North Dakota Medicaid
Drug Utilization Review Board
Meeting
March 3, 2021
Via Teleconference

North Dakota Medicaid
DUR Board Meeting Agenda

Click here to join the meeting

(Click on link)
Join by phone: 1 701-328-0950, Conference ID 786 389 645#
March 3, 2021
1:00 pm

1. Administrative items
    - DHS announcements

2. Old business
    - Review and approval of January 2021 meeting minutes
    - Budget update
    - Review top 25 drugs for Fourth quarter of 2020
    - Prior authorization/PDL update
    - Second review of Evrysdi (risdiplam)
    - Update to criteria for hereditary angioedema
    - Update to criteria irritable bowel syndrome

3. New business
    - Review of Enspryng (satralizumab-mwge)
    - Review of agents for the management of Sickle Cell disease
    - Review of agents for the treatment of Fabry disease
    - Review of Imcivree (setmelonotide)
    - Review of utilization data for select medication classes
    - Retrospective DUR criteria recommendations
    - Upcoming meeting date/agenda.
        - Next meeting is June 2, 2021
4. Adjourn

Please remember to silence all cellular phones during the meeting.

North Dakota Medicaid Drug Use Review (DUR) Board
Meeting Minutes
January 6, 2021

Members Present: Amy Werremeyer, Andrea Honeyman, Gabriela Balf, Joshua Askvig, Laura Schield, Mary Aaland, Michael Booth, Michael Quast, Tanya Schmidt

Medicaid Pharmacy Department: Alexi Murphy, Brendan Joyce, LeNeika Roerich

Announcements

Chair A. Honeyman called the meeting to order at 1:04 p.m. The Board was notified of the open Vice-Chair position on the Board and opened the floor for nominations. A. Honeyman nominated T. Schmidt and M. Booth seconded the nomination. T. Schmidt consented to accept the nomination. No other nominations were made. The chair called for a voice vote on the position and T. Schmidt was elected unanimously by all present Board members.

Old Business

Chair A. Honeyman asked for a motion to approve the minutes of the September 2020 meeting. T. Schmidt moved that the minutes be approved, and JA seconded the motion. The chair called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 25 Drugs

B. Joyce presented budget updates and the quarterly review of the top 25 drugs based on total cost od claims, as well as the top 25 drugs based on the total number of claims for the 3rd quarter of 2020.

PDL/PA Criteria Updates

A. Murphy shared with the Board all of changes made to the Preferred Drug List since the last version of the Preferred Drug List was posted. Notable changes included Byetta, Cosentyx, amd Repatha being added to the list of medications requiring prior authorization; removing prior authorization requirements for Toujeo Max Solostar 300 unit/mL and Tresiba 200 unit/mL when used at a dose between 100 and 200 units per day; and the removal of prior authorization requirements for coverage of Xeljanz. All PDL updates are listed in the handouts for the September 2020 DUR Board meeting. When a new version of the PDL is published and posted to the website, all updates/changes made since the last version are called out at the top of the document itself.

Second Review of Agents for the Treatment of Diabetic Gastroparesis

A motion and second was made at the September 2020 DUR Board meeting to place agents for the treatment of diabetic gastroparesis on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. There were no public comments. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Second Review of Ohriahnn (elagolix/estradiol/norethindrone)
A motion and second was made at the September 2020 DUR Board meeting to place Ohriahnn on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. J. Gianninoto from Abbvie presented information on Ohriahnn and Orilissa to the Board. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Second Review of Dojolvi (triheptanoin)
A motion and second was made at the September 2020 DUR Board meeting to place Dojolvi on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. T. Arnhart provided testimony on Dojolvi and made himself available to the Board for questions during public comments. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Update to Criteria for Nucala (mepolizumab) for Hypereosinophilic Syndrome & EGPA
T. DeRuiter presented proposed updates to the prior authorization criteria for Nucala to include criteria for diagnoses of hypereosinophilic syndrome and eosinophilic granulomatosis with polyangiitis (EGPA). There was no public comment. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Annual Review of Prior Authorization Forms and Criteria
The Board reviewed all forms and criteria utilized for all medications that are currently placed on prior authorization. Notable updates to the criteria were highlighted by A. Murphy, including the listing of non-solid dosage formulation criteria; changes to prior authorization requirements for select insulin products; updates to criteria for agents used for the treatment of hepatitis C; changes to prior authorization criteria for Eucrisa; changes in preferred and non-preferred agents for the treatment of eosinophilic asthma; and updates to prior authorization criteria for agents used in the treatment of Parkinson's. A motion was made by M. Quast to approve the reviewed forms and criteria, which was seconded by A. Werremeyer. Chair A. Honeyman then called for a voice vote for approval of the reviewed forms and criteria, which passed with no audible dissent.

New Business
Review of Evrysdi (risdiplam)
T. DeRuiter presented a review of Evrysdi (risdiplam) for the treatment of spinal muscular atrophy (SMA) to the Board. There was no public comment. A motion was made by A. Werremeyer to manage these medications through prior authorization. The motion was seconded by J. Askvig. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Retrospective Drug Utilization Review (RDUR) Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. M. Booth moved to approve the new criteria and T. Schmidt seconded the motion. The motion passed with no audible dissent.

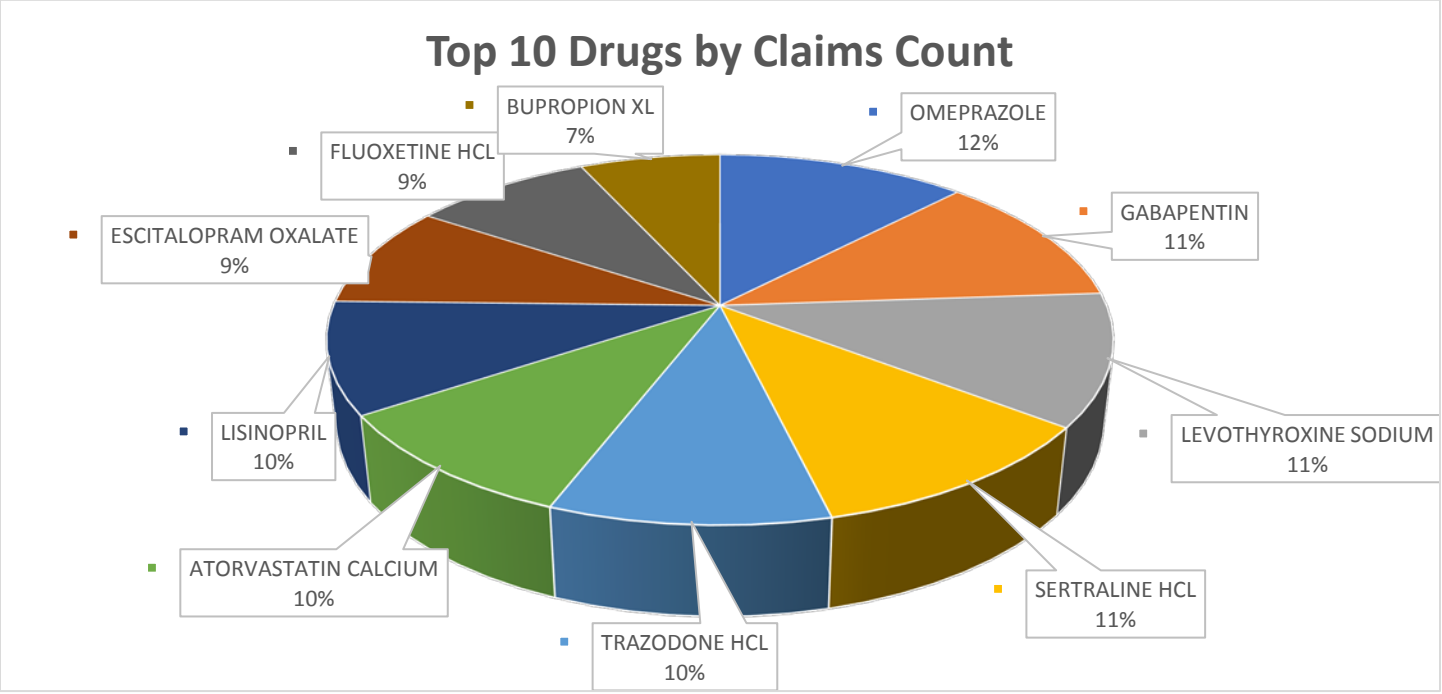
Adjournment and Upcoming Meeting Date

Chair A. Honeyman adjourned the meeting at 2:45 pm. The next DUR Board meeting will be held March 3, 2021 at 1:00 pm and will be held via teleconference.

Top 25 Drugs Based on Number of Claims from 10/01/2020 – 12/31/2020

Drug	Claims	Patients	Claims Cost	Cost Per Claim	% Total Claims
OMEPRAZOLE	5,060	2,278	$65,756.11	$13.00	2.14%
GABAPENTIN	4,819	1,843	$74,891.75	$15.54	2.04%
LEVOTHYROXINE SODIUM	4,748	1,751	$87,318.07	$18.39	2.01%
SERTRALINE HCL	4,461	2,254	$60,719.44	$13.61	1.89%
TRAZODONE HCL	4,024	1,826	$55,904.94	$13.89	1.70%
ATORVASTATIN CALCIUM	4,021	1,906	$57,584.64	$14.32	1.70%
LISINOPRIL	4,017	1,939	$50,783.31	$12.64	1.70%
ESCITALOPRAM OXALATE	3,691	1,870	$49,844.04	$13.50	1.56%
FLUOXETINE HCL	3,641	1,755	$49,777.05	$13.67	1.54%
BUPROPION XL	2,847	1,254	$49,393.07	$17.35	1.21%
HYDROCODONE-ACETAMINOPHEN	2,831	1,735	$44,792.64	$15.82	1.20%
METFORMIN HCL	2,812	1,337	$35,577.72	$12.65	1.19%
DULOXETINE HCL	2,798	1,167	$45,934.24	$16.42	1.19%
MONTELUKAST SODIUM	2,710	1,299	$39,017.15	$14.40	1.15%
PANTOPRAZOLE SODIUM	2,653	1,198	$37,099.67	$13.98	1.12%
VYVANSE	2,519	958	$618,206.03	$245.42	1.07%
LAMOTRIGINE	2,387	855	$33,226.32	$13.92	1.01%
PROAIR HFA	2,383	2,342	$169,883.83	$71.29	1.01%
BUPRENORPHINE-NALOXONE	2,383	487	$103,780.15	$43.55	1.01%
AMLODIPINE BESYLATE	2,341	1,175	$29,981.04	$12.81	0.99%
CLONIDINE HCL	2,316	1,002	$29,494.65	$12.74	0.98%
CYCLOBENZAPRINE HCL	2,310	1,311	$26,259.71	$11.37	0.98%
VENLAFAXINE HCL ER	2,275	892	$38,326.93	$16.85	0.96%
QUETIAPINE FUMARATE	2,241	837	$31,835.29	$14.21	0.95%
ARIPIPRAZOLE	2,237	968	$34,723.78	$15.52	0.95%

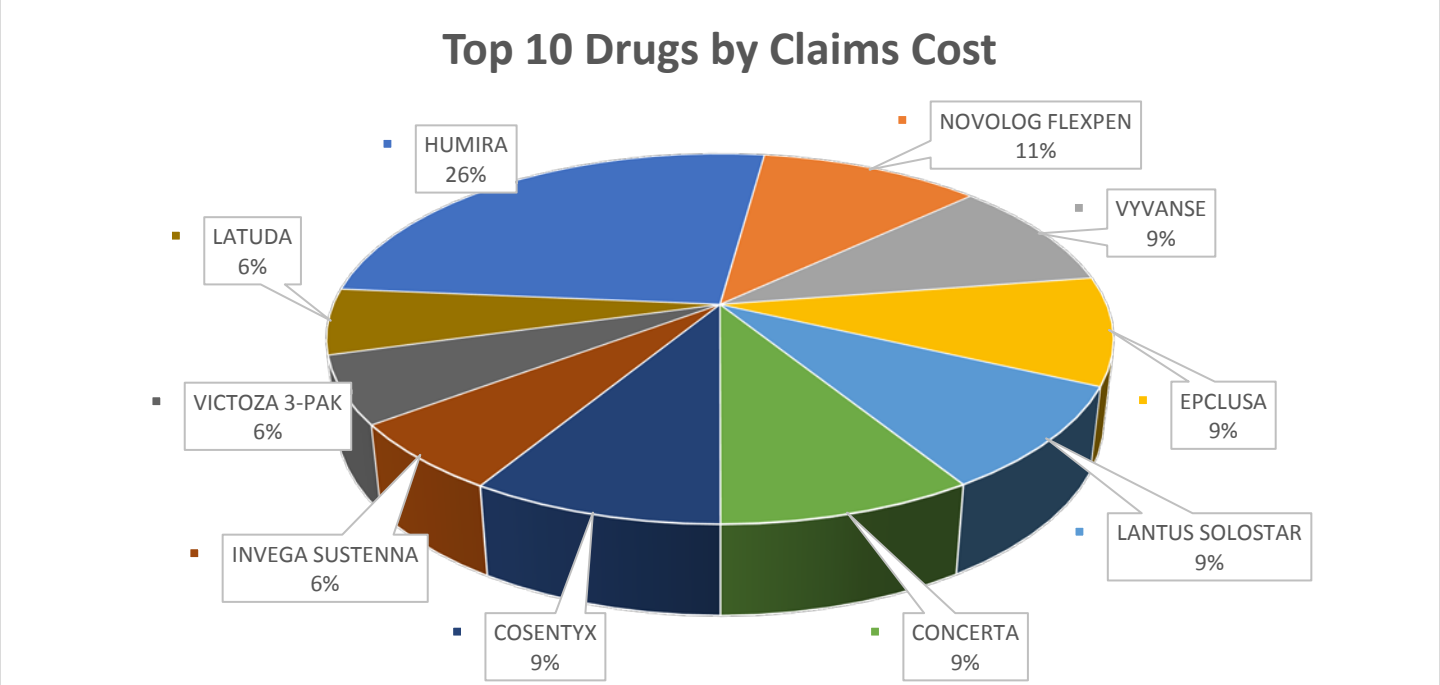
Total Claims From 10/01/2020 – 12/31/2020	**236,077**



Top 25 Drugs Based on Total Claims Cost from 10/01/2020 – 12/31/2020

Drug	Claims Cost	Claims	Patients	Cost Per Claim	% Total Cost
HUMIRA	$1,670,402.52	253	104	$6,602.38	6.85%
NOVOLOG FLEXPEN	$703,037.23	997	534	$1,316.55	2.88%
VYVANSE	$618,206.03	2,519	958	$645.31	2.54%
EPCLUSA	$608,645.00	25	12	$50,720.42	2.50%
LANTUS SOLOSTAR	$592,105.33	1,247	698	$848.29	2.43%
CONCERTA	$574,886.37	1,720	668	$860.61	2.36%
COSENTYX	$566,452.09	89	36	$6,364.63	2.32%
INVEGA SUSTENNA	$391,205.43	170	66	$5,927.36	1.61%
VICTOZA 3-PAK	$381,451.37	428	193	$1,976.43	1.57%
LATUDA	$371,350.46	475	195	$1,904.36	1.52%
JARDIANCE	$359,984.36	786	319	$1,128.48	1.48%
NORDITROPIN FLEXPRO	$357,004.40	90	37	$9,648.77	1.46%
ADVAIR DISKUS	$320,421.95	888	451	$710.47	1.31%
SYMBICORT	$312,687.04	940	506	$617.96	1.28%
STELARA	$301,334.64	14	11	$27,394.06	1.24%
LEVEMIR FLEXTOUCH	$292,777.35	544	287	$1,020.13	1.20%
TRIKAFTA	$286,903.08	12	4	$71,725.77	1.18%
ADDERALL XR	$250,368.93	1,450	604	$414.52	1.03%
SABRIL	$249,867.37	16	5	$49,973.47	1.03%
ENBREL SURECLICK	$233,521.39	43	19	$12,290.60	0.96%
ABILIFY MAINTENA	$223,611.47	108	39	$5,733.63	0.92%
STRATTERA	$223,116.56	554	264	$845.14	0.92%
ELIQUIS	$222,369.07	526	223	$997.17	0.91%
XIFAXAN	$220,291.73	98	47	$4,687.06	0.90%
BIKTARVY	$214,896.63	124	51	$4,213.66	0.88%

Total Claims Cost From 10/01/2020 – 12/31/2020	**$24,371,408.66**



Top 15 Therapeutic Classes Based on Number of Claims from 10/01/2020 – 12/31/2020

Therapeutic Class Description	Claims	Patients	Claims Cost	Cost/Claim	% Total Claims
ANTIDEPRESSANTS	30,384	10,903	$617,035.20	$20.31	12.87%
ANTICONVULSANTS, MISC	13,957	4,475	$974,027.28	$69.79	5.91%
ANTIPSYCHOTIC AGENTS	9,524	3,174	$1,709,155.53	$179.46	4.03%
PROTON-PUMP INHIBITORS	8,194	3,624	$149,092.29	$18.20	3.47%
OPIATE AGONISTS	7,384	3,552	$150,188.78	$20.34	3.13%
NSAIDS	6,883	3,937	$101,390.29	$14.73	2.92%
STATINS	6,643	3,116	$95,428.51	$14.37	2.81%
SEDATIVE/HYPNOTICS	6,556	3,033	$102,835.04	$15.69	2.78%
BETA BLOCKERS	5,922	2,696	$110,041.66	$18.58	2.51%
AMPHETAMINES	5,140	2,005	$912,402.16	$177.51	2.18%
ACE INHIBITORS	5,074	2,462	$70,886.74	$13.97	2.15%
THYROID AGENTS	5,057	1,824	$98,087.13	$19.40	2.14%
NON-AMPHETAMINE STIMULANTS	4,547	1,585	$839,620.59	$184.65	1.93%
BIGUANIDES	4,164	1,992	$55,144.61	$13.24	1.76%
INSULINS	3,723	1,281	$2,065,082.67	$554.68	1.58%

Top 15 Therapeutic Classes Based on Claims Cost from 10/01/2020 – 12/31/2020

Therapeutic Class Description	Claims Cost	Claims	Patients	Cost/Claim	% Total Cost
DMARDS	$2,314,008.68	452	175	$13,222.91	9.49%
INSULINS	$2,065,082.67	3,723	1,281	$1,612.09	8.47%
ANTIPSYCHOTIC AGENTS	$1,709,155.53	9,524	3,174	$538.49	7.01%
SKIN & MUCOUS MEMBRANE AGENTS, MISC	$1,147,460.24	517	307	$3,737.66	4.71%
INHALED CORTICOSTEROIDS	$979,665.50	3,438	1,892	$517.79	4.02%
ANTICONVULSANTS, MISC	$974,027.28	13,957	4,475	$217.66	4.00%
AMPHETAMINES	$912,402.16	5,140	2,005	$455.06	3.74%
NON-AMPHETAMINE STIMULANTS	$839,620.59	4,547	1,585	$529.73	3.45%
HCV ANTIVIRALS	$810,441.60	44	26	$31,170.83	3.33%
ANTINEOPLASTIC AGENTS	$809,794.57	531	207	$3,912.05	3.32%
ANTIRETROVIRALS	$764,897.45	599	204	$3,749.50	3.14%
INCRETIN MIMETICS	$737,535.81	1,030	446	$1,653.67	3.03%
ANTIDEPRESSANTS	$617,035.20	30,384	10,903	$56.59	2.53%
IMMUNOMODULATORY AGENTS MISC	$531,715.84	74	25	$21,268.63	2.18%
SGLT2 INHIBITORS	$462,845.35	1,015	416	$1,112.61	1.90%

PDL Update

ADDED TO PA	
Drug	**Class**
cycloserine	Antibiotic Resistance
Sirturo (bedaquline)	Antibiotic Resistance
Solosec (secnidazole)	Vaginal Anti-Infectives
ZOKINVY	3000
Impeklo	topical steroids
Qdolo	short acting opioids
Sutab	Bowel Prep agents
Eysuvis	ophthalmic anti-inflammatories
Oxlumo	3000
Sevenfact	Hemophilia
Orladeyo	HAE
Kesimpta	Multiple Sclerosis
Imcivree	3000
Alkindi Sprinkle	Oral Steroids
Semglee	Insulin
Armonair Digihaler	inhaled steroid
Xywav	narcolepsy
Bafiertam	Multiple Sclerosis
Breztri Aerosphere	COPD
Mycapssa	3000
AirDuo Digihaler	Steroid/LABA
Ortikos	Oral Steroids

REMOVED FROM PA	
Drug	**Class**
Sunosi	Narcolepsy

Evrysdi

General Prior Authorization Form

- **Initial Criteria:** *Approval Duration = 12 months*
  - The patient must have a diagnosis of spinal muscular atrophy (SMA), confirmed by genetic testing showing bi-allelic deletions or mutations in the SMN1 gene
  - The medication must be prescribed by or in consultation with a neurologist
  - The patient must be 2 years of age or older
  - The patient must not require invasive ventilation or tracheostomy
  - The patient must not be receiving/have received treatment a SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier or gene therapy
  - The patient's weight and prescribed dose must be provided and within dosing recommendations per the manufacturer label
  - **For SMA Type 1**
    - The patient must have experienced signs or symptoms of SMA prior to the age of 3 months
    - The patient must have at least two survival motor neuron 2 (SMN2) gene copies, as confirmed by genetic testing
  - **For SMA Type 2 or 3:**
    - The provider must submit documentation of the patient's current motor function, as evidenced by scores from at least one of the following assessments (A and/or B):
      A. Motor Function Measure 32 (MFM32)
      B. Revised Upper Limb Module (RULM)

- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient must not require invasive ventilation or tracheostomy
  - The patient's weight and prescribed dose must be provided and within dosing recommendations per the manufacturer label
  - **For SMA Type 1**
    - The patient must have experienced and/or maintained clinical benefit since starting treatment with Evrysdi, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)
  - **For SMA Type 2 or 3:**
    - The provider must submit documentation showing that the patient has experienced clinical benefit since starting treatment with Evrysdi, as evidenced by documentation of current MFM23 and/or RULM scores showing improvement or maintenance of baseline motor function.

PA REQUIRED
EVRYSDI (Risdiplam)

health information designs

Evrysdi
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Evrysdi must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

- Please complete this form in its entirety and provide any and all required documentation (if available)

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this request:** □ SMA Type 1 □ SMA Type 2 □ SMA Type 3
Patient Weight	**Requested Dose**

Does the patient require invasive ventilation or tracheostomy?	□ YES □ NO
Has the patient previously received treatment a SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier or gene therapy?	□ YES □ NO
SMA Type 1 ONLY: • Did the patient signs or symptoms of SMA prior to 3 months of age? • Does the patient have at least 2 (SMN2) gene copies, as confirmed by testing?	□ YES □ NO □ YES □ NO
SMA Type 2 or 3 ONLY: • Has the provider attached documentation of the patient's current motor function, as evaluated by MFM32 and/or RULM scores?	□ YES □ NO

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hereditary Angioedema

General Prior Authorization Form

Group Criteria: *Approval Duration = 12 months*

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The medication must be prescribed by or in consultation with an allergist, immunologist, or rheumatologist

Non-Preferred Agents Criteria:

- The request must meet the group criteria
- The patient must have a contraindication to or failed a trial of all preferred agents with the same indication for use (prophylaxis or acute treatment), as evidenced by paid claims or pharmacy print-outs
    - Required trial durations
        - Agents for acute attacks: a single trial
        - Agents for attack prophylaxis: 3 months

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BERINERT (C1 Esterase Inhibitor)	FIRAZYR (icatibant)
CINRYZE (C1 Esterase Inhibitor)	KALBITOR (ecallantide)
HAEGARDA (C1 Esterase Inhibitor)	RUCONEST (C1 Esterase Inhibitor)
icatibant	
ORLADEYO (berotrlastat)	
TAKHZYRO (lanadelumab-FLYO)	

Irritable Bowel Syndrome - Diarrhea

General Prior Authorization Form

Group Criteria:

- **Non-Preferred Agents Criteria:**
    - Initial Criteria: Approval Duration = 3 months
        - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis, age, and duration of treatment).
        - The provider must submit medication documentation confirming that infectious and medication-induced etiologies of diarrhea have been ruled out
        - The patient must have had a 30-day trial of each preferred unique active ingredient, as evidenced by paid claims or pharmacy printouts.
    - Product Specific Criteria:
        - ***__alosetron__: The patient must be a female.
        - *** **dicyclomine** Oral Syrup: The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation
    - Renewal Criteria: Approval Duration = 12 months
        - The patient must have experienced and maintained clinical benefit since starting treatment with requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
dicyclomine Capsule	alosetron***
dicyclomine Tablet	dicyclomine oral syrup***
diphenoxylate/atropine	LOMOTIL (diphenoxylate/atropine)
loperamide	VIBERZI (eluxadoline)
LOTRONEX (alosetron)*** - Brand Preferred	XIFAXAN (rifaximin) 550 mg tablet

health information designs

General
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred medications to meet specific diagnosis and step-therapy requirements. Criteria for agents requiring prior authorization can be found the following location:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**

Additional Qualifications for Coverage (e.g. medical justification explaining inability to meet required trials)

□ Patient is pregnant: Due Date _____
□ Patient has inability to take or tolerate solid oral dosage forms (please attach swallow study)
□ Patient has feeding tube in place: (please state specific type of feeding tube _____)
□ Other: (please fill out below)

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

REVIEW OF ENSPRYNG (satralizumab-mwge))

Indication: Treatment of neuromyelitis optica spectrum disorder in adults who are anti-aquaporin-4 (AQP4) antibody positive.

- **Neuromyelitis Optica Spectrum Disorders (NMOSD):**
  - inflammatory disorders of the central nervous system characterized by severe, immune-mediated demyelination and axonal damage predominantly targeting optic nerves and spinal cord.
  - Stepwise deterioration due recurrent attacks and accumulated disability
    - Acute attacks of bilateral or rapidly sequential optic neuritis (leading to severe visual loss) or transverse myelitis (often causing limb weakness, sensory loss, and bladder dysfunction)
      - Typically, relapsing course with attacks most often occuring over days, with variable degrees of recovery over weeks to months
  - Treatment:
    - Acute treatment for attacks: IV steroids and/or plasma exchange
    - Attack prevention: long-term immunotherapy.
      - Soliris (eculizumab) - IV
      - Uplizna (Inebilizumab) - IV
      - Enspryng (Satralizumab)

Mechanism of action: Antagonist of the interleukin-6 (IL-6) receptor, presumed to be via binding to soluble and membrane-bound IL-6 receptors

Clinical Trial Experience

- **Study 1**
  - **Patient demographics:**
    - EDSS Score of 0-6.5
    - Clinical evidence of relapse in the previous 12 months
    - Anti-AQP4 antibody positive and anti-AQP4 antibody negative patients
    - No recent other immunosuppressive therapy
  - **Results:**
    - The time to the first confirmed relapse was significantly increased in the treatment group vs placebo
      - 74% relapse risk reduction in anti-AQP4 antibody positive patients, no benefit in anti-AQP4 antibody negative patients
    - Sit without support for 5 seconds at 12 months
      - 41% able to sit independently (vs 0% expected)
    - Survival without permanent ventilation
      - 90% at 12 months (>15 months old)
      - 81% at 23 months (>28 months old)
      - In the normal population, 25% survive w/o ventilation beyond 14 months
- **Study 2**
  - **Patient demographics:**
    - EDSS Score of 0-6.5
    - Clinical evidence of at least 2 relapses in the previous 24 months, at least 1 of which occurred in past 12 months
    - Anti-AQP4 antibody positive and anti-AQP4 antibody negative patients
    - All patients receiving either oral steroids, mycophenolate, or azathioprine concurrently
  - **Results (at 12 months):**
    - The time to the first confirmed relapse was significantly increased in the treatment group vs placebo
      - 78% relapse risk reduction in anti-AQP4 antibody positive patients, no benefit in anti-AQP4 antibody negative patients

Contraindications:

- Hypersensitivity to satralizumab or any component of the formulation
- Active hepatitis B infection
- Active or untreated latent tuberculosis

Administration and Dosing:

- Adults:
  - **Loading Dose:** 120 mg subcutaneously once every 2 weeks for 3 doses (weeks 0, 2, and 4)
    - **If dose missed:** 120 mg subcutaneously as soon as possible (do not wait until next dose)
  - **Maintenance Dose:** 120 mg subcutaneously every 4 weeks
    - **If dose missed:**
      - <8 weeks since last dose: 120 mg subcutaneously as soon as possible, Reset dose schedule to every 4 weeks after missed dose administered
      - 8 to <12 weeks since last dose: 120 mg subcutaneously every 2 weeks for 2 doses (weeks 0 and 2), followed by 120 mg every 4 weeks.
      - ≥12 weeks since last dose: Re-do loading dose
  - **Dosage adjustment for toxicity causing neutropenia:** Interrupt therapy until neutrophil count >1,000/mm3
  - **Renal Impairment:**Has not been studied in patients with renal impairment
  - **Hepatic Impairment:**
    - ALT/AST >5 × ULN and any bilirubin elevation
      - Discontinue therapy. Reinitiation not recommended
    - ALT/AST >5 × ULN and not associated with bilirubin elevation
      - Interrupt therapy until ALT/AST return to normal range, then restart treatment

Warnings/Precautions:

- **Infection:** An increased risk of infection (sometimes serious or potentially fatal) has been observed with interleukin-6 (IL-6) receptor antagonist treatments. Enspryng is associated with an increased risk for cellulitis, nasopharyngitis, upper respiratory tract infections, and pharyngitis.
- **Hepatitis B reactivation:** Hepatitis B reactivation has occurred with immunosuppressant therapies
- **Tuberculosis:** Has occurred in patients treated with other IL-6 receptor antagonists. Evaluate for active/latent TB prior to initiating therapy. Do not administer to patients with an active TB infection or positive screening without history of appropriate treatment.
- **Immunizations:** Immunization with live-attenuated or live vaccines is not recommended during therapy.
- **Elevated liver enzymes:** Mild to moderate elevations in liver enzymes have occurred; monitor ALT/AST
- **Hematologic effects:** Decreased neutrophil counts and neutropenia may occur; monitor neutrophil counts

Adverse Effects

- **Common (>10%)**
  - **Dermatologic:** Skin rash
  - **Endocrine & metabolic:** Decreased serum fibrinogen, increased serum cholesterol, increased serum triglycerides, weight gain
  - **Gastrointestinal:** Nausea
  - **Hematologic & oncologic:** Decreased platelet count, disorder of hemostatic components of blood (reduction in C3 and C4 complement levels)
  - **Hepatic:** Increased serum alanine aminotransferase, increased serum aspartate aminotransferase
  - **Immunologic:** Antibody development
  - **Nervous system:** Fatigue
  - **Neuromuscular & skeletal:** Arthralgia, limb pain
  - **Respiratory:** Nasopharyngitis
- **Less Common (1-10%)**
  - **Dermatologic:** Cellulitis, pruritus
  - **Gastrointestinal:** Diarrhea
  - **Hematologic & oncologic:** Neutropenia
  - **Local:** Injection site reaction (including residual mass at injection site)
  - **Nervous system:** Depression, falling

Drug interactions

- No formal drug-drug interaction studies have been performed with Enspryng

Cost

Drug	Strength	Package Size	WAC Pkg Price	WAC Price Per Dose	Cost Per Loading Dose	Cost Per Year on Maintenance Dose
Enspryng	120 mg/1 mL	1 mL	$14,615.39	$14,615.39	$43,846.17	$190,000.07

CURRENT UTILIZATION

ND Medicaid Utilization (12/2019 – 12/2020)		
Label Name	**Rx Num**	**Total Reimb Amt**
Enspryng	0	-

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on February 11. 2021.
2. UpToDate. Available at https://www.uptodate.com/contents/search. Accessed on February 11. 2021.
3. Enspryng (satralizumab) [prescribing information]. South San Francisco, CA: Genentech Inc; August 2020.

REVIEW OF AGENTS FOR THE TREATMENT OF SICKLE CELL DISEASE

Sickle Cell Disease

- Sickle cell disease is a group of disorders affecting hemoglobin, which distorts red blood cells (RBCs) into a sickle, or crescent, shape
- **Clinical Presentation**
    - Vaso-occlusive phenomena and hemolysis are the clinical hallmarks of sickle cell disease (SCD)
        - Vaso-occlusion results in recurrent painful episodes and a variety of serious organ system complications that can lead to life-long disabilities and even death
            - Stroke
            - Renal infarction
            - Bone infarction
            - Myocardial infarction
            - Priapism
            - Venous thromboembolism
        - Hemolysis of RBCs causes chronic anemia and pigment gallstones
- Treatment/Management
    - There are multiple components to the management of SCD, including the prevention and treatment of the complications of SCD, as well as the potential cure for this illness:
        - Prevention and treatment of complications:
            - Infection prevention
            - Reduce vaso-occlusive events
                - Disease-modifying agents
                    - Hydroxyurea (Siklos, Droxia) – administered PO
                    - Voxelotor (Oxbryta) – administered PO
                    - Crizanlizumab (Adakveo) – administered IV
                - Blood transfusions
        - Cure: only through hematopoietic stem cell transplantation.

Hydroxyurea (Droxia and Siklos) and voxelotor Oxbryta

Indications

Hydroxyurea (Droxia and Siklos)	**Oxbryta**
Management of sickle cell anemia (to reduce the frequency of painful crises and to reduce the need for blood transfusions in patients with recurrent moderate to severe painful crises).	Treatment of sickle cell disease in adults and pediatric patients ≥12 years of age

Boxed Warning

Hydroxyurea (Droxia and Siklos)	**Oxbryta**
Bone marrow suppression Hydroxyurea may cause severe myelosuppression. Monitor blood counts at baseline and throughout treatment. Interrupt treatment and reduce dose as necessary **Secondary malignancy** Hydroxyurea is carcinogenic. Advise sun protection and monitor patients for malignancies	None

Mechanism of Action

Hydroxyurea (Droxia and Siklos)	Oxbryta
Antimetabolite that inhibits ribonucleoside diphosphate reductase. In sickle cell anemia, hydroxyurea increases (RBC) hemoglobin F levels, RBC water content, deformability of sickled cells, and alters adhesion of RBCs to endothelium.	HbS polymerization inhibitor that reversibly binds to Hb and stabilizes the oxygenated Hb state • Through the increased Hb affinity for oxygen, causes dose-dependent inhibition of HbS polymerization, and may inhibit RBC sickling, improve RBC deformability, and reduce whole blood viscosity o May also extend RBC half-life and reduce anemia and hemolysis

Dosing

	Hydroxyurea (Droxia and Siklos)	Oxbryta
Adult Dosing	**Initial**: 15 mg/kg (Droxia), 20 mg/kg/day (Siklos) **Maximum**: 35 mg/kg/day Dose should be adjusted for toxicity based on blood cell counts	1.5 g once daily May be administered with or without hydroxyurea
Pediatric Dosing	**≥2 years of age (Siklos only):** same as adult	**≥12 years of age:** same as adults
Renal/Hepatic Impairment	**Renal Impairment**: CrCl <60 mL/minute, reduce dose to 50% of initial **Hepatic Impairment:** No adjustments	**Renal Impairment**: no dose adjustments **Hepatic Impairment:** Reduce dose to 1 gram in severe impairment

Contraindications

Hydroxyurea (Droxia and Siklos)	Oxbryta
Hypersensitivity to hydroxyurea or any other component of its formulation.	Serious hypersensitivity (eg, generalized rash, urticaria, mild shortness of breath, mild facial swelling, eosinophilia) to any component of the formulation.

Warnings/Precautions

Hydroxyurea (Droxia and Siklos)	Oxbryta
Bone marrow suppression Correct severe anemia prior to initiating treatment. Do not initiate therapy if bone marrow function is markedly reduced. **Secondary malignancy** Hydroxyurea is carcinogenic **Cutaneous vasculitic toxicity** Vasculitic ulcerations and gangrene have been reported **Pulmonary toxicity** Interstitial lung disease, including pulmonary fibrosis, lung infiltration, pneumonitis, and alveolitis/allergic alveolitis (some cases fatal). D/C if pulmonary toxicity occurs and manage appropriately. **Macrocytosis** Self-limiting macrocytosis may be seen early in treatment. Prophylactic folic acid supplementation is recommended **Radiation therapy recipients** Patients with a history of radiation therapy are at risk for exacerbation of post irradiation erythema and myelosuppression. **Immunizations** Avoid use of live vaccines during hydroxyurea therapy	**Laboratory test interference** May interfere with high-performance liquid chromatography measurement of Hb subtypes (HbA, HbS, and HbF)

Adverse Effects

Hydroxyurea (Droxia and Siklos)	Oxbryta
Common (>10%): • Dermatologic: Eczema • Hematologic & oncologic: Macrocytosis, neutropenia • Infection: Infection, bacterial infection **Less Common (1-10%)** • CNS: Headache, severe nervous system disease • Dermatologic: Leg ulcer, dermatological reaction, dermal ulcer • Endocrine & metabolic: Vitamin D deficiency, weight gain • GI: Acute mucocutaneous toxicity, constipation, nausea • Hematologic & oncologic: Thrombocytopenia, anemia • Infection: Viral infection • Respiratory: Asthma • Miscellaneous: Fever	**Common (>10%):** • CNS: Headache, fatigue • Dermatologic: Skin rash • GI: Diarrhea, abdominal pain, nausea • Miscellaneous: Fever **Less Common (1-10%)** • Cardiovascular: Pulmonary embolism • Hypersensitivity: Hypersensitivity reaction

Drug Interactions

Hydroxyurea (Droxia and Siklos)	Oxbryta
No metabolic/transport effects, so interactions are with other immunosuppressive drugs, or those that may worsen ADRs of hydroxyurea	Substrate of CYP2B6 (minor), CYP2C19 (minor), CYP2C9 (minor), CYP3A4 (minor), and is a weak inhibitor of CYP3A4 • Consider therapy modification in CYP3A4 inducers or CYP substrates with a narrow therapeutic index

Cost

Drug	Strength	Package Size	WAC Pkg Price	Cost per dose*	Cost per Month*	Cost per Year*
Siklos	100 mg	60	$300.00	$65.00 - $115.00	$1,950.00 - $3,450.00	$23,725.00 - $41,975.00
Siklos	1,000 mg	30	$1,500.00			
Oxbryta	500 mg	90	$10,417.00	$347.23	$10,417.00	$126,740.17
Droxia	200 mg	60	$45.41	$136.23 - $275.64	$4,086.90 - $8,269.20	$49,723.95 - $100,608.60
Droxia	300 mg	60	$48.59			
Droxia	400 mg	60	$45.41			
*=based on a weight of 65 kg and using the most cost effective combination of strengths to achieve recommended dose						

Current Utilization

ND Medicaid Utilization (12/2019 – 12/2020)		
Label Name	**Rx Num**	**Total Reimb Amt**
Siklos	0	N/A
Oxbryta	0	N/A
Droxia	1	$31.34

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on February 11. 2021.
2. UpToDate. Available at https://www.uptodate.com/contents/search. Accessed on February 11. 2021.
3. Oxbryta (voxelotor) [prescribing information]. South San Francisco, CA: Global Blood Therapeutics Inc; November 2019.
4. Siklos (hydroxyurea) [prescribing information]. Rosemont, PA: Medunik USA Inc; May 2019.
5. Droxia (hydroxyurea) [prescribing information]. Princeton, NJ: Bristol-Myers Squibb Company; December 2020.

REVIEW OF AGENTS FOR THE TREATMENT OF FABRY DISEASE

Spinal muscular atrophy (SMA):

- Genetic, X-linked, disease caused by pathogenic variants in the alpha-galactosidase A (alpha-Gal A) gene, resulting in a deficiency of the lysosomal hydrolase alpha-galactosidase A
    - Causes a buildup of glycolipids within cells such as globotriaosylceramide (Gb3), which is thought to have cytotoxic, proinflammatory, and profibrotic effects
    - 3 majoy phenotypic "types"

Type	Presentation	alpha-Gal A Activity	Symptomology
Classic	Most severe phenotype, most common in males	<1% of normal mean	Severe neuropathic or limb pain Telangiectasias and angiokeratomas GI symptoms Corneal opacities Kidney disease
Heterozygous	Range from asymptomatic to as severe as classic disease	Large range	May have any or all classic symptoms
Atypical	Typically, has later onset and less severe disease	2-30% of normal mean	Usually disease symptoms dominate a particular organ system

- **Symptoms**
    - Spectrum of clinical manifestations, ranging from severe to asymptomatic. {potential symptoms include the following:
        - Severe neuropathic or limb pain
        - Telangiectasias and angiokeratomas
        - Abdominal pain, recurrent nausea and vomiting, and either diarrhea or constipation
        - Corneal opacities
        - Proteinuria, isosthenuria, polyuria, and polydipsia or otherwise unexplained renal insufficiency
        - Cardiac effects
            - Left ventricular hypertrophy (LVH), myocardial fibrosis, heart failure, coronary artery disease, aortic and mitral valve abnormalities, and conduction abnormalities
        - Cerebrovascular effects
            - TIA, ischemic strokes, blindness

- **Treatment of Fabry Disease:**
    - Treatment primarily focuses upon replacing the missing or deficient alpha-Gal A with enzyme replacement therapy (ERT) as well as treating the various symptoms and disease complications
        - ERT with the agent Fabrazyme (agalsidase beta), which is given IV
        - A pharmacologic chaperone (Galafold) can now be used instead of ERT in patients with amenable genetic variants (present in 35 to 50 percent of patients)
    - **Candidates for ERT or Galafold (if appropriate)**
        - All classically affected males, regardless of whether or not clinical manifestations are present
        - Female carriers and atypically affected males, if clinical manifestations (eg, kidney, cardiovascular, neurologic) are present
        - Other patients such as those with ESRD may be candidates for ERT, depending on their symptoms

GALAFOLD (migalastat)

- **Indication**: Treatment of adults with a confirmed diagnosis of Fabry disease and an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data
- **Mechanism of action:** reversibly binds to the active site of the alpha-galactosidase A (alpha-Gal A) protein (encoded by the galactosidase alpha gene, GLA), which is deficient in Fabry disease.
    - Binding to the active site stabilizes alpha-Gal A allowing trafficking from the endoplasmic reticulum into the site of action, the lysosome.
- **Contraindications:** None per label
- **Administration and Dosing:**
    - Adults:
        - 123 mg once every other day (do not administer on 2 consecutive days)
    - Pediatric:
        - Safety and efficacy have not been established
    - Renal/Hepatic Impairment
        - Use not recommended if eGFR <30 mL/minute/1.73 m2
        - Has not been studied in patients with hepatic impairment
- **Warnings/Precautions:**
    - Select patients with confirmed Fabry disease for migalastat treatment if an amenable galactosidase alpha (GLA) variant is present
        - Consultation with a clinical geneticist is strongly recommended in cases where clinical significance of the amenable GLA variant is uncertain or may be benign
- **Adverse Effects**
    - **Common (>10%)**
        - **CNS:** Headache (35%)
        - **Gastrointestinal:** Nausea (12%)
        - **Genitourinary:** Urinary tract infection (15%)
        - **Respiratory:** Nasopharyngitis (18%)
        - **Miscellaneous:** Fever (12%)
    - **Less Common (1-10%)**
        - **Gastrointestinal:** Abdominal pain (9%), diarrhea (9%)
        - **Neuromuscular & skeletal:** Back pain (9%)
        - **Respiratory:** Cough (9%), epistaxis (9%)
- **Drug interactions**
    - There are no known significant interactions

Cost

Drug	Strength	Package Size	WAC Pkg Price	Cost per dose	Cost per Month	Cost per Year
Galafold	123 mg	14	$25,080.00	$1,791.43	$26,871.43	$326,935.70

Current Utilization

ND Medicaid Utilization (12/2019 – 12/2020)		
Label Name	**Rx Num**	**Total Reimb Amt**
Galafold	0	-

REFERENCES:

1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on February 11. 2021.
2. UpToDate. Available at https://www.uptodate.com/contents/search. Accessed on February 11. 2021.
3. Galafold (migalastat) [prescribing information]. Philadelphia, PA: Amicus Therapeutics US, LLC; February 2021.

REVIEW OF IMCIVREE (setmelanotide)

Indication:

- For chronic weight management in adult and pediatric patients ≥6 years of age with obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing demonstrating variants in POMC, PCSK1, or LEPR genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance.
    - **Not for treatment of patients with**
        - Obesity due to suspected POMC, PCSK1, or LEPR deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign
        - Other types of obesity not related to POMC, PCSK1, or LEPR deficiency, including obesity associated with other genetic syndromes and general (polygenic) obesity.

Mechanism of action:

- Analog of endogenous melanocortin peptide alpha-melanocyte stimulating hormone, and primarily acts as a melanocortin 4 (MC4) receptor agonist
    - MC4 receptors in the brain are involved in regulation of hunger, satiety, and energy expenditure
    - In patients with obesity due to POMC, PCSK1, or LEPR deficiency associated with insufficient activation of the MC4 receptor, Imcivree may reestablish MC4 receptor pathway activity to reduce hunger and promote weight loss through decreased caloric intake and increased energy expenditure

Contraindications: None per label

Administration and Dosing: Weight loss target in clinical trials was 1 to 2 kg/week and dosages were adjusted no more frequently than every 2 weeks

- **≥12 Years of Age:**
    - Initial Dosing: 2 mg subcutaneously once daily for 2 weeks
    - Dosage Adjustment/Maintenance:
        - If 2 mg dose is tolerated, increase to 3 mg dose
        - If 2 or 3 mg dose is not tolerated, reduce dose by 1 mg /day
- **6-<12 Years of Age:**
    - Initial Dosing: 1 mg subcutaneously once daily for 2 weeks
    - Dosage Adjustment/Maintenance:
        - If 1 mg dose is tolerated, increase by 1 mg per day up to max of 3 mg per day
        - If 1 mg dose is not tolerated, reduce to 0.5 mg/day
        - If 2 or 3 mg dose is not tolerated, reduce dose by 1 mg /day
- **Renal/Hepatic Impairment**
    - Use not recommended if eGFR <60 mL/minute/1.73 m2
    - Has not been studied in patients with hepatic impairment

Warnings/Precautions:

- Sexual adverse reactions (eg, spontaneous penile erection, priapism, labial hypersensitivity) may occur
- New or worsened depression or suicidal ideation may occur; patients with a history of severe depression were not included in clinical trials
- Increased skin pigmentation and darkening of preexisting nevi may occur

Adverse Effects

- **Common (>10%)**
    - **Dermatologic:** Alopecia, skin hyperpigmentation, skin rash, xeroderma
    - **Gastrointestinal:** Abdominal pain, constipation, diarrhea, nausea, vomiting, xerostomia
    - **Genitourinary:** Spontaneous erections
    - **Immunologic:** Antibody development
    - **Local:** Injection site reaction
    - **Nervous system:** Chills, depression, dizziness, fatigue, headache, insomnia, vertigo
    - **Neuromuscular & skeletal:** Arthralgia, asthenia, back pain, limb pain, muscle spasm
    - **Respiratory:** Flu-like symptoms, upper respiratory tract infection

Pregnancy:

- **Pregnancy:**
  - Adverse events were not observed in animal reproduction studies; however, moderate weight gain is required for positive fetal outcomes during pregnancy, therefore, medications for weight loss therapy are not recommended during pregnancy

Drug Interactions:

- There are no known significant drug interactions

Cost

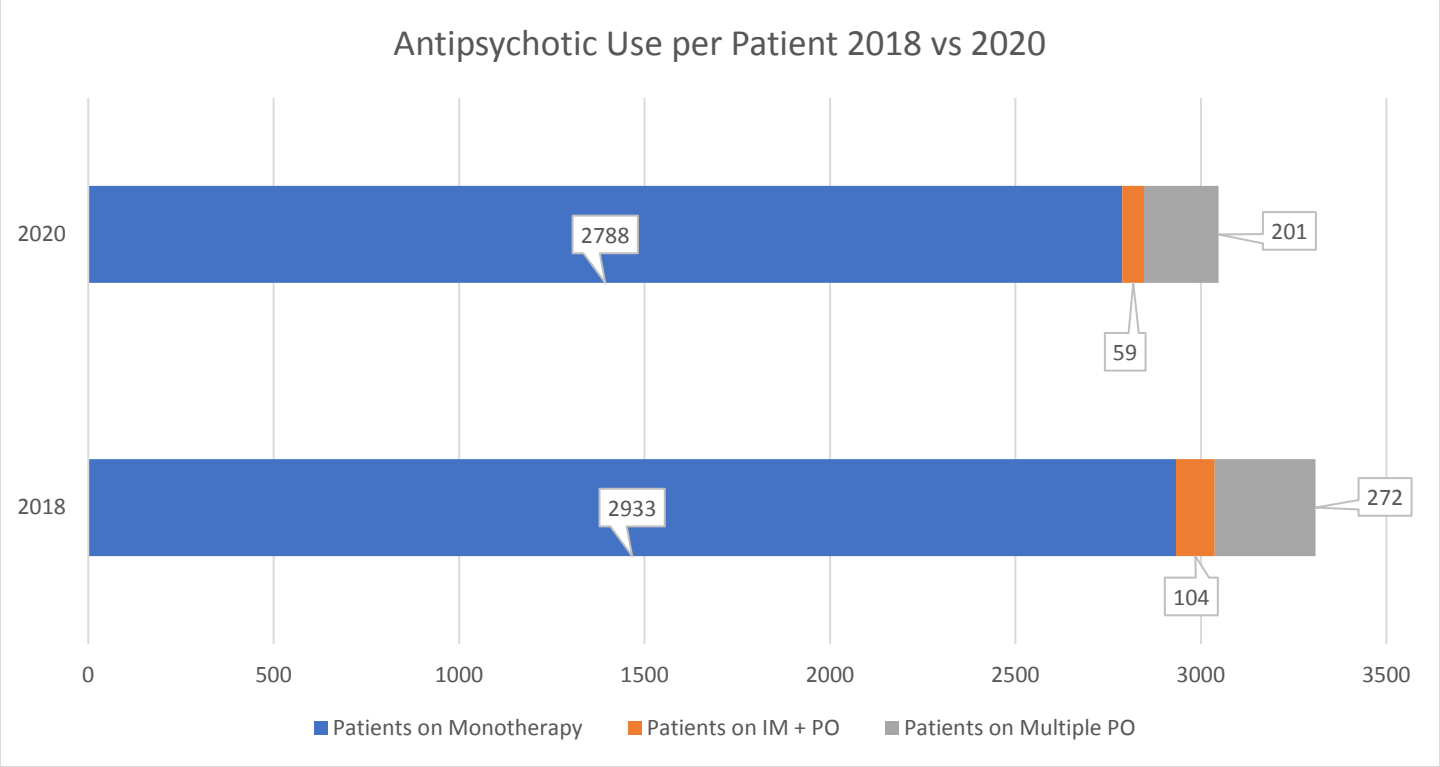
Drug	Strength	Package Size	WAC Pkg Price	Cost per dose	Cost per Month	Cost per Year
Imcivree	10 mg/mL	1 mL	$3,300.00	$165 - $990	$4,950 - $29,700	$60,225 - $361,350

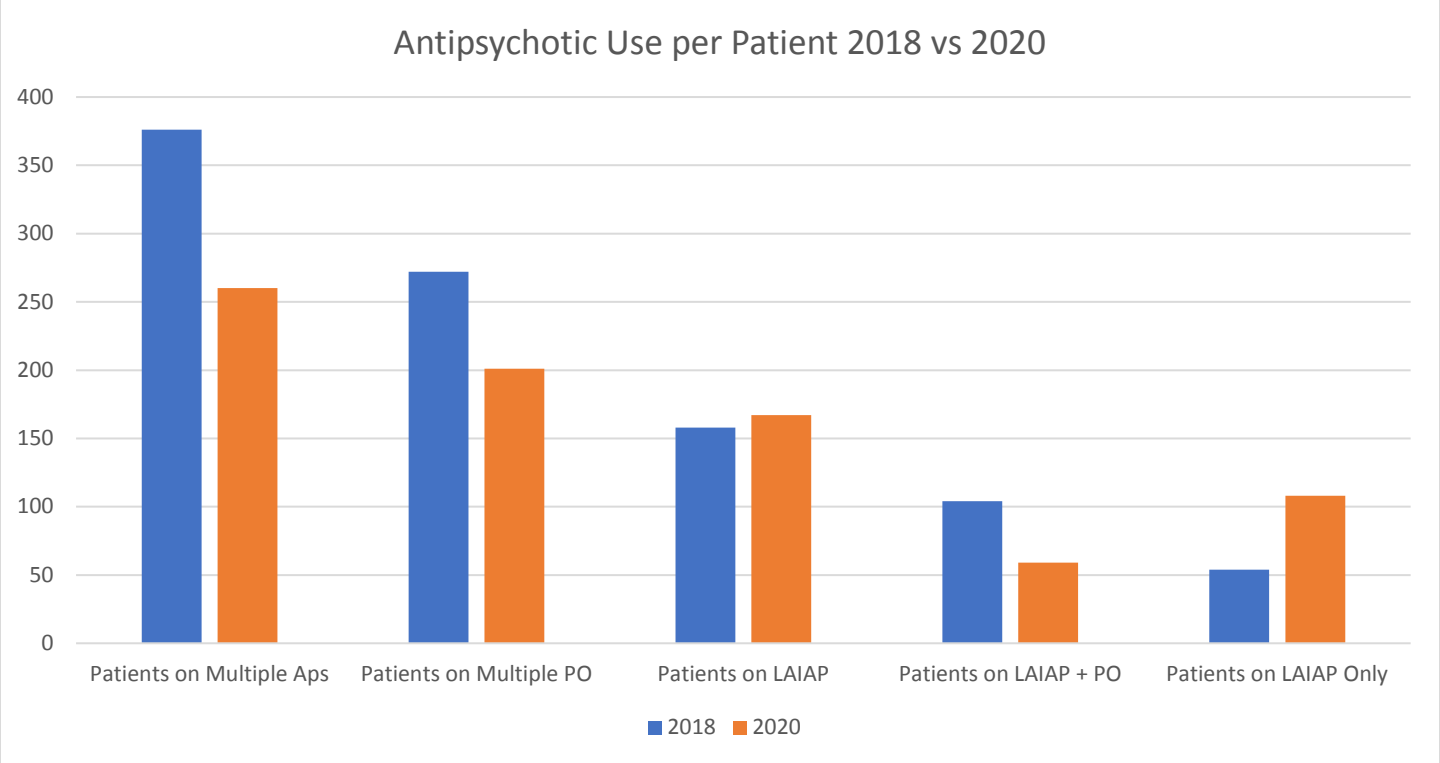
Current Utilization

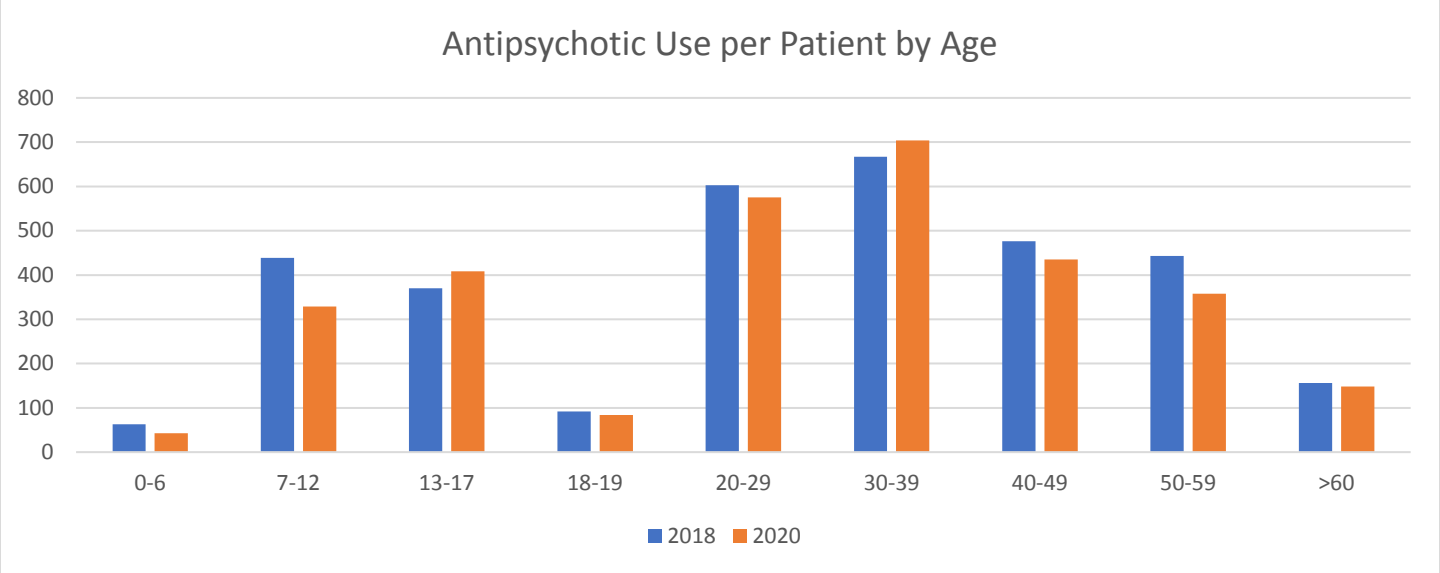
ND Medicaid Utilization (12/2019 – 12/2020)		
Label Name	**Rx Num**	**Total Reimb Amt**
Imcivree	0	-

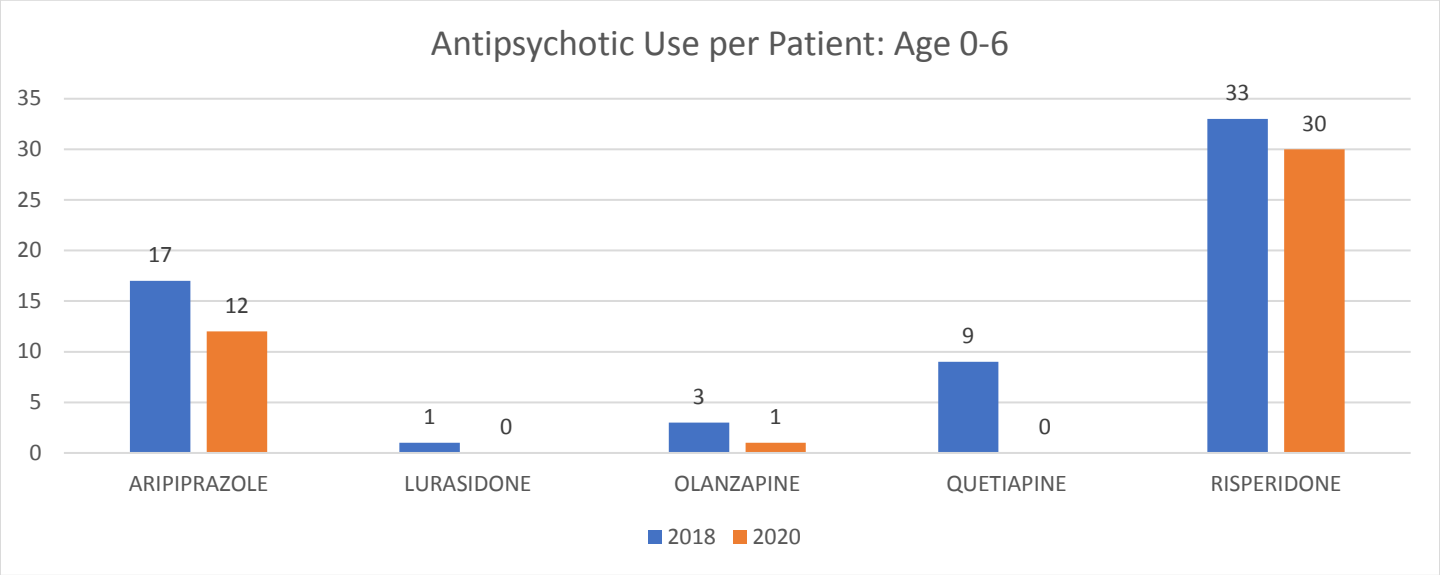
REFERENCES:

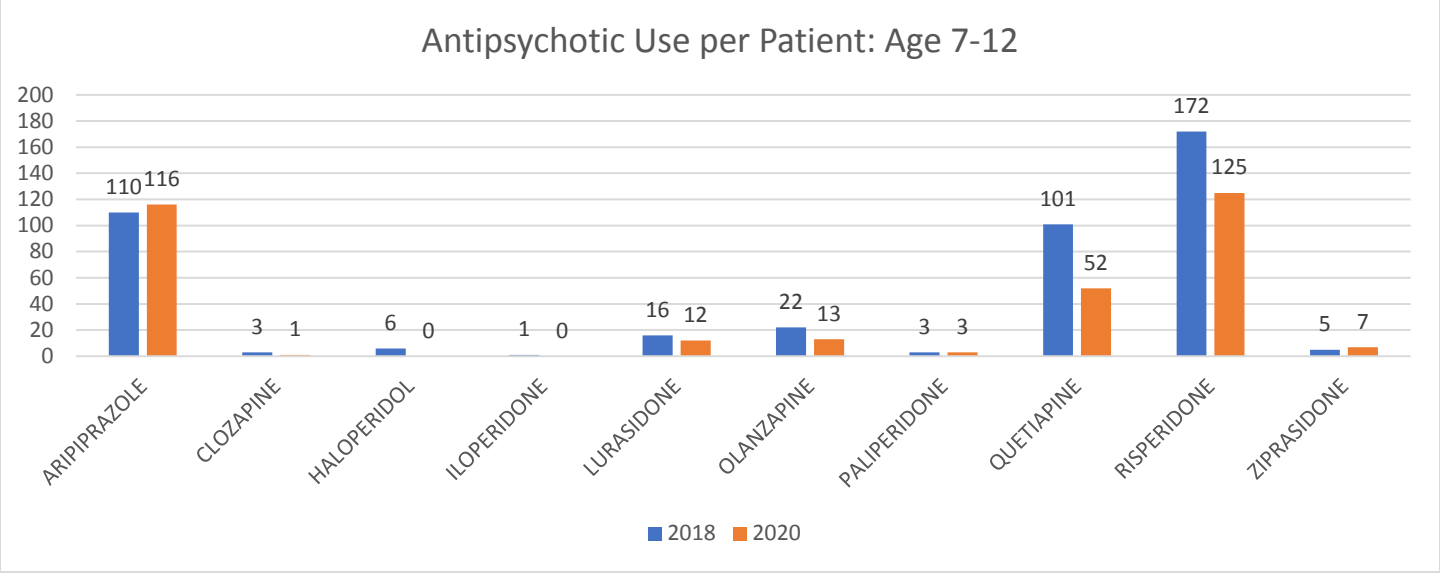
1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on February 10, 2021.
2. UpToDate. Available at https://www.uptodate.com/contents/search. Accessed on February 10. 2021.
3. Imcivree (setmelanotide) [prescribing information]. Boston, MA; Rhythm Pharmaceuticals Inc; November 2020.

