermatology, 84(2), 432-470.

4 . Revision History

Date	Notes
10/9/2023	Annual review. Updated potency class verbiage to match classificatio n key. Updated references.

Stivarga

Prior Authorization Guideline

Guideline ID	GL-148154
Guideline Name	Stivarga
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	06/16/2021 ; 09/15/2021 ; 06/15/2022 ; 10/19/2022 ; 06/21/2023 ; 08/18/2023 ; 6/17/2024

1 . Indications

Drug Name: Stivarga (regorafenib)
Colorectal cancer (CRC) Indicated for the treatment of patients with metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild type, an anti-EGFR therapy. **Gastrointestinal stromal tumor (GIST)** Indicated for the treatment of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (generic Sutent). **Hepatocellular carcinoma (HCC)** Indicated for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib tosylate (generic Nexavar). [1] **Other Uses:** The National Cancer Comprehensive Network (NCCN) also recommends

additional use of Stivarga in colon cancer, rectal cancer, soft tissue sarcoma, hepatocellular carcinoma, biliary tract cancer, bone cancer, gastrointestinal stromal tumor (GIST), and glioblastoma.

2 . Criteria

Product Name: Stivarga [a]	
Diagnosis	Colorectal Cancer (CRC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced or metastatic colorectal cancer

AND

2 - History of failure, contraindication, or intolerance to treatment with ALL of the following:^

- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy
- Fluoropyrimidine-based chemotherapy
- Anti-VEGF therapy-based chemotherapy

AND

3 - ONE of the following:

3.1 Tumor is RAS mutant-type

OR

3.2 BOTH of the following: • Tumor is RAS wild-type • History of failure, contraindication, or intolerance to anti-EGFR therapy [e.g., Erbitux (cetuximab), Vectibix (panitumumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines.

Product Name: Stivarga [a]	
Diagnosis	Colorectal Cancer (CRC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Stivarga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of soft tissue sarcoma

AND

2 - ONE of the following:

- Extremity/superficial trunk or head/neck that is non-adipocytic with advanced/metastatic disease with disseminated metastases
- Retroperitoneal/intra-abdominal that is non-adipocytic with recurrent unresectable or stage IV disease
- Advanced/metastatic pleomorphic rhabdomyosarcoma
- Angiosarcoma

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of gastrointestinal stromal tumor (GIST)

AND

2 - Disease is ONE of the following:

- Gross residual (R2 resection)
- Unresectable primary
- Tumor rupture
- Recurrent/metastatic

AND

3 - ONE of the following:

3.1 SDH-deficient GIST

OR

3.2 History of failure, contraindication, or intolerance to BOTH of the following:

- Imatinib mesylate (Gleevec)
- Sutent (sunitinib malate)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Stivarga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic cholangiocarcinoma
- Intrahepatic cholangiocarcinoma

AND

1.1.2 Disease is ONE of the following:

- Unresectable
- Resected gross residual (R2)
- Metastatic

OR

1.2 BOTH of the following

- Diagnosis of hepatocellular carcinoma
- Used as subsequent-line therapy for disease progression

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Osteosarcoma
- Dedifferentiated chondrosarcoma
- High grade undifferentiated pleomorphic sarcoma (UPS)
- Ewing Sarcoma

AND

1.2 Disease is ONE of the following:

- Relapsed/refractory
- Metastatic

AND

1.3 Used as second-line therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Glioblastoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of recurrent or progressive glioblastoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	Glioblastoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Stivarga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Stivarga will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Stivarga [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Stivarga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

Background:

Stivarga (regorafenib) is a kinase inhibitor indicated for the treatment of patients with metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild type, an anti-EGFR therapy; locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (generic Gleevec) and sunitinib malate (generic Sutent); hepatocellular carcinoma (HCC) who have been previously treated with sorafenib tosylate (generic Nexavar). [1]

The National Cancer Comprehensive Network (NCCN) also recommends additional use of Stivarga in colon cancer, rectal cancer, soft tissue sarcoma, hepatocellular carcinoma, biliary tract cancer, bone cancer, gastrointestinal stromal tumor (GIST), and glioblastoma. [2]

4 . References

1. Stivarga [package insert]. Whippany, NJ: Bayer Healthcare Pharmaceuticals, Inc. December 2020.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/professionals/drug_compendium/content. Accessed May 2, 2024.

5 . Revision History

Date	Notes
6/5/2024	Annual review. Added examples to anti-EGFR therapy. Removed “criteria” from all reauthorization sections. Separated gastrointestinal stromal tumor criteria from soft tissue sarcoma criteria and updated criteria per NCCN guideline. Added disease subtype criteria to hepatobiliary cancer section. Changed osteosarcoma section to bone cancer and added Ewing Sarcoma to criteria per NCCN guideline. Updated background and reference. Updated “initial therapy” to “initial authorization” for consistency.

Strensiq

Prior Authorization Guideline

Guideline ID	GL-134467
Guideline Name	Strensiq
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	11/13/2020
P&T Revision Date:	05/21/2021 ; 06/16/2021 ; 06/15/2022 ; 06/21/2023 ; 10/18/2023

1 . Indications

Drug Name: Strensiq (asfotase alfa)
Perinatal/infantile and juvenile-onset hypophosphatasia (HPP) Indicated for the treatment of patients with perinatal/infantile and juvenile-onset hypophosphatasia (HPP).

2 . Criteria

Product Name: Strensiq [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia based on ALL of the following:

1.1 ONE of the following:

- Onset of clinical signs and symptoms of hypophosphatasia prior to age 18 years (e.g., respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, delayed walking, waddling gait, dental abnormalities, low trauma fractures)
- Radiographic evidence supporting the diagnosis of hypophosphatasia at the age of onset prior to age 18 years (e.g., craniosynostosis, infantile rickets, non-traumatic fractures)

AND

1.2 ONE of the following:

1.2.1 BOTH of the following:

- Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age and gender-adjusted normal range
- Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])

OR

1.2.2 Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing*

AND

2 - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone disorders

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Diagnosis of perinatal/infantile-onset hypophosphatasia
- Request does not exceed a maximum supply limit of 9 mg/kg/week

OR

3.2 BOTH of the following:

- Diagnosis of juvenile-onset hypophosphatasia
- Request does not exceed a maximum supply limit of 6 mg/kg/week

AND

4 - ONE of the following:

4.1 Patient is prescribed Strensiq 18 mg/0.45 mL, Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

4.2 Both of the following:

- Patient is prescribed Strensiq 80 mg/0.8 mL vial
- Patient's weight is greater than or equal to 40 kg

Notes	*Results of prior genetic testing can be submitted as confirmation of diagnosis of HPP, however please note that the provider should confirm coverage status of any new genetic testing under the patient's United Healthcare plan prior to ordering. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Strensiq [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Strensiq therapy (e.g., improvement in clinical symptoms, improvement in Radiographic Global Impression of Change) [3,4]

AND

2 - Clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g., serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone diseases

AND

4 - ONE of the following:

4.1 BOTH of the following:

- Diagnosis of perinatal/infantile-onset hypophosphatasia
- Request does not exceed a maximum supply limit of 9 mg/kg/week

OR

4.2 BOTH of the following:

- Diagnosis of juvenile-onset hypophosphatasia
- Request does not exceed a maximum supply limit of 6 mg/kg/week

AND

5 - ONE of the following:

5.1 Patient is prescribed Strensiq 18 mg/0.45 mL, Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

5.2 BOTH of the following:

- Patient is prescribed Strensiq 80 mg/0.8 mL vials
- Patient's weight is greater than or equal to 40 kg

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Strensiq is a tissue nonspecific alkaline phosphatase indicated for the treatment of patients with perinatal/infantile and juvenile-onset hypophosphatasia (HPP). [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Strensiq [package insert]. Cheshire, CT: Alexion Pharmaceuticals, Inc; June 2020.
2. Strensiq (asfotase alfa) CEDR Medical Review. FDA/CEDR resources page. Food and Drug Administration Web site. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2015/125513Orig1s000MedR.pdf Accessed April 28, 2023.
3. Kishnani, P. S., Rush, E. T., Arundel, P., Bishop, N., Dahir, K., Fraser, W., Harmatz, P., Linglart, A., Munns, C. F., Nunes, M. E., Saal, H. M., Seefried, L., & Ozono, K. (2017). Monitoring guidance for patients with hypophosphatasia treated with asfotase alfa. Molecular genetics and metabolism, 122(1-2), 4–17. https://doi.org/10.1016/j.ymgme.2017.07.010
4. Michigami, T., Ohata, Y., Fujiwara, M., Mochizuki, H., Adachi, M., Kitaoka, T., Kubota, T., Sawai, H., Namba, N., Hasegawa, K., Fujiwara, I., & Ozono, K. (2020). Clinical Practice Guidelines for Hypophosphatasia. Clinical pediatric endocrinology: case reports and clinical investigations: official journal of the Japanese Society for Pediatric Endocrinology, 29(1), 9–24. https://doi.org/10.1297/cpe.29.9

5 . Revision History

Date	Notes
10/9/2023	Annual review with no changes to criteria except removal of “routine audit” language.

Stromectol

Prior Authorization Guideline

Guideline ID	GL-139070
Guideline Name	Stromectol
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	9/22/2021
P&T Revision Date:	08/19/2022 ; 12/14/2022 ; 1/17/2024

1 . Indications

Drug Name: Stromectol (ivermectin) tablets
Parasitic Infections Indicated for the treatment of parasitic infections including strongyloidiasis and onchocerciasis. Ivermectin may also be used for other compendia supported parasitic infections including but not limited to scabies, hookworm disease, and ascariasis.

2 . Criteria

Product Name: Brand Stromectol, generic ivermectin tablets [a]	
Approval Length	1 Month
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following*:

- Onchocerciasis due to nematode parasite
- Pediculosis
- Strongyloidiasis
- Ascariasis
- Scabies (including crusted scabies)
- Cutaneous larva migrans (hook worm disease)
- Enterobiasis
- Filariasis
- Trichuriasis
- Gnathostomiasis

Notes	*Requests for COVID treatment and/or prophylaxis are to be denied. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Stromectol (ivermectin) is indicated for the treatment of parasitic infections including strongyloidiasis and onchocerciasis. It may also be used for other compendia supported parasitic infections including but not limited to scabies, hookworm disease, and ascariasis. Most infections are treated with a single weight-based dose. The National Institutes of Health's (NIH) COVID-19 Treatment Guidelines recommends against the use of Stromectol (ivermectin) for treatment of COVID-19[1]. **Additional Clinical Rules** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

• Supply limits may be in place

4 . References

1. National Institute of Health. COVID-19 Treatment Guidelines. Updated March 6, 2023. Accessed November 7, 2023.
2. Ivermectin [package insert]. Parsipany, NJ: Edenbridge Pharmaceuticals, LLC.; March 2022.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2022. URL: Ivermectin Indications - Clinical Pharmacology (clinicalkey.com) Updated March 2022.

5 . Revision History

Date	Notes
1/16/2024	Annual review. Updated references.

Sucraid

Prior Authorization Guideline

Guideline ID	GL-145517
Guideline Name	Sucraid
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 01/19/2022 ; 01/18/2023 ; 01/17/2024 ; 4/17/2024

1 . Indications

Drug Name: Sucraid (sacrosidase)
Sucrase deficiency Indicated for the treatment of genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency (CSID). [1]

2 . Criteria

Product Name: Sucraid [a]	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital sucrase-isomaltase deficiency (CSID)

AND

2 - Diagnosis has been confirmed by ONE of the following:

2.1 Endoscopic biopsy of the small bowel indicating ALL of the following:

2.1.1 Normal small bowel morphology

AND

2.1.2 Absent or markedly reduced sucrase activity

AND

2.1.3 Isomaltase activity varying from 0 to full activity

AND

2.1.4 Reduced maltase activity

AND

2.1.5 ONE of the following:

2.1.5.1 Normal lactase activity

OR

2.1.5.2 BOTH of the following:

- Reduced lactase
- Sucrase:lactase ratio of less than 1.0

OR

2.2 Molecular genetic testing of the sucrase-isomaltase (SI) gene indicating a pathogenic isomaltase gene variant

OR

2.3 Carbon-13 sucrose breath test (13C SBT) indicating a cumulative [13C] CO2 exhalation over 90 minutes below 10th percentile (i.e.,

AND

3 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist

AND

4 - Will be used with a sucrose-free, low starch diet

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Sucraid [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response Sucraid therapy [e.g., reduced symptoms (e.g., abdominal pain, bloating, gas, vomiting), reduced number of stools per day, reduced number of symptomatic days] **AND** **2** - Prescribed by or in consultation with a gastroenterologist or rare disease specialist **AND** **3** - Will be used with a sucrose-free, low starch diet	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Sucraid (sacrosidase) is an oral enzyme replacement therapy indicated for the treatment of genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency (CSID).[1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Sucraid [package insert]. Vero Beach, FL: QOL Medical, LLC. May 2023.
2. Congenital sucrase-isomaltase deficiency. U.S. Nation Library of Medicine. October 2019.
3. Puntis JW, Zamvar V. Congenital sucrase-isomaltase deficiency: diagnostic challenges and response to enzyme replacement therapy. Arch Dis Child. September 2015.
4. Treem WR. Clinical aspects and treatment of congenital sucrase-isomaltase deficiency. J Ped Gastro Nutr. 55 (Sup 2 Nov): S7-S13. November 2012.
5. Treem WR, McAdams L, Stanford L, Kastoff G, Justinich C, Hyams J. Sacrosidase therapy for congenital sucrase-isomaltase deficiency. J Pediatr Gastroenterol Nutr. 1999 Feb;28(2):137-42. doi: 10.1097/00005176-199902000-00008. PMID: 9932843.
6. Robayo-Torres CC, Opekun AR, Quezada-Calvillo R, Villa X, Smith EO, Navarrete M, Baker SS, Nichols BL. 13C-breath tests for sucrose digestion in congenital sucrase isomaltase-deficient and sacrosidase-supplemented patients. J Pediatr Gastroenterol Nutr. 2009 Apr;48(4):412-8. doi: 10.1097/mpg.0b013e318180cd09. PMID: 19330928; PMCID: PMC3955999.

5 . Revision History

Date	Notes
4/8/2024	Added carbon-13 sucrose breath test as an acceptable confirmatory diagnostic test. Added SML. Updated references.

Sunosi

Prior Authorization Guideline

Guideline ID	GL-154319
Guideline Name	Sunosi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	2/17/2023
P&T Revision Date:	08/18/2023 ; 11/17/2023 ; 9/18/2024

1 . Indications

Drug Name: Sunosi (solriamfetol)
Narcolepsy or Obstructive Sleep Apnea Indicated to improve wakefulness in adult patients with excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA).

2 . Criteria

Product Name: Sunosi [a]	
Diagnosis	Narcolepsy
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AND

2 - Symptoms of excessive daytime sleepiness (including but not limited to daily periods of irrepressible need to sleep or daytime lapses into sleep) are present

AND

3 - History of failure, contraindication, or intolerance of BOTH the following:

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 ONE of the following:

- modafinil (generic Provigil)
- armodafinil (generic Nuvigil)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Sunosi [a]	
Diagnosis	Narcolepsy
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Sunosi [a]	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of obstructive sleep apnea defined by ONE of the following:

1.1 Fifteen or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

OR

1.2 BOTH of the following:

1.2.1 Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AND

1.2.2 One or more of the following sign/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by bed partner or other observer
- Observed apnea

AND

2 - BOTH of the following:

2.1 Standard treatments for the underlying airway obstruction (e.g., continuous positive airway pressure [CPAP], bi-level positive airway pressure [BiPAP]) have been used for one month or longer

AND

2.2 Patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - History of failure, contraindication, or intolerance to ONE of the following:

- armodafinil (generic Nuvigil)
- modafinil (generic Provigil)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Sunosi [a]	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy **AND** **2** - Patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Sunosi is a dopamine and norepinephrine reuptake inhibitor (DNRI) indicated to improve wakefulness in adult patients with excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA). Limitations of Use: Sunosi is not indicated to treat the underlying airway obstruction in OSA. Ensure that the underlying airway obstruction is treated (e.g., with continuous positive airway pressure (CPAP)) for at least one month prior to initiating Sunosi for excessive daytime sleepiness. Modalities to treat the underlying airway obstruction should be continued during treatment with Sunosi. Sunosi is not a substitute for these modalities. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Sunosi [package insert]. New York, NY: Axsome Therapeutics, Inc.; June 2023.
2. American Academy of Sleep Medicine. International Classification of Sleep Disorders: Diagnostic and Coding Manual. 3rd ed. Darien, IL: American Academy of Sleep Medicine; 2014.
3. Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: an American 4. Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2021;17(9):1881–1893.
4. Epstein LJ, Kristo D, Strollo PJ Jr, et al. Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults. J Clin Sleep Med. 2009;5(3):263-276.

5 . Revision History

Date	Notes
9/4/2024	Updated initial authorization to 12 months.

Sutent

Prior Authorization Guideline

Guideline ID	GL-143847
Guideline Name	Sutent
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 03/16/2022 ; 08/19/2022 ; 03/15/2023 ; 3/20/2024

1 . Indications

Drug Name: Sutent (sunitinib malate)
Gastrointestinal stromal tumor (GIST) Indicated for the treatment of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to Gleevec (imatinib mesylate). **Renal cell carcinoma (RCC)** Indicated for the treatment of advanced renal cell carcinoma (RCC). **Recurrent RCC** Indicated for the treatment of adjuvant treatment of adult patients at high risk of recurrent RCC following nephrectomy. **Pancreatic neuroendocrine tumors (pNET)** Indicated for the treatment of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in patients with unresectable locally advanced or metastatic disease. **Off Label Uses:** **Other Uses:** The National Cancer Comprehensive Network (NCCN)

recommends use of Sutent for medullary, follicular, oncocytic, or papillary thyroid carcinoma; chordoma; meningiomas; thymic carcinoma; and treatment of myeloid/lymphoid neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement. NCCN also approves the use of Sutent for other soft tissue sarcomas: alveolar soft part sarcoma (ASPS), angiosarcoma, and solitary fibrous tumor/ hemangiopericytoma.

2 . Criteria

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of gastrointestinal stromal tumor (GIST) **AND** **2** - ONE of the following: **2.1** History of disease progression on, contraindication, or intolerance to one of the following^: • imatinib (generic Gleevec) • Stivarga (regorafenib) • Standard dose Qinlock (ripretinib) **OR** **2.2** SDH-deficient GIST	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may ap

	ply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NC CN guidelines

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of renal cell carcinoma (RCC) **AND** **2** - ONE of the following: **2.1** Disease has relapsed	

OR

2.2 Disease is advanced

OR

2.3 BOTH of the following

- Used in adjuvant setting
- Patient has a high risk of recurrence following nephrectomy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of progressive pancreatic neuroendocrine tumors (pNET)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following:	

• Alveolar soft part sarcoma (ASPS) • Angiosarcoma • Solitary fibrous tumor/hemangiopericytoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: **1.1** ALL of the following:	

1.1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic cell carcinoma
- Papillary carcinoma

AND

1.1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.1.4 Disease is refractory to radioactive iodine treatment

OR

1.2 ALL of the following:

1.2.1 Diagnosis of medullary thyroid carcinoma

AND

1.2.2 ONE of the following:

- Patient has progressive disease

- Patient has symptomatic metastatic disease

AND

1.2.3 One of the following^:

- Clinical trials or preferred systemic therapy options are not available or appropriate [e.g., Caprelsa (vandetanib), Cometriq (cabozantinib)]
- There is progression on preferred systemic therapy options [e.g., Caprelsa (vandetanib), Cometriq (cabozantinib)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of recurrent chordoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Central Nervous System Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of surgically inaccessible meningiomas	

AND

2 - ONE of the following:

- Disease is recurrent
- Disease is progressive

AND

3 - Further radiation is not possible

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Central Nervous System Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of thymic carcinoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia	

AND **2** - Patient has a FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic or blast phase
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Sutent will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Sutent, generic sunitinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Sutent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Sutent (sunitinib malate) is a tyrosine kinase inhibitor indicated for the treatment of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to Gleevec (imatinib mesylate); treatment of advanced renal cell carcinoma (RCC); adjuvant treatment of adult patients at high risk of recurrent RCC following nephrectomy; and treatment of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in patients with unresectable locally advanced or metastatic disease. The National Cancer Comprehensive Network (NCCN) recommends use of Sutent for medullary, follicular, oncocytic, or papillary thyroid carcinoma; chordoma; meningiomas; thymic carcinoma; and treatment of myeloid/lymphoid neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement. [2] NCCN also approves the use of Sutent for

other soft tissue sarcomas: alveolar soft part sarcoma (ASPS), angiosarcoma, and solitary fibrous tumor/hemangiopericytoma.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Sutent [package insert]. New York, NY: Pfizer Lab; August 2021.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at www.nccn.org. Accessed February 5, 2024

5 . Revision History

Date	Notes
3/4/2024	Annual review. Updated GIST, neuroendocrine/adrenal tumors, and t hyroid carcinoma per NCCN recommendations.

Synribo

Prior Authorization Guideline

Guideline ID	GL-136225
Guideline Name	Synribo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 08/19/2022 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Synribo
Chronic myeloid leukemia Indicated for the treatment of adult patients with chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to two or more tyrosine kinase inhibitors (TKI). [1] **Other Uses** The National Cancer Comprehensive Network (NCCN) also recommends the use of Synribo for patients with advanced phase CML with progression to accelerated phase and for patients with relapsed or refractory disease after hematopoietic stem cell transplantation. [2]

2 . Criteria

Product Name: Synribo [a]	
Diagnosis	Chronic myeloid leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a history of resistance and/or intolerance to two or more tyrosine kinase inhibitors [e.g., Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib), Bosulif (bosutinib), Iclusig (ponatinib)]^

AND

2 - One of the following:

2.1 Diagnosis of chronic or accelerated phase chronic myelogenous leukemia

OR

2.2 Diagnosis of advanced phase chronic myelogenous leukemia with progression to accelerated phase

OR

2.3 Patient has relapsed disease after hematopoietic stem cell transplant for chronic myeloid leukemia

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines

Product Name: Synribo [a]	
Diagnosis	Chronic myeloid leukemia

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Synribo therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Synribo [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Synribo will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Synribo [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Synribo therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. **Background** Synribo (omacetaxine) is indicated for the treatment of adult patients with chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to two or more tyrosine kinase inhibitors (TKI).[1] The National Cancer Comprehensive Network (NCCN) also recommends the use of Synribo for patients with advanced phase CML with progression to accelerated phase and for patients with relapsed disease after hematopoietic stem cell transplantation with resistance and/or intolerance to two or more tyrosine kinase inhibitors.[2]

4 . References

1. Synribo [package insert]. Parsippany, NJ: Teva Pharmaceuticals USA, Inc.; May 2021.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 22, 2023.

5 . Revision History

Date	Notes
11/11/2023	Annual review with no change to clinical criteria.

Syprine

Prior Authorization Guideline

Guideline ID	GL-150425
Guideline Name	Syprine
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	06/15/2022 ; 08/19/2022 ; 06/21/2023 ; 11/17/2023 ; 07/17/2024

1 . Indications

Drug Name: Syprine (trientine)
Wilson's disease Indicated for the treatment of patients with Wilson's disease who are intolerant of penicillamine.

2 . Criteria

Product Name: Brand Syprine, generic trientine [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration) **AND** **2** - History of intolerance, failure or contraindication to penicillamine^	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines

Product Name: Brand Syprine, generic trientine [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Syprine (trientine hydrochloride) and trientine hydrochloride 500mg are indicated for the treatment of patients with Wilson's disease who are intolerant of penicillamine. Trientine hydrochloride and penicillamine cannot be considered interchangeable. Trientine hydrochloride should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects. [1-4]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Syprine [package insert]. Bridgewater, NJ: Bausch Health US, LLC. September 2020.
2. Cuprimine [package insert]. Bausch Health US, LLC. Bridgewater NJ. October 2020.
3. Depen [package insert]. Meda Pharmaceuticals, Inc. Somerset, NJ. January 2019.

5 . Revision History

Date	Notes
7/25/2024	Removed Clovique from policy as it is off the market

Tafinlar

Prior Authorization Guideline

Guideline ID	GL-147355
Guideline Name	Tafinlar
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	03/16/2022 ; 08/19/2022 ; 05/25/2023 ; 06/21/2023 ; 5/17/2024

1 . Indications

Drug Name: Tafinlar
Melanoma Indicated as a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation. Tafinlar is also indicated, in combination with trametinib, for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations, and the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations and involvement of lymph node(s), following complete resection. **Non-small cell lung cancer** Indicated, in combination with trametinib, for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation. **Anaplastic thyroid cancer** Indicated, in combination with trametinib, for the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options. **Solid Tumors** Indicated for the treatment of adult and pediatric patients 6 years of age and

older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options.