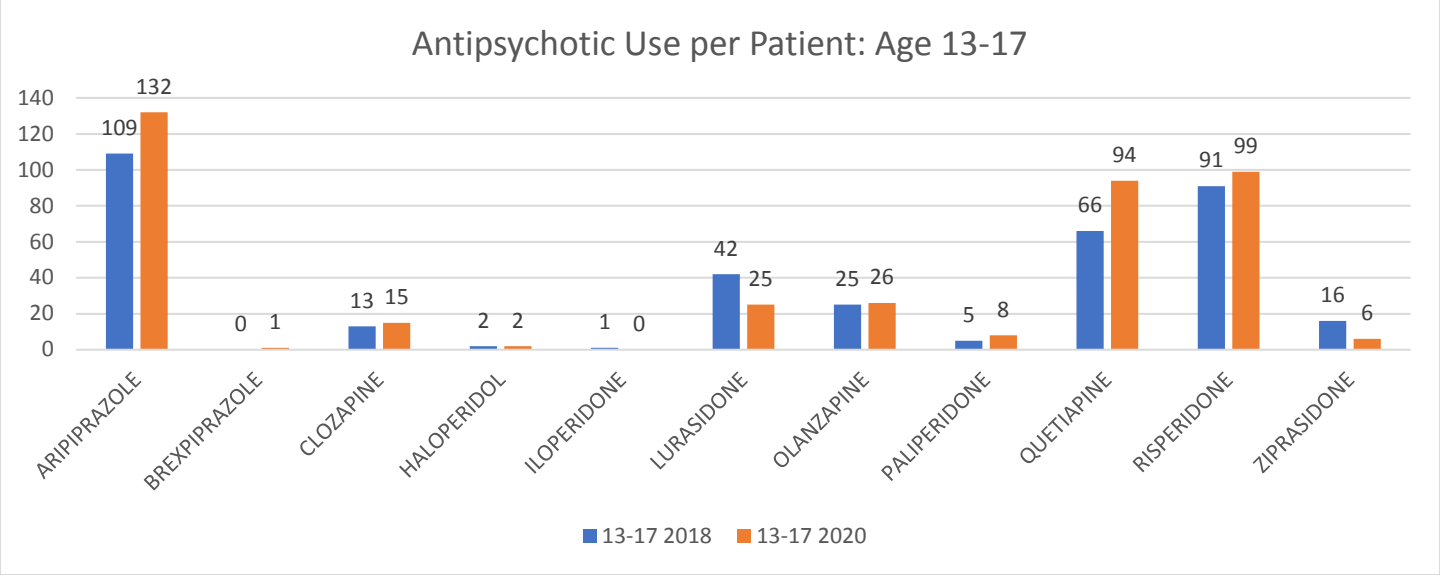

Antipsychotic Use per Patient 2018 vs 2020
2020
2018
2788
59
201
2933
104
272
0
500
1000
1500
2000
2500
3000
3500
Patients on Monotherapy
Patients on IM + PO
Patients on Multiple PO

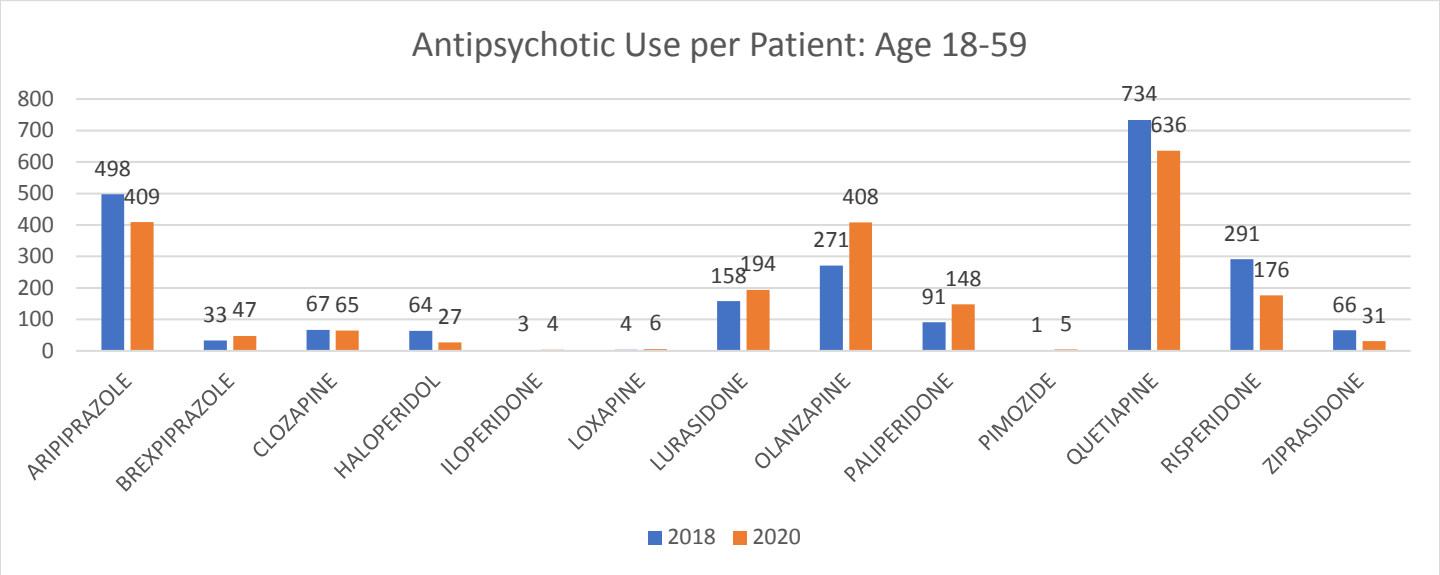

Antipsychotic Use per Patient 2018 vs 2020
400
350
300
250
200
150
100
50
0
Patients on Multiple Aps
Patients on Multiple PO
Patients on LAIAP
Patients on LAIAP + PO
Patients on LAIAP Only
2018
2020

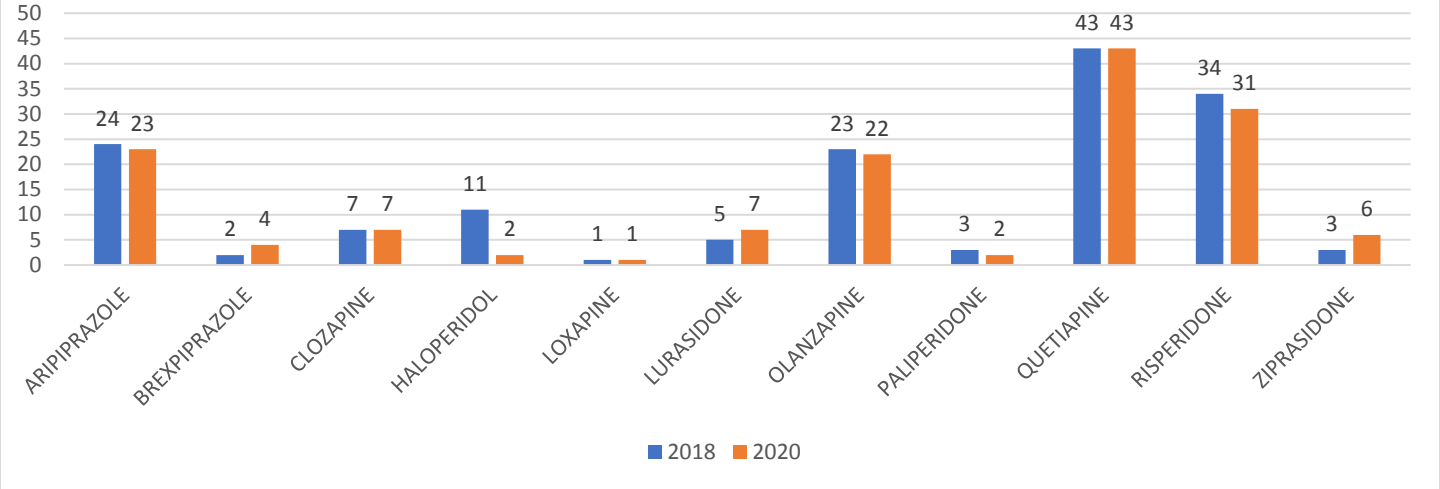

Antipsychotic Use per Patient by Age
800
700
600
500
400
300
200
100
0
0-6
7-12
13-17
18-19
20-29
30-39
40-49
50-59
>60
2018
2020

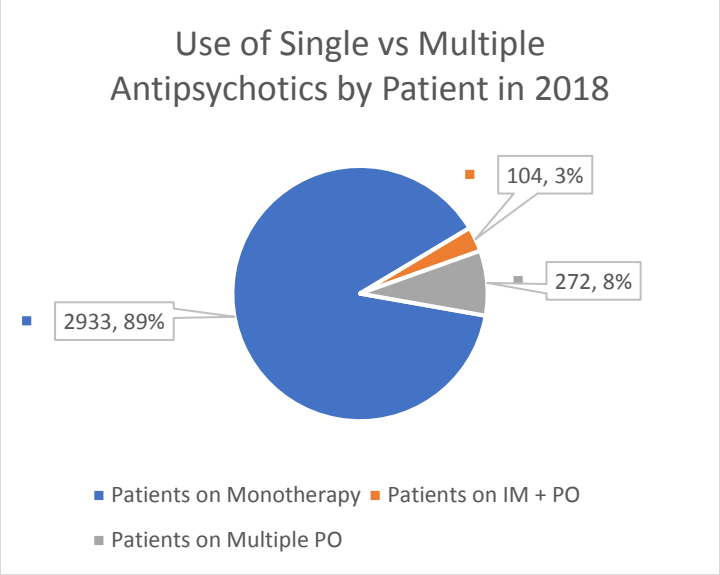

Antipsychotic Use per Patient: Age 0-6
35
30
25
20
15
10
5
0
17
12
1
0
3
1
9
0
33
30
ARIPIPRAZOLE
LURASIDONE
OLANZAPINE
QUETIAPINE
RISPERIDONE
2018
2020

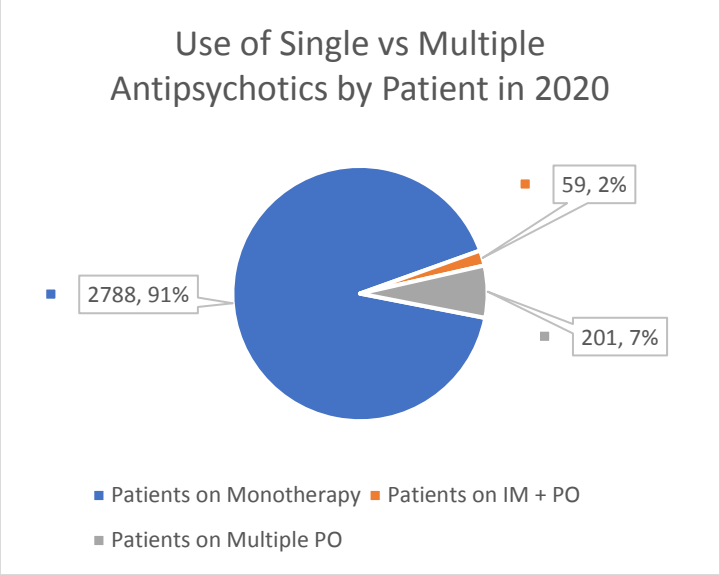

Antipsychotic Use per Patient: Age 7-12
200
180
160
140
120
100
80
60
40
20
0
110
116
3
1
6
0
1
0
16
12
22
13
3
3
101
52
172
125
5
7
ARIPIPRAZOLE
CLOZAPINE
HALOPERIDOL
ILOPERIDONE
LURASIDONE
OLANZAPINE
PALIPERIDONE
QUETIAPINE
RISPERIDONE
ZIPRASIDONE
2018
2020


Antipsychotic Use per Patient: Age 13-17
140
120
100
80
60
40
20
0
109 132
0 1
13 15
2 2
1 0
42 25
25 26
5 8
66 94
91 99
16 6
ARIPIPRAZOLE
BREXPIPRAZOLE
CLOZAPINE
HALOPERIDOL
ILOPERIDONE
LURASIDONE
OLANZAPINE
PALIPERIDONE
QUETIAPINE
RISPERIDONE
ZIPRASIDONE
13-17 2018
13-17 2020


Antipsychotic Use per Patient: Age 18-59
800
700
600
500
400
300
200
100
0
498 409
33 47
67 65
64 27
3 4
4 6
158 194
271 408
91 148
1 5
734 636
291 176
66 31
ARIPIPRAZOLE
BREXPIPRAZOLE
CLOZAPINE
HALOPERIDOL
ILOPERIDONE
LOXAPINE
LURASIDONE
OLANZAPINE
PALIPERIDONE
PIMOZIDE
QUETIAPINE
RISPERIDONE
ZIPRASIDONE
2018
2020


Antipsychotic Use per Patient: Age 60+
50
45
40
35
30
25
20
15
10
5
0
24 23
2 4
7 7
11 2
1 1
5 7
23 22
3 2
43 43
34 31
3 6
ARIPIPRAZOLE
BREXPIPRAZOLE
CLOZAPINE
HALOPERIDOL
LOXAPINE
LURASIDONE
OLANZAPINE
PALIPERIDONE
QUETIAPINE
RISPERIDONE
ZIPRASIDONE
2018
2020





Number of Patients on Each Antipsychotic by Drug and Age: 2018										
Age	**0-6**	**7-12**	**13-17**	**18-19**	**20-29**	**30-39**	**40-49**	**50-59**	**>60**	**TOTALS**
ARIPIPRAZOLE IM	0	0	1	3	17	16	5	7	3	52
ARIPIPRAZOLE PO	17	110	108	17	109	141	92	91	21	706
BREXPIPRAZOLE PO	0	0	0	0	8	15	7	3	2	35
CLOZAPINE PO	0	3	13	7	29	16	6	9	7	90
HALOPERIDOL IM	0	0	1	1	3	3	4	7	5	24
HALOPERIDOL PO	0	6	1	2	9	16	7	12	6	59
ILOPERIDONE PO	0	1	1	0	1	1	1	0	0	5
LOXAPINE PO	0	0	0	0	0	2	1	1	1	5
LURASIDONE PO	1	16	42	6	53	46	33	20	5	222
OLANZAPINE IM	0	0	0	0	4	0	0	0	0	4
OLANZAPINE PO	3	22	25	12	74	69	57	55	23	340
PALIPERIDONE IM	0	0	0	3	16	17	8	7	2	53
PALIPERIDONE PO	0	3	5	2	13	8	9	8	1	49
PIMOZIDE PO	0	0	0	0	0	0	1	0	0	1
QUETIAPINE PO	9	101	66	14	154	234	183	149	43	953
RISPERIDONE IM	0	0	1	1	12	6	2	0	2	24
RISPERIDONE PO	33	172	90	21	87	57	43	62	32	597
ZIPRASIDONE IM	0	1	0	0	0	0	0	0	0	1
ZIPRASIDONE PO	0	4	16	3	14	20	17	12	3	89

Number of Patients on Each Antipsychotic by Drug and Age: 2020										
Age	**0-6**	**7-12**	**13-17**	**18-19**	**20-29**	**30-39**	**40-49**	**50-59**	**>60**	**TOTALS**
ARIPIPRAZOLE IM	0	0	0	1	13	15	12	6	3	50
ARIPIPRAZOLE PO	12	116	132	11	99	114	78	60	20	642
BREXPIPRAZOLE PO	0	0	1	1	12	17	10	7	4	52
CLOZAPINE PO	0	1	15	7	26	19	7	6	7	88
HALOPERIDOL IM	0	0	0	0	2	3	2	2	0	9
HALOPERIDOL PO	0	0	2	0	7	7	1	3	2	22
ILOPERIDONE PO	0	0	0	0	2	1	1	0	0	4
LOXAPINE PO	0	0	0	0	5	0	0	1	1	7
LURASIDONE PO	0	12	25	6	83	56	30	19	7	238
OLANZAPINE IM	0	0	0	0	0	0	2	0	0	2
OLANZAPINE PO	1	13	26	15	167	96	72	56	22	468
PALIPERIDONE IM	0	0	0	2	42	35	9	7	1	96
PALIPERIDONE PO	0	3	8	2	30	13	3	5	1	65
PIMOZIDE PO	0	0	0	0	4	0	1	0	0	5
QUETIAPINE PO	0	52	94	16	81	252	158	129	43	825
RISPERIDONE IM	0	0	0	0	2	5	2	1	0	10
RISPERIDONE PO	30	125	99	19	0	57	42	48	31	451
ZIPRASIDONE IM	0	0	0	0	0	0	0	0	0	0
ZIPRASIDONE PO	0	7	6	4	0	14	5	8	6	50

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
1ST QUARTER 2021

Criteria Recommendations ***Approved Rejected***

1. Encorafenib / Overuse _____ _____

Alert Message: Braftovi (encorafenib) may be over-utilized. The recommended maximum dose of encorafenib is 450 mg (6 - 75 mg capsules) orally taken once daily in combination with binimetinib until disease progression or unacceptable toxicity.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib		

Max Dose: 450 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, April 2020, Array BioPharma.

2. Encorafenib / Therapeutic Appropriateness - Pediatric _____ _____

Alert Message: The safety and effectiveness of Braftovi (encorafenib) have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

3. Encorafenib / Therapeutic Appropriateness _____ _____

Alert Message: A review of the patient's drug profile does not reveal a prescription for binimetinib. Braftovi (encorafenib) is approved to be used in combination with binimetinib. If binimetinib is temporarily interrupted or permanently discontinued, reduce the dose of encorafenib as recommended in the official prescribing information.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Encorafenib		Binimetinib

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

4. Encorafenib / Hemorrhage _____ _____

Alert Message: Hemorrhage can occur when Braftovi (encorafenib) is administered in combination with binimetinib. The most frequent hemorrhagic events were gastrointestinal, including rectal hemorrhage (4.2%), hematochezia (3.1%), and hemorrhoidal hemorrhage (1%). Withhold, reduce dose, or permanently discontinue encorafenib based on the severity of the adverse reaction.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib	Hemorrhage	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

5. Encorafenib / Uveitis _____ _____

Alert Message: Uveitis, including iritis and iridocyclitis, has been reported in patients treated with Braftovi (encorafenib) in combination with binimetinib. Assess the patient for visual symptoms at each visit. Perform an ophthalmologic evaluation at regular intervals and for new or worsening visual disturbances, and to follow new or persistent ophthalmologic findings. Withhold, reduce dose, or permanently discontinue encorafenib based on the severity of the adverse reaction.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib	Uveitis	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

6. Encorafenib / QT Prolongation _____ _____

Alert Message: Braftovi (encorafenib) is associated with dose-dependent QTc interval prolongation in some patients. Monitor patients who already have or who are at significant risk of developing QTc prolongation, including patients with known long QT syndromes, clinically significant bradyarrhythmias, severe or uncontrolled heart failure, and those taking other medicinal products associated with QT prolongation. Correct hypokalemia and hypomagnesemia prior to and during encorafenib administration. Withhold, reduce dose, or permanently discontinue for QTc > 500 ms.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib	QT Prolongation	
	Heart Failure	
	Bradyarrhythmias	
	Hypokalemia	
	Hypomagnesemia	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

7. Encorafenib / Moderate & Strong CYP3A4 Inhibitors _____ _____

Alert Message: The concomitant administration of Braftovi (encorafenib) with a strong or moderate CYP3A4 inhibitor increased encorafenib plasma concentrations and may increase encorafenib adverse reactions. Avoid co-administration of encorafenib with strong or moderate CYP3A4 inhibitors, including grapefruit juice. If co-administration of strong or moderate CYP3A4 inhibitors cannot be avoided, modify the encorafenib dose as recommended in the official prescribing information.

Drugs/Diseases

Util A	Util B		Util C
Encorafenib	Atazanavir	Fosamprenavir	
	Aprepitant	Indinavir	
	Ciprofloxacin	Itraconazole	
	Clarithromycin	Ketoconazole	
	Cobicistat	Nefazodone	
	Crizotinib	Nelfinavir	
	Cyclosporine	Posaconazole	
	Diltiazem	Ritonavir	
	Dronedarone	Saquinavir	
	Erythromycin	Verapamil	
	Fluconazole	Voriconazole	
	Fluvoxamine		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

8. Encorafenib / Moderate & Strong CYP3A4 Inducers _____ _____

Alert Message: Concomitant administration of Braftovi (encorafenib) with a strong or moderate CYP3A4 inducer may decrease encorafenib plasma concentrations and may decrease encorafenib efficacy. Avoid concomitant administration of strong or moderate CYP3A4 inducers with encorafenib.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib	Apalutamide	
	Bosentan	
	Carbamazepine	
	Efavirenz	
	Enzalutamide	
	Etravirine	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifabutin	
	Rifampin	
	Rifapentine	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

9. Encorafenib / Sensitive CYP3A4 Substrates _____ _____

Alert Message: The coadministration of Braftovi (encorafenib) with CYP3A4 substrates may result in increased toxicity or decreased efficacy of these agents. In in vivo studies, encorafenib was shown to be a time-dependent CYP3A4 inhibitor and also a CYP3A4 inducer.

Drugs/Diseases

Util A	Util B			Util C
Encorafenib	Acalabrutinib	Felodipine	Quetiapine	
	Aprepitant	Ibrutinib	Simvastatin	
	Avanafil	Indinavir	Sirolimus	
	Bosutinib	Isavuconazonium	Tacrolimus	
	Budesonide	Ivacaftor	Ticagrelor	
	Buspirone	Lomitapide	Tolvaptan	
	Cobimetinib	Lovastatin	Triazolam	
	Darifenacin	Lurasidone	Venetoclax	
	Darunavir	Maraviroc		
	Dasatinib	Midazolam		
	Eletriptan	Midostaurin		
	Eplerenone	Nisoldipine		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

10. Encorafenib / Hormonal Contraceptives _____ _____

Alert Message: The coadministration of Braftovi (encorafenib) with hormonal contraceptives (CYP3A4 substrates) can result in decreased hormone concentrations and loss of hormonal contraceptive efficacy. Avoid coadministration of hormonal contraceptives with encorafenib. Counsel patients to use a non-hormonal method of contraception during treatment with encorafenib and for 2 weeks after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib	Hormonal Contraceptives	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

11. Encorafenib / Drugs that Cause QT Prolongation _____ _____

Alert Message: Braftovi (encorafenib) use is associated with dose-dependent QTc interval prolongation in some patients. Avoid the coadministration of encorafenib with medicinal products with a known potential to prolong the QT/QTc interval.

Drugs/Diseases

Util A	Util B				Util C
Encorafenib	Abiraterone	Droperidol	Levofloxacin	Rilpivirine	
	Alfuzosin	Efavirenz	Lithium	Risperidone	
	Amiodarone	Eliglustat	Lofexidine	Ritonavir	
	Amitriptyline	Entrectinib	Loperamide	Romidepsin	
	Anagrelide	Eribulin	Maprotiline	Saquinavir	
	Aripiprazole	Erythromycin	Methadone	Sertraline	
	Arsenic Trioxide	Escitalopram	Metoclopramide	Siponimod	
	Asenapine	Ezogabine	Midostaurin	Solifenacin	
	Atazanavir	Famotidine	Mifepristone	Sotalol	
	Atomoxetine	Felbamate	Mirabegron	Sunitinib	
	Azithromycin	Fingolimod	Mirtazapine	Tacrolimus	
	Bedaquiline	Flecainide	Moexipril	Tamoxifen	
	Bortezomib	Fluconazole	Moxifloxacin	Telavancin	
	Bendamustine	Fluoxetine	Nelfinavir	Tetrabenazine	
	Bosutinib	Fluvoxamine	Nilotinib	Thioridazine	
	Buprenorphine	Foscarnet	Nortriptyline	Tizanidine	
	Ceritinib	Galantamine	Ofloxacin	Tolterodine	
	Chloroquine	Ganciclovir	Ondansetron	Toremifene	
	Chlorpromazine	Gemifloxacin	Osimertinib	Tramadol	
	Cilostazol	Gilteritinib	Oxaliplatin	Trazodone	
	Ciprofloxacin	Glasdegib	Paliperidone	Trimipramine	
	Citalopram	Granisetron	Panobinostat	Valbenazine	
	Clarithromycin	Haloperidol	Paroxetine	Vandetanib	
	Clomipramine	Hydroxychloroquine	Pasireotide	Vemurafenib	
	Clozapine	Hydroxyzine	Pazopanib	Venlafaxine	
	Crizotinib	Ibutilide	Pentamidine	Voriconazole	
	Dabrafenib	Iloperidone	Pimavanserin		
	Dasatinib	Imipramine	Pimozide		
	Desipramine	Indapamide	Pitolisant		
	Deutetrabenazine	Indinavir	Posaconazole		
	Diphenhydramine	Ivabradine	Procainamide		
	Disopyramide	Itraconazole	Promethazine		
	Dofetilide	Ivosidenib	Propafenone		
	Dolasetron	Ketoconazole	Quetiapine		
	Donepezil	Lapatinib	Quinidine		
	Doxepin	Lefamulin	Quinine		
	Dronedarone	Lenvatinib	Ranolazine		
		Leuprolide	Ribociclib		

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

12. Encorafenib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on its mechanism of action, Braftovi (encorafenib) can cause fetal harm when administered to a pregnant patient. Encorafenib produced embryo-fetal developmental changes in rats and rabbits and was an abortifacient in rabbits at doses greater than or equal to those resulting in exposures approximately 26 (in the rat) and 178 (in the rabbit) times the human exposure at the recommended dose of 450 mg, with no clear findings at lower doses. Advise patients of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Encorafenib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

13. Encorafenib / Lactation _____ _____

Alert Message: There are no data on the presence of Braftovi (encorafenib) or its metabolites in human milk or the effects of encorafenib on the breastfed infant, or milk production. Because of the potential for serious adverse reactions from encorafenib in breastfed infants, advise patients not to breastfeed during treatment with encorafenib and for 2 weeks after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

14. Encorafenib / Therapeutic Appropriateness _____ _____

Alert Message: Advise patients of reproductive potential to use an effective, non-hormonal method of contraception since Braftovi (encorafenib) can render hormonal contraceptives ineffective, during treatment and for 2 weeks after the final dose of encorafenib. Based on its mechanism of action, encorafenib can cause fetal harm when administered to a pregnant patient.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib		

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, May 2019, Array BioPharma.

15. Encorafenib / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Braftovi (encorafenib). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487-97.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence With Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

16. Rimegepant / Overuse _____ _____

Alert Message: Nurtec ODT (rimegepant) may be over-utilized. The recommended maximum dose of rimegepant is 75 mg in a 24-hour period. The safety of treating more than 15 migraines in a 30-day period has not been established.

Drugs/Diseases

Util A	Util B	Util C
Rimegepant		

Max Dose: 75 mg/day

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

17. Rimegepant / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Nurtec ODT (rimegepant) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Rimegepant		

Age Range: 0 – 17 yoa

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

18. Rimegepant / Therapeutic Appropriateness _____ _____

Alert Message: Avoid the use of Nurtec ODT (rimegepant) in patients with severe hepatic impairment. In clinical studies, plasma concentrations of rimegepant were significantly higher in subjects with severe (Child-Pugh C) hepatic impairment. No dosage adjustment rimegepant is required in patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment.

Drugs/Diseases

Util A	Util B	Util C
Rimegepant	Cirrhosis	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

19. Rimegepant / ESRD _____ _____

Alert Message: Avoid the use of Nurtec ODT (rimegepant) in patients with end-stage renal disease (CLcr < 15 mL/min). Rimegepant has not been studied in patients with end-stage renal disease and patients on dialysis. No dosage adjustment of rimegepant is required in patients with mild, moderate, or severe renal impairment.

Drugs/Diseases

Util A	Util B	Util C
Rimegepant	ESRD	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

20. Rimegepant / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Avoid the concomitant administration of Nurtec ODT (rimegepant) with strong inhibitors of CYP3A4. The co-administration of rimegepant, a CYP3A4 substrate, with strong inhibitors of CYP3A4 may result in a significant increase in rimegepant exposure.

Drugs/Diseases

Util A	Util B		Util C
Rimegepant	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

21. Rimegepant / Moderate CYP3A4 Inhibitors _____ _____

Alert Message: Concomitant administration of Nurtec ODT (rimegepant) with moderate inhibitors of CYP3A4 may result in increased exposure of rimegepant. Avoid another dose of rimegepant within 48 hours when it is concomitantly administered with moderate inhibitors of CYP3A4.

Drugs/Diseases

Util A	Util B		Util C
Rimegepant	Atazanavir	Dronedarone	
	Aprepitant	Erythromycin	
	Ciprofloxacin	Fluconazole	
	Crizotinib	Fluvoxamine	
	Cyclosporine	Fosamprenavir	
	Diltiazem	Verapamil	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.

Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

22. Rimegepant / Moderate & Strong CYP3A4 Inducers _____ _____

Alert Message: The concurrent use of Nurtec ODT (rimegepant) with strong or moderate CYP3A4 inducers should be avoided. Rimegepant is a CYP3A4 substrate, and concurrent use with a strong or moderate CYP3A4 inducer may result in decreased rimegepant exposure and loss of rimegepant efficacy.

Drugs/Diseases

Util A	Util B		Util C
Rimegepant	Apalutamide	Phenobarbital	
	Bosentan	Phenytoin	
	Carbamazepine	Primidone	
	Efavirenz	Rifabutin	
	Enzalutamide	Rifampin	
	Etravirine	Rifapentine	
	Mitotane		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.

Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

23. Rimegepant / P-gp & BCRP Transport Inhibitors _____ _____

Alert Message: Nurtec ODT (rimegepant) is a substrate of P-gp and BCRP efflux transporters. Concomitant administration of rimegepant with inhibitors of P-gp or BCRP may result in a significant increase in rimegepant exposure. Avoid concurrent use of rimegepant with inhibitors of P-gp or BCRP.

Drugs/Diseases

Util A	Util B					Util C
Rimegepant	Acalabrutinib	Etravirine	Leflunomide	Ranolazine	Teriflunomide	
	Amiodarone	Flibanserin	Lomitapide	Regorafenib	Tolvaptan	
	Brigatinib	Fostamatinib	Mefloquine	Ritonavir	Velpatasvir	
	Cabozantinib	Glecaprevir	Mifepristone	Rolapitant	Vemurafenib	
	Carvedilol	Grazoprevir	Nelfinavir	Safinamide	Venetoclax	
	Clarithromycin	Ibrutinib	Neratinib	Sapropterin	Verapamil	
	Cobicistat	Isavuconazonium	Osimertinib	Saquinavir	Voxilaprevir	
	Cyclosporine	Istradefylline	Paritaprevir	Sarecycline		
	Daclatasvir	Itraconazole	Pibrentasvir	Sirolimus		
	Darolutamide	Ivacaftor	Ponatinib	Sorafenib		
	Ketoconazole	Lapatinib	Posaconazole	Sulfasalazine		
	Eltrombopag	Lasmiditan	Propafenone	Tafamidis		
	Erythromycin	Ledipasvir	Quinidine	Tedizolid		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.

Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

24. Rimegepant / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate data on the developmental risk associated with the use of Nurtec ODT (rimegepant) in pregnant patients. In animal studies, oral administration of rimegepant during organogenesis resulted in adverse effects on development in rats (decreased fetal body weight and increased incidence of fetal variations) at exposures greater than those used clinically, and which were associated with maternal toxicity.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Rimegepant	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

25. Rimegepant / Lactation _____ _____

Alert Message: There are no data on the presence of Nurtec ODT (rimegepant) in human milk, the effects of rimegepant on the breastfed infant, or the effects of rimegepant on milk production. There are no animal data on the excretion of rimegepant in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for rimegepant and any potential adverse effects on the breastfed infant from rimegepant or from the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Rimegepant	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

26. Ibrutinib / Overutilization MCL & MZL _____ _____

Alert Message: Imbruvica (ibrutinib) may be over-utilized. The recommended dosage of ibrutinib for mantle cell lymphoma (MCL) and marginal zone lymphoma (MZL) is 560 mg orally once daily until disease progression or unacceptable toxicity.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ibrutinib		Mantle Cell Lymphoma
		Marginal Zone Lymphoma

Max Dose: 560 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

27. Ibrutinib / Overutilization CLL/SLL & WM _____ _____

Alert Message: Imbruvica (ibrutinib) may be over-utilized. The recommended dosage of ibrutinib for chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) and Waldenstrom's macroglobulinemia (WM) as a single agent, in combination with rituximab for WM, or in combination with bendamustine and rituximab or with obinutuzumab for CLL/SLL is 420 mg once daily until disease progression or unacceptable toxicity.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ibrutinib		Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Waldenstrom's Macroglobulinemia

Max Dose: 420 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

28. Ibrutinib / Overutilization cGVHD _____ _____

Alert Message: Imbruvica (ibrutinib) may be over-utilized. The recommended dosage of ibrutinib for chronic graft versus host disease (cGVHD) is 420 mg once daily until disease cGVHD progression, recurrence of underlying malignancy, or unacceptable toxicity.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ibrutinib		Chronic Graft versus Host Disease

Max Dose: 420 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

29. Ibrutinib / Overutilization – Mild Hepatic Impairment _____ _____

Alert Message: Imbruvica (ibrutinib) may be over-utilized. The recommended dosage of ibrutinib for patients with mild hepatic impairment (Child-Pugh class A) is 140 mg daily. The recommended dosage of ibrutinib for patients with moderate hepatic impairment (Child-Pugh class B) is 70 mg daily.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ibrutinib		Hepatic Impairment

Max Dose: 140 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

30. Ibrutinib / Overutilization – Severe Hepatic Impairment _____ _____

Alert Message: Imbruvica (ibrutinib) use should be avoided in patients with severe hepatic impairment (Child-Pugh class C). In clinical studies, the AUC of ibrutinib increased 2.7-fold in subjects with mild hepatic impairment (Child-Pugh class A), 8.2-fold in subjects with moderate hepatic impairment (Child-Pugh class B), and 9.8-fold in subjects with severe hepatic impairment (Child-Pugh class C) relative to subjects with normal liver function.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ibrutinib		Cirrhosis
		Hepatic Failure

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

31. Ibrutinib / Strong CYP3A4 Inducers _____ _____

Alert Message: The concurrent use of Imbruvica (ibrutinib), a CYP3A4 substrate, with strong CYP3A4 inducers should be avoided. The coadministration of ibrutinib with a strong CYP3A4 inducer may decrease ibrutinib concentrations, and therefore its efficacy.

Drugs/Diseases

Util A	Util B		Util C
Ibrutinib	Apalutamide	Phenytoin	
	Carbamazepine	Phenobarbital	
	Enzalutamide	Primidone	
	Mitotane	Rifampin	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

32. Ibrutinib / Strong CYP3A4 Inhibitors _____ _____

Alert Message: The coadministration of Imbruvica (ibrutinib), a CYP3A4 substrate, with a strong CYP3A inhibitor may result in increased ibrutinib plasma concentrations. Increased ibrutinib concentrations may increase the risk of ibrutinib-related toxicity. Refer to the official prescribing information for the recommended ibrutinib dose modifications when used concomitantly with posaconazole or voriconazole. Avoid concomitant use of ibrutinib with other strong CYP3A inhibitors. If a strong CYP3A4 inhibitor will be used short-term (such as anti-infectives for seven days or less), interrupt ibrutinib therapy.

Drugs/Diseases

Util A	Util B		Util C
Ibrutinib 280 mg	Clarithromycin	Nelfinavir	
Ibrutinib 420 mg	Cobicistat	Posaconazole	
Ibrutinib 560 mg	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

33. Ibrutinib / Moderate CYP3A4 Inhibitors _____ _____

Alert Message: The coadministration of Imbruvica (ibrutinib), a CYP3A4 substrate, with a moderate CYP3A inhibitor may increase ibrutinib plasma concentrations. Increased ibrutinib concentrations may increase the risk of ibrutinib-related toxicity. Refer to the official prescribing information for the recommended ibrutinib dose modifications when used concomitantly with moderate CYP3A inhibitors. Interrupt ibrutinib if these inhibitors will be used short-term (such as anti-infectives for seven days or less).

Drugs/Diseases

Util A	Util B		Util C
Ibrutinib 420 & 560 mg	Atazanavir	Dronedarone	
	Aprepitant	Erythromycin	
	Ciprofloxacin	Fluconazole	
	Crizotinib	Fluvoxamine	
	Cyclosporine	Imatinib	
	Diltiazem	Verapamil	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

34. Ibrutinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Imbruvica (ibrutinib) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib		

Age Range: 0- 17 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

35. Ibrutinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Imbruvica (ibrutinib), a kinase inhibitor, can cause fetal harm based on findings from animal studies. There are no available data on ibrutinib use in pregnant patients to inform a drug-associated risk of major birth defects and miscarriage. If ibrutinib is used during pregnancy or if the patient becomes pregnant while taking ibrutinib, the patient should be apprised of the potential hazard to the fetus.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ibrutinib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

36. Ibrutinib / Lactation _____ _____

Alert Message: There is no information regarding the presence of Imbruvica (ibrutinib) or its metabolites in human milk, the effects on the breastfed child, or the effects on milk production. The development and health benefits of breastfeeding should be considered along with the mother's clinical need for ibrutinib and any potential adverse effects on the breastfed child from ibrutinib or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

37. Ibrutinib / Reproductive Potential - Female _____ _____

Alert Message: Advise patients of reproductive potential to avoid pregnancy while taking Imbruvica (ibrutinib) and for up to 1 month after ending treatment. If the drug is used during pregnancy or if the patient becomes pregnant while taking this drug, the patient should be informed of the potential hazard to a fetus.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib		

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

38. Ibrutinib / Reproductive Potential - Male _____ _____

Alert Message: Advise males with partners of reproductive potential to avoid fathering a child while receiving Imbruvica (ibrutinib), and for 1 month following the last dose of ibrutinib.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib		

Gender: Male

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

39. Ibrutinib / Hemorrhage _____ _____

Alert Message: Fatal bleeding events have occurred in patients treated with Imbruvica (ibrutinib). Major hemorrhage (≥ Grade 3, serious, or any central nervous system events; e.g., intracranial hemorrhage [including subdural hematoma], gastrointestinal bleeding, hematuria, and post-procedural hemorrhage) have occurred in 4% of patients, with fatalities occurring in 0.4% of 2,838 patients exposed to ibrutinib in 27 clinical trials. Bleeding events of any grade, including bruising and petechiae, occurred in 39% of patients treated with ibrutinib. Monitor patients for signs and symptoms of bleeding.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib	Intracranial Hemorrhage	
	Gastrointestinal Bleeding	
	Hematuria	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

40. Ibrutinib / Hemorrhage _____ _____

Alert Message: Fatal bleeding events have occurred in patients treated with Imbruvica (ibrutinib). Use of either anticoagulant or antiplatelet agents concomitantly with ibrutinib increases the risk of major hemorrhage. In ibrutinib clinical trials, 3.1% of patients taking ibrutinib without antiplatelet or anticoagulant therapy experienced major hemorrhage. Consider the risks and benefits of anticoagulant or antiplatelet therapy when co-administered with ibrutinib. Monitor for signs and symptoms of bleeding.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib	Anticoagulants	
	Antiplatelets	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

41. Ibrutinib / Serious Infections _____ _____

Alert Message: Fatal and non-fatal infections (including bacterial, viral, or fungal) have occurred with Imbruvica (ibrutinib) therapy. Grade 3 or greater infections occurred in 24% of 1,124 patients exposed to ibrutinib in clinical trials. Cases of progressive multifocal leukoencephalopathy (PML) and Pneumocystis jirovecii pneumonia (PJP) have occurred in patients treated with ibrutinib. Consider prophylaxis according to the standard of care in patients who are at increased risk for opportunistic infections. Monitor and evaluate patients for fever and infections and treat appropriately.

Drugs/Diseases

Util A	Util B	Util C
Ibrutinib	Serious Infections	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

42. Ibrutinib / Arrhythmia _____ _____

Alert Message: Fatal and serious cardiac arrhythmias have occurred with Imbruvica (ibrutinib) therapy. Grade 3 or greater ventricular tachyarrhythmias and Grade 3 or greater atrial fibrillation and atrial flutter occurred in patients exposed to ibrutinib in clinical trials. These events have occurred particularly in patients with cardiac risk factors, hypertension, acute infections, and a previous history of cardiac arrhythmias. Periodically monitor patients clinically for cardiac arrhythmias. Manage cardiac arrhythmias appropriately, and if it persists, consider the risks and benefits of ibrutinib treatment and follow dose modification guidelines.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ibrutinib	Arrhythmias	Antiarrhythmic Agents

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

43. Ibrutinib / Hypertension _____ _____

Alert Message: Hypertension has been reported with Imbruvica (ibrutinib) therapy. Hypertension of any grade occurred in 12% of 1,124 patients treated with ibrutinib in clinical trials. Grade 3 or greater hypertension occurred in 5% of patients with a median time to onset of 5.9 months (range, 0.03 to 24 months). Monitor blood pressure in patients treated with ibrutinib and initiate or adjust antihypertensive medication throughout ibrutinib treatment as appropriate.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ibrutinib	Hypertension	Antihypertensive Agents

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Imbruvica Prescribing Information, April 2020, Pharmacyclics.

44. Ibrutinib / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Imbruvica (ibrutinib). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Encorafenib		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487-97.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

45. Cenobamate / Overuse _____ _____
Alert Message: Xcopri (cenobamate) may be over-utilized. The recommended maximum daily dose of cenobamate is 400 mg once daily.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Cenobamate		Hepatic Impairment

Max Dose: 400 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

46. Cenobamate / Overuse _____ _____
Alert Message: Xcopri (cenobamate) should be used with caution in patients with mild to moderate hepatic impairment. For patients with mild to moderate (5-9 points on Child-Pugh assessment) hepatic impairment, the maximum recommended dosage is 200 mg once daily. The use of cenobamate is not recommended in patients with severe hepatic impairment.

Drugs/Diseases

Util A	Util B	Util C (Include)
Cenobamate		Hepatic Impairment

Max Dose: 200 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

47. Cenobamate / Short QT Syndrome _____ _____
Alert Message: Xcopri (cenobamate) use is contraindicated in patients with familial short QT syndrome. In a placebo-controlled study of the QT interval, a higher percentage of subjects who took cenobamate (31% at 200 mg and 66% at 500 mg) had a QT shortening of greater than 20 msec compared to placebo (6-17%).

Drugs/Diseases

Util A	Util B	Util C (Include)
Cenobamate		Ventricular Fibrillation
		Ventricular Tachycardia

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.
Rudic B, Schimpf R, Borggrefe M. Short QT Syndrome - Review of Diagnosis and Treatment. Arrhythm Electrophysiol *Rev*. 2014;3(2):76-79. doi:10.15420/aer.2014.3.2.76

48. Cenobamate / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Xcopri (cenobamate) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

49. Cenobamate / DRESS _____ _____

Alert Message: Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) has been reported in patients taking Xcopri (cenobamate). DRESS has occurred, including one fatality, when cenobamate was titrated rapidly (weekly or faster titration). If such signs or symptoms are present, the patient should be evaluated immediately. Cenobamate should be discontinued immediately and not restarted if an alternative etiology for the signs or symptoms cannot be established.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Fever	
	Generalized Skin Eruption Due to Drugs	
	Lymphadenopathy	
	Facial Swelling	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

50. Cenobamate / Phenytoin _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with phenytoin may result in as much as a 2-fold increase in phenytoin plasma concentrations. The official prescribing information recommends that the phenytoin dosage be gradually decreased by up to 50% as cenobamate is being titrated.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Phenytoin	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

51. Cenobamate / Phenobarbital _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with phenobarbital may result in elevated phenobarbital plasma concentrations and an increased risk of phenobarbital-related adverse effects. Consider a reduction in the dosage of phenobarbital, as clinically appropriate, when used concomitantly with cenobamate.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Phenobarbital	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

52. Cenobamate / Clobazam _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with clobazam may result in elevated clobazam plasma concentrations and an increased risk of clobazam-related adverse effects. Consider a reduction in the dosage of clobazam, as clinically appropriate, when used concomitantly with cenobamate.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Clobazam	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

53. Cenobamate / Lamotrigine _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with lamotrigine may result in decreased plasma concentrations of lamotrigine and decreased efficacy. Increase the dose of lamotrigine as needed, when used concomitantly with cenobamate.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Lamotrigine	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

54. Cenobamate / Carbamazepine _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with carbamazepine may result in decreased plasma concentrations of carbamazepine and decreased efficacy. Increase the dose of carbamazepine as needed, when used concomitantly with cenobamate.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Carbamazepine	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

55. Cenobamate / CYP2B6 or CYP3A4 Substrates _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with a CYP2B6 or CYP3A4 substrate may result in decreased plasma concentrations of substrate and decreased substrate efficacy. Increase the dose of the CYP2B6 or CYP3A4 substrate as needed, when used concomitantly with cenobamate.

Drugs/Diseases

Util A	Util B				Util C
Cenobamate	Avanafil	Eletriptan	Maraviroc	Sirolimus	Vardenafil
	Budesonide	Eplerenone	Midazolam	Tacrolimus	
	Bupropion	Everolimus	Naloxegol	Tadalafil	
	Buspirone	Felodipine	Nisoldipine	Ticagrelor	
	Darifenacin	Ibrutinib	Quetiapine	Tipranavir	
	Darunavir	Lomitapide	Sertraline	Tolvaptan	
	Dronedarone	Lovastatin	Sildenafil	Triazolam	
	Efavirenz	Lurasidone	Simvastatin	Thiotepa	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

56. Cenobamate / CYP2C19 Substrates _____ _____

Alert Message: The concurrent use of Xcopri (cenobamate) with a CYP2C19 substrate may result in increased substrate plasma concentrations and risk of CYP2C19 substrate-related adverse reactions. If clinically appropriate, consider a reduction in dosage of the CYP2C19 substrate when used concomitantly with cenobamate.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Carisoprodol	
	Cilostazol	
	Citalopram	
	Diazepam	
	Lansoprazole	
	Omeprazole	
	Voriconazole	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

57. Cenobamate / Oral Hormonal Contraceptives _____ _____

Alert Message: The coadministration of Xcopri (cenobamate) with oral hormonal contraceptives (CYP3A4 substrates) can result in decreased hormone concentrations and loss of hormonal contraceptive efficacy. Counsel patients to use additional or alternative non-hormonal methods of contraception while taking cenobamate.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Oral Hormonal Contraceptives	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

58. Cenobamate / CNS Depressants _____ _____

Alert Message: The coadministration of Xcopri (cenobamate) with CNS depressants may increase the risk of neurological adverse reactions, including sedation and somnolence. Educate the patient to the risk of excessive CNS depression when these medications are coadministered.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	CNS Depressants	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

59. Cenobamate / Drugs That Shorten Q Interval _____ _____

Alert Message: Xcopri (cenobamate) can shorten the QT interval; therefore, caution should be used when administering cenobamate with drugs that shorten the QT interval, as a synergistic effect on the QT interval could occur. Cenobamate use is contraindicated in patients with familial short QT syndrome.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Isavuconazonium	
	Rufinamide	
	Mexiletine	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

60. Cenobamate / Non-adherence _____ _____

Alert Message: Based on the refill history, your patient may be underutilizing Xcopri (cenobamate). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Faught E, Duh MS, Weiner JR, et al. Nonadherence to Antiepileptic Drugs and Increased Mortality, Findings from the RANSOM Study. Neurology 2008;71(20): 1572-1578.
Faught RE, Weiner JR, Guerin A, et al. Impact of Nonadherence to Antiepileptic Drugs on Health Care Utilization and Costs: Findings from the RANSOM Study. Epilepsia 2009;50(3):501-509.
Hodges JC, Treadwell J, Malphrus AD, et al., Identification and Prevention of Antiepileptic Drug Noncompliance: The Collaborative Use of State-Supplied Pharmaceutical Data. ISRN Pediatr. 2014 Feb 19:1-8.
Viswanathan M, Golin CE, Jones DC, et al., Interventions to Improve Adherence to Self-administered Medications for Chronic Disease in the\United States: A Systemic Review. Ann Intern Med. 2012:157:785-792.

61. Cenobamate / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate data on the developmental risk associated with the use of Xcopri (cenobamate) in pregnant patients. In animal studies, administration of cenobamate during pregnancy or throughout pregnancy and lactation resulted in adverse effects on development (increased embryofetal mortality, decreased fetal and offspring body weights, neurobehavioral and reproductive impairment in offspring) at clinically relevant drug exposures. Encourage patients who are taking cenobamate during pregnancy to enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Cenobamate	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

62. Cenobamate / Lactation _____ _____

Alert Message: There are no data available on the presence of Xcopri (cenobamate) in human milk, the effects on the breastfed infant, or the effects of the drug on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for cenobamate and any potential adverse effects on the breastfed infant from cenobamate or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Cenobamate	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

63. Cenobamate / End-Stage Renal Disease _____ _____

Alert Message: The use of Xcopri (cenobamate) is not recommended in patients with end-stage renal disease undergoing dialysis. The effect of hemodialysis on cenobamate pharmacokinetics has not been studied.

Drugs/Diseases

Util A	Util B	Util C (Include)
Cenobamate		End-Stage Renal Disease
		Hemodialysis

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

64. Cenobamate / Mild to Severe Renal Impairment _____ _____

Alert Message: Xcopri (cenobamate) should be used with caution and dosage reduction considered in patients with mild to moderate (CLcr 30 to less than 90 mL/min) and severe (CLcr less than 30 mL/min) renal impairment. In pharmacokinetic studies, cenobamate plasma AUC was 1.4 fold to 1.5 fold higher in subjects with mild (CLcr 60 to less than 90 mL/min) and moderate (CLcr 30 to less than 60 mL/min) following a single oral 200 mg dose of cenobamate compared to healthy controls.

Drugs/Diseases

Util A	Util B	Util C (Include)
Cenobamate		CKD Stage 2, 3, 4, & 5.

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Xcopri Prescribing Information, August 2020, SK Life Science. Inc.

65. Budesonide/Glycopyrrolate/Formoterol / Overutilization _____ _____

Alert Message: The manufacturer's recommended maximum daily dose of Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) is two inhalations twice daily. Excessive use of a formoterol-containing agent or use in conjunction with other medications containing a beta-2-agonist can result in clinically significant cardiovascular effects and may be fatal.

Drugs/Diseases

Util A	Util B	Util C
Budesonide/Glycopyrrolate/Formoterol		

Max Dose: 4 inhalations/day

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

66. Budesonide/Glycopyrrolate/Formoterol / Therapeutic Appropriateness _____ _____

Alert Message: The safety and efficacy of Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) in patients with asthma have not been established. Budesonide/glycopyrrolate/formoterol is not indicated for the treatment of asthma.

Drugs/Diseases

Util A	Util B	Util C (Include)
Budesonide/Glycopyrrolate/Formoterol		Asthma

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

67. Budesonide/Glycopyrrolate/Formoterol / Therapeutic Appropriateness _____ _____

Alert Message: Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) is not indicated for use in children. The safety and effectiveness of budesonide/glycopyrrolate/formoterol have not been established in children.

Drugs/Diseases

Util A	Util B	Util C
Budesonide/Glycopyrrolate /Formoterol		

Age Range: 0 – 17 yoa

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

68. Budesonide/Glycopyrrolate/Formoterol / Cardiovascular, Diabetes, Convulsive Disorders, & Thyrotoxicosis _____ _____

Alert Message: Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) should be used with caution in patients with cardiovascular or convulsive disorders, thyrotoxicosis, or sensitivity to sympathomimetic drugs. The formoterol component is a sympathomimetic amine and can exacerbate these conditions.

Drugs/Diseases

Util A	Util B	Util C
Budesonide/Glycopyrrolate/Formoterol	Hypertension	
	Arrhythmias	
	Heart Failure	
	Diabetes	
	Seizures	
	Epilepsy	
	Thyrotoxicosis	

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

69. Budesonide/Glycopyrrolate/Formoterol / Adrenergic Drugs _____ _____

Alert Message: Caution should be exercised when Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) is prescribed concurrently with other adrenergic sympathomimetic agents, administered by any route, because the sympathetic effects of the formoterol component of the combination product may be potentiated.

Drugs/Diseases

Util A	Util B		Util C
Budesonide/Glycopyrrolate/Formoterol	Amphetamine	Methylphenidate	
	Benzphetamine	Naphazoline	
	Dextroamphetamine	Oxymetazoline	
	Diethylpropion	Phenylephrine	
	Ephedrine	Phendimetrazine	
	Epinephrine	Phentermine	
	Lisdexamfetamine	Pseudoephedrine	
	Methamphetamine	Tetrahydrozoline	

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

70. Budesonide/Glycopyrrolate/Formoterol / Xanthine Derivatives & Steroids _____ _____

Alert Message: Caution should be exercised when Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) is prescribed concurrently with xanthine derivatives or steroids because concomitant administration may potentiate the hypokalemic effect of the formoterol component of the combination agent.

Drugs/Diseases

Util A	Util B		Util C
Budesonide/Glycopyrrolate/Formoterol	Aminophylline	Dexamethasone	
	Dyphylline	Hydrocortisone	
	Theophylline	Methylprednisolone	
	Betamethasone	Prednisolone	
	Budesonide	Prednisone	
	Cortisone		

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

71. Budesonide/Glycopyrrolate/Formoterol / Non-Potassium Sparing Diuretics _____ _____

Alert Message: Caution should be exercised when Breztri Aerosphere (budesonide/glycopyrrolate/formoterol), a beta2-agonist containing combo product, is prescribed concurrently with non-potassium-sparing diuretics. The hypokalemia and/or ECG changes that may result from the administration of non-potassium sparing diuretics (such as loop or thiazide diuretics) can be acutely worsened by beta2-agonists, especially when the recommended dose of the beta2-agonist is exceeded.

Drugs/Diseases

Util A	Util B		Util C
Budesonide/Glycopyrrolate/Formoterol	Bumetanide	Indapamide	
	Furosemide	Metolazone	
	Chlorothiazide	Torsemide	
	Chlorthalidone		
	HCTZ		

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

72. Budesonide/Glycopyrrolate/Formoterol / Nonselective Beta Blockers _____ _____

Alert Message: Concurrent use of a beta-adrenergic blocker with Breztri Aerosphere (budesonide/glycopyrrolate/formoterol), a beta2-agonist containing combo product, may diminish the pulmonary effect of the beta-agonist component, formoterol. Beta-blockers not only block the therapeutic effects of beta2-agonists but may produce severe bronchospasm in patients with COPD. If concomitant therapy cannot be avoided, consider a cardioselective beta-blocker, but administer with caution.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Budesonide/Glycopyrrolate/Formoterol	Carvedilol	Acebutolol
	Labetalol	Atenolol
	Nadolol	Betaxolol
	Pindolol	Bisoprolol
	Propranolol	Metoprolol
	Sotalol	Nebivolol
	Timolol	

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

73. Budesonide/Glycopyrrolate/Formoterol / QT Prolonging Meds _____ _____

Alert Message: Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) should be administered with extreme caution to patients being treated with MAOIs, TCAs, or other drugs known to prolong the QTc interval because the action of the adrenergic agonist, formoterol, on the cardiovascular system may be potentiated by these agents.

Drugs/Diseases

Util A	Util B				Util C
Budesonide/Glyco/Form	Abiraterone	Efavirenz	Lithium	Rilpivirine	
	Alfuzosin	Eliglustat	Lofexidine	Risperidone	
	Amiodarone	Encorafenib	Loperamide	Ritonavir	
	Amitriptyline	Entrectinib	Maprotiline	Romidepsin	
	Amoxapine	Eribulin	Methadone	Saquinavir	
	Anagrelide	Erythromycin	Metoclopramide	Sertraline	
	Aripiprazole	Escitalopram	Midostaurin	Siponimod	
	Arsenic Trioxide	Ezogabine	Mifepristone	Solifenacin	
	Artemether/Lum	Famotidine	Mirabegron	Sotalol	
	Asenapine	Felbamate	Mirtazapine	Sunitinib	
	Atazanavir	Fingolimod	Moexipril	Tacrolimus	
	Atomoxetine	Flecainide	Moxifloxacin	Tamoxifen	
	Azithromycin	Fluconazole	Nelfinavir	Telavancin	
	Bedaquiline	Fluoxetine	Nilotinib	Tetrabenazine	
	Bortezomib	Fluvoxamine	Nortriptyline	Thioridazine	
	Bendamustine	Foscarnet	Ofloxacin	Tizanidine	
	Bosutinib	Galantamine	Ondansetron	Tolterodine	
	Buprenorphine	Ganciclovir	Osimertinib	Toremifene	
	Ceritinib	Gemifloxacin	Oxaliplatin	Tramadol	
	Chloroquine	Gilteritinib	Paliperidone	Trazodone	
	Chlorpromazine	Glasdegib	Palonosetron	Tranylcypromine	
	Cilostazol	Granisetron	Panobinostat	Trimipramine	
	Ciprofloxacin	Haloperidol	Paroxetine	Valbenazine	
	Citalopram	Hydroxychloroquine	Pasireotide	Vandetanib	
	Clarithromycin	Hydroxyzine	Pazopanib	Vemurafenib	
	Clomipramine	Ibutilide	Pentamidine	Venlafaxine	
	Clozapine	Iloperidone	Pimavanserin	Voriconazole	
	Crizotinib	Imipramine	Pimozide		
	Dabrafenib	Indapamide	Pitolisant		
	Dasatinib	Indinavir	Phenelzine		
	Desipramine	Isocarboxazid	Posaconazole		
	Deutetrabenazine	Itraconazole	Procainamide		
	Diphenhydramine	Ivosidenib	Promethazine		
	Disopyramide	Ivabradine	Propafenone		
	Dofetilide	Ketoconazole	Protriptyline		
	Dolasetron	Lapatinib	Quetiapine		
	Donepezil	Lefamulin	Quinidine		
	Doxepin	Lenvatinib	Quinine		
	Dronedarone	Leuprolide	Ranolazine		

References:

Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

74. Budesonide/Glycopyrrolate/Formoterol / Anticholinergics _____ _____

Alert Message: The concurrent use of Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) with anticholinergic agents should be avoided. The glycopyrrolate component of the combo product is an anticholinergic agent, and concomitant use with other anticholinergics may lead to an increase in anticholinergic adverse effects.

Drugs/Diseases

Util A	Util B		Util C
Budesonide/Glycopyrrolate/Formoterol	Benztropine	Oxybutynin	
	Darifenacin	Propantheline	
	Dicyclomine	Scopolamine	
	Fesoterodine	Solifenacin	
	Flavoxate	Tolterodine	
	Glycopyrrolate	Trihexyphenidyl	
	Hyoscyamine	Trospium	
	Methscopolamine		
	Orphenadrine		

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

75. Budesonide/Glycopyrrolate/Formoterol / Other LABAs _____ _____

Alert Message: Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) should not be used in conjunction with other medications containing a LABA, as an overdose may result. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs.

Drugs/Diseases

Util A	Util B	Util C
Budesonide/Glycopyrrolate/Formoterol	Arformoterol	
	Formoterol	
	Indacaterol	
	Olodaterol	
	Salmeterol	
	Vilanterol	

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

76. Budesonide/Glycopyrrolate/Formoterol / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Caution should be exercised when co-administering Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) with long-term ketoconazole or other known strong CYP3A4 inhibitors. The budesonide component of the combination inhalation product is a CYP3A4 substrate, and the concurrent use with a strong CYP3A4 inhibitor can result in increased budesonide plasma concentrations and risk of budesonide-related adverse effects.

Drugs/Diseases

Util A	Util B		Util C
Budesonide/Glycopyrrolate/Formoterol	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:
Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

77. Budesonide/Glycopyrrolate/Formoterol / Narrow Angle Glaucoma _____ _____

Alert Message: Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) should be used with caution in patients with narrow-angle glaucoma. Glaucoma, increased intraocular pressure, and cataracts have been reported in patients with COPD following the long-term administration of ICS or with the use of inhaled anticholinergics. Prescribers and patients should be alert for signs and symptoms of acute narrow-angle glaucoma. Instruct patients to consult a physician immediately should any signs or symptoms develop. Consider referral to an ophthalmologist in patients who develop ocular symptoms.

Drugs/Diseases

Util A	Util B	Util C
Budesonide/Glycopyrrolate/Formoterol	Narrow Angle Glaucoma	

References:

Breztri Aerosphere Prescribing Information, July 2020, AstraZeneca.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

78. Budesonide/Glycopyrrolate/Formoterol / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Breztri Aerosphere (budesonide/glycopyrrolate/formoterol). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Budesonide/Glycopyrrolate/Formoterol		

References:

van Boven JF, Chavannes NH, van der Molen T, et al. Clinical and Economic Impact of Non-adherence in COPD: A Systematic Review. Respir Med. 2015 Jan;108(1):103-113.
Restrepo RD, Alvarez MT, Wittnebel LD, et al., Medication Adherence Issues in Patients Treated for COPD. International Journal of COPD. 2008;3(3):371-384.
Simoni-Wastila L, Wei Y, Qian J, et al., Association of Chronic Obstructive Pulmonary Disease Maintenance Medication Adherence With All-Cause Hospitalization and Spending in a Medicare Population. Am Jrnl Geriatr Pharmacother. 2012 Jun;10(3):201-210.
Lareau SC, Yawn BP. Improving Adherence with Inhaler Therapy in COPD. International Journal COPD. 2010 Nov 24;5:401-406.

79. Fluticasone-Umeclidinium-Vilanterol / Overutilization (Asthma) _____ _____

Alert Message: The manufacturer's recommended dose of Trelegy Ellipta (fluticasone/umeclidinium/vilanterol) for the maintenance treatment of asthma is 1 inhalation (200 mcg fluticasone/62.5mcg umeclidinium/25mcg vilanterol) once daily by orally inhaled route only. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic-containing drugs.

Drugs/Diseases

Util A	Util B	Util C (Include)
Fluticasone/Umeclidinium/Vilanterol		Asthma

Max Dose: 200mcg fluticasone/62.5 mcg umeclidinium/25mcg vilanterol per day

References:

Trelegy Ellipta Prescribing Information, September 2020, GlaxoSmithKline.
Clinical Pharmacology, 2020 Elsevier/Gold Standard.

Criteria Recommendations *Approved* *Rejected*

80. Osilodrostat / Overuse _____ _____

Alert Message: Isturisa (osilodrostat) may be over-utilized. The recommended maximum dose of osilodrostat is 30 mg twice daily. The maintenance dosage varied between 2 mg and 7 mg twice daily in clinical trials.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat		

Max Dose: 60 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.

81. Osilodrostat / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Isturisa (osilodrostat) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.

82. Osilodrostat / QT Prolongation _____ _____

Alert Message: Isturisa (osilodrostat) is associated with a dose-dependent QT interval prolongation (maximum mean estimated QTcF increase of up to 5.3 ms at 30 mg), which may cause cardiac arrhythmias. Use osilodrostat with caution in patients with risk factors for QT prolongation, (such as congenital long QT syndrome, congestive heart failure, bradyarrhythmias, uncorrected electrolyte abnormalities, and concomitant medications known to prolong the QT interval) and consider more frequent ECG monitoring.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat	QT Prolongation	
	Heart Failure	
	Bradyarrythmias	
	Hypomagnesemia	
	Hypokalemia	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.

83. Osilodrostat / Strong CYP3A4 Inhibitor _____ _____

Alert Message: Concomitant use of Isturisa (osilodrostat) with a strong CYP3A4 inhibitor (e.g., itraconazole, clarithromycin) may cause an increase in osilodrostat concentrations and may increase the risk of osilodrostat-related adverse reactions. Reduce the dose of osilodrostat by half with concomitant use of a strong CYP3A4 inhibitor.

Drugs/Diseases

Util A	Util B		Util C
Osilodrostat	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors, and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

84. Osilodrostat / Strong CYP3A4 and CYP2B6 Inducers _____ _____

Alert Message: Concomitant use of Isturisa (osilodrostat) with strong CYP3A4 and/or CYP2B6 inducers (e.g., carbamazepine, rifampin, phenobarbital) may cause a decrease in osilodrostat concentration and may reduce the efficacy of osilodrostat. During concomitant use of osilodrostat with strong CYP3A4 and CYP2B6 inducers, monitor cortisol concentration and patient's signs and symptoms. An increase in osilodrostat dosage may be needed.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors, and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

85. Osilodrostat / CYP1A2 and CYP2C19 Substrates _____ _____

Alert Message: Isturisa (osilodrostat) should be used with caution when coadministered with CYP1A2 and CYP2C19 substrates with a narrow therapeutic index, such as theophylline, tizanidine, and omeprazole. In drug studies, osilodrostat has shown inhibition potential of CYP1A2 and CYP2C19 isozymes.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat	Alosetron	
	Duloxetine	
	Omeprazole	
	Ramelteon	
	Tasimelteon	
	Tizanidine	
	Theophylline	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors, and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

86. Osilodrostat / Therapeutic Appropriateness _____ _____

Alert Message: There are no available data on the presence of Isturisa (osilodrostat) in human or animal milk, the effects on the breastfed infant, or the effects on milk production. Because of the potential for serious adverse reactions (such as adrenal insufficiency) in the breastfed infant, advise patients that breastfeeding is not recommended during treatment with osilodrostat and for one week after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.

87. Osilodrostat / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Isturisa (osilodrostat). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Osilodrostat		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
Brown MT, Bussell J, Supmarna D, et al. Medication Adherence: Truth and Consequences. Am J Med Sci. 2016 Apr;351(4):387-399.
Iuga AO, McGuire MJ. Adherence and Health Care Costs. Risk Manag Healthc Policy. 2014 Feb 20;7:35-44.

88. Osilodrostat / QT prolongation _____ _____

Alert Message: Isturisa (osilodrostat) is associated with a dose-dependent QT interval prolongation (maximum mean estimated QTcF increase of up to 5.3 ms at 30 mg), which may cause cardiac arrhythmias. Use osilodrostat with caution in patients with risk factors for QT prolongation, (such as congenital long QT syndrome, congestive heart failure, bradyarrhythmias, uncorrected electrolyte abnormalities, and concomitant medications known to prolong the QT interval) and consider more frequent ECG monitoring.

Drugs/Diseases

Util A	Util B				Util C
Osilodrostat	Abiraterone	Efavirenz	Lithium	Rilpivirine	
	Alfuzosin	Eliglustat	Lofexidine	Risperidone	
	Amiodarone	Encorafenib	Loperamide	Ritonavir	
	Amitriptyline	Entrectinib	Maprotiline	Romidepsin	
	Amoxapine	Eribulin	Methadone	Saquinavir	
	Anagrelide	Erythromycin	Metoclopramide	Sertraline	
	Aripiprazole	Escitalopram	Midostaurin	Siponimod	
	Arsenic Trioxide	Ezogabine	Mifepristone	Solifenacin	
	Artemether/Lum	Famotidine	Mirabegron	Sotalol	
	Asenapine	Felbamate	Mirtazapine	Sunitinib	
	Atazanavir	Fingolimod	Moexipril	Tacrolimus	
	Atomoxetine	Flecainide	Moxifloxacin	Tamoxifen	
	Azithromycin	Fluconazole	Nelfinavir	Telavancin	
	Bedaquiline	Fluoxetine	Nilotinib	Tetrabenazine	
	Bortezomib	Fluvoxamine	Nortriptyline	Thioridazine	
	Bendamustine	Foscarnet	Ofloxacin	Tizanidine	
	Bosutinib	Galantamine	Ondansetron	Tolterodine	
	Buprenorphine	Ganciclovir	Osimertinib	Toremifene	
	Ceritinib	Gemifloxacin	Oxaliplatin	Tramadol	
	Chloroquine	Gilteritinib	Paliperidone	Trazodone	
	Chlorpromazine	Glasdegib	Palonosetron	Tranylcypromine	
	Cilostazol	Granisetron	Panobinostat	Trimipramine	
	Ciprofloxacin	Haloperidol	Paroxetine	Valbenazine	
	Citalopram	Hydroxychloroquine	Pasireotide	Vandetanib	
	Clarithromycin	Hydroxyzine	Pazopanib	Vemurafenib	
	Clomipramine	Ibutilide	Pentamidine	Venlafaxine	
	Clozapine	Iloperidone	Pimavanserin	Voriconazole	
	Crizotinib	Imipramine	Pimozide		
	Dabrafenib	Indapamide	Pitolisant		
	Dasatinib	Indinavir	Phenelzine		
	Desipramine	Isocarboxazid	Posaconazole		
	Deutetrabenazine	Itraconazole	Procainamide		
	Diphenhydramine	Ivosidenib	Promethazine		
	Disopyramide	Ivabradine	Propafenone		
	Dofetilide	Ketoconazole	Protriptyline		
	Dolasetron	Lapatinib	Quetiapine		
	Donepezil	Lefamulin	Quinidine		
	Doxepin	Lenvatinib	Quinine		
	Dronedarone	Leuprolide	Ranolazine		

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Isturisa Prescribing Information, March 2020, Recordati Rate Diseases, Inc.

North Dakota Medicaid
Drug Utilization Review Board
Meeting
June 2, 2021
Conference Room 210/212

North Dakota Medicaid
DUR Board Meeting Agenda
Conference Room 210/212
North Dakota State Capitol
Click here to join the meeting
(Click on link)
Join by phone: 1 701-328-0950, Conference ID 903 925 001#
June 2, 2021
1:00 pm

1. Administrative items
    - DHS announcements

2. Old business
    - Review and approval of March 2021 meeting minutes
    - Budget update
    - Review top 25 drugs for first quarter of 2021
    - Prior authorization/PDL update
    - Second review of agents for the management of Sickle Cell disease
    - Second review of agents for the treatment of Fabry disease
    - Second review of Imcivree (setmelonotide)
    - Second review of bowel prep agents
    - Update to Evrysdi (risdiplam) criteria
    - Update to Medications that cost over $3000/month criteria
    - Update to Hepatitis C criteria

3. New business
    - Review of agents for the treatment of heart failure
    - Review of drug utilization trends for select medication classes
    - Retrospective DUR profile review update
    - Retrospective DUR criteria recommendations
    - Upcoming meeting date/agenda.
        - Next meeting is September 1, 2021
4. Adjourn

Please remember to silence all cellular phones during the meeting.

North Dakota Medicaid Drug Use Review (DUR) Board
Meeting Minutes
March 3, 2021

Members Present: Joshua Askvig, Andrea Honeyman, Michael Quast, Kathleen Traylor, Gabriela Balf, Mary Aaland, Amy Werremeyer, Laura Schield, Tanya Schmidt

Medicaid Pharmacy Department: Alexi Murphy, Brendan Joyce, LeNeika Roerich

Old Business

Chair A. Honeyman called the meeting to order at 1:05 p.m. Chair A. Honeyman asked for a motion to approve the minutes of the January 6, 2021 meeting. J. Askvig moved that the minutes be approved, and T. Schmidt seconded the motion. The chair called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 25 Drugs

B. Joyce presented budget updates and the quarterly review of the top 25 drugs based on total cost of claims, the top 25 drugs based on the total number of claims, and the top drug classes based on claims and cost for the 1st quarter of 2021. B. Joyce presented data to the Board that was reflective of actual end costs to ND Medicaid to better reflect potential areas of high cost to the program. M. Aaland inquired about the possibility of getting information that is reflective of the trends on where drugs/drug classes rank on the top 25 lists and T. DeRuiter stated he will attempt to do so at future meetings.

PDL/PA Criteria Updates

A. Murphy shared with the Board all of changes made to the Preferred Drug List since the last version of the Preferred Drug List was posted. Notable changes included the addition of 4 medications to the >$3,000 prior authorization criteria; the addition of cycloserine and Sirturo to the Antibiotic Resistance class on the PDL requiring prior authorization; and removing prior authorization requirements for Sunosi. All PDL updates are listed in the handouts for the March 2021 DUR Board meeting. When a new version of the PDL is published and posted to the website, all updates/changes made since the last version are called out at the top of the document itself.

Second Review of Evrysdi

A motion and second was made at the January 2021 DUR Board meeting to place Evrysdi on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. During public comment, M. Schroth from Cure SMA, J. Whalen from Genetech, and R. Richardson from Gillette Children's Hospital presented information to the Board and spoke in favor of adjusting the criteria as presented. During Board discussion, changes were proposed based on speaker testimony including correcting the age requirements, removing limitations on use in patients with tracheostomy, adding in a route for approval for patients that were diagnosed at newborn screening, and adjusting requirements around assessments used. M. Aaland made a motion to table the criteria for the next meeting, but the motion was not seconded. A. Werremeyer made a motion to correct the age requirements, removing limitations on use in patients with tracheostomy, and removing the testing requirements for SMA1. G. Balf seconded the motion. The Board requested that the criteria be brough back for

potential updates at the next meeting after consultation on further potential adjustments to the criteria. Chair A. Honeyman called for a voice vote to approve the amended criteria, which passed with no audible dissent.

Update to the Prior Authorization Criteria for Hereditary Angioedema

T. DeRuiter presented proposed updates to the prior authorization criteria for agents used to treat hereditary angioedema. The proposed updates included criteria that requires that the patient has an FDA-approved indication for use, that the medication be prescribed by or in consultation with a specialist, and that the patient has had a trial of the preferred agents to meet criteria for coverage for non-preferred agents. During public comment, J. Williamson from the U.S. Hereditary Angioedema Association presented information on HAE to the Board. J. Askvig made a motion to adopt the updated criteria and T. Schmidt seconded the motion. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Update to the Prior Authorization Criteria for Irritable Bowel Syndrome

T. DeRuiter presented proposed updates to the prior authorization criteria for agents used to treat irritable bowel syndrome. The proposed updates included criteria for non-preferred agents that requires that the patient has an FDA-approved indication for use, confirmation that the provider has ruled out other etiologies for diarrhea, and that the patient has had a trial of each preferred agent. Renewal criteria requiring documentation of improvement while taking the medication was also added. A. Werremeyer made a motion to adopt the updated criteria and G. Balf seconded the motion. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

New Business

Review of Enspryng (satralizumab)

T. DeRuiter presented a review of Enspryng (satralizumab) for the treatment of neuromyelitis optica spectrum disorder to the Board. During public comment, J. Whalen of Genetech presented information on Enspryng to the Board. A motion was made by A. Werremeyer to manage these medications through prior authorization. The motion was seconded by G. Balf. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Review of Agents for the Management of Sickle Cell Disease

T. DeRuiter presented a review of agents used in the management of sickle cell disease to the Board. J. Smutko of Global Blood Therapeutics presented information on Oxbryta to the Board. A motion was made by L. Schield to manage these medications through prior authorization. The motion was seconded by J. Askvig. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Review of Agents for the Treatment of Fabry Disease

T. DeRuiter presented a review of agents for the treatment of Fabry disease to the Board. There was no public comment. A motion was made by A. Werremeyer to manage these medications through prior authorization. The motion was seconded by T. Schmidt. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Review of Imcivree (setmelonotide)
T. DeRuiter presented a review of Imcivree (setmelonotide) for the weight management in patients with POMC, PCSK1, or LEPR deficiencies to the Board. There was no public comment. A motion was made by T. Schmidt to manage these medications through prior authorization. The motion was seconded by A. Werremeyer. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Utilization Review of Antipsychotic Agents
T. DeRuiter presented data on the utilization of antipsychotic agents in the Medicaid population, comparing utilization before and after new requirements have been implemented including requiring use for FDA-approved indications and ages to qualify for coverage. The data indicated an overall reduction in antipsychotic utilization, including a 31% reduction in patients receiving multiple antipsychotics concurrently with the overall reduction in antipsychotic utilization only decreasing by 5%.

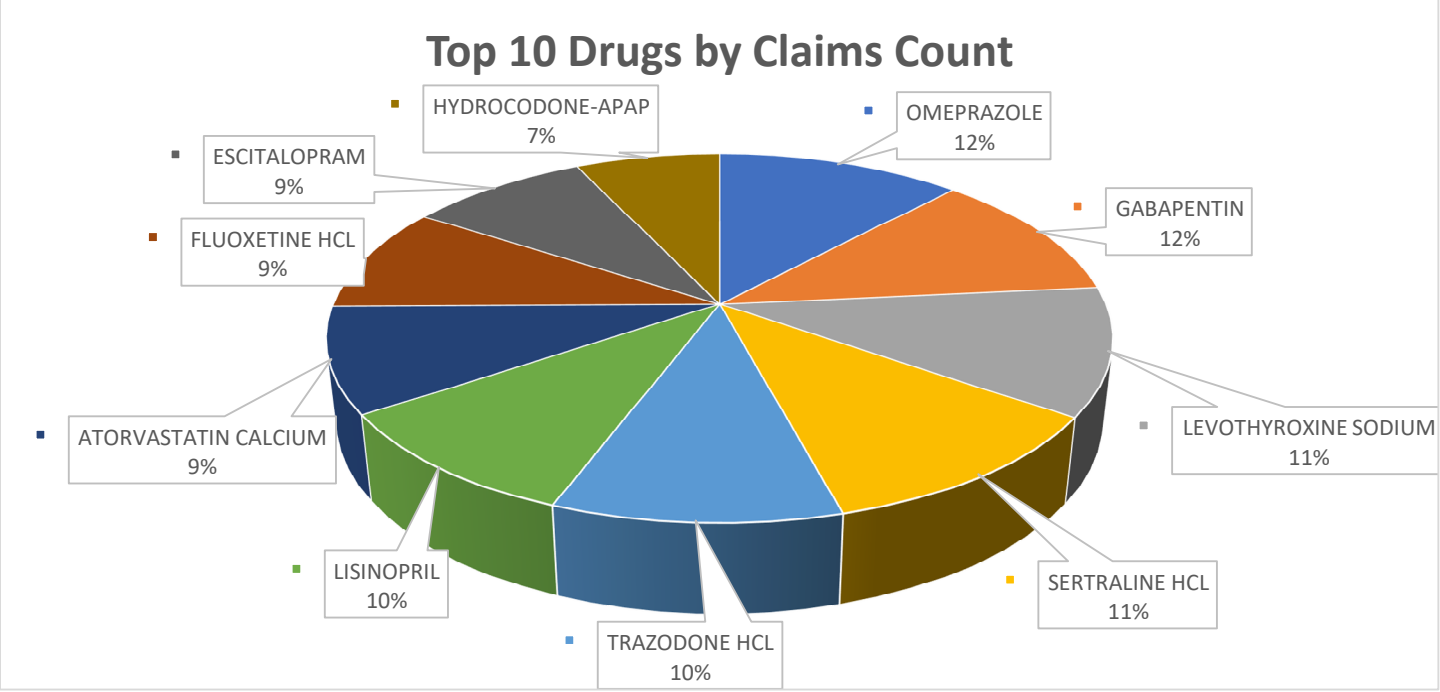
Retrospective Drug Utilization Review (RDUR) Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. MW moved to approve the new criteria and T. Schmidt seconded the motion. Chair A. Honeyman called for a voice vote to approve the new criteria, which passed with seven members voting to approve and one voting against approval.

Adjournment and Upcoming Meeting Date
Chair A. Honeyman adjourned the meeting at 3:21 pm. The next DUR Board meeting will be held June 2, 2021 at 1:00 pm with location TBD.

Top 25 Drugs Based on Number of Claims from 01/01/2021 – 03/31/2021

Drug	Claims	Patients	Claims Cost	Cost / Claim	% Total Claims	Dif.
OMEPRAZOLE	4,819	2,376	$62,363.55	$12.94	1.94%	NC
GABAPENTIN	4,600	1,912	$70,947.09	$15.42	1.86%	NC
LEVOTHYROXINE SODIUM	4,503	1,794	$81,051.57	$18.00	1.82%	NC
SERTRALINE HCL	4,458	2,355	$60,944.53	$13.67	1.80%	NC
TRAZODONE HCL	4,027	1,951	$54,555.62	$13.55	1.62%	NC
LISINOPRIL	3,911	2,045	$49,479.64	$12.65	1.58%	↑1
ATORVASTATIN CALCIUM	3,716	1,964	$53,005.21	$14.26	1.50%	↓1
FLUOXETINE HCL	3,715	1,929	$50,876.84	$13.69	1.50%	↑1
ESCITALOPRAM OXALATE	3,548	1,941	$47,740.61	$13.46	1.43%	↓1
HYDROCODONE-APAP	2,847	1,768	$44,455.62	$15.61	1.15%	↑1
BUPROPION XL	2,794	1,358	$49,478.39	$17.71	1.13%	↓1
DULOXETINE HCL	2,709	1,237	$42,882.46	$15.83	1.09%	↑1
METFORMIN HCL	2,699	1,400	$34,188.73	$12.67	1.09%	↓1
PANTOPRAZOLE SODIUM	2,665	1,292	$35,531.51	$13.33	1.08%	↑1
VYVANSE	2,593	1,021	$647,038.26	$249.53	1.05%	↑1
MONTELUKAST SODIUM	2,526	1,328	$35,666.63	$14.12	1.02%	↓2
CYCLOBENZAPRINE HCL	2,447	1,433	$27,208.07	$11.12	0.99%	↑5
BUPRENORPHINE-NALOXONE	2,391	516	$100,170.00	$41.89	0.96%	↑1
CLONIDINE HCL	2,337	1,096	$29,468.82	$12.61	0.94%	↑2
PROAIR HFA	2,318	2,282	$167,755.57	$72.37	0.94%	↓2
ARIPIPRAZOLE	2,287	1,034	$34,818.73	$15.22	0.92%	↑4
LAMOTRIGINE	2,277	903	$31,897.13	$14.01	0.92%	↓5
VENLAFAXINE HCL ER	2,214	950	$37,140.68	$16.78	0.89%	NC
AMLODIPINE BESYLATE	2,195	1,219	$27,474.80	$12.52	0.89%	↓4
CLONAZEPAM	2,119	911	$28,830.27	$13.61	0.85%	↑1

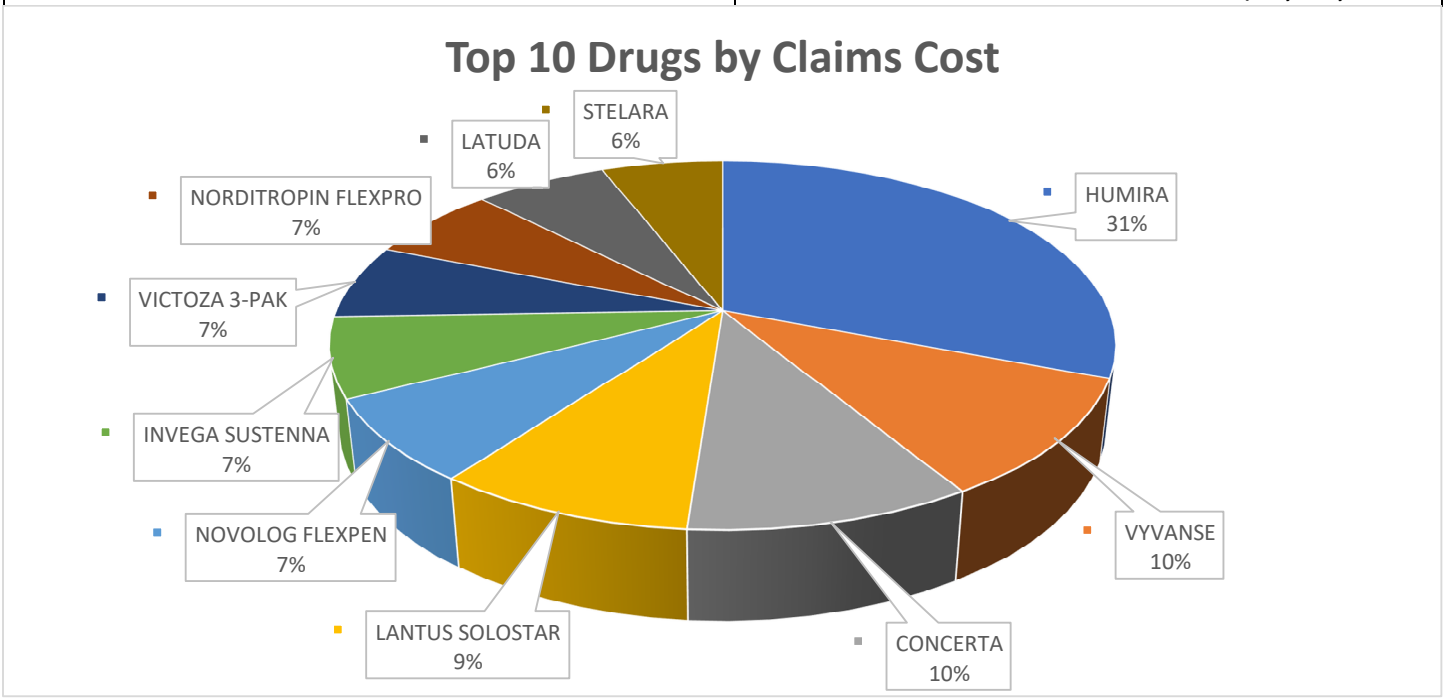
Total Claims	**247,852**



Top 25 Drugs Based on Total Claims Cost from 01/01/2021 – 03/31/2021

Drug	Claims Cost	Claims	Patients	Cost /Claim	% Total Cost	Dif.
HUMIRA	$1,895,499.03	264	126	$7,179.92	6.98%	NC
VYVANSE	$647,038.26	2,593	1,021	$249.53	2.38%	↑1
CONCERTA	$611,971.83	1,838	751	$332.96	2.25%	↑3
LANTUS SOLOSTAR	$553,906.58	1,199	721	$461.97	2.04%	↑1
NOVOLOG FLEXPEN	$447,707.81	674	417	$664.25	1.65%	↓3
INVEGA SUSTENNA	$431,579.55	183	74	$2,358.36	1.59%	↑2
VICTOZA 3-PAK	$402,805.93	448	221	$899.12	1.48%	↑2
NORDITROPIN FLEXPRO	$402,130.43	106	45	$3,793.68	1.48%	↑4
LATUDA	$400,813.34	499	197	$803.23	1.48%	↑1
STELARA	$367,336.02	16	11	$22,958.50	1.35%	↑5
COSENTYX	$364,510.36	61	32	$5,975.58	1.34%	↓4
JARDIANCE	$361,189.05	756	332	$477.76	1.33%	↓1
ENBREL	$350,693.02	64	28	$5,479.58	1.29%	↑7
SYMBICORT	$317,809.37	952	530	$333.83	1.17%	NC
ADVAIR DISKUS	$309,970.55	855	467	$362.54	1.14%	↓2
TRIKAFTA	$294,458.51	14	6	$21,032.75	1.08%	↑1
LEVEMIR FLEXTOUCH	$292,580.46	547	296	$534.88	1.08%	↓1
BIKTARVY	$281,933.60	159	69	$1,773.17	1.04%	↑7
ADDERALL XR	$269,513.58	1,564	646	$172.32	0.99%	↓1
TALTZ AUTOINJECTOR	$261,254.92	22	13	$11,875.22	0.96%	↑70
SABRIL	$245,192.64	12	6	$20,432.72	0.90%	↓2
STRATTERA	$232,284.87	574	282	$404.68	0.86%	NC
ABILIFY MAINTENA	$230,712.45	113	47	$2,041.70	0.85%	↓2
ELIQUIS	$223,744.11	518	242	$431.94	0.82%	↓1
XIFAXAN	$217,283.75	90	49	$2,414.26	0.80%	↓1

Total Claims Cost	**$27,152,365.52**



Top 15 Therapeutic Classes Based on Number of Claims from 01/01/2021 – 03/31/2021

Therapeutic Class Description	Claims	Patients	Claims Cost	Cost/Claim	% Total Claims	Dif.
ANTIDEPRESSANTS	29,827	11,538	$611,489.67	$20.50	12.03%	NC
ANTICONVULSANTS, MISC	13,517	4,665	$1,008,794.76	$74.63	5.45%	NC
ANTIPSYCHOTIC AGENTS	9,305	3,348	$1,912,545.54	$205.54	3.75%	NC
PROTON-PUMP INHIBITORS	7,935	3,820	$143,810.85	$18.12	3.20%	NC
OPIATE AGONISTS	6,967	3,553	$129,423.57	$18.58	2.81%	NC
SEDATIVE/HYPNOTICS	6,798	3,337	$125,847.76	$18.51	2.74%	↑2
NSAIDS	6,647	4,132	$98,217.99	$14.78	2.68%	↓1
STATINS	6,205	3,240	$89,263.14	$14.39	2.50%	↓1
BETA BLOCKERS	5,521	2,792	$104,088.32	$18.85	2.23%	NC
AMPHETAMINES	5,345	2,144	$959,416.06	$179.50	2.16%	NC
NON-AMPHETAMINE STIMULANTS	4,964	1,784	$925,295.19	$186.40	2.00%	↑2
ACE INHIBITORS	4,920	2,585	$71,227.89	$14.48	1.99%	↓1
THYROID AGENTS	4,786	1,870	$90,903.73	$18.99	1.93%	↓1
BIGUANIDES	4,057	2,118	$53,993.81	$13.31	1.64%	NC
BENZODIAZEPINES	3,617	1,801	$65,267.19	$18.04	1.46%	↑1

Top 15 Therapeutic Classes Based on Claims Cost from 01/01/2021 – 03/31/2021

Therapeutic Class Description	Claims Cost	Claims	Patients	Cost/Claim	% Total Cost	Dif.
DMARDS	$2,525,540.42	444	188	$5,688.15	9.30%	NC
ANTIPSYCHOTIC AGENTS	$1,912,545.54	9,305	3,348	$205.54	7.04%	↑1
INSULINS	$1,847,279.99	3,595	1,342	$513.85	6.80%	↓1
SKIN & MUCOUS MEMBRANE AGENTS, MISC	$1,469,372.24	532	337	$2,761.98	5.41%	NC
ANTIRETROVIRALS	$1,048,417.24	772	269	$1,358.05	3.86%	↑6
ANTICONVULSANTS, MISC	$1,008,794.76	13,517	4,665	$74.63	3.72%	NC
INHALED CORTICOSTEROIDS	$969,036.36	3,376	1,929	$287.04	3.57%	↓2
AMPHETAMINES	$959,416.06	5,345	2,144	$179.50	3.53%	↓1
NON-AMPHETAMINE STIMULANTS	$925,295.19	4,964	1,784	$186.40	3.41%	↓1
ANTINEOPLASTIC AGENTS	$865,554.67	582	230	$1,487.21	3.19%	NC
INCRETIN MIMETICS	$775,468.33	1,040	480	$745.64	2.86%	↑1
ANTIDEPRESSANTS	$611,489.67	29,827	11,538	$20.50	2.25%	↑1
IMMUNOMODULATORY AGENTS MISC	$564,259.33	79	34	$7,142.52	2.08%	↑1
SGLT2 INHIBITORS	$481,604.99	1,011	450	$476.36	1.77%	↑1
ANTIMUSCARINICS/ANTISPASMODICS	$412,972.10	1,827	894	$226.04	1.52%	↑1

PDL Update

ADDED TO PA	
Drug	**Class**
Fulphila	Hematopoietic, Colony Stimulating Factors
Udenyca	Hematopoietic, Colony Stimulating Factors
Epclusa 200-50mg	Hepatitis C
Hetlioz	Over 3000
Nulibry	Over 3000
Thyquidity	Preferred Dosage Forms
Gemtesa	Overactive Bladder
Klisyri	Actinic Keratosis
Lupkynis	Over 3000
Reltone	Preferred Dosage Forms
INAVIX (diclofenac/capsaicin)	Kit
NUVAKAAN KIT (lidocaine/prilocaine/silicone)	Kit
NUSURGEPAK (mupirocin/chlorhexidine/dimethacone)	Kit
Dojolvi	Doljovi
Gimoti	Gastroparesis
TRIVIX (Triamcinolone/dimethacone/silicone)	Kit
Wynzora	Antipsoriatics - Topical
Hemady	Oral Steroids
Tramadol 100mg	Opioid Analgesic - Short Acting
Ponvory	Multiple Sclerosis
Roszet	Lipid-Lowering Agents
Zegalogue	Glucose Rescue Medications
DERMALID (lidocaine/elastic bandage)	Kit

Sickle Cell Disease

General Prior Authorization Form

Initial Criteria *Approval Duration = 12 months*

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis, age, and duration of treatment)
- The patient must have had a 30-day trial of a preferred agent at the maximum (35 mg/kg/day) or maximally tolerated dose, as evidenced by paid claims or pharmacy print-outs
- Prescribed by, or in consultation, with a hematologist, or other specialist with expertise in the diagnosis and management of sickle cell disease
- Patient has experienced at least one sickle cell-related vaso-occlusive crisis within past 12 months (documentation required)
- Baseline hemoglobin (Hb) ≤ 10.5 g/dL

Product Specific Criteria:

****Siklos:**

- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).

Renewal Criteria *Approval Duration = 12 months*

- The patient must have experienced and/or maintained clinical benefit since starting treatment with the requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review) by one of the following:
    - Increase in hemoglobin (Hb) by ≥ 1 g/dL from baseline
    - Decrease in indirect bilirubin from baseline
    - Decrease in percent reticulocyte count from baseline
    - Patient has experienced a reduction in sickle cell-related vasoocculusive crisis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DROXIA (Hydroxyurea capsule)	SIKLOS (Hydroxyurea tablet)**
Hydroxyurea capsule	OXBRYTA (voxelotor)

Fabry Disease

General Prior Authorization Form

Initial Criteria: *Approval Duration = 6 months*

- The patient must have a diagnosis of Fabry disease
- The patient must be 18 years of age or older
- The patient must be assigned male at birth.
- Baseline value for plasma or urinary globotriosylceramide (GL-3) levels ≥ 5 ng/mcL or GL-3 inclusions ≥ 0.3 per kidney interstitial capillary (KIC) as measured in kidney biopsy
- The patient's diagnosis must be confirmed to be caused by a pathologic galactosidase alpha gene (GLA) variant that is amenable to treatment with Galafold interpreted from a clinical genetics professional, as evidenced by medical documentation attached to the request.
- The medication must not be used in conjunction with enzyme replacement therapy.
- The patient must not have significant renal impairment (eGFR <30 mL/minute/1.73 m2)

Renewal Criteria: *Approval Duration = 12 months*

- The patient must have a decreased GL-3 level or CL-3 inclusion per KIC level and experienced and maintained improvement in one of the following symptoms since starting treatment with requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review):
    - Proteinuria
    - GFR
    - Left ventricular hypertrophy
    - Cardiac conduction or rhythm
    - Mitral or aortic insufficiency
    - Optic neuropathy
    - Neuropathic pain
    - Gastrointestinal symptoms

PA REQUIRED
GALAFOLD (Migalastat)

Imcivree

General Prior Authorization Form

Initial Criteria: *Approval Duration = 4 months*

- The patient must have a diagnosis of obesity (BMI > 30 kg/m2 for adults or > 95th percentile using growth chart assessments for pediatric patients), as confirmed by genetic testing attached to the request
- The patient's obesity must be due to one of the following variants interpreted as pathogenic, likely pathogenic, or of unknown significance:
    - proopiomelanocortin (POMC)
    - proprotein convertase subtilisin/kexin type 1 (PCSK1)
    - leptin receptor (LEPR) deficiency
- The patient must be 6 years of age or older
- The medication is prescribed by, or in consultation with, an endocrinologist or expert in rare genetic disorders of obesity
- The patient's weight and body mass index (BMI) must be provided within the last 60 days
- The patient must not have significant renal impairment (eGFR <60 mL/minute/1.73 m2)

Renewal Criteria: *Approval Duration = 12 months*

- The patient must have achieved or maintained a 5% weight reduction or 5% of BMI for patients < 18 years old, since starting treatment with Imcivree, as evidenced by medical documentation (e.g. chart notes) attached to the request.

PA REQUIRED
IMCIVREE (Setmelanotide)

Bowel Prep Agents

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 1 month*

- The patient must have a diagnosis of an FDA-approved indication for use
- One of the following must be met (A or B):
    A. The patient must have failed a trial of each preferred agent within the past 2 years, as evidenced by paid claims or pharmacy printouts
    B. Clinical justification must be provided explaining why the patient is unable to use the preferred agents, with medical documentation (e.g. chart notes) documenting the reason(s) preferred agents cannot be used (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE
MOVIPREP	GOLYTELY 236-22.74G
OSMOPREP	GAVILYTE-C
PEG-3350 AND ELECTROLYTES 236-22.74G	GAVILYTE-N
	NULYTELY
	PEG 3350-ELECTROLYTE 240-22.72G
	PEG 3350-ELECTROLYTE 420 G
	PEG 3350/SOD SUL/NACL/KCL/ASB/C
	PLENVU
	SUPREP
	SUTAB
	TRILYTE

Medications that cost over $3000/month

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The patient must meet criteria as outlined in prescribing information (PI) including recommendations for diagnosis and age.
  - The prescriber is a specialist, or the prescriber has consulted with a specialist in the area of the patient's diagnosis
  - As applicable, documentation must be attached to confirm serum marker or pathogenic gene variants amenable to treatment
- **Renewal Criteria**: *Approval Duration = 12 months*
  - The provider must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review).

PA REQUIRED
CYSTADROPS (cysteamine)
CYSTARAN (cysteamine)
ENSPRYNG (satralizumab)
GATTEX (teduglutide)
HETLIOZ (tasimelteon)
INCRELEX (mecasermin)
LUPKYNIS (voclosporin)
MYCAPSSA (octreotide)
NULIBRY (fosdenopterin)
OXERVATE (cenegermin-bkbj)
SAMSCA (tolvaptan)
SYPRINE (trientine)
ZOKINVY (lonafamib)

Evrysdi

Evrysdi Prior Authorization Form

- **Initial Criteria:** *Approval Duration = 12 months*
  - The patient must have a diagnosis of spinal muscular atrophy (SMA) with the following (as evidenced with submitted documentation):
    - Bi-allelic deletions or mutations of SMN1 as confirmed by genetic testing, reported as one of the following:
      - Homozygous deletions of exon 7
      - Compound heterozygous mutations
    - One of the following (A and/or B):
      A. Patient has number of SMN2 gene copies ≥ 1 but ≤ 4 as confirmed by genetic testing
      B. Patient is symptomatic (e.g. loss of reflexes, motor delay, motor weakness, abnormal EMG/neuromuscular ultrasound)
  - The medication must be prescribed by or in consultation with a neuromuscular neurologist or neuromuscular physiatrist
  - The patient must visit with a neuromuscular clinic once per year and clinic name, contact information, and date of last visit must be provided
  - The patient must be 2 months of age or older
  - The patient must not require continuous intubation > 3 weeks
  - The patient must not be receiving/have received treatment a SMN2-targeting antisense oligonucleotide, SMN2 splicing modifier or gene therapy (i.e. Spinraza and Zolgensma)
  - The patient's weight and prescribed dose must be provided and within dosing recommendations per the manufacturer label
  - The provider must submit documentation of the patient's current motor function, as evidenced by scores from at least two of the following assessments
    A. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND)
    B. Hammersmith Infant Neurological Examination (HINE) Section 2 motor milestone score
    C. Hammersmith Functional Motor Scale Expanded (HFMSE)
    D. Motor Function Measure – 32 items (MFM-32)
    E. Revised Upper Limb Module (RULM)
    F. 6 minute walk test (6MWT)
    G. Forced Vital Capacity (FVC) via Pulmonary Function Test

- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient's weight and prescribed dose must be provided and within dosing recommendations per the manufacturer label
  - The patient must visit with a neuromuscular clinic once per year and clinic name, contact information, and date of last visit must be provided
  - The patient must not require continuous intubation > 3 weeks
    A. The provider must submit documentation showing that the patient has experienced clinical benefit since starting treatment with Evrysdi, as evidenced by documentation of current Forced Vital capacity (FVC and FEV1) via Pulmonary Function Test, CHOP-INTEND, HINE, HFMSE, MFM-32, 6MWT, or RULM scores showing maintenance of baseline motor function or significant slowed rate of decline (vs expected natural course of the disease).

PA REQUIRED
EVRYSDI (Risdiplam)

Hepatitis C Treatments

Electronic Step Care and Concurrent Medications

- A total of 28 days of ribavirin must be billed within the previous 14 days of an Epclusa (and its generic) claim if patient has decompensated cirrhosis (Child Pugh B or C).
    - Epclusa (and its generic) requires prior authorization and after prior authorization is approved, Epclusa (and its generic) will continue to reject for prior authorization unless ribavirin is billed first when it is recommended to be used concurrently.

Prior Authorization Criteria

Prior Authorization Form – Hepatitis C

Antivirals

Category Criteria: *Approval duration – based on label recommendations*

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Chronic Hepatitis C must be documented by one of the following:
    - **Liver fibrosis F1 and below**: 2 positive HCV RNA levels at least 6 months apart.
    - **Liver fibrosis F2 and above**: 1 positive HCV RNA test within the last 12 months.
- The patient must be drug (drugs of abuse by injection) and alcohol free as documented by 2 drug and alcohol tests, dated at least 3 months apart, with the most current test completed within 30 days of the request date, in addition to meeting criteria below as applicable:
- **If the patient has a history of alcohol use disorder**, one of the following must be met (A or B)
    A. The provider must submit chart notes documenting that the patient has abstained from alcohol for the past year
    B. All of the following must be met:
        - The patient must be receiving treatment from an enrolled addiction medicine/chemical dependency treatment provider, and the provider/facility name must be provided with the request
        - Chart notes must be attached regarding assessment of patient's readiness for treatment including readiness for abstinence from alcohol use during and after treatment
- **If the patient has a history of using drugs of abuse by injection**, one of the following must be met (A or B)
    A. The provider must submit chart notes documenting that the patient has abstained from drugs of abuse for the past year
    B. All of the following must be met:
        - The patient must be receiving treatment from an enrolled addiction medicine/chemical dependency treatment (or buprenorphine waived) provider, and the provider/facility name must be provided with the request
        - Chart notes must be attached regarding assessment of readiness for treatment of the patient including readiness for abstinence from illicit drug use by injection during and after treatment
- The patient must not be receiving a known recreationally used high risk combination of drugs (e.g. "the holy trinity") for the past 6 months.
- Prescriber must be a hepatology, gastroenterology, or infectious disease specialist if the patient has any of the following:
    - Decompensated cirrhosis (Child's Pugh B or C)
    - Status post solid organ transplantation
    - Known or suspected hepatocellular carcinoma
    - Evidence/suspicion of acute liver injury while on HCV treatment
    - Prior hepatitis C treatment with a Direct Acting Antiviral Regimen
    - HIV or HBsAg positive
    - Current pregnancy or breastfeeding
- Prescriber must be, or in consult with, a hepatology, gastroenterology, or infectious disease specialist (including via Project ECHO) if the patient has any of the following:
    - Compensated cirrhosis (Child's Pugh A)
    - Prior hepatitis C treatment with a Direct Acting Antiviral Regimen

- Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.
- Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling all maintenance medications on time for the past 90 days, as evidenced by pharmacy claims history.
- Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment.
- Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
- Patient and Prescriber attestation forms must be attached to request

Non-Preferred Agents Criteria:

- The patient must have had a trial of each preferred treatment options indicated for the patient's genotype, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- Epclusa 200mg-50mg:
  - Patient must be 6 years old or older and weigh between 17 to 30 kg
- Harvoni:
  - 45mg-200mg strength: Patient must be 3 years old or older and weigh between 17 and 35kg
  - 33.75mg/150mg strength: Patient must be 3 years old or older and weigh less than 17 kg.
- Sovaldi 200mg:
  - Patient must be 3 years old or older and weigh between 17 to 35 kg
- Vosevi:
  - If the patient has experienced reinfection due to use of **drugs of abuse by injection**, all of the following (A, B AND C) must be met:
    A. The patient must submit an additional drug test dated 6 months prior to request date
    B. The patient must have received/be receiving treatment from an enrolled addiction medicine/chemical dependency treatment (or buprenorphine waived) provider, and the provider/facility name must be provided with the request.
    C. The patient must have risk assessment attached and must not be at high risk of relapse from illicit drug use by injection during and after treatment.
  - If the patient has prior treatment failure due to non-compliance, the patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling all maintenance medications on time for the past 180 days, as evidenced by pharmacy claims history.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HARVONI (ledipasvir/sofosbuvir) 45 mg/200mg tablet	EPCLUSA (sofosbuvir/velpatasvir)
MAVYRET (glecaprevir/pibrentasvir)***	HARVONI (ledipasvir/sofosbuvir) 90mg/400mg tablet
sofosbuvir/velpatasvir	HARVONI (ledipasvir/sofosbuvir) ORAL PALLET
SOVALDI (sofosbuvir) 200 MG TABLET	ledipasvir/sofosbuvir 90mg/400mg tablet
VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)***	SOVALDI (sofosbuvir) 400MG TABLET
	SOVALDI (sofosbuvir) ORAL PALLET
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	ZEPATIER (elbasvir/grazoprevir)

Ribavirin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ribavirin capsule	
ribavirin tablet	

health information designs

Hepatitis C Treatments Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for hepatitis C treatments must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

- Please complete this form in its entirety and provide any and all required documentation (if available)

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dose:	**Duration requested:**	**Patient's liver fibrosis score:** □ F0-F1 □ F2-F4
Diagnosis: □ HCV □ OTHER:	**Genotype:**	**Patient's Child–Pugh Class:** □ A □ B □ C □ N/A

Please list any previous treatments the patient has failed for chronic HCV: □ N/A	Regimen:	Dates of treatment:	Response:

Has the patient remained drug (illicit use by injection) and alcohol free for the past 3 months?	□ YES □ NO
Does patient have a diagnosis of alcohol use disorder?	□ YES □ NO
Does patient have a history of illicit use of drugs by injection?	□ YES □ NO
Has patient completed or is currently in a treatment program from an enrolled addiction medicine/chemical dependency provider (or buprenorphine waived provider if history of IV drug use)? Approximate Dates of Treatment:	□ YES □ NO Attested by: □ PROVIDER □ PATIENT
Does the patient have Hepatitis B?	□ YES □ NO
If the patient has Hepatitis B, has it been treated or will it be closely monitored during treatment?	□ YES □ NO
Is the patient post-liver transplant?	□ YES □ NO
Does the patient's life expectancy greater than one year?	□ YES □ NO
Does patient attended scheduled visits with no more than 1 no-show and fill maintenance medications on time?	□ YES □ NO
Does patient have any contraindications to therapy with the requested agent?	□ YES □ NO
ONLY IF RIBAVIRIN IS BEING USED IN A PATIENT OF CHILD-BEARING POTENTIAL Has the patient had a negative pregnancy test in the last 30 days and will receive monthly pregnancy tests during treatment?	□ YES □ NO □ N/A

Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:

□ Baseline HCV RNA
□ ≥ 2 drug and alcohol tests dated at least 3 months apart
□ Chart notes addressing patient's alcohol and drug free status over the past year
□ Patient & Prescriber attestation forms
□ Documentation of patient's fibrosis score if available (e.g. APRI, Fibroscan, Fibrotest)

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I am planning to live in North Dakota during the entire treatment period. I will complete the entire course of treatment, attend office visits, and have laboratory tests as ordered by my healthcare provider during the treatment period.
- ☐ I will notify my chosen pharmacy of a need to refill one week prior to running out of medication. I understand I must take my medication each day as directed for the entire course of treatment. If the medication does not work due to missed doses, I may not be approved for re-treatment.
- ☐ I understand to keep my liver healthy, I must not drink alcohol or use illicit injectable drugs prior to, during, or after my treatment. If indicated, I will participate in a treatment program to remain abstinent.
- ☐ I understand that after treatment, I can be re-infected with Hepatitis C. My provider has educated me on routes of Hepatitis C transmission, and I will avoid or modify high risk activities to avoid re-infection.
- ☐ I understand that medications that treat Hepatitis C may be harmful to unborn babies. I will use methods to avoid getting pregnant or another person pregnant during treatment and when advised by my provider or pharmacist, for at least 6 months after treatment is complete.

Patient Signature _____ **Date** __/__/____

Pharmacy or Prescriber Representative:

Signature _____**Date** __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient

Hepatitis C Prescriber Agreement Form

- ☐ I agree that I will counsel my patient on how, where, and when to obtain refills on their hepatitis C medications.
- ☐ I agree that I will have intermittent telephone check-ins with my patient, at minimum at 2 weeks and 6 weeks of treatment. I will assess continued adherence with medication, labs, and office visits, treatment tolerability, as well as medication changes that may affect treatment.
- ☐ I have reviewed my patient's medications for drug interactions that would make Hepatitis C medications less effective or cause other adverse effects.
- ☐ I have reviewed the treatment plan with my patient including medications, lab, vaccinations, and follow-up visits.
- ☐ I have assessed my patient's readiness for treatment and believe they are ready and willing to comply with the treatment plan. I have assessed social and psychological stability, substance use abstinence, compliance to follow up visits and medications, pregnancy status, and concurrent health risks.
- ☐ I understand that ND Medicaid tracks refill history and may contact me to provide additional information in the event of a dropped or late refill.
- ☐ I have a dedicated individual or team which may include pharmacy and nursing support to fulfill the elements of this form and have listed key members contact information below.

Name: _____Location: _____

Phone #: _____

Name: _____Location: _____

Phone #: _____

Pharmacy or Prescriber Representative:

Signature _____**Date** __/__/____

REVIEW OF AGENTS FOR MANAGEMENT OF HEART FAILURE WITH REDUCED EJECTION FRACTION

Heart Failure with Reduced Ejection Fraction Overview

- Heart failure (HF) is a common clinical syndrome in which symptoms result from a structural or functional cardiac disorder that impairs the ability of the ventricle to fill with or eject blood
    - May be caused by disease of the myocardium, pericardium, endocardium, heart valves, vessels, or by metabolic disorders
        - HF due to left ventricular (LV) dysfunction is categorized according to LV ejection fraction (LVEF)
            - HF with reduced ejection fraction (HFrEF) is patients with LVEF ≤40%
            - HF with preserved ejection fraction (HFpEF) is patients with LVEF ≥50%
            - HF with mid-range ejection fraction (HFmrEF) is patients with LVEF 41-49%

Goals of Pharmacotherapy Treatment in HFrEF:

- Reduce morbidity (symptoms, QoL/functional status, and rate of hospitalization)
    - Can be achieved by diuretics, beta blockers, renin-angiotensin system (RAS) agents, dapagliflozin, hydralazine plus nitrate, digoxin, and mineralocorticoid receptor antagonists (MRA)
- Reduce mortality
    - Prolongation of patient survival has been documented with beta blockers, angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARB), angiotensin receptor-neprilysin inhibitor (ARNI), dapagliflozin (an SGLT2 inhibitor), hydralazine plus nitrate, and MRA.
- Several published guidelines for the treatment of HFrEF exist, however these guidelines make similar recommendations regarding the treatment of HFrEF and all recommend combination therapy with drugs proven to improve clinical outcomes in randomized trials:
    - **Initial pharmacologic therapy of HFrEF includes the following combination:**
        - Diuretic therapy (as needed to treat volume overload)
        - A renin-angiotensin system (RAS) targeted medication
            - Or hydralazine plus nitrate if RAS targeted medications cannot be used
        - A beta blocker
    - **Secondary pharmacologic agents:** used in selected patients with HFrEF
        - Mineralocorticoid receptor antagonist (MRAs)
        - Ivabradine
        - SGLT2 inhibitors (e.g. dapagliflozin)
        - Hydralazine plus nitrate
        - Digoxin

Overview of Agents Used in HFrEF

- **Renin-angiotensin system (RAS) targeted agents:** Block harmful effects of renin-angiotensin-aldosterone system activation and attenuates adverse cardiac and vascular remodeling.

	ACE Inhibitors	**ARBS**	**ARNI**
Agents Indicated for HF	Captopril Enalapril Fosinopril Lisinopril Quinapril Ramipril Trandolapril	Candesartan Valsartan Losartan	Entresto (sacubitril/valsartan)
Mechanism of Action	Prevents conversion of angiotensin I to angiotensin II	Blocks angiotensin II receptors	Blocks angiotensin II receptors + inhibits neprilysin
FDA-Approved Ages for Use	Adults	Adults	≥1 year old

Efficacy Evidence	Reduced mortality and hospitalizations	Reduced mortality and hospitalizations	Reduced mortality and hospitalizations vs ACE inhibitor alone
Contraindications	Prior HSR; use with aliskiren in patients with DM; prior angioedema w/ ACE; use with a neprilysin inhibitor	Prior HSR; use with aliskiren in patients with DM	Prior HSR; history of angioedema related to previous ACE inhibitor or ARB therapy; concomitant use or use within 36 hours of ACE inhibitors; use with aliskiren in patients with DM
Warnings/Precautions	Angioedema Hypotension Renal function loss Renal artery stenosis Cough Hyperkalemia Cholestatic jaundice Collagen vascular disease Aortic stenosis Ascites Aortic/Mitral stenosis Pregnancy	Angioedema Hypotension Renal function loss Renal artery stenosis Hyperkalemia Ascites Aortic/Mitral stenosis Pregnancy	Angioedema Hypotension Renal function loss Renal artery stenosis Hyperkalemia Aortic/Mitral stenosis Pregnancy
Dose Adjustments for Renal Impairment	Reduce dose, agent dependent	Use with caution	Reduce dose 50% in severe impairment
Dose Adjustments for Hepatic Impairment	None	Reduce dose in hepatic impairment (Losartan)	Lower dose in moderate impairment; avoid use in severe impairment

- **<u>Beta Blocker Agents:</u>**
  - **Agents Studied for HF**
    - Carvefilol, metoprolol succinate, and bisoprolol
  - **Mechanism of action**
    - Blocks beta1-adrenergic receptors (metoprolol and bisoprolol)
    - Blocks beta-adrenergic and alpha-adrenergic receptors
  - **Approved Ages for Use**
    - Adults
  - **Efficacy Evidence**
    - Reduced mortality and hospitalizations (NYHA functional class II to III)
  - **Contraindications**
    - HSR; decompensated cardiac failure; 2nd or 3rd degree AV block; severe bradycardia; cardiogenic shock; severe hepatic impairment; bronchial asthma or related bronchospastic conditions (carvedilol only)
  - **Warnings/Precautions**
    - Should not be withdrawn abruptly
    - Bradycardia
    - Hypotension
    - Use with caution in patients with
      - Angina, PVD, DM, bronchospastic disease, conduction abnormalities, pheochromocytoma, thyroid disease, myasthenia gravis, aortic/mitral stenosis
  - **Dose Adjustments for Renal Impairment**
    - Bisoprolol requires dose reduction in severe impairment
  - **Dose Adjustments for Hepatic Impairment**
    - Bisoprolol requires dose reduction in severe impairment

        - Carvedilol is contraindicated in severe impairment

- **Mineralocorticoid receptor antagonists (MRA):**
    - **Agents Studied for HF**
        - Spironolactone, eplerenone
    - **Mechanism of action**
        - Blocks the binding of aldosterone at mineralocorticoid receptors at the distal renal tubules, increasing NaCl and water excretion while conserving K
    - **Approved Ages for Use**
        - Adults
    - **Efficacy Evidence**
        - Reduced mortality, manage edema, and reduce and hospitalizations (NYHA functional class II to III)
    - **Contraindications**
        - Hyperkalemia; Addison disease; concomitant use with each other; CrCl 30 mL/min or less (eplerenone); concomitant administration of strong CYP3A4 inhibitors (eplerenone)
    - **Warnings/Precautions**
        - Tumorigenic (spironolactone): avoid unnecessary use
        - Hyperkalemia may occur
        - Fluid/electrolyte imbalance
        - Heart failure
        - Gout
        - Gynecomastia
        - Avoid use as triple therapy with ACE and ARB
    - **Dose Adjustments for Renal Impairment**
        - Requires dosing adjustments in moderate impairment and not recommended in severe (contraindicated for eplerenone).
    - **Dose Adjustments for Hepatic Impairment**
        - Eplerenone
            - No dosage adjustments
        - Spironolactone
            - Use with caution

- **Sodium-glucose cotransporter 2 (SGLT2) inhibitors:**
    - **Agents Studied for HF**
        - **FDA-approved indication:**
            - Separate indication: **Farxiga** (dapagliflozin)
                - To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure with reduced ejection fraction (NYHA class II to IV)
            - Included in DM indication: **Invokana** (canagliflozin)
                - “risk reduction of major cardiovascular events (cardiovascular death, nonfatal myocardial infarction, and nonfatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease”
        - **Off-label: Jardiance** (empagliflozin)
    - **Mechanism of action**
        - Inhibits sodium-glucose cotransporter 2 (SGLT2) in the proximal renal tubules, reducing reabsorption of filtered glucose and sodium. Exact mechanism unknown.
    - **Approved Ages for Use**
        - Adults
    - **Efficacy Evidence**
        - Reduced mortality and hospitalizations (NYHA functional class II to IV)
    - **Contraindications**
        - HSR; severe renal impairment (eGFR <30 mL/minute/1.73 m2), end-stage renal disease (dapagliflozin, empagliflozin only), or patients on dialysis

- **Warnings/Precautions**
  - Increased risk of volume depletion/AKI; necrotizing fasciitis; limb amputation; UTI; genital mycotic infection; hyperkalemia; and hypotension
- **Dose Adjustments for Renal Impairment**
  - Dose adjustments required, contraindicated in ESRD (or GFR<30 for dapagliflozin and empagliflozin)
- **Dose Adjustments for Hepatic Impairment**
  - Not recommended for severe (canagliflozin) or <30 mL/minute/1.73 m2 (others) and contraindicated in ESRD
  - Not studied in severe (dapagliflozin)

- **Hydralazine + nitrates:**
  - **Mechanism of action**
    - Causes direct vasodilation of arterioles (with little effect on veins) with decreased systemic resistance
  - **Approved Ages for Use**
    - Adults, off-label for pediatric patients
  - **Efficacy Evidence**
    - May reduce symptoms and mortality (NYHA functional class II to III)
  - **Contraindications**
    - Hydralazine
      - HSR; coronary artery disease; mitral valve rheumatic heart disease
    - Isosorbide dinitrate
      - HSR; concurrent use with PDE inhibitors or riociguat.
  - **Warnings/Precautions**
    - Hydralazine
      - Increased risk of drug-induced lupous like syndrome; hypotension; peripheral neuritis; MI; blood dyscrasias
    - Isosorbide dinitrate
      - Increased risk of increased ICP; hypotension.
      - May worsen hypertrophic cardiomyopathy
  - **Dose Adjustments for Renal Impairment**
    - Reduce dosing interval (hydralazine)
  - **Dose Adjustments for Hepatic Impairment**
    - No adjustments necessary

- **Corlanor (ivabradine)**
  - **Mechanism of action**
    - Selective and specific inhibition of the hyperpolarization-activated cyclic nucleotide-gated (HCN) channels (f-channels) within the sinoatrial (SA), leading to reduced heart rate.
  - **Approved Ages for Use**
    - ≥6 months
  - **Efficacy Evidence**
    - Reduced hospitalizations (NYHA functional class II to III)
  - **Contraindications**
    - Acute decompensated heart failure; Clinically significant hypotension; sick sinus syndrome, SA block, or 3rd-degree AV; clinically significant bradycardia; severe hepatic impairment; pacemaker dependence; concomitant use with strong CYP3A4 inhibitors
  - **Warnings/Precautions**
    - Increased risk of atrial fibrillation
    - Bradycardia, sinus arrest, and heart block may occur
    - Phosphenes may occur (visual function effects)
    - Effective contraception is recommended in women of reproductive potential (fetal harm may occur)
  - **Dose Adjustments for Renal Impairment**
    - No dose adjustments provided

- **Dose Adjustments for Hepatic Impairment**
  - Contraindicated in severe impairment

- **Digoxin**
  - **Mechanism of action**
    - Inhibition of the sodium/potassium ATPase pump in myocardial cells results in a transient increase of intracellular sodium, which in turn promotes calcium influx via the sodium-calcium exchange pump leading to increased contractility
  - **Approved Ages for Use**
    - All ages
  - **Efficacy Evidence**
    - Reduced hospitalizations (NYHA functional class III and IV)
  - **Contraindications**
    - HSR; ventricular fibrillation
  - **Warnings/Precautions**
    - Increases risk of prolonged PR interval; digoxin toxicity (anorexia, nausea, vomiting, visual changes and cardiac arrhythmias); arrhythmias
    - Use with caution in patients with history of ACS; myocarditis; electrolyte imbalances; and thyroid disease
  - **Dose Adjustments for Renal Impairment**
    - Requires renal dosing adjustments
  - **Dose Adjustments for Hepatic Impairment**
    - Bisoprolol requires dose reduction in severe impairment

- **Verquvo (vericiguat)**
  - **Indication**
    - To reduce the risk of cardiovascular death and heart failure hospitalization following a hospitalization for heart failure or need for outpatient IV diuretics, in adults with symptomatic chronic heart failure and ejection fraction <45%
  - **Mechanism of Action**
    - Enhances production of cGMP by directly stimulating soluble guanylate cyclase (sGC) and enhances sGC sensitivity to endogenous NO, increasing cGMP production
      - Increased levels of cGMP lead to smooth muscle relaxation and vasodilation.
  - **Approved Ages for Use**
    - Adults
  - **Efficacy Evidence**
    - Reduced mortality and hospitalizations (NYHA functional class II to IV)
  - **Contraindications**
    - Concomitant use of other soluble guanylate cyclase stimulators (eg, riociguat); pregnancy.
  - **Warnings/Precautions**
    - Has not been studied in patients concurrently using long-acting nitrates or PDE-5 inhibitors
    - Based on data from animal reproduction studies, in utero exposure to vericiguat may cause fetal harm
  - **Dose Adjustments for Renal Impairment**
    - No dose adjustments for eGFR ≥15 mL/minute/1.73 m2
      - eGFR <15 mL/minute/1.73 m2 has not been studied
  - **Dose Adjustments for Hepatic Impairment**
    - No dose adjustments for mild-moderate impairment (severe has not been studied)

Cost

Drug	Strength	Package Size	WAC Pkg Price	Cost per day*	Cost per Month*	Cost per Year*
Lisinopril	2.5-20 mg	30-5,000 tablets	$0.97-$215.20	$0.14	$4.20	$51.10
Valsartan	40-320 mg	30-500 tablets	$3.00-$258.38	$0.20	$6.00	$73.00
Entresto	24/26 mg 49/51 mg 97/103 mg	1-180 tablets	$7.71-$1,748.68	$15.42	$462.60	$5,628.30
Metoprolol Succinate	25-200 mg	10-1000 tablets	$6.00-$1,251.33	$0.05	$1.50	$18.25
Hydralazine	10-100 mg	100-1000 tablets	$2.95-$279.78	$0.06	$1.98	$22.08
Spironolactone	25-100 mg	30-1000 tablets	$5.76-$372.25	$0.06	$1.98	$22.08
Verquvo	2.5 mg 5 mg 10 mg	14-100 tablets	$272.02-$1,943.00	$38.86	$1,165.80	$14,183.90
Corlanor	5 mg 7.5 mg	60-180 tablets	$491.49-$1,288.59	$14.32	$429.60	$5,226.80
Digoxin	0.125-0.25 mg	100-1000 tablets	$59.25-$1,523.83	$0.59	$17.70	$215.35
**= based on lowest per unit WAC cost*						

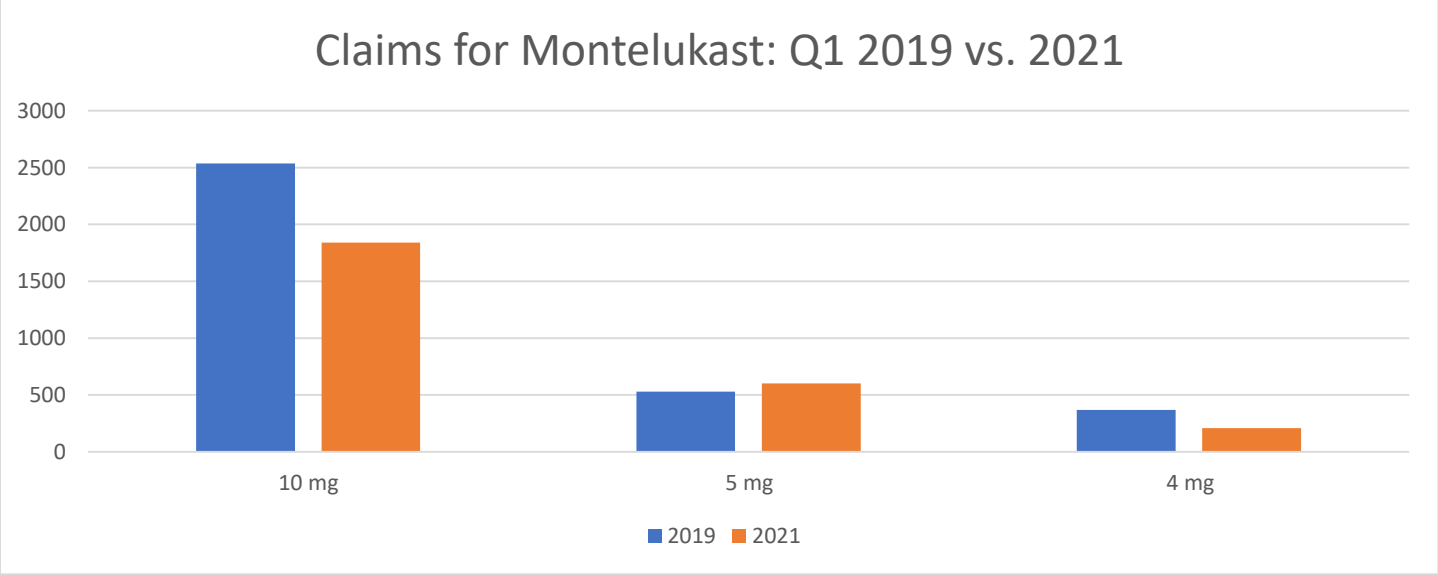
Current Utilization

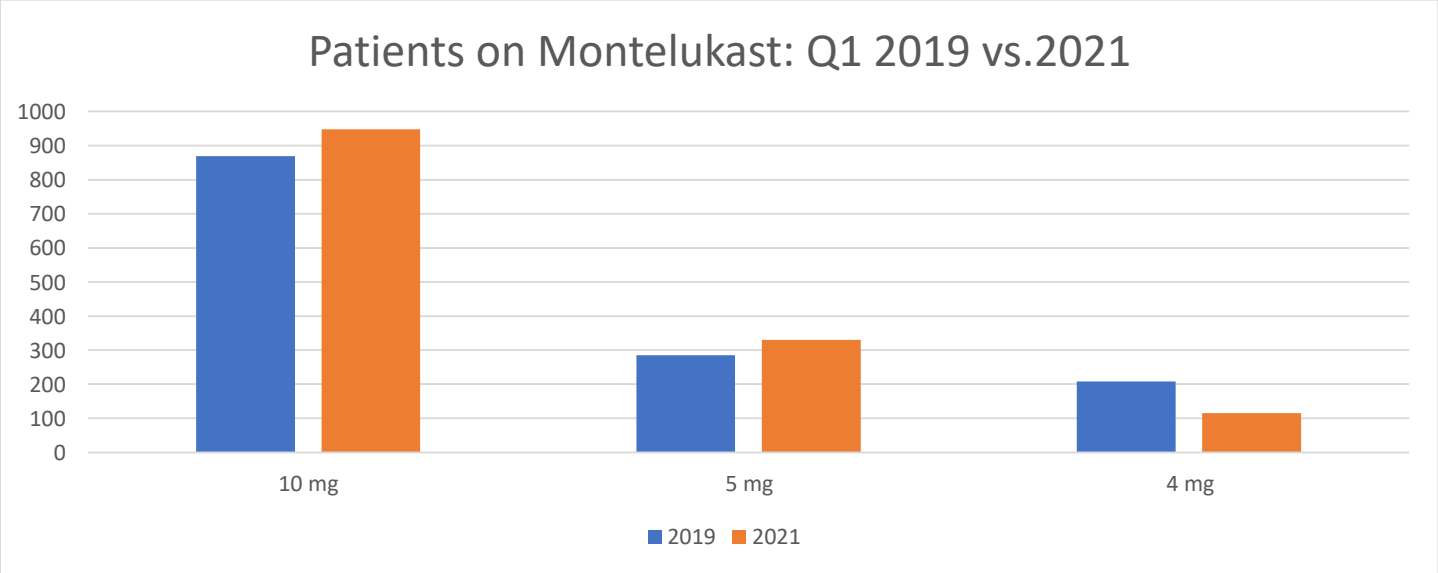
ND Medicaid Utilization (03/2020 – 02/2021)		
Label Name	**Rx Num**	**Total Reimb Amt**
bisoprolol fumarate	7	$126.65
bumetanide	433	$16,986.03
candesartan cilexetil	1	$55.73
captopril	26	$346.07
carvedilol	1517	$31,885.55
dapagliflozin propanediol	55	$28,103.94
digoxin	265	$5,138.62
enalapril maleate	126	$11,144.27
eplerenone	0	$0.00
fosinopril sodium	0	$0.00
hydralazine HCl	241	$3,596.25
ivabradine HCl	44	$19,737.63
lisinopril	2260	$45,270.13
losartan potassium	905	$19,527.57
metoprolol succinate	1499	$29,716.46
quinapril HCl	26	$501.59
ramipril	63	$853.67
Entresto	170	$86,023.84
spironolactone	1168	$17,756.98
telmisartan	50	$937.17
valsartan	22	$771.29
Verquvo	0	N/A

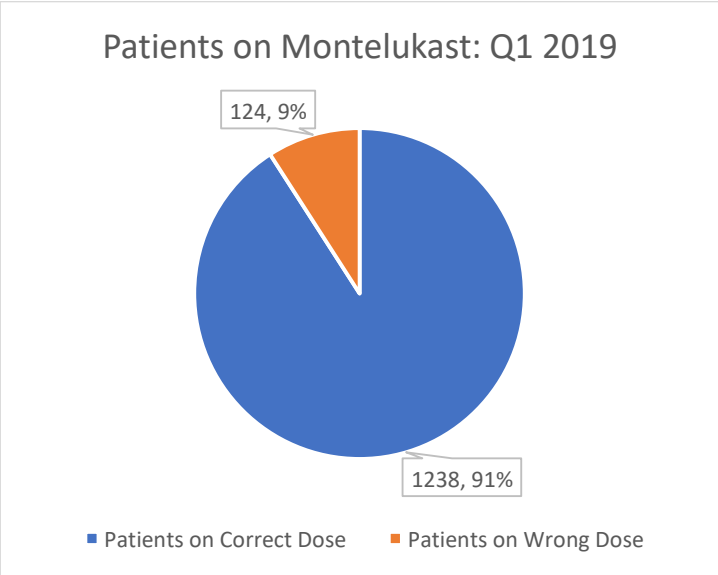
REFERENCES:

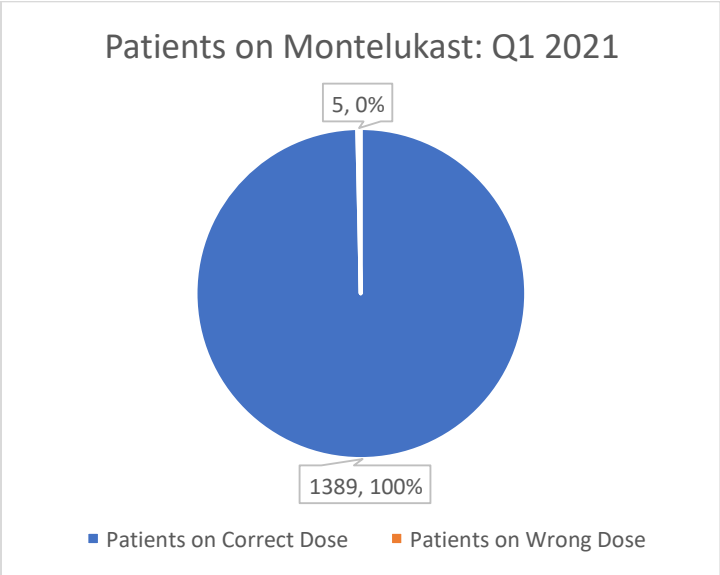
1. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on April 11. 2021.
2. UpToDate. Available at https://www.uptodate.com/contents/search. Accessed on April 11. 2021.
3. Cozaar (losartan) [prescribing information]. Whitehouse Station, NJ: Merck & Co Inc; October 2018.
4. Diovan (valsartan) [prescribing information]. East Hanover, NJ: Novartis; June 2019.
5. Atacand (candesartan) [prescribing information]. AstraZeneca; May 2018.
6. Mavik (trandolapril) [prescribing information]. North Chicago, IL: AbbVie; August 2017.
7. Altace (ramipril) [prescribing information]. New York, NY: Pfizer; June 2017.
8. Capoten (captopril) [prescribing information]. Spring Valley, NY: Par Pharmaceutical Companies Inc; August 2017.
9. Fosinopril sodium [prescribing information]. Weston, FL: Apotex; November 2013.
10. Zestril (lisinopril) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals; July 2017.
11. Vasotec oral (enalapril) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals; August 2018.
12. Aldactone (spironolactone) [prescribing information]. New York, NY: Pfizer Inc; February 2021.
13. Inspra (eplerenone) [prescribing information]. New York, NY: Pfizer; June 2020.

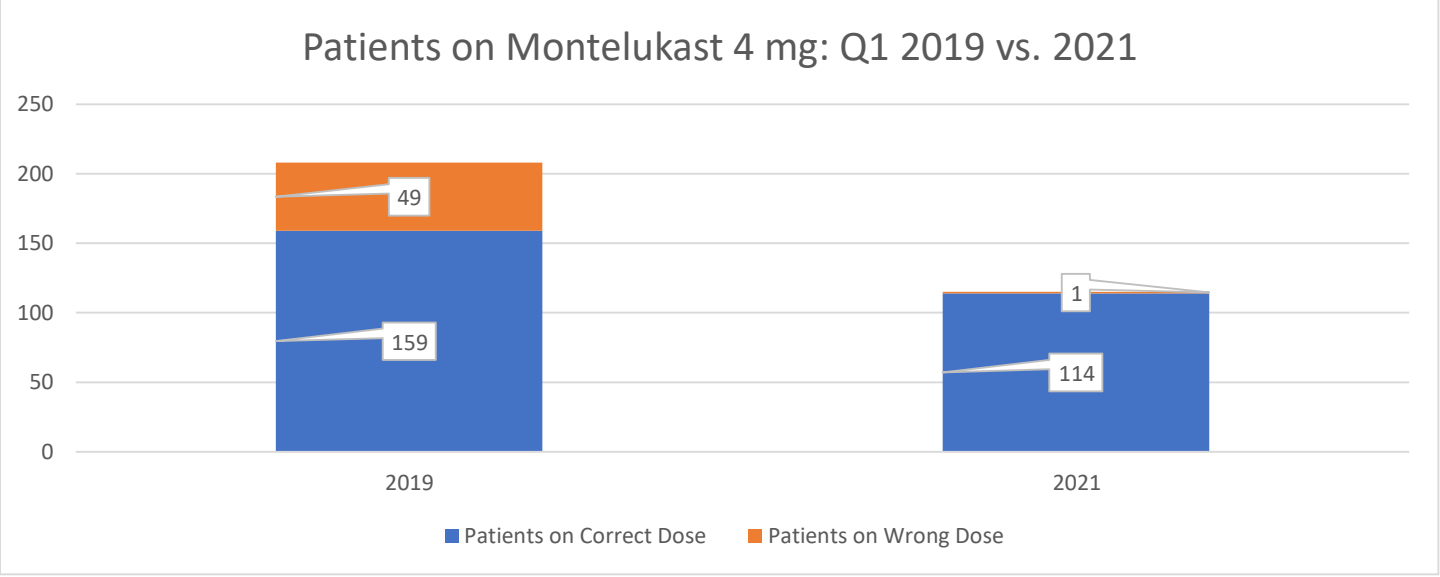
14. Accupril (quinapril) [prescribing information]. New York, NY: Pfizer; July 2017.
15. Bisoprolol fumarate (bisoprolol) [prescribing information]. Tampa, FL: TruPharma, LLC; February 2019.
16. Toprol XL (metoprolol succinate) [prescribing information]. Princeton, NJ: Aralez Pharmaceuticals; December 2016.
17. Coreg (carvedilol immediate release) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; September 2017.
18. Coreg CR (carvedilol extended release) [prescribing information]. Research Triangle Park, NC: GlaxoSmithKline; November 2020.
19. Verquvo (vericiguat) [prescribing information]. Whitehouse Station, NJ: Merck Sharp and Dohme Corp; January 2021.
20. Corlanor (ivabradine) [prescribing information]. Thousand Oaks, CA: Amgen Inc; April 2019.
21. Invokana (canagliflozin) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals; January 2020.
22. Farxiga (dapagliflozin) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; January 2020.
23. Jardiance (empagliflozin) [prescribing information]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals Inc; January 2020.
24. Steglatro (ertugliflozin) [prescribing information]. Whitehouse Station, NJ: Merck Sharp & Dohme; January 2020.
25. Digoxin (digoxin) oral solution [prescribing information]. Largo, FL: VistaPharm, Inc; August 2019.
26. Hydralazine Hydrochloride tablets [prescribing information]. Hauppauge, NY; ScieGen Pharmaceuticals, Inc; February 2021.
27. Verquvo (vericiguat) [prescribing information]. Whitehouse Station, NJ: Merck Sharp and Dohme Corp; January 2021.