Low-Grade Glioma Indicated, in combination with Mekinist, for the treatment of pediatric patients 1 year of age and older with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy.

Other Uses: The National Cancer Comprehensive Network (NCCN) also approves the use of Tafinlar in combination with Mekinist for the adjuvant treatment of ATC with BRAF V600E mutations following resection; and as monotherapy for the treatment of follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation; in combination with Mekinist for the treatment for recurrent, advanced, or metastatic NSCLC in patients with BRAF V600E mutation, or as single agent if the combination of Tafinlar and Mekinist is not tolerated; in the treatment of glioblastomas and other high-grade gliomas; in the treatment of central nervous system (CNS) cancer in patients with melanoma; ovarian cancer/fallopian tube cancer/primary peritoneal cancer with persistent disease or recurrence in BRAF V600E positive tumors; pancreatic and ampullary adenocarcinomas if BRAF V600E mutation positive; and certain BRAF V600E mutation positive histiocytic neoplasms and hepatobiliary cancers; hairy cell leukemia; salivary gland tumor; and gastrointestinal stromal tumor.

2 . Criteria

Product Name: Tafinlar [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Unresectable melanoma

OR

1.2 Metastatic melanoma

OR

1.3 BOTH of the following:

1.3.1 Prescribed as adjuvant therapy for melanoma involving the lymph node(s)

AND

1.3.2 Used in combination with Mekinist (trametinib)

AND

2 - Cancer is positive for BRAF V600 mutation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]

Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient has metastatic brain lesions
- Tafinlar is active against primary tumor (melanoma)

OR

1.2 Patient has a glioma

AND

2 - Cancer is positive for BRAF V600E mutation

AND

3 - Used in combination with Mekinist (trametinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - ONE of the following:

• In combination with Mekinist (trametinib) • As single agent if the combination of Mekinist and Tafinlar is not tolerated	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Non-Small Cell Lung Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ALL of the following: **1.1** Diagnosis of anaplastic thyroid cancer (ATC)	

AND

1.2 Cancer is positive for BRAF V600E mutation

AND

1.3 Used in combination with Mekinist (trametinib)

AND

1.4 ONE of the following:

1.4.1 Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

OR

1.4.2 Prescribed as adjuvant therapy following resection

OR

2 - ALL of the following:

2.1 ONE of the following diagnoses:

- Follicular Carcinoma
- Oncocytic Carcinoma
- Papillary Carcinoma

AND

2.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

2.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

2.4 Disease is refractory to radioactive iodine treatment

AND

2.5 Cancer is positive for BRAF V600 mutation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Tafinlar [a]	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Gallbladder cancer
- Extrahepatic Cholangiocarcinoma
- Intrahepatic Cholangiocarcinoma

AND

2 - Used as subsequent treatment after progression on or after systemic treatment

AND

3 - Disease is unresectable or metastatic

AND

4 - Cancer is positive for BRAF V600E mutation

AND

5 - Used in combination with Mekinist (trametinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Tafinlar [a]	
Diagnosis	Hepatobiliary Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Tafinlar [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Langerhans Cell Histiocytosis • Erdheim-Chester Disease **AND** **2** - Cancer is positive for BRAF V600E mutation	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Presence of solid tumor **AND** **2** - Used as subsequent treatment after progression on or after systemic treatment	

AND **3** - Disease is unresectable or metastatic **AND** **4** - Cancer is positive for BRAF V600E mutation **AND** **5** - Used in combination with Mekinist (trametinib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

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

Approval Criteria

1 - Diagnosis of ONE of the following:

- Epithelial Ovarian Cancer
- Fallopian Tube Cancer
- Primary Peritoneal Cancer

AND

2 - ONE of the following:

- Persistent disease
- Recurrence in BRAF V600E positive tumors
- Recurrence of low-grade serous carcinoma.

AND

3 - Used in combination with Mekinist (trametinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Pancreatic Cancer / Ampullary Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Pancreatic adenocarcinoma
- Ampullary adenocarcinoma

AND

2 - Disease is ONE of the following:

- Metastatic
- Locally advanced
- Unresectable

AND

3 - Cancer is positive for BRAF V600E mutation

AND **4** - Used in combination with Mekinist (trametinib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Pancreatic Cancer / Ampullary Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hairy cell leukemia	

AND **2** - Used in combination with Mekinist (trametinib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of salivary gland tumor	

AND

2 - Disease is ONE of the following:

- Recurrent and unresectable
- Metastatic

AND

3 - Cancer is positive for BRAF V600E mutation

AND

4 - Used in combination with Mekinist (trametinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Salivary Gland Tumor
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of BRAF V600E-mutated GIST

AND

2 - Disease is ONE of the following:

- Gross residual disease (R2 resection)
- Unresectable primary disease
- Tumor rupture
- Progressive
- Recurrent
- Metastatic

AND

3 - Used in combination with Mekinist (trametinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tafinlar therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Tafinlar will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tafinlar [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Tafinlar therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tafinlar® (dabrafenib) is a kinase inhibitor indicated as a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. Tafinlar is not indicated for treatment of patients with wild-type BRAF solid tumors.[1] Tafinlar, in combination with Mekinist® (trametinib), is indicated for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutations as detected by an FDA-approved test and for the adjuvant treatment of melanoma with BRAF V600E or BRAF V600K mutations, as detected by an FDA approved test, involving the lymph node(s), following complete resection. Tafinlar, in combination with Mekinist, is indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test, for the treatment of locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options, and for the treatment of adult and pediatric patients 6 years of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options.1 The latter indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s). Tafinlar, in combination with Mekinist, is also indicated for the treatment of pediatric patients 1 year of age and older with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy. The National Comprehensive Cancer Network (NCCN) also recommends use of Tafinlar in combination with Mekinist for the adjuvant treatment of ATC with BRAF V600E mutations following resection; and as monotherapy for the treatment of follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation; in combination with Mekinist for the treatment for recurrent, advanced, or metastatic NSCLC in patients with BRAF V600E

mutation, or as single agent if the combination of Tafinlar and Mekinist is not tolerated; in the treatment of glioblastomas and other high-grade gliomas; in the treatment of central nervous system (CNS) cancer in patients with melanoma; ovarian cancer/fallopian tube cancer/primary peritoneal cancer with persistent disease or recurrence in BRAF V600E positive tumors; pancreatic and ampullary adenocarcinomas if BRAF V600E mutation positive; and certain BRAF V600E mutation positive histiocytic neoplasms and hepatobiliary cancers; hairy cell leukemia; salivary gland tumor; and gastrointestinal stromal tumor.[2]

Information on FDA-approved tests for the detection of BRAF V600 mutations in melanoma may be found at: http://www.fda.gov/CompanionDiagnostics

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Tafinlar [package insert]. Research Triangle Park, NC: GlaxoSmithKline; March 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed April 16, 2024.

5 . Revision History

Date	Notes
5/17/2024	Added coverage criteria for hairy cell leukemia, salivary gland tumor, and GIST per NCCN. Updated background and references.

Takhzyro

Prior Authorization Guideline

Guideline ID	GL-146063
Guideline Name	Takhzyro
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	3/20/2024

1 . Indications

Drug Name: Takhzyro
Hereditary angioedema (HAE) Takhzyro is a plasma kallikrein inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 2 years and older.

2 . Criteria

Product Name: Takhzyro [a]	
Approval Length	^See Note
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - BOTH of the following:

- For prophylaxis against HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

AND

3 - BOTH of the following:

- Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Takhzyro.

- Documentation of baseline HAE attack rate is greater than or equal to one attack per 4 weeks

AND

4 - Submission of medical records documenting a history of failure, contraindication, or intolerance to Haegarda (C1 esterase inhibitor, human)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Approval durations: 1) Adult and pediatric patients 12 years of age and older: Authorization of Takhzyro 300mg given every 2 weeks will be issued for 8 months. 2) Pediatric patients 6 to less than 12 years of age: Authorization of Takhzyro 150 mg given every 2 weeks will be issued for 8 months. 3) Pediatric patients less than 6 years of age: Authorization of Takhzyro 150 mg given every 4 weeks will be issued for 12 months.

Product Name: Takhzyro [a]	
Approval Length	^See Note
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response while on Takhzyro therapy

AND

2 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Ruconest, Firazyr, Kalbitor) as determined by claims information, while on Takhzyro therapy

AND

3 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

4 - ALL of the following:

- For prophylaxis against HAE attacks
- Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Haegarda, Orladeyo)

AND

5 - One of the following:

5.1 Patient is less than 6 years of age

OR

5.2 Documentation of the number of acute HAE attacks in the previous 6 months, while on Takhzyro therapy, therefore:

5.2.1 Patient experienced no (zero) acute HAE attacks in the previous 6 months:

OR

5.2.2 Patient experienced one or more acute HAE attacks in the previous 6 months:

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Approval durations: 1) Pediatric patients less than 6 years of age: Authorization of Takhzyro 150 mg given every 4 weeks for 12 months. 2) No (zero) acute HAE attacks in the previous 6 months while on Takhzyro therapy: Adult and pediatric patients 12 years of age and older: Authorization of Takhzyro 300mg given every 4 weeks for 12 months* 3) No (zero) acute HAE attacks in the previous 6 months while on Takhzyro therapy: Pediatric patients 6 to less than 12 years of age: Authorization of Takhzyro 150 mg given every 4 weeks for 12 months* 4) One or more acute HAE attacks in the previous 6 months while on Takhzyro therapy: Adult and pediatric patients 12 years of age and older: Authorization of Takhzyro 300 mg given every 2 weeks for 6 months 5) One or more acute HAE attacks in the previous 6 months while on Takhzyro therapy: Pediatric patients 6 to less than 12 years of age: Authorization of Takhzyro 150 mg given every 2 weeks for 6 months. *Patients experiencing unexpected breakthrough HAE attacks once switched to every 4 week dosing will require additional review to allow for 2 weeks dosing.

3 . Background

Benefit/Coverage/Program Information
Background: Takhzyro is a plasma kallikrein inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 2 years and older.[1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Takhzyro [package insert]. Lexington, MA: Dyax Corp; February 2023.
2. Riedl MA, Bernstein JA, Craig T, et al. An open-label study to evaluate the long-term safety and efficacy of lanadelumab for prevention of attacks in hereditary angioedema: design of the HELP study extension. Clin Transl Allergy. 2017 Oct 6;7:36.
3. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. Allergy. 2018 Jan 10.
4. Wu, E. Hereditary angioedema with normal C1 inhibitor. In: UpToDate, Saini, S (Ed), UpToDate, Waltham, MA, 2023.
5. Busse, P., Christiansen, S., Riedl, M., et. al. “US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema.” The Journal of Allergy and Clinical Immunology. 2020 September 05.
6. Maurer M, Magerl M, Betschel S, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2021 revision and update. Allergy. 2022;77(7):1961-1990. doi:10.1111/all.15214

5 . Revision History

Date	Notes
4/24/2024	Annual review. Update to diagnostic criteria for HAE with normal C1 i nhibitor levels. Updated and simplified reauthorization criteria.

Talzenna

Prior Authorization Guideline

Guideline ID	GL-150908
Guideline Name	Talzenna
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 12/15/2021 ; 12/14/2022 ; 08/18/2023 ; 8/16/2024

1 . Indications

Drug Name: Talzenna (talazoparib)
BRCA-mutated (gBRCAm) HER2-negative Locally Advanced or Metastatic Breast Cancer Indicated for the treatment of adult patients with deleterious or suspected deleterious germline BRCA mutated (gBRCAm), human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer. Appropriate patients for therapy are selected based on an FDA-approved companion diagnostic for Talzenna. [1] **HRR Gene-mutated mCRPC** Indicated in combination with Xtandi (enzalutamide) for the treatment of adult patients with homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC). **Other Uses:** The National Comprehensive Cancer Network (NCCN) also supports use of Talzenna in any localized or metastatic breast cancer subtype associated with a germline BRCA1 or BRCA2 mutation.

2 . Criteria

Product Name: Talzenna [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of breast cancer **AND** **2** - Disease is one of the following: • Locally advanced • Metastatic **AND** **3** - Presence of a germline BRCA-mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Talzenna [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Talzenna [a]	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic castration-resistant prostate cancer

AND

2 - Presence of homologous recombination repair (HRR) gene mutations

AND

3 - Used in combination with Xtandi (enzalutamide)

AND

4 - One of the following:

- Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g., Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)]

• Patient has had bilateral orchiectomy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Talzenna [a]	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Talzenna therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Talzenna [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Talzenna will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Talzenna [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Talzenna therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Talzenna (talazoparib) is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated as a single agent for the treatment of adult patients with deleterious or suspected deleterious germline BRCA mutated (gBRCAm), human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer. Appropriate patients for therapy are selected based on an FDA-approved companion diagnostic for Talzenna. [1] Talzenna is also indicated in combination with Xtandi (enzalutamide) for the treatment of adult patients with homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC). The National Comprehensive Cancer Network (NCCN) also supports use of Talzenna in any localized or metastatic breast cancer subtype associated with a germline BRCA1 or BRCA2 mutation. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place.

4 . References

1. Talzenna [package insert]. New York, NY: Pfizer Labs, February 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed June 2, 2024.

5 . Revision History

Date	Notes
8/2/2024	Annual review. Updated references.

Tarceva

Prior Authorization Guideline

Guideline ID	GL-154487
Guideline Name	Tarceva
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Tarceva (erlotinib)
Locally advanced or metastatic non-small cell lung cancer (NSCLC) Indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations receiving first-line, maintenance, or second or greater line treatment after progression following at least one prior chemotherapy regimen. [1] **Locally advanced, unresectable, or metastatic pancreatic cancer** indicated as first-line treatment for locally advanced, unresectable, or metastatic pancreatic cancer in combination with gemcitabine. [1] **Other Indications** In addition, the National Cancer Comprehensive Network (NCCN) also recommends Tarceva for the treatments of chordoma, brain, leptomeningeal, and spine metastases originating from NSCLC, relapsed or stage IV kidney cancer with non-clear cell histology, NSCLC with known sensitizing EGFR mutations, and vulvar cancer. [2]

2 . Criteria

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of pancreatic cancer **AND** **2** - Disease is ONE of the following: • Locally advanced • Unresectable • Metastatic **AND** **3** - Used in combination with gemcitabine	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of non-small cell lung cancer (NSCLC)

AND

1.2 Disease is ONE of the following:

- Metastatic
- Recurrent
- Advanced

AND

1.3 ONE of the following:

- Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions

• Tumors are positive for exon 21 (L858R) substitution mutations • Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chordoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following • Diagnosis of kidney cancer • Disease is stage IV or relapsed **AND** **2** - Disease is of non-clear cell histology	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of brain, leptomeningeal, or spine metastases from NSCLC **AND** **2** - ONE of the following: • Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions	

• Tumors are positive for exon 21 (L858R) substitution mutations • Tumors are positive for a known sensitizing EGFR mutation (e.g., S768I, L861Q, G719X)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Vulvar Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of vulvar cancer	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	Vulvar Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Tarceva will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Tarceva, generic erlotinib [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tarceva (erlotinib) is a kinase inhibitor indicated for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations receiving first-line, maintenance, or second or greater line treatment after progression following at least one prior chemotherapy regimen. [1] Tarceva is also indicated as first-line treatment for locally advanced, unresectable, or metastatic pancreatic cancer in combination with gemcitabine. [1] In addition, the National Cancer Comprehensive Network (NCCN) also recommends Tarceva for the treatments of chordoma, brain, leptomeningeal, and spine metastases originating from NSCLC, relapsed or stage IV kidney cancer with non-clear cell histology, NSCLC with known sensitizing EGFR mutations, and vulvar cancer. [2] The safety and efficacy of Tarceva has not been established in patients with NSCLC whose tumors have other EGFR mutations. Tarceva is not recommended for use in combination with platinum-based chemotherapy. [1] **Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Tarceva [package insert]. South San Francisco, CA: Genentech USA, Inc.; October 2016.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 27, 2023.

5 . Revision History

Date	Notes
9/6/2024	Updated generic formatting

Tarpeyo

Prior Authorization Guideline

Guideline ID	GL-141089
Guideline Name	Tarpeyo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	2/18/2022
P&T Revision Date:	04/20/2022 ; 07/20/2022 ; 07/19/2023 ; 2/16/2024

1 . Indications

Drug Name: Tarpeyo (budesonide delayed-release capsules)
Primary immunoglobulin A nephropathy (IgAN) Indicated to reduce the loss of kidney function in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease

2 . Criteria

Product Name: Tarpeyo [a]	
Approval Length	9 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk for disease progression

AND

3 - Used to reduce the loss of kidney function

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m2

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following:

- maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs

AND

6 - History of failure, contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) **AND** **7** - Prescribed by or in consultation with a nephrologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tarpeyo (budesonide delayed-release capsule) is indicated to reduce the loss of kidney function in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

1. Tarpeyo [package insert]. Stockholm, Sweedem: Calliditas Therapeutics AB; December 2023.
2. KDIGO 2021 Glomerular Diseases Guideline. October 2021; 100 (4S).

5 . Revision History

Date	Notes
2/4/2024	Updated indication and removed example for disease progression. U pdated references.

Tegsedi

Prior Authorization Guideline

Guideline ID	GL-141090
Guideline Name	Tegsedi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	2/16/2024
P&T Revision Date:	

1 . Indications

Drug Name: Tegsedi (inotersen)
Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy Indicated for treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults.

2 . Criteria

Product Name: Tegsedi [a]	
Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - BOTH of the following:

- Diagnosis of hATTR amyloidosis with polyneuropathy
- Documentation that the patient has a pathogenic TTR mutation (e.g., V30M)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb
- Patient has a baseline FAP Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score ≥ 10 and ≤ 130

AND

4 - Patient has not had a liver transplant

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is not receiving Tegsedi in combination with EITHER of the following:

• Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)] • Tafamidis (e.g., Vyndaqel, Vyndamax)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tegsedi [a]	
Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation that the patient has experienced a positive clinical response to Tegsedi therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.) **AND** **2** - Patient is not receiving Tegsedi in combination with EITHER of the following: • Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran)] • Tafamidis (e.g., Vyndaqel, Vyndamax)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tegsedi (inotersen) is a transthyretin-directed antisense oligonucleotide indicated for treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

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5 . Revision History

Date	Notes
2/5/2024	Policy reviewed and approved for application to UnitedHealthcare Value & Balance Exchange for 4/2024 implementation.

Temodar

Prior Authorization Guideline

Guideline ID	GL-134178
Guideline Name	Temodar
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Temodar (temozolomide)
Glioblastoma multiforme Indicated for treatment in patients with newly diagnosed glioblastoma multiforme concomitantly with radiotherapy and then as maintenance treatment. **Refractory anaplastic astrocytoma** Indicated for treatment of adult patients with refractory anaplastic astrocytoma who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine.

2 . Criteria

Product Name: Brand Temodar, generic temozolomide [a]

Diagnosis	Central Nervous Systems (CNS) Tumor
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following types of central nervous systems tumor:

- Intracranial and Spinal Ependymoma (Excluding Subependymoma)
- World Health Organization (WHO) Grade 2, 3, or 4 isocitrate dehydrogenase (IDH)-mutant Astrocytoma
- WHO Grade 2 or 3 IDH-mutant, 1p19q Codeleted Oligodendroglioma
- Medulloblastoma
- Circumscribed Glioma
- Glioblastoma
- Limited or extensive brain metastases
- Primary CNS lymphoma

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Central Nervous Systems (CNS) Tumor
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following types of melanoma: • Metastatic or unresectable cutaneous melanoma • Metastatic or unresectable uveal melanoma • Mucosal melanoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Neuroendocrine and Adrenal Tumors

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following types of neuroendocrine tumors: • Bronchopulmonary/thymic disease • Poorly controlled carcinoid syndrome in gastrointestinal tract, lung or thymus • Pancreas • Pheochromocytoma/paraganglioma • Poorly differentiated (High Grade)/ large or small cell • Well differentiated grade 3 neuroendocrine tumors	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Primary Cutaneous Lymphomas

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following types of primary cutaneous lymphomas: • Mycosis fungoides (MF) • Sezary syndrome (SS)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of recurrent unresectable or stage IV retroperitoneal/intra-abdominal soft tissue sarcoma

OR

1.2 Diagnosis of rhabdomyosarcoma

OR

1.3 Undifferentiated pleomorphic sarcoma

OR

1.4 BOTH of the following:

1.4.1 Diagnosis of soft tissue sarcoma of the extremity/body wall, head/neck

AND

1.4.2 ONE of the following:

- Disease is stage IV
- Disease has disseminated metastases

OR

1.5 Diagnosis of solitary fibrous tumor/hemangiopericytoma

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Ewing's sarcoma family of tumors • Mesenchymal Chondrosarcoma **AND** **2** - ONE of the following:	

- Disease has relapsed
- Disease is progressive following primary treatment
- Used as second-line therapy for metastatic disease

AND

3 - Used in combination with Campostar (irinotecan)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Bone Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of recurrent or metastatic uterine sarcoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Small Cell Lung Cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of small cell lung cancer (SCLC) **AND**	

2 - ONE of the following:

- Relapse following complete or partial response or stable disease with primary treatment
- Primary progressive disease

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	Small Cell Lung Cancer (SCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Temodar will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Temodar, generic temozolomide [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Temozolomide (generic Temodar) is an alkylating drug indicated for treatment of adult patients with newly diagnosed glioblastoma concomitantly with radiotherapy and then as maintenance treatment.[1] It is also indicated for treatment of adult patients with refractory anaplastic astrocytoma who have experienced disease progression on a drug regimen containing nitrosourea and procarbazine. The National Comprehensive Cancer Network (NCCN) also recommends temozolomide (generic Temodar)for the treatment of CNS cancers - infiltrative supratentorial astrocytoma/oligodendroglioma or anaplastic glioma, intracranial and spinal ependymoma, limited and extensive brain metastases, glioblastoma, primary central nervous system lymphoma, medulloblastoma; cutaneous melanoma, uveal melanoma, and mucosal melanoma; pancreatic neuroendocrine disorders; primary cutaneous lymphomas – mycosis fungoides (MF) and Sézary syndrome (SS); soft tissue sarcoma (STS), Ewing's sarcoma; mesenchymal chondrosarcoma; lung neuroendocrine

tumors; pheochromocytoma/paraganglioma, carcinoid syndrome, neuroendocrine and adrenal tumors; uterine sarcoma; or small cell lung cancer (SCLC).[2]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Temodar [package insert]. Rahway, NJ: Merck Sharp & Dohme Corp.; November 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/compendia-templates/compendia/nccn-compendia Accessed September 1, 2023.

5 . Revision History

Date	Notes
10/3/2023	Annual review. Updated coverage criteria and classifications for CNS Tumor, Melanoma, and Neuroendocrine and Adrenal Tumors per NC CN guidelines. Updated references.

Testosterone

Prior Authorization Guideline

Guideline ID	GL-143212
Guideline Name	Testosterone
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	08/20/2021 ; 09/15/2021 ; 05/20/2022 ; 11/18/2022 ; 01/18/2023 ; 2/16/2024

1 . Indications

Drug Name: Androgel and Pump 1%,1.62% (testosterone gel), Testim, Vogelxo and Pump, Androderm (testosterone patch), Natesto (testosterone nasal gel), Fortesta, Jatenzo (testosterone undecanoate capsule), Kyzatrex, Tlando, testosterone 30 mg/act soln, Xyosted
Hypogonadism (congenital or acquired) or hypogonadrotropic hypogonadism Testosterone products are approved by the Food and Drug Administration (FDA) for testosterone replacement therapy in males with primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired). Primary hypogonadism originates from a deficiency or disorder in the testicles. Secondary hypogonadism indicates a problem in the hypothalamus or the pituitary gland. Testosterone use has been strongly linked to improvements in muscle mass, bone density, and libido.