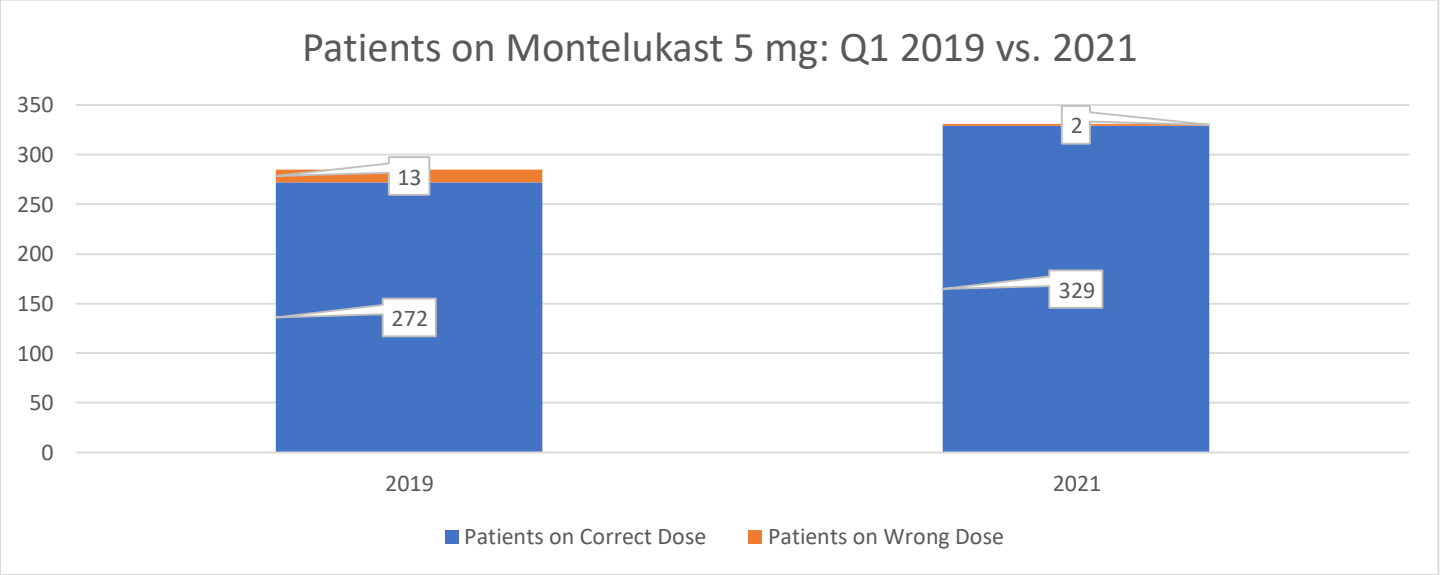

Claims for Montelukast: Q1 2019 vs. 2021
3000
2500
2000
1500
1000
500
0
10 mg
5 mg
4 mg
2019
2021

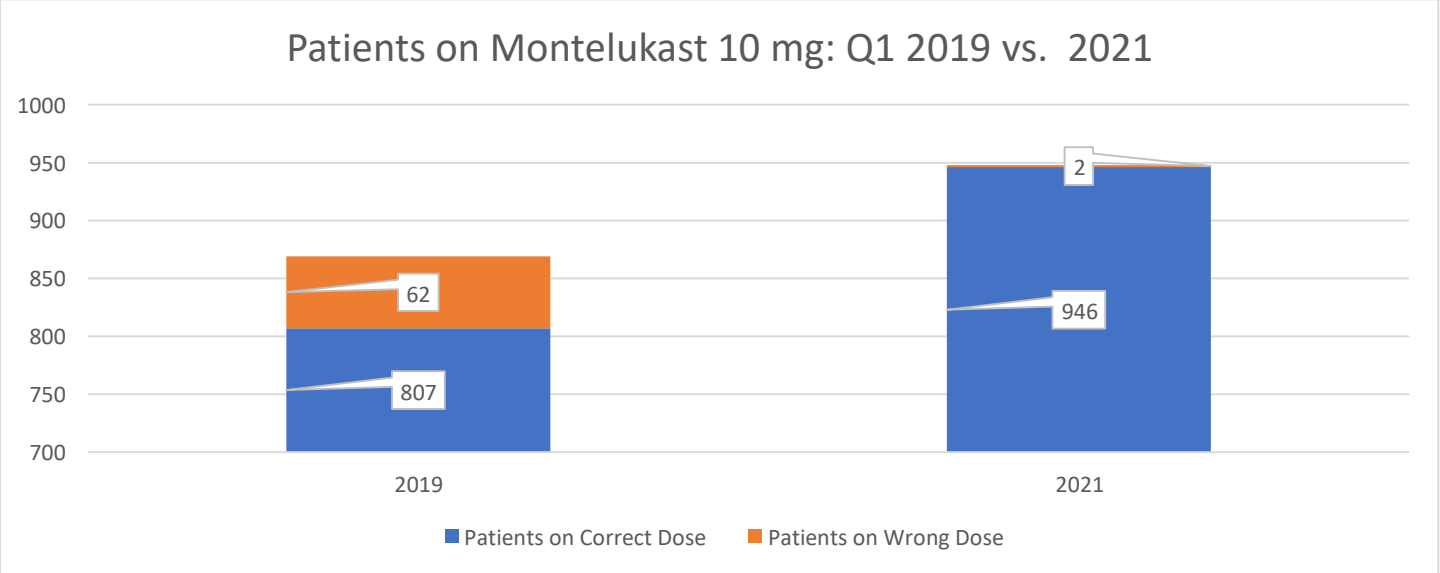

Patients on Montelukast: Q1 2019 vs.2021
1000
900
800
700
600
500
400
300
200
100
0
10 mg
5 mg
4 mg
2019
2021

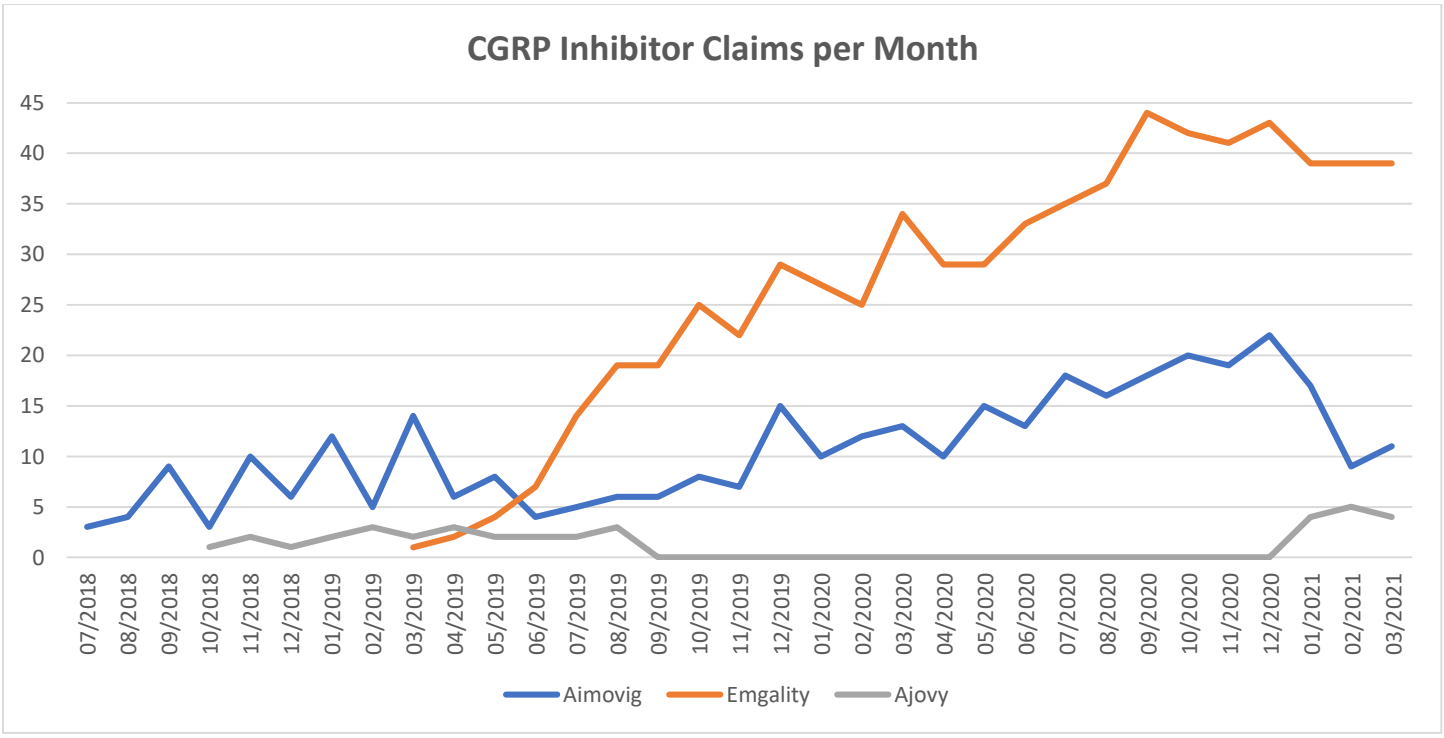

Patients on Montelukast: Q1 2019
124, 9%
1238, 91%
Patients on Correct Dose
Patients on Wrong Dose

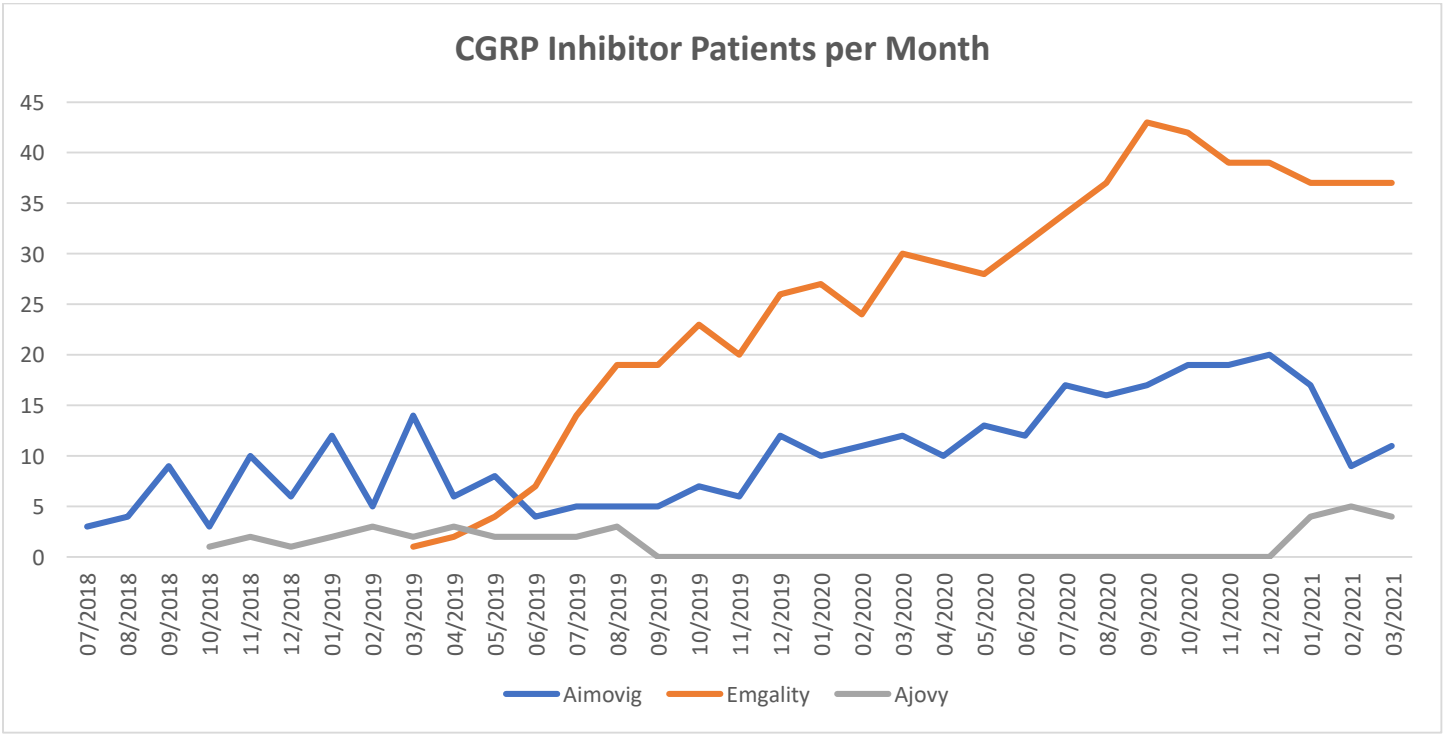

Patients on Montelukast: Q1 2021
5, 0%
1389, 100%
Patients on Correct Dose
Patients on Wrong Dose

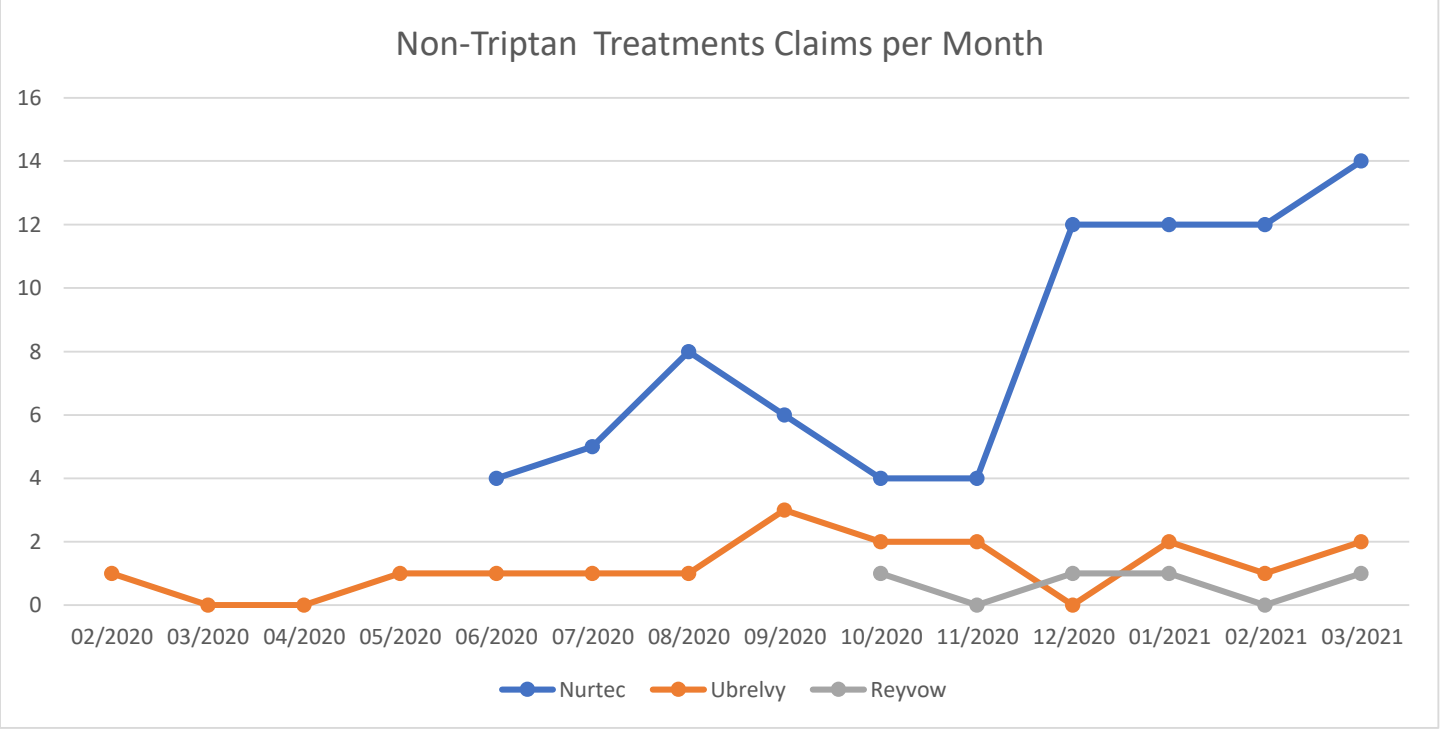

Patients on Montelukast 4 mg: Q1 2019 vs. 2021
250
200
150
100
50
0
49
159
1
114
2019
2021
Patients on Correct Dose
Patients on Wrong Dose

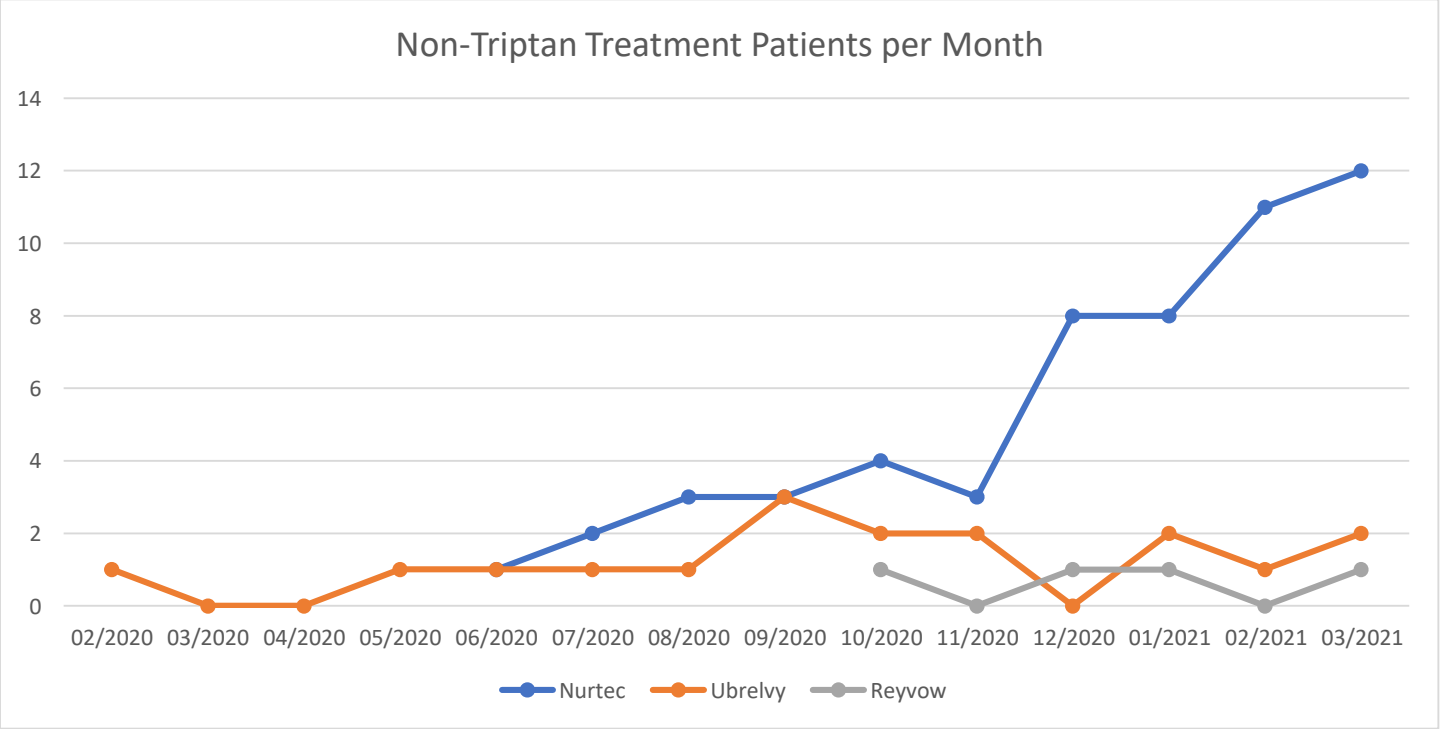

Patients on Montelukast 5 mg: Q1 2019 vs. 2021
350
300
250
200
150
100
50
0
13
272
2
329
2019
2021
Patients on Correct Dose
Patients on Wrong Dose

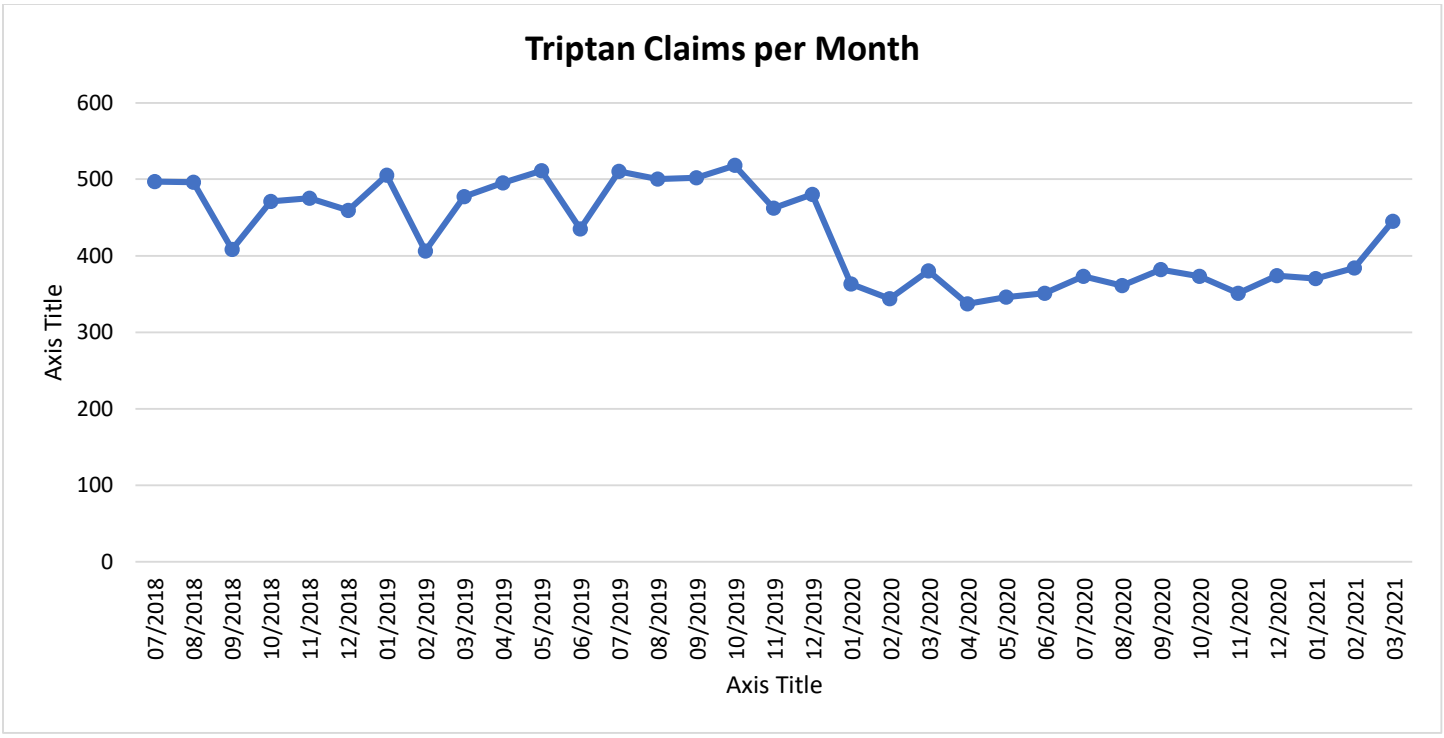

Patients on Montelukast 10 mg: Q1 2019 vs. 2021
1000
950
900
850
800
750
700
62
807
2
946
2019
2021
Patients on Correct Dose
Patients on Wrong Dose


CGRP Inhibitor Claims per Month
45
40
35
30
25
20
15
10
5
0
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
03/2020
04/2020
05/2020
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Aimovig
Emgality
Ajovy


CGRP Inhibitor Patients per Month
45
40
35
30
25
20
15
10
5
0
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
03/2020
04/2020
05/2020
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Aimovig
Emgality
Ajovy


Non-Triptan Treatments Claims per Month
16
14
12
10
8
6
4
2
0
02/2020
03/2020
04/2020
05/2020
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Nurtec
Ubrelvy
Reyvow


Non-Triptan Treatment Patients per Month
14
12
10
8
6
4
2
0
02/2020
03/2020
04/2020
05/2020
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Nurtec
Ubrelvy
Reyvow


Triptan Claims per Month
600
500
400
300
200
100
0
Axis Title
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
03/2020
04/2020
05/2020
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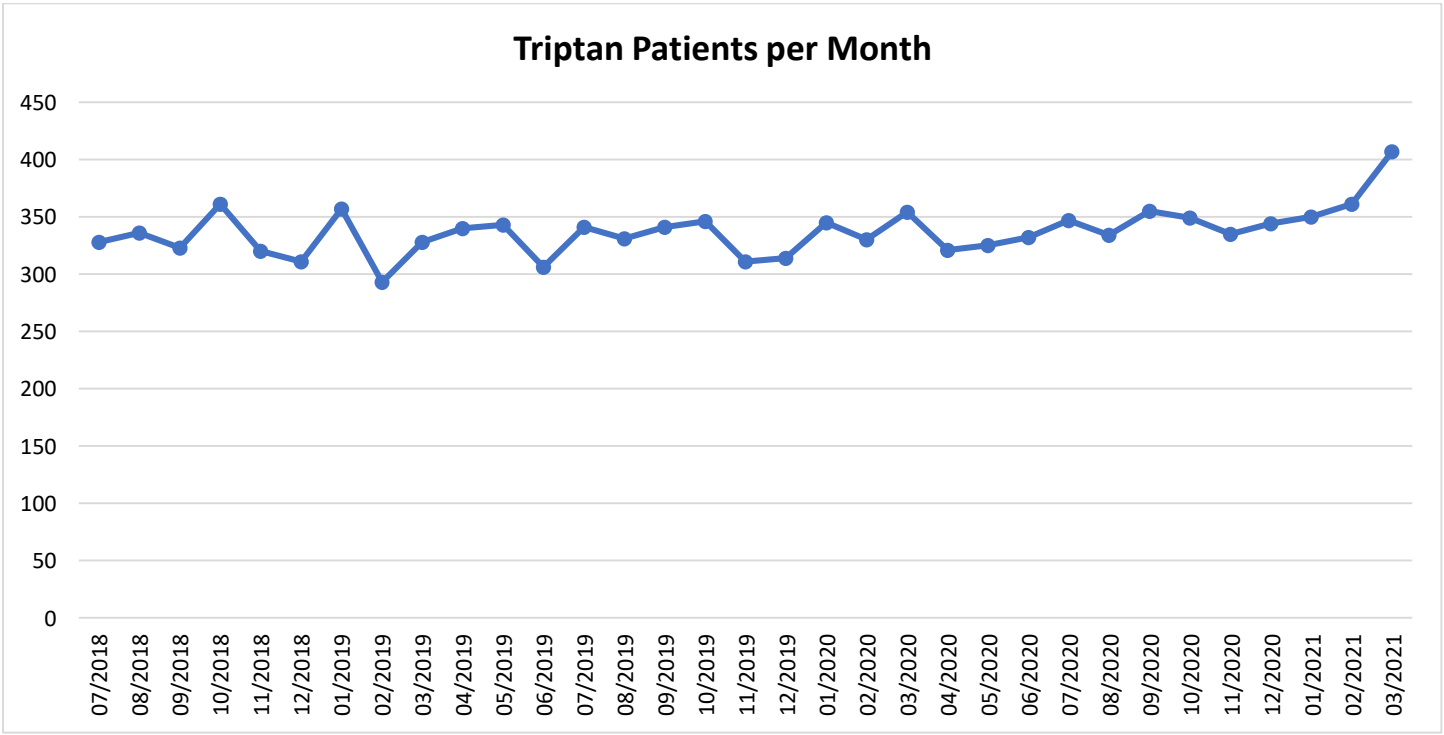
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Axis Title


Triptan Patients per Month
450
400
350
300
250
200
150
100
50
0
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
03/2020
04/2020
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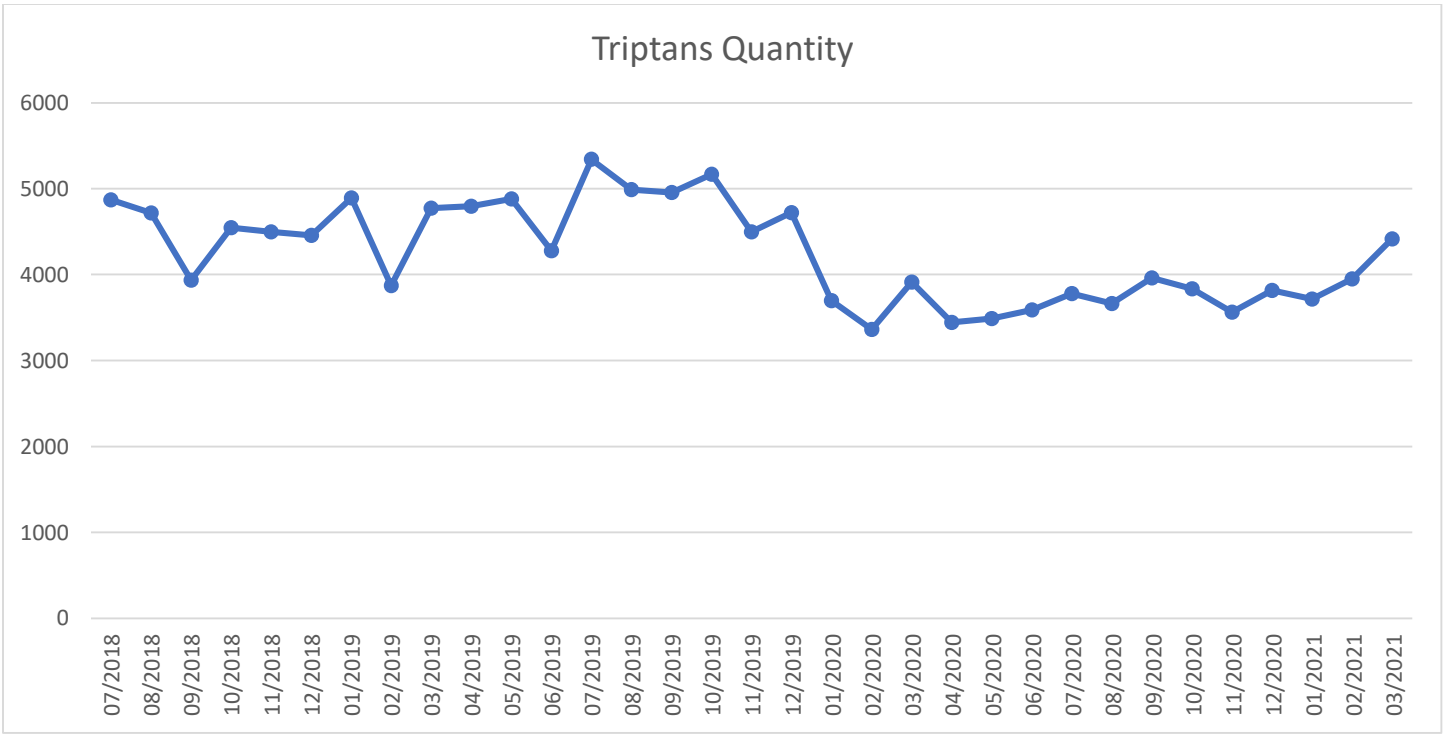
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021


Triptans Quantity
6000
5000
4000
3000
2000
1000
0
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
03/2020
04/2020
05/2020
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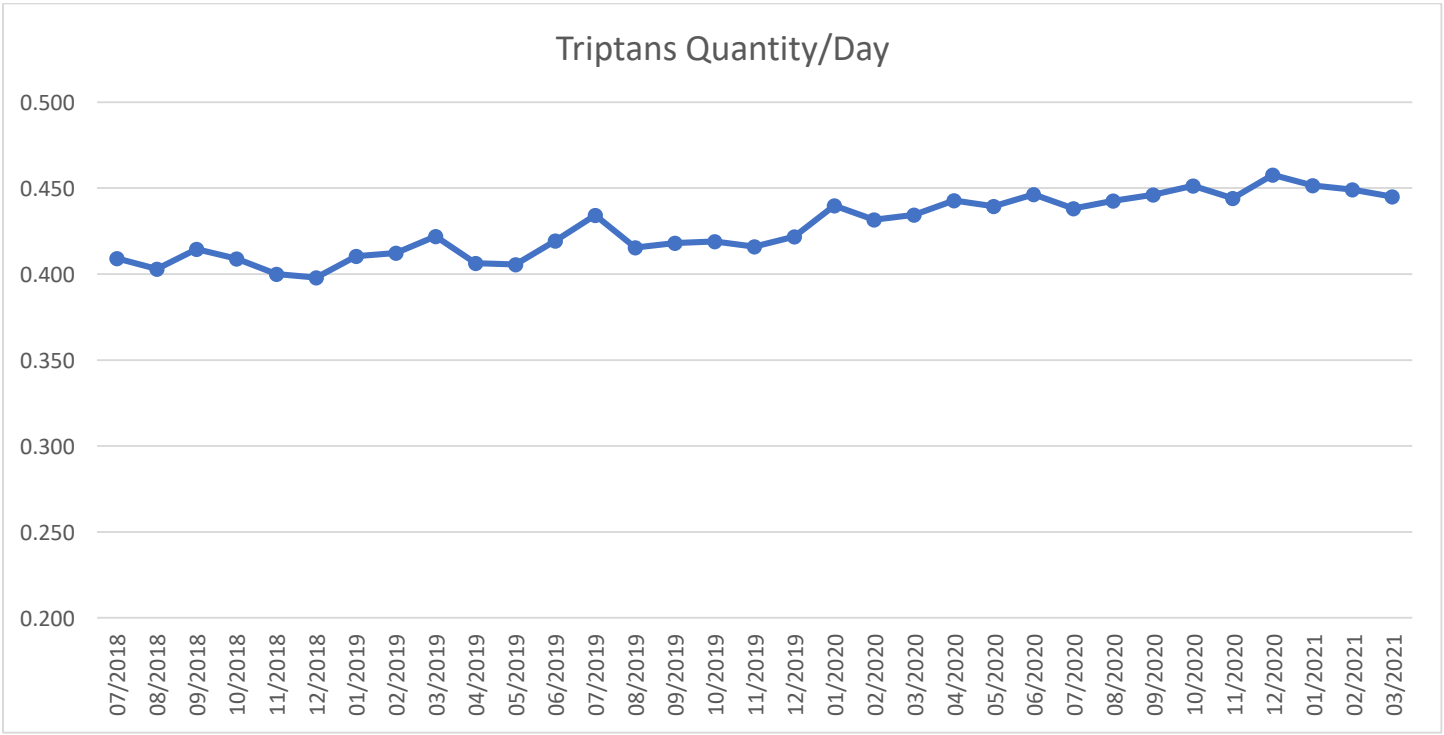
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021


Triptans Quantity/Day
0.500
0.450
0.400
0.350
0.300
0.250
0.200
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
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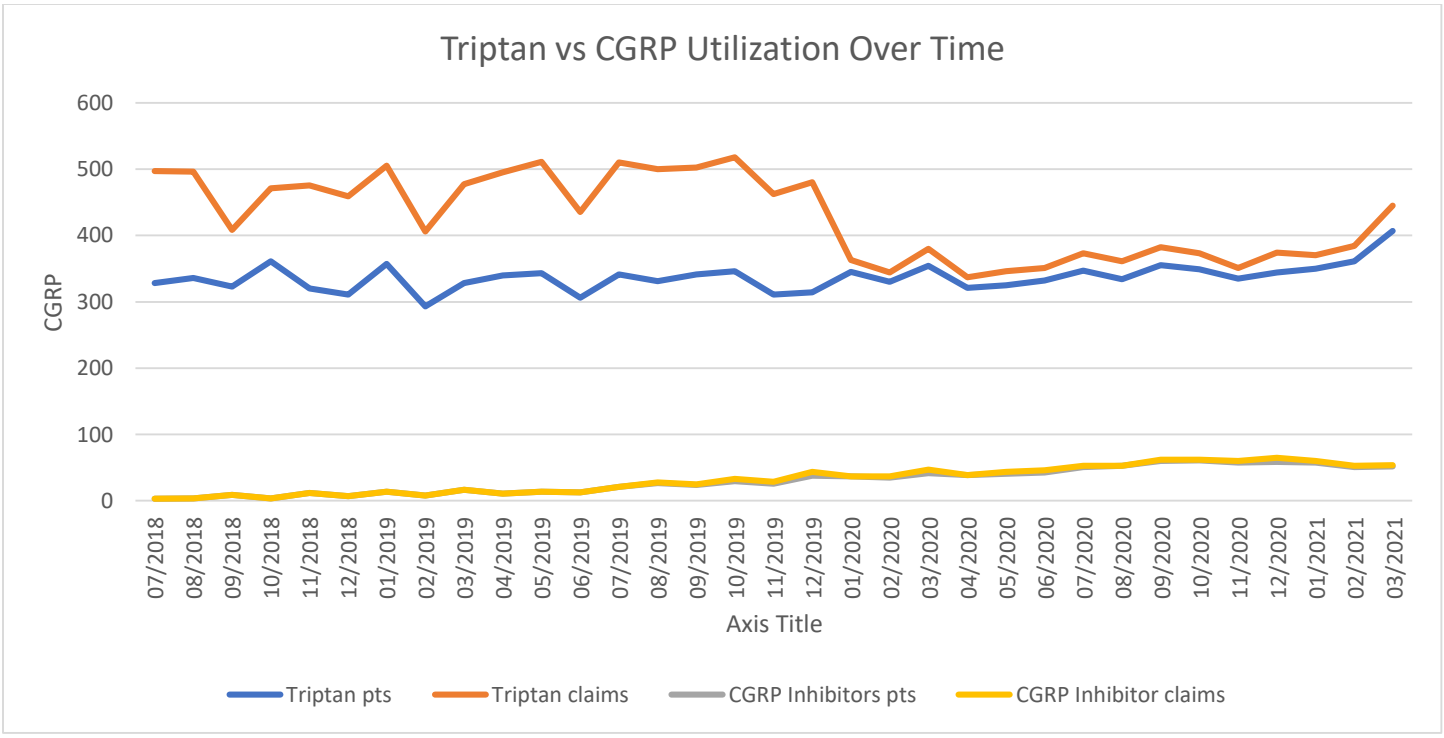
11/2020
12/2020
01/2021
02/2021
03/2021


Triptan vs CGRP Utilization Over Time
600
500
400
300
200
100
0
CGRP
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
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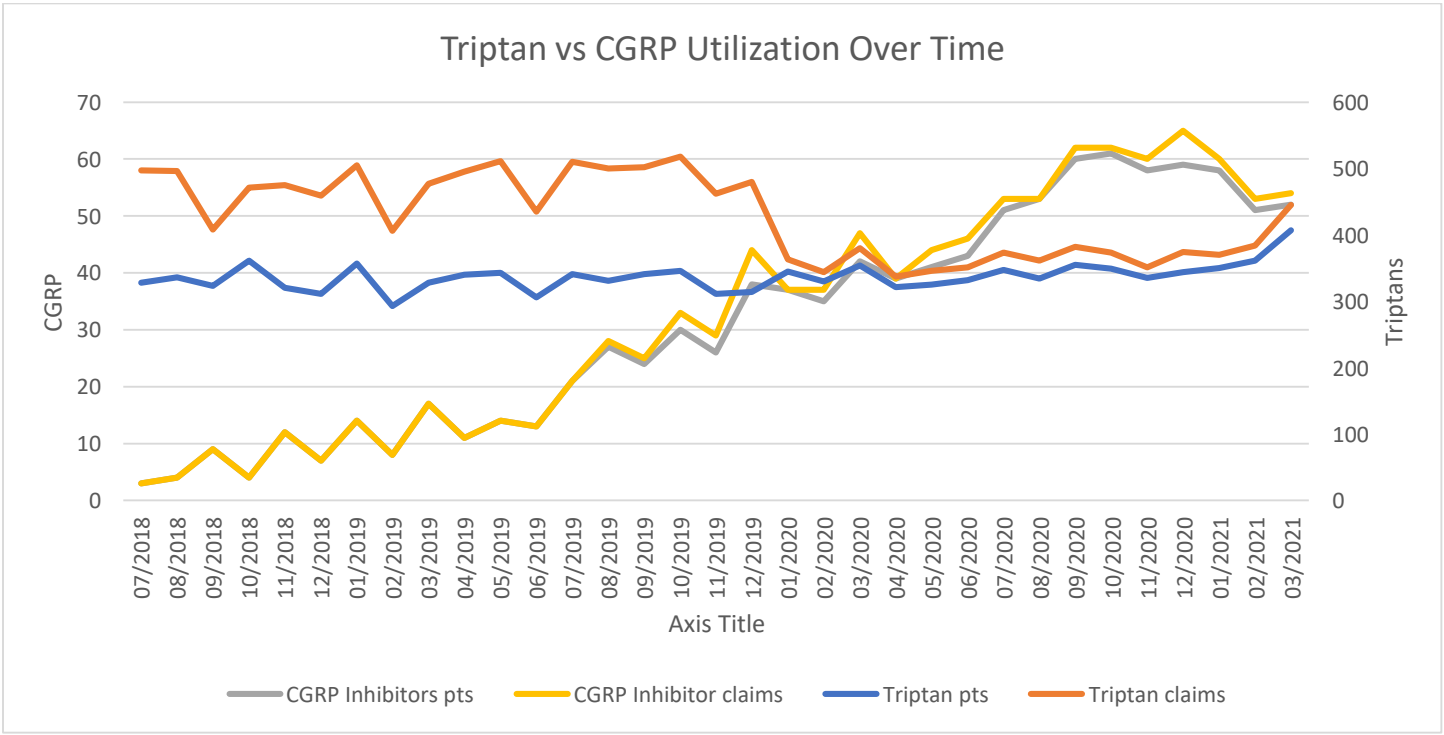
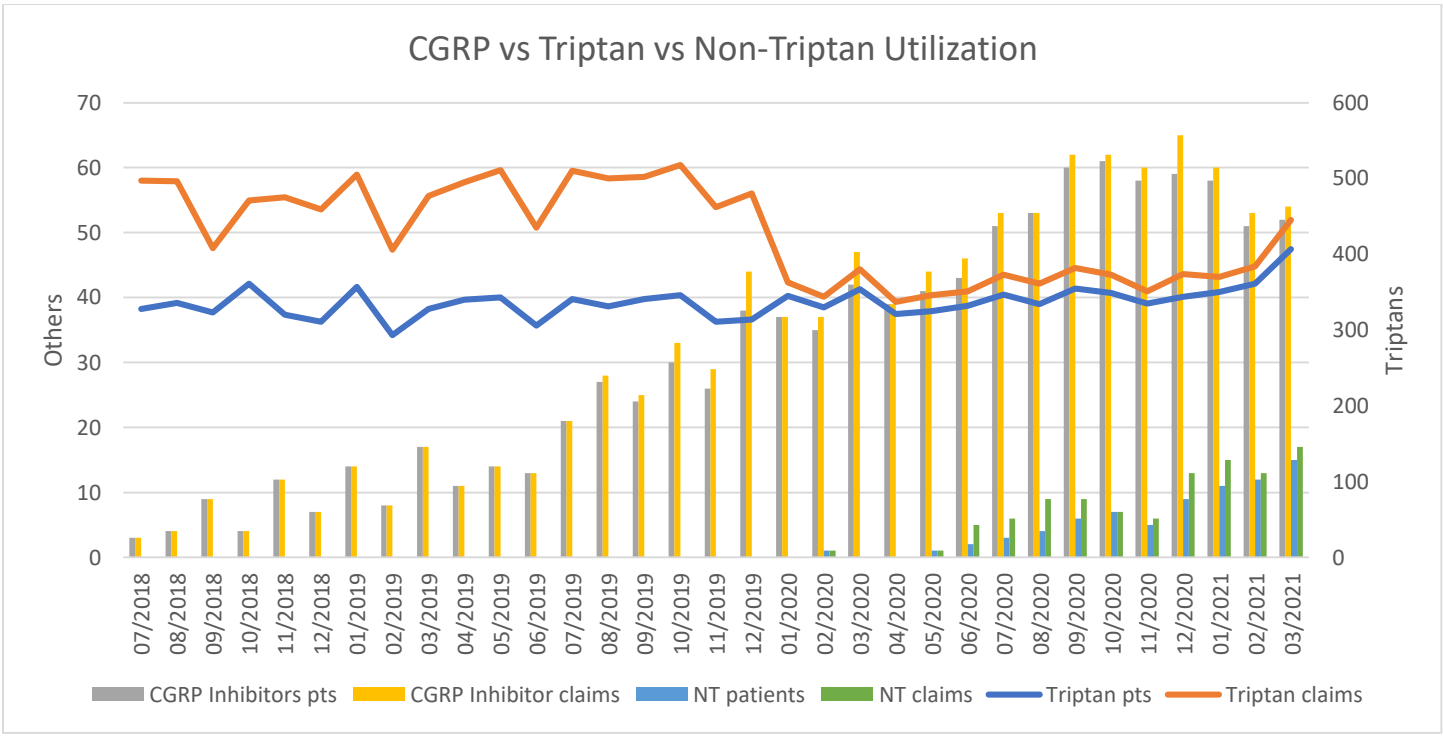
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Axis Title
Triptan pts
Triptan claims
CGRP Inhibitors pts
CGRP Inhibitor claims


Triptan vs CGRP Utilization Over Time
70
60
50
40
30
20
10
0
CGRP
600
500
400
300
200
100
0
Triptans
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
03/2020
04/2020
05/2020
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
Axis Title
CGRP Inhibitors pts
CGRP Inhibitor claims
Triptan pts
Triptan claims


CGRP vs Triptan vs Non-Triptan Utilization
Others
Triptans
70
60
50
40
30
20
10
0
600
500
400
300
200
100
0
07/2018
08/2018
09/2018
10/2018
11/2018
12/2018
01/2019
02/2019
03/2019
04/2019
05/2019
06/2019
07/2019
08/2019
09/2019
10/2019
11/2019
12/2019
01/2020
02/2020
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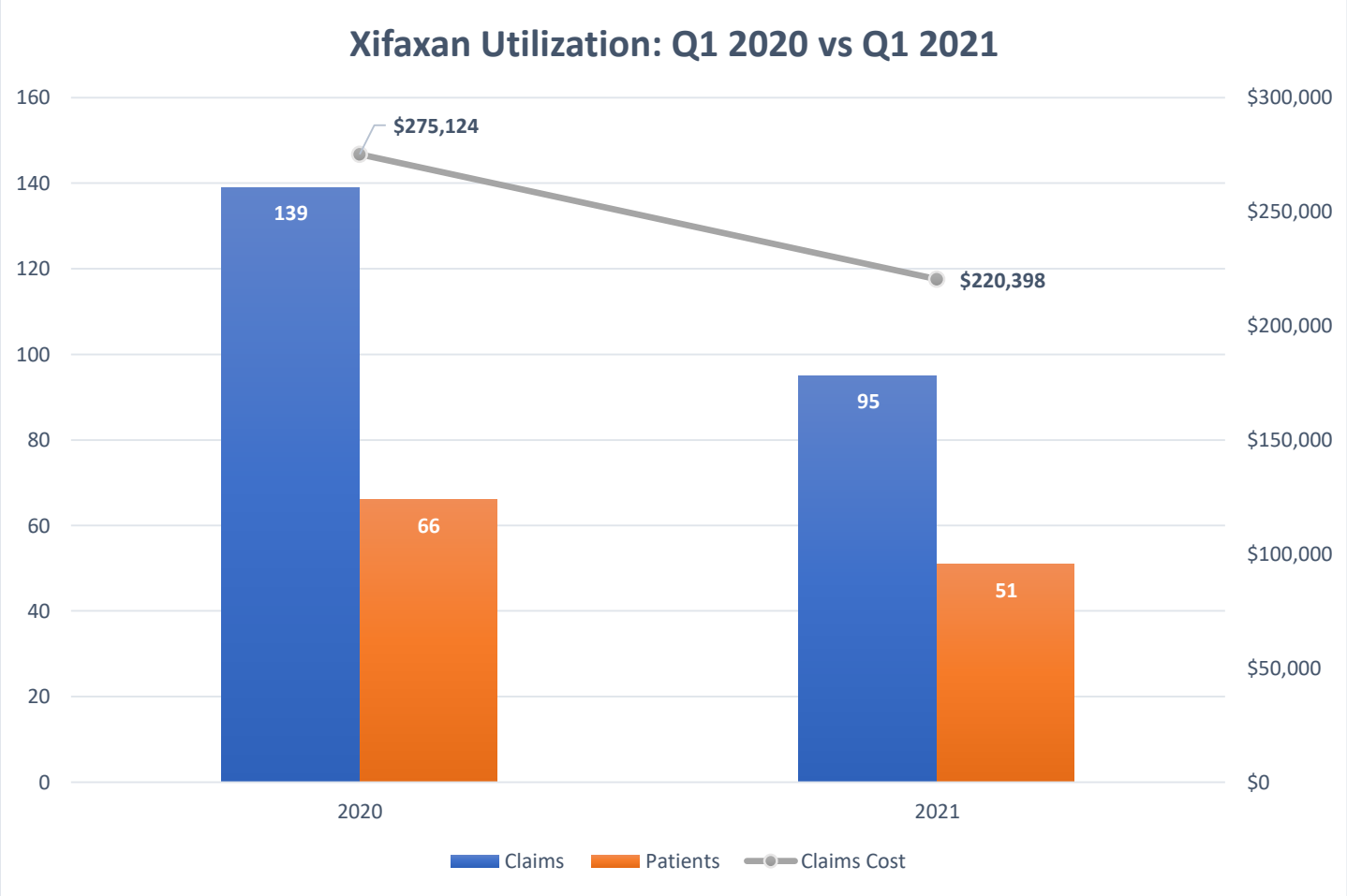
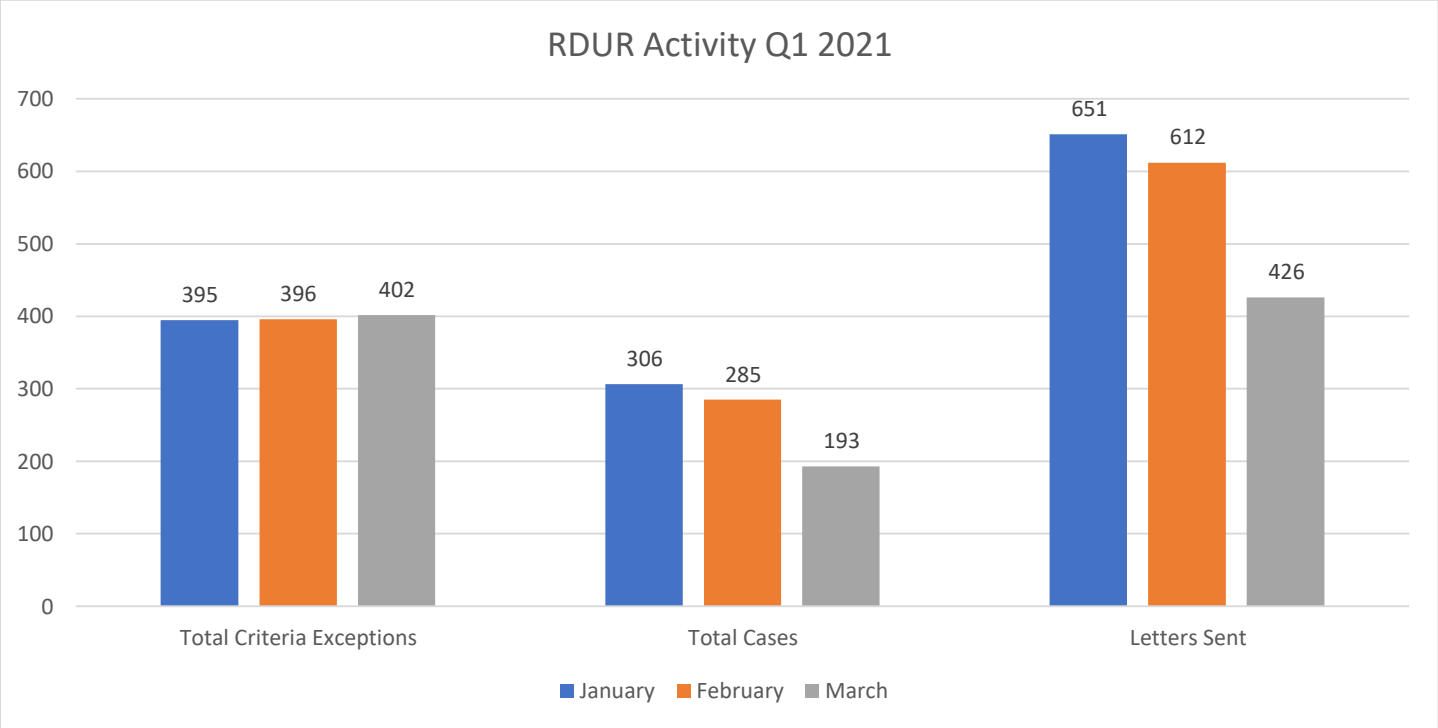
04/2020
05/2020
06/2020
07/2020
08/2020
09/2020
10/2020
11/2020
12/2020
01/2021
02/2021
03/2021
CGRP Inhibitors pts
CGRP Inhibitor claims
NT patients
NT claims
Triptan pts
Triptan claims


Xifaxan Utilization: Q1 2020 vs Q1 2021
160
140
120
100
80
60
40
20
0
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
$275,124
$220,398
139
66
95
51
2020
2021
Claims
Patients
Claims Cost

RDUR Activity Overview: Q1 2021



January Cases by Type of Criteria			
Classification of Criteria	**Criteria Description**	**# of Cases**	**% of Cases**
Clinical Appropriateness	HYPERTENSION	34	11.11%
	RENAL IMPAIRMENT	4	1.31%
	ADVERSE FETAL EFFECTS	1	0.33%
	RESPIRATORY DEPRESSION	5	1.63%
	CONGESTIVE HEART FAILURE	2	0.65%
	INAPPROPRIATE THERAPY FOR ELDERLY	11	3.59%
	OVERUTILIZATION	2	0.65%
	DISEASE STATE MANAGEMENT	43	14.05%
	COST CONTROL	4	1.31%
	INAPPROPRIATE MIGRAINE THERAPY	5	1.63%
	INAPPROPRIATE PEDIATRIC THERAPY	30	9.80%
	INAPPROPRIATE THERAPY	2	0.65%
	QT PROLONGATION	1	0.33%
	INAPPROPRIATE USE OF LABA	1	0.33%
	SEDATIVE USE IN ADHD	41	13.40%
	TOPICAL CORTICOSTEROIDS IN PEDIATRIC PATIENTS	2	0.65%
	INAPPROPRIATE LIDODERM USE	50	16.34%
	INAPPROPRIATE PPI DURATION/USE	68	22.22%

February Cases by Type of Criteria			
Classification of Criteria	**Criteria Description**	**# of Cases**	**% of Cases**
Drug/Drug Conflicts	ADD. ANTICHOLINERGIC EFFECTS	15	5.26%
	DUPLICATE ANTIPSYCHOTIC THERAPY	38	13.33%
	THERAPEUTIC DUPLICATION OF ANXIOLYTIC AGENTS	18	6.32%
	DISEASE STATE MANAGEMENT	33	11.58%
	THERAPEUTIC DUPLICATION OF ANTIHISTAMINES	17	5.96%
	THERAPEUTIC DUPLICATION OF ANTICHOLINERGIC BRONCHODILATORS	6	2.11%
Clinical Appropriateness	DELAYED GASTRIC EMPTYING	13	4.56%
	INCREASED CANCER RISK	25	8.77%
	INCREASED LDL-C LEVELS	28	9.82%
	CONTRAINDICATION	2	0.70%
	PATIENT AT RISK OF ASCVD AND NOT ON STATIN	68	23.85%
	ARTHRALGIA	7	2.46%
	OPIOID USE IN PEDIATRIC PATIENTS	3	1.05%
	BEERS CRITERIA	2	0.70%
	INAPPROPRIATE STIRIPENTOL REGIMEN	1	0.35%
	INCREASED RISK OF LOWER LIMB AMPUTATION	9	3.16%

March Cases by Type of Criteria			
Classification of Criteria	**Criteria Description**	**# of Cases**	**% of Cases**
Drug/Disease Interaction	BETA BLOCKERS + RESPIRATORY DISEASE	38	19.69%
	RENAL IMPAIRMENT	57	29.53%
	LITHIUM TOXICITY	2	1.04%
	ARRHYTHMIAS	9	4.66%
	GASTROINTESTINAL DISORDER	32	16.58%
	COUGH	9	4.66%
	HORMONE EFFECTS	29	15.03%
	RENAL INSUFFICIENCY	5	2.59%
	URINARY RETENTION	12	6.22%

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
2ND QUARTER 2021

Criteria Recommendations ***Approved Rejected***

1. Tolvaptan / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Jynarque (tolvaptan) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Tolvaptan		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

2. Tolvaptan / Therapeutic Appropriateness _____ _____
Alert Message: Jynarque (tolvaptan) is contraindicated in patients with a history, signs or symptoms of significant liver impairment or injury. Tolvaptan can cause serious and potentially fatal liver injury. This contraindication does not apply to uncomplicated polycystic liver disease.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Tolvaptan	Liver Impairment	Cystic Liver Disease

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

3. Tolvaptan / Contraindicated Conditions _____ _____
Alert Message: Jynarque (tolvaptan) is contraindicated in patients with uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, or anuria. Tolvaptan increases free water clearance and, as a result, may cause dehydration, hypovolemia, and hypernatremia.

Drugs/Diseases

Util A	Util B	Util C
Tolvaptan	Anuria	
	Hypovolemia	
	Urinary Tract Obstruction	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

4. Tolvaptan / Strong CYP3A Inhibitors _____ _____

Alert Message: The coadministration of Jynarque (tolvaptan) with strong CYP3A inhibitors is contraindicated. Tolvaptan is a CYP3A4 substrate, and concurrent use with a strong CYP3A inhibitor has been shown to increase tolvaptan exposure, increasing the risk of tolvaptan-related adverse effects.

Drugs/Diseases

Util A	Util B		Util C
Tolvaptan	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

5. Tolvaptan / Moderate CYP3A Inhibitors _____ _____

Alert Message: The coadministration of Jynarque (tolvaptan) with moderate CYP3A inhibitors should be avoided. If concurrent use cannot be avoided, reduce the tolvaptan dose per the official prescribing information. Tolvaptan is a CYP3A substrate, and concurrent use with a moderate CYP3A inhibitor can result in increased tolvaptan exposure, increasing the risk of tolvaptan-related adverse effects.

Drugs/Diseases

Util A	Util B			Util C
Tolvaptan	Atazanavir	Diltiazem	Verapamil	
	Aprepitant	Dronedarone		
	Cimetidine	Erythromycin		
	Ciprofloxacin	Fluconazole		
	Crizotinib	Fluvoxamine		
	Cyclosporine	Imatinib		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

6. Tolvaptan / Strong CYP3A Inducers _____ _____

Alert Message: The coadministration of Jynarque (tolvaptan) with strong CYP3A inducers should be avoided. Tolvaptan is a CYP3A4 substrate, and coadministration with a CYP3A4 inducer can lead to a reduction in the plasma concentration of tolvaptan and decreased effectiveness of treatment.

Drugs/Diseases

Util A	Util B	Util C
Tolvaptan	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

7. Tolvaptan / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Available data with Jynarque (tolvaptan) use in pregnant women are insufficient to determine if there is a drug-associated risk of adverse developmental outcomes. In animal studies, tolvaptan has been shown to have adverse effects on the fetus when given to pregnant animals at maternally toxic doses. Advise pregnant patients of the potential risk to the fetus.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Tolvaptan	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

8. Tolvaptan / Therapeutic Appropriateness _____ _____

Alert Message: There are no data on the presence of Jynarque (tolvaptan) in human milk, the effects on the breastfed infant, or the effects on milk production. Tolvaptan is present in rat milk. When a drug is present in animal milk, it is possible that the drug will be present in human milk, but relative levels may vary. Because of the potential for serious adverse reactions, including liver toxicity, electrolyte abnormalities (e.g., hypernatremia), hypotension, and volume depletion in breastfed infants, advise women not to breastfeed during treatment with tolvaptan.

Drugs/Diseases

Util A	Util B	Util C
Tolvaptan	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Jynarque Prescribing Information, Oct. 2020, Otsuka America Pharmaceuticals, Inc.

9. Tacrolimus / Strong CYP3A4 Inducers _____ _____

Alert Message: The concomitant use of tacrolimus (a CYP3A4 substrate) with strong CYP3A4 inducers may increase the metabolism of tacrolimus, leading to lower whole blood trough concentrations and greater risk of rejection. Dose adjustment of tacrolimus may be necessary when administered concomitantly with CYP3A4 inducers. Closely monitor tacrolimus whole blood trough concentrations.

Drugs/Diseases

Util A	Util B	Util C
Tacrolimus	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

10. Rosuvastatin Sprinkle / Overuse _____ _____

Alert Message: Ezallor Sprinkle (rosuvastatin) may be over-utilized. The recommended maximum dosage of rosuvastatin is 40 mg once daily.

Drugs/Diseases

Util A	Util B	Util C (Negating)	
Rosuvastatin sprinkle		CKD Stage 4 & 5	Gemfibrozil
		ESRD	Glecaprevir/Pibrentasvir
		Atazanavir	Lopinavir/rtv
		Cyclosporine	Regorafenib
		Darolutamide	Sofosbuvir/Velpatasvir
		Elbasvir/Grazoprevir	Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir

Max Dose: 40 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

11. Rosuvastatin Sprinkle / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Ezallor Sprinkle (rosuvastatin) have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin Sprinkle		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

12. Rosuvastatin Sprinkle / Hepatic Impairment _____ _____

Alert Message: Ezallor Sprinkle (rosuvastatin) use is contraindicated in patients with active liver disease, which may include unexplained persistent elevations of hepatic transaminase levels.

Drugs/Diseases

Util A	Util B	Util C (Include)
Rosuvastatin sprinkle		Hepatic Impairment

Max Dose
References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

13. Rosuvastatin Sprinkle / Severe Renal Impairment _____ _____

Alert Message: For patients with severe renal impairment (CLcr < 30 mL/min/1.73 m2) not on hemodialysis, dosing of Ezallor Sprinkle (rosuvastatin) should be started at 5 mg once daily and not exceed 10 mg once daily.

Drugs/Diseases

Util A	Util B	Util C (Include)
Rosuvastatin sprinkle		CKD Stage 4 & 5 ESRD

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

14. Rosuvastatin Sprinkle / Gemfibrozil _____ _____

Alert Message: Due to the observed increased risk of myopathy/rhabdomyolysis, the concurrent use of Ezallor Sprinkle (rosuvastatin) with gemfibrozil should be avoided. If concomitant use cannot be avoided, initiate rosuvastatin at 5 mg once daily. The dose of rosuvastatin should not exceed 10 mg once daily.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Gemfibrozil	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

15. Rosuvastatin Sprinkle / Cyclosporine _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 5 mg once daily when coadministered with cyclosporine. Rosuvastatin is a BCRP and OATP1B1 substrate, and concurrent use with cyclosporine, a BCRP and OATP1B1 transport inhibitor, has been shown to elevate rosuvastatin plasma concentrations, increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Cyclosporine	

Max Dose: 5 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

16. Rosuvastatin Sprinkle / Darolutamide _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 5 mg once daily when co-administered with Nubeqa (darolutamide). Rosuvastatin is a BCRP substrate, and concurrent use with darolutamide, a BCRP transport inhibitor, has been shown to elevate rosuvastatin plasma concentrations, increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Darolutamide	

Max Dose: 5 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

17. Rosuvastatin Sprinkle / Regorafenib _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg once daily when co-administered with regorafenib. Rosuvastatin is a BCRP substrate, and concurrent use with regorafenib, a BCRP transport inhibitor, has been shown to elevate rosuvastatin plasma concentrations, increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Regorafenib	

Max dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

18. Rosuvastatin Sprinkle / Lopinavir & Atazanavir _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg once daily when co-administered with lopinavir/ritonavir or ritonavir-boosted atazanavir. Lopinavir and atazanavir are OATP1B1 transport inhibitors, and concurrent use with rosuvastatin, an OATP1B1 substrate, may elevate rosuvastatin plasma concentrations and increase the risk of rosuvastatin-related adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Atazanavir Lopinavir/Ritonavir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

19. Rosuvastatin Sprinkle / Viekira Pak _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg per day when co-administered with ombitasvir/paritaprevir/ritonavir/dasabuvir (Viekira Pak). Rosuvastatin is a BCRP, OATP1B1, and OATP1B3 substrate. The components of the antiviral combination product inhibit BCRP-, OATP1B1-, and OAT1B3-mediated transport. Concurrent use of these agents may result in increased rosuvastatin plasma concentrations and risk of rosuvastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Ombitasvir/paritaprevir/ritonavir/dasabuvir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

20. Rosuvastatin Sprinkle / Elbasvir/Grazoprevir _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg once daily when co-administered with Zepatier (elbasvir/grazoprevir). Both elbasvir and grazoprevir are BCRP inhibitors, and concurrent use with rosuvastatin, a BCRP substrate, can result in elevated rosuvastatin plasma concentrations increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Elbasvir/Grazoprevir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

21. Rosuvastatin Sprinkle / Sofosbuvir/Velpatasvir _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg once daily when co-administered with Epclusa (sofosbuvir/velpatasvir). The velpatasvir component of the combination antiviral product is a BCRP and OATP1B1 transport inhibitor, and concurrent use with rosuvastatin, a BCRP and OATP1B1 substrate, can result in elevated rosuvastatin plasma concentrations increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Sofosbuvir/Velpatasvir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

22. Rosuvastatin Sprinkle / Glecaprevir/Pibrentasvir _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg per day when co-administered with Mavyret (glecaprevir/pibrentasvir). Rosuvastatin is a BCRP, OATP1B1, and OATP1B3 substrate. The components of the antiviral combination product inhibit BCRP-, OATP1B1-, and OAT1B3-mediated transport. Concurrent use of these agents may result in increased rosuvastatin plasma concentrations and risk of rosuvastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Glecaprevir/Pibrentasvir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

23. Rosuvastatin Sprinkle / Atazanavir/Cobicistat _____ _____

Alert Message: The dose of Ezallor Sprinkle (rosuvastatin) should not exceed 10 mg once daily when co-administered with Evotaz (atazanavir/cobicistat). The components of the antiretroviral combination product inhibit BCRP-, OATP1B1-, and OAT1B3-mediated transport. Concurrent use of these agents may result in increased rosuvastatin plasma concentrations and risk of rosuvastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Atazanavir/Cobicistat	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

24. Rosuvastatin Sprinkle / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Ezallor Sprinkle (rosuvastatin) is contraindicated for use in pregnant patients since safety in these patients has not been established, and there is no apparent benefit to therapy with rosuvastatin during pregnancy. Because HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, rosuvastatin may cause fetal harm when administered to pregnant patients. Rosuvastatin should be discontinued as soon as pregnancy is recognized.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Rosuvastatin sprinkle	Pregnancy	Abortion Delivery Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

25. Rosuvastatin Sprinkle / Therapeutic Appropriateness _____ _____

Alert Message: Ezallor Sprinkle (rosuvastatin) use is contraindicated during breastfeeding. Limited data indicate that rosuvastatin is present in human milk. There is no available information on the effects of the drug on the breastfed infant or the effects of the drug on milk production. Because of the potential for serious adverse reactions in a breastfed infant, advise patients that breastfeeding is not recommended during treatment with rosuvastatin.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin sprinkle	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ezallor Prescribing Information, Sept. 2020, Sun Pharmaceuticals Industries.

26. Eptinezumab / Overuse _____ _____

Alert Message: Vyepti (eptinezumab) may be over-utilized. The recommended dosage of eptinezumab is 100 mg administered by intravenous infusion every 3 months. Some patients may benefit from a dosage of 300 mg administered by intravenous infusion every 3 months.

Drugs/Diseases

Util A	Util B	Util C
Eptinezumab		

Max Dose: 300mg/3 months

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Vyepti Prescribing Information, Feb. 2020, Lundbeck Seattle BioPharmaceuticals, Inc.

27. Eptinezumab / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Vyepti (eptinezumab) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Eptinezumab		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Vyepti Prescribing Information, Feb. 2020, Lundbeck Seattle BioPharmaceuticals, Inc.

28. Eptinezumab/ Non-adherence _____ _____
Alert Message: Based on refill history, your patient may be underutilizing Vyepti (eptinezumab). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Eptinezumab		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med.2005;353:487-97.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Vyepti Prescribing Information, Feb. 2020, Lundbeck Seattle BioPharmaceuticals, Inc.

29. Rimegepant / Overuse _____ _____
Alert Message: Nurtec ODT (rimegepant) may be over-utilized. The recommended maximum dose of rimegepant is 75 mg in a 24-hour period. The safety of treating more than 15 migraines in a 30-day period has not been established.

Drugs/Diseases

Util A	Util B	Util C
Rimegepant		

Max Dose: 75 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Nurtec ODT Prescribing Information, Feb. 2020, Biohaven Pharmaceuticals Inc.

30. Opicapone / Overuse _____ _____
Alert Message: Ongentys (opicapone) may be over-utilized. The recommended dosage of opicapone is 50 mg once daily at bedtime.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Opicapone		Hepatic Impairment

Max Dose: 50 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

31. Opicapone / Overuse – Hepatic Impairment _____ _____

Alert Message: Ongentys (opicapone) may be over-utilized. The recommended dosage of opicapone in patients with moderate hepatic impairment (Child-Pugh B) is 25 mg once daily at bedtime. In a pharmacokinetic study, the mean overall opicapone plasma exposure (AUC) in subjects with moderate hepatic impairment increased by 84%. Opicapone has not been studied in patients with severe hepatic impairment (Child-Pugh C), and its use should be avoided in this population.

Drugs/Diseases

Util A	Util B	Util C (Include)
Opicapone		Hepatic Impairment

Max Dose: 25 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

32. Opicapone / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Ongentys (opicapone) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Opicapone		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

33. Opicapone / Therapeutic Appropriateness _____ _____

Alert Message: The use of Ongentys (opicapone) should be avoided in patients with end-stage renal disease (ESRD) (CLcr < 15 mL/min). No dosage adjustment is required for patients with mild, moderate, or severe renal impairment. However, because of the potential for increased exposure, monitor patients with severe renal impairment for adverse reactions and discontinue opicapone if tolerability issues arise.

Drugs/Diseases

Util A	Util B	Util C
Opicapone	ESRD	

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

34. Opicapone / Non-Selective MAO Inhibitors _____ _____

Alert Message: The concurrent use of Ongentys (opicapone) with non-selective MAO inhibitors is contraindicated. Both opicapone and non-selective MAO inhibitors (e.g., phenelzine, isocarboxazid, and tranylcypromine) inhibit catecholamine metabolism, leading to increased levels of catecholamines. Concomitant use may increase the risk of possible arrhythmias, increased heart rate, and excessive changes in blood pressure.

Drugs/Diseases

Util A	Util B	Util C
Opicapone	Isocarboxazid	
	Phenelzine	
	Tranylcypromine	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

35. Opicapone / Catecholamine Secreting Neoplasm _____ _____

Alert Message: Ongentys (opicapone) use is contraindicated in patients with a history of pheochromocytoma, paraganglioma, or other catecholamine secreting neoplasms.

Drugs/Diseases

Util A	Util B	Util C (Include)
Opicapone		Malignant Neoplasm of Adrenal Gland
		Benign Neoplasm of Adrenal Gland

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

36. Opicapone / COMT Substrates _____ _____

Alert Message: Possible arrhythmias, increased heart rate, and excessive changes in blood pressure may occur with concomitant use of Ongentys (opicapone) and drugs metabolized by COMT (e.g., ephedrine, epinephrine, and methyldopa), regardless of the route of administration (including inhalation). Monitor patients treated concomitantly with opicapone and drugs metabolized by COMT.

Drugs/Diseases

Util A	Util B	Util C
Opicapone	Ephedrine	
	Epinephrine	
	Methyldopa	

References:

Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

37. Opicapone / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate data on the developmental risk associated with the use of Ongentys (opicapone) in pregnant patients. In animal studies, oral administration of opicapone during pregnancy resulted in adverse effects on embryofetal development (increased incidence of fetal abnormalities) at clinically relevant plasma exposures in one of two species tested. In addition, opicapone is always given concomitantly with levodopa/carbidopa, which is known to cause developmental toxicity in rabbits.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Opicapone	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

38. Opicapone / Lactation _____ _____

Alert Message: There are no data on the presence of Ongentys (opicapone) in human milk, the effects on the breastfed infant, or the effects on milk production. In lactating rats, oral administration of opicapone resulted in levels of opicapone or metabolites in milk similar to those in maternal plasma. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for opicapone and any potential adverse effects on the breastfed infant from opicapone or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Opicapone	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

39. Opicapone / Therapeutic Appropriateness _____ _____

Alert Message: A review of the patient's drug history did not reveal a current prescription for levodopa/carbidopa. Ongentys (opicapone) is indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing "off " episodes.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Opicapone		Carbidopa/Levodopa

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

40. Opicapone / Hallucinations & Psychosis _____ _____

Alert Message: Hallucinations (auditory hallucinations, visual hallucinations, mixed hallucinations) have been reported in patients receiving Ongentys (opicapone). Patients with a major psychotic disorder ordinarily should not be treated with opicapone because of the risk of exacerbating the psychosis with an increase in central dopaminergic tone. Consider stopping opicapone if hallucinations or psychotic-like behaviors occur.

Drugs/Diseases

Util A	Util B	Util C
Opicapone	Hallucinations	
	Delusions	
Psychosis		

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Ongentys Prescribing Information, April 2020, Neurocrine Biosciences, Inc.

41. Opicapone / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Ongentys (opicapone). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Opicapone		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487-97.
Grosset D, Antonini A, Canesi M, et al. Adherence to Antiparkinson Medication in a Multicenter European Study. Movement Disord. 2009. Vol 24, No. 6:826-832.
Straka I, Minár M, Škorvánek M, et al. Adherence to Pharmacotherapy in Patients With Parkinson's Disease Taking Three and More Daily Doses of Medication. Front Neurol. 2019;10:799. Published 2019 Jul 31. doi:10.3389/fneur.2019.00799

42. Viloxazine / Overuse _____ _____

Alert Message: Qelbree (viloxazine) may be over-utilized. The recommended maximum daily dose of viloxazine is 400 mg once daily.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Viloxazine		Chronic Kidney Disease Stage 4
		Chronic Kidney Disease Stage 5

Max Dose: 400 mg/day

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

43. Viloxazine / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Qelbree (viloxazine) have not been established in pediatric patients younger than 6 years old.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine		

Age Range: 0 – 5 yoa

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

44. Viloxazine / Overuse Renal Impairment _____ _____

Alert Message: Qelbree (viloxazine) may be over-utilized. The recommended maximum daily dose of viloxazine in patients with severe renal impairment (eGFR < 30 mL/min/1.73m2), is 200 mg once daily. No dosage adjustment is recommended in patients with mild to moderate (eGFR of 30 to 89 mL/min/1.73m2) renal impairment.

Drugs/Diseases

Util A	Util B	Util C (Include)
Viloxazine		Chronic Kidney Disease Stage 4
		Chronic Kidney Disease Stage 5

Max Dose: 200 mg/day

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

45. Viloxazine / Therapeutic Appropriateness (Black Box Warning) _____ _____

Alert Message: In clinical studies, higher rates of suicidal thoughts and behavior were reported in pediatric patients with ADHD treated with Qelbree (viloxazine) than in patients treated with placebo. Closely monitor all viloxazine-treated patients for clinical worsening, and emergence of suicidal thoughts and behaviors.

Drugs/Diseases

Util A	Util B	Util C (Include)
Viloxazine		Suicide, Attempt
		Suicidal Ideation
		History of Self Harm

Age Range: 6 - 17 yoa

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals..
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

46. Viloxazine / Therapeutic Appropriateness _____ _____

Alert Message: The effect of hepatic impairment on the pharmacokinetics of Qelbree (viloxazine) is unknown. Viloxazine use is not recommended in patients with hepatic impairment.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Hepatic Impairment	

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

47. Viloxazine / Heart Rate and Blood Pressure Increases _____ _____

Alert Message: Qelbree (viloxazine) can cause an increase in heart rate and diastolic blood pressure. Assess heart rate and blood pressure prior to initiating treatment with viloxazine, following increases in dosage, and periodically while on therapy.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Hypertension	

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

48. Viloxazine / MAO Inhibitors _____ _____

Alert Message: Qelbree (viloxazine) is contraindicated in patients receiving concomitant treatment with monoamine oxidase inhibitors (MAOI), or within 14 days following discontinuing an MAOI, because of an increased risk of hypertensive crisis.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Isocarboxazid	
	Phenelzine	
	Rasagiline	
	Safinamide	
	Selegiline	
	Tranylcypromine	

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

49. Viloxazine / Sensitive/NTI CYP1A2 Substrates _____ _____

Alert Message: Qelbree (viloxazine) is contraindicated in patients receiving concomitant administration of sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range. Viloxazine is a strong CYP1A2 inhibitor. Concomitant use of viloxazine significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2 substrates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Alosetron	
	Duloxetine	
	Ramelteon	
	Tasimelteon	
	Tizanidine	
	Theophylline	

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

50. Viloxazine / Mania or Hypomania _____ _____

Alert Message: Noradrenergic drugs, such as Qelbree (viloxazine), may induce a manic or mixed episode in patients with bipolar disorder. Prior to initiating treatment with viloxazine, screen patients to determine if they are at risk for bipolar disorder; such screening should include a detailed psychiatric history, including a personal or family history of suicide, bipolar disorder, and depression.

Drugs/Diseases

Util A	Util B	Util C (Include)
Viloxazine		Bipolar Disorder
		Depression
		History of Self Harm
		Suicide, Attempt
		Suicidal Ideation

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

51. Viloxazine / Moderately Sensitive CYP1A2 Substrates _____ _____

Alert Message: The concurrent use of Qelbree (viloxazine) with a moderately sensitive CYP1A2 substrate is not recommended. Dose reduction of the CYP1A2 substrate may be warranted if coadministration is necessary. Viloxazine is a strong CYP1A2 inhibitor, and concomitant use of viloxazine increases the total exposure, but not peak exposure, of sensitive CYP1A2 substrates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Clozapine	
	Pirfenidone	

References:

Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

52. Viloxazine / CYP3A4 Substrates _____ _____

Alert Message: The concurrent use of Qelbree (viloxazine) with a CYP3A4 substrate may increase the exposure of the CYP3A4 substrate. Dose reduction of the CYP3A4 substrate may be warranted if coadministration is necessary. Viloxazine is a weak inhibitor of CYP3A4 inhibitor. Monitor patients for adverse reactions and adjust the dosage of CYP3A4 substrates, as clinically indicated.