2 . Criteria

Product Name: generic testosterone 1.62%, generic testosterone pump 1.62%, Brand Androgel Pump, Brand Testim, generic testosterone 1%, Brand Vogelxo, generic testosterone pump 1%, Brand Vogelxo Pump, Androderm, Natesto, Brand Fortesta, generic testosterone 2%, Jatenzo, Kyzatrex, Tlando, Xyosted, testosterone 30 mg/act, Brand Androgel [a]	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

1.2 ALL of the following:

1.2.1 ONE of the following:

1.2.1.1 Two pre-treatment serum total testosterone levels less than 300 ng/dL (less than 10.4 nmol/L) or less than the reference range for the lab, taken at separate times (This may require treatment to be temporarily held. Document lab value and date for both levels)

OR

1.2.1.2 BOTH of the following:

- Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

- One pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (<5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

AND

1.2.2 Patient is NOT taking any of the following:

- One of the following growth hormones, unless diagnosed with panhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Nutropin AQ, Omnitrope, Saizen
- Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

AND

1.2.3 Patient was male at birth

AND

1.2.4 Diagnosis of hypogonadism

AND

1.2.5 ONE of the following:

- Significant reduction in weight (less than 90% ideal body weight) (e.g., AIDS wasting syndrome)
- Osteopenia
- Osteoporosis
- Decreased bone density
- Decreased libido
- Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic testosterone 1.62%, generic testosterone pump 1.62%, Brand Androgel Pump, Brand Testim, generic testosterone 1%, Brand Vogelxo, generic testosterone pump 1%, Brand Vogelxo Pump, Androderm, Natesto, Brand Fortesta, generic testosterone 2%, Jatenzo, Kyzatrex, Tlando, Xyosted, testosterone 30 mg/act, Brand Androgel [a]	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Using hormones to change physical characteristics

AND

2 - The covered person must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

3 - Patient is NOT taking any of the following:

- One of the following growth hormones, unless diagnosed with panhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Nutropin AQ, Omnitrope, Saizen
- Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: generic testosterone 1.62%, generic testosterone pump 1.62%, Brand Androgel Pump, Brand Testim, generic testosterone 1%, Brand Vogelxo, generic testosterone pump 1%, Brand Vogelxo Pump, Androderm, Natesto, Brand Fortesta, generic testosterone 2%, Jatenzo, Kyzatrex, Tlando, Xyosted, testosterone 30 mg/act, Brand Androgel [a]	
Diagnosis	Non-Gender Dysphoria (includes hypogonadism) and Gender Dysphoria

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

Approval Criteria

1 - ONE of the following:

1.1 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

OR

1.2 BOTH of the following:

1.2.1 ONE of the following:

1.2.1.1 Follow-up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e. on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e. on therapy for one year or longer), is within or below the normal male limits of the reporting lab (document value and date)

OR

1.2.1.2 Follow-up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e. on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e. on therapy for one year or longer), is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

OR

1.2.1.3 BOTH of the following:

1.2.1.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

1.2.1.3.2 ONE of the following:

- Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e. on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e. on therapy for one year or longer), is within or below the normal male limits of the reporting lab (document lab value and date)
- Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e. on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e. on therapy for one year or longer), is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

AND

1.2.2 Patient is not taking ANY of the following:

- One of the following growth hormones, unless diagnosed with panhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Nutropin AQ, Omnitrope, Saizen
- Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Testosterone products are approved by the Food and Drug Administration (FDA) for testosterone replacement therapy in males with primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired). Primary hypogonadism originates from a deficiency or disorder in the testicles. Secondary

hypogonadism indicates a problem in the hypothalamus or the pituitary gland. Testosterone use has been strongly linked to improvements in muscle mass, bone density, and libido.

The purpose of this program is to provide coverage for androgens and anabolic steroid therapy for the treatment of conditions for which they have shown to be effective and are within the scope of the plan's pharmacy benefit. Coverage for the enhancement of athletic performance or body building will not be provided.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. AACE Hypogonadism Task Force. American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for the Evaluation and Treatment of Hypogonadism in Adult Male Patients – 2002 Update. Endocr Pract. 2002; 8(No. 6): 439-456.
2. The World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of, Transgender and Gender Diverse People, 8th Version, Sept 15, 2022
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13. Testim [package insert]. Malvern, PA: Endo Pharmaceuticals Inc; November 2020.
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15. Vogelxo [package insert]. Maple Grove, MN: Upsher-Smith Laboratories, LLC; April 2020.
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18. Mulhall JP, et al. Evaluation and Management of Testosterone Deficiency: AUA Guideline. American Urological Association Education and Research, Inc 2018.
19. Xyosted [package insert]. Ewing, NJ: Antares Pharma, Inc; November 2019.
20. Jatenzo [package insert]. Fort Collins, CO: Tolmar, Inc; August 2023.
21. Tlando [package insert]. Salt Lake City, UT: Lipocine Enhancing Health; March 2022.
22. Kyzarex [package insert]. Raleigh, NC: Marius Pharmaceuticals; July 2022.

5 . Revision History

Date	Notes
2/15/2024	Annual review. Updated references.

Tezspire

Prior Authorization Guideline

Guideline ID	GL-149941
Guideline Name	Tezspire
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	7/19/2023
P&T Revision Date:	08/18/2023 ; 7/17/2024

Note:

This program applies to the prefilled pen for self-administration

1 . Indications

Drug Name: Tezspire (tezepelumab) prefilled pen
Severe Asthma Indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

2 . Criteria

Product Name: Tezspire auto-inj prefilled pen [a]	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Tezspire under an active UnitedHealthcare medical benefit prior authorization for the treatment of severe asthma

AND

1.2 Documentation of positive clinical response to Tezspire therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

AND

1.3 Tezspire is being used in combination with an inhaled corticosteroid (ICS)-containing controller medication [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

AND

1.4 Patient is not receiving Tezspire in combination with ANY of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE-therapy [e.g., Xolair (omalizumab)]

- Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]

AND

1.5 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

OR

2 - ALL of the following:

2.1 Diagnosis of severe asthma

AND

2.2 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

- Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

2.3 Tezspire will be used in combination with ONE of the following:

2.3.1 ONE maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) product [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]

OR

2.3.2 Combination therapy including BOTH of the following:

- ONE high-dose (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]
- ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

2.4 ONE of the following:

2.4.1 BOTH of the following:

- Tezspire will be used to treat eosinophilic asthma
- History of failure, contraindication, or intolerance to a 4-month trial of Dupixent (dupilumab)

OR

2.4.2 BOTH of the following:

- Tezspire will be used to treat persistent allergic asthma
- History of failure, contraindication, or intolerance to a 4-month trial of Xolair (omalizumab)

OR

2.4.3 BOTH of the following:

- Tezspire will be used to treat oral corticosteroid dependent asthma
- History of failure, contraindication, or intolerance to a 4-month trial of Dupixent (dupilumab)

OR

2.4.4 Patient's asthma is not of the eosinophilic, allergic, or oral corticosteroid dependent phenotype

AND

2.5 Patient is not receiving Tezspire in combination with ANY of the following:

- Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

AND

2.6 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tezspire auto-inj prefilled pen [a]	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Tezspire therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations

• Decreased utilization of rescue medications • Increase in percent predicted FEV1 from pretreatment baseline • Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) **AND** **2** - Tezspire is being used in combination with an ICS-containing controller medication [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] **AND** **3** - Patient is not receiving Tezspire in combination with ANY of the following • Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)] • Anti-IgE therapy [e.g., Xolair (omalizumab)] • Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Tezspire (tezepelumab) is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma. *Limitations of use:* Tezspire is not indicated for relief of acute bronchospasm of status asthmaticus.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2022. Available at http://www.ginasthma.org. Accessed May 29, 2024
2. Tran TN, Zeiger RS, Peters SP, et al. Overlap of atopic, eosinophilic, and TH2-high asthma phenotypes in a general population with current asthma. Ann Allergy Asthma Immunol. 2016;116(1):37-42. doi:10.1016/j.anai.2015.10.027.
3. Corren J, Ziegler SF. TSLP: from allergy to cancer. Nat Immunol. 2019;20(12):1603-1609. doi:10.1038/s41590-019-0524-9.
4. Tezspire™ [package insert]. Thousand Oakes, CA: Amgen Inc.; May 2023.
5. Institute for Clinical and Economic Review (ICER). Tezepelumab for Severe Asthma. November 4, 2021. Available at ICER | Working Towards Fair Pricing, Fair Access, & Future Innovation. Accessed May 29, 2024
6. 6. Holguin F, Cardet JC, Chung KF, Diver S, Ferreira DS, Fitzpatrick A, Gaga M, Kellermeyer L, Khurana S, Knight S, McDonald VM, Morgan RL, Ortega VE, Rigau D, Subbarao P, Tonia T, Adcock IM, Bleecker ER, Brightling C, Boulet LP, Cabana M, Castro M, Chanez P, Custovic A, Djukanovic R, Frey U, Frankemölle B, Gibson P, Hamerlijnck D, Jarjour N, Konno S, Shen H, Vitary C, Bush A. Management of severe asthma: a European Respiratory Society/American Thoracic Society guideline. Eur Respir J. 2020 Jan 2;55(1):1900588. doi: 10.1183/13993003.00588-2019. PMID: 31558662

5 . Revision History

Date	Notes
7/17/2024	Annual review. Modified criteria for existing prior authorization for und er the medical benefit. Updated references.

Thalomid

Prior Authorization Guideline

Guideline ID	GL-147358
Guideline Name	Thalomid
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	05/21/2021 ; 09/15/2021 ; 05/20/2022 ; 05/25/2023 ; 5/17/2024

1 . Indications

Drug Name: Thalomid
Erythema nodosum leprosum (ENL) Indicated for the acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL). It is also indicated as maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence. It is not indicated as monotherapy for such ENL treatment in the presence of moderate to severe neuritis. **Multiple myeloma** Indicated for treatment of newly diagnosed multiple myeloma in combination with dexamethasone. **Off Label Uses:** The National Cancer Comprehensive Network (NCCN) also recommends the use of Thalomid for treatment of histiocytic neoplasms – Langerhans cell histiocytosis and Rosai-Dorman disease, Castleman's disease, and kaposi sarcoma.

2 . Criteria

Product Name: Thalomid [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of multiple myeloma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Thalomid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe erythema nodosum leprosum (ENL)

AND

2 - One of the following:

2.1 Used for acute treatment

OR

2.2 Used as maintenance therapy for prevention and suppression of cutaneous manifestations of ENL recurrence

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Castleman Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Castleman's Disease (CD)

AND

2 - One of the following:

2.1 Not used as first line therapy

OR

2.2 All of the following:

2.2.1 Therapy is for active idiopathic multicentric CD with no evidence of organ failure

AND

2.2.2 Used in combination with cyclophosphamide and prednisone

AND

2.2.3 Patient is human immunodeficiency virus (HIV)-negative

AND

2.2.4 Patient is human herpesvirus-8 (HHV8)-negative	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Castleman Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Thalomid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: **1.1** Diagnosis of HIV-negative Kaposi Sarcoma **OR**	

1.2 BOTH of the following:

1.2.1 Diagnosis of AIDS-related Kaposi Sarcoma

AND

1.2.2 Patient is currently being treated with antiretroviral therapy (ART)

AND

2 - Not used as first line therapy

AND

3 - Patient has immune reconstitution inflammatory syndrome (IRIS)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Langerhans cell histiocytosis **OR** **2** - Diagnosis of Rosai-Dorfman Disease	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Thalomid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Thalomid will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Thalomid [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Thalomid therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Thalomid (thalidomide) is a synthetic glutamic acid derivative indicated for the treatment of patients with newly diagnosed multiple myeloma (MM) in combination with dexamethasone. It is also indicated for the acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) and as maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence. It is not indicated as monotherapy for such ENL treatment in the presence of moderate to severe neuritis.

The National Cancer Comprehensive Network (NCCN) also recommends the use of Thalomid for treatment of histiocytic neoplasms – Langerhans cell histiocytosis and Rosai-Dorman disease, Castleman's disease, and kaposi sarcoma.

Because of the risk of serious malformations if given during pregnancy, the manufacturer has an extensive risk management program requiring registration by patients, prescribers and dispensing pharmacies. Additional information about the Thalomid Risk Evaluation and Mitigation Strategy (REMS) [Thalomid REMS®] program may be found at http://www.thalidomiderems.com/.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Thalomid [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; December 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed March 26, 2024.
3. Thalomid REMS®. Available at http://www.thalomidrems.com/. Accessed March 26, 2024.

5 . Revision History

Date	Notes

5/14/2024	Annual review. Removed criteria for myelofibrosis-associated anemia and updated background based on NCCN recommendations. Renamed section D from b-cell lymphoma to castleman disease. Updated criteria for Kaposi sarcoma per NCCN guidance. Updated references.

Prior Authorization Guideline

Guideline ID	GL-155312
Guideline Name	Therapeutic Duplication
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/18/2024
P&T Revision Date:	

1 . Criteria

Product Name: Therapeutic Duplication Criteria	
Approval Length	2 Week(s)
Guideline Type	Administrative
Approval Criteria **1** - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued	

OR

2 - Special circumstances exist that necessitate the need for duplicate therapy such as a nationally recognized drug shortage (document special circumstances)

2 . Background

Benefit/Coverage/Program Information
Background: A concurrent DUR (cDUR) program screens all retail and mail service prescription claims at the point of service before the drug is dispensed. The cDUR system screens each prescription against the member's prescription drug history. The system evaluates drug prescribing and utilization, including therapeutic duplication, as well as drug interactions to improve quality and cost effectiveness of dispensed medications by helping to ensure that adjudicated and covered prescriptions are clinically appropriate. The program includes communication avenues through claims edits and messaging to the dispensing pharmacy at point-of-service. The following situations would result in application of the therapeutic duplication edit: • The requested medication has been utilized concurrently with a different drug in the same therapeutic class per recent prescription claims history. • The requested medication has been utilized concurrently in a different dosage of the same medication per recent prescription claims history. • The requested medication has been utilized concurrently with a different drug in a different therapeutic class per recent prescription claims history, when the two medications share the same clinical indication but lack support for concomitant use from evidence-based medicine. **Drug Classes Subject to a Therapeutic Duplication Edit:** **A. Drug Classes Subject to Therapeutic Duplication Edit (Reject 88):** • Both brand and generic versions of medications are subject to edit **B. Diabetes Agents:**

- GLP-1 Receptor Agonists

Additional Clinical Rules:

- Supply limits may be in place.
- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

3 . Revision History

Date	Notes
9/19/2024	New program

Therdose Administrative

Prior Authorization Guideline

Guideline ID	GL-133947
Guideline Name	Therdose Administrative
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	10/20/2021

1 . Criteria

Product Name: Cumulative doses of acetaminophen exceeding 4 grams per day	
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - The cumulative* total daily dose of acetaminophen is supported by one of the following references: • American Hospital Formulary Service Drug Information	

• Micromedex DRUGDEX Information System • National Comprehensive Cancer Network (NCCN) • Clinical pharmacology • Wolters Kluwer Lexi-Drugs • United States Pharmacopoeia-National Formulary (USP-NF) • Drug Facts and Comparisons	
Notes	*For any given member, all medications containing acetaminophen wil l accumulate to the total daily dose. For members who need one time overrides for acetaminophen exceeding 4 grams per day due to admin istrative reasons such as vacation supplies, drug changes, dosage ch anges, etc., please refer the prescriber/member to the Help Desk by i ncluding the following verbiage in closure letters: If you exceed the ma ximum FDA approved dosing of 4 grams of acetaminophen per day b ecause you need extra medication due to reasons such as going on a vacation, replacement for a stolen medication, your doctor changed to another medication that has acetaminophen, or your doctor changed the dosing on your medication that resulted in acetaminophen exceedi ng 4 grams per day, please have your pharmacy contact the OptumR x Pharmacy Helpdesk at the time they are filling your prescription for a one-time override.

2 . Background

Benefit/Coverage/Program Information
Background: A hard safety edit assesses the total cumulative daily dose of acetaminophen based on FDA approved maximum dosing of 4 grams. The edit is triggered if total daily dose exceeds the FDA-defined maximum daily dose. This program is administered who have triggered the hard safety edit.

3 . Revision History

Date	Notes
9/28/2023	Added background.

Prior Authorization Guideline

Guideline ID	GL-145607
Guideline Name	Tobacco Cessation Health Care Reform Zero Dollar Cost Share Review
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	2/19/2021
P&T Revision Date:	09/15/2021 ; 08/19/2022 ; 4/17/2024

1 . Criteria

Product Name: Apo-varenicline*, generic varenicline, Nicotrol inhaler, or Nicotrol NS [a]	
Approval Length	Authorization will be issued for zero copay with deductible bypass for 12-month period
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is 18 years of age or older	

AND **2** - Treatment is being requested for tobacco cessation **AND** **3** - History of failure, contraindication, or intolerance to one of the following: • Nicotine replacement patches OTC (e.g. Nicoderm CQ-OTC) • Nicotine gum OTC (e.g. Nicorette gum- OTC) • Nicotine lozenge or mini-lozenge OTC (e.g. Nicorette lozenge-OTC) **AND** **4** - History of failure, contraindication, or intolerance to bupropion	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply. *For members in Illinois, members do not need to meet the age check or try/fail the listed alternatives.

2 . Background

Benefit/Coverage/Program Information
Background: Tobacco cessation therapies are more likely to succeed for patients who are motivated to stop tobacco use and who are given additional advice and support. Patients should be provided with appropriate educational materials and counseling to support the quit attempt. The patient should set a quit date. This program is designed to meet Health Care Reform requirements for tobacco cessation coverage at zero dollar cost share.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

3 . References

1. Nicotrol NS [package insert]. New York, NY: Pharmacia and Upjohn: August 2019.
2. Nicotrol Inhaler [package insert]. New York, NY: Pharmacia and Upjohn; August 2019.
3. Bupropion Hydrochloride SR [package insert]. Parsippany, NJ: Teva Pharmaceuticals; March 2023.
4. Varenicline [package insert]. Indianapolis, IN: Major Pharmaceuticals; August 2023.
5. US Department of Health and Human Services. Clinical practice guideline for treating tobacco use and dependence: 2008 Update. Washington, DC: US Department of Health and Human Services;.Am J Prev Med 2008;35(2)

4 . Revision History

Date	Notes
4/10/2024	Added operational note for Illinois, removed brand Zyban and Chanti x, updated references.

Tobramycin inhalation

Prior Authorization Guideline

Guideline ID	GL-154799
Guideline Name	Tobramycin inhalation
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 02/18/2022 ; 09/20/2023 ; 01/17/2024 ; 08/16/2024 ; 9/18/2024

1 . Indications

Drug Name: TOBI (tobramycin), TOBI Podhaler (tobramycin inhalation capsules) 28 mg, Bethkis (tobramycin solution for inhalation) 300 mg/4ml, Kitabis PAK (tobramycin solution for inhalation) 300 mg/5 ml
Management of cystic fibrosis An aminoglycoside antibacterial indicated for the management of CF patients with Pseudomonas aeruginosa. Safety and efficacy have not been demonstrated in patients under the age of 6 years, patients with a forced expiratory volume in less than one second (FEV1) less than 25% or greater than 75% predicted, or patients colonized with Burkholderia cepacia. [1,2]

2 . Criteria

Product Name: Brand TOBI, Brand Bethkis, generic tobramycin, TOBI Podhaler, Kitabis, tobramycin solution for inhalation [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis (CF) **OR** **2** - BOTH of the following: **2.1** Diagnosis of noncystic fibrosis bronchiectasis **AND** **2.2** ONE of the following: • Three or more exacerbations per year • Two or more exacerbations requiring hospitalization per year	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap plya

3 . Background

Benefit/Coverage/Program Information
Background: TOBI is an aminoglycoside antibacterial indicated for the management of CF patients with *P. aeruginosa*. Safety and efficacy have not been demonstrated in patients under the age of 6

years, patients with FEV_1 <25% or >75% predicted, or patients colonized with *B. cepacia.* TOBI is specifically formulated for inhalation using the DeVilbiss® Pulmo-Aide® air compressor and PARI LC Plus® Reusable Nebulizer. After 28 days of therapy, patients should stop TOBI therapy for the next 28 days, and then resume therapy for the next 28 day on and 28 day off cycle. [1,2]

Additional Clinical Rules

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. TOBI Inhalation Solution [package insert]. East Hanover, NJ: Mylan Pharmaceuticals; February 2023.
2. Tobramycin Inhalation Solution [package insert]. Sellersville, PA.: Teva Pharmaceuticals USA; October 2023.
3. Bilton D, Henig N, Morrissey B, Gotfried M. Addition of inhaled tobramycin to ciprofloxacin for acute exacerbations of Pseudomonas aeruginosa infection in adult bronchiectasis. Chest. 2006;130(5):1503-1510. doi:10.1378/chest.130.5.1503
4. Polverino E, Goeminne PC, McDonnell MJ, et al. European Respiratory Society guidelines for the management of adult bronchiectasis. Eur Respir J. 2017;50(3):1700629. Published 2017 Sep 9. doi:10.1183/13993003.00629-2017
5. Spencer S, Felix LM, Milan SJ, et al. Oral versus inhaled antibiotics for bronchiectasis. Cochrane Database Syst Rev. 2018;3(3):CD012579. Published 2018 Mar 27. doi:10.1002/14651858.CD012579.pub2
6. Chang AB, Bell SC, Torzillo PJ, et al. Chronic suppurative lung disease and bronchiectasis in children and adults in Australia and New Zealand Thoracic Society of Australia and New Zealand guidelines [published correction appears in Med J Aust. 2015 Feb 16;202(3):130]. Med J Aust. 2015;202(1):21-23. doi:10.5694/mja14.00287
7. Chang AB, Bell SC, Byrnes CA, et al. Thoracic Society of Australia and New Zealand (TSANZ) position statement on chronic suppurative lung disease and bronchiectasis in children, adolescents and adults in Australia and New Zealand. Respirology. 2023;28(4):339-349. doi:10.1111/resp.14479
8. Laska IF, Crichton ML, Shoemark A, Chalmers JD. The efficacy and safety of inhaled antibiotics for the treatment of bronchiectasis in adults: a systematic review and meta-analysis. Lancet Respir Med. 2019;7(10):855-869. doi:10.1016/S2213-2600(19)30185-7
9. TOBI Podhaler [package insert]. San Carlos, CA: Mylan Pharmaceuticals; February 2023.
10. Bethkis [package insert]. Woodstock, Illinois: Chesi USA, Inc; February 2023.
11. Kitabis Pak [package insert]. Woodstock, Illinois: Woodstock Sterile Solutions, LLC; April 2023.

5 . Revision History

Date	Notes
9/12/2024	Annual review. Added SML and updated references.

Prior Authorization Guideline

Guideline ID	GL-155298
Guideline Name	Topical Retinoids
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	09/15/2021 ; 04/20/2022 ; 10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Topical retinoid products
Cosmetic and medical conditions Indicated for cosmetic and medical conditions (e.g. acne vulgaris, psoriasis, precancerous skin lesions).

2 . Criteria

Product Name: Adapalene solution, adapalene pads, Aklief, Altreno, Arazlo, Brand Atralin, Avita, Fabior, Brand Retin-A, Brand Retin-A Micro, Tazorac, tarzarotene, generic tretinoin, generic tretinoin microsphere [a]	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The member has a non-cosmetic medical condition (e.g. acne vulgaris, psoriasis, precancerous skin lesions, other conditions listed in Background Section)**

AND

2 - Medication is not being requested solely for cosmetic purposes (e.g., photoaging, wrinkling, hyperpigmentation, sun damage, melasma)

Notes	** See table in Background section. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Differin, generic adapalene [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The member has a non-cosmetic medical condition (e.g. acne vulgaris)

AND

2 - Medication is not being requested solely for cosmetic purposes (e.g., photoaging, wrinkling, hyperpigmentation, sun damage, melasma)

AND

3 - History of failure, contraindication, or intolerance to a trial of Tretinoin cream.

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Differin, generic adapalene [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Non-cosmetic medical conditions:

Acanthosis nigricans	Keratoderma
Acne	Keratoderma palmaris et plantaris
Acne keloidalis nuchae	Keratosis rubra figurata
Acne rosacea	Kyrle's disease
Acne vulgaris	Lamellar ichthyosis
Actinic cheilitis	Leukoplakia
Actinic dermatitis	Lichen planus

Actinic keratosis	Mal de Meleda
Basal cell carcinoma	Malignancy
Bowen's disease	Mendes da Costa syndrome
Cystic acne	Molluscum contagiosum
Darier's disease	Non-bullous congenital ichthyosis
Darier-White Disease	Papillon-Lefevre syndrome
Dermal mucinosis	Porokeratosis
Discoid lupus erythematosus	Pseudofollicular barbae
Epidermoid cysts	Pseudoacanthosis nigricans
Epidermolytic hyperkeratosis	Psoriasis
Erythrokeratoderma variabilis	Psoriasis erythrodermic, palmoplantar
Favre Raucochet disease	Psoriasis pustular
Flat warts	Psoriatic arthritis
Folliculitis	Rosacea
Fox Fordyce disease	Sebaceous cysts
Grover's disease	Senile keratosis
Hidradenitis suppurativa	Solar keratosis
Hyperkeratosis	Squamous cell carcinoma
Hyperkeratosis follicularis	Systematized epidermal nevus
Hyperkeratotic eczema	Transient acantholytic dermatosis
Ichthyoses	Tylotic eczema
Ichthyosis vulgaris	X-linked ichthyosis
Keloid scar	Verucca planae

Keratoacanthoma	Von Zumbusch pustular
Keratosis follicularis	Warts
	Wound healing (mild)

Background:

Topical retinoid products are indicated for cosmetic and medical conditions (e.g. acne vulgaris, psoriasis, precancerous skin lesions). Prior Authorization is in place to verify the use is for the diagnosis of a medical condition.