Drugs/Diseases

Util A	Util B					Util C
Viloxazine	Amiodarone	Buprenorphine	Budesonide	Etoposide	Dexamethasone	
	Fentanyl	Cabozantinib	Buspirone	Estrogens	Dexlansoprazole	
	Midazolam	Disopyramide	Cariprazine	Copanlisib	Quinidine	
	Abemaciclib	Amlodipine	Ceritinib	Crizotinib	Diazepam	
	Acalabrutinib	Aripiprazole	Chlordiazepoxide	Dabrafenib	Diltiazem	
	Oxycodone	Bedaquiline	Cilostazol	Saxagliptin	Rilpivirine	
	Hydrocodone	Bortezomib	Avanafil	Dapsone	Tolterodine	
	Tacrolimus	Bosutinib	Citalopram	Darifenacin	Duvelisib	
	Cyclosporine	Brexpiprazole	Cariprazine	Darunavir	Efavirenz	
	Fluticasone	Brigatinib	Clonazepam	Dasatinib	Elbasvir/Grazoprevir	
	Escitalopram	Bromocriptine	Clorazepate	Eletriptan	Everolimus	
	Felodipine	Encorafenib	Eplerenone	Erlotinib	Estazolam	
	Estradiol	Eszopiclone	Ethosuximide	Vilazodone	Flurazepam	
	Fosamprenavir	Gefitinib	Glasdegib	Guanfacine	Haloperidol	
	Idelalisib	Imatinib	Isradipine	Itraconazole	Ixabepilone	
	Ketoconazole	Lapatinib	Larotrectinib	Levomilnacipran	Macitentan	
	Maraviroc	Mefloquine	Lurasidone	Midostaurin	Mifepristone	
	Mirtazapine	Nelfinavir	Netupitant	Nevirapine	Nifedipine	
	Nilotinib	Nisoldipine	Ospemifene	Paclitaxel	Palbociclib	
	Panobinostat	Pazopanib	Pimavanserin	Valbenazine	Tadalafil	
	Quetiapine	Ranolazine	Regorafenib	Ribociclib	Rifabutin	
	Roflumilast	Romidepsin	Ruxolitinib	Saquinavir	Sildenafil	
	Silodosin	Solifenacin	Sunitinib	Suvorexant	Ibrutinib	
	Tasimelteon	Temsirolimus	Ticagrelor	Tipranavir	Lomitapide	
	Toremifene	Trabectedin	Trazodone	Triazolam	Lovastatin	
	Verapamil	Vardenafil	Vemurafenib	Venlafaxine	Simvastatin	
	Vinblastine	Vincristine	Vinorelbine	Zolpidem	Sirolimus	

References:

Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

53. Viloxazine / CYP2D6 Substrates _____ _____

Alert Message: The concurrent use of Qelbree (viloxazine) with a CYP2D6 substrate may increase the exposure of the CYP2D6 substrate. Viloxazine is a weak inhibitor of CYP2D6. Monitor patients for adverse reactions and adjust the dosage of CYP2D6 substrates, as clinically indicated.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Atomoxetine	
	Desipramine	
	Dextromethorphan	
	Nortriptyline	
	Metoprolol	
	Nebivolol	
	Perphenazine	
	Tolterodine	
	Venlafaxine	
	Risperidone	

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

54. Viloxazine / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on findings from animal reproduction studies, Qelbree (viloxazine) may cause maternal harm when used during pregnancy. Discontinue viloxazine when pregnancy is recognized unless the benefits of therapy outweigh the potential risk to the mother. Available data from case series with viloxazine use in pregnant patients are insufficient to determine a drug-associated risk of major birth defects, miscarriage, or adverse maternal outcomes.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Viloxazine	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

55. Viloxazine / Lactation _____ _____

Alert Message: There are no data on the presence of Qelbree (viloxazine) in human milk, the effects on the breastfed infant, or the effects on milk production. Viloxazine is likely present in rat milk. When a drug is present in animal milk, it is likely that the drug will be present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for viloxazine and any potential adverse effects on the breastfed child from viloxazine or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Viloxazine	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Qelbree Prescribing Information, April 2021, Supernus Pharmaceuticals.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

56. Vorinostat / Overuse _____ _____
Alert Message: Zolinza (vorinostat) may be over-utilized. The recommended dose of vorinostat is 400 mg orally once daily with food.

Drugs/Diseases

Util A	Util B	Util C
Vorinostat		

Max Dose: 40 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

57. Vorinostat / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Zolinza (vorinostat) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Vorinostat		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

58. Vorinostat / Pulmonary Embolism _____ _____
Alert Message: Pulmonary embolism occurred in 5% (4/86) of patients receiving Zolinza (vorinostat), and deep vein thrombosis has also been reported. Monitor patients for signs and symptoms of these events, particularly in patients with a prior history of thromboembolic events.

Drugs/Diseases

Util A	Util B	Util C (Include)
Vorinostat		Embolism
		Thrombosis

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

59. Vorinostat / Gastrointestinal Toxicity _____ _____

Alert Message: Gastrointestinal disturbances, including nausea, vomiting, and diarrhea, have been reported with Zolinza (vorinostat) use and may require the use of antiemetic and antidiarrheal medications. Fluid and electrolytes should be replaced to prevent dehydration. Pre-existing nausea, vomiting, and diarrhea should be adequately controlled before beginning therapy with Zolinza (vorinostat).

Drugs/Diseases

Util A	Util B	Util C
Vorinostat	Diarrhea	
	Nausea	
	Vomiting	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

60. Vorinostat / Hyperglycemia _____ _____

Alert Message: Zolinza (vorinostat) may cause hyperglycemia. Monitor serum glucose every 2 weeks during the first 2 months of therapy and monthly thereafter.

Drugs/Diseases

Util A	Util B	Util C (Include)
Vorinostat		Diabetes

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

61. Vorinostat / Warfarin _____ _____

Alert Message: Prolongation of prothrombin time (PT) and International Normalized Ratio (INR) were observed in patients receiving Zolinza (vorinostat) concomitantly with coumarin-derivative anticoagulants. Physicians should monitor PT and INR more frequently in patients concurrently administered vorinostat and coumarin derivatives.

Drugs/Diseases

Util A	Util B	Util C
Vorinostat	Warfarin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

62. Vorinostat / Valproic Acid _____ _____

Alert Message: Severe thrombocytopenia and gastrointestinal bleeding have been reported with concomitant use of Zolinza (vorinostat) and other HDAC inhibitors (e.g., valproic acid). Monitor platelet count every 2 weeks for the first 2 months.

Drugs/Diseases

Util A	Util B	Util C
Vorinostat	Valproic Acid	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

63. Vorinostat / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on its mechanism of action and findings from animal studies, Zolinza (vorinostat) can cause fetal harm when administered to a pregnant woman. There are insufficient data on vorinostat use in pregnant women to inform a drug-associated risk of major birth defects and miscarriage. In animal reproduction studies, administration of vorinostat to pregnant rats and rabbits during the period of organogenesis caused adverse developmental outcomes at maternal exposures approximately 0.5 times the human exposure based on AUC0-24 hours. Advise pregnant women of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Vorinostat	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

64. Vorinostat / Therapeutic Appropriateness _____ _____

Alert Message: There are no data on the presence of Zolinza (vorinostat) or its metabolites in human milk, the effects on a breastfed child, or the effects on milk production. Because many drugs are excreted in human milk and because of the potential for serious adverse drug reactions in a nursing child, advise lactating patients not to breastfeed during treatment with vorinostat and for at least 1 week after the last dose.

Drugs/Diseases

Util A	Util B	Util C
Vorinostat	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

65. Vorinostat / Therapeutic Appropriateness _____ _____
Alert Message: Advise females of reproductive potential to use effective contraception during treatment with Zolinza (vorinostat) and for at least 6 months after the last dose.

Drugs/Diseases
Util A Util B Util C
Vorinostat

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

66. Vorinostat / Therapeutic Appropriateness _____ _____
Alert Message: Advise males with female partners of reproductive potential to use effective contraception and to avoid fathering a child during treatment with Zolinza (vorinostat) and for at least 3 months after the last dose.

Drugs/Diseases
Util A Util B Util C
Vorinostat

Gender: Male

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

67. Vorinostat / Non-adherence _____ _____
Alert Message: Based on refill history, your patient may be under-utilizing Zolinza (vorinostat). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases
Util A Util B Util C
Vorinostat

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487-497.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence With Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

68. Ivosidenib / Overuse _____ _____

Alert Message: Tibsovo (ivosidenib) may be over-utilized. The recommended dose of ivosidenib is 500 mg taken orally once daily until disease progression or unacceptable toxicity.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib		

Max Dose: 500 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

69. Ivosidenib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Tibsovo (ivosidenib) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

70. Ivosidenib / Differentiation Syndrome (Black Box Warning) _____ _____

Alert Message: Patients treated with Tibsovo (ivosidenib) have experienced differentiation syndrome, which can be fatal or life-threatening if not treated. Symptoms may include; fever, dyspnea, hypoxia, pulmonary infiltrates, pleural or pericardial effusions, rapid weight gain or peripheral edema, hypotension, or renal dysfunction. If differentiation syndrome is suspected, administer corticosteroid therapy as instructed in the official prescribing information and initiate hemodynamic monitoring until symptom resolution. Interrupt ivosidenib if severe signs and/or symptoms persist for more than 48 hours after initiation of systemic corticosteroids.

Drugs/Diseases

Util A	Util B		Util C
Ivosidenib	Dyspnea	Pericardial Effusion	
	Edema	Pleural Effusion	
	Fever	Renal Dysfunction	
	Hypoxia		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

71. Ivosidenib / QT Prolongation _____ _____

Alert Message: Patients treated with Tibsovo (ivosidenib) can develop QT (QTc) prolongation and ventricular arrhythmias. In patients with congenital long QTc syndrome, congestive heart failure, electrolyte abnormalities, or those taking medications known to prolong the QTc interval, more frequent monitoring may be necessary. Interrupt ivosidenib if QTc increases to greater than 480 msec and less than 500 msec. Interrupt and reduce ivosidenib if QTc increases to greater than 500 msec. Permanently discontinue ivosidenib in patients who develop QTc interval prolongation with signs or symptoms of life-threatening arrhythmia.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib	Long QT Syndrome	
	Heart Failure	
	Arrhythmias	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

72. Ivosidenib / Gillian-Barre Syndrome & Symptoms _____ _____

Alert Message: Guillain-Barre syndrome has occurred in patients treated with Tibsovo (ivosidenib) in the clinical study. Monitor patients taking Tibsovo (ivosidenib) for the onset of new signs or symptoms of motor and/or sensory neuropathy such as unilateral or bilateral weakness, sensory alterations, paresthesias, or difficulty breathing. Permanently discontinue ivosidenib in patients who are diagnosed with Guillain-Barre syndrome.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib	Gillian Barre Syndrome	
	Dyspnea	
	Paresthesias	
	Weakness	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

73. Ivosidenib / Strong CYP3A4 Inhibitors _____ _____

Alert Message: Co-administration of Tibsovo (ivosidenib) with strong CYP3A4 inhibitors increased ivosidenib plasma concentrations. Increased ivosidenib plasma concentrations may increase the risk of QTc interval prolongation. If a strong CYP3A4 inhibitor must be coadministered, reduce the ivosidenib dose to 250 mg once daily. If the strong inhibitor is discontinued, increase the ivosidenib dose (after at least 5 half-lives of the strong CYP3A4 inhibitor) to the recommended dose of 500 mg once daily.

Drugs/Diseases

Util A	Util B		Util C
Ivosidenib	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

Max Dose: 250 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

74. Ivosidenib / Moderate CYP3A4 Inhibitors _____ _____

Alert Message: Co-administration of Tibsovo (ivosidenib) with moderate CYP3A4 inhibitors increased ivosidenib plasma concentrations. Increased ivosidenib plasma concentrations may increase the risk of QTc interval prolongation. If a moderate CYP3A4 inhibitor must be coadministered, monitor the patient for QT prolongation.

Drugs/Diseases

Util A	Util B		Util C
Ivosidenib	Atazanavir	Diltiazem	Verapamil
	Aprepitant	Dronedarone	
	Cimetidine	Erythromycin	
	Ciprofloxacin	Fluconazole	
	Crizotinib	Fluvoxamine	
	Cyclosporine	Imatinib	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

75. Ivosidenib / Strong CYP3A4 Inducers _____ _____

Alert Message: The concurrent administration of Tibsovo (ivosidenib) with strong CYP3A4 inducers should be avoided. Ivosidenib is a CYP3A4 substrate and concomitant use with strong CYP3A4 inducers is predicted to decrease ivosidenib steady-state AUC by 33%.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

76. Ivosidenib / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Tibsovo (ivosidenib). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487-497.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence With Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

77. Ivosidenib / QT Prolongation Drugs _____ _____

Alert Message: Patients treated with Tibsovo (ivosidenib) can develop QT (QTc) prolongation and ventricular arrhythmias, therefore concurrent administration of ivosidenib with medications that prolong the QT interval should be avoided. If co-administration of a QTc prolonging drug is unavoidable, monitor patients for increased risk of QTc interval prolongation.

Drugs/Diseases

Util A	Util B				Util C
Ivosidenib	Abiraterone	Efavirenz	Lithium	Rilpivirine	
	Alfuzosin	Eliglustat	Lofexidine	Risperidone	
	Amiodarone	Encorafenib	Loperamide	Ritonavir	
	Amitriptyline	Entrectinib	Maprotiline	Romidepsin	
	Amoxapine	Eribulin	Methadone	Saquinavir	
	Anagrelide	Erythromycin	Metoclopramide	Sertraline	
	Aripiprazole	Escitalopram	Midostaurin	Siponimod	
	Arsenic Trioxide	Ezogabine	Mifepristone	Solifenacin	
	Artemether/Lum	Famotidine	Mirabegron	Sotalol	
	Asenapine	Felbamate	Mirtazapine	Sunitinib	
	Atazanavir	Fingolimod	Moexipril	Tacrolimus	
	Atomoxetine	Flecainide	Moxifloxacin	Tamoxifen	
	Azithromycin	Fluconazole	Nelfinavir	Telavancin	
	Bedaquiline	Fluoxetine	Nilotinib	Tetrabenazine	
	Bortezomib	Fluvoxamine	Nortriptyline	Thioridazine	
	Bendamustine	Foscarnet	Ofloxacin	Tizanidine	
	Bosutinib	Galantamine	Ondansetron	Tolterodine	
	Buprenorphine	Ganciclovir	Osimertinib	Toremifene	
	Ceritinib	Gemifloxacin	Oxaliplatin	Tramadol	
	Chloroquine	Gilteritinib	Paliperidone	Trazodone	
	Chlorpromazine	Glasdegib	Palonosetron	Tranylcypromine	
	Cilostazol	Granisetron	Panobinostat	Trimipramine	
	Ciprofloxacin	Haloperidol	Paroxetine	Valbenazine	
	Citalopram	Hydroxychloroquine	Pasireotide	Vandetanib	
	Clarithromycin	Hydroxyzine	Pazopanib	Vemurafenib	
	Clomipramine	Ibutilide	Pentamidine	Venlafaxine	
	Clozapine	Iloperidone	Pimavanserin	Voriconazole	
	Crizotinib	Imipramine	Pimozide		
	Dabrafenib	Indapamide	Pitolisant		
	Dasatinib	Indinavir	Phenelzine		
	Desipramine	Isocarboxazid	Posaconazole		
	Deutetrabenazine	Itraconazole	Procainamide		
	Diphenhydramine	Ivosidenib	Promethazine		
	Disopyramide	Ivabradine	Propafenone		
	Dofetilide	Ketoconazole	Protriptyline		
	Dolasetron	Lapatinib	Quetiapine		
	Donepezil	Lefamulin	Quinidine		
	Doxepin	Lenvatinib	Quinine		
	Dronedarone	Leuprolide	Ranolazine		

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

78. Ivosidenib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on animal embryo-fetal toxicity studies, Tibsovo (ivosidenib) may cause fetal harm when administered to a pregnant patient. There are no available data on ivosidenib use in pregnant patients to inform a drug-associated risk of major birth defects and miscarriage. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, advise the patient of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ivosidenib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

79. Ivosidenib / Lactation _____ _____

Alert Message: There are no data on the presence of Tibsovo (ivosidenib) or its metabolites in human milk, the effects on the breastfed child, or the effects on milk production. Because many drugs are excreted in human milk and because of the potential for adverse reactions in breastfed children, advise patients not to breastfeed during treatment with ivosidenib and for at least 1 month after the last dose.

Drugs/Diseases

Util A	Util B	Util C
Ivosidenib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

80. Encorafenib / Overuse _____ _____

Alert Message: Braftovi (encorafenib) may be over-utilized. The recommended maximum dose of encorafenib is 300 mg (four 75 mg capsules) orally once daily in combination with cetuximab until disease progression or unacceptable toxicity.

Drugs/Diseases

Util A	Util B	Util C (Include)
Encorafenib		Cetuximab

Max Dose: 300 mg/day

References:
Clinical Pharmacology, 2020 Elsevier/Gold Standard.
Braftovi Prescribing Information, April 2020, Array BioPharma.

North Dakota Medicaid
Drug Utilization Review Board
Meeting
September 1st, 2021
Conference Room 210/212

North Dakota Medicaid
DUR Board Meeting Agenda
Conference Room 210/212
North Dakota State Capitol

Click here to join the meeting

(Click on link)

Join by phone: 1 701-328-0950, Conference ID 496 023 327#

September 1, 2021

1:00 pm

1. Administrative items
    - DHS announcements

2. Old business
    - Review and approval of June 2021 meeting minutes
    - Budget update
    - Review top 25 drugs for second quarter of 2021
    - Prior authorization/PDL update
    - Second review of agents for the treatment of heart failure
    - Update to agents for nasal polyps criteria
    - Update to agents for chronic idiopathic urticaria
    - Update to agents for the treatment of uterine fibroids criteria
    - Update to Empaveli criteria
    - Update to Sedative/Hypnotics - Hetlioz criteria

3. New business
    - Review of non-stimulant agents for the treatment of ADHD
    - Review of drug utilization trends for select medication classes
    - Retrospective DUR profile review update
    - Retrospective DUR criteria recommendations
    - Upcoming meeting date/agenda.
        - Next meeting is December 1, 2021
4. Adjourn

Please remember to silence all cellular phones during the meeting.

North Dakota Medicaid Drug Use Review (DUR) Board
Meeting Minutes
June 2, 2021

Members Present: Joshua Askvig, Andrea Honeyman, Michael Quast, Kathleen Traylor, Gabriela Balf, Mary Aaland, Amy Werremeyer, Laura Schield, Tanya Schmidt, Peter Woodrow

Medicaid Pharmacy Department: Alexi Murphy, Brendan Joyce

Old Business

Chair A. Honeyman called the meeting to order at 1:07 p.m. Chair A. Honeyman asked for a motion to approve the minutes of the March 3, 2021 meeting. M. Quast moved that the minutes be approved, and J. Askvig seconded the motion. The chair called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 25 Drugs

A. Murphy presented budget updates and the quarterly review of the top 25 drugs based on total cost of claims, the top 25 drugs based on the total number of claims, and the top drug classes based on claims and cost for the 2nd quarter of 2021. Newly added to the top drug/drug class lists was a column showing the difference from the previous quarter, as requested by the Board. A. Murphy presented data to the Board that was reflective of the changes in the number of patients enrolled in ND Medicaid from January 2020 to March 2021, as well as per member spend, which indicated increased costs to the Medicaid program over the past year have been due to the increased number of enrollees during this time. A Murphy also presented utilization data of select medication classes to the Board to illustrate drug utilization trends during this time. Drug classes presented included Antipsychotics, beta agonists, non-steroidal anti-inflammatory drugs, and antidepressants.

PDL/PA Criteria Updates

A. Murphy shared with the Board all of changes made to the Preferred Drug List since the last version of the Preferred Drug List was posted. Notable changes included the addition of multiple combination agents to the "Kit" PA criteria, as well as adding newly approved agents such as Filphilia, Udenyca, Gemtasa, Epclusa 200-50 mg to already existing PA category criteria. All PDL updates are listed in the handouts for the Junea 2021 DUR Board meeting. When a new version of the PDL is published and posted to the website, all updates/changes made since the last version are called out at the top of the document itself.

Second Review of Agents for the Management of Sickle Cell Anemia

A motion and second was made at the March 2021 DUR Board meeting to place agents for the management of sickle cell anemia on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. During public comment, C. Henderson from Global Blood Therapeutics, Inc. made herself available to the Board for any questions they had. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Second Review of Agents for the Treatment of Fabry Disease

A motion and second was made at the March 2021 DUR Board meeting to place agents for the treatment of Fabry disease on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. There were no public comments. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Second Review of Imcivree (setmelonotide)
A motion and second was made at the March 2021 DUR Board meeting to place Imcivree (setmelonotide) on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. There were no public comments. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Second Review of Bowel Prep Agents
A motion and second was made at a prior DUR Board meeting to place bowel prep agents on prior authorization. The topic was brought up for a second review. Prior authorization criteria were presented to the Board by T. DeRuiter. There were no public comments. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Update to the Prior Authorization Criteria for Evrysdi (risdiplam)
At the March 2021 DUR Board meeting, Evrysdi criteria was approved by the Board and the Medicaid Pharmacy Department informed the Board that the criteria would be updated at the following meeting after further discussion with specialists and experts in the treatment of SMA. T. DeRuiter presented the proposed updates to the prior authorization criteria for Evrysdi (risdiplam). The proposed updates included more clearly specifying requirements for confirmation of the patient's diagnosis, requiring the medication be prescribed by or in consultation with a neuromuscular neurologist or neuromuscular physiatrist, clarifying requirements surrounding ventilation/intubation, specifying what medications the patient cannot previously have been treated with, expanding the acceptable baseline motor function tests, requiring neuromuscular clinical information, and consolidating the criteria to apply to all SMA types. J. Whalen from Genentech presented on Evrysdi to the Board and made himself available for questions. A. Murphy proposed that the Board amend the criteria to specify that only patients who have received prior treatment with Zolgensma be excluded from coverage, allowing for coverage for those who had been treated with Spinraza. M. Aaland spoke to concerns they had with allowing coverage for Evrysdi due to concerns with its cost and available trial data. J. Askvig made a motion to amend the criteria to specify that only patients who have received/are receiving Zolgensma should not meet criteria for coverage. A. Werremeyer seconded the motion. Chair A. Honeyman called for a voice vote to approve the amendment, and all but one member voted in the affirmative, with M. Aaland voting against the amendment. A. Werremeyer made a motion to approve the amended criteria, and J. Askvig seconded the motion. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Update to the Prior Authorization Criteria for Medications that Cost >$3,000
T. DeRuiter presented proposed updates to the prior authorization criteria for medications that cost >$3,000. The proposed updates included the addition of criteria that requires documentation to confirm serum marker or pathogenic gene variants amenable to treatment, if applicable. There was no public comment. L. Schield made a motion to adopt the updated criteria and P. Woodrow seconded the motion. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Update to the Prior Authorization Criteria for Hepatitis C Treatment Agents
T. DeRuiter presented proposed updates to the prior authorization criteria for agents used to treat hepatitis C. The proposed updates included criteria that eliminated additional drug and alcohol testing for patients with a history of drug or alcohol abuse, lowering the medication adherence timeframe to 90 days, and adding medication-specific criteria for select agents in specified scenarios. P. Woodrow inquired as to who covers incarcerated patients, and A. Murphy clarified they are covered by the department of corrections. P. Woodrow made a motion to approve the updated criteria and L. Schield seconded the motion. Chair A. Honeyman called for a voice vote to approve the updated criteria, which passed with no audible dissent.

New Business

Review of Agents Used in the Treatment of Heart Failure

T. DeRuiter presented a review of agents used in the treatment of heart failure to the Board. There was no public comment. A motion was made by L. Schield to manage these medications through prior authorization. The motion was seconded by A. Werremeyer. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Utilization Review of Select Medication Classes

A. Murphy presented utilization data to the board regarding the use of opioid analgesics vs. NSAIDs by family medicine practitioners. T. DeRuiter presented data on the utilization of montelukast, comparing utilization by dose per age, comparing utilization before and after new requirements were implemented that required the appropriate, FDA-approved dose of the medication is being used for the patient's age. The data indicated a significant decrease in the number of patient's receiving the incorrect dose of montelukast since the requirements were implemented (7% of patients vs 0.2% of patients after the change). T. DeRuiter also presented utilization data of CGRP inhibitors and migraine abortive therapies over time. The data indicated that there was a sharp decline in triptan claims in January 2020, however triptan claims have been increasing over time to approach December 2019 levels despite utilization of CGRP inhibitors increasing over time. T. DeRuiter also presented data on the utilization of Xifaxan with and without lactulose, comparing utilization before and after new requirements were implemented that require a PA for Xifaxan for diagnoses other than hepatic encephalopathy, and required concomitant use of lactulose for a diagnosis of hepatic encephalopathy. The data indicated an overall decrease in Xifaxan over this period of time.

Retrospective Drug Utilization Review (RDUR) Criteria Recommendations

T. DeRuiter reviewed the RDUR criteria that were selected for review of each month of the last quarter. Presented data included number of profiles reviewed, number of cases identified for intervention, and the number of letters sent, as well as an overview of what RDUR interventions were identified as most prevalent for each monthly cycle.

Retrospective Drug Utilization Review (RDUR) Criteria Recommendations

The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. A. Werremeyer moved to approve the new criteria and M. Quast seconded the motion. Chair A. Honeyman called for a voice vote to approve the new criteria, which passed with seven members voting to approve and one voting against approval.

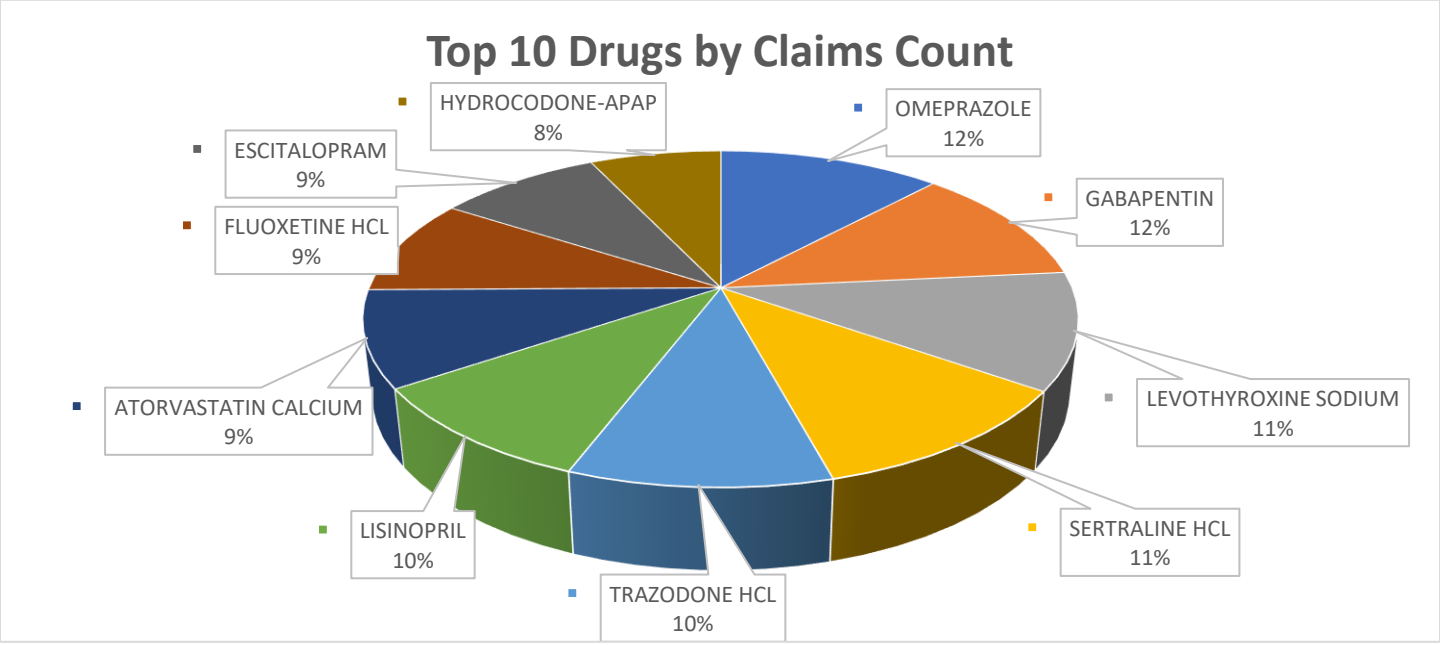
Adjournment and Upcoming Meeting Date

Chair A. Honeyman adjourned the meeting at 3:20 pm. The next DUR Board meeting will be held September 1, 2021 at 1:00 pm at the state capitol building.

Top 25 Drugs Based on Number of Claims from 04/01/2021 – 06/30/2021

Drug	Claims	Patients	Claims Cost	Cost / Claim	% Total Claims	Dif.
OMEPRAZOLE	4,890	2,384	63,339.20	$12.95	1.94%	NC
GABAPENTIN	4,656	1,929	69,416.58	$14.91	1.84%	NC
SERTRALINE HCL	4,368	2,297	59,576.91	$13.64	1.73%	↑1
LEVOTHYROXINE SODIUM	4,319	1,821	80,418.96	$18.62	1.71%	↓1
TRAZODONE HCL	3,964	1,879	54,451.82	$13.74	1.57%	NC
LISINOPRIL	3,810	2,037	48,744.55	$12.79	1.51%	NC
ATORVASTATIN CALCIUM	3,731	1,933	52,835.04	$14.16	1.48%	NC
ESCITALOPRAM OXALATE	3,683	1,994	49,470.02	$13.43	1.46%	↑1
FLUOXETINE HCL	3,671	1,900	50,729.89	$13.82	1.45%	↓1
HYDROCODONE-APAP	3,099	1,941	46,776.00	$15.09	1.23%	NC
BUPROPION XL	2,814	1,373	49,468.63	$17.58	1.11%	NC
PANTOPRAZOLE SODIUM	2,800	1,321	37,557.27	$13.41	1.11%	↑2
METFORMIN HCL	2,676	1,383	34,857.75	$13.03	1.06%	NC
DULOXETINE HCL	2,640	1,247	41,610.39	$15.76	1.05%	↓2
MONTELUKAST SODIUM	2,597	1,410	36,487.53	$14.05	1.03%	↑1
VYVANSE	2,469	1,007	638,134.01	$258.46	0.98%	↓1
LAMOTRIGINE	2,354	912	32,917.18	$13.98	0.93%	↑5
CYCLOBENZAPRINE HCL	2,342	1,434	27,091.45	$11.57	0.93%	↓1
BUPRENORPHINE-NALOXONE	2,324	520	106,133.46	$45.67	0.92%	↓1
PROAIR HFA	2,315	2,295	170,233.73	$73.54	0.92%	NC
CLONIDINE HCL	2,264	1,043	28,590.37	$12.63	0.90%	↓2
AMLODIPINE BESYLATE	2,258	1,221	28,188.30	$12.48	0.89%	↑2
AMOXICILLIN	2,230	2,044	30,562.77	$13.71	0.88%	↑6
PREDNISONE	2,198	1,693	27,572.69	$12.54	0.87%	↑8
CLONAZEPAM	2,185	944	29,755.05	$13.62	0.87%	NC

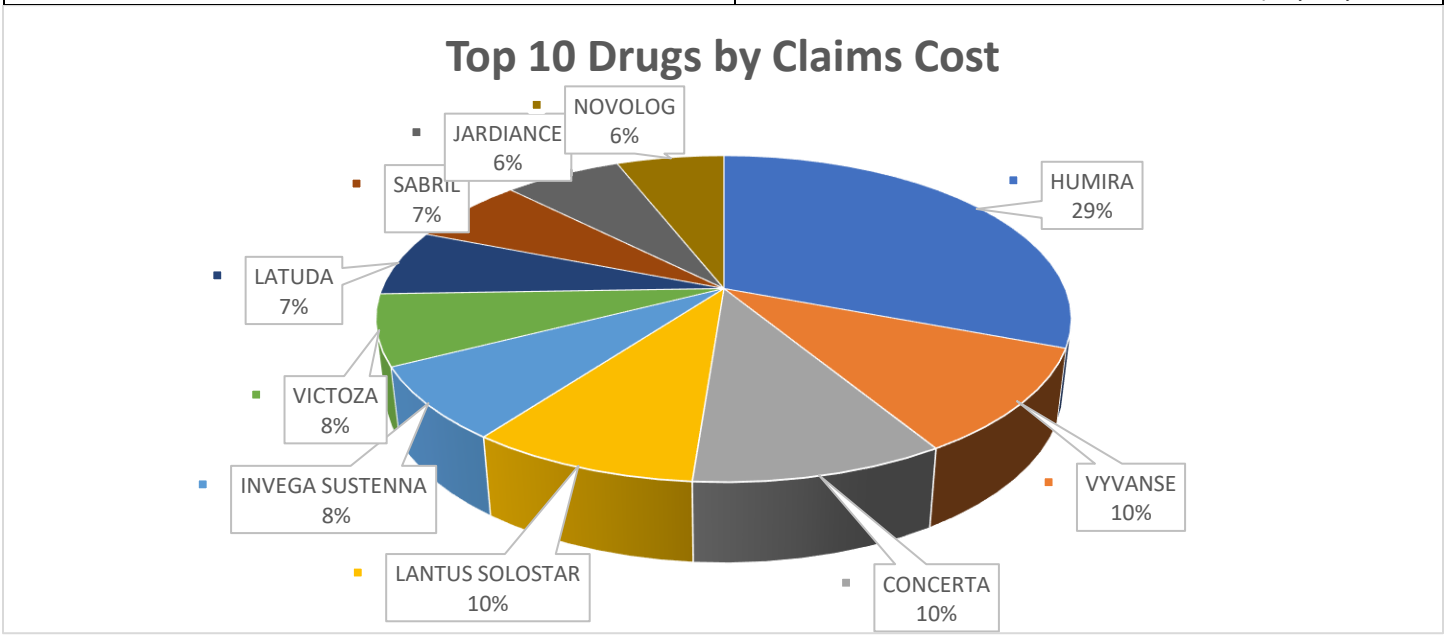
Total Claims	**252,543**



Top 25 Drugs Based on Total Claims Cost from 04/01/2021 – 06/30/2021

Drug	Claims Cost	Claims	Patients	Cost /Claim	% Total Cost	Dif.
HUMIRA PEN	1,757,824.41	255	104	$6,893.43	6.32%	NC
VYVANSE	638,134.01	2,469	1,007	$258.46	2.29%	NC
CONCERTA	611,454.44	1,775	749	$344.48	2.20%	NC
LANTUS SOLOSTAR	598,676.01	1,255	736	$477.03	2.15%	NC
INVEGA SUSTENNA	462,519.05	195	78	$2,371.89	1.66%	↑1
VICTOZA 3-PAK	461,745.23	508	249	$908.95	1.66%	↑1
LATUDA	407,868.70	506	199	$806.06	1.47%	↑2
SABRIL	400,037.01	18	6	$22,224.28	1.44%	↑13
JARDIANCE	391,268.20	822	359	$476.00	1.41%	↑3
NOVOLOG FLEXPEN	381,826.86	538	333	$709.72	1.37%	↓5
STELARA	350,392.50	15	12	$23,359.50	1.26%	↓1
NORDITROPIN FLEXPRO	344,594.05	84	39	$4,102.31	1.24%	↓4
ADVAIR DISKUS	326,917.72	888	487	$368.15	1.17%	↑2
SYMBICORT	310,825.76	929	524	$334.58	1.12%	NC
TRIKAFTA	310,440.15	13	5	$23,880.01	1.12%	↑1
TALTZ AUTOINJECTOR	305,205.26	41	18	$7,444.03	1.10%	↑4
LEVEMIR FLEXTOUCH	300,775.57	552	305	$544.88	1.08%	NC
COSENTYX PEN (2 PENS)	299,359.48	46	18	$6,507.81	1.08%	↓7
ADDERALL XR	294,795.33	1,699	696	$173.51	1.06%	NC
XIFAXAN	266,911.18	109	53	$2,448.73	0.96%	↑5
GILENYA	265,935.82	32	13	$8,310.49	0.96%	↑8
ELIQUIS	262,755.46	606	268	$433.59	0.94%	↑2
BIKTARVY	260,719.72	138	64	$1,889.27	0.94%	↓5
ENBREL SURECLICK	250,295.69	43	20	$5,820.83	0.90%	↓11
STRATTERA	243,006.74	605	290	$401.66	0.87%	↓2

Total Claims Cost	**$27,832,755.31**



Top 15 Therapeutic Classes Based on Number of Claims from 04/01/2021 – 06/30/2021

Therapeutic Class Description	Claims	Patients	Claims Cost	Cost/Claim	% Total Claims	Dif.
ANTIDEPRESSANTS	29,465	11,497	$611,617.88	$20.76	11.67%	NC
ANTICONVULSANTS, MISC	13,623	4,631	$1,138,926.72	$83.60	5.39%	NC
ANTIPSYCHOTIC AGENTS	8,985	3,361	$2,008,140.17	$223.50	3.56%	NC
PROTON-PUMP INHIBITORS	8,125	3,856	$150,753.39	$18.55	3.22%	NC
OPIATE AGONISTS	7,469	3,789	$129,782.43	$17.38	2.96%	NC
SEDATIVE/HYPNOTICS	6,685	3,279	$144,632.27	$21.64	2.65%	NC
NSAIDs	6,560	4,112	$96,182.39	$14.66	2.60%	NC
STATINS	6,257	3,234	$89,593.82	$14.32	2.48%	NC
BETA BLOCKERS	5,684	2,851	$104,988.87	$18.47	2.25%	NC
AMPHETAMINES	5,395	2,184	$976,236.20	$180.95	2.14%	NC
ACE INHIBITORS	4,824	2,578	$68,343.20	$14.17	1.91%	↑1
NON-AMPHETAMINE STIMULANTS	4,729	1,755	$908,366.16	$192.08	1.87%	↓1
THYROID AGENTS	4,614	1,898	$90,751.47	$19.67	1.83%	NC
BIGUANIDES	4,128	2,157	$56,177.31	$13.61	1.63%	NC
PENICILLIN ANTIBIOTICS	4,101	3,618	$64,616.96	$15.76	1.62%	↑2

Top 15 Therapeutic Classes Based on Claims Cost from 04/01/2021 – 06/30/2021

Therapeutic Class Description	Claims Cost	Claims	Patients	Cost/Claim	% Total Cost	Dif.
DMARDS	$2,810,667.35	503	193	$5,587.81	10.10%	NC
ANTIPSYCHOTIC AGENTS	$2,008,140.17	8,985	3,361	$223.50	7.22%	NC
INSULINS	$1,892,628.00	3,716	1,362	$509.32	6.80%	NC
SKIN & MUCOUS MEMBRANE AGENTS, MISC.	$1,505,887.29	610	382	$2,468.67	5.41%	NC
ANTICONVULSANTS, MISCELLANEOUS	$1,138,926.72	13,623	4,631	$83.60	4.09%	↑1
AMPHETAMINES	$976,236.20	5,395	2,184	$180.95	3.51%	↑2
INHALED CORTICOSTEROIDS	$955,172.15	3,278	1,896	$291.39	3.43%	NC
ANTINEOPLASTIC AGENTS	$954,285.77	584	227	$1,634.05	3.43%	↑2
NON-AMPHETAMINE STIMULANTS	$908,366.16	4,729	1,755	$192.08	3.26%	NC
ANTIRETROVIRALS	$861,557.58	686	243	$1,255.91	3.10%	↓5
INCRETIN MIMETICS	$786,657.60	1,019	478	$771.99	2.83%	NC
ANTIDEPRESSANTS	$611,617.88	29,465	11,497	$20.76	2.20%	NC
IMMUNOMODULATORY AGENTS	$610,429.45	82	33	$7,444.26	2.19%	NC
SGLT2 INHIBITORS	$525,953.41	1,103	487	$476.84	1.89%	NC
ANTIMUSCARINICS/ANTISPASMODICS	$408,588.39	1,803	901	$226.62	1.47%	NC

PDL Update

Drug Name	PA status	Class
Ingrezza 60mg	PA	Tardive Dyskinesia
Koselugo	PA	Over 3000
Exservan	PA	Non-Solid Dosage Forms
Clobetex	PA	Kit
Empaveli	PA	Over 3000
Doxycycline ER 80mg	PA	Acne
Atelvia	PA	Osteoporosis
Varubi	PA	Chemo Induced Nausea and Vomiting
Tetracycline	remove PA	Acne
Fluorouracil topical solution	remove PA	Actinic Keratosis
Enstilar foam	remove PA	Antipsoriatics - Topical
Sorilux foam	remove PA	Antipsoriatics - Topical
Testopel	remove PA	Androgens
teriparatide	remove PA	Osteoporosis
Peg 3350 - Electrolyte 420 G (Nulytely/Gavilte-N)	remove PA	Bowel Prep agents
Clenpiq	remove PA	Bowel Prep agents
Relistor vial and syringe	remove PA	Constipation

Heart Failure

Electronic Diagnosis Verification

- Corlanor, Entresto, and Verquvo require an FDA-approved indication for use.

Product Specific Criteria:

- **Verquvo:**
  - The member must meet FDA-approved age for use.
  - The member must have left ventricular ejection fraction (LVEF) < 45%
  - Documentation of a recent hospitalization or need for IV diuretics (within the past 6 months) must be submitted with request
  - The member is receiving concurrent Entresto, a beta-blocker, a SGLT-2 Inhibitor, and a mineralocorticoid receptor antagonist.
- **Corlanor:**
  - The member must meet FDA-approved age for use.
  - The member must have a resting HR ≥ 70 beats per minute on maximally tolerated or target beta blocker dose in sinus rhythm

AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACE (angiotensin-converting enzyme) inhibitors - *all oral agents preferred*	
ARBs (angiotensin receptor blockers) - *all oral agents preferred*	
Beta blockers - *all oral agents preferred*	
CORLANOR (ivabradine)	
ENTRESTO (sacubitril/valsartan)	
eplerenone	
FARXIGA (dapagliflozin)	
spironolactone	
VERQUVO (vericiguat) PA***	

Nasal polyps

General Prior Authorization Form

Category Criteria (Initial): *Approval Duration = 3 months*

- The member must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, an ear/nose/throat specialist or allergist/immunologist.
- The member must have had a 12-week trial of intranasal or oral corticosteroid
- The member must have bilateral polyps confirmed by sinus CT, sinus MRI, or nasal endoscopy
- The member must have documentation of at least two of the following symptoms:
  - Nasal blockade/obstruction/congestion or nasal discharge (anterior/posterior nasal drip)
  - Facial pain/pressure
  - Reduction or loss of smell

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the member has achieved a significant reduction in nasal polyp size and symptoms since treatment initiation
- The member must be receiving intranasal steroids

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)	
XOLAIR (omalizumab)	

Chronic Idiopathic urticaria

General Prior Authorization Form

Category Criteria (Initial): *Approval Duration = 3 months*

- The member must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, an allergist/immunologist.
- The member must have had a 30-day trial of a type 1 (H1) antihistamine at maximally tolerated dose either non-sedating (e.g. cetirizine, fexofenadine, loratadine, desloratadine, or levocetirizine) or sedating (e.g. diphenhydramine, chlorpheniramine, cyproheptadine) in addition to one of the following:
  - Leukotriene receptor antagonist (e.g. Montelukast, zafirlukast, zileuton)
  - Histamine H2-receptor (e.g. ranitidine, famotidine, nizatidine, cimetidine)

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the member has achieved a clinical benefit since treatment initiation.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
XOLAIR (omalizumab)	

Uterine Fibroids Criteria

Electronic Diagnosis Verification

- The patient must have an FDA approved indication

Electronic Age Verification

- The patient must be 18 years of age or older

Prior Authorization Form

General Prior Authorization Form

Category Criteria:

- **Initial Criteria:** *Approval Duration = 12 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - The patient must not be pregnant
  - The provider must attest that the patient does not have any contraindications to treatment with the requested product
- The patient must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts:
  - A. A 3-menstual cycle trial of mefenamic acid or meclofenamate, celecoxib, ibuprofen 1800mg/day or equivalent high dose NSAID
  - B. A 3-menstual cycle trial of an oral estrogen-progestin or progestin contraceptives
- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient must not have received ≥24 months of the requested product, as evidenced by paid claims or pharmacy printouts
  - The provider must attest that the patient does not have any contraindications to treatment with the requested product
  - The patient must have experienced and maintained clinical benefit since starting treatment with the requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ORIAHNN (Elagolix, Estradiol, and Norethindrone acetate)	
MYFEMBREE (Relugolix, Estradiol, and Norethindrone acetate)	

Empaveli (pegcetacoplan)

General Prior Authorization Form

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 18 years of age or older
- Must be prescribed by or in consultation with a hematologist, oncologist, or immunology specialist
- Must have a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) laboratory confirmed by one of the following:
    a. flow cytometry
    b. LDH level of 1.5 times the upper limit of normal
    c. bone marrow aspirate and biopsy
- Must have documented full course of meningococcal, pneumococcal, and Hib vaccines or a test for antibodies against encapsulated bacteria at least 2 weeks before starting treatment
- One of the following criteria must be met (A or B):
    A. Patient is transfusion dependent (Hb ≤ 7 g/dL or Hb ≤ 9 g/dL and member is experiencing symptoms of anemia)
    B. Patient has symptoms of thromboembolic complications (abdominal pain, shortness of breath, chest pain, end-organ damage)

Renewal Criteria: *Approval Duration = 12 months*

- The patient must have experienced an improvement, such as decreased fatigue, decrease in transfusions, increase in Hb levels, or normalization of LDH levels.

AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
EMPAVELI (pegcetacoplan)	

health information designs

Empaveli

Prior Authorization Form

Fax Completed Form to:

855-207-0250

For questions regarding this

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Empaveli (pegcetacoplan) to meet specific clinical criteria for coverage. Criteria for coverage for Empaveli can be found the following location:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:** □ PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) □ OTHER:

Qualifications for coverage:	
Does the patient have transfusion dependent anemia and is currently experiencing symptoms of anemia?	□ YES □ NO
Does the patient have symptoms of thromboembolic complications (abdominal pain, shortness of breath, chest pain, end-organ damage)?	□ YES □ NO
Has the patient received a full course of meningococcal, pneumococcal, and Hib vaccines OR a test for antibodies against encapsulated bacteria, at least 2 weeks before starting treatment?	□ YES □ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

□ Documentation of lab results confirming a diagnosis of PNH (i.e. flow cytometry, LDH level of 1.5 times the upper limit of normal, or bone marrow aspirate and biopsy).

□ (Renewal ONLY): Documentation supporting that the patient has experienced and/or maintained a clinical benefit since starting treatment with Empaveli, as evidenced by medical documentation (e.g. reduced fatigue, decrease in transfusions, increase in Hb levels, or normalization of LDH).

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Non-24 Hour Sleep-Wake Disorder

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The member must meet criteria as outlined in prescribing information (PI) including recommendations for diagnosis and age.
  - The prescriber is a specialist, or the prescriber has consulted with a specialist in sleep disorders
  - The member must have had a 30-day trial of Rozerem (ramelteon), as evidenced by paid claims or pharmacy printouts.
  - Documentation must be attached to confirm one of the following:
    - Member must be unable to perceive light in either eye
    - Sighted members must confirm diagnosis by self-reported sleep diaries or actigraphy for at least 14 days demonstrating a gradual daily drift (typically later) in rest-activity patterns not better explained by sleep hygiene, substance or medication use, or other neurological or mental disorders.
- **Renewal Criteria**: *Approval Duration = 12 months*
  - The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ROZEREM (ramelteon) – *Brand Preferred*	HETLIOZ (tasimelteon)
	ramelteon

REVIEW OF NON-STIMULANT ADHD PRODUCTS

Attention-deficit hyperactivity disorder is usually treated with cognitive behavioral therapy (CBT), stimulants, and/or nonstimulants. Nonstimulants are not typically used first-line; for use of nonstimulant medication is suggested in patients who are intolerant of or lacked a response to stimulants. Nonstimulants may be used as monotherapy or as adjunctive with concurrent stimulant therapy.

General Dosing and FDA Indications

Drug Name	Mechanism of Action	Dosing	Indication
Clonidine (off-label)	Alpha2-Adrenergic Agonist	**≤45 kg:** 0.05mg/day; sequentially increase to 4 times daily **>45 kg:** 0.1mg/day; sequentially increase to 4 times daily	ADHD, Hypertension (adults)
Clonidine ER	Alpha2-Adrenergic Agonist	0.1mg – 0.2mg twice daily after titration	ADHD monotherapy or as adjunctive therapy
Guanfacine (off-label)	Alpha2-Adrenergic Agonist	**≤45 kg:** 0.5mg/day; may titrate up to 4 times daily **>45 kg:** 1mg/day; may titrate up to 4 times daily	ADHD, Hypertension (adults)
Guanfacine ER	Alpha2-Adrenergic Agonist	**Weight based:** 1mg once daily up to 7mg per day	ADHD
viloxazine	SNRI	**6-11 years old:** 100mg – 400mg per day **≥12 and ≤17 years old:** 200mg – 400mg per day	ADHD
Atomoxetine	SNRI	<u>Adults</u> **Target dose:** ~80mg per day **Dose adjustments based on CYP2D6 poor metabolizer:** Initiate at 40mg/day and increase to 80mg/day if symptoms fail to improve after 4 weeks at initial dose <u>Children 6-17</u> **>70 kg:** Dosed as adults **≤70 kg:** Target dose: 1.2mg/kg/day **Dose adjustments based on CYP2D6 poor metabolizer:** Initiate at 0.5mg/kg/day and increase to 1.2mg/kg/day if symptoms fail to improve after 4 weeks at initial dose	ADHD

Approval Status and Special Designations

Drug Name	Special Designation	Approval Status
Clonidine (off-label)	Children ≥6 years of age and adolescents	Approved 09/03/1974
Kapvay (clonidine ER) **Clonidine ER**	Children ≥6 years of age and adolescents	Approved 09/03/1974
Guanfacine (off-label)	Children ≥6 years of age and adolescents	Approved 10/27/1986
Intuniv (guanfacine ER) **Guanfacine ER**	Children ≥6 years of age and adolescents	Approved 10/27/1986
Qelbree (viloxazine)	Children ≥6 years of age and adolescents	Approved 04/02/2021
Strattera (atomoxetine) **Atomoxetine**	Children 6 years of age and adolescents; **adults**	Approved 11/26/2002

Place in Therapy/Guidelines

Childhood ADHD

Preschool-aged children: age 4 years to the sixth birthday

- First line: parent training in behavior management (PTBM) and/or behavioral classroom interventions. PTBM evidence is strong in the preschool aged population.
- Should these non-pharmacologic measures not work, methylphenidate may be trialed. Other stimulant and nonstimulant medications in children < 6 years of age has not been adequately studied.

Elementary and middle school–aged children: age 6 years to the 12th birthday

- First line: FDA approved medication for ADHD (methylphenidate or amphetamine stimulants) in conjunction with behavioral and classroom interventions.
- The evidence is strongest for stimulant medications in this age group, however, there is sufficient data for atomoxetine, extended-release guanfacine, and extended-release clonidine. (Strength of evidence follows in that order)
- Nonstimulants are suggested in patients who are intolerant of or lacked a response to stimulants; an adequate stimulant trial of at least 6 weeks is suggested prior to initiating nonstimulants.

Adolescents: age 12 years to the 18th birthday

- First line: FDA approved medication for ADHD (methylphenidate or amphetamine stimulants).
- Behavioral interventions and school accommodations are encouraged.
- Nonstimulants are suggested in patients who are intolerant of or lacked a response to stimulants; an adequate stimulant trial of at least 6 weeks is suggested prior to initiating nonstimulants.

Adult ADHD

- First line: typically medications (methylphenidate or amphetamine stimulants).
- Amphetamine products are typically recommended first before methylphenidate or non-stimulant products.
- Alternative, nonpharmacologic treatment options include cognitive behavioral therapy (CBT), although there have been no trials evaluating their comparative efficacy to pharmacotherapy.
- Nonstimulants (Strattera or atomoxetine) are suggested in patients who are intolerant of or lacked a response to stimulants; an adequate stimulant trial of at least 6 weeks is suggested prior to initiating nonstimulants.

Wolraich ML, Hagan JF Jr, Allan C, et al. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents [published correction appears in Pediatrics. 2020 Mar;145(3):]. Pediatrics. 2019;144(4):e20192528. doi:10.1542/peds.2019-2528

Therapeutically Important Adverse Effects/Advantages

Clonidine, Clonidine ER:

- Withdrawal: Abrupt discontinuation may result in symptoms of withdrawal (eg. agitation, headache, tachycardia, nausea, tightness in chest, anxiety, tremor, rebound hypertension)
- Decreased BP and HR
- Clonidine may be an optimal selection for patients with tics or Tourette syndrome comorbidity
- Typically utilized in patients who have not had an adequate response to stimulants or atomoxetine

Guanfacine, Guanfacine ER, Intuniv (guanfacine ER):

- Rebound hypertension and increases in heart rate, in some cases leading to hypertensive encephalopathy, has been reported with abrupt discontinuation of therapy
- Decreased BP and HR
- May be an optimal selection for patients with tics or Tourette syndrome comorbidity or if stimulant diversion or misuse is a concern
- Typically utilized in patients who have not had an adequate response to stimulants or atomoxetine

Qelbree (viloxazine):

- BBW: Suicidal thoughts and behaviors
- Do not administer Qelbree during therapy with or within 2 weeks of discontinuing an MAOI
- Can be opened and sprinkled over applesauce or other soft foods, unlike atomoxetine
- May be more appropriate if there are concerns about illicit drug abuse

Strattera (atomoxetine), atomoxetine:

- BBW: Increased risk of suicidal ideation in children and adolescents
- Do not administer Strattera/atomoxetine during therapy with or within 2 weeks of discontinuing an MAOI
- Increased HR and BP
- Indicated for adult use also
- May be more appropriate if there are concerns about illicit drug abuse

Cost

Drug	Strength	Package Size	WAC Pkg Price	Cost Per Day*	Cost Per Month*	Cost Per Year*
Clonidine	0.1mg – 0.3mg	30 - 1,000 tablets	$2 - 77	$0.06	$1.80	$21.60
Clonidine ER	0.1mg	60 tablets	$19.80-199.80	$1.32	$39.60	$475.20
Kapvay (clonidine ER)	0.1mg	60 tablets	$484.80	$32.32	$969.60	$11,635.20
Guanfacine	1 mg – 2mg	30 – 100 tablets	$14.50 - 112	$0.14 – 0.58	$4.20 – 17.40	$50.40 – 208.80
Guanfacine ER	1mg, 2mg, 3mg, 4mg	100 tablets	$41.90-349	$0.42 – 0.84	$12.60 – 25.14	$151.20 – 301.68
Intuniv (guanfacine ER)	1mg, 2mg, 3mg, 4mg	100 tablets	$971	$9.71 – 19.42	$291.30 – 582.60	$3,495.60 – 6,991.20
Strattera (atomoxetine)	10mg, 18mg, 25mg, 40mg, 60mg, 80mg (target dose), 100mg	30 tablets	$395.40 – 463.50	$15.45 (target dose)	$463.50 (target dose)	$5,562 (target dose)
Atomoxetine	10mg, 18mg, 25mg, 40mg, 60mg, 80mg (target dose), 100mg	30 tablets	$54.90 - 208.35	$2.37 (target dose)	$70.80 (target dose)	$849.60 (target dose)
Qelbree (viloxazine)	100mg, 150mg, 200mg	30 tablets	$298.98	$9.97 – 19.93	$299.10 - 597.96	$3,589.20 -7,175.52

*Based on lowest per unit WAC cost

Current Utilization

ND Medicaid Utilization (07/01/20 – 06/30/21)		
Label Name	**Rx Number**	**Total Reimbursement Amt**
Clonidine (IR and ER)	9809	$222,636.37
Guanfacine (IR and ER)	8243	$186,533.76
Qelbree (viloxazine)	0	0
Strattera (atomoxetine)	1790	$723,324.47
atomoxetine	2914	$780,968.84

Qelbree Clinical Trials:

The efficacy of Qelbree in the treatment of ADHD in pediatric patients 6 to 17 years of age was evaluated in three short-term, randomized, placebo-controlled monotherapy trials (Studies 1, 2, and 3):

Study 1 (NCT03247530) was a multicenter, randomized, double-blind, three-arm placebo-controlled, parallel group monotherapy trial in patients 6 to 11 years of age with ADHD.

- Total duration of treatment was 6 weeks, including a 1-week titration period (starting at 100 mg once daily) and 5-week maintenance phase. Patients were randomized to receive 100 mg, 200 mg, or placebo, given once daily as a single dose.
- The primary endpoint was the change from baseline to the end of study on the total score on the ADHD Rating Scale (ADHD-RS-5 The Clinical Global Impression-Improvement (CGI-I) score at the end of the study was a secondary endpoint.
- A total of 477 patients were randomized in Study 1; 399 completed the study, and 78 discontinued.
- The change from baseline (reduction) in ADHD-RS-5 total score was statistically significantly greater in patients treated with Qelbree 100 mg or with Qelbree 200 mg than in patients on placebo. Compared with patients on placebo, a statistically significantly greater reduction (improvement) in CGI-I score at the end of the study was observed both in patients treated with Qelbree 100 mg and in patients treated with Qelbree 200 mg.

Study 2 (NCT03247543) was a multicenter, randomized, double-blind, three-arm, placebo-controlled, parallel-group monotherapy trial in patients 6 to 11 years of age with ADHD.

- Total duration of treatment was 8 weeks, including a 3-week titration period (starting at 100 mg once daily), and a 5-week maintenance phase. Patients were randomized to receive Qelbree 200 mg, Qelbree 400 mg, or placebo, given once daily as a single dose.
- The primary endpoint was the change from baseline to the end of study on the total score on the ADHD Rating Scale (ADHD-RS-5). The Clinical Global Impression-Improvement (CGI-I) score at the end of the study was a secondary endpoint.
- A total of 313 patients were randomized in Study 2; 251 completed the study, and 62 discontinued.
- The change from baseline (reduction) in ADHD-RS-5 total score was statistically significantly greater in patients treated with Qelbree 200 mg or with Qelbree 400 mg than in patients on placebo. Compared with patients on placebo, a statistically significantly greater reduction (improvement) in CGI-I score at the end of the study was observed both in patients treated with Qelbree 200 mg and in patients treated with Qelbree 400 mg.

Study 3 (NCT03247517) was a multicenter, randomized, double-blind, three-arm, placebo-controlled, parallel-group monotherapy trial in patients 12 to 17 years of age with ADHD.

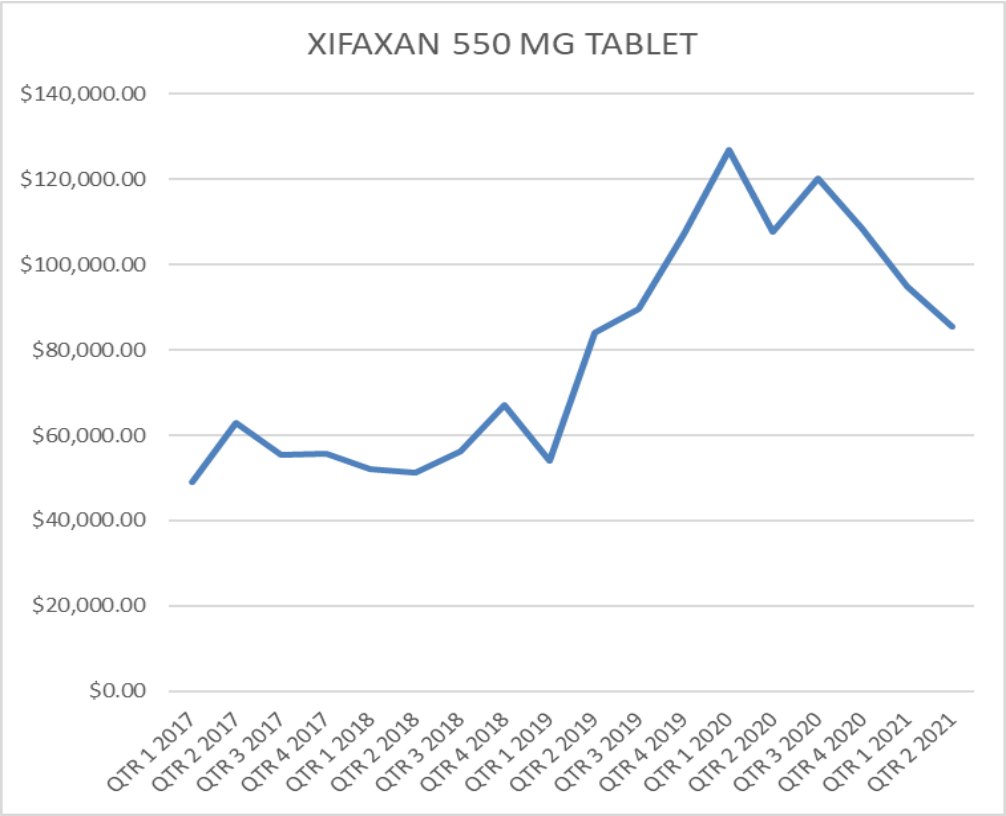
- Total duration of treatment was 6 weeks, including 1-week titration period (starting at 200mg once daily) and a 5-week maintenance phase. Patients were randomized to receive Qelbree 200 mg, Qelbree 400 mg, or placebo, given once daily as a single dose.
- The primary endpoint was the change from baseline to the end of study on the total score on the ADHD Rating Scale (ADHD-RS-5). The Clinical Global Impression-Improvement (CGI-I) score at the end of the study was a secondary endpoint.
- A total of 310 patients were randomized in Study 3; 266 completed and 44 discontinued.
- The change from baseline (reduction) in ADHD-RS-5 total score was statistically significantly greater in patients treated with Qelbree 200 mg or with Qelbree 400 mg than in patients on placebo. Compared with patients on placebo, a statistically significantly greater reduction (improvement) in CGI-I score at the end of the study was observed both in patients treated with Qelbree 200 mg and in patients treated with Qelbree 400 mg.

References

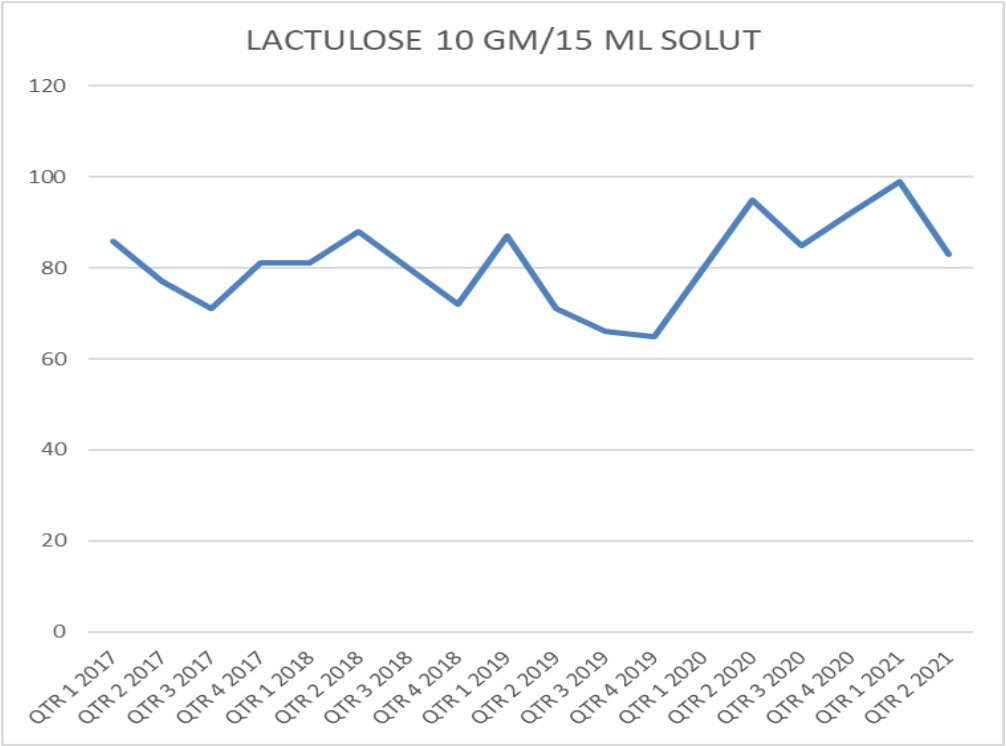
1. Wolraich ML, Hagan JF Jr, Allan C, et al. Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents [published correction appears in Pediatrics. 2020 Mar;145(3):]. Pediatrics. 2019;144(4):e20192528. doi:10.1542/peds.2019-2528
2. Facts & Comparisons eAnswers. Available at http://online.factsandcomparisons.com. Accessed on July 12. 2021.
3. Kapvay (clonidine) [prescribing information]. Dublin 9, Ireland: Concordia Pharmaceuticals; February 2020.
4. Qelbree (viloxazine) [prescribing information]. Rockville, MD: Supernus Pharmaceuticals Inc; April 2021.
5. Intuniv (guanfacine) [prescribing information]. Lexington, MA: Takeda Pharmaceuticals America, Inc; August 2020.
6. Strattera (atomoxetine) [prescribing information]. Indianapolis, IN: Lilly USA LLC; February 2020.