Additional Clinical Programs:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Atralin [package insert] Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; July 2016.
2. Avita cream [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; June 2018.
3. Avita gel [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; January 2018.
4. Differin gel [package insert]. Fort Worth, TX: Galderma Laboratories LP; August 2022.
5. Differin lotion [package insert]. Fort Worth, TX: Galderma Laboratories LP; April 2022.
6. Differin cream [package insert]. Fort Worth, TX: Galderma Laboratories LP; October 2022.
7. Retin-A [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC.; June 2018.
8. Retin-A Micro [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC.; October 2017.
9. Tazorac cream [package insert]. Exton, PA: Almirall, LLC; August 2019.
10. Tazorac gel [package insert]. Exton, PA: Almirall, LLC; August 2019.
11. Fabior [package insert] Greenville, NC: Mayne Pharma; June 2018.
12. Altreno [package insert]. Bridgewater, NJ: Bausch Health US, LLC; March 2020.
13. Aklief [package insert]. Fort Worth, TX; Galderma Laboratories LP; January 2022.
14. Arazlo [package insert]. Bridgewater, NJ: Bausch Health US. LLC; May 2021.

5 . Revision History

Date	Notes
9/19/2024	Added generic tazarotene

Tryvio

Prior Authorization Guideline

Guideline ID	GL-148232
Guideline Name	Tryvio
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	9/15/2024
P&T Approval Date:	6/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Tryvio (aprocitentan)
Hypertension Indicated for the treatment of hypertension in combination with other antihypertensive drugs, to lower blood pressure in adult patients who are not adequately controlled on other drugs.

2 . Criteria

Product Name: Tryvio [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of resistant hypertension

AND

2 - One of the following:

- Systolic blood pressure greater than or equal to 130 mm Hg on two consecutive measurements
- Diastolic blood pressure greater than or equal to 80 mm Hg on two consecutive measurements

AND

3 - Patient is on a stabilized dose and receiving concomitant therapy with ALL of the following:

- Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]
- Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)
- Maximally tolerated diuretics (e.g., hydrochlorothiazide)

AND

4 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)]
- Patient has a contraindication, or intolerance to mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)]

AND

5 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a beta-blocker (e.g., labetalol, carvedilol)
- Patient has a contraindication, or intolerance to beta-blockers (e.g., labetalol, carvedilol)

AND

6 - Prescribed by or in consultation with a cardiologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tryvio [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation the patient is receiving clinical benefit to Tryvio therapy

AND

2 - Patient is on a stabilized dose and receiving concomitant therapy with ALL of the following:

- Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]
- Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)
- Maximally tolerated diuretics (e.g., hydrochlorothiazide)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tryvio (aprocitentan) is an endothelin receptor antagonist indicated for the treatment of hypertension in combination with other antihypertensive drugs, to lower blood pressure in adult patients who are not adequately controlled on other drugs. Resistant hypertension (RH) is defined as above-goal elevated blood pressure (BP) in a patient despite the concurrent use of 3 antihypertensive drug classes, commonly including a long-acting calcium channel blocker, a blocker of the renin-angiotensin system (angiotensin-converting enzyme inhibitor or angiotensin receptor blocker), and a diuretic. The antihypertensive drugs should be administered at maximum or maximally tolerated daily doses. [1] Tryvio is only available through a restricted distribution program called the Tryvio REMS. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Tryvio [package insert]. Radnor, PA: Idorsia Pharmaceuticals US Inc; March 2024.
2. Carey, RM, Calhoun, DA, Bakris, GL, et. al. Resistant Hypertension: Detection, Evaluation, and Management: A Scientific Statement From the American Heart Association. Hypertension. 2018: 72(5); e53-e90.

5 . Revision History

Date	Notes

9/10/2024	New program

Tukysa

Prior Authorization Guideline

Guideline ID	GL-144151
Guideline Name	Tukysa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	08/19/2022 ; 11/18/2022 ; 03/15/2023 ; 3/20/2024

1 . Indications

Drug Name: Tukysa
HER2-positive breast cancer Indicated in combination with trastuzumab and capecitabine for treatment of adult patients with advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases, who have received one or more prior anti-HER2-based regimens in the metastatic setting. **Colorectal Cancer** Indicated in combination with trastuzumab for the treatment of adult patients with RAS wild-type HER2-positive unresectable or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. **Other Uses:** The National Cancer Comprehensive Network (NCCN) recommends the use of Tukysa for the treatment of central nervous system cancers (limited and extensive brain metastases) when used in combination with capecitabine and trastuzumab in patients with HER2 positive breast cancer if previously treated with one or more anti-HER2-based regimens. The NCCN also recommends the use of Tukysa in combination with trastuzumab

for the treatment of advanced or metastatic colorectal cancer (HER2-amplified and RAS and BRAF wild-type) if intensive therapy not recommended.

2 . Criteria

Product Name: Tukysa [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is one of the following:

- Advanced unresectable
- Metastatic

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

4 - Patient has been previously treated with an anti-HER2-based regimen in the metastatic setting (e.g., trastuzumab (Herceptin, Kanjinti), pertuzumab (Perjeta), ado-trastuzumab emtansine (T-DM1)

AND **5** - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti, Ontruzant) and capecitabine (Xeloda)
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tukysa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	CNS Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of brain metastases with HER2 positive breast cancer	

AND **2** - Patient has been previously treated with an anti-HER2-based regimen (e.g., trastuzumab [Herceptin, Kanjinti], pertuzumab [Perjeta], ado-trastuzumab emtansine [T-DM1]) **AND** **3** - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti, Ontruzant) and capecitabine (Xeloda)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	CNS Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tukysa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of unresectable, advanced, or metastatic colorectal cancer (HER2-amplified and RAS and BRAF wild-type)

AND

2 - Disease is human epidermal growth factor receptor 2 (HER2)-positive

AND

3 - One of the following:

3.1 Patient has previously been treated with one of the following regimens:

- Fluoropyrimidine-based chemotherapy
- Oxaliplatin-based chemotherapy
- Irinotecan-based chemotherapy

OR

3.2 Patient is not appropriate for intensive therapy

AND

4 - Used in combination with trastuzumab (e.g., Herceptin, Kanjinti)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	Colorectal Cancer
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tukysa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Tukysa will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Tukysa [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Tukysa therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tukysa (tucatinib) is a kinase inhibitor indicated in combination with trastuzumab and capecitabine for treatment of adult patients with advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including patients with brain metastases, who have received one or more prior anti-HER2-based regimens in the metastatic setting. [1] Tukysa is also indicated in combination with trastuzumab for the treatment of adult patients with RAS wild-type HER2-positive unresectable or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy. The National Cancer Comprehensive Network (NCCN) recommends the use of Tukysa for the treatment of central nervous system cancers (limited and extensive brain metastases) when used in combination with capecitabine and trastuzumab in patients with HER2 positive breast cancer if previously treated with one or more anti-HER2-based regimens. The NCCN also recommends the use of Tukysa in combination with trastuzumab for the treatment of advanced or metastatic colorectal cancer (HER2-amplified and RAS and BRAF wild-type) if intensive therapy not recommended. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Tukysa [package insert]. Bothell, WA: Seattle Genetics, Inc.; January 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed January 24, 2024.

5 . Revision History

Date	Notes
3/11/2024	Annual review. No changes to clinical criteria.

Turalio

Prior Authorization Guideline

Guideline ID	GL-134480
Guideline Name	Turalio
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 08/19/2022 ; 11/18/2022 ; 11/18/2022 ; 10/18/2023

1 . Indications

Drug Name: Turalio (pexidartinib)
Tenosynovial giant cell tumor Indicated for the treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery.

2 . Criteria

Product Name: Turalio [a]

Diagnosis	Tenosynovial Giant Cell Tumor/ Pigmented Villonodular Synovitis (PVNS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of tenosynovial giant cell tumor (TGCT) / pigmented villonodular synovitis (PVNS)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Turalio [a]	
Diagnosis	Tenosynovial Giant Cell Tumor/ Pigmented Villonodular Synovitis (PVNS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Turalio therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Turalio [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Langerhans Cell Histiocytosis • Erdheim-Chester Disease • Rosai-Dorfman Disease **AND** **2** - Colony stimulating factor 1 receptor (CSF1R) mutation positive	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Turalio [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Turalio therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Turalio [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Turalio will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Turalio [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Turalio therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Turalio (pexidartinib) is a kinase inhibitor indicated for the treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery.

The National Cancer Comprehensive Network (NCCN) also recommends Turalio as single-agent therapy for the treatment of TGCT/ pigmented villonodular synovitis (PVNS) in patients without respect to morbidity and surgery eligibility. NCCN also recommends Turalio for colony stimulating factor 1 receptor (CSF1R) mutation positive histiocytic neoplasms.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Turalio [package insert]. Basking Ridge, NJ: Daiichi Sankyo, Inc. October 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at https://www.nccn.org/professionals/drug_compendium/content/ Accessed September 5, 2023.

5 . Revision History

Date	Notes
10/9/2023	Annual review with no change to clinical coverage criteria. Updated r eferences.

Tykerb

Prior Authorization Guideline

Guideline ID	GL-134190
Guideline Name	Tykerb
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	10/20/2021
P&T Revision Date:	10/19/2022 ; 10/18/2023

1 . Indications

Drug Name: Tykerb
Metastatic breast cancer Indicated for use in combination with Femara (letrozole) for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the human epidermal growth factor receptor 2 (HER2) receptor for whom hormonal therapy is indicated **Advanced or metastatic breast cancer** Indicated in combination with Xeloda (capecitabine) for treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy, including an anthracycline, a taxane, and the HER2 receptor antagonist Herceptin (trastuzumab). Patients should have disease progression on Herceptin prior to initiation of treatment with Tykerb in combination with Xeloda.

2 . Criteria

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Diagnosis of recurrent or stage IV hormone receptor positive, human epidermal growth factor receptor 2-positive (HER2+) breast cancer
- Used in combination with an aromatase inhibitor [e.g., Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)]

OR

2 - ALL of the following:

2.1 Diagnosis of recurrent or stage IV HER2+ breast cancer

AND

2.2 Used in combination with ONE of the following:

- Herceptin (trastuzumab)
- Xeloda (capecitabine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]

Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tykerb therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

- Diagnosis of recurrent, central nervous system (CNS) cancer with metastatic lesions
- Tykerb is active against primary (breast) tumor
- Used in combination with Xeloda (capecitabine)

OR

2 - ALL of the following:

2.1 Diagnosis of recurrent intracranial or spinal ependymoma (excluding subependymoma)

AND

2.2 Patient has received previous radiation therapy

AND

2.3 Patient has received one of the following:

- Gross total or subtotal resection
- Localized recurrence
- Evidence of metastasis (brain, spine, or cerebral spinal fluid)

AND

2.4 Used in combination with Temodar (temozolomide)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Chordoma

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of EGFR-positive, recurrent chordoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tykerb therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Colon Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of unresectable, advanced or metastatic colon cancer (HER2-amplified and RAS and BRAF wild type)

AND

1.2 Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

AND

1.3 ONE of the following:

1.3.1 Patient has previously been treated with ONE of the following regimens:

- Oxaliplatin-based therapy without irinotecan
- Irinotecan-based therapy without oxaliplatin
- FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
- A fluoropyrimidine without irinotecan or oxaliplatin

OR

1.3.2 Patient is not appropriate for intensive therapy

AND

1.4 Used in combination with trastuzumab

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Colon Cancer
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Rectal Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of unresectable, advanced or metastatic rectal cancer (HER2-amplified and RAS and BRAF wild type)

AND

1.2 Patient has not previously been treated with a HER2 inhibitor [e.g., trastuzumab, Perjeta (pertuzumab), Nerlynx (neratinib)]

AND

1.3 Used in combination with trastuzumab

AND

1.4 ONE of the following:

1.4.1 Patient has previously been treated with ONE of the following regimens:

- Oxaliplatin-based therapy without irinotecan
- Irinotecan-based therapy without oxaliplatin
- FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen
- A fluoropyrimidine without irinotecan or oxaliplatin

OR

1.4.2 Patient is not appropriate for intensive therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	Rectal Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Tykerb will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Tykerb, generic lapatinib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Tykerb therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Tykerb (lapatinib) is a kinase inhibitor indicated for use in combination with Femara (letrozole) for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the human epidermal growth factor receptor 2 (HER2) receptor for whom hormonal therapy is indicated. Tykerb is also indicated in combination with Xeloda (capecitabine) for treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy, including an anthracycline, a taxane, and trastuzumab. Patients should have disease progression on trastuzumab prior to initiation of treatment with Tykerb in combination with Xeloda. The National Cancer Comprehensive Network (NCCN) also recommends the use of Tykerb in metastatic central nervous system (CNS) lesions with primary tumor of the breast, intracranial and spinal ependymomas, EGFR-positive chordoma and colon and rectal cancers not previously treated with HER2 inhibitors.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Tykerb [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corp.; March 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed August 29, 2023.

5 . Revision History

Date	Notes
10/5/2023	Annual review. Updated coverage criteria for colon cancer.

Tymlos

Prior Authorization Guideline

Guideline ID	GL-136227
Guideline Name	Tymlos
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	1/20/2021
P&T Revision Date:	10/20/2021 ; 11/18/2022 ; 02/17/2023 ; 10/18/2023 ; 11/17/2023

1 . Indications

Drug Name: Tymlos (abaloparatide)
Osteoporosis Indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy. Tymlos is also indicated to increase bone density in men with osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy.

2 . Criteria

Product Name: Tymlos [a]

Diagnosis	Osteoporosis
Approval Length	Authorization will be issued for up to 24 months. Duration of coverage will be limited to 24 months of cumulative parathyroid hormone analog therapy (e.g., Teriparatide injection, Forteo, Tymlos) in the member's lifetime.
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Patient is female
- Diagnosis of postmenopausal osteoporosis

OR

1.2 BOTH of the following:

- Patient is male
- Diagnosis of osteoporosis

AND

2 - ONE of the following:

- Patient is at high risk of fracture [e.g., recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than −3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture >30%, hip fracture >4.5%)]
- Patient has a history of failure, intolerance or contraindication to other available osteoporosis therapy (e.g., alendronate, denosumab, risedronate, zoledronate)

AND

3 - Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Tymlos is a human parathyroid hormone analog indicated for the treatment of postmenopausal women with osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy. Tymlos is also indicated to increase bone density in men with osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy. [1] The American Association of Clinical Endocrinologists/American College of Endocrinology recommend the use of Tymlos in patients unable to sue oral therapy and as initial therapy for patients at very high fracture risk defined as the following: patients with a recent fracture (e.g., within the past 12 months), fractures while on approved osteoporosis therapy, multiple fractures, fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), very low T-score (e.g., less than −3.0), high risk for falls or history of injurious falls, and very high fracture probability by FRAX® (fracture risk assessment tool) (e.g., major osteoporosis fracture >30%, hip fracture >4.5%) or other validated fracture risk algorithm to be at very high fracture risk.[2] The safety and efficacy of Tymlos have not been evaluated beyond 2 years of treatment. Cumulative use of Tymlos and other parathyroid hormone analogs (e.g., Forteo, teriparatide injection) for more than 2 years during a patient's lifetime is not recommended. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes

(ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Tymlos [package insert]. Boston, MA: Radius Health, Inc.; June 2023.
2. American Association of Clinical Endocrinologists /American College of Endocrinology Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis - 2020 Update. Endocr Pract. 2020;26(Suppl 1):1-46. doi:10.4158/GL-2020-0524SUPPL

5 . Revision History

Date	Notes
11/11/2023	Convert from a non-formulary to a prior authorization.

Vafseo

Prior Authorization Guideline

Guideline ID	GL-154330
Guideline Name	Vafseo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	9/18/2024
P&T Revision Date:	

1 . Indications

Drug Name: Vafseo (vadadustat)
Anemia due to chronic kidney disease Indicated for the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least three months.

2 . Criteria

Product Name: Vafseo [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of anemia due to chronic kidney disease (CKD)

AND

2 - Patient has been receiving dialysis for at least three months

AND

3 - BOTH of the following:

- Ferritin greater than 100 mcg/L
- Transferrin saturation (TSAT) greater than 20%

AND

4 - Hemoglobin level less than 11 g/dL

AND

5 - Trial and failure, contraindication or intolerance to an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

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

- Hematologist
- Nephrologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vafseo [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Vafseo therapy (e.g., clinically meaningful increase in hemoglobin level)

AND

2 - Adequate iron stores confirmed by BOTH of the following:

- Ferritin greater than 100 mcg/L
- Transferrin saturation (TSAT) greater than 20%

AND

3 - Hemoglobin level does not exceed 12 g/dL

AND

4 - Patient is not on concurrent treatment with an erythropoietin stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)]

AND

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

• Hematologist • Nephrologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Vafseo (vadadustat) is a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor indicated for the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least three months. The treatment of anemia includes intravenous (IV) iron and/or treatment with either an erythropoiesis-stimulating agent (ESA) [e.g., Aranesp (darbepoetin), Epogen (epoetin alfa), Procrit (epoetin alfa), Retacrit (epoetin alfa-epbx)] or a hypoxia-inducible factor prolyl hydroxylase inhibitor (HIF PHI) [e.g., Jesduvroq (daprodustat), Vafseo (vadadustat)]. *Limitations of Use* • Vafseo has not been shown to improve quality of life, fatigue, or patient well-being. • Vafseo is not indicated for use as a substitute for transfusion in patients requiring immediate correction of anemia or in patients with CKD not on dialysis. **Additional Clinical Rules:** • Supply limits may be in place. • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

4 . References

1. Vafseo [package insert]. Cambridge, MA: Akebia Therapeutics, Inc.; March 2024.
2. Eckardt K, Agarwal R, Aswad A, et al. Safety and efficacy of vadadustat for anemia in patients undergoing dialysis. N Engl J Med. 2021;384(17):1601-1612.
3. Huang Q, Liao Z, Liu X, Xia Y, Wang J. Efficacy and safety of vadadustat compared to darbepoetin alfa on anemia in patients with chronic kidney disease: a meta-analysis. Int Urol Nephrol. 2023 Feb;55(2):325-334. doi: 10.1007/s11255-022-03316-z. Epub 2022 Aug 12. PMID: 35960479.
4. Ketteler M, Block GA, Evenepoel P, Fukagawa M, Herzog CA, McCann L, Moe SM, Shroff R, Tonelli MA, Toussaint ND, Vervloet MG, Leonard MB. KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (CKD-MBD). Ann Intern Med. 2018 Mar 20;168(6):422-430.

5 . Revision History

Date	Notes
9/4/2024	New program

Valchlor

Prior Authorization Guideline

Guideline ID	GL-134484
Guideline Name	Valchlor
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 09/21/2022 ; 10/18/2023

1 . Indications

Drug Name: Valchlor (mechlorethamine) gel for topical use
Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma Indicated for the topical treatment of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy. **Langerhans Cell Histiocytosis (LCH)** The National Cancer Comprehensive Network (NCCN) recommends use of topical mechlorethamine in Langerhans Cell Histiocytosis (LCH). **Off Label Uses: T-cell leukemia/lymphoma** The National Cancer Comprehensive Network (NCCN) recommends use of topical mechlorethamine in T-cell leukemia/lymphoma. **Primary cutaneous B-cell lymphoma** The National Cancer Comprehensive Network (NCCN) recommends use of topical mechlorethamine in primary cutaneous B-cell lymphoma. **Primary cutaneous CD30+ T-cell lymphoproliferative disorders** The National Cancer

Comprehensive Network (NCCN) recommends use of topical mechlorethamine in primary cutaneous CD30+ T-cell lymphoproliferative disorders.

2 . Criteria

Product Name: Valchlor [a]	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Chronic or smoldering T-cell leukemia/lymphoma • Primary cutaneous marginal zone or follicle center B-cell lymphoma • Lymphomatoid papulosis (LyP) with extensive lesions • Mycosis fungoides (MF)/Sezary syndrome (SS)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Valchlor [a]	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on Valchlor	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Valchlor [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Langerhans Cell Histiocytosis (LCH) **AND** **2** - Skin disease is unifocal and isolated	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Valchlor [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Valchlor	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Valchlor [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Valchlor will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Valchlor [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Valchlor therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Valchlor gel for topical use (mechlorethamine) is an alkylating drug indicated for the topical treatment of Stage IA and IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received prior skin-directed therapy. [1]. The National Cancer Comprehensive Network (NCCN) recommends use of topical mechlorethamine in T-cell leukemia/lymphoma, primary cutaneous B-cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorders, and Langerhans Cell Histiocytosis (LCH).[2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program. • Supply limits may be in place.

4 . References

1. Valchlor [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; January 2020.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at https://www.nccn.org/compendia-templates/compendia/drugs-and-biologics-compendia. Accessed September 1, 2023.

5 . Revision History

Date	Notes
10/9/2023	Annual review. No changes to coverage criteria. Updated reference.

Vecamyl

Prior Authorization Guideline

Guideline ID	GL-134492
Guideline Name	Vecamyl
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	12/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	07/21/2021 ; 10/18/2023

1 . Indications

Drug Name: Vecamyl (mecamylamine)
Moderately Severe to Severe Essential Hypertension Indicated for the management of moderately severe to severe essential hypertension and uncomplicated cases of malignant hypertension.

2 . Criteria

Product Name: Vecamyl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately severe to severe essential hypertension

OR

2 - Diagnosis of uncomplicated malignant hypertension

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

Approval Criteria

1 - Documentation of a positive clinical response to Vecamyl therapy

3 . Background

Benefit/Coverage/Program Information
Background: Vecamyl (mecamylamine) is indicated for the management of moderately severe to severe essential hypertension and uncomplicated cases of malignant hypertension.[1] Vecamyl was originally approved under the brand name Inversine, which was launched in the 1950s. The product was withdrawn in September 2009; withdrawal was not due to safety concerns. As of March 2013, the FDA issued an approval for mecamylamine to be re-marketed in the United States.[2]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Vecamyl [package insert]. New York, NY: Vyera Pharmaceuticals LLC; July 2018.
2. U.S. Food and Drug Administration website. www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=overview.process&ApplNo=204054. Accessed August 9, 2023.

5 . Revision History

Date	Notes
10/9/2023	Annual review. Updated references.

Velsipity

Prior Authorization Guideline

Guideline ID	GL-145537
Guideline Name	Velsipity
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	4/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Velsipity (etrasimod)
Ulcerative colitis Indicated for the treatment of moderately to severely active ulcerative colitis in adults

2 . Criteria

Product Name: Velsipity [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - ONE of the following:

- Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)
- Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)].

AND

3 - History of failure, contraindication, or intolerance to THREE of the following preferred products (document drug, date, and duration of trial):

- One of the preferred formulary adalimumab products [b]
- Rinvoq (upadacitinib)
- Simponi (golimumab)
- Stelara (ustekinumab)
- Xeljanz/Xeljanz XR (tofacitinib)

AND

4 - Patient is not receiving Velsipity in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]

AND

5 - Prescribed by or in consultation with a gastroenterologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. [b] For a list of formulary adalimumab products please reference drug coverage tools.

Product Name: Velsipity [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Velsipity therapy **AND** **2** - Patient is not receiving Velsipity in combination with a targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Stelara (ustekinumab), Skyrizi (risankizumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Velsipity (etrasimod) is a sphingosine 1-phosphate receptor modulator indicated for the treatment of moderately to severely active ulcerative colitis in adults.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class
- Supply limits may be in place

4 . References

1. Velsipity [package insert]. New York, NY: Pfizer Inc.; November 2023.
2. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology. 2020; 158(5):1450-61.

5 . Revision History

Date	Notes
4/9/2024	New program

Venclexta

Prior Authorization Guideline

Guideline ID	GL-145540
Guideline Name	Venclexta
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	4/17/2024

1 . Indications

Drug Name: Venclexta (venetoclax)
Acute Myeloid Leukemia (AML) Indicated in combination with azacitidine or decitabine or low-dose cytarabine for the treatment of newly-diagnosed acute myeloid leukemia (AML) in adults who are age 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy. **Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)** Indicated for the treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). **National Cancer Comprehensive Network (NCCN)** In addition, the National Cancer Comprehensive Network (NCCN) recommends the use of Venclexta in in acute lymphoblastic leukemia (ALL); in newly diagnosed, relapsed/refractory, and blastic plasmacytoid dendritic cell neoplasm (BPDCN) AML; relapsed/refractory hairy cell leukemia; mantle cell lymphoma as second line or subsequent therapy; in relapsed or progressive multiple myeloma with t(11;14) translocation; for relapsed/refractory systemic light chain amyloidosis with t(11;14)

translocation; in previously treated Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma; in accelerated/blast phase myeloproliferative neoplasm (MPN) with disease progression; and in chronic myelomonocytic leukemia (CMML).

2 . Criteria

Product Name: Venclexta [a]	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of relapsed/refractory T-cell acute lymphoblastic leukemia (ALL) **AND** **2** - Venclexta therapy to be given in combination with one of the following^: • Decitabine • HyperCVAD • Nelarabine • Mini-hyperCVD	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines

Product Name: Venclexta [a]	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of newly-diagnosed acute myeloid leukemia (AML)

AND

1.2 ONE of the following:

- Used as treatment induction in candidates for intensive induction therapy
- Used as treatment induction in candidates for lower-intensity induction therapy
- Used as follow-up after induction therapy following response to previous lower intensity therapy with the same regimen
- Used as consolidation therapy as continuation of lower-intensity regimen used for induction

AND

1.3 Used in combination with decitabine, azacitidine, or low-dose cytarabine

OR

2 - ALL of the following:

- Diagnosis of relapsed/refractory acute myeloid leukemia (AML)
- Used as a component of repeating the initial successful induction regimen
- Greater than or equal to 12 months since induction regimen if not administered continuously
- Therapy was not stopped due to development of clinical resistance

OR

3 - ALL of the following:

- Diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) - acute myeloid leukemia (AML)
- Considered systemic disease and therapy is given as palliative intent
- Patient has low performance and/or nutritional status (i.e., serum albumin less than 3.2 g/dL; not a candidate for intensive remission therapy or Elzonris)
- Venclexta therapy to be given in combination with azacitidine, decitabine, or low-dose cytarabine

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines

Product Name: Venclexta [a]	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Chronic Lymphocytic Leukemia /Small Lymphocytic Lymphoma (CLL/SLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic lymphocytic leukemia (CLL)/ small lymphocytic lymphoma (SLL)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Chronic Lymphocytic Leukemia /Small Lymphocytic Lymphoma (CLL/SLL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Venclexta [a]	
Diagnosis	Chronic Myelomonocytic Leukemia (CMML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic myelomonocytic leukemia (CMML) **AND** **2** - Classified as CMML-2 (less than 20% bone marrow blasts or blast equivalents) **AND** **3** - Venclexta therapy to be given in combination with azacitidine or decitabine	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Venclexta [a]	
Diagnosis	Chronic Myelomonocytic Leukemia (CMML)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hairy cell leukemia **AND** **2** - Disease is progressive after relapsed/refractory therapy **AND** **3** - Disease is resistant to BRAF inhibitor therapy (i.e., Zelboraf, Tafinlar)^	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines

Product Name: Venclexta [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Mantle Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of mantle cell lymphoma (MCL) **AND** **2** - Not used as first line therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Mantle Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of relapsed or progressive multiple myeloma which has been previously treated **AND** **2** - Patient has t(11;14) translocation **AND** **3** - Venclexta therapy to be given in combination with dexamethasone	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Multiple Myeloma

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Myeloproliferative Neoplasms – Accelerated/Blast Phase Myeloproliferative Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of accelerated/blast phase myeloproliferative neoplasm **AND** **2** - Used for management of disease progression of myeloproliferative neoplasm **AND** **3** - Venclexta therapy to be given in combination with azacitidine or decitabine	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Myeloproliferative Neoplasms – Accelerated/Blast Phase Myeloproliferative Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Venclexta [a]	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of relapsed/refractory systemic light chain amyloidosis **AND** **2** - Patient has t(11;14) translocation	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Venclexta [a]	
Diagnosis	Systemic Light Chain Amyloidosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma which has been previously treated	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Venclexta therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Venclexta will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Venclexta [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Venclexta therapy	

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Venclexta (venetoclax) is a BCL-2 inhibitor indicated for the treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). Venclexta is also indicated in combination with azacitidine, or decitabine, or low-dose cytarabine for the treatment of newly diagnosed acute myeloid leukemia (AML) in adults who are age 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy. In addition, the National Cancer Comprehensive Network (NCCN) recommends the use of Venclexta in in acute lymphoblastic leukemia (ALL); in newly diagnosed, relapsed/refractory, and blastic plasmacytoid dendritic cell neoplasm (BPDCN) AML; relapsed/refractory hairy cell leukemia; mantle cell lymphoma as second line or subsequent therapy; in relapsed or progressive multiple myeloma with t(11;14) translocation; for relapsed/refractory systemic light chain amyloidosis with t(11;14) translocation; in previously treated Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma; in accelerated/blast phase myeloproliferative neoplasm (MPN) with disease progression; and in chronic myelomonocytic leukemia (CMML). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class Supply limits may be in place.

4 . References

1. Venclexta [package insert]. North Chicago, IL: AbbVie Inc. June, 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed February 20, 2024.

5 . Revision History

Date	Notes
4/9/2024	Annual review. Updated background on NCCN recommendations. U pdated criteria for ALL and AML based on NCCN recommendations. Added criteria for additional indications based on NCCN recommend ations for the following: hairy cell leukemia, myeloproliferative neopla sms – accelerated/blast phase myeloproliferative neoplasms, and C MML. Removed oncology medications footnote.

Veozah (fezolinetant)

Prior Authorization Guideline

Guideline ID	GL-150909
Guideline Name	Veozah (fezolinetant)
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	8/16/2024

1 . Indications

Drug Name: Veozah (fezolinetant)
Moderate to severe vasomotor symptoms due to menopause Indicated for the treatment of moderate to severe vasomotor symptoms due to menopause

2 . Criteria

Product Name: Veozah [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause

AND

2 - History of failure (after a 30-day trial), contraindication or intolerance to one of the following:

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Veozah [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Veozah (fezolinetant) is a neurokinin 3 (NK3) receptor antagonist indicated for the treatment of moderate to severe vasomotor symptoms due to menopause. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. Supply limits may be in place.

4 . References

1. Veozah [package insert]. Northbrook, IL: Astellas US LLC. October 2023.
2. Khan, SJ, Kapoor, E, Faubion, SS, Kling, JM. Vasomotor Symptoms During Menopause: A Practical Guide on Current Treatments and Future Perspectives. Int J Womens Health.2023: 15: 273-87.

5 . Revision History

Date	Notes
8/2/2024	Annual review. Updated references.

Verzenio

Prior Authorization Guideline

Guideline ID	GL-147377
Guideline Name	Verzenio
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	8/18/2023
P&T Revision Date:	5/17/2024

1 . Indications

Drug Name: Verzenio (abemaciclib)
Breast cancer Indicated in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence; in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer; in combination with Faslodex® (fulvestrant) for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy; and as monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting.

2 . Criteria

Product Name: Verzenio [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - Disease is hormone-receptor (HR)-positive

AND

3 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

4 - ONE of the following:

4.1 BOTH of the following:

4.1.1 Disease is advanced, recurrent, or metastatic

AND

4.1.2 ONE of the following:

4.1.2.1 Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or Faslodex (fulvestrant)

OR

4.1.2.2 ALL of the following:

- Used as monotherapy
- Patient has disease progression following endocrine therapy
- Patient has already received at least one prior chemotherapy regimen

OR

4.2 BOTH of the following:

- Disease is early breast cancer at high risk of recurrence (i.e., at least 4 positive lymph nodes, or 1-3 positive lymph nodes with one or both of the following: Grade 3 disease, tumor size at least 5 centimeters)
- Used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) or tamoxifen

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Verzenio [a]	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Verzenio [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of recurrent or metastatic endometrial cancer **AND** **2** - Tumor is estrogen receptor (ER)-positive **AND** **3** - Used in combination with letrozole	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Verzenio [a]	
Diagnosis	Endometrial Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Verzenio therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Verzenio [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Verzenio will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Verzenio [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Verzenio® (abemaciclib) is a kinase inhibitor indicated in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor 2 (HER2)-negative, node-positive, early breast cancer at high risk of recurrence; in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer; in combination with Faslodex® (fulvestrant) for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy; and as monotherapy for the treatment of adult patients with HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting. The National Comprehensive Cancer Network (NCCN) recommends the use of Verzenio similarly for men and premenopausal women treated with ovarian ablation/suppression with recurrent or metastatic HR-positive, HER2-negative breast cancer disease, in combination with an aromatase inhibitor or Faslodex (fulvestrant). The use of an aromatase inhibitor in men with breast cancer is ineffective without concomitant suppression of testicular steroidogenesis. The NCCN recommends the use of Verzenio for 2 years as adjuvant therapy in combination with endocrine therapy in patients with HR-positive, HER2-negative, high risk (i.e., ≥4 positive lymph nodes, or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease, tumor size ≥5 cm) disease. The NCCN also recommends Verzenio for estrogen receptor (ER)-positive recurrent or metastatic endometrial carcinoma in combination with letrozole. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Verzenio [package insert]. Indianapolis, IN: Lilly USA, LLC; January 2024.

2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed April 8, 2024.

5 . Revision History

Date	Notes
5/16/2024	Annual review. Updated background and added clinical criteria for en dometrial carcinoma per NCCN. Updated references.

Viberzi

Prior Authorization Guideline

Guideline ID	GL-143896
Guideline Name	Viberzi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 03/16/2022 ; 03/15/2023 ; 3/20/2024

1 . Indications

Drug Name: Viberzi (eluxadoline)
Irritable bowel syndrome with diarrhea (IBS-D) Indicated for the treatment of irritable bowel syndrome with diarrhea (IBS-D) in adults

2 . Criteria

Product Name: Viberzi [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) **AND** **2** - History of failure, contraindication or intolerance to a tricyclic antidepressant (e.g., amitriptyline)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

Product Name: Viberzi [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Viberzi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply

3 . Background

Benefit/Coverage/Program Information
Background

Viberzi (eluxadoline) is a mu-opioid receptor agonist, indicated for the treatment of irritable bowel syndrome with diarrhea (IBS-D) in adults.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may apply

4 . References

1. Viberzi [package insert]. Madison, NJ:Allergan USA, Inc.; June 2020.
2. Lacey, BE, Pimentel, M, Brenner, DM, et. al. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. Am J Gastroenterol. 2021; 116 (1): 17-44
3. Lembo, A., Sultan, S, et. al. AGA Clinical Practice Guideline on the Pharmacological Management of Irritable Bowel Syndrome with Diarrhea. Gastroenterology. 2022;163:137-151.

5 . Revision History

Date	Notes
3/7/2024	Annual review. Increased initial authorization to 12 months.

Vijoice

Prior Authorization Guideline

Guideline ID	GL-148730
Guideline Name	Vijoice
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	6/15/2022
P&T Revision Date:	06/21/2023 ; 06/17/2024

1 . Indications

Drug Name: Vijoice (alpelisib)
PIK3CA-Related Overgrowth Spectrum (PROS) Indicated for the treatment of adult and pediatric patients 2 years of age and older with severe manifestations of PIK3CA-Related Overgrowth Spectrum (PROS) who require systemic therapy.

2 . Criteria

Product Name: Vijoice [a]	
Diagnosis	PIK3CA-Related Overgrowth Spectrum (PROS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS)

AND

2 - ONE of the following criteria:

2.1 Confirmed presence of a mutation in the PIK3CA gene

OR

2.2 ONE of the following:

2.2.1 TWO or more of the following spectrum features:

- Overgrowth: adipose, muscle, nerve, skeletal
- Vascular malformations: capillary, venous, arteriovenous, lymphatic
- Epidermal nevus

OR

2.2.2 ONE or more of the following isolated features:

- Large isolated lymphatic malformation
- Isolated macrodactyly or overgrown splayed feet/hands with overgrown limbs
- Truncal adipose overgrowth
- Hemimegalencephaly (bilateral) / dysplastic megalencephaly / focal cortical dysplasia
- Epidermal nevus
- Seborrheic keratoses
- Benign lichenoid keratoses

AND

3 - Patient is 2 years of age or older

AND

4 - Patient has severe manifestations of PROS requiring systemic therapy [3]

AND

5 - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PROS manifestations

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vijoice [a]	
Diagnosis	PIK3CA-Related Overgrowth Spectrum (PROS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Vijoice therapy

AND

2 - Prescribed by, or in consultation with, a clinical geneticist or a practitioner who has specialized expertise in the management of PROS manifestations

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Vijoice (alpelisib) is a kinase inhibitor indicated for the treatment of adult and pediatric patients 2 years of age and older with severe manifestations of PIK3CA-Related Overgrowth Spectrum (PROS) who require systemic therapy. This indication is approved under accelerated approval based on response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s). [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Vijoice [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2024.
2. Keppler-Noreuil, K. M., Rios, J. J., Parker, V. E., Semple, R. K., Lindhurst, M. J., Sapp, J. C., Alomari, A., Ezaki, M., Dobyns, W., & Biesecker, L. G. (2015). PIK3CA-related overgrowth spectrum (PROS): diagnostic and testing eligibility criteria, differential diagnosis, and evaluation. American journal of medical genetics. Part A, 167A(2), 287–295. https://doi.org/10.1002/ajmg.a.36836
3. Venot, Q., Blanc, T., Rabia, S. H., Berteloot, L., Ladraa, S., Duong, J. P., Blanc, E., Johnson, S. C., Hoguin, C., Boccara, O., Sarnacki, S., Boddaert, N., Pannier, S., Martinez, F., Magassa, S., Yamaguchi, J., Knebelmann, B., Merville, P., Grenier, N., Joly, D., … Canaud, G. (2018). Targeted therapy in patients with PIK3CA-related overgrowth syndrome. Nature, 558(7711), 540–546. https://doi.org/10.1038/s41586-018-0217-9.

5 . Revision History

Date	Notes

6/20/2024	Annual Review. Updated Initial Authorization Criteria to align with E&I policy. Updated Initial Authorization duration to 12 months. Updated references. Added new granules product.

Vitrakvi

Prior Authorization Guideline

Guideline ID	GL-139079
Guideline Name	Vitrakvi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 01/19/2022 ; 09/21/2022 ; 01/18/2023 ; 1/17/2024

1 . Indications

Drug Name: Vitrakvi (larotrectinib)
Solid tumors Indicated for the treatment of adult and pediatric patients with solid tumors that: • Have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation • Are metastatic or where surgical resection is likely to result in severe morbidity, and • Have no satisfactory alternative treatments or that have progressed following treatment. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. [1]

2 . Criteria

Product Name: Vitrakvi [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Presence of a solid tumor

AND

2 - Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.)

AND

3 - Disease is without a known acquired resistance mutation [e.g., TRKA G595R, G623R, G696A, F617L]

AND

4 - Disease is ONE of the following:

- Metastatic
- Unresectable

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vitrakvi [a]	
Diagnosis	Solid Tumors
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Vitrakvi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vitrakvi [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Vitrakvi will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vitrakvi [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Vitrakvi therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules: • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. **Background** Vitrakvi® (larotrectinib) is a kinase inhibitor indicated for the treatment of adult and pediatric patients with solid tumors that: • have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, • are metastatic or where surgical resection is likely to result in severe morbidity, and • have no satisfactory alternative treatments or that have progressed following treatment. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.[1]

4 . References

1. Vitrakvi [package insert]. Whippany, NJ: Bayer HealthcCare Pharmaceuticals Inc.; November 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed November 7, 2023.

5 . Revision History

Date	Notes
1/16/2024	Annual review with no changes to clinical criteria. Updated reference s.

Vivjoa

Prior Authorization Guideline

Guideline ID	GL-129934
Guideline Name	Vivjoa
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	10/1/2023
P&T Approval Date:	8/19/2022
P&T Revision Date:	8/18/2023

1 . Indications

Drug Name: Vivjoa (oteseconazole)
Recurrent vulvovaginal candidiasis Indicated to reduce the incidence of recurrent vulvovaginal candidiasis (RVVC) in females with a history of RVVC who are not of reproductive potential.

2 . Criteria

Product Name: Vivjoa [a]	
Approval Length	4 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis

AND

2 - Patient is not of reproductive potential (i.e., persons who are biological females who are postmenopausal or have another reason for permanent infertility [(e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)]

AND

3 - Both of the following:

- Other causes (including but not limited to bacterial vaginosis or trichomoniasis) have been ruled out
- Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months.

AND

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

- Infectious disease physician
- Obstetrician/Gynecologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Vivjoa (oteseconazole) is an azole antifungal indicated to reduce the incidence of recurrent vulvovaginal candidiasis (RVVC) in females with a history of RVVC who are not of reproductive potential.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Vivjoa [package insert]. Durham, NC: Mycovia Pharmaceuticals, Inc; April 2022.
2. Sexually Transmitted Infections Treatment Guidelines, 2021. Vulvovaginal Candidiasis (VVC). Centers for Disease Control and Prevention. https://www.cdc.gov/std/treatment-guidelines/candidiasis.htm. Accessed June 2023.

5 . Revision History

Date	Notes
8/21/2023	New Program
8/21/2023	Annual review. Reference updates

Votrient

Prior Authorization Guideline

Guideline ID	GL-136334
Guideline Name	Votrient
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	09/21/2022 ; 10/19/2022 ; 11/18/2022 ; 08/18/2023 ; 11/17/2023

1 . Indications

Drug Name: Votrient (pazopanib)
Renal cell carcinoma Indicated for the treatment of adults with advanced renal cell carcinoma (RCC). **Soft tissue sarcoma** Indicated for the treatment of adults with advanced soft tissue sarcoma (STS) who have received prior chemotherapy. **Other Uses:** The National Comprehensive Cancer Network (NCCN) recommends use of Votrient in treatment of medullary, follicular, oncocytic, and papillary thyroid carcinomas; ovarian cancer; additional soft tissue sarcomas, chondrosarcoma, uterine sarcoma, merkel cell carcinoma, and gastrointestinal stromal tumors (GIST)

2 . Criteria

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Renal cell carcinoma (RCC)/Kidney cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following: **1.1** Diagnosis of renal cell carcinoma (RCC) **AND** **1.2** ONE of the following: • Disease has relapsed • Stage IV disease • Disease is advanced **OR** **2** - Diagnosis of von Hippel-Lindau (VHL)-associated renal cell carcinoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Renal cell carcinoma (RCC)/Kidney cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Soft Tissue Sarcoma (STS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Angiosarcoma • Alveolar soft part sarcoma • Pleomorphic rhabdomyosarcoma • Retroperitoneal/Intra-abdominal disease that is unresectable, stage IV, or postoperative treatment for residual disease • Soft Tissue Sarcoma of the Extremity/Superficial Trunk or Head/Neck with disease that is stage IV or recurrent and has disseminated metastases • Solitary fibrous tumor/hemangiopericytoma • Desmoid tumors (aggressive fibromatosis) • Dermatofibrosarcoma Protuberans (DFSP) with Fibrosarcomatous Transformation • Dedifferentiated Chordoma	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Soft Tissue Sarcoma (STS)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.4 ONE of the following:

- Disease is refractory to radioactive iodine treatment
- Distant metastatic disease not amenable to radioactive iodine treatment

OR

2 - ALL of the following:

2.1 Diagnosis of medullary carcinoma

AND

2.2 ONE of the following:

- Disease is progressive
- Disease is symptomatic with distant metastases

AND

2.3 History of failure, contraindication, or intolerance to ONE of the following^:

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

	^Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of uterine sarcoma **AND** **2** - ONE of the following: • Disease is advanced • Disease is recurrent/metastatic	

• Disease is inoperable	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Uterine Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of ONE of the following: • Epithelial Ovarian Cancer • Fallopian Tube Cancer • Primary Peritoneal Cancer	

AND **2** - ONE of the following: • Disease is persistent • Disease is recurrent
Notes | [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Ovarian Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of chondrosarcoma **AND** **2** - Disease is metastatic and widespread
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Chondrosarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of GIST	

AND

2 - Disease is unresectable, progressive, or metastatic

AND

3 - ONE of the following:

3.1 Used as first-line therapy in SDH-deficient GIST

OR

3.2 Used after progression on ALL of the following^:

- imatinib (generic Gleevac)
- sunitinib (generic Sutent)
- Stivarga (regorafenib)
- standard dose Qinlock (ripretinib)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^ Tried/failed alternative(s) are supported by FDA labeling and/or NCCN guidelines.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Gastrointestinal Stromal Tumors (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Merkel Cell Carcinoma

AND

2 - Disease is M1 disseminated

AND

3 - ONE of the following:

- Anti-PD-L1 or anti-PD-1 therapy is contraindicated
- Disease has progressed on anti-PD-L1 or anti-PD-1 therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	Merkel Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Votrient will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Votrient, generic pazopanib [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Documentation of positive clinical response to Votrient therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Votrient (pazopanib) is a kinase inhibitor indicated for the treatment of advanced renal cell carcinoma and advanced soft tissue sarcoma in patients who have received prior chemotherapy. [1] Additionally, the National Comprehensive Cancer Network (NCCN) recommends use of Votrient in treatment of medullary, follicular, oncocytic, and papillary thyroid carcinomas; ovarian cancer; additional soft tissue sarcomas, chondrosarcoma, uterine sarcoma, merkel cell carcinoma, and gastrointestinal stromal tumors (GIST). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Votrient [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; December 2021.

2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed September 18, 2023.

5 . Revision History

Date	Notes
11/14/2023	Annual review. Moved and updated criteria for GIST into its own section. Added Merkel Cell Carcinoma criteria per NCCN recommendations. Updated Soft Tissue Sarcoma criteria to align with NCCN. Updated Uterine Sarcoma criteria to align with NCCN. Updated Hürthle cell to oncocytic to align with NCCN nomenclature. Updated background to align with NCCN recommendations. Updated reference.

Vowst

Prior Authorization Guideline

Guideline ID	GL-137166
Guideline Name	Vowst
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	7/19/2023
P&T Revision Date:	12/13/2023

1 . Indications

Drug Name: Vowst (fecal microbiota spores, live-brpk)
Clostridioides difficile infection (CDI) Indicated indicated to prevent the recurrence of Clostridioides difficile infection (CDI) in individuals 18 years of age and older following antibacterial treatment for recurrent CDI (rCDI).

2 . Criteria

Product Name: Vowst (fecal microbiota spores, live-brpk) [a]	
Approval Length	1 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by BOTH of the following:

- Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days
- A positive stool test for Clostridioides difficile toxin

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had one or more recurrences of CDI following an initial episode of CDI

AND

4 - Patient has completed at least 10 days of one of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst^:

- Oral vancomycin
- Dificid (fidaxomicin)

AND

5 - Previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]

AND

6 - Patient will drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst

AND **7** - Prescribed by or in consultation with ONE of the following: • Gastroenterologist • Infectious disease specialist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling and/or treatment guidelines.

3 . Background

Benefit/Coverage/Program Information
Background Vowst is indicated to prevent the recurrence of Clostridioides difficile infection (CDI) in individuals 18 years of age and older following antibacterial treatment for recurrent CDI (rCDI). **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Vowst [package insert]. Cambridge, MA: Seres Therapeutics, Inc.; April 2023.

5 . Revision History

Date	Notes
11/30/2023	Updated criteria to lower the number of required recurrent CDI. Removed antibiotic course requirement.

Voxzogo

Prior Authorization Guideline

Guideline ID	GL-137250
Guideline Name	Voxzogo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	2/1/2024
P&T Approval Date:	3/16/2022
P&T Revision Date:	09/21/2022 ; 03/15/2023 ; 12/13/2023

1 . Indications

Drug Name: Voxzogo (vosoritide)
Achondroplasia Indicated to increase linear growth in pediatric patients with achondroplasia with open epiphyses.

2 . Criteria

Product Name: Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Patient is less than 18 years of age

AND

2 - Diagnosis of achondroplasia as confirmed by ONE of the following:

2.1 Submission of medical records documenting BOTH of the following:

- Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis)
- Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest)

OR

2.2 Submission of medical records documenting molecular genetic testing confirmed c.1138G>A or c.1138G>C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene

AND

3 - Patient has open epiphyses

AND

4 - BOTH of the following:

- Patient has not had limb-lengthening surgery in the previous 18 months

- Patient does not plan to have limb-lengthening surgery while on Voxzogo

AND

5 - Prescribed by ONE of the following:

- Clinical geneticist
- Endocrinologist
- A practitioner who has specialized expertise in the management of achondroplasia

Product Name: Voxzogo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Voxzogo therapy (e.g., improvement in annualized growth velocity (AGV) compared to baseline)

AND

2 - Patient continues to have open epiphyses

AND

3 - Patient does not plan to have limb-lengthening surgery while on Voxzogo

AND

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

- Clinical geneticist
- Endocrinologist

- A practitioner who has specialized expertise in the management of achondroplasia

3 . Background

Benefit/Coverage/Program Information
Background: Voxzogo (vosoritide) is a C type natriuretic peptide (CNP) analog indicated to increase linear growth in pediatric patients with achondroplasia with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply Limits may also be in place

4 . References

1. Voxzogo [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; October 2023.
2. Pauli RM. Achondroplasia: a comprehensive clinical review. Orphanet J Rare Dis 2019;14(1):1-49.
3. Bacino CA. Achondroplasia. UpToDate. Available by subscription at: http://www.uptodate.com/. Accessed January 18, 2023.