Claims before and after Xifaxan Step Care was initiated

- **Xifaxan reimbursement has decreased from Qtr 1 2020 by approximately $40,000 per quarter**

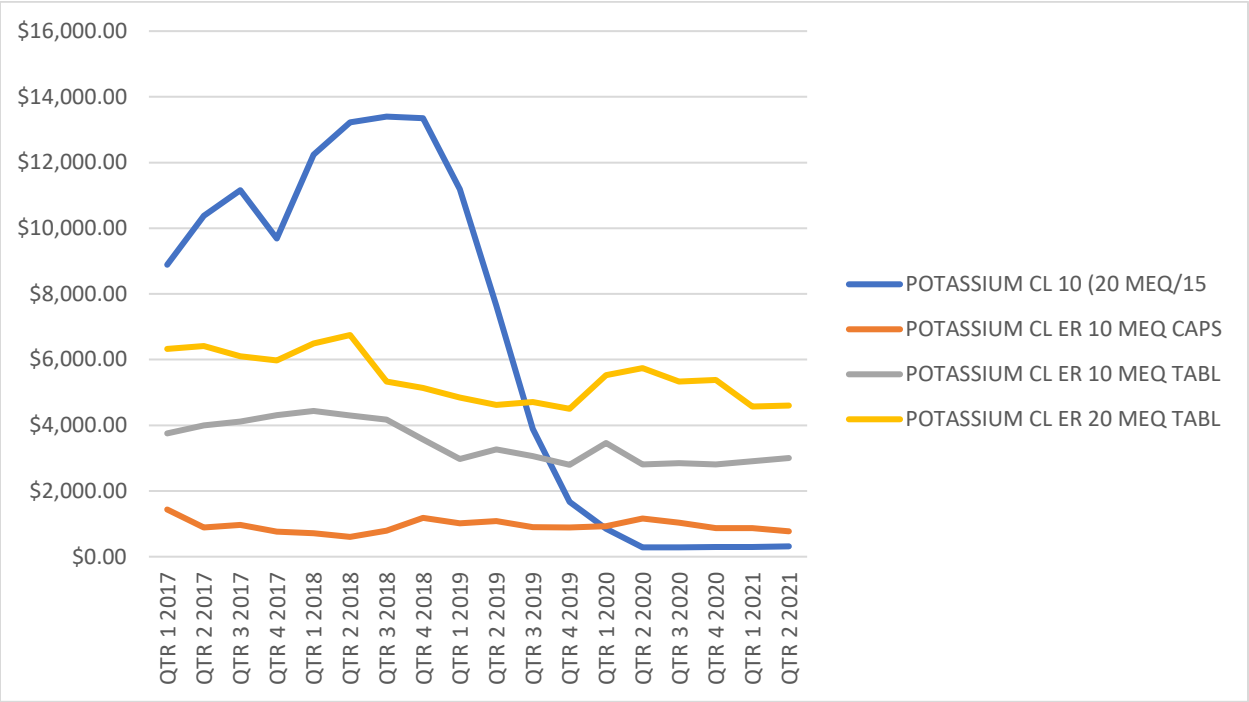


- **At the same time, the number of members receiving Lactulose has increased since Qtr1 2020**

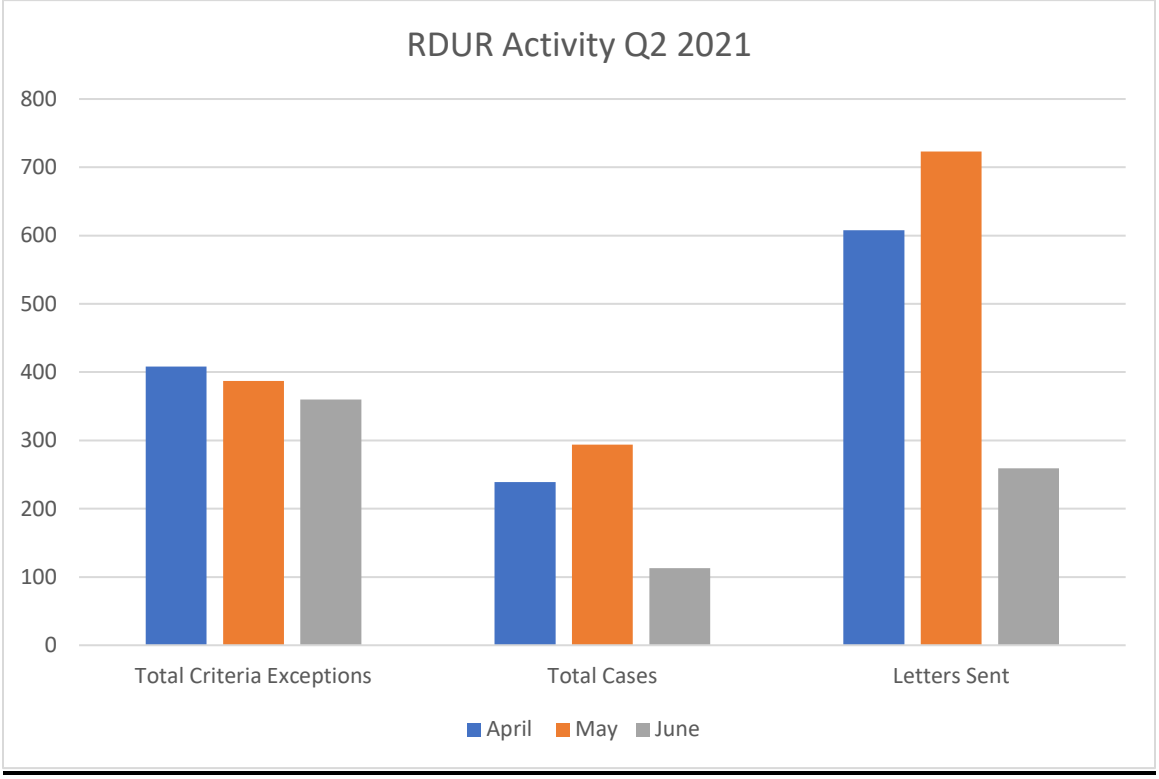


Effect of Potassium utilization management initiated

- **Liquid potassium – swallowing difficulty verification and quantity limits implemented**



RDUR Activity Overview: Q2 2021



April Cases by Type of Criteria

Criteria Description	# of Cases	% of Cases
STIMULANT + HTN	106	44.35%
DIURETIC + HYPERURICEMIA	24	10.04%
ANTIPSYCHOTICS + PARKINSON'S	9	3.77%
HEPATIC IMPAIRMENT	1	0.42%
NSAIDS + CV DISEASE/RENAL TOXICITY	60	25.10%
ANTIDEPRESSANT	5	2.09%
ARIPIPRAZOLE AND HYPOTENSION	23	9.62%
TRIPTAN CONTRAINDICATIONS	8	3.35%
QT PROLONGATION	3	1.26%

May Cases by Type of Criteria

Criteria Description	# of Cases	% of Cases
CLONIDINE SIDE EFFECTS	58	18.83%
CARBAMAZEPINE INTERACTIONS	1	0.32%
BARBITURATE TOXICITY	2	0.65%
DRUG INDUCED RESP/CNS DEPRESSION	42	13.64%
TRICYCLIC ANTIDEPRESSANT INTERACTIONS	11	3.57%
BARBITURATE DOSING	1	0.32%
NSAID INTERACTION	122	39.61%
SSRI INTERACTIONS	2	0.65%
LITHUM TOXICITY	14	4.55%
HEPATIC IMPAIRMENT	2	0.65%
ZIPRASIDONE + ANTIHYPERTENSIVE INTERACTION	16	5.19%
HYPOGLYCEMIA + B-BLOCKERS	19	6.17%
NSAIDS + BP/RENAL FAILURE	5	1.62%
METHOTREXATE + PPI INTERACTION	13	4.22%

June Cases by Type of Criteria

Criteria Description	# of Cases	% of Cases
HYPERKALEMIA	9	7.89%
BENZODIAZEPINE INTERACTIONS/TOXICITY	14	12.28%
SALICYLATE CONCENTRATIONS	1	0.88%
POTASSIUM -SPARING DIURETIC INTERACTIONS	11	9.65%
B-BLOCKERS + PVD	1	0.88%
DUPLICATE SEDATIVE/HYPNOTIC THERAPY	2	1.75%
MYOPATHY/RHABDOMYOLYSIS	12	10.53%
DROSPIRENONE INTERACTIONS	1	0.88%
NSAID INTERACTIONS	32	28.07%
SALICYLATE INTERACTIONS	1	0.88%
OMEPRAZOLE INTERACTIONS	4	3.51%
SSRIS + TRIPTANS	12	10.53%
SEIZURE THRESHOLD	12	10.53%
RISPERDAL CONSTA + ORAL SUPPLEMENTATION	2	1.75%

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
3RD QUARTER 2021

Criteria Recommendations ***Approved Rejected***

1. Rosuvastatin/Ezetimibe / Overuse _____ _____
Alert Message: Roszet (rosuvastatin/ezetimibe) may be over-utilized. The recommended daily dose of rosuvastatin/ezetimibe is 40 mg/10 mg once daily.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe		

Max Dose: 40 mg/10 mg once daily

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

2. Rosuvastatin/Ezetimibe / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Roszet (rosuvastatin/ezetimibe) have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

3. Rosuvastatin/Ezetimibe / Therapeutic Appropriateness _____ _____
Alert Message: Roszet (rosuvastatin/ezetimibe) is contraindicated in patients with decompensated cirrhosis or active liver disease.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Cirrhosis	
	Liver Disease	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

4. Rosuvastatin/Ezetimibe / Warfarin _____ _____

Alert Message: The concurrent use of Roszet (rosuvastatin/ezetimibe) with warfarin may result in significantly increased INR in patients receiving warfarin. In patients taking warfarin, obtain an INR before starting rosuvastatin/ezetimibe and frequently enough after initiation, dose titration, or discontinuation to ensure that no significant alteration in INR occurs. Once the INR is stable, monitor INR at regularly recommended intervals.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Warfarin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

5. Rosuvastatin/Ezetimibe / Bile Acid Sequestrants _____ _____

Alert Message: The concurrent use of Roszet (rosuvastatin/ezetimibe) with bile acid sequestrants may result in decreased mean exposure of ezetimibe. In patients taking a bile acid sequestrant, administer rosuvastatin/ezetimibe at least 2 hours before or at least 4 hours after the bile acid sequestrant.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Cholestyramine	
Colesevelam		
Colestipol		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

6. Rosuvastatin/Ezetimibe / Antacids _____ _____

Alert Message: The concurrent use of Roszet (rosuvastatin/ezetimibe) with aluminum and magnesium hydroxide combination antacid may result in decreased mean exposure of rosuvastatin (50%) and total ezetimibe (4%). In patients taking an antacid, administer rosuvastatin/ezetimibe at least 2 hours after the antacid.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Al/Mg Antacids	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

7. Rosuvastatin/Ezetimibe / Cyclosporine _____ _____

Alert Message: The concurrent use of Roszet (rosuvastatin/ezetimibe) with cyclosporine should be avoided, as concurrent use may increase the risk of myopathy and rhabdomyolysis. Both rosuvastatin and ezetimibe have been shown to cause myopathy and rhabdomyolysis. Concomitant use of cyclosporine with rosuvastatin has been shown to increase rosuvastatin exposure approximately 7-fold. The coadministration of cyclosporine with ezetimibe has been shown to increase exposure to both ezetimibe and cyclosporine.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Cyclosporine	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

8. Rosuvastatin/Ezetimibe / Gemfibrozil _____ _____

Alert Message: The concurrent use of Roszet (rosuvastatin/ezetimibe) with gemfibrozil should be avoided, as concurrent use may increase the risk of myopathy and rhabdomyolysis. Rosuvastatin, ezetimibe, and gemfibrozil have been shown to cause myopathy and rhabdomyolysis. Concomitant use of gemfibrozil with rosuvastatin has been shown to significantly increase rosuvastatin exposure.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Gemfibrozil	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

9. Rosuvastatin/Ezetimibe / Viekira Pak _____ _____

Alert Message: The dose of Roszet (rosuvastatin/ezetimibe) should not exceed 10 mg of rosuvastatin per day when co-administered with Viekira Pak (ombitasvir/paritaprevir/ritonavir/dasabuvir). Rosuvastatin is a BCRP, OATP1B1, and OATP1B3 substrate. The components of the antiviral combination product inhibit BCRP-, OATP1B1-, and OAT1B3-mediated transport. Concurrent use of these agents may result in increased rosuvastatin plasma concentrations and risk of rosuvastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Ombitasvir/paritaprevir/ritonavir/dasabuvir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

10. Rosuvastatin/Ezetimibe / Elbasvir/Grazoprevir _____ _____

Alert Message: The dose of Roszet (rosuvastatin/ezetimibe) should not exceed 10 mg of rosuvastatin once daily when co-administered with Zepatier (elbasvir/grazoprevir). Both elbasvir and grazoprevir are BCRP inhibitors, and concurrent use with rosuvastatin, a BCRP substrate, can result in elevated rosuvastatin plasma concentrations increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Elbasvir/Grazoprevir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

11. Rosuvastatin/Ezetimibe / Sofosbuvir/Velpatasvir _____ _____

Alert Message: The dose of Roszet (rosuvastatin/ezetimibe) should not exceed 10 mg of rosuvastatin once daily when co-administered with Epclusa (sofosbuvir/velpatasvir). The velpatasvir component of the combination antiviral product is a BCRP and OATP1B1 transport inhibitor, and concurrent use with rosuvastatin, a BCRP and OATP1B1 substrate, can result in elevated rosuvastatin plasma concentrations increasing the risk of rosuvastatin-associated adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Sofosbuvir/Velpatasvir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

12. Rosuvastatin/Ezetimibe / Glecaprevir/Pibrentasvir _____ _____

Alert Message: The dose of Roszet (rosuvastatin/ezetimibe) should not exceed 10 mg of rosuvastatin per day when co-administered with Mavyret (glecaprevir/pibrentasvir). Rosuvastatin is a BCRP, OATP1B1, and OATP1B3 substrate. The components of the antiviral combination product inhibit BCRP-, OATP1B1-, and OAT1B3-mediated transport. Concurrent use of these agents may result in increased rosuvastatin plasma concentrations and risk of rosuvastatin-related adverse effects (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Glecaprevir/Pibrentasvir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

13. Rosuvastatin/Ezetimibe / Lopinavir/Ritonavir _____ _____

Alert Message: The dose of Roszet (rosuvastatin/ezetimibe) should not exceed 10 mg once daily when co-administered with lopinavir/ritonavir. Lopinavir is a OATP1B1 transport inhibitor, and concurrent use with rosuvastatin, an OATP1B1 substrate, may elevate rosuvastatin plasma concentrations and increase the risk of rosuvastatin-related adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Lopinavir/ritonavir	

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

14. Rosuvastatin/Ezetimibe / Atazanavir / Ritonavir _____ _____

Alert Message: The dose of Roszet (rosuvastatin/ezetimibe) should not exceed 10 mg once daily when co-administered ritonavir-boosted atazanavir. Atazanavir is an OATP1B1 transport inhibitor, and concurrent use with rosuvastatin, an OATP1B1 substrate, may elevate rosuvastatin plasma concentrations and increase the risk of rosuvastatin-related adverse reactions (e.g., myopathy and rhabdomyolysis).

Drugs/Diseases

Util A	Util B	Util C (Include)
Rosuvastatin/Ezetimibe	Atazanavir	Ritonavir

Max Dose: 10 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

15. Rosuvastatin/Ezetimibe / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Discontinue Roszet (rosuvastatin/ezetimibe) when pregnancy is recognized. Alternatively, consider the ongoing therapeutic needs of the individual patient. The rosuvastatin component of the combination product decreases the synthesis of cholesterol and possibly other biologically active substances derived from cholesterol; therefore, the rosuvastatin-containing product may cause fetal harm when administered to pregnant patients based on the mechanism of action.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Rosuvastatin/Ezetimibe	Pregnancy	Abortion Delivery Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

16. Rosuvastatin/Ezetimibe / Lactation _____ _____

Alert Message: Because of the potential for serious adverse reactions in a breastfed infant, based on the mechanism of action, advise patients that breastfeeding is not recommended during treatment with Roszet (rosuvastatin/ezetimibe). Limited data from case reports in published literature indicate that rosuvastatin is present in human milk. There is no information about the presence of ezetimibe in human milk. Ezetimibe is present in rat milk.

Drugs/Diseases

Util A	Util B	Util C
Rosuvastatin/Ezetimibe	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Roszet Prescribing Information, March 2021, Althera Pharmaceuticals, LLC.

17. Capmatinib / Overuse _____ _____

Alert Message: Tabrecta (capmatinib) may be over-utilized. The recommended dosage of capmatinib is 400 mg orally twice daily with or without food.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib		

Max Dose: 800 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

18. Capmatinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Tabrecta (capmatinib) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

19. Capmatinib / Interstitial Lung Disease _____ _____

Alert Message: Tabrecta (capmatinib) can cause interstitial lung disease (ILD)/pneumonitis. Monitor the patient for new or worsening pulmonary symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, and fever). Immediately withhold capmatinib in patients with suspected ILD/pneumonitis and permanently discontinue capmatinib if no other potential causes of ILD/pneumonitis are identified.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib	Cough	
	Dyspnea	
	Fever	
	Interstitial Pneumonia	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

20. Capmatinib / Hepatotoxicity _____ _____

Alert Message: Hepatotoxicity has occurred in patients treated with Tabrecta (capmatinib). Monitor liver function tests (including ALT, AST, and total bilirubin) prior to the start of capmatinib, every 2 weeks during the first 3 months of treatment, then once a month or as clinically indicated, with more frequent testing in patients who develop increased transaminases or bilirubin. Based on the severity of the adverse reaction, withhold, dose reduce, or permanently discontinue capmatinib.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib	Liver Function Test	
	Unspecified Jaundice	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

21. Capmatinib / Strong & Moderate CYP3A4 Inducers _____ _____

Alert Message: Avoid coadministration of Tabrecta (capmatinib) with strong and moderate CYP3A inducers. Capmatinib is a CYP3A substrate, and coadministration with a strong CYP3A inducer has been shown to decrease capmatinib exposure. Coadministration of capmatinib with a moderate CYP3A inducer may also decrease capmatinib exposure. Decreases in capmatinib exposure may decrease capmatinib anti-tumor activity.

Drugs/Diseases

Util A	Util B		Util C
Capmatinib	Apalutamide	Modafinil	
	Bosentan	Phenobarbital	
	Butalbital	Phenytoin	
	Carbamazepine	Primidone	
	Efavirenz	Rifabutin	
	Enzalutamide	Rifampin	
	Etravirine	Rifapentine	
	Mitotane		

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

22. Capmatinib / Strong CYP3A Inhibitors _____ _____

Alert Message: Tabrecta (capmatinib) is a CYP3A substrate. Coadministration of capmatinib with a strong CYP3A inhibitor has been shown to increase capmatinib exposure, which may increase the incidence and severity of capmatinib-related adverse reactions. Closely monitor patients for adverse reactions during coadministration of capmatinib with strong CYP3A inhibitors.

Drugs/Diseases

Util A	Util B		Util C
Capmatinib	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

23. Capmatinib / CYP1A2 Substrates _____ _____

Alert Message: Coadministration of Tabrecta (capmatinib) with a CYP1A2 substrate has been shown to increase the exposure of the CYP1A2 substrate. Concurrent use of capmatinib with a CYP1A2 substrate may increase the risk of substrate-related adverse reactions. If coadministration is unavoidable between capmatinib and CYP1A2 substrates where minimal concentration changes may lead to serious adverse reactions, decrease the CYP1A2 substrate dosage in accordance with the approved prescribing information.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib	Alosetron	
	Anagrelide	
	Clozapine	
	Duloxetine	
	Mexiletine	
	Ramelteon	
	Tasimelteon	
	Tizanidine	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors, and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

24. Capmatinib / P-gp Substrates & BCRP Substrates _____ _____

Alert Message: In drug studies, the coadministration of Tabrecta (capmatinib) with P-gp or BCRP substrates resulted in increased exposure of the P-gp substrate and BCRP substrate. The concurrent use of capmatinib with drugs that are P-gp or BCRP substrates may increase the adverse reactions of these substrates. If coadministration is unavoidable between capmatinib and P-gp or BCRP substrates where minimal concentration changes may lead to serious adverse reactions, decrease the P-gp or BCRP substrate dosage in accordance with the approved prescribing information.

Drugs/Diseases

Util A	Util B		Util C
Capmatinib	Alpelisib	Rimegepant	
	Atorvastatin	Rosuvastatin	
	Digoxin	Sulfasalazine	
	Fexofenadine	Talazoparib	
	Glecaprevir	Tenofovir	
	Glyburide	Topotecan	
	Loperamide	Ubrogepant	
	Ombitasvir/Paritaprevir/RTV		
	Ombitasvir/Paritaprevir/Dasabuvir/RTV		
	Quinidine		
	Pazopanib		

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors, and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

25. Capmatinib / MATE1 and MATE2 Substrates _____ _____

Alert Message: In in vivo studies, Tabrecta (capmatinib) inhibits MATE1 and MATE2K transport. The coadministration of capmatinib may increase the exposure of MATE1 and MATE2K substrates, which may increase the adverse reactions of these substrates. If coadministration is unavoidable between capmatinib and MATE1 or MATE2K substrates where minimal concentration changes may lead to serious adverse reactions, decrease the MATE1 or MATE2K substrate dosage in accordance with the approved prescribing information.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib	Metformin	

References:

Tabrecta Prescribing Information, May 2021, Novartis Pharmaceuticals Corporation.
FDA: Drug Development and Drug Interactions: Tables of Substrates, Inhibitors, and Inducers. Available at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/DevelopmentResources/DrugInteractionaLabeling/ucm093664.htm

26. Capmatinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on findings from animal studies and its mechanism of action, Tabrecta (capmatinib) can cause fetal harm when administered to a pregnant patient. Oral administration of capmatinib to pregnant rats and rabbits during the period of organogenesis resulted in malformations at exposures less than the human exposure based on area under the curve (AUC) at the 400 mg twice daily clinical dose. Advise pregnant patients of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Capmatinib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

27. Capmatinib / Lactation _____ _____

Alert Message: There are no data on the presence of Tabrecta (capmatinib) or its metabolites in either human or animal milk or its effects on the breastfed child or milk production. Because of the potential for serious adverse reactions in breastfed children, advise patients not to breastfeed during treatment with capmatinib and for 1 week after the last dose.

Drugs/Diseases

Util A	Util B	Util C
Capmatinib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

28. Capmatinib / Therapeutic Appropriateness _____ _____

Alert Message: Advise patients of reproductive potential to use effective contraception during treatment with Tabrecta (capmatinib) and for 1 week after the last dose.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Capmatinib		Contraceptives

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

29. Capmatinib / Therapeutic Appropriateness _____ _____
Alert Message: Advise males with partners of reproductive potential to use effective contraception during treatment with Tabrecta (capmatinib) and for 1 week after the last dose.

Drugs/Diseases
Util A Util B Util C
Capmatinib

Gender: Male

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Tabrecta Prescribing Information, May 2020, Novartis Pharmaceuticals Corporation.

30. Capmatinib / Non-adherence _____ _____
Alert Message: Based on refill history, your patient may be under-utilizing Tabrecta (capmatinib). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases
Util A Util B Util C
Capmatinib

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487-97.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence With Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

31. Vibegron / Overuse _____ _____
Alert Message: Gemtesa (vibegron) may be over-utilized. The recommended dosage of vibegron is one 75 mg tablet orally, once daily with or without food. Swallow vibegron whole with a glass of water.

Drugs/Diseases
Util A Util B Util C
Vibegron

Max Dose: 75 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

32. Vibegron / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Gemtesa (vibegron) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Vibegron		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

33. Vibegron / Therapeutic Appropriateness _____ _____
Alert Message: Urinary retention has been reported in patients taking Gemtesa (vibegron). The risk of urinary retention may be increased in patients with bladder outlet obstruction and also in patients taking muscarinic antagonist medications for the treatment of OAB. Monitor patients for signs and symptoms of urinary retention, particularly in patients with bladder outlet obstruction and patients taking muscarinic antagonist medications for the treatment of OAB. Discontinue vibegron in patients who develop urinary retention.

Drugs/Diseases

Util A	Util B	Util C (Include)
Vibegron		Urinary Retention

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

34. Vibegron / Digoxin _____ _____
Alert Message: Concomitant use of Gemtesa (vibegron) increases digoxin maximal concentrations (Cmax) and systemic exposure as assessed by area under the concentration-time curve (AUC). Serum digoxin concentrations should be monitored before initiating and during therapy with vibegron and used for titration of the digoxin dose to obtain the desired clinical effect. Continue monitoring digoxin concentrations upon discontinuation of vibegron and adjust digoxin dose as needed.

Drugs/Diseases

Util A	Util B	Util C
Vibegron	Digoxin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

35. Vibegron / CKD Stage 5 _____ _____
Alert Message: Gemtesa (vibegron) has not been studied in patients with eGFR < 15mL/min/1.73m2 (with or without hemodialysis) and is not recommended in these patients.

Drugs/Diseases

Util A	Util B	Util C (Include)
Vibegron		CKD Stage 5

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

36. Vibegron / Severe Hepatic Impairment _____ _____
Alert Message: Gemtesa (vibegron) has not been studied in patients with severe hepatic impairment (Child-Pugh C) and is not recommended in this patient population.

Drugs/Diseases

Util A	Util B	Util C (Include)
Vibegron		Cirrhosis
		Hepatic Failure

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

37. Vibegron / Lactation _____ _____
Alert Message: There are no data on the presence of Gemtesa (vibegron) in human milk, the effects of the drug on the breastfed infant, or the effects on milk production. When a single oral dose of radiolabeled vibegron was administered to postnatal nursing rats, radioactivity was observed in milk. When a drug is present in animal milk, it is likely that the drug will be present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for vibegron and any potential adverse effects on the breastfed infant from vibegron or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Vibegron	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gemtesa Prescribing Information, Dec. 2020, Urovant Sciences, Inc.

38. Pralsetinib / Overuse _____ _____

Alert Message: Gavreto (pralsetinib) may be over-utilized. The recommended maintenance dose of pralsetinib is 400 mg orally once daily on an empty stomach (no food intake for at least 2 hours before and at least 1 hour after taking pralsetinib.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib		

Max Dose: 400 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

39. Pralsetinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Gavreto (pralsetinib) for the treatment of RET fusion-positive NSCLC have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C (Include)
Pralsetinib		Malignant Neoplasm of Bronchus and Lung

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

40. Pralsetinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Gavreto (pralsetinib) for the treatment of with RET-mutant MTC or RET-fusion thyroid cancer have not been established in pediatric patients younger than 12 years of age.

Drugs/Diseases

Util A	Util B	Util C (Include)
Pralsetinib		Malignant Neoplasm of Thyroid

Age Range: 0 – 11 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

41. Pralsetinib / Interstitial Lung Disease _____ _____

Alert Message: Severe, life-threatening, and fatal interstitial lung disease (ILD)/pneumonitis can occur in patients treated with Gavreto (pralsetinib). Monitor the patient for pulmonary symptoms indicative of ILD/pneumonitis. Withhold pralsetinib and promptly investigate for ILD in any patient who presents with acute or worsening of respiratory symptoms that may be indicative of ILD (e.g., dyspnea, cough, and fever). Withhold, reduce dose, or permanently discontinue pralsetinib based on the severity of confirmed ILD.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib	Cough	
	Dyspnea	
	Fever	
	Interstitial Pneumonia	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

42. Pralsetinib / Hypertension _____ _____

12ert Message: Do not initiate Gavreto (pralsetinib) in patients with uncontrolled hypertension. In clinical studies, hypertension occurred in 29% of patients, including Grade 3 hypertension in 14% of patients. Optimize blood pressure prior to initiating pralsetinib. Monitor blood pressure after 1 week, at least monthly thereafter, and as clinically indicated during pralsetinib therapy. Initiate or adjust anti-hypertensive therapy an appropriate. Withhold, reduce dose, or permanently discontinue pralsetinib based on the severity.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Pralsetinib	Hypertension	Antihypertensive Medication

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

43. Pralsetinib / Hepatotoxicity _____ _____

Alert Message: In clinical studies, serious hepatic adverse reactions occurred in 2.1% of patients treated for Gavreto (pralsetinib). Increased AST occurred in 69% of patients, including Grade 3 or 4 in 5.4% and increased ALT occurred in 46% of patients, including Grade 3 or 4 in 6%. Monitor AST and ALT prior to initiating pralsetinib, every 2 weeks during the first 3 months, then monthly thereafter and as clinically indicated. Withhold, reduce dose, or permanently discontinue pralsetinib based on severity.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib	Liver Function Test	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

44. Pralsetinib / Hemorrhage _____ _____

Alert Message: Serious, including fatal, hemorrhagic events can occur with Gavreto (pralsetinib). In clinical studies, Grade ≥ 3 hemorrhagic events occurred in 2.5% of patients treated with pralsetinib including one patient with a fatal hemorrhagic event. Permanently discontinue pralsetinib in patients with severe or life-threatening hemorrhage.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib	Hemorrhage	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

45. Pralsetinib / Therapeutic Appropriateness _____ _____

Alert Message: Gavreto (pralsetinib) is a kinase inhibitor that can inhibit the vascular endothelial growth factor (VEGF) signaling pathway, therefore, pralsetinib has the potential to adversely affect wound healing. Withhold pralsetinib for at least 5 days prior to elective surgery. Do not administer pralsetinib for at least 2 weeks following major surgery and until adequate wound healing. The safety of resumption of pralsetinib after resolution of wound healing complications has not been established.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

46. Pralsetinib / Certain Strong CYP3A Inhibitors _____ _____

Alert Message: Avoid coadministration of Gavreto (pralsetinib) with strong CYP3A inhibitors. Coadministration of pralsetinib with a strong CYP3A inhibitor increases pralsetinib exposure, which may increase the incidence and severity of adverse reactions of pralsetinib.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib	Nefazodone	
	Voriconazole	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

47. Pralsetinib / Strong Combined CYP3A Inhibitors/P-gp Inhibitors _____ _____

Alert Message: Avoid coadministration of Gavreto (pralsetinib) with drugs that are known combined P-gp and strong CYP3A inhibitors. If coadministration with a combined P-gp and strong CYP3A inhibitor cannot be avoided, a pralsetinib dose reduction is recommended. If taking pralsetinib 400 mg or 300 mg once daily, reduce to 200 mg once daily. If taking 200 mg once daily, reduce to 100 mg once daily. After the inhibitor has been discontinued for 3 to 5 elimination half-lives, resume pralsetinib at the dose taken prior to initiating the combined P-gp and strong CYP3A inhibitor.

Drugs/Diseases

Util A	Util B		Util C
Pralsetinib	Clarithromycin	Mifepristone	
	Cobicistat	Nelfinavir	
	Indinavir	Posaconazole	
	Itraconazole	Ritonavir	
	Ketoconazole	Saquinavir	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

48. Pralsetinib / Strong CYP3A Inducers _____ _____

Alert Message: Avoid coadministration of Gavreto (pralsetinib) with strong CYP3A inducers. Coadministration of pralsetinib with a strong CYP3A inducer decreases pralsetinib exposure, which may decrease the efficacy of pralsetinib. If coadministration cannot be avoided, increase the starting dose of pralsetinib to double the current pralsetinib dosage starting on Day 7 of coadministration of pralsetinib with the strong CYP3A inducer. After the inducer has been discontinued for at least 14 days, resume pralsetinib at the dose taken prior to initiating the strong CYP3A inducer.

Drugs/Diseases

Util A	Util B		Util C
Pralsetinib	Apalutamide	Phenobarbital	
	Carbamazepine	Phenytoin	
	Enzalutamide	Primidone	
	Mitotane	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

49. Pralsetinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on findings from animal studies and its mechanism of action, Gavreto (pralsetinib) can cause fetal harm when administered to a pregnant patient. Oral administration of pralsetinib to pregnant rats during the period of organogenesis resulted in malformations and embryolethality at maternal exposures below the human exposure at the clinical dose of 400 mg once daily. Advise pregnant patients of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Pralsetinib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:Clinical Pharmacology, 2021 Elsevier/Gold Standard., Gavreto Prescribing Information, April 2021, Genentech.

50. Pralsetinib / Therapeutic Appropriateness _____ _____

Alert Message: There are no data on the presence of Gavreto (pralsetinib) or its metabolites in human milk or their effects on either the breastfed child or on milk production. Because of the potential for serious adverse reactions in breastfed children, advise patients not to breastfeed during treatment with pralsetinib and for 1 week after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

51. Pralsetinib / Therapeutic Appropriateness _____ _____

Alert Message: Advise patients of reproductive potential to use effective non-hormonal contraception during treatment with Gavreto (pralsetinib) and for 2 weeks after the final pralsetinib dose. Pralsetinib can cause fetal harm when administered to a pregnant patient.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Pralsetinib		Contraceptives

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

52. Pralsetinib / Therapeutic Appropriateness _____ _____

Alert Message: Advise males with partners of reproductive potential to use effective contraception during treatment with Gavreto (pralsetinib) and for 1 week after the last dose.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib		

Gender: Male

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Gavreto Prescribing Information, April 2021, Genentech.

53. Pralsetinib / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Gavreto (pralsetinib). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Pralsetinib		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487-97.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence with Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

54. Brigatinib / Overuse _____ _____

Alert Message: Alunbrig (brigatinib) may be over-utilized. The recommended dosage of brigatinib is 90 mg orally once daily for the first 7 days, then increase the dose to 180 mg orally once daily.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Brigatinib		Moderate CYP3A Inducers
		Cirrhosis
		Hepatic Failure
		CKD Stage 4 & 5
		ESRD

Max Dose: 180 mg/day

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

55. Brigatinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Alunbrig (brigatinib) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib		

Age Range: 0 – 17 yoa

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

56. Brigatinib / Interstitial Lung Disease _____ _____

Alert Message: Severe, life-threatening, and fatal pulmonary adverse reactions consistent with interstitial lung disease (ILD)/pneumonitis have occurred with Alunbrig (brigatinib). Monitor patient for new or worsening respiratory symptoms, particularly during the first week of initiating brigatinib. Withhold brigatinib in any patient with new or worsening respiratory symptoms, and promptly evaluate for ILD/pneumonitis or other causes of respiratory symptoms. For Grade 1 or 2 ILD/pneumonitis, either resume brigatinib with dose reduction according to official prescribing information after recovery to baseline or permanently discontinue brigatinib. Permanently discontinue brigatinib for Grade 3 or 4 ILD/pneumonitis or recurrence of Grade 1 or 2 ILD/pneumonitis.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Cough	
	Dyspnea	
	Fever	
	Interstitial Pneumonia	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

57. Brigatinib / Hypertension _____ _____

Alert Message: Alunbrig (brigatinib) can cause hypertension. Control blood pressure prior to treatment with brigatinib. Monitor blood pressure after 2 weeks and at least monthly thereafter during treatment with brigatinib. Withhold brigatinib for Grade 3 hypertension despite optimal antihypertensive therapy. Upon resolution or improvement to Grade 1, resume brigatinib at the same dose. Consider permanent discontinuation of treatment with brigatinib for Grade 4 hypertension or recurrence of Grade 3 hypertension.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Hypertension	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

58. Brigatinib / Bradycardia _____ _____

Alert Message: Alunbrig (brigatinib) can cause bradycardia. For symptomatic bradycardia, withhold brigatinib and review concomitant medications for those known to cause bradycardia. If a concomitant medication known to cause bradycardia is identified and discontinued or dose adjusted, resume brigatinib at the same dose following resolution of symptomatic bradycardia; otherwise, reduce the dose of brigatinib following resolution of symptomatic bradycardia. Discontinue brigatinib for life-threatening bradycardia if no contributing concomitant medication is identified.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Bradycardia	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

59. Brigatinib / Visual Disturbances _____ _____

Alert Message: Alunbrig (brigatinib) can cause visual disturbances (e.g., blurred vision, photophobia, diplopia, and reduced visual acuity). Advise patients to report any visual symptoms. Withhold brigatinib and obtain an ophthalmologic evaluation in patients with new or worsening visual symptoms of Grade 2 or greater severity. Upon recovery of Grade 2 or Grade 3 visual disturbances to Grade 1 severity or baseline, resume brigatinib at a reduced dose. Permanently discontinue treatment with brigatinib for Grade 4 visual disturbances.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Blurred Vision	
	Diplopia	
	Photophobia	
	Photopsia	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

60. Brigatinib / Creatine Phosphokinase Elevation _____ _____

Alert Message: Alunbrig (brigatinib) can cause creatine phosphokinase elevation. Advise patients to report any unexplained muscle pain, tenderness, or weakness. Monitor the patient's CPK levels during brigatinib treatment. Withhold brigatinib for Grade 3 or 4 CPK elevation with Grade 2 or higher muscle pain or weakness. Upon resolution or recovery to Grade 1 CPK elevation or baseline, resume brigatinib at the same dose or a reduced dose as described in the official prescribing information.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Myopathy	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

61. Brigatinib / Hyperglycemia _____ _____

Alert Message: Alunbrig (brigatinib) can cause new or worsening hyperglycemia. Assess fasting serum glucose prior to initiation of brigatinib and monitor periodically thereafter. Initiate or optimize antihyperglycemic medications as needed. If adequate hyperglycemic control cannot be achieved with optimal medical management, withhold brigatinib until adequate hyperglycemic control is achieved and consider reducing the dose of brigatinib as described in the official prescribing information or permanently discontinuing brigatinib.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Hyperglycemia	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

62. Brigatinib / Strong CYP3A Inhibitors _____ _____

Alert Message: Coadministration of Alunbrig (brigatinib) with a strong CYP3A inhibitor may increase brigatinib plasma concentrations, which may increase the incidence of adverse reactions. Avoid coadministration of brigatinib with strong CYP3A inhibitors. If coadministration of a strong CYP3A inhibitor cannot be avoided, reduce the brigatinib once daily dose by approximately 50% (i.e., from 180 mg to 90 mg, or from 90 mg to 60 mg). After discontinuation of a strong CYP3A inhibitor, resume the brigatinib dose that was tolerated prior to initiating the CYP3A inhibitor.

Drugs/Diseases

Util A	Util B		Util C
Brigatinib	Clarithromycin	Nelfinavir	
	Cobicistat	Posaconazole	
	Indinavir	Ritonavir	
	Itraconazole	Saquinavir	
	Ketoconazole	Voriconazole	
	Nefazodone		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

63. Brigatinib / Moderate CYP3A Inhibitors _____ _____

Alert Message: Coadministration of Alunbrig (brigatinib) with a moderate CYP3A inhibitor may increase brigatinib plasma concentrations, which may increase the incidence of adverse reactions. Avoid coadministration of brigatinib with moderate CYP3A inhibitors. If coadministration of a moderate CYP3A inhibitor cannot be avoided, reduce the brigatinib once daily dose by approximately 40% (i.e., from 180 mg to 120 mg, 120 mg to 90 mg, or from 90 mg to 60 mg). After discontinuation of a moderate CYP3A inhibitor, resume the brigatinib dose that was tolerated prior to initiating the CYP3A inhibitor.

Drugs/Diseases

Util A	Util B			Util C
Brigatinib	Atazanavir	Diltiazem	Verapamil	
	Aprepitant	Dronedarone		
	Cimetidine	Erythromycin		
	Ciprofloxacin	Fluconazole		
	Crizotinib	Fluvoxamine		
	Cyclosporine	Imatinib		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

64. Brigatinib / Strong CYP3A Inducers _____ _____

Alert Message: Coadministration of Alunbrig (brigatinib) with a strong CYP3A inducer should be avoided as concomitant use can result in decreased brigatinib exposure which may result in decreased brigatinib efficacy. In clinical studies, the concurrent use of brigatinib with the strong CYP3A inducer rifampin resulted in a decrease in brigatinib Cmax by 60% and AUC0-inf by 80%.

Drugs/Diseases

Util A	Util B		Util C
Brigatinib	Apalutamide	Phenobarbital	
	Carbamazepine	Phenytoin	
	Enzalutamide	Primidone	
	Mitotane	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

Criteria Recommendations ***Approved Rejected***

65. Brigatinib / Moderate CYP3A Inducers _____ _____

Alert Message: Coadministration of Alunbrig (brigatinib) with a moderate CYP3A inducer should be avoided as concomitant use can cause decreased brigatinib exposure resulting in decreased brigatinib efficacy. A moderate CYP3A inducer is predicted to decrease the AUC of brigatinib by approximately 50%. If coadministration cannot be avoided, increase the brigatinib once daily dose in 30 mg increments after 7 days of treatment with the current brigatinib dose as tolerated, up to a maximum of twice the brigatinib dose that was tolerated prior to initiating the moderate CYP3A inducer. After discontinuation of a moderate CYP3A inducer, resume the brigatinib dose that was tolerated prior to initiating the moderate CYP3A inducer.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Bosentan	
	Butalbital	
	Efavirenz	
	Etravirine	
	Modafinil	
	Rifabutin	
	Rifapentine	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

66. Brigatinib / Sensitive CYP3A Substrates _____ _____

Alert Message: Caution should be exercised when co-administrating Alunbrig (brigatinib) with sensitive CYP3A substrates. Coadministration of brigatinib with CYP3A substrates, including hormonal contraceptives, can result in decreased substrate concentrations and loss of efficacy of sensitive CYP3A substrates. In in vitro studies, brigatinib, at clinically relevant plasma concentrations, induced CYP3A via activation of the pregnane X receptor (PXR).

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Budesonide	
	Buspirone	
	Darifenacin	
	Ergotamine	
	Everolimus	
	Dihydroergotamine	
	Hormonal Contraceptives	
	Midazolam	
	Sildenafil	
	Sirolimus	
	Tacrolimus	
	Triazolam	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

67. Brigatinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on its mechanism of action and findings in animals, Alunbrig (brigatinib) can cause fetal harm when administered to a pregnant patient. There are no clinical data on the use of brigatinib in pregnant patients. Administration of brigatinib to pregnant rats during the period of organogenesis resulted in dose-related skeletal anomalies at doses as low as 12.5 mg/kg/day as well as increased post-implantation loss, malformations, and decreased fetal body weight at doses of 25 mg/kg/day (approximately 1.26 times the human exposure at 180 mg once daily) or greater. Advise pregnant patients of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Brigatinib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

68. Brigatinib / Lactation _____ _____

Alert Message: There are no data regarding the secretion of Alunbrig (brigatinib) in human milk or its effects on the breastfed infant or milk production. Because of the potential for adverse reactions in breastfed infants, advise lactating women not to breastfeed during treatment with brigatinib and for 1 week following the final dose.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

69. Brigatinib / Therapeutic Appropriateness _____ _____

Alert Message: Alunbrig (brigatinib) can cause fetal harm when administered to a pregnant patient. Advise patients of reproductive potential to use effective non-hormonal contraception during treatment with brigatinib and for at least 4 months after the final dose. Counsel patients to use a non-hormonal method of contraception since brigatinib can render some hormonal contraceptives ineffective.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Brigatinib		Contraceptives

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

Criteria Recommendations *Approved* *Rejected*

70. Brigatinib / Therapeutic Appropriateness _____ _____

Alert Message: Because of the potential for genotoxicity, advise males with partners of reproductive potential to use effective contraception during treatment with Alunbrig (brigatinib) and for at least 3 months after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib		

Gender: Male

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

71. Brigatinib / Overuse – Severe Hepatic Impairment _____ _____

Alert Message: Alunbrig (brigatinib) may be over-utilized. The recommended once daily dose of brigatinib should be reduced by approximately 40% (i.e., from 180 mg to 120 mg, 120 mg to 90 mg, or from 90 mg to 60 mg) for patients with severe hepatic impairment (Child-Pugh C). In drug studies, following a single dose of brigatinib 90 mg, unbound brigatinib systemic exposure (AUC0-INF) was 37% higher in subjects with severe hepatic impairment (Child-Pugh C) compared to subjects with normal hepatic function.

Drugs/Diseases

Util A	Util B	Util C (Include)
Brigatinib		Cirrhosis
		Hepatic Failure

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

72. Brigatinib / Overuse – Severe Renal Impairment _____ _____

Alert Message: Alunbrig (brigatinib) may be over-utilized. The recommended once daily dose of brigatinib should be reduced by approximately 50% without breaking tablets (i.e., from 180 mg to 90 mg, or from 90 mg to 60 mg) for patients with severe renal impairment (creatinine clearance (CLcr) 15 to 29 mL/min by Cockcroft-Gault). In drug studies, following a single dose of brigatinib 90 mg, unbound brigatinib systemic exposure (AUC0-INF) was 86% higher in subjects with severe renal impairment (creatinine clearance (CLcr) 15 to 29 mL/min) compared to subjects with normal renal function.

Drugs/Diseases

Util A	Util B	Util C (Include)
Brigatinib		CKD Stage 4
		CKD Stage 5
		ESRD

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

73. Brigatinib / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Alunbrig (brigatinib). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Brigatinib		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487-497.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence With Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

74. Guselkumab / Infection _____ _____

Alert Message: Tremfya (guselkumab) may increase the risk of infection. In clinical trials, infections occurred in 23% of subjects in the guselkumab group versus 21% of subjects in the placebo group through 16 weeks of treatment. Treatment with guselkumab should not be initiated in patients with any clinically important active infection until the infection resolves or is adequately treated. Instruct patients to seek medical help if signs or symptoms of clinically important chronic or acute infection occur.

Drugs/Diseases

Util A	Util B	Util C
Guselkumab	Infections	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

75. Guselkumab / Therapeutic Appropriateness (0 – 17 yoa) _____ _____

Alert Message: The safety and effectiveness of Tremfya (guselkumab) in pediatric patients less than 18 years of age have not been established.

Drugs/Diseases

Util A	Util B	Util C
Guselkumab		

Age Range: 0 - 17 yoa

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

76. Guselkumab / Tuberculosis _____ _____

Alert Message: Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with Tremfya (guselkumab). Initiate treatment of latent TB prior to administering guselkumab. Monitor patients for signs and symptoms of active TB during and after guselkumab treatment. Do not administer guselkumab to patients with active TB infection.

Drugs/Diseases

Util A	Util B	Util C (Include)
Guselkumab		Tuberculosis

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

77. Guselkumab / Nonadherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Tremfya (guselkumab). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Guselkumab		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005; 353(5):487–497.
Soobraty A, Boughdady S, Selinger CP. Current Practice and Clinicians' Perception of Medication Non-adherence in Patients with Inflammatory Bowel Disease: A Survey of 98 Clinicians. World J Gastro Pharma Ther. 2017; 8(1):67-73.
McKay KA, Tremlett H, Patten SB, et al. Determinants of Non-Adherence to Disease-Modifying Therapies in Multiple Sclerosis: A Cross-Canada Prospective Study. Mult Scler. 2016;23(4):588-596.
Joplin S, van der Zwan R, Joshua F, Wong PK. Medication Adherence in Patients with Rheumatoid Arthritis: The Effect of Patient Education, Health Literacy, and Musculoskeletal Ultrasound. Biomed Res Int. 2015;2015:150658.

78. Guselkumab / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no available data on Tremfya (guselkumab) use in pregnant women to inform a drug-associated risk of adverse developmental outcomes. Human IgG antibodies are known to cross the placental barrier, therefore, guselkumab may be transmitted from the mother to the developing fetus.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Guselkumab	Pregnancy	Miscarriage
		Delivery
		Abortion

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

79. Guselkumab / Lactation _____ _____

Alert Message: There are no data on the presence of Tremfya (guselkumab) in human milk, the effects on the breastfed infant, or the effects on milk production. Maternal IgG is known to be present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for guselkumab and any potential adverse effects on the breastfed infant from guselkumab or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Guselkumab	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

80. Tacrolimus / Strong CYP3A4 Inducers _____ _____

Alert Message: The concomitant use of tacrolimus (a CYP3A4 substrate) with strong CYP3A4 inducers may increase the metabolism of tacrolimus, leading to lower whole blood trough concentrations and greater risk of rejection. Dose adjustment of tacrolimus may be necessary when administered concomitantly with CYP3A4 inducers. Closely monitor tacrolimus whole blood trough concentrations.

Drugs/Diseases

Util A	Util B	Util C
Tacrolimus	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

North Dakota Medicaid
Drug Utilization Review Board
Meeting
December 1st, 2021
Conference Room 210/212

NORTH Dakota | Human Services
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North Dakota Medicaid
DUR Board Meeting Agenda
Conference Room 210/212
North Dakota State Capitol

Click here to join the meeting

(Click on link)

Join by phone: 1 701-328-0950, Conference ID 262 340 82#

December 1, 2021

1:00 pm

1. Administrative items
    - DHS announcements

2. Old business
    - Review and approval of September 2021 meeting minutes
    - Budget update
    - Review top 25 drugs for third quarter of 2021
    - Prior authorization/PDL update
    - Update to eczema/atopic dermatitis (Opzelura)
    - Second review of non-stimulant agents for the treatment ADHD
    - Annual prior authorization review of prior authorization forms and criteria

3. New business
    - Review of chronic kidney disease
    - Review of lupus
    - Retrospective DUR profile review update
    - Retrospective DUR criteria recommendations
    - Upcoming meeting date/agenda.
        - Next meeting is March 2, 2022
4. Adjourn

Please remember to silence all cellular phones during the meeting.

North Dakota Medicaid Drug Use Review (DUR) Board
Meeting Minutes
September 1, 2021

Members Present: Joshua Askvig, Andrea Honeyman, Kathleen Traylor, Gabriela Balf, Mary Aaland, Amy Werremeyer, Laura Kroetsch, Tanya Schmidt

Medicaid Pharmacy Department: Alexi Murphy, Brendan Joyce

Old Business

Chair T. Schmidt called the meeting to order at 1:03 p.m. Chair T. Schmidt asked for a motion to approve the minutes of the June 2, 2021, meeting. J. Askvig moved that the minutes be approved, and A. Werremeyer seconded the motion. The chair called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 25 Drugs

B. Joyce presented budget updates and the quarterly review of the top 25 drugs based on total cost of claims, the top 25 drugs based on the total number of claims, and the top drug classes based on claims and cost for the 3rd quarter of 2021. B. Joyce presented data to the Board that was reflective of the average number of patients enrolled in ND Medicaid expansion from 3Q 2017 to 2Q 2021 which showed a significant increase of patients beginning at 1Q 2020. The rise in number of patients is directly linked to the COVID-19 pandemic and the public health emergency that coincided with the pandemic. B. Joyce also presented utilization data of select medication classes to the Board to illustrate drug utilization trends during this time. Drug classes presented included steroids, immunomodulators, insulins, antidepressants, and antipsychotic agents. During public comment, J. Askvig asked if there was an uptick in antidepressants since the pandemic began in which B. Joyce stated antidepressants and narcotics have both increased. G. Balf noted that she has notice antidepressants being used more for anxiety than depression during the pandemic.

PDL/PA Criteria Updates

A. Murphy shared with the Board all of the changes made to the Preferred Drug List since the last version of the Preferred Drug List was posted. Notable changes include removing tetracycline, Peg 3350, and Clenpig from PA, as well as adding agents such as Ingrezza, Koselugo, Empaveli, Atelvia, and Varubi to already existing PA category criteria. All PDL updates are listed in the handouts for the September 2021 DUR Board meeting. When a new version of the PDL is published and posted to the website, all updates/changes made since the last version are called out at the top of the document itself.

Second Review of Agents Used in the Treatment of Heart Failure

A motion and second was made at the June 2021 DUR Board meeting to place some agents, Corlanor, Entresto, and Verquvo, for the management of heart failure on electronic diagnosis verification. The topic was brought up for a second review. Product specific heart failure criteria for Verquvo and Corlanor were presented to the Board by L. Morgan. Chair T. Schmidt called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Proposed New Criteria for Nasal Polyps

L. Morgan presented the proposed prior authorization criteria for nasal polyps. The proposed updates included adding Xolair (omalizumab) and Dupixent (dupilumab) to preferred agents, requiring clinical prior authorization, and Nucala (mepolizumab) to non-preferred, requiring prior authorization. Xolair recently received the FDA indication for nasal polyps which supports the addition of nasal polyp criteria to the PDL. A. Werremeyer raised the question about requiring the patient to have bilateral nasal polyps for authorization. J. Ritter (guest) answered by

stating in the dupilumab trial, inclusion criteria required patients to have bilateral nasal polyps as they are more common than unilateral polyps.

Proposed New Criteria for Chronic Idiopathic Urticaria

L. Morgan presented criteria for the use of Xolair in chronic idiopathic urticaria. Xolair is a preferred agent and will require a clinical prior authorization. It is considered first-in-class therapy for patients with chronic idiopathic urticaria. There were no public comments or concerns about the criteria listed.

Update to the Prior Authorization Criteria for Uterine Fibroid Criteria

L. Morgan presented proposed updates to the prior authorization criteria for agents used to treat uterine fibroids. The proposed update included adding Myfembree (relugolix, estradiol, and norethindrone acetate) to the preferred agents list, requiring clinical prior authorization. During public comment, C. Lickert, with Myovant Sciences and representing Myfembree, brought to the Board's attention the recent update to The American Colleges of Obstetricians and Gynecologists guideline for management of symptomatic uterine fibroids. C. Lickert discussed the use of oral contraception for management of uterine fibroids to be less effective than other agents and the quality of evidence of oral contraception use to be low. C. Lickert added the suggestion to remove or edit the step therapy for oral contraception prior to Oriahnn and Myfembree approval. The Board discussed the requirement for a 3-menstual cycle trial of an oral contraceptive and decided to leave the criteria as is. H. Budlong, with Abbvie and representing Oriahnn, voiced agreement with C. Lickert's assessment of the criteria and thanked the Board for allowing coverage of additional products to treat uterine fibroids. No other public comments were made.

Review of Empaveli (pegcetacoplan)

L. Morgan presented a review of Empaveli (pegcetacoplan) for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) to the Board. A prior authorization form was also presented for ease of prescriber submission, as well as ease of approval determination. Changes between the original handout and new handout were pointed out and discussed, as well. During public discussion, T. Schmidt discussed clarifying how much the Hb levels should increase prior to granting approval for renewal of Empaveli. J. Tobitt, with Apellis and representing Empaveli, clarified that patients eligible for Empaveli do not necessarily need to be transfusion dependent based on the patients included in Empaveli trials not requiring transfusions. G. Balf brought up the concern of documentation to support patient diagnosis for PNH if they are new to North Dakota Medicaid and have limited laboratory documentation. A. Murphy discussed now only requiring documentation of flow cytometry as it is the gold standard for diagnosis of PNH. A motion was made by A. Werremeyer to manage this medication through prior authorization. The motion was seconded by A. Honeyman. Chair T. Schmidt called for a voice vote to approve the updated criteria, which passed with no audible dissent.

Update to Non-24 Hour Sleep-Wake Disorder Criteria

L. Morgan presented an update to the criteria for agents used for non-24 hour sleep-wake disorder. Hetlioz (tasimelteon) is now indicated for sighted members diagnosed by self-reported sleep diaries or actigraphy for at least 14 days. A. Murphy discussed the drastic price difference between Rozerem (ramelteon) and Hetlioz (tasimelteon) – two agents that have the same mechanism-of-action and efficacy. The higher price and similar efficacy of Hetlioz were used to determine the non-preferred status. No public comment followed presentation.

New Business

Review of Non-Stimulant Agents Used in the Treatment of ADHD

L. Morgan presented a review of non-stimulant agents used in the treatment of attention-deficit hyperactivity disorder to the Board. During public comment, G. Balf commented on the confusion in the mechanism-of-action table which listed viloxazine and atomoxetine as SNRI agents, which is incorrect, as they are norepinephrine reuptake inhibitors. G. Balf also discussed the missing dosing information for atomoxetine which should include the utilization of higher doses, specifically up to 100mg per day. A motion was made by M. Aaland to manage these medications through prior authorization. The motion was seconded by A. Honeyman. Prior authorization criteria for these agents will be presented, reviewed, and voted on by the Board at the next meeting.

Utilization Review of Xifaxan and Potassium

A. Murphy presented utilization data to the board regarding the utilization of Xifaxan with and without lactulose, comparing utilization before and after new requirements were implemented that require a PA for Xifaxan for diagnoses other than hepatic encephalopathy, and required concomitant use of lactulose for a diagnosis of hepatic encephalopathy. A. Murphy then went on to discuss the requirement for liquid potassium to require prior authorization for swallow study and quantity limits, as patients were using liquid over tablets due to the inconvenience of swallowing a large tablet.

Retrospective Drug Utilization Review (RDUR) Criteria Recommendations

L. Morgan reviewed the RDUR criteria that were selected for review of each month of the last quarter. Presented data included number of profiles reviewed, number of cases identified for intervention, and the number of letters sent, as well as an overview of what RDUR interventions were identified as most prevalent for each monthly cycle. L. Morgan discussed the decrease in letters sent during the month of June and correlated the decrease to her taking over after T. DeRuiter. L. Morgan stated she will monitor letters sent in the future and will discuss changes in this process at the next meeting.

Retrospective Drug Utilization Review (RDUR) Criteria Recommendations

The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. J. Askvig moved to approve the new criteria and M. Aaland seconded the motion. Chair T. Schmidt called for a voice vote to approve the new criteria, which passed with all present members voting to approve.

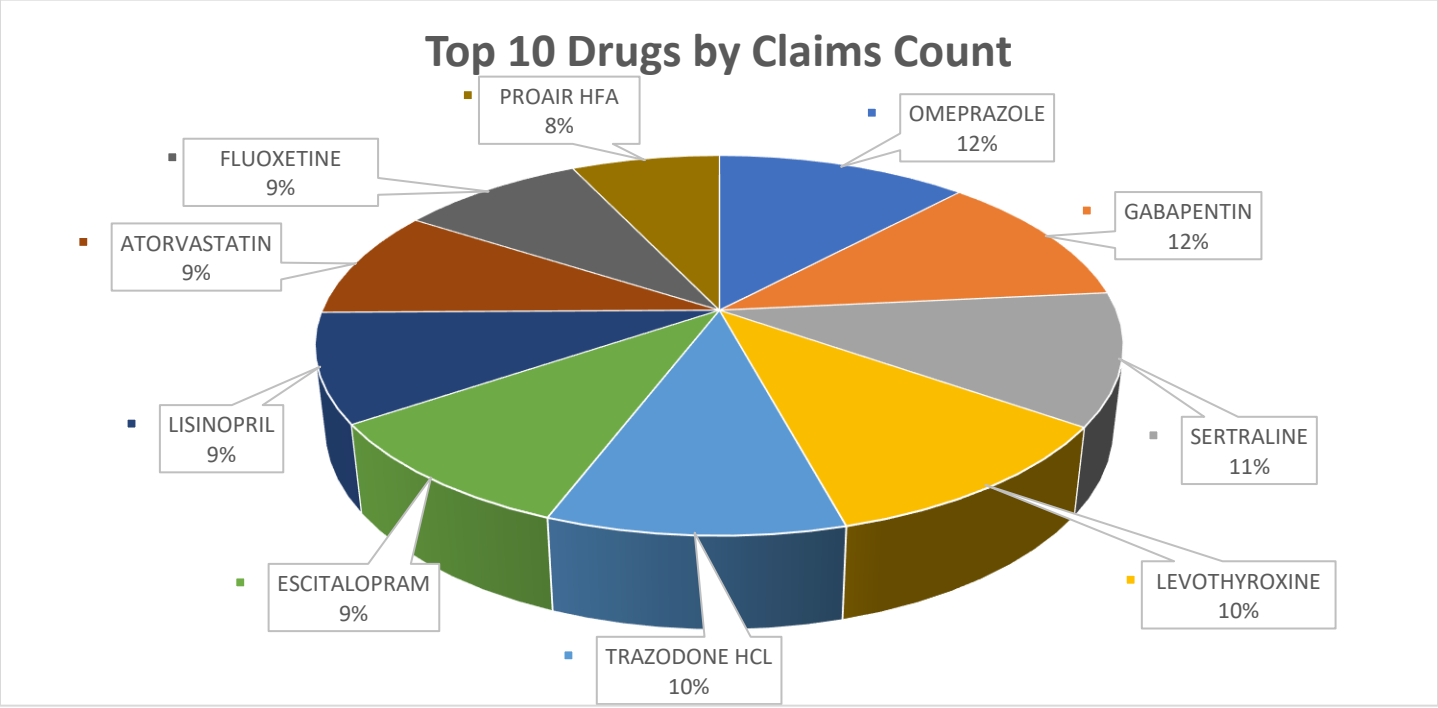
Adjournment and Upcoming Meeting Date

Chair T. Schmidt adjourned the meeting at 2:40 pm. The next DUR Board meeting will be held December 1, 2021, at 1:00 pm at the state capitol building.

Top 25 Drugs Based on Number of Claims from 07/01/2021 – 09/30/2021

Drug	Claims	Patients	Claims Cost	Cost / Claim	% Total Claims	Dif.
OMEPRAZOLE	4,668	2,301	60,593.72	$12.95	1.87%	NC
GABAPENTIN	4,626	1,943	69,007.69	$14.91	1.85%	NC
SERTRALINE HCL	4,226	2,276	58,143.37	$13.64	1.69%	NC
LEVOTHYROXINE SODIUM	3,938	1,777	76,660.94	$18.62	1.57%	NC
TRAZODONE HCL	3,775	1,844	51,893.80	$13.74	1.51%	NC
ESCITALOPRAM OXALATE	3,624	1,984	49,514.65	$12.79	1.45%	↑2
LISINOPRIL	3,573	1,990	46,323.98	$14.16	1.43%	↓2
ATORVASTATIN CALCIUM	3,556	1,885	50,135.83	$13.43	1.42%	↓1
FLUOXETINE HCL	3,378	1,814	46,566.10	$13.82	1.35%	NC
PROAIR HFA	2,874	2,831	224,139.29	$15.09	1.15%	↑10
HYDROCODONE-ACETAMINOPHEN	2,860	1,769	43,273.49	$17.58	1.14%	↓1
PANTOPRAZOLE SODIUM	2,811	1,357	37,769.76	$13.41	1.12%	NC
AMOXICILLIN	2,740	2,540	38,107.07	$13.03	1.10%	↑10
BUPROPION XL	2,675	1,376	47,076.39	$15.76	1.07%	↓3
METFORMIN HCL	2,568	1,353	33,707.98	$14.05	1.03%	↓2
MONTELUKAST SODIUM	2,547	1,413	35,591.09	$258.46	1.02%	↓1
PREDNISONE	2,515	1,976	31,298.92	$13.98	1.01%	↑7
DULOXETINE HCL	2,505	1,226	39,765.86	$11.57	1.00%	↓4
VYVANSE	2,455	1,007	626,592.35	$45.67	0.98%	↓3
BUPRENORPHINE-NALOXONE	2,397	555	104,851.66	$73.54	0.96%	↓1
CYCLOBENZAPRINE HCL	2,386	1,502	27,933.37	$12.63	0.95%	↓3
CLONIDINE HCL	2,298	1,105	28,811.37	$12.48	0.92%	↓1
CLONAZEPAM	2,260	957	30,984.85	$13.71	0.90%	↑2
LAMOTRIGINE	2,253	897	31,753.18	$12.54	0.90%	↓7
AMLODIPINE BESYLATE	2,122	1,197	26,577.41	$13.62	0.85%	↓3

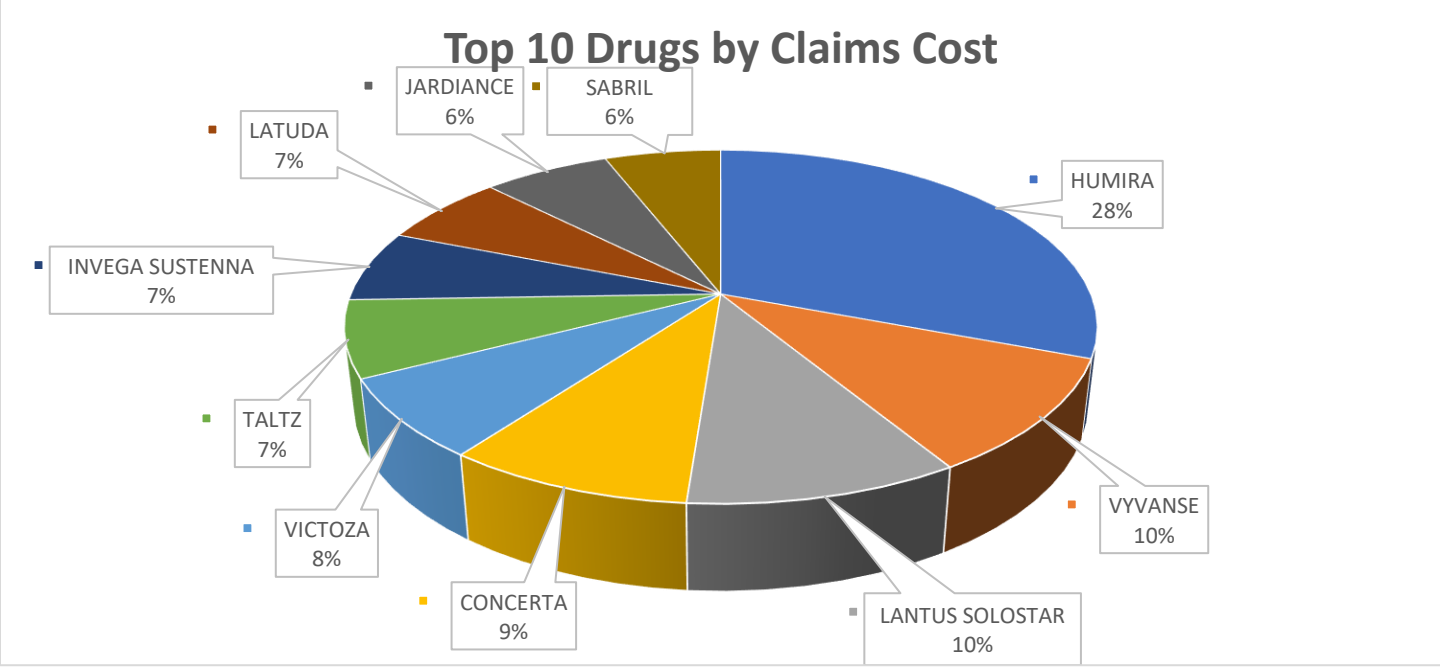
Total Claims	**250,036**



Top 25 Drugs Based on Total Claims Cost from 07/01/2021 – 09/30/2021

Drug	Claims Cost	Claims	Patients	Cost /Claim	% Total Cost	Dif.
HUMIRA PEN	1,747,399.22	259	108	$6,893.43	6.16%	NC
VYVANSE	626,592.35	2,455	1,007	$258.46	2.21%	NC
LANTUS SOLOSTAR	611,779.72	1,257	767	$344.48	2.16%	↑1
CONCERTA	574,551.57	1,695	727	$477.03	2.03%	↓1
VICTOZA 3-PAK	514,109.53	554	257	$2,371.89	1.81%	↑1
TALTZ AUTOINJECTOR	442,828.28	58	22	$908.95	1.56%	↑10
INVEGA SUSTENNA	438,876.71	186	77	$806.06	1.55%	↓2
LATUDA	422,797.49	503	194	$22,224.28	1.49%	↓1
JARDIANCE	399,778.16	827	371	$476.00	1.41%	NC
SABRIL	384,296.79	16	6	$709.72	1.36%	↓2
NOVOLOG FLEXPEN	377,592.58	524	330	$23,359.50	1.33%	↓1
STELARA	350,392.50	15	12	$4,102.31	1.24%	↓1
ADVAIR DISKUS	333,702.40	900	500	$334.58	1.18%	↓1
NORDITROPIN FLEXPRO	330,833.29	82	39	$23,880.01	1.17%	↓3
SYMBICORT	311,881.18	912	516	$7,444.03	1.10%	↓2
TRIKAFTA	310,419.47	13	5	$544.88	1.09%	↑1
BIKTARVY	307,448.16	160	74	$6,507.81	1.08%	↑6
ADDERALL XR	290,376.86	1,670	708	$173.51	1.02%	↑1
LEVEMIR FLEXTOUCH	284,724.86	520	298	$2,448.73	1.00%	↓2
COSENTYX PEN (2 PENS)	279,644.48	46	18	$8,310.49	0.99%	↓2
ELIQUIS	257,053.01	587	252	$433.59	0.91%	↑1
VICTOZA 2-PAK	255,079.81	421	220	$1,889.27	0.90%	↑4
XIFAXAN	251,855.54	108	49	$5,820.83	0.89%	↓4
STRATTERA	232,605.66	567	282	$401.66	0.82%	↑1
PROAIR HFA	224,139.29	2,874	2,831	$79.17	0.79%	↑9

Total Claims Cost	**$28,361,165.05**



Top 15 Therapeutic Classes Based on Number of Claims from 07/01/2021 – 09/30/2021

Therapeutic Class Description	Claims	Patients	Claims Cost	Cost/Claim	% Total Claims	Dif.
ANTIDEPRESSANTS	28,231	11,341	$607,837.52	$21.53	11.29%	NC
ANTICONVULSANTS	13,307	4,636	$1,119,956.77	$84.16	5.32%	NC
ANTIPSYCHOTIC AGENTS	8,549	3,217	$2,051,259.41	$239.94	3.42%	NC
PROTON-PUMP INHIBITORS	7,872	3,793	$142,138.19	$18.06	3.15%	NC
OPIATE AGONISTS	7,048	3,598	$126,365.63	$17.93	2.82%	NC
SEDATIVES/HYPNOTICS	6,456	3,191	$120,071.29	$18.60	2.58%	NC
NSAIDS	6,274	4,027	$91,424.01	$14.57	2.51%	NC
STATINS	6,020	3,159	$86,726.49	$14.41	2.41%	NC
BETA BLOCKERS	5,497	2,813	$100,698.17	$18.32	2.20%	NC
AMPHETAMINES	5,309	2,224	$955,304.00	$179.94	2.12%	NC
PENICILLIN ANTIBIOTICS	4,773	4,251	$75,048.16	$15.72	1.91%	↑4
ACE INHIBITORS	4,535	2,514	$65,676.87	$14.48	1.81%	↓1
NON-AMPHETAMINE STIMULANTS	4,506	1,730	$852,876.65	$189.28	1.80%	↓1
BETA AGONISTS	4,503	4,055	$332,174.31	$73.77	1.80%	↑4
THYROID AGENTS	4,235	1,855	$86,722.88	$20.48	1.69%	↓2

Top 15 Therapeutic Classes Based on Claims Cost from 07/01/2021 – 09/30/2021

Therapeutic Class Description	Claims Cost	Claims	Patients	Cost/Claim	% Total Cost	Dif.
DMARDS	2,658,149.54	484	189	$5,492.04	9.37%	NC
ANTIPSYCHOTIC AGENTS	2,051,259.41	8,549	2838	$239.94	7.23%	NC
SKIN AND MUCOUS MEMBRANE AGENTS	1,891,099.65	638	143	$2,964.11	6.67%	↑1
INSULINS	1,871,987.05	3,644	2055	$513.72	6.60%	↓1
ANTICONVULSANTS	1,119,956.77	13,307	4778	$84.16	3.95%	NC
INHALED CORTICOSTEROIDS	984,913.05	3,394	2183	$290.19	3.47%	↑1
AMPHETAMINES	955,304.00	5,309	1743	$179.94	3.37%	↓1
ANTIRETROVIRALS	917,856.47	706	524	$1,300.08	3.24%	↑2
ANTINEOPLASTIC AGENTS	873,426.31	549	251	$1,590.94	3.08%	↓1
INCRETIN MIMETICS	871,328.00	1,102	28	$790.68	3.07%	↑1
NON-AMPHETAMINE STIMULANTS	852,876.65	4,506	1598	$189.28	3.01%	↓2
IMMUNOMODULATORY AGENTS	677,728.42	89	36	$7,614.93	2.39%	↑1
ANTIDEPRESSANTS	607,837.52	28,231	500	$21.53	2.14%	↓1
SGLT-2 INHIBITORS	544,209.49	1,132	11931	$480.75	1.92%	NC
ANTIMUSCARINICS/ANTISPASMODICS	417,959.33	1,793	366	$233.11	1.47%	NC

PDL UPDATE

Drug Name	PA	Class
Betimol	PA	Glaucoma
Bevespi Aerosphere	PA	COPD - Anticholinergics/Beta Agonists Combination
Bronchitol	PA	Cystic Fibrosis
Bylvay	PA	Over 3000
desoximetasone 0.25% cream	PA	topical steroids
diflorasone diacetate	PA	topical steroids
Endari	PA	Sickle Cell Disease
Firdapse	PA	Over 3000
fluocinolone 0.1% cream	PA	topical steroids
Livmarli	PA	Over 3000
Mitagare	PA	Gout
Myfembree	PA	Uterine Fibroids
Nyvepria	PA	Hematopoietic, Colony Stimulating Factors
Rezurock	PA	Over 3000
Skytrofa	PA	Growth Hormone
Tudorza Pressair	PA	Long-Acting Anticholinergics
Varubi	PA	Nausea and Vomiting
voriconazole	PA	Antibiotic Resistance
Welireg	PA	Over 3000
Asmanex Twisthaler	remove PA	Corticosteroid - Inhaled
betamethasone dipropionate emollient 0.05% cream	remove PA	topical steroids
Brovana	remove PA	Long-Acting Beta Agonists
Cambia	remove PA	Migraine Treatment
clobetasol emollient 0.05% cream	remove PA	topical steroids
Delestrogen	remove PA	Estrogens
estradiol-norethindrone	remove PA	Estrogens
Femring	remove PA	Estrogens
fluocinonide 0.1% cream	remove PA	topical steroids
Frova	remove PA	Migraine Treatment
halobetasol 0.05% cream	remove PA	topical steroids
PANDEL (hydrocortisone probutate)	remove PA	topical steroids
Rebif	remove PA	Multiple Sclerosis
Spiriva Respimat	remove PA	Long-Acting Anticholinergics
Stiolto Respimat	remove PA	COPD - Anticholinergics/Beta Agonists Combination
triamcinolone acetonide 0.05% cream	remove PA	topical steroids
Zomig ODT	remove PA	Migraine Treatment
Zyptimag	remove PA	Hyperlipidemia

Eczema / Atopic Dermatitis

Electronic Age Verification

Product Specific: Protopic (tacrolimus) ointment 0.1%

- The member must be 16 years of age or older

Prior Authorization Criteria

Topical Corticosteroids: Please see the Preferred Drug List of Topical Corticosteroids

Product Specific Criteria (Initial): *Approval Duration = 3 months*

- **Eucrisa, Dupixent, and Opzelura**
  - Member must meet FDA label recommendations for indication and age
  - Member must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy printouts:
    - tacrolimus OR pimecrolimus
  - One of the following must be met (A or B):
    A. Member must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy printouts.
    B. Member must meet both of the following (1 AND 2):
       1. Affected area is on face, groin, axilla, or under occlusion
       2. Member must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy printouts.
  - **Opzelura**: *Approval Duration = 3 months*
    - Indicated for short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis.
    - The member must have a percentage BSA (excluding scalp) with AD involvement of 3% - 20%.
    - The member must not be immunocompromised.
    - The member must have had a 3-month trial of Eucrisa ointment, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria (Renewal): *Approval Duration = 12 months*

- **Eucrisa and Dupixent**
  - The prescriber must submit documentation showing that the member has achieved a significant reduction in severity of atopic dermatitis since treatment initiation

Biologics

Prior Authorization Form - Dupixent

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)	

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
azathioprine	
Cyclosporine	
Methotrexate	
Systemic oral corticosteroids	

Topical

General Prior Authorization - Eucrisa

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELIDEL (pimecrolimus) CREAM – *Brand Required*	EUCRISA (crisaborole) OINTMENT***
PROTOPIC (tacrolimus) OINTMENT 0.03% – *Brand Required*	OPZELURA (ruxolitinib)
PROTOPIC (tacrolimus) OINTMENT 0.1% – *Brand Required*	Tacrolimus 0.03%
Topical Corticosteroids	Tacrolimus 0.1%
	Pimecrolimus

SECOND REVIEW

Non-Stimulants

Prior Authorization Criteria

General Prior Authorization Form

Product Specific Criteria:

- **Qelbree:**
  - The member must have had a 30-day trial of a stimulant at the maximally tolerated dose, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
atomoxetine	INTUNIV (guanfacine ER)
clonidine	KAPVAY (clonidine ER) ***
clonidine ER***	STRATTERA (atomoxetine
guanfacine	
guanfacine ER	
QELBREE (viloxazine)	

ANNUAL REVIEW

Major Changes Since Last Version

Albuterol/Levalbuterol Rescue Inhalers
- electronic step added to Xopenex

Aplastic Anemia
- Renewal criteria added

Chronic hepatitis C infection-associated thrombocytopenia
- Initial criterion added
- Renewal criteria added

Cystic Fibrosis:
- Bronchitol added to prior authorization with Bronchitol Tolerance Test requirement

Diabetes
- Sulfonylureas and TZDs are covered together

Empaveli
- Hb level added for renewal criteria

Eosinophilic asthma
- Eosinophil and IgE levels added to criteria

Glucose Rescue Medications
- Added step therapy

Huntington's Disease
- Added step therapy

Narcolepsy
- Criteria added specific to Xywav

Insulins
- Regular insulin criteria added
- Humalog U-200 criteria added
- TZDs are allowed with insulin

Otezla
- Preferred for all indications

Parkinson's Disease
- Renewal therapy added

Plaque Psoriasis:
- Anti-interleukin (IL) 17 Antibodies - Taltz and Cosentyx: Require 3-month trial of a TNF Inhibitor
- Otezla covered for all indications without prior authorization

Steroid/Anticholinergic/Long-Acting Beta Agonist Combination:
- Step Therapy added with the entry of competitor

Taltz and Cosentyx:
- Require step therapy

Xeljanz
- Preferred for all indications

Preferred Drug Preferred Drug List (PDL)

General

Biosimilar Agents

General Prior Authorization Form

Group Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review)

Combination Agents

General Prior Authorization Form

Group Criteria:

- Clinical justification must be provided for combination products that are comprised of components available and more cost effective when prescribed separately (subject to clinical review).

Dispense as Written (DAW1)

Prior Authorization Form - Dispense As Written (DAW1)
MedWatch Form

Criteria for ALL DAW requests (must meet one of the following (A or B):

A. Primary insurance requires a ND Medicaid non-preferred branded product
   - *Approval: until the end of the calendar year*

B. All of the following are met (1-4):
   1. The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
   2. The requested brand-name product must not have an authorized generic available
   3. The member must have failed a 30-day trial of each pharmaceutically equivalent generic product from each available manufacturer, as evidenced by paid claims or pharmacy print outs
      a. A failure is defined as product was not effective at maximum tolerated dose or caused adverse reaction where the branded product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the member
      b. The member or prescriber preference is NOT criteria considered for approval
   4. A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request

Medications that cost over $3000/month

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The member must meet criteria as outlined in prescribing information (PI) including recommendations for diagnosis and age.
  - The prescriber is a specialist, or the prescriber has consulted with a specialist in the area of the member's diagnosis
  - As applicable, documentation must be attached to confirm serum marker or pathogenic gene variants amenablTe to treatment
- **Renewal Criteria**: *Approval Duration = 12 months*
  - The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review).

PA REQUIRED
BYLVAY (odevixibat)
CERDELGA (eliglustat)
CYSTADROPS (cysteamine)
CYSTARAN (cysteamine)
DOJOVI (triheptanoin)
ENSPRYNG (satralizumab)
FIRDAPSE (amifampridine)
GATTEX (teduglutide)
ILARIS (canakinumab)
INCRELEX (mecasermin)
LUPKYNIS (voclosporin)
MYCAPSSA (octreotide)
NULIBRY (fosdenopterin)
OXERVATE (cenegermin-bkbj)
RAVICTI (glycerol phenylbutyrate)
REZUROCK (belumosudil)
SAMSCA (tolvaptan)
SYPRINE (trientine)
TAVNEOS (avacopan)
WELIREG (belzutifan)
ZOKINVY (lonafamib)

Non-solid dosage preparations

General Prior Authorization Form

Electronic Age Verification

A. Non-solid dosage preparations of preferred products are automatically covered for all members younger than 9 years old. For coverage of these products in members 9 years of age or older, one of the following criteria must be met (A or B): The member is unable to swallow solid dosage medications due to one of the following:
   - Swallow study documentation – *Approval 1 year*
   - Feeding tube placement and the medication is not available in a dosage form that can be crushed or poured into the tube – *Approval 1 year*
   - Permanent disability of swallowing solid dosage forms - A*pproval 2 years*
   - Short-term restriction (e.g. mouth surgery) - *Approval 1 month*

B. Clinical justification has been provided as to why a solid dosage medication cannot be used (subject to clinical review)

Preferred Dosage Forms List:

General Prior Authorization Form

See Preferred Dosage Forms List

Allergy/Immunology

Biologic Agents

Chronic Idiopathic Urticaria

General Prior Authorization Form

Category Criteria (Initial): *Approval Duration = 3 months*

- The member must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, an allergist/immunologist.
- The member must have had a 30-day trial of a type 1 (H1) antihistamine at maximally tolerated dose either non-sedating (e.g. cetirizine, fexofenadine, loratadine, desloratadine, or levocetirizine) or sedating (e.g. diphenhydramine, chlorpheniramine, cyproheptadine) in addition to one of the following:
    - leukotriene receptor antagonist (e.g. montelukast, zafirlukast, zileuton)
    - histamine H2-receptor (e.g. ranitidine, famotidine, nizatidine, cimetidine)

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the member has achieved a clinical benefit since treatment initiation.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
XOLAIR (omalizumab) SYRINGES	

Eosinophilic Asthma

General Prior Authorization Form

Category Criteria (Initial): *Approval Duration = 3 months*

- The member must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, a pulmonologist or allergist/immunologist
- The member must have had at least one exacerbation despite continued compliant use of a high dose inhaled steroid in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts

Product Specific Criteria (Initial):

- Anti-IL-5 and Anti-IL-4/13 biologics:
    - The member has eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL within the past 90 days
- Eosinophil-directed biologics:
    - The member has a serum total IgE level, measured before the start of treatment, of ≥ 30 IU/mL and ≤ 700 IU/mL in members age ≥ 12 years or ≥ 30 IU/mL and ≤ 1300 IU/mL in members ages 6 to < 12 years.
    - The member has had a positive skin test or in vitro reactivity to a perennial aeroallergen

Non-Preferred Agents Criteria:

- The member must have had a 3-month trial of 1 preferred Eosinophilic Asthma agent, as evidenced by paid claims or pharmacy printouts

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the member has achieved a significant reduction in asthma exacerbations and utilization of rescue medications since treatment initiation

Anti-IL-5 biologics

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FASENRA (benralizumab) PEN	NUCALA (mepolizumab)

Anti-IL-4/13 biologics

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)	

Eosinophil-directed biologics:

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
XOLAIR (omalizumab) SYRINGES	

Eosinophilic granulomatosis with polyangiitis (EGPA)

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
    - The member must be 18 years of age or older
    - The prescription must be written by, or in consultation with, a hematologist, pulmonolgist, or allergy/immunology specialist
    - The member must have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) characterized by
        - Member has asthma poorly controlled on moderate doses of inhaled glucocorticoids

        - Member has a greater than blood eosinophilia > 1000 cells/mcL or 10% eosinophils on the differential leukocyte count, as evidenced by laboratory documentation attached to the request
        - Two of more of the following:
            - Mononeuropathy (including multiplex) or polyneuropathy
            - Pulmonary infiltrates
            - Paranasal sinus abnormality
            - Eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
            - Glomerulonephritis
            - Alveolar hemorrhage
            - Palpable purpura
            - Myocardial infarction due to coronaritis
            - Anti-neutrophil cytoplasmic antibody (ANCA) positivity
    - The member must have had relapsing or recurring disease requiring systemic corticosteroids in previous year despite a 3-month trial with good compliance of one of the following medication, as evidenced by paid claims or pharmacy printouts:
        - Cyclophosphamide
        - Azathioprine
        - Methotrexate
        - Leflunomide
- **Renewal Criteria:** *Approval Duration = 12 months*
    - The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NUCALA (mepolizumab)	

Hypereosinophilic Syndrome

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
    - The member must be 12 years of age or older
    - The prescription must be written by, or in consultation with, a hematologist, or allergy/immunology specialist
    - The member must have a diagnosis of hypereosinophilic syndrome (HES) characterized by the following:
        - The member must have experienced hypereosinophilic syndrome for ≥6 months
        - The provider must attest that there is no identifiable nonhematologic secondary cause
    - The member must have experienced at least 2 HES flares within the past 12 months despite continued compliant use of oral corticosteroids and/or steroid sparing therapy (e.g. hydroxyurea)
    - The member must have a blood eosinophil count of 1,000 cells/mcL or higher, as evidenced by laboratory documentation attached to the request
- **Renewal Criteria:** *Approval Duration = 12 months*
    - The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NUCALA (mepolizumab)	

Nasal polyps

General Prior Authorization Form

Category Criteria (Initial): *Approval Duration = 3 months*

- The member must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, an ear/nose/throat specialist or allergist/immunologist.
- The member must have had a 12-week trial of intranasal or oral corticosteroid
- The member must have bilateral polyps confirmed by sinus CT, sinus MRI, or nasal endoscopy
- Member must have documentation of at least two of the following symptoms:

- Nasal blockade/obstruction/congestion or nasal discharge (anterior/posterior nasal drip)
- Facial pain/pressure
- Reduction or loss of smell

Non-Preferred Agent Criteria:

- The member must have had a 90-day trial with a preferred agent, as evidenced by paid claims or pharmacy printouts

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the member has achieved a significant reduction in nasal polyp size and symptoms since treatment initiation.
- The member must be receiving intranasal steroids

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)	NUCALA (mepolizumab)
XOLAIR (omalizumab) SYRINGES	

Medical Billing Drug Clinical Criteria Only

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
XOLAIR (omalizumab) VIAL	

Epinephrine

Electronic Duration Verification

- 3 packs (initial and replacement doses) are covered every 180 days without prior authorization.

General Prior Authorization Form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
epinephrine – labeler 49502	epinephrine – labeler 00935
SYMJEPI (epinephrine)	epinephrine – labeler 11516
	EPIPEN (epinephrine)
	EPIPEN (epinephrine) JUNIOR

Gout

Krystexxa (pegloticase) – Medical Billing Drug Clinical Criteria

Prior Authorization

General Prior Authorization Form

Product Specific Criteria:

- **Colchicine capsules:**
  - See **Preferred Dosage Form List** Criteria
- **Uloric:**
  - The member must have had a 30-day trial of allopurinol, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
allopurinol tablet	colchicine capsules
COLCRYS (colchicine) TABLETS – *Brand Required*	colchicine tablets
probenecid-colchicine tablets	febuxostat
probenecid tablets	GLOPERBA (colchicine) ORAL SOLUTION
	MITIGARE (colchicine) CAPSULE
	ULORIC (febuxostat) TABLET
	ZYLOPRIM (allopurinol) TABLET

Hereditary Angioedema

General Prior Authorization Form

Group Criteria: *Approval Duration = 12 months*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The medication must be prescribed by or in consultation with an allergist, immunologist, or rheumatologist

Non-Preferred Agents Criteria:

- The request must meet the group criteria

- The member must have a contraindication to or failed a trial of all preferred agents with the same indication for use (prophylaxis or acute treatment), as evidenced by paid claims or pharmacy printouts
    - Required trial durations
        - Agents for acute attacks: a single trial
        - Agents for attack prophylaxis: 3 months

Product Specific Criteria:

- Takhyzro
    - The number of attacks in the last 6 months must be included if the requested dose is 300mg every 2 weeks.

Acute Attack

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BERINERT (C1 Esterase Inhibitor)	FIRAZYR (icatibant)
Icatibant	KALBITOR (ecallantide)
RUCONEST (C1 Esterase Inhibitor)	

Prophylaxis

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HAEGARDA (C1 Esterase Inhibitor)	CINRYZE (C1 Esterase Inhibitor)
ORLADEYO (berotrlastat)	
TAKHZYRO (lanadelumab-flyo)	

Immune Globulins

General Prior Authorization Form

Category Criteria:

- If the member's BMI > 30, adjusted body weight must be provided along with the calculated dose
- The member must have a diagnosis of an FDA-approved indication for use

Non-Preferred Product Specific Criteria:

- The member must meet one of the following criteria:
    - The member must have failed a trial of each of the preferred products, as evidenced by paid claims or pharmacy printouts.
    - The member is stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

IVIG

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BIVIGAM (human immunoglobulin gamma)	ASCENIV (human immune globulin G- slra)
FLEBOGAMMA DIF (human immunoglobulin gamma)	GAMMAPLEX (human immunoglobulin gamma)
GAMMAGARD S-D (human immunoglobulin gamma)	OCTAGAM (human immunoglobulin gamma)
PRIVIGEN (human immunoglobulin gamma)	PANZYGA (Immune Globulin- ifas)

IVIG/SCIG

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GAMMAGARD LIQUID (human immunoglobulin gamma)	GAMMAKED (human immunoglobulin gamma)
GAMUNEX-C (human immunoglobulin gamma)	

SCIG

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HIZENTRA (human immunoglobulin gamma)	CUTAQUIG (human immune globulin G - hipp)
	CUVITRU (human immunoglobulin gamma)
	HYQVIA (human immune globulin G and hyaluronidase)

Palforzia

Palforzia Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
    - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
    - The member does not have any contraindications to treatment

- The prescriber must be or be in consultation with an allergy and/or immunology specialist
- The provider must attest that the member has access to injectable epinephrine, and that the member/caregiver has been instructed and trained on its appropriate use
- The member must not have any of the following:
  - Uncontrolled asthma
  - A history of eosinophilic esophagitis or another eosinophilic GI disease
  - Severe or life-threatening anaphylaxis in the 60 days prior to the request
- The member must have a clinical history of allergy to peanuts or peanut-containing foods AND one of the following:
  - The member has had a serum immunoglobulin E (IgE) to peanut ≥0.35 kUA/L
  - Skin prick test (SPT) to peanut ≥ 3mm compared to control
  - Allergic reaction produced during a provider observed intake of peanuts

- **Renewal Criteria:** *Approval Duration = 6 months for continued up-titration or 12 months for maintenance the 300mg dose*
  - The member must have been compliant with Palforzia, as evidenced by pharmacy records or pharmacy claims history showing on-time fills during the last 6 months
  - The member must not have any of the following:
    - Uncontrolled asthma
    - Severe or persistent GI symptoms
    - Eosinophilic esophagitis
  - The member must have experienced and maintained clinical benefit since starting treatment with Palforzia, as evidenced by the following:
    - The member continues to have a peanut allergy and has been/is being monitored for resolution of their allergy
    - The member has been able to tolerate the maintenance dose of Palforzia (300 mg daily)
      OR
    - The prescriber has submitted a plan to continue up-titration to a final dose of 300 mg daily and have not already requested a renewal PA for the up-titration period

PA REQUIRED
PALFORZIA (peanut allergen powder)

Steroids - Nasal

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have failed a 30-day trial (within the past 2 years) of 1 preferred agent, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- ***Xhance (fluticasone):**
  - Clinical justification must be provided explaining why the member is unable to use another product with the same active ingredient (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BECONASE AQ (beclomethasone)	flunisolide
Fluticasone	mometasone
OMNARIS (ciclesonide)	XHANCE (fluticasone)***
QNASL (beclomethasone)	
QNASL CHILDREN'S (beclomethasone)	
ZETONNA (ciclesonide)	

Cardiology

Therapeutic Duplication

- One Strength of one medication is allowed at a time
  - Exceptions:
    - Carvedilol IR 25mg allowed with all other strengths
    - Warfarin strengths are allowed together
    - Prazosin strengths are allowed together

- Medication classes not payable together:
  - Entresto, ACE Inhibitors, ARBs, and Renin Inhibitors are not allowed with each other
  - Sildenafil, Tadalafil, Adempas, nitrates are not allowed with each other
  - Carvedilol and Labetalol are not allowed with other alpha blockers (Alfuzosin ER, doxazosin, dutasteride-tamsulosin, prazosin, terazosin, and tamsulosin)
    - Carvedilol and Labetalol are nonselective beta blockers with alpha 1 blocking activity
  - Tizanidine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
    - Tizanidine is also an alpha 2 agonist
  - Clopidogrel is not covered with esomeprazole or omeprazole. Other PPIs such as pantoprazole are covered with clopidogrel.
    - Clopidogrel is a substrate for 2C19 and esomeprazole and omeprazole are strong 2C19 inhibitors and can decrease effectiveness of Clopidogrel.
  - Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine are not covered with morphine. Other opioid analgesics are covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine.
    - Morphine may diminish the antiplatelet effect and serum concentrations of P2Y12 Inhibitor antiplatelet agents (clopidogrel, prasugrel, ticagrelor, and ticlopidine).

Beta Blockers – Override Request

Please have the following information when requesting an override by calling provider relations at 1-800-755-2604. Overrides may be available for beta blockers with slightly different mechanisms of action for use within the cardiac or nephrology specialty: non-selective or selective beta blocking activity; with or without alpha-1 blocker activity.

1. Are prescribers of each medication aware of the other?
2. Is a cardiologist and/or nephrologist involved in therapy who agrees to duplication?

Anticoagulants - Oral:

Underutilization

- Eliquis, Pradaxa, Xarelto, and Savaysa must be used compliantly and will reject on point of sale for late fill

Prior Authorization

General Prior Authorization Form

Product Specific Criteria:

***Xarelto 2.5mg** - Member must have an FDA approved indication.

Non-Preferred Agents Criteria:

- The member must have a diagnosis of an FDA-approved indication.
- The member must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELIQUIS (Apixaban)	SAVAYSA (edoxaban)
PRADAXA (dabigatran)	
XARELTO (rivaroxaban) 10mg, 15mg, 20mg	
XARELTO (rivaroxaban) 2.5mg PA***	
XARELTO (rivaroxaban) STARTER PACK	

Anticoagulants - Injectable

Electronic Diagnosis Verification

- Fondaparinux is covered for a diagnosis of heparin-induced thrombocytopenia (HIT)

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of enoxaparin, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
enoxaparin	ARIXTRA (fondaparinux)
fondaparinux	FRAGMIN (dalteparin)

	LOVENOX (enoxaparin)

Heart Failure

Electronic Diagnosis Verification

- Corlanor, Entresto, and Verquvo require an FDA-approved indication for use.

Prior Authorization Criteria

General Prior Authorization Form

Product Specific Criteria:

- **Verquvo:**
  - The member must meet FDA-approved age for use.
  - The member must have left ventricular ejection fraction (LVEF) < 45%
  - Documentation of a recent hospitalization or need for IV diuretics (within the past 6 months) must be submitted with request
  - The member is receiving concurrent Entresto, a beta-blocker, a SGLT-2 Inhibitor, and a mineralocorticoid receptor antagonist.
- **Corlanor:**
  - The member must meet FDA-approved age for use.
  - The member must have a resting HR ≥ 70 beats per minute on maximally tolerated or target beta blocker dose in sinus rhythm

AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACE (angiotensin-converting enzyme) inhibitors - *all oral agents preferred*	
ARBs (angiotensin receptor blockers) - *all oral agents preferred*	
Beta blockers - *all oral agents preferred*	
CORLANOR (ivabradine) PA	
ENTRESTO (sacubitril/valsartan)	
eplerenone	
FARXIGA (dapagliflozin)	
JARDIANCE (empagliflozin)	
spironolactone	
VERQUVO (vericiguat) PA	

Loop Diuretics

General Prior Authorization Form

Product Specific Criteria:

- **Ethacrynic acid**: One of the following must be met:
  - The member must have a documented sulfa allergy
  - The member must have failed a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy print outs.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
furosemide	ethacrynic acid
bumetanide	
torsemide	

Lipid-Lowering Agents

General Prior Authorization Form

Non-Preferred Agent Criteria (Initial): *Approval Duration = 3 months*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The member must have LDL levels of >100 mg/dL after a 90-day trial of each of the following, as evidenced by paid claims or pharmacy printouts:
  - A PCSK9 inhibitor combined with Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg

Product Specific Criteria:

- Evkeeza: See Medical Billing Drug Clinical Criteria
- **Juxtapid:**
    - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
    - The member must have LDL levels of >100 mg/dL after a 90-day trial of each of the following, as evidenced by paid claims or pharmacy printouts:
        - A PCSK9 inhibitor combined with Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
        - Nexlizet combined with Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
    - Clinical justification must be provided explaining why the member is unable to use all other products to lower their cholesterol (subject to clinical review)

Group Criteria (Renewal): *Approval Duration = 12 months*

- The member must currently be receiving a maximally tolerated statin (HMG-CoA reductase inhibitor) agent, as evidenced by paid claims or pharmacy printouts
- The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

ACL (ATP Citrate Lyase) INHIBITORS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
	NEXLETOL (bempedioc acid)
	NEXLIZET (bempedoic acid and ezetimibe)
Cholesterol Absorption Inhibitor - 2-Azetidinone	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Ezetimibe	ZETIA (ezetimibe)
MTP (Microsomal Triglyceride Transfer Protein) INHIBITOR	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
	JUXTAPID (lomitapide)
EICOSAPENTAENOIC ACID (ESA) ETHYL ESTER	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
VASCEPA (icosapent ethyl) – *Brand Required*	icosapent ethyl
FENOFIBRATE	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
fenofibrate capsules	fenofibrate tablets 40mg, 120mg
fenofibrate tablets 48mg, 54mg, 145mg, 160mg	FENOGLIDE (fenofibrate)
	LIPOFEN (fenofibrate)
	TRICOR (fenofibrate)
	TRIGLIDE (fenofibrate)
PCSK9 (Proprotien Convertase Subtilisin/Kexin Type 9) INHIBITORS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
PRALUENT PEN (alirocumab)	REPATHA PUSHTRONEX (evolocumab)
	REPATHA SURECLICK (evolocumab)
	REPATHA SYRINGE (evolocumab)
STATINS (HMG-CoA (3-hydroxy-3-methylglutaryl-CoA Reductase Inhibitors)	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
amlodipine/atorvastatin	ALTROPREV (lovastatin)
atorvastatin	CADUET (amlodipine/atorvastatin)
ezetimibe/simvastatin	CRESTOR (rosuvastatin)
fluvastatin	EZALLOR SPRINKLE (rosuvastatin)
LIVALO (pitavastatin)	Fluvastatin ER
lovastatin	LESCOL XL (fluvastatin)
pravastatin	LIPITOR (atorvastatin)
rosuvastatin	PRAVACHOL (pravastatin)
simvastatin	VYTORIN (ezetimibe/simvastatin)
ZYPITAMAG (pitavastatin)	ZOCOR (simvastatin)

Platelet Aggregation Inhibitors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

- The member must have had 30-day trials of at least 2 preferred platelet aggregation inhibitor agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
aspirin	clopidogrel 300mg
aspirin/dipyridamole ER	EFFIENT (prasugrel)
BRILINTA (ticagrelor)	PLAVIX (clopidogrel)
clopidogrel 75 mg	ZONTIVITY (vorapaxar)
dipyridamole	
prasugrel	

Pulmonary Hypertension

PDE-5 Inhibitors

Electronic Age Verification

- Sildenafil/Tadalafil: Prior authorization is not required for ages less than 12 years old
- Revatio Suspension: Prior authorization is not required for ages less than 9 years old

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age), with medical documentation (e.g. clinical notes) of their diagnosis attached to the request.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
REVATIO (sildenafil) SUSPENSION – *Brand Required*	ADCIRCA (tadalafil) TABLET
sildenafil tablet	ALYQ (tadalafil)
tadalafil tablet	REVATIO (sildenafil) TABLET
	sildenafil suspension

Soluble Guanylate Cyclase Stimulators

Electronic Diagnosis Verification

- The member must have an FDA-approved diagnosis for use

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ADEMPAS (riociguat)	

Endothelin Receptor Antagonists

Electronic Diagnosis Verification

- The member must have an FDA-approved diagnosis for use

Prior Authorization Criteria

Group Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of ambrisentan, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ambrisentan	bosentan
TRACLEER (bosentan) SUSPENSION	LETAIRIS (ambrisentan)
TRACLEER (bosentan) TABLETS - *Brand Required*	OPSUMIT (macitentan)

Prostacyclins

Electronic Diagnosis Verification

- The member must have an FDA-approved diagnosis for use

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ORENITRAM ER (treprostinil) TABLET	REMODULIN (treprostinil) INJECTION

UPTRAVI (selexipag) TABLET	
treprostinil injection	
TYVASO (treprostinil) INHALATION	
UPTRAVI (selexipag) VIAL	
VENTAVIS (iloprost) INHALATION	

Vecamyl

General Prior Authorization Form

Group Criteria:

- The member must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses) of all first- and second-line agents as defined by the most recent JNC report.

Dermatology

Acne

Therapeutic Duplication

- One strength of one retinoid medication is allowed at a time
- One strength of one benzoyl peroxide containing medication is allowed at a time

Electronic Age Verification

- The member must be between 12 and 35 years of age

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review)

CLINDAMYCIN-BENZOYL PEROXIDE	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
clindamycin-benzoyl peroxide 1.2%-2.5%	ACANYA (Clindamycin-benzoyl peroxide) 1.2%-2.5%
clindamycin-benzoyl peroxide 1%-5% with pump	BENZACLIN (Clindamycin/benzoyl peroxide without pump) 1%-5%
clindamycin-benzyl peroxide 1.2%-5%	BENZACLIN (Clindamycin/benzoyl peroxide with pump) 1%-5%
clindamycin/benzoyl peroxide 1%-5% without pump	NEUAC (Clindamycin/benzoyl peroxide) 1.2%-5%
ONEXTON (Clindamycin/benzoyl peroxide) 1.2%-3.75%	
CLINDAMYCIN	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
clindamycin capsule	CLEOCIN T (Clindamycin) GEL
clindamycin gel	CLEOCIN T (Clindamycin) LOTION
clindamycin lotion	CLEOCIN T (Clindamycin) MED SWAB
clindamycin solution	CLINDACIN P (Clindamycin) MED SWAB
clindamycin med. swab	CLINDACIN ETZ (Clindamycin) MED SWAB
EVOCLIN (Clindamycin) FOAM – *Brand Required*	CLINDAGEL (Clindamycin) GEL DAILY
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) - *Brand Required*	clindamycin gel daily
	clindamycin foam
	clindamycin-tretinoin 1.2%-0.025%
RETINOID	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ALTRENO (tretinoin) LOTION	ATRALIN (tretinoin) 0.05% GEL
FABIOR (tazarotene) 0.1% FOAM - *Brand Required*	ARAZLO (tazarotene) 0.045% LOTION
RETIN-A MICRO PUMP (tretinoin microsphere) 0.04%, 0.1% - *Brand Required*	clindamycin-tretinoin 1.2%-0.025%

RETIN-A MICRO PUMP (tretinoin microsphere) 0.08%	RETIN-A (tretinoin) CREAM
tretinoin cream	RETIN-A (tretinoin) GEL
tretinoin gel	RETIN-A MICRO PUMP (tretinoin microsphere) 0.06%
tretinoin microsphere without pump	RETIN-A MICRO (tretinoin microsphere) GEL WITHOUT PUMP
ZIANA (clindamycin-tretinoin 1.2%-0.025%) - *Brand Required*	tazarotene 0.1% foam
	tretinoin microsphere with pump
ADAPALENE	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
adapalene gel	adapalene cream
adapalene gel with pump	DIFFERIN (adapalene) GEL
adapalene/Benzoyl Peroxide 0.1%-2.5%	DIFFERIN (adapalene) GEL W/ PUMP
DIFFERIN (adapalene) CREAM - *Brand Required*	
DIFFERIN (adapalene) LOTION	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
BP 10-1 (sodium sulfacetamide/sulfur cleanser) 10%-1%	ACZONE (dapsone) GEL WITH PUMP 7.5%
Cleansing Wash (sulfacetamide sodium/sulfur/urea) 10%-4%-10%	AKLIEF (trifarotene) CREAM 0.005%
dapsone gel without pump 5%	BP 10-1 (sulfacetamide sodium/sulfur) CLEANSER
SSS 10-5 (sulfacetamide) FOAM	dapsone gel pump 7.5%
sulfacetamide 10% suspension	SSS 10-5 (sulfacetamide) CLEANSER
sodium sulfacetamide/sulfur cleanser 10%-5% (W/W)	sodium sulfacetamide/sulfur pads 10%-4%
sodium sulfacetamide/sulfur cleanser 9%-4%	sodium sulfacetamide/sulfur cream 10%-2%
sodium sulfacetamide/sulfur cleanser 9%-4.5%	SUMADAN (sodium sulfacetamide/sulfur) CLEANSER 9%-4.5%
sodium sulfacetamide/sulfur cleanser 9.8% -4.8%	SUMAXIN (sodium sulfacetamide/sulfur pads) PADS 10%-4%
sodium sulfacetamide/sulfur cleanser 10%-2%	SUMAXIN TS (sodium sulfacetamide/sulfur) SUSPENSION 8%-4%
sodium sulfacetamide/sulfur cleanser 10%-5%-10%	
sodium sulfacetamide/sulfur cream 10%-5% (W/W)	
sodium sulfacetamide/sulfur suspension 8%-4%	
SUMAXIN (sodium sulfacetamide/sulfur) CLEANSER 9%-4%	
TETRACYCLINES	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
doxycycline hyclate capsule	AMZEEQ (minocycline) Foam
doxycycline hyclate tablet 20mg, 100mg	demeclocycline
doxycycline monohydrate 25 mg/5mL suspension	DORYX (doxycycline hyclate) TABLET DR
doxycycline monohydrate tablet 50 mg, 75mg, 100mg	DORYX MPC (doxycycline hyclate) TABLET DR
doxycycline monohydrate capsule 50 mg, 100mg	doxycycline monohydrate capsule 75mg, 150mg
minocycline capsule	doxycycline hyclate tablet 75mg, 150 mg
tetracycline	doxycycline monohydrate tablet 150 mg
VIBRAMYCIN (Doxycycline calcium) 50 mg/5mL SYRUP	doxycycline hyclate tablet DR
	MINOCIN (minocycline) CAPSULE
	minocycline tablet
	minocycline Tablet ER
	MINOLIRA ER (minocycline) TABLET
	MORGIDOX (doxycycline hyclate) CAPSULE
	SEYSARA (sarecycline)
	SOLODYN ER (minocycline) TABLET
	VIBRAMYCIN (doxycycline monohydrate) 25mg/5mL SUSPENSION
	XIMINO (minocycline) CAPSULE ER

Actinic Keratosis

General Prior Authorization Form

Product Specific Criteria:

- Diclofenac 3% sodium gel requires electronic diagnosis verification of FDA indication

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 6-month trial of each preferred agent of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CARAC (fluorouracil) 0.5% CREAM – *Brand Required*	ALDARA (imiquimod) 0.5% CREAM
diclofenac 3% sodium gel	EFUDEX (fluorouracil) 5% CREAM
imiquimod 5% cream packet	fluorouracil 0.5% cream
fluorouracil 5% cream	imiquimod 3.75% cream pump
fluorouracil 2% solution	KLISYRI (tirbanibulin) OINTMENT
fluorouracil 5% solution	PICATO (ingenol mebutate)
ZYCLARA (imiquimod) 3.75% CREAM PUMP – *Brand Required*	TOLAK (fluorouracil) 4% CREAM
	ZYCLARA (imiquimod) 3.75% CREAM PACKET
	ZYCLARA (imiquimod) 2.5% CREAM PUMP

Antifungals – Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Onychomycosis:** *Approval Duration = 12 months*
  - The member must have a diagnosis of an FDA approved indication for use
    - Diagnosis must be confirmed by potassium hydroxide (KOH) preparation
  - The member must have had a trial of one oral agent (terbinafine, fluconazole, or itraconazole), for the length of recommended treatment time for member's particular infection, as evidenced by paid claims or pharmacy printouts
  - Adequate time must have passed since treatment cessation to accurately assess healthy toenail outgrow (at least 6 months)
  - One of the following must be met (A or B):
    A. Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review)
    B. The active ingredient of the requested product is not available in a preferred formulation
- **Other diagnoses:** *Approval Duration = 12 months*
  - The member must have had a trial of 3 preferred agents, for the length of recommended treatment time for member's particular infection, as evidenced by paid claims or pharmacy printouts
  - One of the following must be met (A or B):
    A. Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review)
    B. The active ingredient of the requested product is not available in a preferred formulation

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ciclopirox cream	CICLODAN (ciclopirox) CREAM
ciclopirox gel	CICLODAN (ciclopirox) SOLUTION
ciclopirox shampoo	EXTINA (ketoconazole) FOAM
ciclopirox solution	JUBLIA (efinaconazole) SOLUTION
ciclopirox suspension	KERYDIN (tavaborole) SOLUTION
clotrimazole cream	ketoconazole foam
clotrimazole solution	LOPROX (ciclopirox) CREAM

econazole cream	LOPROX (ciclopirox) SHAMPOO
ERTACZO (sertraconazole) CREAM	LOPROX (ciclopirox) SUSPENSION
EXELDERM CREAM (sulconazole) – *Brand Required*	LUZU (luliconazole) Cream
EXELDERM SOLUTION (sulconazole) – *Brand Required*	miconazole/zinc oxide/white petrolatum ointment
ketoconazole cream	natfifine Cream
ketoconazole shampoo	natfifine Gel
luliconazole cream	NAFTIN (naftifine) CREAM
MENTAX (butenafine) CREAM	NAFTIN (naftifine) GEL
miconazole cream	oxiconazole cream
nystatin cream	OXISTAT (oxiconazole) CREAM
nystatin ointment	OXISTAT (oxiconazole) LOTION
nystatin powder	tavaborole solution
NYAMYC (nystatin) POWDER	VUSION (miconazole/zinc/white petrolatum) OINTMENT
nystatin – triamcinolone cream	
nystatin – triamcinolone ointment	
NYSTOP (nystatin) POWDER	

Eczema / Atopic Dermatitis

Electronic Age Verification

Product Specific: Protopic (tacrolimus) ointment 0.1%

- The member must be 16 years of age or older

Prior Authorization Criteria

Topical Corticosteroids: Please see the Preferred Drug List of Topical Corticosteroids

Product Specific Criteria (Initial): *Approval Duration = 3 months*

- **Dupixent and Eucrisa**
  - Member must meet FDA label recommendations for indication and age
  - Member must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy printouts:
    - tacrolimus OR pimecrolimus
  - One of the following must be met (A or B):
    A. Member must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy printouts.
    B. Member must meet both of the following:
    - Affected area is on face, groin, axilla, or under occlusion
    - Member must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria (Renewal): *Approval Duration = 12 months*

- **Dupixent and Eucrisa**
  - The prescriber must submit documentation showing that the member has achieved a significant reduction in severity of atopic dermatitis since treatment initiation

Biologics

Prior Authorization Form - Dupixent

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)	

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
azathioprine	
cyclosporine	
methotrexate	

systemic oral corticosteroids	

Topical

General Prior Authorization Form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELIDEL (pimecrolimus) CREAM – *Brand Required*	EUCRISA (crisaborole) OINTMENT***
PROTOPIC (tacrolimus) OINTMENT 0.03% – *Brand Required*	pimecrolimus
PROTOPIC (tacrolimus) OINTMENT 0.1% – *Brand Required*	tacrolimus 0.03%
Topical Corticosteroids	tacrolimus 0.1%

Hidradenitis Suppurativa

Electronic Diagnosis Verification

- The member must have an FDA-approved indication for use

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	

Infantile Hemangioma

Electronic Age Verification

- The patient must be less than 1 years of age

Electronic Diagnosis Verification

- The patient must have an FDA approved diagnosis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HEMANGEOL (propranolol) ORAL SOLUTION	

Lice

General Prior Authorization Form

Category Criteria:

- The member must have had a 28-day/2-application trial of each preferred agent, as evidenced by paid claims or pharmacy printouts (not required *in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent).*

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
EURAX (crotamiton) CREAM	CROTAN (crotamiton)
LICE KILLING SHAMPOO (piperonyl butoxide/pyrethrins)	ELIMITE (permethrin) CREAM
NIX 1% (Permethrin) CRÈME RINSE LIQUID	EURAX (crotamiton) LOTION
Permethrin 5% cream	Lindane shampoo
SM LICE TREATMENT (permethrin) 1% CRÈME RINSE LIQUID	Malathion
Spinosad	NATROBA (spinosad)
VANALICE (piperonyl butoxide/pyrethrins)	OVIDE (malathion)

Plaque Psoriasis

Biologic Agents

Electronic Diagnosis Verification

- The member must have an FDA-approved indication for use

Prior Authorization

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 3-month trial of a TNF inhibitor and an Anti-IL 17 agent, as evidenced by paid claims or pharmacy printouts.

Anti – TNF Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	

Anti – Interleukin (IL) 12/IL-23

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	STELARA (ustekinumab)

Anti – Interleukin (IL) 17 Antibodies

Product Specific Criteria:

- The member must have had a 3-month trial of a TNF inhibitor, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
TALTZ (ixekizumab)***	COSENTYX (secukinumab)

Anti – Interleukin (IL) 17 Receptor Antibody

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	SILIQ (brodalumab)

Anti – Interleukin (IL) 23/ Interleukin (IL) 39

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	SKYRIZI (risankizumab-rzaa)
	TREMFYA (guselkumab)

Phosphodiesterase 4 (PDE4) Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
OTEZLA (apremilast)	

Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **For Foams and Sprays:**
  - Member must have failed 30-day trials of the preferred solution and shampoo formulations, as evidenced by paid claims or pharmacy print outs
- **For Lotions:**
  - Member must have failed a 30-day trial of a preferred agent, as evidenced by paid claims or pharmacy print outs
- **For Ointments:**
  - Member must have failed 30-day trials of the preferred ointment formulations, as evidenced by paid claims or pharmacy print outs

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
calcipotriene ointment	calcipotriene/betamethasone ointment
calcipotriene solution	calcipotriene/betamethasone suspension
calcipotriene cream	calcipotriene foam
ENSTILAR (calcipotriene/betamethasone) FOAM	calcitriol ointment
SORILUX (calcipotriene) FOAM – *Brand Required*	DOVONEX (calcipotriene) CREAM
TACLONEX (calcipotriene/betamethasone) SUSPENSION – *Brand Required*	DUOBRII (halobetasol/tazarotene) LOTION
TACLONEX (calcipotriene/betamethasone) OINTMENT – *Brand Required*	
tazarotene 0.1% cream	
VECTICAL (calcitriol) OINTMENT – *Brand Required*	

Steroids - Topical

Electronic Duration Verification

Class 1 topical steroids are covered for 30 days every 90 days. Joint AAD-NFP guidelines for management and treatment of psoriasis recommend limiting the use of Class 1 topical steroids to no more than twice daily up to 4 weeks.

- Transitions to lower potent agents, intermittent therapy, and combination treatment with non-steroids are recommended to minimize side effects. Class 1 steroids are covered with class 2 steroids to facilitate an alternating schedule.
- Please call for an override if the following conditions apply by calling provider relations at 1-800-755-2604:
  - Location of application: palms and soles
  - Indication: psoriasis
  - Close monitoring for side effects

Prior Authorization

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Non-preferred Step 1 agents (not labeled as "STEP 2"):**
  - The member must have failed a 2-week trial of all preferred drug entities within the same potency category and dosage form group within the last 3 months, as evidenced by paid claims or pharmacy printouts
- **Non-preferred agents labeled as "STEP 2":**
  - The member must have failed a 2-week trial of all preferred and non-preferred drug entities within the same potency category and dosage form group within the last 3 months.

SUPER-HIGH POTENCY (GROUP 1)

Dosage Form	Preferred		Non-Preferred	
Cream	clobetasol emollient	0.05%		
	clobetasol propionate	0.05%		
	fluocinonide	0.10%		
	halobetasol propionate	0.05%		
Lotion	clobetasol propionate	0.05%	betamethasone dipropionate, augmented	0.05%
			STEP 2* IMPEKLO (clobetasol)	0.05%
			STEP 2* ULTRAVATE (halobetasol) MDP	0.05%
Ointment	betamethasone dipropionate, augmented	0.05%	halobetasol propionate	0.05%
	clobetasol propionate	0.05%		
Foam, Gel, Shampoo, Solution, Spray	clobetasol propionate shampoo	0.05%	betamethasone dipropionate, augmented gel	0.05%
	clobetasol propionate solution	0.05%	clobetasol propionate foam	0.05%
	clobetasol propionate spray	0.05%	clobetasol emulsion foam	0.05%
	clobetasol propionate gel	0.05%	STEP 2* halobetasol propionate foam	0.05%

HIGH POTENCY (GROUP 2)

Dosage Form	Preferred		Non-Preferred	
Cream	betamethasone dipropionate, augmented	0.05%	STEP 2* APEXICON E (diflorasone emollient)	0.05%
	fluocinonide	0.05%	desoximetasone	0.25%
	HALOG (halcinonide)– *Brand Required*	0.10%		
Lotion			BRYHALI (halobetasol) LOTION	0.01%
Ointment	betamethasone dipropionate	0.05%	STEP 2* diflorasone diacetate	0.05%
	desoximetasone	0.25%		

	fluocinonide	0.05%		
	fluticasone propionate	0.01%		
	HALOG (halcinonide)	0.10%		
Gel, Solution, Spray	fluocinonide gel	0.05%	desoximetasone gel	0.05%
	fluocinonide solution	0.05%	desoximetasone spray	0.25%
			STEP 2* HALOG (halcinonide) SOLUTION	0.10%

HIGH POTENCY (GROUP 3)

Dosage Form	Preferred		Non-Preferred	
Cream	betamethasone dipropionate emollient	0.05%	STEP2* amcinonide	0.10%
	triamcinolone acetonide	0.50%	desoximetasone	0.05%
			STEP2* diflorasone diacetate	0.05%
			fluocinonide-E	0.05%
Lotion			amcinonide	0.10%
Ointment	betamethasone valerate	0.10%	desoximetasone	0.05%
	fluticasone propionate	0.01%		
	mometasone furoate	0.10%		
	triamcinolone acetonide	0.50%		
Foam			betamethasone valerate foam	0.12%

MEDIUM POTENCY (GROUP 4)

Dosage Form	Preferred		Non-Preferred	
Cream	fluticasone propionate	0.05%	STEP2* clocortolone pivalate	0.10%
	mometasone furoate	0.10%		
	triamcinolone acetonide	0.10%		
Ointment	fluocinolone acetonide	0.025%	hydrocortisone valerate	0.20%
	triamcinolone acetonide	0.10%	STEP2* flurandrenolide	0.05%
	triamcinolone acetonide	0.05%		
Aerosol, Solution, Spray	mometasone furoate solution	0.10%	triamcinolone acetonide aerosol	0.147 MG/G
			STEP2* SERNIVO (betamethasone) SPRAY	0.05%

LOWER-MID POTENCY (GROUP 5)

Dosage Form	Preferred		Non-Preferred	
Cream	betamethasone valerate	0.10%	fluocinolone acetonide	0.03%
	PANDEL (hydrocortisone probutate)	0.10%	prednicarbate	0.10%
			STEP2* flurandrenolide	0.05%
			hydrocortisone butyrate	0.10%
			hydrocortisone butyrate emollient	0.10%
			hydrocortisone valerate	0.20%
Lotion	betamethasone dipropionate	0.05%	flurandrenolide	0.05%
	triamcinolone acetonide	0.10%	fluticasone propionate	0.05%
Ointment	desonide	0.05%	hydrocortisone butyrate	0.10%

	triamcinolone acetonide	0.025%	prednicarbate	0.10%
Gel, Solution	hydrocortisone butyrate solution	0.10%	desonide gel	0.05%

Low Potency (Group 6)

Dosage Form	Preferred		Non-Preferred	
Cream	alclometasone dipropionate	0.05%	fluocinolone acetonide	0.01%
	desonide	0.05%		
	triamcinolone acetonide	0.03%		
Lotion	betamethasone valerate lotion	0.10%		
	desonide lotion	0.05%		
	triamcinolone acetonide lotion	0.025%		
Ointment	alclometasone dipropionate	0.05%		
Oil, Shampoo, Solution	CAPEX (flucinolone) SHAMPOO	0.01%		
	fluocinolone acetonide oil	0.01%		
	fluocinolone acetonide solution	0.01%		

Least Potent (Group 7)

Dosage Form	Preferred		Non-Preferred	
Cream	hydrocortisone	2.50%		
Lotion	hydrocortisone	2.50%		
Ointment	hydrocortisone	2.50%		
Solution			TEXACORT (hydrocortisone) SOLUTION	2.50%

Endocrinology

Androgens

General Prior Authorization Form

Group Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of each preferred agent with a comparable route of administration, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

Injectable

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
testosterone cypionate injection	AVEED (testosterone undecanoate)
testosterone enanthate injection	DEPO-TESTOSTERONE (testosterone cypionate)
	XYOSTED (testosterone enanthate)

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
JATENZO (testosterone undecanoate)	ANDROID (methyltestosterone)
	methyltestosterone
	METHITEST (methyltestosterone)
	TESTRED (methyltestosterone)

Topical

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ANDRODERM (testosterone) PATCH	ANDROGEL (testosterone)
testosterone 1% (50mg/5g) gel packet	FORTESTA (testosterone) 2% (10mg/0.5g) GEL MD PMP
testosterone 1% (25mg/2.5g) gel packet	TESTIM (testosterone) GEL TUBE
testosterone 1% (25mg/2.5g) gel tube	testosterone 2% (10mg/0.5g) gel MD PMP bottle
testosterone 1% (50mg/5g) gel tube	testosterone 1.62% (20.25mg/1.25g) gel packet
testosterone 1% (12.5mg/1.25g) gel MD PMP bottle	testosterone 1.62% (40.5mg/2.5g) gel packet
testosterone 1.62% (20.25mg/1.25g) gel MD PMP bottle	VOGELXO (testosterone)
testosterone 2% (30mg/1.5g) solution MD PMP	

Diabetes

References:

1. American Diabetes Association Diabetes Care 2020 Jan; 43(Supplement 1): S98-S110. https://doi.org/10.2337/dc20-S009

Underutilization

- Toujeo, Tresiba, and Metformin 1000mg must be used compliantly and will reject on point of sale for late fill

Therapeutic Duplication

- One Strength of one medication is allowed at a time
- Medication classes not payable together:
  - DPP4-Inhibitors and GLP-1 Agonists
    - GLP-1 and DPP4-Inhibitors should not be used concurrently due to similar mechanisms of action
  - DPP4-Inhibitors and Insulins
    - GLP-1 should be considered in most members prior to insulin
    - When initiating injectable therapy, sulfonylureas and DPP-4 inhibitors are typically discontinued
  - Sulfonylureas and Insulins
    - When initiating injectable therapy, sulfonylureas and DPP-4 inhibitors are typically discontinued
  - Humulin R U-500 is not allowed with any other insulin (basal or prandial)
    - Humulin R U-500 is indicated for monotherapy. It acts differently than regular insulin (U-100). It provides both basal and prandial coverage. Injections can be increased to 3 times per day for prandial coverage.

Covered options in combination with Insulin therapy:

GLP-1 Agonists, SGLT-2 inhibitors, TZDs, and metformin.

- GLP-1 Agonist and SGLT-2 inhibitors are recommended first line treatments for every pathway indicated in the guidelines (ASCVD, HF, CKD, hypoglycemia risk, and to minimize weight gain)
- TZDs increase insulin sensitivity and hypoglycemia risk should be monitored
- Metformin is recommended throughout treatment escalation.

DPP4-Inhibitors

Electronic Age Verification

- The member must be 18 years or older for Januvia, Janumet, or Janumet XR

Electronic Step Care and Concurrent Medications

- DPP4-Inhibitors require concurrent metformin
  - A total of 84-day supply of metformin must be paid within 100 days prior to the DPP4-Inhibitor's date of service.
    - Metformin is recommended to be continued with escalation of therapy with DPP4-Inhibitors. If metformin is not tolerated, SGLT2 inhibitor and GLP-1 Agonists are recommended as part of the glucose-lowering regimen independent of A1C and are first line alternatives.
    - Members with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER.

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial with EACH of the following agents, as evidenced by paid claims or pharmacy printouts:
    - A preferred sitagliptin product (Janumet, Janumet XR, or Januvia)
    - A preferred linagliptin preferred product (Jentadueto or Tradjenta)
    - A preferred SGLT2 inhibitor

++Clinically Non-Preferred: Alogliptin and Saxagliptan have a potentially higher risk for heart failure

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
JANUMET (sitagliptin/metformin)	++alogliptan/pioglitazone
JANUMET XR (sitagliptin/metformin)	++alogliptin
JANUVIA (sitagliptin)	++alogliptin/metformin
JENTADUETO (linagliptin/metformin)	++KAZANO (alogliptin/metformin)
JENTADUETO XR (linagliptin/metformin)	++KOMBIGLYZE XR (saxagliptin/metformin)
TRADJENTA (linagliptin)	++NESINA (alogliptin)
	++ONGLYZA (saxagliptin)
	++OSENI (alogliptin/pioglitazone)

DPP4-Inhibitors/SGLT2 Inhibitors Combination

General Prior Authorization Form

Non-Preferred Agent Criteria:

- The prescriber must provide medical justification explaining why the member cannot use individual preferred products separately

++Clinically Non-Preferred: Saxagliptan has a potentially higher risk for heart failure

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
TRIJARDY XR (empagliflozin/linagliptan/metformin)	GLYXAMBI (empagliflozin/linagliptin)
	STEGLUJAN (ertugliflozin/sitagliptin)
	++QTERN (dapagliflozin/saxagliptin)

GLP-1 Agonists

General Prior Authorization Form

Non-Preferred Step 1 Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had 90-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Victoza
    - An SGLT-2 Inhibitor: Jardiance, Farxiga, or Invokana

Non-Preferred Step 2 Agents Criteriae

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had 90-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Victoza
    - An SGLT-2 Inhibitor: Jardiance, Farxiga, or Invokana
    - Trulicity titrated to max dose

++Clinically Non-Preferred: Byetta is less effective than other available agents

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (STEP 1 – PA REQUIRED)	NON-PREFERRED AGENTS (STEP 2 – PA REQUIRED)
VICTOZA (liraglutide)	TRULICITY (dulaglutide)	ADLYXIN (lixisenatide)
		BYDUREON BCISE (exenatide microspheres)
		++BYETTA (exenatide)
		OZEMPIC (semaglutide)

		RYBELSUS (semaglutide)

Gastroparesis

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 3 months*
  - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - Clinical justification must be provided explaining why the member is unable to use an oral dosage formulation (including ODT and solution formulations) with relevant medical documentation (e.g. swallow study) attached to the request, subject to clinical review.
- **Renewal Criteria:** *Approval Duration = 3 months*
  - The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
metoclopramide tablet	GIMOTI (metoclopramide nasal spray)

Glucose Rescue Medications

Electronic Duration Verification

- 2 doses (initial and replacement doses) are covered every 180 days without prior authorization.
  - The following information will need to be submitted as a follow up for the override by either emailing medicaidpharmacy@nd.gov or documenting on General Prior Authorization Form:
    - The provider must attest if it is known that the previous dose was taken by the member (and not diverted or given to another person)
    - One of the following criteria must be met (A, B, or C)
      A. The previous dose has expired
      B. The dose was used by member for a hypoglycemic episode
      C. The member is currently taking insulins or sulfonylureas and meets one of the following criteria:
        - The diabetes treatment has been adjusted to prevent future instances of hypoglycemia
        - The provider has provided medical justification why the diabetes treatment has not been adjusted at this time to prevent future instances of hypoglycemia.

Prior Authorization

General Prior Authorization Form:

Product Specific Criteria: Baqsimi and Zegalogue
One of the following criteria must be met:

- The member must have had a trial of glucagon kit, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

Non-Preferred Criteria:

- The member must have had a trial of Baqsimi, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BAQSIMI (glucagon) SPRAY PA***	GVOKE (glucagon)
Glucagon Kit	GLUCOGEN (glucagon) HYPOKIT
ZEGALOGUE (dasiglucagon) AUTOINJECTOR PA***	

Insulin/GLP-1 Agonist Combination

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the member cannot use the individual preferred products separately (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	SOLIQUA (Insulin glargine/lixisenatide)

	XULTOPHY (insulin degludec/liraglutide)

Insulin

Electronic Duration Verification

- Products containing NPH insulin are limited to 210 days of coverage for every 365 days to allow for use in pregnancy and breastfeeding.
    - Lantus and Levemir have been demonstrated to reduce the risk of symptomatic and nocturnal hypoglycemia compared with NPH insulin.
    - For an override request: please submit clinical justification explaining why the member is unable to use Lantus or Levemir (subject to clinical review) and attach to Insulin Prior Authorization Form

Quantity Limit

- **Toujeo Max Solostar 300 unit/mL and Tresiba 200 unit/mL:**
    - Doses between 100 unit/day to 200 unit/day are covered automatically (do not require prior authorization approval for coverage).
        - Please request an override if day supply is less than 30 days and dose is between 100 units/day and 200 units/day by calling 1-800-755-2604 (e.g. short-cycle filling).
    - **For dose <100 unit/day**, member must meet prior authorization criteria
    - **For dose >200 units of insulin per day**, clinical justification must be provided explaining why the member is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin).

Prior Authorization

General Prior Authorization Form

Product Specific Criteria:

- **Fiasp:** *Approval 12 months*
    - The member must have had a 3-month trial of one of the following agents, as evidenced by paid claims or pharmacy printouts.
        - Novolog, Humalog, or Apidra
- **Humalog U-200:** *Approval 12 months*
    - Clinical justification must be provided why member cannot tolerate the volume of insulin required to use Humalog U-100 or tolerate two injections per dose
    - if insulin requirement is > 200 units/day: clinical justification must be provided why member is not a candidate for Humulin R U-500
    - Request must not be for use in an insulin pump: HUMALOG® (insulin lispro) 200 Units/mL: Do Not Use in a Pump (lillymedical.com)
- **Regular Insulin (Humulin R / Novolin R / Afrezza):** *Approval 12 months*
    - The member must have had a 3-month trial of two of the following agents, as evidenced by paid claims or pharmacy printouts.
        - Novolog, Humalog, or Apidra

    ++**Clinically Non-Preferred:** ACOG guidelines prefer insulin analogues (insulin aspart and lispro) over regular insulin due to better compliance, better glycemic control, and overall fever hypoglycemic episodes
        - ACOG: American College of Obstetricians and Gynecologists

- **Toujeo Solostar and Tresiba:**
    - **Initial Criteria:** *Approval 6 months*
        - The requested agent must be prescribed by or in consultation with an endocrinologist or diabetes specialist.
        - The member has had a 90-day trial with good compliance, as evidenced by paid claims or pharmacy printouts, of each of the following:
            - Lantus
            - Levemir
        - One of the following must be met, as evidenced by provided clinical notes or labs (1 or 2):
            - The member experiences recurrent episodes of hypoglycemia despite adjustments to current regimen (prandial insulin, interacting drugs, meal, and exercise timing).
            - The member must be experiencing inconsistent blood sugars
        - ~~Basal insulin requirement is less than 100 units per day~~
        - ~~**Toujeo Solostar 300 unit/mL**: Clinical justification must be provided explaining why the patient needs for a smaller volume of insulin (max is 80 units/injection for both Insulin glargine 300 units/mL and 100 units/mL. Patients using Insulin glargine 300 unit/mL may require more basal insulin than those receiving 100 units/mL).~~
    - **Renewal Criteria:** *Approval 12 months*

        - The member must have experienced at least one of the following, as evidenced by provided clinical notes or labs:
            - Reduction in frequency and/or severity of hypoglycemia
            - Improved glycemic control (A1C)
- **All other non-preferred insulins:**
    - Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

Rapid Acting Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG (insulin lispro) CARTRIDGE	++AFREZZA (insulin regular, human)
HUMALOG U-100 (insulin lispro) KWIKPEN – *Brand Co-Preferred*	FIASP (insulin aspart) CARTRIDGE***
HUMALOG (insulin lispro) VIAL– *Brand Co-Preferred*	FIASP (insulin aspart) SYRINGE***
HUMALOG JUNIOR KWIKPEN (insulin lispro) – *Brand Co-Preferred*	FIASP (insulin aspart) VIAL***
Insulin aspart cartridge	HUMALOG U-200 (insulin lispro) KWIKPEN
Insulin aspart syringe	++HUMULIN R (insulin regular, human) VIAL
Insulin aspart vial	LYUMJEV (Insulin lispro-aabc) KWIKPEN
Insulin lispro junior syringe	LYUMJEV (Insulin lispro-aabc) VIAL
Insulin lispro cartridge	++NOVOLIN R (insulin regular, human) FLEXPEN
Insulin lispro syringe	++NOVOLIN R (insulin regular, human) VIAL
Insulin lispro vial	
NOVOLOG (insulin aspart) CARTRIDGE – *Brand Co-Preferred*	
NOVOLOG (insulin aspart) FLEXPEN – *Brand Co-Preferred*	
NOVOLOG (insulin aspart) VIAL– *Brand Co-Preferred*	
Intermediate Acting Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NOVOLIN N (insulin NPH human isophane) FLEXPEN	HUMULIN N (insulin NPH human isophane) VIAL
HUMULIN R (Insulin regular, human) U-500 KWIKPEN	HUMULIN N (insulin NPH human isophane) KWIKPEN
HUMULIN R U-500 (insulin regular, human) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL
Long Acting Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
LANTUS (insulin glargine) SOLOSTAR	BASAGLAR KWIKPEN U-100 (insulin glargine)
LANTUS (insulin glargine) VIAL – *Brand Required*	SEMGLEE (insulin glargine)
LEVEMIR (insulin detemir) VIAL	TOUJEO SOLOSTAR (insulin glargine)***
LEVEMIR (insulin detemir) FLEXTOUCH	TRESIBA (insulin degludec) FLEXTOUCH U-100***
TOUJEO MAX SOLOSTAR (insulin glargine)[PA]***	TRESIBA (insulin degludec) VIAL***
TRESIBA (insulin degludec) FLEXTOUCH U-200 [PA]***	
Mixed Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN – *Brand Required*	NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	
HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
Insulin aspart protamine/insulin aspart insulin pen	

Insulin aspart protamine/insulin aspart vial	
Insulin lispro mix 75/25 kwikpen	

SGLT2 Inhibitors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of each preferred SGLT2 inhibitor of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FARXIGA (dapagliflozin)	STEGLATRO (ertugliflozin
INVOKANA (canagliflozin)	STEGLATROMET (ertugliflozin/metformin)
INVOKAMET (canagliflozin)	
INVOKAMET XR (canagliflozin/metformin)	
JARDIANCE (empagliflozin)	
SYNJARDY (empagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)	
XIGDUO XR (dapagliflozin/metformin)	

Sulfonylureas

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have failed a 30-day trial of glipizide, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use the preferred agents and other classes of medication (subject to clinical review).

++Clinically Non-preferred: Glyburide is not recommended due to hypoglycemia

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
glimepiride	++glyburide
glipizide	++glyburide/metformin
glipizide/metformin	++glyburide, micronized
glipizide ER	++GLYNASE (glyburide, micronized)

Growth Hormone

Prior Authorization Form - Growth Hormone

Category Criteria:

- Members new to GH therapy must meet the criteria below and be started on a preferred growth hormone.
    - Members continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone.
- **For Initial or Renewal Requests:**
    - Member must have a diagnosis of a **covered indication** (listed below):
        - Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
        - Turner's syndrome
        - SHOX syndrome
        - Noonan syndrome
        - Chronic renal insufficiency
        - Prader–Willi syndrome
        - Endogenous growth hormone deficiency
    - For all covered indications:
        - Member must not have active malignancy
        - Prescriber must be an endocrinologist or nephrologist, or prescriber must have at least one annual consultation about the member with the pediatric specialty.

        - Member must not have epiphyseal closure and must still be growing, unless one of the below exceptions is present:
            - Exceptions:
                - Member has a diagnosis of Prader-Willi syndrome
                - Member has a diagnosis of endogenous growth hormone deficiency - and is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose.
                    - Skytrofa is contraindicated in patients with epiphyseal closure
    - Diagnosis of chronic renal insufficiency (additional criteria):
        - Member must not have received a renal transplant.
        - Member must consult with a dietitian to maintain a nutritious diet.
    - Diagnosis of Prader–Willi syndrome (additional criteria):
        - Sleep apnea must be ruled out by sleep study in obese members.
        - Member must consult with a dietitian to maintain a nutritious diet.
- **Additional Criteria for Initial Authorization Requests:**
    - Diagnosis of endogenous growth hormone deficiency:
        - Must meet ONE of below criteria (A OR B)
            A. Members with multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation) must have an IGF-1 or IGFBP-3 level of less than SDS -1.3.
            B. Member must have had two GH stimulation tests by insulin, levodopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart

- **Additional Criteria for Subsequent Authorization**
    - For all covered indications:
        - Member must have been compliant with growth hormone (last 6 fills must have been on time).
    - Diagnosis of Prader–Willi syndrome (additional criteria):
        - If member is obese, BMI must have decreased. If member is not obese, BMI must have maintained or decreased.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NORDITROPIN FLEXPRO (somatropin)	GENOTROPIN (somatropin)
	GENOTROPIN MINIQUICK (somatropin)
	NUTROPIN AQ (somatropin)
	OMNITROPE (somatropin)
	SAIZEN (somatropin)
	SKYTROFA (somatropin)
	ZOMACTON (somatropin)

Serostim

Prior Authorization Form - Growth Hormone

Product Specific Criteria (Initial):

- Member must have a diagnosis of treatment of HIV with wasting cachexia
- Member must not have an active malignancy
- Prescriber must be experienced in the diagnosis and management of HIV infection
- Member must be on concomitant antiretroviral therapy
- Member must have failed a 3-month trial with Megace, as evidenced by paid claims or pharmacy Printouts

Product Specific Criteria (Renewal):

- Lean body mass and body weight must have increased in the past 12 weeks
- Physical endurance must have increased in past 12 weeks
- Member must not have completed 48 weeks of continuous treatments

Zorbtive

Prior Authorization Form - Growth Hormone

Product Specific Criteria:

- Member must not have active malignancy
- Member must have diagnosis of short bowel syndrome
- Member must be receiving specialized nutritional support
- Treatment duration must not be longer than 4 weeks

Imcivree

General Prior Authorization Form

- **Initial Criteria:** *Approval Duration = 4 months*
  - The member must have a diagnosis of obesity (BMI > 30 kg/m2 for adults or > 95th percentile using growth chart assessments for pediatric members), as confirmed by genetic testing attached to the request
  - The member's obesity must be due to one of the following variants interpreted as pathogenic, likely pathogenic, or of unknown significance:
    - proopiomelanocortin (POMC)
    - proprotein convertase subtilisin/kexin type 1 (PCSK1)
    - leptin receptor (LEPR) deficiency
  - The member must be 6 years of age or older
  - The medication is prescribed by, or in consultation with, an endocrinologist or expert in rare genetic disorders of obesity
  - The member's weight and body mass index (BMI) must be provided within the last 60 days
  - The member must not have significant renal impairment (eGFR <60 mL/minute/1.73 m2)

- **Renewal Criteria:** *Approval Duration = 12 months*
  - The member must have achieved or maintained a 5% weight reduction or 5% of BMI for members < 18 years old, since starting treatment with Imcivree, as evidenced by medical documentation (e.g. chart notes) attached to the request.

PREFERRED AGENTS (CLINICAL PA REQUIRED)
IMCIVREE (Setmelanotide)

GI - Gastroenterology

Bowel Prep Agents

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 1 month*

- The member must have a diagnosis of an FDA-approved indication for use
- One of the following must be met (A or B):
  - A. The member must have failed a trial of each preferred agent within the past 2 years, as evidenced by paid claims or pharmacy printouts
  - B. Clinical justification must be provided explaining why the member is unable to use the preferred agents, with medical documentation (e.g. chart notes) documenting the reason(s) preferred agents cannot be used (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CLENPIQ	GAVILYTE-N
GAVILYTE-C	GOLYTELY 236-22.74G
GAVILYTE-G	NULYTELY
GOLYTELY 227.1-21.5	PEG 3350/SOD SUL/NACL/KCL/ASB/C
MOVIPREP – *Brand Required*	PLENVU
OSMOPREP	SUPREP
PEG-3350 AND ELECTROLYTES 236-22.74G	SUTAB
PEG 3350-ELECTROLYTE 420 G	
TRILYTE	

Crohn's Disease

Electronic Diagnosis Verification

- The member must have an FDA-approved indication for use

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 3-month trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Anti – TNF inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	CIMZIA (certolizumab)

Anti – interleukin (IL) 12/IL-23

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	STELARA (ustekinumab)

Clostridium difficile-associated diarrhea (CDAD)

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 5 days*

- The member must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- The member must have failed a 10-day trial with a preferred agent, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FIRVANQ (vancomycin) SOLUTION 25mg/mL	DIFICID (fidaxomicin) 40 MG/ML SUSPENSION
Vancomycin capsule	DIFICID (fidaxomicin) TABLET
Vancomycin solution 50mg/mL	FIRVANQ (vancomycin) SOLUTION 50 MG/ML
	VANCOCIN (vancomycin) CAPSULE

Constipation – Irritable Bowel Syndrome/Opioid Induced

Therapeutic Duplication

- One medication is allowed at a time

Idiopathic Constipation

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of Linzess, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria

- ***Motegrity: The member must have had a 30-day trial with Trulance, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone) - *Brand Required*	LINZESS (linaclotide) 72 mcg
LINZESS (linaclotide) 145 mcg, 290 mcg	lubiprostone
	MOTEGRITY (prucalopride)***
	TRULANCE (plecanatide)

Opioid-Induced Constipation:

Electronic Step Care and Concurrent Medications

- Medications indicated for opioid-induced constipation should be discontinued when opioids are stopped.
    - A total of 28 days of opioid analgesics must be paid within 40 days prior to requested Movantik, Symproic, or Relistor's date of service

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had 30-day trials of each of the oral preferred agents, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone) - *Brand Required*	lubiprostone
MOVANTIK (naloxegol)	RELISTOR (methylnaltrexone) TABLET
RELISTOR (methylnaltrexone) SYRINGE	SYMPROIC (naldemedine)
RELISTOR (methylnaltrexone) VIAL	

Diarrhea

Electronic Step Care and Concurrent Medications

- Xifaxan: Xifaxan 550mg does not require prior authorization for hepatic encephalopathy if used concurrently with lactulose
  - A total of 30 days of Lactulose must be paid within 65 days prior to Xifaxan's date of service
  - An override may be available after an adequate trial of Lactulose where Lactulose is not tolerated

Non-Preferred Agents Criteria:

- **Initial Criteria**: *Approval Duration = 3 months*
  - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis, age, and duration of treatment).
  - The provider must submit medication documentation confirming that infectious and medication-induced etiologies of diarrhea have been ruled out
  - The member must have had a 30-day trial of each preferred unique active ingredient, as evidenced by paid claims or pharmacy printouts.
- **Product Specific Criteria:**
  - ***__alosetron__: The member must be a female.
- **Renewal Criteria:** *Approval Duration = 12 months*
  - The member must have experienced and maintained clinical benefit since starting treatment with requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

Irritable Bowel Syndrome

General Prior Authorization Form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
dicyclomine capsule	alosetron***
dicyclomine tablet	dicyclomine oral syrup
diphenoxylate/atropine	LOMOTIL (diphenoxylate/atropine)
loperamide	VIBERZI (eluxadoline)
LOTRONEX (alosetron)*** - *Brand Required*	XIFAXAN (rifaximin) 550 mg tablet

HIV/AIDs

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
diphenoxylate/atropine	LOMOTIL (diphenoxylate/atropine)
loperamide	MYTESI (crofelemer)

Digestive Enzymes

General Prior Authorization Form

Non-Preferred Agents Criteria:

- A 30-day trial of all PREFERRED AGENTS will be required before a non-preferred agent will be authorized unless member stable on a pancreatic enzyme written by a gastroenterologist or pancreas disease specialist

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)

ZENPEP (lipase/protease/amylase)	PERTZYE (lipase/protease/amylase)
	VIOKACE (lipase/protease/amylase)

Proton Pump Inhibitor

References

1. Katz PO, Gerson LB, Vela MF. Guidelines for the diagnosis and management of gastroesophageal reflux disease. Am J Gastroenterol 2013;108:308-28.
2. Fackler WK, Ours TM, Vaezi MF, Richter JE. Long-term effect of H2RA therapy on nocturnal gastric breakthrough. Gastroenterology. 2002;122:625-632.

Therapeutic Duplication

- One strength of one medication is allowed at a time
- Proton Pump Inhibitors is not allowed with:
  - Esomeprazole or omeprazole are not covered with clopidogrel. Other PPIs such as pantoprazole are covered with clopidogrel.
    - Clopidogrel is a substrate for 2C19 and esomeprazole and omeprazole are strong 2C19 inhibitors and can decrease effectiveness of Clopidogrel.
  - Dextroamphetamine/Amphetamine ER
    - Proton Pump Inhibitors increase blood levels and potentiate the action of amphetamine. Co-administration of Adderall XR and gastrointestinal or urinary alkalizing agents should be avoided
  - H2 Blockers:
    - **Please call for an override** if any of the following circumstances apply by calling provider relations at 1-800-755-2604:
      - Member is experiencing nocturnal symptoms after compliance with nighttime dose of proton pump inhibitor. A two-month override may be approved for concurrent H2 blocker use.
      - H2 blocker is being used concurrently with a H1 blocker for severe allergy prophylaxis, unrelated to PPI use for GI symptoms

Electronic Age Verification

- Nexium 2.5mg and 5mg Packet: The member must be less than 1 years old (or less than 7.5kg)

Electronic Step Care and Concurrent Medications

Non-Preferred Agents Criteria - Step 1 Agents:

- A total of 28 days of 2 preferred agents at max dose must be paid within 365 days prior to non-preferred step 1 agents date of service.