5 . Revision History

Date	Notes
12/1/2023	Updated background and coverage criteria with expanded indication i n pediatric patients of all ages. Updated references.

Voydeya

Prior Authorization Guideline

Guideline ID	GL-147382
Guideline Name	Voydeya
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	5/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Voydeya (danicopan)
Extravascular hemolysis (EVH) Indicated as add-on therapy to Ultomiris (ravulizumab) or Soliris (eculizumab) for the treatment of extravascular hemolysis (EVH) in adults with paroxysmal nocturnal hemoglobinuria (PNH).

2 . Criteria

Product Name: Voydeya [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following: [2,3,4,5]

- Flow cytometry analysis confirming presence of PNH clones
- Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

2 - ALL of the following:

- Patient is currently receiving complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)
- Patient is experiencing extravascular hemolysis (EVH) while on complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)
- Patient will continue to receive complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab)

AND

3 - Patient is not receiving Voydeya in combination with a complement protein C3 inhibitor [e.g., Empaveli (Pegcetacoplan)] or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)] used for the treatment of PNH

AND

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

- Hematologist
- Oncologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Voydeya [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to Voydeya therapy [e.g., decrease in extravascular hemolysis (EVH), increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, etc.)]

AND

2 - Patient continues to receive Voydeya in combination with complement protein C5 inhibitor Soliris (eculizumab) or Ultomiris (ravulizumab) for PNH

AND

3 - Patient is not receiving Voydeya in combination with a complement protein C3 inhibitor [e.g., Empaveli (Pegcetacoplan)] or a complement factor B inhibitor [e.g., Fabhalta (iptacopan)] used for the treatment of PNH

AND

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

- Hematologist
- Oncologist

Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Voydeya (danicopan) is a complement factor D inhibitor indicated as add-on therapy to Ultomiris (ravulizumab) or Soliris (eculizumab) for the treatment of extravascular hemolysis (EVH) in adults with paroxysmal nocturnal hemoglobinuria (PNH). [1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Vodeya [package insert]. Boston, Massachusetts: Alexion Pharmaceuticals, Inc.; March 2024.
2. Parker C, Omine M, Richards S, et al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. Blood. 2005 Dec 1; 106(12): 3699–3709.
3. Devalet B, Mullier F, Chatelain B, et al. Pathophysiology, diagnosis, and treatment of paroxysmal nocturnal hemoglobinuria: a review. Eur J Haematol. 2015 Sep;95(3):190-8.
4. Sutherland DR, Keeney M, Illingworth A. Practical guidelines for the high-sensitivity detection and monitoring of paroxysmal nocturnal hemoglobinuria clones by flow cytometry. Cytometry B Clin Cytom. 2012 Jul;82(4):195-208.
5. Röth A, Maciejewski J, Nishimura JI, et al. Screening and diagnostic clinical algorithm for paroxysmal nocturnal hemoglobinuria: Expert consensus. Eur J Haematol. 2018 Jul;101(1):3-11.

5 . Revision History

Date	Notes
5/14/2024	New program

Vtama

Prior Authorization Guideline

Guideline ID	GL-135968
Guideline Name	Vtama
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	9/21/2022
P&T Revision Date:	12/14/2022 ; 11/17/2023

1 . Indications

Drug Name: Vtama (tapinarof)
Plaque Psoriasis Indicated for topical treatment of plaque psoriasis in adults.

2 . Criteria

Product Name: Vtama [a]	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies [2]:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Coal tar

AND

3 - Patient is not receiving Vtama in combination with a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vtama [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response to therapy **AND** **2** - Patient is not receiving Vtama in combination with a Targeted Immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Siliq (brodalumab), Ilumya (tildrakizumab), Xeljanz (tofacitinib), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Vtama cream is an aryl hydrocarbon receptor agonist indicated for the topical treatment of plaque psoriasis in adults. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Vtama [package insert]. Long Beach, CA: Dermavant Sciences Inc.; May 2022.

2. Elmets CA, Korman NJ, Farley Prater E, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol 2021;84:432-70.

5 . Revision History

Date	Notes
11/3/2023	Annual review. Updated not to be used in combination to Targeted Immunomodulators. Simplified reauthorization criteria to only require positive clinical response and not used in combination with other treatment medications.

Vyndaqel, Vyndamax

Prior Authorization Guideline

Guideline ID	GL-154852
Guideline Name	Vyndaqel, Vyndamax
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 02/18/2022 ; 06/21/2023 ; 08/18/2023 ; 9/18/2024

1 . Indications

Drug Name: Vyndaqel (tafamidis meglumine), Vyndamax (tafamidis)
Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) Indicated for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization. [1]

2 . Criteria

Product Name: Vyndaqel, Vyndamax [a]	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

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

Approval Criteria

1 - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)

AND

2 - ONE of the following:

2.1 Documentation that the patient has a pathogenic TTR mutation (e.g., V30M)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits

OR

2.3 ALL of the following:

2.3.1 Echocardiagram or cardiac magnetic resonance imaging suggestive of amyloidosis

AND

2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*

AND

2.3.3 Absence of monoclonal protein identified in serum, urine immunofixation (IFE), serum free light chain (sFLC) assay

AND

3 - Prescribed by or in consultation with a cardiologist

AND

4 - Presence of clinical signs and symptoms of cardiomyopathy (e.g., heart failure, dyspnea, edema, hepatomegaly, ascites, angina, etc.)

AND

5 - Documentation of BOTH of the following:

5.1 ONE of the following:

5.1.1 Patient has New York Heart Association (NYHA) Functional Class I or II heart failure

OR

5.1.2 BOTH of the following:

5.1.2.1 Patient has New York Heart Association (NYHA) Functional Class III heart failure

AND

5.1.2.2 Patient's cardiopulmonary functional status allows patient to ambulate 100 meters or greater in six minutes or less

AND

5.2 Patient has an N-terminal pro-B-type naturetic peptide (NT-proBNP) level greater than or equal to 600 pg/mL (picograms/milliliter)

AND

6 - ONE of the following:

6.1 Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]

OR

6.2 Physician attests that he/she will coordinate care with other specialist(s) involved in the patient's amyloidosis treatment plan to determine optimal long term monotherapy¥ treatment regimen (Subsequent requests for combination therapy will result in an adverse coverage determination)

Notes	*May require prior authorization and notification. ¥ Referring to monotherapy with Amvuttra, Vyndaqel/Vyndamax, Onpattro, Tegsedi or Wainua. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Vyndaqel, Vyndamax [a]	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation that the patient has experienced a positive clinical response to Vyndaqel/Vyndamax (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

AND

2 - Prescribed by or in consultation with a cardiologist

AND **3** - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure **AND** **4** - Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Vyndaqel® (tafamidis meglumine) and Vyndamax™ (tafamidis) are transthyretin stabilizers indicated for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization.[1] **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Vyndaqel and Vyndamax [package insert]. Pfizer, Inc: New York, NY; October 2023.
2. Mauer MS, Schwartz JH, Gundapeneni B, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med. 2018; 379:1007-16.
3. Gillmore JD, Maurer MS, Falk RH, et al. Nonbiopsy diagnosis of cardiac transthyretin amyloidosis. Circulation. 2016; 133:2404-12.
4. Mckenna WJ. Treatment of amyloid cardiomyopathy. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com (Accessed on July 29, 2024).
5. Mckenna WJ. Clinical manifestations and diagnosis of amyloid cardiomyopathy. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com (Accessed on July 29, 2024.)
6. Falk RH. Diagnosis and management of the cardiac amyloidoses. Circulation 2005; 112:2047.
7. Kittleson MM, Maurer MS, Ambardekar AV, Bullock-Palmer RP, Chang PP, Eisen HJ, Nair AP, Nativi-Nicolau J, Ruberg FL; American Heart Association Heart Failure and Transplantation Committee of the Council on Clinical Cardiology. Cardiac Amyloidosis: Evolving Diagnosis and Management: A Scientific Statement From the American Heart Association. Circulation. 2020 Jul 7;142(1):e7-e22. doi: 10.1161/CIR.0000000000000792. Epub 2020 Jun 1. Erratum in: Circulation. 2021 Jul 6;144(1):e10. Erratum in: Circulation. 2021 Jul 6;144(1):e11. PMID: 32476490.
8. Kittleson MM, Ruberg FL, Ambardekar AV, Brannagan TH, Cheng RK, Clarke JO, Dember LM, Frantz JG, Hershberger RE, Maurer MS, Nativi-Nicolau J, Sanchorawala V, Sheikh FH. 2023 ACC Expert Consensus Decision Pathway on Comprehensive Multidisciplinary Care for the Patient With Cardiac Amyloidosis: A Report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2023 Mar 21;81(11):1076-1126. doi: 10.1016/j.jacc.2022.11.022. Epub 2023 Jan 23. Erratum in: J Am Coll Cardiol. 2023 Mar 21;81(11):1135. doi: 10.1016/j.jacc.2023.02.013. PMID: 36697326.

5 . Revision History

Date	Notes
9/13/2024	Annual review. Renamed and added examples of RNA-targeted ther apies for ATTR amyloidosis. Updated and added references.

Wainua

Prior Authorization Guideline

Guideline ID	GL-141091
Guideline Name	Wainua
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	2/16/2024
P&T Revision Date:	

1 . Indications

Drug Name: Wainua (eplontersen)
Polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis Indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis in adults.

2 . Criteria

Product Name: Wainua [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - BOTH of the following:

- Diagnosis of hATTR amyloidosis with polyneuropathy
- Documentation that the patient has a pathogenic TTR mutation (e.g., V30M)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score ≤ IIIb
- Patient has a baseline FAP Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score ≥ 10 and ≤ 130

AND

4 - Patient has not had a liver transplant

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is not receiving Wainua in combination with EITHER of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran), Tegsedi (inotersen)]

• Tafamidis (e.g., Vyndaqel, Vyndamax)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Wainua [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation that the patient has experienced a positive clinical response to Wainua therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.) **AND** **2** - Patient is not receiving Wainua in combination with EITHER of the following: • Oligonucleotide agents [e.g., Onpattro (patisiran), Amvuttra (vutrisiran), Tegsedi (inotersen)] • Tafamidis (e.g., Vyndaqel, Vyndamax)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Wainua (eplontersen) is a transthyretin-directed antisense oligonucleotide indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis in adults.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Wainua [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; December 2023.

5 . Revision History

Date	Notes
2/5/2024	New program

Wakix

Prior Authorization Guideline

Guideline ID	GL-154372
Guideline Name	Wakix
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	2/17/2023
P&T Revision Date:	10/18/2023 ; 9/18/2024

1 . Indications

Drug Name: Wakix (pitolisant)
Narcolepsy Indicated for the treatment of excessive daytime sleepiness (EDS) or cataplexy in adult patients with narcolepsy.

2 . Criteria

Product Name: Wakix [a]	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

- The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months
- A mean sleep latency of ≤ 8 minutes and two or more sleep onset REM periods (SOREMPs) are found on a MSLT performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

- Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness
- Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Pulmonologist
- Sleep Medicine Specialist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Wakix [a]	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation demonstrating a reduction in frequency of cataplexy attacks associated with therapy

OR

2 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Wakix [a]	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy without cataplexy (i.e., Narcolepsy Type 2) with BOTH of the following:

- The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months
- A mean sleep latency of ≤ 8 minutes and two or more sleep onset REM periods (SOREMPs) are found on a MSLT performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep

onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to the following:

- Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - History of failure, contraindication, or intolerance of BOTH of the following:

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 ONE of the following:

- modafinil (generic Provigil)
- armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Pulmonologist
- Sleep Medicine Specialist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Wakix [a]	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Wakix is a histamine-3 (H3) receptor antagonist/inverse agonist indicated for the treatment of excessive daytime sleepiness (EDS) or cataplexy in adult and pediatric patients 6 years of age and older with narcolepsy. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Wakix [package insert]. Plymouth Meeting, PA: Harmony Biosciences, LLC; June 2024.
2. American Academy of Sleep Medicine. International Classification of Sleep Disorders: Diagnostic and Coding Manual. 3rd ed. Darien, IL: American Academy of Sleep Medicine; 2014.
3. Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: An American Academy of Sleep Medicine clinical practice guideline. Journal of Clinical Sleep Medicine. 2021. Sept (17):1881-1893.
4. Wise MS1, Arand DL, Auger RR, et al. Treatment of narcolepsy and other hypersomnias of central origin. Sleep. 2007 Dec;30(12):1712-27.

5 . Revision History

Date	Notes
9/11/2024	Annual review, updated background and references. Updated initial a uthorization durations to 12 months.

Winrevair

Prior Authorization Guideline

Guideline ID	GL-148719
Guideline Name	Winrevair
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	6/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Winrevair (sotatercept-csrk)
Pulmonary arterial hypertension Indicated for the treatment of adults with pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class (FC) and reduce the risk of clinical worsening events.

2 . Criteria

Product Name: Winrevair [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

- Diagnosis of pulmonary arterial hypertension
- PAH has been confirmed by right heart catheterization
- Prescriber attestation that other types of pulmonary hypertension (PH) are excluded as a diagnosis
- Pulmonary arterial hypertension is symptomatic

OR

1.2 BOTH of the following:

- Diagnosis of pulmonary arterial hypertension
- Patient is currently on Winrevair therapy as documented by claims history or submission of medical records (document date and duration of therapy)

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.1.2 Patient is currently taking at least ONE of the following oral therapies:

- Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]
- Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)

OR

2.2 BOTH of the following:

2.2.1 Patient does not have a cardiopulmonary comorbidity (e.g., obesity, hypertension, diabetes mellitus, coronary heart disease)

AND

2.2.2 Patient is currently taking oral combination therapy with BOTH of the following:

2.2.2.1 Endothelin receptor antagonist (ERA) [e.g., ambrisentan, bosentan, Opsumit (macitentan)]

AND

2.2.2.2 ONE of the following:

- Phosphodiesterase-5 inhibitor (PDE5i) (e.g., sildenafil, tadalafil)
- Soluble guanylate cyclase stimulator (sGC) [e.g., Adempas (riociguat)]

AND

3 - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Winrevair [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of a positive clinical response to Winrevair therapy [e.g., improvement in symptoms of right heart failure, exercise tolerance, six-minute walk distance (6MWD), resting and ambulatory oximetry] **AND** **2** - Prescribed by, or in consultation with, a cardiologist, pulmonologist, or rheumatologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Winrevair (sotatercept-csrk) is an activin signaling inhibitor indicated for the treatment of adults with pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class (FC) and reduce the risk of clinical worsening events. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Winrevair [package insert]. Rahway, NJ: Merck & Co., Inc; March 2024.
2. Humbert M, Kovacs G, Hoeper MM, et al. 2022 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension. Eur Heart J 2022; 43:3618.

5 . Revision History

Date	Notes
6/20/2024	New program

Xdemvy

Prior Authorization Guideline

Guideline ID	GL-135969
Guideline Name	Xdemvy
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	11/17/2023
P&T Revision Date:	

1 . Indications

Drug Name: Xdemvy (lotilaner)
Demodex blepharitis Indicated for the treatment of Demodex blepharitis.

2 . Criteria

Product Name: Xdemvy [a]	
Approval Length	3 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of DEMODEX blepharitis

AND

2 - Patient demonstrates ONE of the following signs of DEMODEX infestation:

- Cylindrical cuff at the root of the eyelashes
- Lid margin erythema
- Eyelash anomalies (eyelash misdirection)

AND

3 - Patient demonstrates TWO of the following symptoms of DEMODEX infestation

- Itching/Burning
- Foreign body sensation
- Crusting/matter lashes
- Blurry vision
- Discomfort/irritation

AND

4 - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil)

AND

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

- Ophthalmologist
- Optometrist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Xdemvy (lotilaner) ophthalmic solution 0.25% is indicated for the treatment of Demodex blepharitis. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place**.**

4 . References

1. Xdemvy [package insert]. Irvine, CA: Tarsus Pharmaceuticals, Inc. July 2023.
2. M.T Yen. Demodex Infestation. American Academy of Ophthalmology. EyeWiki. April, 25, 2023.

5 . Revision History

Date	Notes
11/3/2023	New program

Xeljanz, Xeljanz XR

Prior Authorization Guideline

Guideline ID	GL-132958
Guideline Name	Xeljanz, Xeljanz XR
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2023
P&T Approval Date:	8/14/2020
P&T Revision Date:	01/21/2021 ; 05/21/2021 ; 06/16/2021 ; 09/15/2021 ; 02/18/2022 ; 05/20/2022 ; 06/15/2022 ; 09/21/2022 ; 02/17/2023 ; 05/25/2023 ; 9/20/2023

1 . Indications

Drug Name: Xeljanz /Xeljanz XR
Rheumatoid Arthritis Indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more TNF blockers. It may be used as monotherapy or in combination with methotrexate or other non-biologic disease-modifying antirheumatic drugs (DMARDs). **Psoriatic Arthritis** Indicated for the treatment of adult patients with active psoriatic arthritis who have an inadequate response or intolerance to one or more TNF blockers. **Ulcerative Colitis** Indicated for the treatment of adult patients with moderately to severely active ulcerative colitis, who have an inadequate response or intolerance to one or more TNF blockers.

Ankylosing Spondylitis Indicated for the treatment of active ankylosing spondylitis in patients who have an inadequate response or intolerance to one or more TNF blockers.
Drug Name: Xeljanz / Xeljanz Solution
Polyarticular Course Juvenile Idiopathic Arthritis Indicated for the treatment of active polyarticular course juvenile idiopathic arthritis in patients 2 years of age and older who have had an inadequate response or intolerance to one or more TNF blockers.

2 . Criteria

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active RA

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 One of the following:

2.1.1.1 History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)

OR

2.1.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of rheumatoid arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Olumiant (baricitinib), Rinvoq (upadacitinib)]

AND

2.1.2 One of the following:

- History of failure, contraindication, or intolerance to at least one TNF inhibitor^
- Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [5])

OR

2.2 Both of the following:

2.2.1 Patient is currently on Xeljanz or Xeljanz XR therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer sponsored XELSOURCE program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Xeljanz or Xeljanz XR*

AND

3 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND **4** - Prescribed by or in consultation with a rheumatologist	
Notes	*Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer sponsored XELSOURCE program shall be required to meet initial authorization criteria as if patient were new to therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/Failed alternatives(s) are supported by FDA labeling.

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Xeljanz or Xeljanz XR therapy **AND** **2** - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following: • Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)] • Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)] • Potent immunosuppressant (e.g., azathioprine or cyclosporine)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active PsA

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 One of the following:

2.1.1.1 History of failure to a 3 month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced (document date and duration of trial)

OR

2.1.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of psoriatic arthritis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Orencia (abatacept), Stelara (ustekinumab), Skyrizi (risankizumab), Tremfya (guselkumab), Cosentyx (secukinumab), Taltz (ixekizumab), Olumiant (baricitinib), Rinvoq (upadacitinib), Otezla (apremilast)]

AND

2.1.2 One of the following:

2.1.2.1 History of failure, contraindication, or intolerance to at least one TNF inhibitor^

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [5])

OR

2.2 Both of the following:

2.2.1 Patient is currently on Xeljanz or Xeljanz XR therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer sponsored XELSOURCE program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Xeljanz or Xeljanz XR*

AND

3 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

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

- Rheumatologist
- Dermatologist

Notes	*Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer sponsored XELSOURCE program shall be required to meet initial authorization criteria as if patient were new to therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/Failed alternatives(s) are supported by FDA labeling.

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xeljanz or Xeljanz XR therapy

AND

2 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active UC

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 One of the following:

2.1.1.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.1.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Rinvoq (upadacitinib)]

AND

2.1.2 One of the following:

2.1.2.1 History of failure, contraindication, or intolerance to at least one TNF inhibitor^

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [5])

OR

2.2 Both of the following:

2.2.1 Patient is currently on Xeljanz or Xeljanz XR therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)

AND

2.2.2 Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer sponsored XELSOURCE program (e.g. sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Xeljanz or Xeljanz XR*

AND

3 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Notes	*Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer sponsored XELSOURCE program shall be required to meet initial authorization criteria as if patient were new to therapy. [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/Failed alternatives(s) are supported by FDA labeling.

Product Name: Xeljanz or Xeljanz XR [a]

Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xeljanz or Xeljanz XR therapy

AND

2 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 One of the following:

2.1.1.1 History of failure to two NSAIDs (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)

OR

2.1.1.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ankylosing spondylitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., Enbrel (etanercept), Cimzia (certolizumab), adalimumab, Simponi (golimumab), Rinvoq (upadacitinib)]

AND

2.1.2 One of the following:

2.1.2.1 History of failure, contraindication, or intolerance to at least one TNF inhibitor^

OR

2.1.2.2 Patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria [5])

OR

2.2 Both of the following:

- Patient is currently on Xeljanz or Xeljanz XR therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)

- Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer sponsored XELSOURCE program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Xeljanz or Xeljanz XR*

AND

3 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer sponsored XELSOURCE program shall be required to meet initial authorization criteria as if patient were new to therapy. ^Tried/Failed alternatives(s) are supported by FDA labeling.

Product Name: Xeljanz or Xeljanz XR [a]	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xeljanz or Xeljanz XR therapy

AND

2 - Patient is not receiving Xeljanz or Xeljanz XR in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xeljanz or Xeljanz Solution [a]	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active polyarticular course juvenile idiopathic arthritis

AND

2 - One of the following:

2.1 History of failure, contraindication, or intolerance to one of the formulary adalimumab products [b](document date and duration of trial)

OR

2.2 Patient has a documented needle-phobia to the degree that the patient has previously

refused any injectable therapy or medical procedure (refer to DSM-V-TR 300.29 for specific phobia diagnostic criteria 5)

OR

2.3 Both of the following:

- Patient is currently on Xeljanz or Xeljanz XR therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)
- Patient has not received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Pfizer sponsored XELSOURCE program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Xeljanz or Xeljanz XR*

AND

3 - Patient is not receiving Xeljanz or Xeljanz Solution in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

4 - Prescribed by or in consultation with a rheumatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Pfizer sponsored XELSOURCE program shall be required to meet initial authorization criteria as if patient were new to therapy. [b] For a list of formulary adalimumab products please reference drug coverage tools.

Product Name: Xeljanz or Xeljanz Solution [a]	
Diagnosis	Polyarticular Course Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xeljanz or Xeljanz Solution therapy

AND

2 - Patient is not receiving Xeljanz or Xeljanz Solution in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), adalimumab, Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Xeljanz/Xeljanz XR (tofacitinib) is an inhibitor of Janus Kinases (JAKs) indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers. It may be used as monotherapy or in combination with methotrexate or other non-biologic disease-modifying antirheumatic drugs (DMARDs). [1] Examples of non-biologic DMARDs commonly used in the treatment of rheumatoid arthritis include methotrexate,

leflunomide, and sulfasalazine. [2,3] Xeljanz/Xeljanz XR is also indicated for the treatment of adult patients with active psoriatic arthritis, active ankylosing spondylitis, and moderately to severely active ulcerative colitis, who have an inadequate response or intolerance to one or more TNF blockers. Xeljanz/Xeljanz Solution is indicated for the treatment of active polyarticular juvenile idiopathic arthritis in patients 2 years of age and older who have had an inadequate response or intolerance to one or more TNF blockers

Limitations of Use:

The use of Xeljanz/Xeljanz XR/Xeljanz Solution in combination with biologic DMARDs or with potent immunosuppressants such as azathioprine and cyclosporine is not recommended.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Xeljanz/Xeljanz XR/Xeljanz Solution [package insert]. New York, NY: Pfizer Labs; January 2022.
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12. Gossec L, et al; European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update, Ann Rheum Dis 2016;75:499-510.
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15. Yu, DT, van Tubergen A. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. UpToDate; 2021. Accessed on December 17th, 2021.

5 . Revision History

Date	Notes
9/20/2023	Updated step therapy requirement to match adalimumab policy langu age in selecting formulary agent. Updated examples throughout polic y.

Xenazine

Prior Authorization Guideline

Guideline ID	GL-154859
Guideline Name	Xenazine
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 10/20/2021 ; 02/18/2022 ; 02/17/2023 ; 08/18/2023 ; 9/18/2024

1 . Indications

Drug Name: Xenazine
Chorea associated with Huntington's disease Indicated for the treatment of chorea associated with Huntington's disease. **Off Label Uses:** **Tardive dyskinesia** Recommended by the American Academy of Neurology and American Psychiatric Association for consideration in the management of patients with tardive dyskinesia.

2 . Criteria

Product Name: Brand Xenazine, generic tetrabenazine [a]	
Diagnosis	Chorea associated with Huntington's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chorea associated with Huntington's disease **AND** **2** - Prescribed by or in consultation with ONE of the following: • Neurologist • Psychiatrist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Xenazine, generic tetrabenazine [a]	
Diagnosis	Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderate to severe tardive dyskinesia **AND**	

2 - ONE of the following:

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

OR

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

AND

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

- Neurologist
- Psychiatrist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Xenazine, generic tetrabenazine [a]	
Diagnosis	Chorea associated with Huntington's disease, Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Xenazine (tetrabenazine) is a vesicular monoamine transporter 2 (VMAT2) inhibitor indicated for the treatment of chorea associated with Huntington's disease. [1] Xenazine is also recommended by the American Academy of Neurology and American Psychiatric Association for consideration in the management of patients with tardive dyskinesia. [2] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place

4 . References

1. Xenazine [package insert]. Deerfield, IL: Lundbeck; November 2019.
2. Bhidayasiri R, Fahn S, Weiner WJ, et al. Evidence-based guideline: Treatment of tardive syndromes: Report of the guidelines development subcommittee of the American Academy of Neurology. Neurology. 2013;81;463-469.
3. Keepers GA, Fochtmann LJ, Anzia JM, et al. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia. Focus (Am Psychiatr Publ). 2020;18(4):493-497. doi:10.1176/appi.focus.18402

5 . Revision History

Date	Notes
9/12/2024	Updated product formatting

Xermelo

Prior Authorization Guideline

Guideline ID	GL-148652
Guideline Name	Xermelo
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	06/15/2022 ; 06/21/2023 ; 6/17/2024

1 . Indications

Drug Name: Xermelo
Carcinoid syndrome diarrhea Indicated for the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy.

2 . Criteria

Product Name: Xermelo [a]	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of carcinoid syndrome diarrhea

AND

2 - Diarrhea is inadequately controlled with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide)

AND

3 - Used in combination with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot, Lanreotide)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xermelo [a]	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xermelo

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Xermelo (telotristat ethyl) is a tryptophan hydroxylase inhibitor indicated for the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy. [1] **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Xermelo [package insert]. Deerfield, IL: TerSera Therapeutics LLC; September 2022.

5 . Revision History

Date	Notes
6/19/2024	Annual review. Updated initial authorization duration to 12 months.

Xifaxan

Prior Authorization Guideline

Guideline ID	GL-149959
Guideline Name	Xifaxan
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	9/1/2024
P&T Approval Date:	9/15/2021
P&T Revision Date:	07/19/2023 ; 04/17/2024 ; 7/17/2024

1 . Indications

Drug Name: Xifaxan
Travelers' diarrhea Indicated for the treatment of travelers' diarrhea (TD) caused by noninvasive strains of Escherichia coli in adult and pediatric patients 12 years of age and older. **Hepatic Encephalopathy** Indicated for the reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults. **Irritable bowel syndrome with diarrhea** Indicated for the treatment of irritable bowel syndrome with diarrhea (IBS-D) in adults.

2 . Criteria

Product Name: Xifaxan [a]	
Diagnosis	Travelers' Diarrhea
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - History of failure, contraindication, or intolerance to ONE of the following:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xifaxan [a]	
Diagnosis	Hepatic Encephalopathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for prophylaxis of hepatic encephalopathy (HE) recurrence

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Used as add-on therapy to lactulose
- Patient is unable to achieve an optimal clinical response with lactulose monotherapy

OR

2.2 History of contraindication or intolerance to lactulose

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xifaxan [a]	
Diagnosis	Hepatic Encephalopathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xifaxan therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xifaxan [a]	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	14 Day(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of IBS-D

AND

2 - History of failure, contraindication, or intolerance to a tricyclic antidepressant (e.g. amitriptyline)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xifaxan [a]	
Diagnosis	Irritable Bowel Syndrome with Diarrhea (IBS-D)
Approval Length	14 Day(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Xifaxan will be approved based on ALL of the following criteria:

- Patient has experienced a recurrence of IBS-D after a prior 14 day course of therapy with Xifaxan
- Patient has had a treatment-free period between courses of therapy
- Patient has not already received 3 treatment courses of Xifaxan for IBS-D in the previous 6 months

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xifaxan [a]

Diagnosis	Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off Label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Inflammatory Bowel Disease

AND

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

- Ciprofloxacin (generic Cipro)
- Metronidazole (generic Flagyl)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xifaxan [a]	
Diagnosis	Inflammatory Bowel Disease (e.g. Crohn's Disease, Ulcerative Colitis, Diverticulitis) (Off Label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xifaxan therapy

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

3 . Background

Benefit/Coverage/Program Information
Background: Xifaxan is an antibacterial agent indicated for the treatment of travelers' diarrhea caused by noninvasive strains of Escherichia coli in patients 12 years of age and older, for the risk reduction of overt hepatic encephalopathy recurrence in adults and for the treatment of irritable bowel syndrome with diarrhea (IBS-D). There is limited data to support the off-label use of Xifaxan for the treatment of inflammatory bowel diseases. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Xifaxan [package insert]. Bridgewater, NJ: Bausch Health US, LLC; October 2023.
2. Prantera C , Lochs H , Grimaldi M et al. Rifaximin-extended intestinal release induces remission in patients with moderately active Crohn's disease . Gastroenterology 2012 ; 142 : 473 – 81 . e4
3. LaRocque, R. Travelers's diarrhea: Treatment and prevention. In: UpToDate, Calderwood, SB (Ed), UpToDate. Waltham, MA. (Accessed on May 2023).
4. Pimentel H, Lembo A, Chey W, et al: Rifaximin therapy for patients with Irritable Bowel Syndrome without constipation. N Engl J Med 2011; 364(1):22-32.
5. Lacey, BE, Pimentel, M, Brenner, DM, et. al. ACG Clinical Guideline: Management of Irritable Bowel Syndrome. Am J Gastroenterol. 2021; 116 (1): 17-44American.
6. AGA Clinical Practice Guideline on the Pharmacological Management of Irritable Bowel Syndrome With Diarrhea. Gastroenterology. 2022.
7. Vilstrup H, Amodio P, Bajaj J, et al. Hepatic encephalopathy in chronic liver disease: 2014 Practice Guideline by the American Association for the Study of Liver Diseases and the European Association for the Study of the Liver. Hepatology. 2014;60:715-735.

8. Travelers' diarrhea - chapter 2 - 2020 yellow book. Centers for Disease Control and Prevention. https://wwwnc.cdc.gov/travel/yellowbook/2020/preparing-international-travelers/travelers-diarrhea. Accessed April 25, 2023.
9. ACG Clinical Guideline: Small Intestinal Bacterial Overgrowth. Am J Gastroenterol. 2020; 115:165-78.

5 . Revision History

Date	Notes
7/18/2024	Annual review. Updated references.

Xolair

Prior Authorization Guideline

Guideline ID	GL-148370
Guideline Name	Xolair
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	8/1/2024
P&T Approval Date:	7/21/2021
P&T Revision Date:	11/19/2021 ; 12/15/2021 ; 02/18/2022 ; 09/21/2022 ; 07/19/2023 ; 08/18/2023 ; 10/18/2023 ; 04/17/2024 ; 05/17/2024 ; 6/17/2024

Note:

This program applies to the prefilled syringe for subcutaneous use formulation

1 . Indications

Drug Name: Xolair (omalizumab) prefilled syringe
Asthma Indicated for moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids **Nasal Polyps** Indicated for chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment

Chronic Idiopathic Urticaria (CIU) Indicated for chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment

IgE-Mediated Food Allergy Indicated for IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods. To be used in conjunction with food allergen avoidance.

2 . Criteria

Product Name: Xolair prefilled syringe [a]	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Xolair for self-administration will be approved based on ONE of the following:

1.1 ALL of the following:

1.1.1 Patient has been established on therapy with Xolair for moderate to severe persistent asthma under an active UnitedHealthcare medical benefit prior authorization

AND

1.1.2 Documentation of positive clinical response to Xolair therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)

AND

1.1.3 Xolair is being used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

1.1.4 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

OR

1.2 ALL of the following:

1.2.1 Diagnosis of moderate or severe asthma

AND

1.2.2 Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following:

- Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

1.2.3 Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting a baseline (pre-omalizumab treatment) serum total IgE (immunoglobulin E) level greater than or equal to 30 IU/mL (international units/milliliter) and less than or equal to 1300 IU/mL

AND

1.2.4 Positive skin test or in vitro reactivity to a perennial aeroallergen

AND

1.2.5 Used in combination with ONE of the following:

1.2.5.1 One maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2-agonist (LABA) product [e.g., fluticasone propionate/salmeterol (AirDuo/Advair), budesonide/formoterol (Symbicort)]

OR

1.2.5.2 Combination therapy including BOTH of the following:

- One maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)]
- One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist - montelukast (Singulair); theophylline]

AND

1.2.6 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.2.7 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Pulmonologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response as demonstrated by at least ONE of the following:

- Reduction in frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted FEV1 from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing)

AND

2 - Used in combination with an ICS-containing controllermaintenance medication [e.g., Advair/AirDuo (fluticasone/salmeterol), Breo Ellipta (fluticasone furoate/vilanterol), Symbicort (budesonide/ formoterol), Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol)]

AND

3 - Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

• Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Xolair for self-administration will be approved based on ONE of the following:

1.1 ALL of the following:

1.1.1 Patient has been established on therapy with Xolair for chronic urticaria under an active UnitedHealthcare medical benefit prior authorization

AND

1.1.2 Documentation of positive clinical response to Xolair therapy (e.g., reduction in exacerbations, itch severity, hives)

AND

1.1.3 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

OR

1.2 ALL of the following:

1.2.1 Diagnosis of chronic urticaria

AND

1.2.2 ONE of the following:

1.2.2.1 Patient remains symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to, TWO H1-antihistamines [e.g., Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)]*^

OR

1.2.2.2 Patient remains symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to BOTH of the following taken in combination:^

1.2.2.2.1 Second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]

AND

1.2.2.2.2 ONE of the following:

- Different second generation H1-antihistamine [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)]
- First generation H1-antihistamine [e.g., Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)]*
- H2-antihistamine [e.g., Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)]
- Leukotriene modifier [e.g., Singulair (montelukast)]

AND

1.2.3 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.2.4 Prescribed by ONE of the following:

- Allergist
- Dermatologist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients 65 years of age and older in whom first generation H1-antihistamines are considered high risk medications to be avoided (e.g., Beers criteria, HEDIS) should be directed to try alternatives that are not considered high risk. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	Chronic Urticaria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., reduction in exacerbations, itch severity, hives)

AND

2 - Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

• Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients 65 years of age and older in whom first generation H1-antihistamines are considered high risk medications to be avoided (e.g., Beers criteria, HEDIS) should be directed to try alternatives that are not considered high risk.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Xolair for self-administration will be approved based on ONE of the following:

1.1 ALL of the following:

1.1.1 Patient has been established on therapy with Xolair for nasal polyps under an active UnitedHealthcare medical benefit prior authorization

AND

1.1.2 Documentation of positive clinical response to Xolair therapy

AND

1.1.3 Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

1.1.4 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

OR

1.2 ALL of the following:

1.2.1 Diagnosis of nasal polyps

AND

1.2.2 TWO OR MORE of the following symptoms for longer than 12 weeks duration:

- Nasal mucopurulent discharge
- Nasal obstruction, blockage, or congestion
- Facial pain, pressure, and/or fullness
- Reduction or loss of sense of smell

AND

1.2.3 ONE of the following findings using nasal endoscopy and/or sinus computed tomography (CT):

- Purulent mucus or edema in the middle meatus or ethmoid regions
- Polyps in the nasal cavity or the middle meatus
- Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses

AND

1.2.4 ONE of the following:

1.2.4.1 Patient has required prior sinus surgery

OR

1.2.4.2 Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for nasal polyps in the previous 2 years

OR

1.2.4.3 Patient has been unable to obtain symptom relief after trial of BOTH of the following:

- Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)^
- ONE other therapy used in the management of nasal polyps [i.e., nasal saline irrigations. antileukotriene agents (e.g., montelukast, zafirlukast, zileuton)]

AND

1.2.5 Patient will receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

1.2.6 Patient is not receiving Xolair in combination with any of the following:

- Anti-interleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.2.7 Prescribed by ONE of the following:

- Allergist
- Immunologist
- Otolaryngologist

• Pulmonologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. ^Tried/failed alternative(s) are supported by FDA labeling.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response

AND

2 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone)

AND

3 - Patient is not receiving Xolair in combination with ANY of the following:

- Anti-intrleukin-5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]
- Anti-interleukin-4 therapy [e.g., Dupixent (dupilumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient has been established on therapy with Xolair for IgE-mediated food allergy under an active UnitedHealthcare medical benefit prior authorization

AND

1.2 Documentation of positive clinical response to Xolair therapy (e.g., reduction in type I allergic reactions)

AND

1.3 Xolair will be used in conjunction with food allergen avoidance

AND

1.4 Patient has access to epinephrine

AND

1.5 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

1.6 Prescribed by an allergist or immunologist

OR

2 - ALL of the following:

2.1 Diagnosis of IgE-mediated food allergy to one or more foods

AND

2.2 Patient is aged greater than or equal to 1 year

AND

2.3 IgE-mediated food allergy to specific food(s) has been confirmed by BOTH of the following:

2.3.1 History of type I allergic reactions (e.g., nausea, vomiting, cramping, diarrhea, flushing, pruritus, urticaria, swelling of the lips, face or throat, wheezing, lightheadedness, syncope)

AND

2.3.2 ONE of the following:

- Skin prick testing (SPT)
- IgE antibody in vitro testing
- Oral food challenge (OFC)

AND

2.4 Xolair will be used in conjunction with food allergen avoidance

AND

2.5 Patient has access to epinephrine

AND

2.6 Patient is not receiving Xolair in combination with ANY of the following:

- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]
- Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)]

AND

2.7 Prescribed by an allergist or immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xolair prefilled syringe [a]	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xolair therapy (e.g., reduction in type I allergic reactions)

AND

2 - Xolair will be used in conjunction with food allergen avoidance **AND** **3** - Patient has access to epinephrine **AND** **4** - Patient is not receiving Xolair in combination with ANY of the following: • Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] • Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)] • Thymic stromal lymphopoietin (TSLP) inhibitor [e.g., Tezspire (tezepelumab)] **AND** **5** - Prescribed by an allergist or immunologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Xolair (omalizumab) is an anti-IgE antibody indicated for: • Moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids

- Chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment
- IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods. To be used in conjunction with food allergen avoidance.
- Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment

This policy refers to Xolair (omalizumab) subcutaneous injection for self-administered subcutaneous injection. Xolair (omalizumab) for administration by a healthcare professional is obtained under the medical benefit.

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Xolair [package insert]. South San Francisco, CA: Genentech USA, Inc. February 2024.
2. Global Initiative for Asthma (GINA). Global strategy for asthma management and prevention - revised 2023. Accessed June 8, 2023.
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9. Anvari S, Miller J, Yeh CY, Davis CM. IgE-Mediated Food Allergy. Clin Rev Allergy Immunol. 2019;57(2):244-260. doi:10.1007/s12016-018-8710-3

5 . Revision History

Date	Notes
6/12/2024	Expanded coverage of Xolair for IgE-mediated food allergy to all food s. Updated references.

Xolremdi

Prior Authorization Guideline

Guideline ID	GL-150649
Guideline Name	Xolremdi
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	10/1/2024
P&T Approval Date:	8/16/2024
P&T Revision Date:	

1 . Indications

Drug Name: Xolremdi (mavorixafor)
WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis) Indicated in patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes.

2 . Criteria

Product Name: Xolremdi [a]	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome

AND

2 - Patient has a genotype-confirmed mutation of chemokine (C-X-C motif) receptor 4 (CXCR4) consistent with WHIM phenotype

AND

3 - Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells /µL

AND

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

- Allergist
- Geneticist
- Hematologist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xolremdi [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria **1** - Documentation of positive clinical response [e.g., improvement in absolute neutrophil counts (ANC), improvement in absolute lymphocyte counts (ALC), reduction in infections] to Xolremdi therapy **AND** **2** - Prescribed by or in consultation with one of the following: • Allergist • Geneticist • Hematologist • Immunologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Xolremdi™ (mavorixafor) is a CXC chemokine receptor 4 antagonist indicated in patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limit may be in place.

4 . References

1. Xolremdi [package insert]. Boston, MA: X4 Pharmaceuticals, Inc.; April 2024.

5 . Revision History

Date	Notes
8/2/2024	New program.

Xospata

Prior Authorization Guideline

Guideline ID	GL-141092
Guideline Name	Xospata
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 09/15/2021 ; 02/18/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Xospata (gilteritinib)
Acute myeloid leukemia Indicated for the treatment of adult patients who have relapsed or refractory acute myeloid leukemia (AML) with an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test. **Other Uses** The National Cancer Comprehensive Network (NCCN) recommends the use of Xospata for the treatment of myeloid/lymphoid neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement. NCCN also recommends Xospata for treatment of AML in combination with azacitidine in patients with FLT3 mutation for low-intensity treatment induction when not a candidate for intensive induction therapy, follow-up treatment after induction therapy following response to previous lower intensity therapy with the same regimen, or for maintenance therapy as a single agent in patients who are post-allogeneic hematopoietic cell transplantation, in remission, and have a history of FLT3 mutation.

2 . Criteria

Product Name: Xospata [a]	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive

AND

3 - ONE of the following:

- Used in combination with azacitidine as low-intensity treatment induction when not a candidate for intensive induction therapy
- Follow-up after induction therapy with response to previous lower intensity therapy with the same regimen
- Post-allogeneic hematopoietic cell transplantation and in remission
- Disease is relapsed or refractory

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xospata [a]	
Diagnosis	Acute Myeloid Leukemia (AML)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Xospata therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xospata [a]	
Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia **AND** **2** - ONE of the following: • Patient has a FMS-like tyrosine kinase 3 (FLT3) rearrangement in chronic phase • Patient has a FMS-like tyrosine kinase 3 (FLT3) rearrangement in blast phase	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xospata [a]

Diagnosis	Myeloid/Lymphoid Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Xospata therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xospata [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Xospata will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xospata [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Xospata therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Xospata (gilteritinib) is a kinase inhibitor indicated for the treatment of adult patients who have relapsed or refractory acute myeloid leukemia (AML) with an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test.[1] The National Cancer Comprehensive Network (NCCN) recommends the use of Xospata for the treatment of myeloid/lymphoid neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement. [2] NCCN also recommends Xospata for treatment of AML in combination with azacitidine in patients with FLT3 mutation for low-intensity treatment induction when not a candidate for intensive induction therapy, follow-up treatment after induction therapy following response to previous lower intensity therapy with the same regimen, or for maintenance therapy as a single agent in patients who are post-allogeneic hematopoietic cell transplantation, in remission, and have a history of FLT3 mutation. **Additional Clinical Rules** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Xospata [package insert]. Northbrook, IL: Astellas Pharma US; January 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed December 22, 2023.

5 . Revision History

Date	Notes
2/5/2024	Annual review. Updated treatment criteria for AML to include addition al NCCN recommendations.

Xphozah

Prior Authorization Guideline

Guideline ID	GL-143897
Guideline Name	Xphozah
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	3/20/2024
P&T Revision Date:	

1 . Indications

Drug Name: Xphozah (tenapanor)
Chronic Kidney Disease (CKD) Indicated to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy

2 . Criteria

Product Name: Xphozah [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary
Approval Criteria **1** - Diagnosis of chronic kidney disease (CKD) **AND** **2** - Patient is receiving dialysis **AND** **3** - Serum phosphorus is > 6.5 mg/dL **AND** **4** - Patient has had an inadequate response to at least a 4-week maximally tolerated dose of BOTH of the following phosphate binders: • Calcium acetate (generic PhosLo) • Sevelamer carbonate (generic Renvela) **AND** **5** - Xphozah will be used as add-on therapy **AND** **6** - Prescribed by or in consultation with a nephrologist.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xphozah [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Xphozah therapy [e.g., reduction of serum phosphorus towards the normal range (3.5 to 5.5 mg/dL)] **AND** **2** - Prescribed by or in consultation with a nephrologist.	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Xphozah (tenapanor) is a sodium hydrogen exchanger 3 (NHE3) inhibitor indicated to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limitations may be in place.

4 . References

1. Xphozah® [package insert]. Waltham, MA: Ardelyx, Inc.; October 2023
2. National Kidney Foundation. K/DOQI clinical practice guidelines for bone metabolism and disease in chronic kidney disease. Am J Kidney Dis. 2003;42(4 Suppl 3):S1-S201.
3. Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group. KDIGO clinical practice guideline for the diagnosis, evaluation, prevention, and treatment of Chronic Kidney Disease-Mineral and Bone Disorder (CKD-MBD). Kidney Int Suppl. 2009;(113):S1-S130. doi:10.1038/ki.2009.188
4. Ketteler M, Block GA, Evenepoel P, et al. Executive summary of the 2017 KDIGO Chronic Kidney Disease-Mineral and Bone Disorder (CKD-MBD) Guideline Update: what's changed and why it matters [published correction appears in Kidney Int. 2017 Dec;92(6):1558]. Kidney Int. 2017;92(1):26-36. doi:10.1016/j.kint.2017.04.006

5 . Revision History

Date	Notes
3/4/2024	New program.

Xyrem, Xywav, Lumryz

Prior Authorization Guideline

Guideline ID	GL-154864
Guideline Name	Xyrem, Xywav, Lumryz
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	11/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/20/2022 ; 11/18/2022 ; 02/17/2023 ; 12/13/2023 ; 9/18/2024

1 . Indications

Drug Name: Xyrem, Lumryz (sodium oxybate)
Narcolepsy Indicated for the treatment of excessive daytime sleepiness (EDS) or cataplexy in patients with narcolepsy.

Drug Name: Xywav (calcium, magnesium, potassium, and sodium oxybates)
Narcolepsy Indicated for the treatment of excessive daytime sleepiness (EDS) or cataplexy in patients with narcolepsy. **Idiopathic hypersomnia (IH)** Indicated for idiopathic hypersomnia (IH) in adults.

2 . Criteria

Product Name: Lumryz, sodium oxybate (Xyrem AG), Xyrem or Xywav [a]	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

- The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months
- A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset REM periods (SOREMPs) on an MSLT performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

- Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness
- Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Pulmonologist

• Sleep Medicine Specialist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lumryz, sodium oxybate (Xyrem AG), Xyrem or Xywav [a]	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation demonstrating a reduction in frequency of cataplexy attacks associated with therapy **OR** **2** - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lumryz, sodium oxybate (Xyrem AG), Xyrem or Xywav [a]	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab values) documenting a diagnosis of narcolepsy without cataplexy (i.e., Narcolepsy Type 2) with BOTH of the following:

- The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months
- A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset REM periods (SOREMPs) are found on a MSLT performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to the following:

- Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - History of failure, contraindication, or intolerance of ALL of the following:

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 ONE of the following:

- modafinil (generic Provigil)
- armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

• Neurologist • Psychiatrist • Pulmonologist • Sleep Medicine Specialist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Lumryz, sodium oxybate (Xyrem AG), Xyrem or Xywav [a]	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xywav [a]	
Diagnosis	Idiopathic Hypersomnia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g. chart notes, lab values) documenting a diagnosis of idiopathic hypersomnia with BOTH of the following:	

- The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months
- A mean sleep latency of less than 8 minutes and fewer than two REM periods (SOREMPs) are found on a MSLT performed according to standard techniques following a normal overnight polysomnogram, or no SOREMPs if the REM sleep latency on the preceding polysomnogram was less than 15 minutes

AND

2 - Physician attestation to the following:

- Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - History of failure, contraindication, or intolerance of BOTH of the following:

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 ONE of the following:

- modafinil (generic Provigil)
- armodafinil (generic Nuvigil)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Pulmonologist

• Sleep Medicine Specialist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Xywav [a]	
Diagnosis	Idiopathic Hypersomnia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Additional Clinical Rules • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place. **Background**

Lumryz, Xyrem (sodium oxybate) and Xywav are central nervous system depressants indicated for the treatment of excessive daytime sleepiness (EDS) or cataplexy in patients with narcolepsy. Xywav is also indicated for idiopathic hypersomnia (IH) in adults.

Lumryz, Xyrem and Xywav are classified as a Schedule III controlled substance by Federal law. The active ingredient, sodium oxybate or gamma-hydroxybutyrate (GHB), is listed in the most restrictive schedule of the Controlled Substances Act (Schedule I). Thus, non-medical uses are classified under Schedule I.

Lumryz, Xyrem and Xywav are available only through a REMS program with restricted distribution. The REMS Program provides educational materials to the prescriber and the patient explaining the risks and proper use of Lumryz, Xyrem and Xywav, and the required prescription form. Once it is documented that the patient has read and/or understood the materials, the drug will be shipped to the patient. The REMS Program also recommends patient follow-up every 3 months. Physicians are expected to report all serious adverse events to the manufacturer.

4 . References

1. Xyrem [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; April 2023.
2. American Academy of Sleep Medicine. International Classification of Sleep Disorders: Diagnostic and Coding Manual [online]. 3rd ed. Westchester, IL: American Academy of Sleep Medicine; 2014.
3. Morgenthaler TI1, Kapur VK, Brown T, et al. Practice parameters for the treatment of narcolepsy and other hypersomnias of central origin. Sleep. 2007 Dec;30(12):1705-11.
4. Wise MS1, Arand DL, Auger RR, et al. Treatment of narcolepsy and other hypersomnias of central origin. Sleep. 2007 Dec;30(12):1712-27.
5. Xywav [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc; April 2023.
6. Sodium Oxybate [package insert]. Bridgewater, NJ: Amneal Pharmaceuticals NY LLC; April 2023.
7. Sodium Oxybate [package insert]. Berkeley Heights, NJ: Hikma Pharmaceuticals USA Inc.; April 2023.
8. Lumryz [package insert]. Chesterfield, MO: Avadel CNS Pharmaceuticals, LLC; May 2023.

5 . Revision History

Date	Notes

9/13/2024	Updated initial authorizations to 12 months. Updated step to indicate the AG is subject to same clinical criteria. Updated references.

Yupelri

Prior Authorization Guideline

Guideline ID	GL-136228
Guideline Name	Yupelri
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/20/2022 ; 11/18/2022 ; 11/17/2023

1 . Indications

Drug Name: Yupelri
Chronic obstructive pulmonary disease (COPD) Indicated for the long-term maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD).

2 . Criteria

Product Name: Yupelri [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD)

AND

2 - One of the following:

2.1 History of failure, contraindication or intolerance to both of the following:

- Incruse Ellipta (umeclidinium)
- Spiriva Handihaler or Respimat (tiotropium)

OR

2.2 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Incruse Ellipta, Spiriva Respimat) to control his/her COPD due to one of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is <60 L/min)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Yupelri [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Yupelri (revefenacin inhalation solution) is a nebulized long-acting antimuscarinic (anticholinergic) agent indicated for the long-term maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD). **Additional Clinical Rules** 1. Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. 2. Supply limits may be in place.

4 . References

1. Global strategy for the diagnosis, management and prevention of COPD. Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2023.
2. Yupelri [package insert]. Morgantown, WV: Mylan Specialty L.P.; May 2022.
3. Ferguson GT, Goodin T, Tosiello R, et al. Long-term safety of glycopyrrolate/eFlow CS in moderate-to-very severe COPD: results from the glycopyrrolate for obstructive lung disease via electronic nebulizer (GOLDEN) 5 randomized study. Respiratory Medicine 132; 2017:251-60.
4. Wise RA, Acevedo RA, Anzueto AR, et al. Guiding principles for the use of nebulized long-acting beta2-agonists in patients with COPD: An expert panel consensus. Chronic Obstr Pulm Dis 2017; 4(1): 7-20

5 . Revision History

Date	Notes
11/11/2023	Annual review. Updated references.

Zelboraf

Prior Authorization Guideline

Guideline ID	GL-144152
Guideline Name	Zelboraf
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	5/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	03/17/2021 ; 09/15/2021 ; 11/18/2022 ; 03/15/2023 ; 3/20/2024

1 . Indications

Drug Name: Zelboraf (vemurafenib)
Melanoma Indicated for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. [1] **Erdheim-Chester Disease** Indicated for the treatment of patients with Erdheim-Chester Disease with BRAF V600 mutation. **Off Label Uses: Other Uses:** The National Cancer Comprehensive Network (NCCN) guideline recommends use of Zelboraf in combination with Cotellic (cobimetinib) for treatment of central nervous system (CNS) cancer and metastatic or unresectable melanoma with a BRAF V600 mutation (or as a single agent if BRAF/MEK inhibitor combination therapy is contraindicated). Zelboraf is also recommended for the treatment of hairy cell leukemia, non-small cell lung cancer (NSCLC), Langerhans cell histiocytosis (LCH), and follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation. [2]

2 . Criteria

Product Name: Zelboraf [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following diagnoses: • Unresectable melanoma • Metastatic melanoma **AND** **2** - Patient is positive for BRAF V600 mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Melanoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Patient does not show evidence of progressive disease while on Zelboraf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Patient has metastatic brain lesions

AND

1.1.2 Zelboraf is active against primary tumor (melanoma)

OR

1.2 Both of the following:

1.2.1 Diagnosis of Glioma

AND

1.2.2 One of the following:

- Incomplete resection, biopsy, or surgically inaccessible location

• Disease is recurrent for progressive **AND** **2** - Cancer is positive for BRAF V600E mutation **AND** **3** - Used in combination with Cotellic (cobimetinib)	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zelboraf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of hairy cell leukemia	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Hairy Cell Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zelboraf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of non-small cell lung cancer (NSCLC)	

AND

2 - Disease is one of the following:

- Metastatic
- Advanced
- Recurrent

AND

3 - Cancer is positive for BRAF V600E mutation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of one of the following: • Erdheim-Chester Disease • Langerhans Cell Histiocytosis **AND** **2** - Cancer is positive for BRAF V600 mutation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zelboraf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Follicular carcinoma
- Oncocytic carcinoma
- Papillary carcinoma

AND

2 - One of the following

- Unresectable locoregional recurrent disease
- Metastatic disease
- Persistent disease

AND

3 - One of the following

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine

AND

5 - Cancer is positive for BRAF V600 mutation

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zelboraf [a]	
Diagnosis	Thyroid Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zelboraf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Zelboraf [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Zelboraf will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Zelboraf [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Zelboraf therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Clinical Practice Guidelines
The National Cancer Comprehensive Network (NCCN): Zelboraf™ (vemurafenib) is a kinase inhibitor indicated for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. It is also indicated for the treatment of patients with Erdheim-Chester Disease with BRAF V600 mutation. Zelboraf is not recommended for use in patients with wild-type BRAF melanoma.[1] The National Cancer Comprehensive Network (NCCN) guideline recommends use of Zelboraf in combination with Cotellic (cobimetinib) for treatment of central nervous system (CNS) cancer and metastatic or unresectable melanoma with a BRAF V600 mutation (or as a single agent if BRAF/MEK inhibitor combination therapy is contraindicated). Zelboraf is also recommended for the treatment of hairy cell leukemia, non-small cell lung cancer (NSCLC), Langerhans cell histiocytosis (LCH), and follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation. [2]
Benefit/Coverage/Program Information
Background: Information on FDA-approved tests for the detection of BRAF V600 mutations in melanoma may be found at: http://www.fda.gov/CompanionDiagnostics. [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Zelboraf [package insert]. South San Francisco, CA: Genentech, Inc.; May 2020.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium). Available at www.nccn.org. Accessed February 6, 2024.

5 . Revision History

Date	Notes
3/11/2024	Annual review. Updated nomenclature under Thyroid carcinoma from Hurthle cell to oncocytic with no change to clinical intent. Updated re ference.

Zeposia

Prior Authorization Guideline

Guideline ID	GL-145807
Guideline Name	Zeposia
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	6/1/2024
P&T Approval Date:	5/20/2022
P&T Revision Date:	08/19/2022 ; 09/21/2022 ; 01/18/2023 ; 05/25/2023 ; 08/18/2023 ; 4/17/2024

1 . Indications

Drug Name: Zeposia
Multiple Sclerosis (MS) Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. **Ulcerative Colitis (UC)** Indicated for the treatment of moderately to severely active ulcerative colitis (UC) in adults.

2 . Criteria

Product Name: Zeposia [a]	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - History of failure, contraindication, or intolerance to two of the following preferred products or classes (document drug, date, and duration of trial):

- dimethyl fumarate (generic Tecfidera)
- fingolimod (generic Gilenya)
- glatiramer acetate
- interferon beta-1a or beta-1b (e.g., Betaseron, Avonex)

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zeposia [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of moderately to severely active UC

AND

2 - ONE of the following:

2.1 Patient has had prior or concurrent inadequate response to a therapeutic course of oral corticosteroids and/or immunosuppressants (e.g., azathioprine, 6-mercaptopurine)

OR

2.2 Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis as documented by claims history or submission of medical records (Document drug, date, and duration of therapy) [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)]

AND

3 - ONE of the following:

3.1 History of failure, contraindication, or intolerance to TWO of the following preferred products (document drug, date, and duration of trial):

- One of the formulary adalimumab products [b]
- Rinvoq (upadacitinib)
- Simponi (golimumab)
- Stelara (ustekinumab)
- Xeljanz/Xeljanz XR (tofacitinib)

OR

3.2 BOTH of the following:

3.2.1 Patient is currently on Zeposia therapy as documented by claims history or submission of medical records (Document drug, date, and duration of therapy)

AND

3.2.2 Patient has NOT received a manufacturer supplied sample at no cost in the prescriber's office, or any form of assistance from the Bristol Myers Squibb sponsored

Zeposia 360 Support Program (e.g., sample card which can be redeemed at a pharmacy for a free supply of medication) as a means to establish as a current user of Zeposia* **AND** **4** - Patient is not receiving Zeposia in combination with any of the following: • Biologic DMARD [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab)] • Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)] **AND** **5** - Prescribed by or in consultation with a gastroenterologist	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply. *Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from the Bristol Myers Squibb sponsored Zeposia 360 Support Program shall be required to meet initial authorization criteria as if patient were new to therapy. [b] For a list of formulary adalimumab products please reference drug coverage tools.

Product Name: Zeposia [a]	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary
Approval Criteria **1** - Documentation of positive clinical response to Zeposia therapy	

AND **2** - Patient is not receiving Zeposia in combination with any of the following: • Biologic DMARD [e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab)] • Janus kinase inhibitor [e.g., Xeljanz (tofacitinib), Rinvoq (upadacitinib)] • Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Zeposia (ozanimod) is a sphingosine 1-phosphate receptor modulator indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults and moderately to severely active ulcerative colitis (UC) in adults. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class • Supply limits may be in place.

4 . References

1. Zeposia [package insert]. Summit, NJ: Celegene Corporation; August 2023.
2. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. Gastroenterology. 2020; 158(5):1450-61.

5 . Revision History

Date	Notes
4/16/2024	Annual review, updated reference.

Zilbrysq

Prior Authorization Guideline

Guideline ID	GL-138569
Guideline Name	Zilbrysq
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	1/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Zilbrysq
Generalized myasthenia gravis (gMG) Indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are antiacetylcholine receptor (AChR) antibody positive.

2 . Criteria

Product Name: Zilbrysq [a]	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming ALL of the following:

- Diagnosis of generalized myasthenia gravis (gMG)
- Positive serologic test for anti-AChR antibodies
- Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy
- Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 6 at initiation of therapy

AND

2 - ONE of the following:

- History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.)
- Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control

AND

3 - Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo)

AND

4 - Prescribed by, or in consultation with, a neurologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zilbrysq [a]	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory tests) demonstrating ALL of the following:

- Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline [4]
- Reduction in signs and symptoms of myasthenia gravis
- Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Zilbrysq Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Zilbrysq therapy will be considered as treatment failure

AND

2 - Patient is not receiving Zilbrysq in combination with another complement inhibitor (e.g., Soliris, Ultomiris) or a neonatal Fc receptor blocker (e.g., Rystiggo, Vyvgart,Vyvgart Hytrulo)

AND

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background:

Zilbrysq (zilucoplan) is a complement inhibitor indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are antiacetylcholine receptor (AChR) antibody positive. [1]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limit may be in place.

4 . References

1. Zilbrysq [package insert], Smyrna, GA: UCB, Inc.; October 2023.
2. Howard JF Jr, Bresch S, Genge A, et al. Safety and efficacy of zilucoplan in patients with generalised myasthenia gravis (RAISE): a randomised, double-blind, placebo-controlled, phase 3 study. Lancet Neurol. 2023;22(5):395-406. doi:10.1016/S1474-4422(23)00080-7
3. Narayanaswami P, Sanders DB, Wolfe G, et al. International Consensus Guidance for Management of Myasthenia Gravis: 2020 Update. Neurology. 2021;96(3):114-122. doi:10.1212/WNL.0000000000011124
4. Barnett C, Herbelin L, Dimachkie MM, Barohn RJ. Measuring Clinical Treatment Response in Myasthenia Gravis. Neurol Clin. 2018;36(2):339-353. doi:10.1016/j.ncl.2018.01.006

5 . Revision History

Date	Notes
1/16/2024	New program.

Zoryve

Prior Authorization Guideline

Guideline ID	GL-141093
Guideline Name	Zoryve
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	9/21/2022
P&T Revision Date:	02/17/2023 ; 11/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Zoryve cream (roflumilast)
Plaque Psoriasis Indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 6 years of age and older.
Drug Name: Zoryve foam (roflumilast)
Seborrheic Dermatitis Indicated for the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.

2 . Criteria

Product Name: Zoryve cream [a]	
Diagnosis	Plaque Psoriasis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - Minimum duration of a 4-week trial and failure, contraindication, or intolerance to ONE of the following topical therapies [2]:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Coal tar

AND

3 - Patient is not receiving Zoryve cream in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), Humira (adalimumab), Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

4 - Prescribed by, or in consultation with, a dermatologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zoryve cream [a]	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Zoryve cream in combination with any of the following:

- Biologic DMARD [e.g., Cimzia (certolizumab), Humira (adalimumab), Simponi (golimumab), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab)]
- Janus kinase inhibitor [e.g., Olumiant (baricitinib), Rinvoq (upadacitinib), Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zoryve foam [a]	
Diagnosis	Seborrheic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Non Formulary

Approval Criteria

1 - Diagnosis of seborrheic dermatitis

AND

2 - Minimum duration of a 4-week trial and failure, contraindication, or intolerance to at least ONE of the following therapies:

- Topical corticosteroids (e.g., betamethasone, hydrocortisone)
- Topical, shampoo, or systemic antifungals (e.g., ketoconazole, ciclopirox, itraconazole)
- Topical calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Patient is not receiving Zoryve foam in combination with ANY of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zoryve foam [a]	
Diagnosis	Seborrheic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Non Formulary

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is not receiving Zoryve foam in combination with ANY of the following:

- Biologic immunomodulator [e.g., Dupixent (dupilumab), Adbry (tralokinumab-ldrm)]
- Janus kinase inhibitor [e.g., Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib), Opzelura (topical ruxolitinib), Cibinqo (abrocitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Zoryve (roflumilast) cream is a phosphodiesterase 4 inhibitor indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 6 years of age and older. [1] Zoryve (roflumilast) foam is indicated for the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older. **Additional Clinical Rules** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Zoryve cream [package insert]. Westlake Village, CA: Arcutis Biotherapeutics, Inc.; October 2023.
2. Elmets CA, Korman NJ, Farley Prater E, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures. J Am Acad Dermatol 2021;84:432-70.
3. Zoryve foam [package insert]. Westlake Village, CA: Arcutis Biotherapeutics, Inc.; December 2023.

5 . Revision History

Date	Notes
2/5/2024	Added criteria for Zoryve foam for seborrheic dermatitis. Updated ba ckground and reference.

Zurzuvae

Prior Authorization Guideline

Guideline ID	GL-138591
Guideline Name	Zurzuvae
Formulary	• UnitedHealthcare Government Programs Exchange Formulary

Guideline Note:

Effective Date:	3/1/2024
P&T Approval Date:	1/17/2024
P&T Revision Date:	

1 . Indications

Drug Name: Zurzuvae
Postpartum depression Indicated for the treatment of postpartum depression (PPD) in adults.

2 . Criteria

Product Name: Zurzuvae [a]	
Approval Length	1 month(s)
Guideline Type	Non Formulary

Approval Criteria **1** - Diagnosis of postpartum depression (PPD) **AND** **2** - Onset of current depressive episode was during the third trimester or within 4 weeks postpartum	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background: Zurzuvae™ is a neuroactive steroid gamma-aminobutyric acid (GABA) A receptor positive modulator indicated for the treatment of postpartum depression (PPD) in adults. **Additional Clinical Programs:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class. • Supply limits may be in place.

4 . References

1. Zurzuvae [package insert]. Cambridge, MA; Biogen Inc.; November 2023.

5 . Revision History

Date	Notes
1/5/2024	New Program

Zydelig

Prior Authorization Guideline

Guideline ID	GL-147499
Guideline Name	Zydelig
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	10/20/2021
P&T Revision Date:	05/20/2022 ; 09/21/2022 ; 05/25/2023 ; 5/17/2024

1 . Indications

Drug Name: Zydelig (idelalisib)
Chronic lymphocytic leukemia Indicated for relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities.

2 . Criteria

Product Name: Zydelig [a]	
Diagnosis	Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL)

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

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia (CLL) / small lymphocytic lymphoma (SLL)

AND

2 - ONE of the following:

- Disease has relapsed
- Disease is refractory

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zydelig [a]	
Diagnosis	Chronic Lymphocytic Leukemia (CLL) / Small Lymphocytic Lymphoma (SLL
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zydelig [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Zydelig will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zydelig [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Zydelig therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information

Background:

Zydelig (idelalisib) is a kinase inhibitor indicated for the treatment of patients with relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities. [1,2] The National Cancer Comprehensive Network (NCCN) also recommends the use of Zydelig as second-line and subsequent therapy as a single agent or in combination with rituximab for CLL/SLL with del(17p)/TP53 mutation in patients who have indications for treatment.[2]

Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4 . References

1. Zydelig [package insert]. Foster City, CA: Gilead Science, Inc.; February 2022.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed April 8, 2024.

5 . Revision History

Date	Notes
5/17/2024	Annual review. Updated references.

Zykadia

Prior Authorization Guideline

Guideline ID	GL-141094
Guideline Name	Zykadia
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 06/16/2021 ; 02/18/2022 ; 09/21/2022 ; 02/17/2023 ; 2/16/2024

1 . Indications

Drug Name: Zykadia (ceritinib)
Anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) Indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. **Other Uses:** The National Cancer Comprehensive Network (NCCN) also recommends Zykadia as first-line therapy for ALK-positive or ROS proto-oncogene 1 (ROS1)-positive recurrent, advanced or metastatic NSCLC, for the treatment of inflammatory myofibroblastic tumor (IMT) with ALK translocation, in treatment of ALK-positive brain metastases from NSCLC, and in the treatment of ALK-positive Erdheim-Chester Disease, advanced, recurrent, metastatic, or inoperable inflammatory myofibroblastic tumor (IMT) with positive ALK translocation, and ALK-positive relapsed or refractory anaplastic large cell lymphoma as palliative intent therapy or second-line and subsequent therapy.

2 . Criteria

Product Name: Zykadia [a]	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - One of the following:

- Disease is metastatic
- Disease is recurrent
- Disease is advanced

AND

3 - One of the following

- Tumor is ALK-positive
- Tumor is ROS1-positive

Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]

Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zykadia therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of inflammatory myofibroblastic tumor (IMT) with ALK translocation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zykadia therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of metastatic brain cancer from NSCLC **AND** **2** - Tumor is anaplastic lymphoma kinase (ALK)-positive	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zykadia therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Erdheim-Chester Disease **AND** **2** - Disease is positive for ALK rearrangement	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zykadia therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of advanced, recurrent, metastatic, or inoperable inflammatory myofibroblastic tumor (IMT) **AND** **2** - Disease is positive for ALK translocation	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zykadia therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Zykadia [a]	
Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of anaplastic large cell lymphoma **AND** **2** - Tumor is anaplastic lymphoma kinase (ALK)-positive **AND** **3** - Disease is relapsed or refractory **AND** **4** - Used as palliative intent therapy or second-line and subsequent therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverag

	e criteria. Other policies and utilization management programs may ap ply.

Product Name: Zykadia [a]	
Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zykadia therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Zykadia [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Zykadia will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements an d the member specific benefit plan coverage may also impact coverag e criteria. Other policies and utilization management programs may ap ply.

Product Name: Zykadia [a]	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Zykadia Therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Zykadia® (ceritinib) is a kinase inhibitor indicated for the treatment of patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. The National Cancer Comprehensive Network (NCCN) also recommends Zykadia as first-line therapy for ALK-positive or ROS proto-oncogene 1 (ROS1)-positive recurrent, advanced or metastatic NSCLC, for the treatment of inflammatory myofibroblastic tumor (IMT) with ALK translocation, in treatment of ALK-positive brain metastases from NSCLC, in the treatment of ALK-positive Erdheim-Chester Disease, advanced, recurrent, metastatic, or inoperable inflammatory myofibroblastic tumor (IMT) with positive ALK translocation, and ALK-positive relapsed or refractory anaplastic large cell lymphoma as palliative intent therapy or second-line and subsequent therapy. **Additional Clinical Rules:** • Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

4 . References

1. Zykadia [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2021.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at www.nccn.org. Accessed December 27, 2023.

5 . Revision History

Date	Notes
2/5/2024	Annual review. Updated background and coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Updated reference.

Zytiga

Prior Authorization Guideline

Guideline ID	GL-147390
Guideline Name	Zytiga
Formulary	• UnitedHealthcare Government Programs Exchange Formulary SP

Guideline Note:

Effective Date:	7/1/2024
P&T Approval Date:	8/14/2020
P&T Revision Date:	02/19/2021 ; 05/21/2021 ; 09/15/2021 ; 05/20/2022 ; 09/21/2022 ; 05/25/2023 ; 5/17/2024

1 . Indications

Drug Name: Zytiga (abiraterone acetate)
Prostate cancer Indicated for use in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer and for high-risk metastatic castration-sensitive prostate cancer.

2 . Criteria

Product Name: Brand Zytiga, generic abiraterone [a]	
Diagnosis	Prostate cancer

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

Approval Criteria

1 - Diagnosis of prostate cancer

AND

2 - ONE of the following

2.1 Disease is metastatic

OR

2.2 Disease is regional node positive (Any T, N1, M0)

OR

2.3 Patient is in a very-high-risk group receiving external beam radiation therapy (EBRT)

OR

2.4 Positive pelvic persistence/recurrence after prostatectomy

AND

3 - Used in combination with prednisone or dexamethasone

AND

4 - ONE of the following:

4.1 Used in combination with a gonadotropin-releasing hormone (GnRH) analog [e.g. Lupron (leuprolide), Zoladex (goserelin), Trelstar (triptorelin), Vantas (histrelin), Firmagon (degarelix)] **OR** **4.2** Patient has had bilateral orchiectomy
Notes: [a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Zytiga, generic abiraterone [a]	
Diagnosis	Prostate cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zytiga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Zytiga, generic abiraterone [a]	
Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of salivary gland tumor **AND** **2** - Used in combination with prednisone **AND** **3** - Androgen receptor positive recurrent disease
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Zytiga, generic abiraterone [a]	
Diagnosis	Salivary Gland Tumors
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on Zytiga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Zytiga, generic abiraterone [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Zytiga will be approved for uses not outlined above if supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

Product Name: Brand Zytiga, generic abiraterone [a]	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Zytiga therapy	
Notes	[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3 . Background

Benefit/Coverage/Program Information
Background Zytiga is a CPY17 inhibitor indicated for use in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer and for high-risk metastatic castration-sensitive prostate cancer. Patients should also receive a gonadotropin-releasing hormone (GnRH) analog concurrently while taking Zytiga or should have had bilateral orchiectomy. [1] The National Comprehensive Cancer Network (NCCN) also

recommends the use of Zytiga in combination with prednisone and androgen deprivation therapy as initial therapy for patients without metastases yet with regional node positive disease in combination with androgen deprivation therapy (ADT) and external bean radiation therapy (EBRT) as initial therapy in patients with very-high-risk, node negative prostate cancer, and in combination with prednisone and ADT in patients with positive pelvic persistence/recurrence after prostatectomy. [2] The NCCN also recommends the use of Zytiga in salivary gland tumors useful in certain circumstances as single-agent systemic therapy (used in combination with prednisone) for androgen receptor positive recurrent disease.

Additional Clinical Rules

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
  Supply limits may be in place.

4 . References

1. Zytiga [package insert]. Horsham, PA: Janssen Biotech Inc.; August 2021.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed March 28, 2024.

5 . Revision History

Date	Notes
5/14/2024	Annual review. Added criteria for salivary gland tumor per NCCN. Up dated reference.