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria - Step 2 Agents: *Approval Duration = 6 months*

- Member must have had a 30-day trial with all preferred agents, as evidenced by paid claims or pharmacy print outs
- Clinical justification must be provided explaining why the member is unable to use the other agents (subject to clinical review).

Solid Dosage Forms

SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
DEXILANT (dexlansoprazole)	esomeprazole magnesium	ACIPHEX (rabeprazole)
lansoprazole	rabeprazole	NEXIUM (esomeprazole)
omeprazole		omeprazole-sodium bicarbonate
pantoprazole		PREVACID (lansoprazole)
		PRILOSEC (omeprazole)
		PROTONIX (pantoprazole)

Non-Solid Dosage Forms

NON-SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
NEXIUM (esomeprazole) PACKET *– Brand Required*	PRILOSEC SUSPENSION (omeprazole)	ACIPHEX SPRINKLE (rabeprazole)
omeprazole ODT		esomeprazole solution packet
PREVACID (lansoprazole) SOLUTAB		lansoprazole ODT

– Brand Required		
PROTONIX (pantoprazole) PACKET *– Brand Required*		omeprazole-sodium bicarbonate packet
		pantoprazole packet

Ulcerative Colitis

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of each preferred biologic agent, as evidenced by paid claims or pharmacy printouts.

Biologic Agents

Electronic Diagnosis Verification

- The member must have an FDA-approved indication for use

Anti – TNF inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	SIMPONI (golimumab)

Anti – interleukin (IL) 12/IL-23

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	STELARA (ustekinumab)

Janus Kinase (JAK) Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
XELJANZ (tofacitinib)	
XELJANZ XR (tofacitinib)	

Sphingosine 1-Phosphate (S1P) Receptor Modulator

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	ZEPOSIA (ozanimod)

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
APRISO (mesalamine) CAPSULE – *Brand Required*	AZULFIDINE (sulfasalazine)
ASACOL HD (mesalamine) – *Brand Required*	AZULFIDINE DR (sulfasalazine)
balsalazide capsule	COLAZAL (balsalazide)
DELZICOL (mesalamine) CAPSULE– *Brand Required*	mesalamine DR
DIPENTUM (olsalazine)	mesalamine ER
LIALDA (mesalamine) TABLET– *Brand Required*	mesalamine HD
PENTASA (mesalamine)	
sulfasalazine DR tablet	
sulfasalazine tablet	

Rectal

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
hydrocortisone enema	CANASA (mesalamine) SUPPOSITORY
mesalamine enema	mesalamine enema kit
mesalamine rectal suppository	ROWASA (mesalamine) ENEMA KIT
	SF ROWASA (mesalamine) ENEMA
	UCERIS (budesonide) RECTAL FOAM

Genetic and Rare Disease

Biologics

General Prior Authorization Form

Category Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age) as follows:

Chronic Infantile Neurological, Cutaneous and Articular Syndrome
Schnitzler Syndrome
Sterile Multifocal Osteomyelitis with Periostitis and Pustulosis

PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KINERET (anakinra)	

Deficiency of IL-A Receptor Antagonists (DIRA)

PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ARCALYST (ritonacept)	
KINERET (anakinra)	

Cytokine release syndrome

PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACTEMRA (tocilizumab)	

Phenylketonuria

Kuvan:

Underutilization

- Kuvan must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 2 months*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have been compliant with a PHE restricted diet for past 6 months.
- The member must not have been known to have two null mutations in TRANS
- Baseline PHE levels must be attached
    - For females of childbearing potential: PHE levels must be above 360 micromoles/liter
    - For males or females unable to bear children: PHE levels must be above 600 micromoles/liter
- The member's weight must be provided. Requested initial dose must be 10 mg/kg or less.

Criteria for renewal requests: *Approval Duration = 12 months*

- The member's weight must be provided
- If dose is the same or less than previous trial:
    - PHE level must be between 60 and 360 micromoles per liter
- For a dose increase from previous trial:
    - PHE levels must be attached that were taken after 1 month of previous trial
    - The member's PHE level must be greater than 360 micromoles per liter
    - For increase > 10 mg/kg - member must have failed a trial of 1 month of 10 mg/kg

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KUVAN (sapropterin) – *Brand Required*	sapropterin

Palynziq (pegvaliase-pqpz):

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 6 months*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- PHE levels must be above 600 micromoles/liter
- The member must have been compliant with a PHE restricted diet and medication management for past 6 months.

Criteria for renewal requests: *Approval Duration = 12 months*

- **If dose is the same or less than previous trial:**
  - PHE level must be between 60 and 360 micromoles per liter
- **For a dose increase to 40 mg:**
  - PHE levels must be attached that were taken after 24 weeks of 20 mg
  - The member's PHE level must be greater than 360 micromoles per liter

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PALYNZIQ (pegvaliase-pqpz)	

Hematology/Oncology

Antihemophilic Factor Products

General Prior Authorization Form

Category Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The date of the member's last appointment with a Hemophilia Treatment Center must be within the past year.
- Contact information for treatment center must be provided

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the member is unable to use the PREFERRED AGENTS (subject to clinical review).
- The member may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

FACTOR VIIa	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NOVOSEVEN RT (coagulation Factor VIIa recombinant)	
SEVENFACT (coagulation Factor VIIa recombinant)	
FACTOR VIII – HEMOPHILIA A	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Non-Extended Half Life	
ADVATE (factor VIII recombinant)	KOVALTRY (factor VIII recombinant)
AFSTYLA (factor VIII recombinant, single chain)	NUWIQ (factor VIII recombinant)
HEMOFIL M (factor VIII plasma derived; mAb-purified)	
KOATE (factor VIII plasma derived, chromatography purified)	
KOGENATE FS (factor VIII recombinant)	
NOVOEIGHT (factor VIII recombinant)	
OBIZUR (recombinant, B domain-deleted porcine (pig) factor VIII)	
RECOMBINATE (factor VIII recombinant)	
XYNTHA (factor VIII recombinant)	
XYNTHA SOLOFUSE (factor VIII recombinant)	
Extended Half Life	
ESPEROCT (factor VIII recombinant, glycopegylated – exei)	ADYNOVATE (factor VIII recombinant, PEGylated)
	ELOCTATE (factor VIII recombinant, Fc fusion protein)
	JIVI (factor VIII recombinant, pegylated-aucl)
FACTOR VIII:C – HEMOPHILIA A	

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
MONOCLATE-P (Antihemophilic Factor VIII:C (human))	
FACTOR VIII – HEMOPHILIA A/vWF	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ALPHANATE (Antihemophilic Factor/Von Willebrand Factor Complex (Human))	
HUMATE-P (Factor VIII/von Willebrand Factor (human))	
WILATE (Factor VIII/von Willebrand Factor (human))	
FACTOR VIII – VON WILLEBRAND FACTOR - RECOMBINANT	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
	VONVENDI (Recombinant human vWF)
FACTOR IX – HEMOPHILIA B	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Non-Extended Half Life	
ALPHANINE SD (factor IX, plasma-derived)	
BENEFIX (factor IX recombinant)	
IXINITY (factor IX recombinant)	
MONONINE (factor IX, plasma-derived mAb purified)	
PROFILNINE (factor IX complex)	
RIXUBIS (factor IX recombinant)	
Extended Half Life	
ALPROLIX (factor IX recombinant, Fc fusion)	IDELVION (factor IX recombinant, albumin fusion)
	REBINYN (factor IX recombinant, glycol-PEGylated)
FACTOR IXa/IX	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HEMLIBRA (Emicizumab-kxwh)	
FACTOR X	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
COAGADEX (Coagulation Factor X (Human))	
FACTOR X	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
CORIFACT (Factor XIII Concentrate (Human))	
FACTOR XIII A – SUBUNIT, RECOMBINANT	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
TRETTEN (Factor XIII A-Subunit, recombinant)	
ANTI-INHIBITOR COAGULANT COMPLEX	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
FEIBA NF (Anti-Inhibitor Coagulant Complex)	

Paroxysmal Nocturnal Hemoglobinuria (PNH)

Soliris/Ultomiris: See Medical Billing Drug Clinical Criteria

Empaveli

Empavali - Prior Authorization Form

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 18 years of age or older
- Must be prescribed by or in consultation with a hematologist, oncologist, or immunology specialist
- Must have a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry (LDH level of 1.5 times the upper limit of normal)
- Must have documented have one of the following at least 2 weeks before starting treatment:
    a. A full course of meningococcal, pneumococcal, and Hib vaccines
    b. A test for antibodies against encapsulated bacteria
    c. 2 weeks of antibacterial drug prophylaxis against S. *pneumoniae*, N. *meningitis*, and H. *influenzae* type B if vaccines are administered less than 2 weeks prior to starting therapy

- One of the following criteria must be met (A or B):
    A. Member is transfusion-dependent
    B. Member has hemoglobin ≤ 7 g/dL or Hb ≤ 9 g/dL and member has symptoms of thromboembolic complications (e.g. abdominal pain, shortness of breath, chest pain, end-organ damage, fatigue)

Renewal Criteria: *Approval Duration = 12 months*

- Documentation has been submitted that support one of the following positive responses to therapy:
    - Decrease in transfusions from baseline
    - Increase in hemoglobin (Hb) by ≥ 1 g/dL from baseline
    - Normalization in LDH levels ≤ 280 U/L

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
EMPAVELI (pegcetacoplan)	

Medical Billing Drug Clinical Criteria Only

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
SOLIRIS (eculizumab)	
ULTOMIRIS (ravulizumab)	

Hematopoietic, Colony Stimulating Factors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Clinical justification must be provided explaining why the member is unable to use the preferred product (subject to clinical review).

Filgrastim

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NEUPOGEN (filgrastim)	GRANIX (TBO-filgrastim)
	NIVESTYM (filgrastim-AAFI)
	ZARXIO (filgrastim-SNDZ)

Pegfilgrastim

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NYVEPRIA (pegfilgrastrim – APGF)	FULPHILA (pegfilgrastrim-JMDB)
ZIEXTENZO (pegfilgrastim-BMEZ)	NEULASTA (pegfilgrastim)
	UDENYCA (pegfligrastim-CBQV)

Sargramostim

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
LEUKINE (sargramostim)	

Nausea/Vomiting

Chemo Induced

Electronic Diagnosis Verification

- **Dronabinol:** The member must have an FDA-approved indication for use

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 6 months or until last day of chemotherapy*

- The member must have diagnosis of nausea and/or vomiting
- Prescriber must be an oncologist
- The member must be receiving a moderately or highly emetogenic chemotherapy
- The final date of chemotherapy treatment must be provided with the request

- Member must have failed a 3-day trial of each preferred product(s) in the same class within the last 6 months as evidenced by paid claims or pharmacy print outs
- Member must not have failed preferred chemical entity with same active ingredient as requested product due to side effects

NK1 RECEPTOR ANTAGONISTS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
AKYNZEO (netupitant/palonosetron)	aprepitant Capsule
	EMEND (aprepitant) CAPSULE
	EMEND (aprepitant) SUSPENSION
	VARUBI (rolapitant) TABLET
5-HT3 RECEPTOR ANTAGONISTS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
AKYNZEO (netupitant/palonosetron)	SANCUSO (granisetron) PATCH
granisetron tablet	ZOFRAN (ondansetron) TABLET
ondansetron ODT	SUSTOL (granisetron) SYRINGE
ondansetron solution	
ondansetron tablet	
CANNABINOIDS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
dronabinol capsule	MARINOL (dronabinol) CAPSULE

Sickle Cell Disease

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial Criteria**: *Approval Duration = 12 months*
  - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis, age, and duration of treatment)
  - The member must have had a 30-day trial of a preferred agent at the maximum (35 mg/kg/day) or maximally tolerated dose, as evidenced by paid claims or pharmacy printouts
  - Prescribed by, or in consultation, with a hematologist, or other specialist with expertise in the diagnosis and management of sickle cell disease
  - Member has experienced at least one sickle cell-related vaso-occlusive crisis within past 12 months (documentation required)
- **Product Specific Criteria:**
  - **Oxbryta:**
    - Baseline hemoglobin (Hb) ≤ 10.5 g/dL
  - **Siklos:**
    - Baseline hemoglobin (Hb) ≤ 10.5 g/dL
    - Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review).

- **Renewal Criteria:** *Approval Duration = 12 months*
  - The member must have experienced and/or maintained clinical benefit since starting treatment with the requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review) by one of the following:
    - Increase in hemoglobin (Hb) by ≥ 1 g/dL from baseline
    - Decrease in indirect bilirubin from baseline
    - Decrease in percent reticulocyte count from baseline
    - Member has experienced a reduction in sickle cell-related vaso-occulusive crisis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DROXIA (hydroxyurea capsule)	ENDARI (glutamine)

hydroxyurea capsule	OXBRYTA (voxelotor)
	SIKLOS (hydroxyurea tablet)

Thrombocytopenia

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had trials with each preferred agent (at the recommended dose and duration) with each preferred agent, as evidenced by paid claims or pharmacy Printouts.

Product Specific Criteria: Promacta Powder Pack: In addition to diagnosis specific criteria

- Patient must be 9 years old or younger OR unable to swallow a solid dosage form

Persistent or Chronic immune thrombocytopenia (ITP):

- **Initial Criteria:** *Approval Duration 4 months*
  - Member has diagnosis of immune thrombocytopenic purpura (ITP) lasting >6 months after diagnosis.
  - Documentation of platelet count of less than 30 x 10^9/L
  - The member must have experienced an inadequate response after one of the following (A, B or C):
    A. The member must have failed a trial of appropriate duration of a corticosteroid or immunoglobulins, as evidenced by paid claims or pharmacy print outs OR
    B. Rituximab OR
    C. The member must have undergone a splenectomy
- **Renewal Criteria:** *Approval Duration 12 months*
  -

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PROMACTA (eltrombopag)	DOPTELET (avatrombopag)
PROMACTA (eltrombopag) POWDER PACK	NPLATE (romiplostim)
	TAVALISSE (fostamatinib)

Chronic liver disease-associated thrombocytopenia

- **Clinical Criteria:** *Approval Duration The 2 weeks prior to procedure*
  - The member must have a diagnosis of chronic liver disease
  - The member must have platelet count of less than 50 x 10^9/L
  - The member must be scheduled to undergo a procedure that puts the member at risk of bleeding
    - The prescriber must include documentation of the name and scheduled date of the procedure
  - The provider must indicate the date therapy will be initiated and discontinued
    - Member must undergo procedure within 8 days after last dose*
      *Doptelet: Member must undergo procedure 5-8 days after last dose
      *Mulpleta: Member must undergo procedure 2-8 days after last dose

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DOPTELET (Avatrombopag)	MULPLETA (Lusutrombopag)

Chronic hepatitis C infection-associated thrombocytopenia

- **Initial Criteria:** *Approval Duration 4 months*
  - Member has diagnosis of hepatitis C-associated thrombocytopenia
  - Prescriber must attest that the member's degree of thrombocytopenia prevents initiation or continuation of interferon-based therapy
  - Member is unable to receive direct acting antivirals for hepatitis C
- **Renewal Criteria:** *Approval Duration 12 months*
  - Platelet counts must have achieved greater than or equal to 50 x 10^9/L in response to therapy (supported by documentation)
  - Member is currently receiving interferon-based therapy

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PROMACTA (eltrombopag)	
PROMACTA (eltrombopag) POWDER PACK	

Aplastic Anemia

- **Initial Criteria:** *Approval Duration 4 months*
  - Member has diagnosis of aplastic anemia

- Member must have failed therapy or be receiving concurrent therapy with immunosuppressive therapy (e.g. corticosteroid, Atgam, cyclosporine, cyclosporine)
- Documentation of platelet count of less than 30 x 10^9/L

- **Renewal Criteria:** *Approval Duration 12 months*
  - Platelet counts must have achieved greater than or equal to 50 x 10^9/L in response to therapy (supported by documentation)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PROMACTA (eltrombopag)	
PROMACTA (eltrombopag) POWDER PACK	

Infectious Disease

Antibiotics - Resistance Prevention

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 5 days*
  - Member must have an FDA-approved indication for use (meets label recommendations for diagnosis & age)
    - Diagnosis must be proven to be caused by a susceptible microorganism by culture and susceptibility testing
  - Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol.
  - One of the following criteria must be met (A or B)
    - A. Prescriber must provide evidence-based medical justification for use, explaining why the preferred antibiotics are not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
    - B. The member is continuing treatment upon discharge from an acute care facility
- **Renewal Criteria:** *Approval Duration = 5 days*
  - It is medically necessary to continue treatment course after re-evaluation of the member's condition.
  - The total requested duration of use must not be greater than manufacturer labeling or treatment guideline recommendations (whichever is greater).

Community-Acquired Pneumonia

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
amoxicillin	BAXDELA (delafloxacin)
amoxicillin-clavulanate	FACTIVE (gemifloxacin)
azithromycin	XENLETA (lefamulin)
cefpodoxime	
cefuroxime	
clarithromycin	
doxycycline	
levofloxacin	
linezolid	
moxifloxacin	

Methicillin-Resistant *Staphylococcus aureus* (MRSA):

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
clindamycin	BAXDELA (delafloxacin)
doxycycline	NUZYRA (omadacycline)
linezolid	SIVEXTRO (tedizolid)
minocycline	
trimethoprim-sulfamethoxazole	

Helicobacter pylori

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
lansoprazole/amoxicillin/clarithromycin	HELIDAC (bismuth ssal/metronidazole/tetracycline)

PYLERA (bismuth subcitrate potassium/metronidazole/tetracycline)	OMECLAMOX-PAK (omeprazole/clarithromycin/amoxicillin)
	PREVPAC (lansoprazole/amoxicillin/clarithromycin)
	TALICIA (omeprazole/amoxicillin/rifabutin)

Tuberculosis

Product specific criteria:

***isoniazid:

- ND Health Department provides for no cost. Please contact 701-328-2378 to obtain supply.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ethambutol	cycloserine
isoniazid[PA]	MYCOBUTIN (rifabutin)
PRIFTIN (rifapentine)	RIFADIN (rifampin)
pyrazinamide	SIRTURO (bedaquiline)
rifabutin	
rifampin	

Antifungals - Aspergillus and Candidiasis Infections

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = Per label recommendations*

- The request must be for use as prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- The member must meet one of the following (A or B):
    - The member must have documented history of failure to all preferred agents as evidenced by paid claims or pharmacy printouts
    - Prescriber must provide evidence-based medical justification for use, explaining why preferred antifungals are not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)

Solid formulations

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
clotrimazole	CRESEMBA (isavuconazonium)
clotrimazole troche	DIFLUCAN (fluconazole)
fluconazole	posaconazole
itraconazole	SPORANOX (itraconazole)
NOXAFIL (posaconazole) – *Brand Required*	TOLSURA (itraconazole) CAPSULE
nystatin	VFEND (voriconazole)
ORAVIG (miconazole)	voriconazole
terbinafine	

Non-solid oral formulations

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
fluconazole suspension	DIFLUCAN (fluconazole) SUSPENSION
itraconazole solution	NOXAFIL (posaconazole) SUSPENSION
	SPORANOX (itraconazole) SOLUTION
	VFEND (voriconazole) SUSPENSION
	voriconazole suspension

Antimalarial Agents

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria:

- The request must be for TREATMENT of malaria (*NOT covered for prophylaxis)*

Non-Preferred Agents Criteria:

- The member must have had a trial of a generic quinine in the last 30 days, as evidenced by paid claims or pharmacy print outs

Product specific criteria:

***atovaquone/proguanil 62.5-25 MG

- The member must be less than 18 years old

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
hydroxychloroquine	atovaquone/proguanil
quinine	chloroquine
	COARTEM (artemether/lumefantrine)
	KRINTAFEL (tafenoquine)
	MALARONE (atovaquone/proguanil)
	mefloquine
	primaquine
	QUALAQUIN (quinine)

Human Immunodeficiency Virus (HIV)

Antiretrovirals

References

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/AdultandAdolescentGL.pdf. Accessed (October 9, 2020)

Category Criteria:

- **Branded non-preferred agents:** The member must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The member must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Integrase Strand Transfer Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BIKTARVY (bictegravir/emtricitabine/tenofovir)	
CABENUVA (cabotegravir/rilprivirine)	
DOVATO (dolutegravir/Lamivudine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
ISENTRESS (raltegravir)	
JULUCA (dolutegravir/rilpivirine)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
TIVICAY (dolutegravir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	

Non-Nucleoside Reverse Transcriptase Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)
EDURANT (rilpivirine)	efavirenz/lamivudine/tenofovir
efavirenz	SUSTIVA (efavirenz)
efavirenz/emtricitabine/tenofovir	
JULUCA (dolutegravir/rilpivirine)	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
PIFELTRO (doravirine)	
rilpivirine	
SYMFI (efavirenz/lamivudine/tenofovir) – *Brand Required*	
SYMFI LO (efavirenz/lamivudine/tenofovir) – *Brand Required*	
NOT RECOMMENDED FOR FIRST LINE USE	
Etravirine: Guidelines do not recommend for treatment-naïve members due to insufficient data. FDA indication is for treatment experienced members and so should be reserved for salvage therapy, pretreated members with NNRTI resistance and PI exposure or who have ongoing adverse effects with first line therapies. **Nevirapine:** Guidelines no longer recommend nevirapine for initial treatment of HIV infection in treatment-naïve members. In resource limited settings, it can be considered as a third agent. Nevirapine demonstrated inferiority relative to efavirenz and is associated with serious and fatal hepatic and rash events.	
INTELENCE (etravirine) – *Brand Required*	etravirine

nevirapine	
nevirapine ER	

Nucleoside Reverse Transcriptase Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
abacavir	ATRIPLA (efavirenz/emtricitabine/tenofovir)
abacavir/lamivudine	efavirenz/lamivudine/tenofovir
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	emtricitabine capsule
CIMDUO (lamivudine/tenofovir)	EPIVIR (lamivudine)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	EPZICOM (abacavir)
DELSTRIGO (doravirine/lamivudine/tenofovir)	TRIZIVIR (abacavir/lamivudine)
DESCOVY (emtricitabine/tenofovir)	TRUVADA (emtricitabine/tenofovir)
EMTRIVA (emtricitabine) CAPSULE – *Brand Required*	VIREAD (tenofovir)
efavirenz/emtricitabine/tenofovir	ZERIT (stavudine) CAPSULE
emtricitabine solution	ZIAGEN (abacavir)
emtricitabine/tenofovir	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
lamivudine	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
SYMFI (efavirenz/lamivudine/tenofovir) – *Brand Required*	
SYMFI LO (efavirenz/lamivudine/tenofovir) – *Brand Required*	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
tenofovir	
TEMIXYS (Lamivudine/Tenofovir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
NOT RECOMMENDED FOR FIRST LINE USE	
abacavir/lamivudine/zidovudine – Guidelines do not recommend ABC/3TC/ZDU (as either a triple-NRTI combination regimen or in combination with tenofovir (TDF) as a quadruple-NRTI combination regimen) due to inferior virologic efficacy. **lamivudine/zidovudine –** Guidelines do not recommend ZDV/3TC due to greater toxicities than recommended NRTIs (including bone marrow suppression, GI toxicities, skeletal muscle myopathy, cardiomyopathy, and mitochondrial toxicities such as lipoatrophy, lactic acidosis and hepatic steatosis). **didanosine –** Guidelines do not recommend ddl/3TC or ddl/FTC regimens due to inferior virologic efficacy, limited trial experience in ART-naïve members, and ddl toxicities (including pancreatitis and peripheral neuropathy). ddl/TDF regimens are not recommended due to high rate of early virologic failure, rapid selection of resistance mutations, potential for immunologic nonresponse/CD4 cell decline, and increased ddl drug exposure and toxicities. **stavudine –** Guidelines do not recommend d4T/3TC due to significant toxicities (including lipoatrophy, peripheral neuropathy) and hyperlactatemia (including symptomatic and life-threatening lactic acidosis, hepatic steatosis, and pancreatitis)	
abacavir/lamivudine/zidovudine	COMBIVIR (lamivudine/zidovudine)
didanosine	RETROVIR (zidovudine)
lamivudine/zidovudine	VIDEX EC (didanosine)
stavudine	ZERIT (stavudine) CAPSULE
VIDEX (didanosine)	
zidovudine	

Post-Attachment Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
TROGARZO (Ibalizumab-uiyk)	

Protease Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
atazanavir	NORVIR (ritonavir)
EVOTAZ (atazanavir/cobicistat)	REYATAZ (atazanavir) CAPSULE
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
REYATAZ (atazanavir) POWDER PACK	
ritonavir	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
NOT RECOMMENDED FOR FIRST LINE USE	
Fosamprenavir – Guidelines do not recommend use of unboosted FPV or FPV/r due to virologic failure with unboosted FPV-based regimens that may result in selection of mutations that confer resistance to FPV and DRV. There is also less clinical trial data for FPV/r than other RTV-boosted PIs. **Lopinavir/ritonavir** – Guidelines do not recommend LPV/r due to GI intolerance, higher pill burden and higher RTV dose than other PI-based regimens **Nelfinavir –** Guidelines do not recommend use of NFV due to inferior virologic efficacy and diarrhea.	

Saqinavir – Guidelines do not recommend use of unboosted SQV due to inadequate bioavailability and inferior virologic efficacy or SQV/r due to high bill burden and QT and PR prolongation. **Tipranavir** – Guidelines do not recommend TPV/r due to inferior virologic efficacy, higher dose of RTV and higher rate of adverse events than other RTV-boosted PIs.	
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir) SOLUTION
fosamprenavir	LEXIVA (fosamprenavir)
INVIRASE (saquinavir)	lopinavir/ritonavir tablet
KALETRA (lopinavir/ritonavir) TABLET – *Brand Required*	
lopinavir/ritonavir solution	
VIRACEPT (nelfinavir)	

Entry Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NOT RECOMMENDED FOR FIRST LINE USE	
Enfuvirtide (Fusion Inhibitor)– Guidelines do not recommend T20 for initial therapy due to twice daily injections, high rate of injection site reactions, and it has only been studied in members with virologic failure **Maraviroc** (CCR5 Antagonist) – Guidelines do not recommend MVC for initial therapy due to twice daily dosing, no virologic benefit compared to recommended regimens, and required CCR5 tropism testing.	
FUZEON (enfuvirtide)	
SELZENTRY (maraviroc)	

Diarrhea

Product Specific Criteria:

*** **Mytesi:** Jump to Criteria

Loss of Appetite

Product Specific Criteria:

*** **Dronabinol:** Jump to Criteria

Wasting Cachexia

Product Specific Criteria:

*** **Serostim:** Jump to Criteria

Hepatitis C Treatments

Electronic Step Care and Concurrent Medications

- A total of 28 days of ribavirin must be billed within the previous 14 days of an Epclusa (and its generic) claim if member has decompensated cirrhosis (Child Pugh B or C).
    - Epclusa (and its generic) requires prior authorization and after prior authorization is approved, Epclusa (and its generic) will continue to reject for prior authorization unless ribavirin is billed first when it is recommended to be used concurrently.

Prior Authorization Criteria

Prior Authorization Form – Hepatitis C

Antivirals

Category Criteria: *Approval duration – based on label recommendations*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must not be receiving a known recreationally used high risk combination of drugs (e.g. “the holy trinity”) for the past 6 months.
- Member must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling all maintenance medications on time for the past 90 days, as evidenced by pharmacy claims history.
- Member must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
- Member and Prescriber attestation forms must be attached to request
- Chronic Hepatitis C must be documented by one of the following:
    - **Liver fibrosis F1 and below**: 2 positive HCV RNA levels at least 6 months apart.
    - **Liver fibrosis F2 and above**: 1 positive HCV RNA test within the last 12 months.

Prescriber may be primary care provider or family practice with the following exceptions:

Prescriber must be a hepatology, gastroenterology, or infectious disease specialist	• Decompensated cirrhosis (Child's Pugh B or C) • Status post solid organ transplantation • Known or suspected hepatocellular carcinoma • Evidence/suspicion of acute liver injury while on HCV treatment • HIV or HBsAg positive • Current pregnancy or breastfeeding
Prescriber must be, or in consult with, a hepatology, gastroenterology, or infectious disease specialist (including via Project ECHO)	• Compensated cirrhosis (Child's Pugh A) • For Hep C retreatment after Direct Acting Antivirals

For <u>FIRST TIME</u> treatments with Direct Acting Antivirals:

Must be drug (drugs of abuse by injection) and alcohol free as documented by:		
No history of alcohol use disorder or history of using drugs of abuse by injection		• 1 drug and alcohol test completed within 30 days of the request date
History of alcohol use disorder or history of drugs of abuse by injection	**Currently enrolled or has completed a substance use treatment program within the past 3 months**	• 1 drug and alcohol test completed within 30 days of the request date • Must be receiving treatment from an enrolled addiction medicine/chemical dependency treatment provider - provider/facility name must be provided with the request • Chart notes must be attached regarding assessment of member's readiness for treatment including readiness for abstinence from alcohol use during and after treatment
	<u>Has not</u> completed a substance use treatment program within the past 3 months	• 2 drug and alcohol tests, dated at least 3 months apart, with the most current test completed within 30 days of the request date • Provider must submit chart notes documenting that the member has maintained sobriety for the past year or since last substance use treatment program completion

For <u>RE-TREATMENT</u> after Direct Acting Antivirals:

Reason for retreatment:		
Due to drugs of abuse by injection	• The member is receiving treatment or must have received from an enrolled addiction medicine/chemical dependency treatment (or buprenorphine waived) provider since initial Hepatitis C treatment with Direct Acting Antivirals, and the provider/facility name must be provided with the request. • The member must not be at high risk of relapse from illicit drug use by injection during and after treatment as evidenced by treatment provider notes or risk assessment	
	Liver fibrosis F2 and below	**Liver fibrosis F3 and above**
	• The provider must submit chart notes documenting that the member has abstained from drugs of abuse for the past year	• Two drug tests: 1 test completed 3 months prior to request and 1 test within 30 days of the request date

	• Two drug tests: 1 test completed 6 months (+/- 1 months) prior to request and 1 test within 30 days of the request date	
	Liver fibrosis F2 and below	**Liver fibrosis F3 and above**
Due to non-compliance (defined as a medication possession ratio (MPR) of less than 80%)	• The member must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling all maintenance medications on time for the past 180 days, as evidenced by pharmacy claims history.	• The member must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling all maintenance medications on time for the past 90 days, as evidenced by pharmacy claims history.
Resistance	• FIRST TIME treatment with Direct Acting Antivirals criteria must be met	

Non-Preferred Agents Criteria:

- The member must have had a trial of each preferred treatment options indicated for the member's genotype, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- Epclusa:
  - 200mg-50mg: Member must be 6 years old or older and weigh between 17 to 30 kg
- Harvoni:
  - 45mg-200mg strength: Member must be 3 years old or older and weigh between 17 and 35 kg
  - 33.75mg/150mg strength: Member must be 3 years old or older and weigh less than 17 kg.
- Sovaldi:
  - 200mg strength: Member must be 3 years old or older and weigh between 17 to 35 kg

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HARVONI (ledipasvir/sofosbuvir) 45 mg/200mg tablet	EPCLUSA (sofosbuvir/velpatasvir)
MAVYRET (glecaprevir/pibrentasvir)***	HARVONI (ledipasvir/sofosbuvir) 90mg/400mg tablet
sofosbuvir/velpatasvir	HARVONI (ledipasvir/sofosbuvir) ORAL PALLET
SOVALDI (sofosbuvir) 200 MG TABLET	ledipasvir/sofosbuvir 90mg/400mg tablet
VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	SOVALDI (sofosbuvir) 400MG TABLET
	SOVALDI (sofosbuvir) ORAL PALLET
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	ZEPATIER (elbasvir/grazoprevir)

Ribavirin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ribavirin capsule	
ribavirin tablet	

Influenza

Electronic Age Verification

- Xofluza: The member must be 12 years of age or older

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
oseltamivir	TAMIFLU (oseltamivir)
XOFLUZA (baloxavir marboxil)	

Nephrology/Urology

Benign Prostatic Hyperplasia

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have diagnosis of benign prostatic hyperplasia (BPH)
- The member must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
alfuzosin ER	AVODART (dutasteride)
CARDURA XL (doxazosin)	CARDURA (doxazosin)
doxazosin	FLOMAX (tamsulosin)
dutasteride	MINIPRESS (prazosin)
finasteride	PROSCAR (finasteride)
prazosin	RAPAFLO (silodosin)
silodosin	sildenafil
tamsulosin	tadalafil
terazosin	

Chronic Kidney Disease

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FARXIGA (dapagliflozin)	
KERENDIA (finerenone)	
TEKTURNA (aliskiren)	

Hematopoietic, Erythropoiesis Stimulating Agents

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 4-week trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ARANESP (darbepoetin alfa)	EPOGEN (epoetin alfa)
PROCRIT (epoetin alfa)	MIRCERA (methoxy polyethylene glycol-epoetin beta)
	RETACRIT (epoetin alfa - epbx)

Hyperkalemia (Chronic)

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial criteria**: *Approval Duration = 3 months*
    - The member must be 18 years of age or older.
    - Medication must be prescribed by, or in consultation with, a nephrologist
    - The member's current serum potassium level must be exceeding the upper limit of normal, as evidenced by documentation from at least two separate lab values, submitted with the request
    - One of the following criteria must be met:
        - The member must have failed 30-day trials with at least two of the following products
            - Bumetanide, Chlorothiazide, Fludrocortisone, Furosemide, Hydrochlorothiazide, Indapamide, Metolazone, Torsemide
    - The member must not be receiving the medications known to cause hyperkalemia listed below, OR medical justification must be provided explaining why discontinuation of these agents would be clinically inappropriate in this member:
        - angiotensin-converting enzyme inhibitor

        - angiotensin II receptor blocker
        - aldosterone antagonist
        - nonsteroidal anti-inflammatory drugs (NSAIDs)
- **Renewal Criteria:** *Approval Duration = 6 months*
    - The member's current serum potassium level is within normal limits or has been significantly reduced from baseline, as evidenced by lab documentation submitted with the request

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
LOKELMA (Sodium Zirconium Cyclosilicate)	VELTASSA (Patiromer)

Overactive Bladder

Step Care and Concurrent Medications

- Non-Preferred Step 1 Agents: Less expensive urinary antispasmodics must be trialed first
    - A total of 30 days of a preferred agent at max dose must be paid within 90 days prior to step 1 agents date of service.

Therapeutic Duplication

- One strength of one of the following medications is allowed at a time: dutasteride, Jalyn, or finasteride
- Alpha 1 blockers (alfuzosin ER, doxazosin, dutasteride-tamsulosin, prazosin, terazosin, tamsulosin) are not allowed with carvedilol or labetalol
    - carvedilol and labetalol are nonselective beta blockers with alpha 1 blocking activity
- Anticholinergic medications (tolterodine, oxybutynin, trospium, solifenacin) are not covered with Acetylcholinesterase Inhibitors. Click here for a full listing of medications included.
    - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other, and the therapeutic effect of both products is diminished

Prior Authorization Criteria

General Prior Authorization Form

Solid dosage forms

Non-Preferred Step 1 Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of a preferred agent, as evidenced by paid claims or pharmacy printouts.

Non-Preferred Step 2 Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of 2 preferred agents and 1 non-preferred step 1 agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
DETROL (tolterodine) – *Brand Required*	MYRBETRIQ (mirabegron)	darifenacin ER
DETROL LA (tolterodine) – *Brand Required*	flavoxate	DITROPAN XL (oxybutynin)
GELNIQUE (oxybutynin)		dutasteride/tamsulosin
oxybutynin ER		FLOMAX (tamsulosin)
oxybutynin tablet		GEMTESA (vibegron)
OXYTROL (oxybutynin) PATCH		JALYN (dutasteride/tamsulosin)
solifenacin		tolterodine
tamsulosin		tolterodine ER
TOVIAZ (fesoterodine)		trospium ER
trospium		VESICARE (solifenacin)

Non-solid dosage form

Non-Preferred Agents Criteria:

- The member must be 9 years old or younger or provide documentation of inability to swallow.
- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of a preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
oxybutynin syrup	MYRBETRIQ (mirabegron) SUSPENSION
	VESICARE (solifenacin) LS SUSPENSION

Phosphate Binders

General Prior Authorization Form

Category Criteria:

- The member must have had 30-day trials of all preferred agents of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.
- The member must have a diagnosis of end-stage renal disease or chronic kidney disease.
- If member is on renal dialysis, Medicare eligibility must be ruled out.

Solid dosage form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Calcium acetate	AURYXIA (ferric citrate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET – *Brand Required*	Lanthanum chew tab
Sevelamer Carbonate Tablet	RENAGEL (Sevelamer HCl) TABLET
	RENVELA (sevelamer carbonate) TABLET
	Sevelamer HCl 400mg Tablet
	Sevelamer HCl 800mg Tablet
	VELPHORO (Sucroferric oxyhydroxide)

Non-solid dosage form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PHOSLYRA (calcium acetate) ORAL solution	FOSRENOL (lanthanum) POWDER PACK
RENVELA (sevelamer) POWDER PACK – *Brand Required*	Sevelamer Powder Pack

Neurology

Alzheimer's Disease

Therapeutic Duplication

- One memantine medication is allowed at a time
- Anticholinergic medications are not covered with acetylcholinesterase inhibitors **(**Aricept, Exelon, Razadyne, pyridostigmine). Click here for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other, and the therapeutic effect of both products is diminished

Electronic Diagnosis Verification

- **Memantine:** Members must have an FDA or compendia supported indication

Electronic Age Verification

- Members must be greater than 30 years old

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Product Criteria:

- The member must have a diagnosis of an FDA-approved indication for use
- The member must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- The member must not reside in facility with skilled nursing care.

Product Specific Criteria:

- Donepezil 23mg:
  - Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

Cholinesterase Inhibitors	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
donepezil 5mg, 10mg Tablet	ARICEPT (donepezil)
EXELON (rivastigmine) PATCH – *Brand Required*	donepezil ODT

galantamine Tablet	donepezil 23mg tablet
galantamine ER	galantamine oral solution
rivastigmine capsule	RAZADYNE (galantamine)
	RAZADYNE ER (galantamine)
	rivastigmine patch
NMDA Receptor Antagonists	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
memantine	memantine oral solution
	memantine ER
	NAMENDA (memantine)
	NAMENDA XR (memantine)
Cholinesterase Inhibitors / NMDA Receptor Antagonist Combinations	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NAMZARIC (memantine/donepezil)	

Anticonvulsants

Therapeutic Duplication

- One Vimpat strength is allowed at a time
- Lyrica and gabapentin are not allowed together.
- Lyrica and gabapentin oral solutions are not allowed with benzodiazepines, muscle relaxants (except baclofen), or narcotic solid dosage forms. If a member can swallow, they should be transitioned to a solid dosage form.
  - **Please call for an override** by calling provider relations at 1-800-755-2604 if:
    - All of member's medications dispensed in solid formulations are being crushed or opened to administer because member is unable to swallow

Electronic Diagnosis Verification

- Diacomit, Epidiolex, Fentepla: The member must have an FDA approved diagnosis

Electronic Step Care and Concurrent Medications

- Diacomit is FDA approved to be used in combination with clobazam.
  - A total of 28 days of clobazam must be paid within 45 days prior to Diacomit (stiripentol)

Prior Authorization Criteria

Group Criteria:

- **Branded non-preferred agents:** The member must have had a 30-day trial of 2 pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The member must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Anticonvulsant Prevention

Carbamazepine Derivatives	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
carbamazepine chewable tablet	carbamazepine ER capsule
carbamazepine oral suspension	carbamazepine XR tablet
carbamazepine tablet	EPITOL (carbamazepine)
CARBATROL (carbamazepine) – *Brand Required*	oxcarbazepine oral solution
EQUETRO (carbamazepine)	TEGRETOL (carbamazepine)
oxcarbazepine tablet	TEGRETOL (carbamazepine oral suspension)
OXTELLAR XR (oxcarbazepine)	
TRILEPTAL (oxcarbazepine) – *Brand Co-Preferred*	
TRILEPTAL (oxcarbazepine) ORAL SUSPENSION – *Brand Required*	
TEGRETOL XR (carbamazepine) – *Brand Required*	
First Generation	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
CELONTIN (methsuximide)	DEPAKENE (valproic acid) CAPSULE

clobazam	DEPAKENE (valproic acid) ORAL SOLUTION
clobazam oral solution	DEPAKOTE (divalproex sodium) TABLET
DEPAKOTE SPRINKLE (divalproex sodium) – *Brand Co-Preferred*	
divalproex ER	DEPAKOTE ER (divalproex sodium)
divalproex sprinkle	
divalproex tablet	DILANTIN (phenytoin) CHEWABLE TABLET
ethosuximide capsule	DILANTIN (phenytoin) ORAL SUSPENSION
ethosuximide oral solution	DILANTIN ER (phenytoin)
FELBATOL (felbamate) TABLET– *Brand Required*	felbamate oral suspension
FELBATOL (felbamate) ORAL SUSPENSION - *Brand Required*	felbamate tablet
PEGANONE (ethotoin)	MYSOLINE (primidone)
phenobarbital elixir	ONFI (clobazam)
phenobarbital tablet	ONFI (clobazam) ORAL SOLUTION
phenytoin chewable tablet	PHENYTEK (phenytoin)
phenytoin ER capsule	SYMPAZAN (clobazam)
phenytoin suspension	ZARONTIN (ethosuximide)
primidone	ZARONTIN (ethosuximide) ORAL SOLUTION
valproic acid capsule	
valproic acid oral solution	
Second Generation	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
BANZEL (rufinamide) ORAL SUSPENSION – *Brand Required*	ELEPSIA XR (levetiracetam)
BANZEL (rufinamide) TABLET – *Brand Required*	KEPPRA (levetiracetam)
BRIVIACT (brivaracetam)	KEPPRA (levetiracetam) ORAL SOLUTION
DIACOMIT (stiripentol)	KEPPRA XR (levetiracetam)
EPIDIOLEX (cannabidiol)	LAMICTAL (lamotrigine)
FINTEPLA (fenfluramine) ORAL SOLUTION	LAMICTAL (lamotrigine) DOSE PACK
FYCOMPA (perampanel)	lamotrigine ODT
FYCOMPA (perampanel) ORAL SUSPENSION	lamotrigine ODT dose pack
gabapentin capsule	lamotrigine chewable tablet
gabapentin oral solution	lamotrigine ER
gabapentin tablet	LYRICA (pregabalin)
GABITRIL (tiagabine) - *Brand Required*	LYRICA (pregabalin) ORAL SOLUTION
LAMICTAL ODT (lamotrigine) DOSE PACK- *Brand Required*	NEURONTIN (gabapentin) CAPSULE
LAMICTAL ER (lamotrigine) DOSE PACK	NEURONTIN (gabapentin) ORAL SOLUTION
LAMICTAL XR (lamotrigine) - *Brand Required*	NEURONTIN (gabapentin) TABLET
LAMICTAL (lamotrigine) CHEWABLE TABLET- *Brand Required*	rufinamide tablet
LAMICTAL ODT (lamotrigine) - *Brand Required*	rufinamide suspension
lamotrigine dose pack	SPRITAM (levetiracetam)
lamotrigine tablet	SUBVENITE (lamotrigine)
levetiracetam ER	tiagabine
levetiracetam oral solution	TOPAMAX (topiramate)
levetiracetam tablet	TOPAMAX (topiramate) SPRINKLE CAPSULE
QUDEXY XR (topiramate) SPRINKLE CAPSULE – *Brand Co-Preferred*	topiramate ER sprinkle cap – Labeler 00245
pregabalin	VIGADRONE (vigabatrin)
pregabalin oral solution	vigabatrin
SABRIL (vigabatrin) - *Brand Required*	vigabatrin powder pack
SABRIL (vigabatrin) POWDER PACK - *Brand Required*	ZONEGRAN (zonisamide)
topiramate ER sprinkle cap – Labeler 00832	
topiramate ER	
topiramate sprinkle capsule	
topiramate tablet	
TROKENDI XR (topiramate)	
XCOPRI (cenobamate)	
zonisamide	
Third Generation	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**

APTIOM (Eslicarbazepine)	
VIMPAT (lacosamide)	
VIMPAT (lacosamide) ORAL SOLUTION	

Anticonvulsant treatment

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED):
DIASTAT PEDIATRIC (diazepam) RECTAL GEL – *Brand Required*	Diazepam pediatric rectal gel
DIASTAT ACUDIAL (diazepam) RECTAL GEL – *Brand Required*	Diazepam rectal gel
NAYZILAM (midazolam) SPRAY	
VALTOCO (diazepam) SPRAY	

Emflaza

Prior Authorization Form - Emflaza

Initial Criteria: *Approval Duration = 6 months*

- The member must be 2 years of age or older
- The member must have diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by the documented presence of abnormal dystrophin or a confirmed mutation of the dystrophin gene
- Onset of weakness must have occurred before 2 years of age
- The medication must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- The member must have serum creatinine kinase activity of at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- The member must have failed a 6-month trial of prednisone due to inadequate treatment response, intolerance, or contraindication, as evidenced by paid claims or pharmacy printouts
- The provider must submit baseline motor milestone score results from at least ONE the following assessments:
    i. 6-minute walk test (6MWT)
    ii. North Star Ambulatory Assessment (NSAA)
    iii. Motor Function Measure (MFM)
    iv. Hammersmith Functional Motor Scale (HFMS)
- The member must have ONE of the following significant intolerable adverse effects supported by documentation:
    i. Cushingoid appearance
    ii. Central (truncal) obesity
    iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
    iv. Diabetes and/or hypertension that is difficult to manage
    v. Severe behavioral adverse effect

Renewal Criteria: *Approval Duration = 12 months*

- The member must have ONE of the following (A or B)
    - Improvement in motor milestone score from baseline from ONE the following assessments:
        i. 6MWT – improvement of 20 meters from baseline
        ii. NSAA – improvement of 2 points from baseline
        iii. MFM – improvement of 2 points from baseline
        iv. HFMS – improvement of 2 points from baseline
    - The member must have had improvement of adverse effects experienced on prednisone supported by documentation:
        i. Cushingoid appearance
        ii. Central (truncal) obesity
        iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
        iv. Diabetes and/or hypertension that is difficult to manage
        v. Severe behavioral adverse effect

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Prednisone	EMFLAZA (deflazacort)

Fabry Disease

General Prior Authorization Form

Fabrazyme: See Medical Billing Drug Clinical Criteria

Initial Criteria: *Approval Duration = 6 months*

- The member must have a diagnosis of Fabry disease
- The member must be 18 years of age or older
- The member must be assigned male at birth.
- Baseline value for plasma or urinary globotriosylceramide (GL-3) levels ≥ 5 ng/mcL or GL-3 inclusions ≥ 0.3 per kidney interstitial capillary (KIC) as measured in kidney biopsy
- The member's diagnosis must be confirmed to be caused by a pathologic galactosidase alpha gene (GLA) variant that is amenable to treatment with Galafold interpreted from a clinical geneticist professional, as evidenced by medical documentation attached to the request.
- The medication must not be used in conjunction with enzyme replacement therapy.
- The member must not have significant renal impairment (eGFR <30 mL/minute/1.73 m2)

Renewal Criteria: *Approval Duration = 12 months*

- The member must have a decreased Gb3 level or Cb3 inclusion per KIC level and experienced and maintained improvement in one of the following symptoms since starting treatment with requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review):
  - Acroparesthesias (burning pain in the extremities)
  - Angiokeratomas (cutaneous vascular lesions)
  - Hypo- or anhidrosis (diminished perspiration)
  - Corneal and lenticular opacities
  - Left ventricular hypertrophy (LVH), hypertrophic cardiomyopathy, or arrythmia of unknown etiology
  - Chronic kidney disease (CKD), multiple renal cysts, and/or proteinuria of unknown etiology

PREFERRED AGENTS (CLINICAL PA REQUIRED)
GALAFOLD (migalastat)

Headache/Migraine

Vyepti – See Medical Billing Drug Clinical Criteria

Prophylaxis of Migraine – CGRP Inhibitors

Prior Authorization Form –Migraine/Cluster Headache Prophylaxis

Group Criteria:

Initial PA Criteria: *Approval Duration: 3 months*

- Member must experience 3 or more migraine days per month.
- The member must have had 2-month trials of at least two of the following agents from different therapeutic classes, as evidenced by paid claims or pharmacy printouts:
  - amitriptyline, atenolol, divalproex sodium, metoprolol, nadolol, propranolol, timolol, topiramate, venlafaxine
- Prescriber must submit documentation, including clinical notes regarding failure of prior treatments to reduce migraine frequency after 2-month trial.

Non-Preferred Agents Criteria:

- The member must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Renewal PA Criteria: *Approval Duration: 12 months*

- The member must have experienced at least a 50% reduction in migraines from baseline, since starting treatment with a CGRP inhibitor.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AJOVY (fremanezumab-vfrm)	AIMOVIG (erenumab-aooe)
EMGALITY (galcanazumab-gnlm)	NURTEC ODT (rimegepant)
	QULIPTA (atogepant)

Treatment of Migraine

Therapeutic Duplication

- One strength of one medication is allowed at a time

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria:

- Within the past 2 years, the member must have had 30-day trials of two triptans (5HT-1 agonists), as evidenced by paid claims or pharmacy printouts.

Non-Preferred Agents:

- Within the past 2 years, the member must have had a 30-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Non-Triptan Agents

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NURTEC ODT (rimegepant)	REYVOW (lasmiditan)
	UBRELVY (ubrogepant)
Ergot Alkaloids	
	D.H.E.45 (dihydroergotamine) INJECTION
	dihydroergotamine injection
	dihydroergotamine nasal spray
	ERGOMAR (ergotamine) SL TABLET
	MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
	TRUDHESA (dihydroergotamine)

Triptans (5HT-1 agonists)

Approval Duration = 6 months

Solid Oral Dosage Forms

Non-Preferred Step 1 Agents Criteria:

- Members 18 years old or older: The member must have had a 30-day trial of rizatriptan and Relpax (eletriptan), as evidenced by paid claims or pharmacy printouts.
- Members 6 to 17 years of age: The member must have had a 30-day trial of rizatriptan, as evidenced by paid claims or pharmacy printouts.

Non-preferred step 2 agents:

- The member must have had either a 30-day trial of each available preferred triptan agent, as evidenced by paid claims or pharmacy printouts or provide clinical justification explaining why the member is unable to use all other products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
FROVA (frovatriptan) TABLET– *Brand Required*	naratriptan tablet	almotriptan tablet
RELPAX (eletriptan) TABLET – *Brand Required*	zolmitriptan tablet	AMERGE (naratriptan) TABLET
rizatriptan tablet		eletriptan tablet
sumatriptan tablet		frovatriptan tablet
		IMITREX (sumatriptan) TABLET
		MAXALT (rizatriptan) TABLET
		sumatriptan/naproxen tablet
		TREXIMET (sumatriptan/naproxen) TABLET
		ZOMIG (zolmitriptan) TABLET

Non-Solid Oral Dosage Forms

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of rizatriptan ODT, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Rizatriptan ODT	MAXALT MLT (rizatriptan)
ZOMIG ODT (zolmitriptan) – *Brand Required*	zolmitriptan ODT

Non-Oral Dosage Forms

All (Preferred and Non-Preferred) Non-Oral Dosage Form Agents:

- Members must not able to take oral medications (subject to clinical review).

Product Specific Criteria

- Onzetra Xsail: Member must have had a 30-day trial of zolmitriptan, as evidenced by paid claims or pharmacy printouts.

Non-Preferred Agents Criteria:

- Member must have had a 30-day trial of zolmitriptan and Imitrex (sumatriptan), as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
IMITREX (sumatriptan) CARTRIDGE – *Brand Required*	sumatriptan cartridge
IMITREX (sumatriptan) PEN INJCTR – *Brand Required*	sumatriptan pen injctr
IMITREX (sumatriptan) SPRAY – *Brand Required*	sumatriptan spray
IMITREX (sumatriptan) SYRINGE – *Brand Required*	sumatriptan syringe
zolmitriptan spray	sumatriptan vial
ONZETRA XSAIL (sumatriptan) NASAL SPRAY^{PA}***	TOSYMRA (sumatriptan) NASAL SPRAY
	ZEMBRACE SYMTOUCH (sumatriptan)
	ZOMIG (zolmitriptan) NASAL SPRAY

Cluster Headache

Initial PA Criteria: *Approval Duration: 3 months*

- Member must meet ICHD-3 criteria for diagnosis of cluster headache:
  - Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15-180 minutes (during active time course)
  - Either or both of the following:
    - At least one of the following symptoms or signs, ipsilateral to the headache:
      - Conjunctival injection and/or lacrimation
      - Nasal congestion and/or rhinorrhea
      - Eyelid edema
      - Forehead and facial swelling
      - Miosis and/or ptosis
    - A sense of restlessness or agitation
  - Occurring with a frequency between one every other day and 8 per day (during active time course)

Cluster Headache Prevention

Non-preferred agents:

- Member must use medication as preventative treatment during episodic cluster headache episodes (cluster periods usually last between 2 weeks and 3 months with pain-free periods lasting at least 3 months), as medication is not indicated for chronic use
- Member must have had a 2-month trial with verapamil

Renewal PA Criteria: *Approval Duration: 12 months*

- Prescriber must submit documentation indicating that the members' cluster headaches have been reduced in frequency and/or severity as a result of therapy per member headache journal

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
topiramate	EMGALITY (galcanazumab-gnlm)
verapamil	

Cluster Headache Treatment

Non-preferred agents:

- The member must have had a 30-day trial of two unique pharmaceutical preferred agents within the past 24 months, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ONZETRA XSAIL (sumatriptan) NASAL SPRAY	D.H.E.45 (dihydroergotamine) INJECTION
IMITREX (sumatriptan) CARTRIDGE – *Brand Required*	Dihydroergotamine (DHE) intranasal
IMITREX (sumatriptan) PEN INJCTR – *Brand Required*	Dihydroergotamine Injection
IMITREX (sumatriptan) SPRAY – *Brand Required*	Dihydroergotamine Nasal Spray
IMITREX (sumatriptan) SYRINGE – *Brand Required*	ERGOMAR (ergotamine) SL TABLET
zolmitriptan oral	IMITREX (sumatriptan) VIAL
zolmitriptan ODT	MIGRANAL (dihydroergotamine) SPRAY
zolmitriptan spray	Sumatriptan Cartridge
	Sumatriptan intranasal
	Sumatriptan Pen Injctr
	Sumatriptan Spray
	Sumatriptan subcutaneous
	Sumatriptan Syringe
	Sumatriptan Vial
	TOSYMRA (Sumatriptan) NASAL SPRAY
	ZEMBRANCE SYMTOUCH (Sumatriptan)
	ZOMIG (Zolmitriptan) NASAL SPRAY

Huntington's Disease

General Prior Authorization Form

- **Initial Criteria:** *Approval Duration = 12 months*
  - The member must have a diagnosis of an FDA-approved indication for use
  - The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).

  Non-Preferred Agents Criteria:
  - The member must have failed a 3-month trial of tetrabenazine, as evidenced by paid claims or pharmacy printouts
- **Renewal Criteria:** *Approval Duration = 12 months*
  - Documentation of disease stabilization or improvement in disease since initiation of treatment must be provided

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
tetrabenazine	AUSTEDO (deutetrabenazine)

Multiple Sclerosis

Injectable Agents

Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 3-month trial of at least 1 preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AVONEX (interferon beta-1A) PEN	EXTAVIA (interferon beta-1B)
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE
BETASERON (interferon beta-1B)	
REBIF (interferon beta-1A)	
REBIF REBIDOSE (interferon beta-1A)	

Injectable Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The member must have had either a 30-day trial of each available preferred multiple sclerosis agent, as evidenced by paid claims or pharmacy printouts or provide clinical justification explaining why the member is unable to use all other products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
COPAXONE (glatiramer) 20 MG/ML – *Brand Required*	COPAXONE (glatiramer) 40 MG/ML
	glatiramer 20mg/ml
	glatiramer 40mg/ml
	GLATOPA (glatiramer)

Monoclonal Antibodies

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KESIMPTA (ofatumumab)	

Oral Agents

Fumerates

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 3-month trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
TECFIDERA (dimethyl fumarate) – *Brand Required*	BAFIERTAM (monomethyl fumarate)
	dimethyl fumarate
	VUMERITY (diroximel fumarate)

Sphingosine 1-Phosphate (S1P) Receptor Modulators

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 3-month trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GILENYA (fingolimod)	MAYZENT (siponimod)
	PONVORY (ponesimod)
	ZEPOSIA (ozanimod)

Pyrimidine Synthesis Inhibitor

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 3-month trial of Kesimpta, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AUBAGIO (teriflunomide)	MAVENCLAD (cladribine)

Narcolepsy

Therapeutic Duplication

- Sunosi and Wakix are not allowed together
- Provigil and Nuvigil are not allowed together
- Xyrem, Xywav is not allowed with sleeping medication or benzodiazepines

Electronic Step Care and Concurrent Medications

- Sunosi and Xyrem requires a 30-day trial of Nuvigil to be paid within 60 days of submitted claim
- Wakix requires titration to 17.8 mg dose with 4.45 mg tablets.

Underutilization

- Wakix, Sunosi, and Xywav must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria- Narcolepsy**:**

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The member must have failed 30-day trials of each preferred agent and at least 1 additional CNS stimulant indicated for treatment of narcolepsy, as evidenced by paid claims or pharmacy printouts
- Provider must submit documentation of prior treatment failure, as evidenced by documentation of one of the following, while on prior treatments:
  - Multiple Sleep Latency Test (MSLT) <8 minutes
  - EPWORTH sleepiness scale score ≥10

Product Specific Criteria:

- Xywav:
  - Clinical justification must be provided explaining why the member is unable to Xyrem due to sodium content (subject to clinical review).
  - The member must have had a 30-day trial with Wakix in addition to Non-Preferred Agents Criteria

Renewal Criteria:

- Provider must submit documentation of symptom improvement, as evidenced by documentation of one of the following, while on prior treatments:
  - Multiple Sleep Latency Test (MSLT) <8 minutes
  - EPWORTH sleepiness scale score ≥10

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
armodafinil	NUVIGIL (armodafinil)
modafinil	PROVIGIL (modafinil)
SUNOSI (solriamfetol)	WAKIX (pitolisant)
XYREM (sodium oxybate)	XYWAV (sodium, calcium, magnesium, potassium oxybate)

Nuedexta (dextromethorphan/quinidine)

Prior Authorization Form - Nuedexta

Group Criteria (Initial): *Approval Duration = 3 months*

- The member must be 18 years of age or older
- The member must not have a diagnosis of any of the following: prolonged QT interval, heart failure, or complete atrioventricular (AV) block
- The prescriber must provide the following information:
  - Baseline Center for Neurological Studies lability (CNS-LS) score
  - Baseline weekly PBA episode count
- The member must have diagnosis of pseudobulbar affect (PBA) due to one of the following neurologic conditions and meet additional criteria for diagnosis:
  - Amytrophic Lateral Sclerosis (ALS)
  - Multiple Sclerosis (MS)
  - Alzheimer's Disease
  - Stroke
- **Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:**
  - Neurologic condition must have been stable for at least 3 months
  - Member must have failed** a 3-month trial of at least one medication from each of the classes listed below (A and B), as evidenced by paid claims or pharmacy print outs:
    A. **SSRIs**: sertraline, fluoxetine, citalopram and paroxetine
    B. **Tricyclic Antidepressants**: nortriptyline and amitriptyline
  - A PBA episode count and CNS-LS score must be provided for before and after each trial

***A failure is defined as one of the following:*

- *PBA count decreased less than 75 percent, stayed the same, or increased from baseline in each trial*
- *CHS-LS score decreased less than 7 points, stayed the same, or increased from baseline in each trial*

Group Criteria (Renewal): *Approval Duration = 6 months*

- Benefit of continued therapy must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode must be reduced by at least 75% from baseline
- **Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:**
    - Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
    - Current CNS-LS score must be reduced by at least 30% from baseline

Parkinson's disease

Electronic Step Care and Concurrent Medications

- Xadago and Nourianz is FDA approved for adjunctive treatment to levodopa/carbidopa.
    - A total of 28 days of levodopa/carbidopa treatment must be paid within 40 days prior to Xadago or Nourianz's date of service

Prior Authorization Criteria

General Prior Authorization Form

Parkinson's Agents – Adenosine Receptor Agonist

- **Non-Preferred Agents Criteria (Initial):**
    - The member must have a diagnosis of an FDA-approved indication for use
    - Medication must be prescribed by, or in consultation with, a neurologist
    - Documentation for deterioration in quality of response to levodopa/carbidopa therapy, including currently experiencing intermittent hypomobility, or "off" episodes (number and frequency) must be provided
    - The member must have had inadequate response to rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts
- **Non-Preferred Agents Criteria (Renewal):**
    - Documentation of disease stabilization or improvement in disease since initiation of treatment must be provided

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NOURIANZ (Istradefylline)	

Parkinson's Agents –Dopaminergic Agents for Intermittent Treatment of Off Episode

- **Group Criteria**
    - The member must have a diagnosis of an FDA-approved indication for use
    - Medication must be prescribed by, or in consultation with, a neurologist
    - The member must be currently taking carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
    - Documentation of intermittent hypomobility or off episodes (number and frequency) must be provided
    - At least one of the following criteria must be met (A and/or B):
        A. Member is experiencing unpredictable off periods, morning off, delayed on, no on or failure of on response
        B. Member is experiencing wearing off episodes or other levodopa dose cycle related dystonias or akathisias, and a treatment adjustment plan is attached (e.g. levodopa dose and interval adjustments, bedtime dose of CR or ER levodopa/ carbidopa, addition of adjunctive therapy)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Subcutaneous	
APOKYN (apomorphine)	
Enteral Suspension	
DUOPA (levodopa/carbidopa)	
Inhalation	
INBRIJA (levodopa)	
Sublingual	
KYNMOBI (apomorphine)	

Parkinson's Agents –Non-ergot Dopamine Receptor Agonists Maintenance

Non-Preferred Agents Criteria:

- The member must have a diagnosis of an FDA-approved indication for use
- The member is must not currently be residing in a facility with skilled nursing care
- Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review).

Maintenance - Oral	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
pramipexole IR	MIRAPEX (pramipexole)
ropinirole IR	MIRAPEX ER (pramipexole)
ropinirole ER	Pramipexole ER
	REQUIP (ropinirole)
Maintenance - Topical	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NEUPRO (Rotigotine) PATCH	

Parkinson's Agents –Dopamine Precursor

Non-Preferred Agents Criteria:

- The member must have a diagnosis of an FDA-approved indication for use
- Clinical justification must be provided explaining why the member is unable to use a preferred agent (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
carbidopa-levodopa-entacapone	carbidopa-levodopa ODT
carbidopa-levodopa	RYTARY (carbidopa-levodopa)
carbidopa-levodopa ER	SINEMET (carbidopa-levodopa)
	STALEVO (carbidopa-levodopa-entacapone)

Parkinson's Agents –MAO-B Inhibitors

Non-Preferred Agents Criteria

- The member must have failed a 30-day trial of selegiline, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- ***Xadago:**
  - The member must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The member must be currently experiencing intermittent hypomobility or "off" episodes
  - The member must be currently taking an extended-release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - The member must be exhibiting deterioration in quality of response to during levodopa/carbidopa therapy for intermittent hypomobility, or "off" episodes
  - The member must have failed a 30-day trial of rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AZILECT (Rasagiline) – *Brand Required*	EMSAM (Selegiline) PATCH
Selegiline	Rasagiline
ZALAPAR ODT (selegiline)	XADAGO (Safinamide)***

Parkinson's Agents – COMT inhibitor

- **Non-Preferred Agents Criteria**
  - The member must have failed a 30-day trial of entacapone, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
entacapone	COMTAN (entacapone)
	ONGENTYS (opicapone)

	TASMAR (tolcapone)
	Tolcapone

Parkinson's Agents – Other

- **Non-Preferred Agents Criteria**
  - The member must have a diagnosis of an FDA-approved indication for use
  - The member is must not currently be residing in a facility with skilled nursing care
  - Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
amantadine IR capsule	amantadine IR tablet
	GOCOVRI (amantadine ER)
	OSMOLEX ER (amantadine ER)

Parkinson's Agents –Ergot Dopamine Receptor Agonists

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
bromocriptine	PARLODEL (bromocriptine)
cabergoline	

Parkinson's Agents – Anticholinergics

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
benztropine	COGENTIN (benztropine)
trihexyphenidyl	

Spinal Muscular Atrophy (SMA)

Zolgensma / Spinraza: See Medical Billing Drug Clinical Criteria

Evrysdi

Evrysdi Prior Authorization Form

- **Initial Criteria:** *Approval Duration = 12 months*
  - The member must have a diagnosis of spinal muscular atrophy (SMA) with the following (as evidenced with submitted documentation):
    - Bi-allelic deletions or mutations of SMN1 as confirmed by genetic testing, reported as one of the following:
      - Homozygous deletions of exon 7
      - Compound heterozygous mutations
    - One of the following (A and/or B):
      - A. Member has number of SMN2 gene copies ≥ 1 but ≤ 4 as confirmed by genetic testing
      - B. Member is symptomatic (e.g. loss of reflexes, motor delay, motor weakness, abnormal EMG/neuromuscular ultrasound)
  - The medication must be prescribed by or in consultation with a neuromuscular neurologist or neuromuscular physiatrist
  - The member must visit with a neuromuscular clinic once per year and clinic name, contact information, and date of last visit must be provided
  - The member must be 2 months of age or older
  - The member must not require continuous intubation > 3 weeks
  - The member must not be receiving/have received treatment with Zolgensma
  - The member's weight and prescribed dose must be provided and within dosing recommendations per the manufacturer label
  - The provider must submit documentation of the member's current motor function, as evidenced by scores from at least two of the following assessments
    - A. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorder (CHOP-INTEND)
    - B. Hammersmith Infant Neurological Examination (HINE) Section 2 motor milestone score
    - C. Hammersmith Functional Motor Scale Expanded (HFMSE)
    - D. Motor Function Measure – 32 items (MFM-32)
    - E. Revised Upper Limb Module (RULM)
    - F. 6 minute walk test (6MWT)
    - G. Forced Vital Capacity (FVC) via Pulmonary Function Test

- **Renewal Criteria:** *Approval Duration = 12 months*
    - The member's weight and prescribed dose must be provided and within dosing recommendations per the manufacturer label
    - The member must visit with a neuromuscular clinic once per year and clinic name, contact information, and date of last visit must be provided
    - The member must not require continuous intubation > 3 weeks
        A. The provider must submit documentation showing that the member has experienced clinical benefit since starting treatment with Evrysdi, as evidenced by documentation of current Forced Vital capacity (FVC and FEV1) via Pulmonary Function Test, CHOP-INTEND, HINE, HFMSE, MFM-32, 6MWT, or RULM scores showing maintenance of baseline motor function or significant slowed rate of decline (vs expected natural course of the disease).

PA REQUIRED
EVRYSDI (Risdiplam)

Tardive Dyskinesia

Electronic Step Care and Concurrent Medications

- Start Ingrezza with Initiation Pack before continuing therapy with 80mg capsules
    - The 30-count 40 mg bottle is not packaged for titration to 80 mg. If therapy is expected to be continued at 40 mg at time of drug initiation, please call for override.

Prior Authorization

Prior Authorization Form – Tardive Dyskinesia

- **Initial Criteria:** *Approval Duration = 12 months*
    - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
    - The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).
    - The member must have a diagnosis of tardive dyskinesia, including the following:
        - Involuntary athetoid or choreiform movements
        - History of treatment with dopamine receptor blocking agent (DRBA)
        - Symptom duration lasting longer than 4-8 weeks
- **Renewal Criteria:** *Approval Duration = 12 months*
    - Documentation of disease stabilization or improvement in disease since initiation of treatment must be provided

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AUSTEDO (deutetrabenazine)	
INGREZZA (valbenazine)	
tetrabenazine	

Ophthalmology

Antihistamines

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 30-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALOCRIL (nedocromil)	bepotastine
ALOMIDE (lodoxamide)	epinastine
azelastine	olopatadine 0.2%
BEPREVE (bepotastine) – *Brand Required*	ZERVIATE (cetirizine)
cromolyn	
LASTACAFT (alcaftadine)	
olopatadine 0.1%	
PAZEO (olopatadine)	

Anti-infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 3-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

Drops

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BESIVANCE (besifloxacin) DROPS	AZASITE (azithromycin) DROPS
ciprofloxacin drops	BLEPH-10 (sulfacetamide) DROPS
gentamicin sulfate drops	CILOXAN (ciprofloxacin) DROPS
moxifloxacin drops	gatifloxacin drops
neomycin SU/polymyxin B/gramicidin drops	levofloxacin drops
ofloxacin drops	MOXEZA (moxifloxacin) DROPS
polymyxin B/trimethoprim drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS
sulfacetamide drops	OCUFLOX (ofloxacin) DROPS
tobramycin drops	POLYTRIM (polymyxin B/trimethoprim) DROPS
	TOBREX (tobramycin) DROPS
	VIGAMOX (moxifloxacin) DROPS
	ZYMAXID (gatifloxacin) DROPS

Ointment

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
bacitracin/polymyxin B ointment	bacitracin ointment
CILOXAN (ciprofloxacin) OINTMENT	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT
erythromycin ointment	POLYCIN (bacitracin/polymyxin) OINTMENT
GENTAK (gentamicin sulfate) OINTMENT	sulfacetamide ointment
gentamicin sulfate ointment	
neomycin SU/bacitracin/polymyxin B ointment	
TOBREX (tobramycin) OINTMENT	

Anti-infectives/Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 7-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Drops

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS
neomycin/polymyxin b/dexamethasone drops	neomycin/polymyxin b/hydrocortisone drops
PRED-G (gentamicin/prednisol ac) DROPS	TOBRADEX ST (tobramycin/dexamethasone) DROPS
sulfacetamide/prednisolone drops	tobramycin/dexamethasone drops
TOBRADEX (tobramycin/dexamethasone) DROPS – *Brand Required*	
ZYLET (tobramycin/lotepred etab) DROPS	

Ointment

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
neomycin/polymyxin b/dexamethasone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment
PRED-G (gentamicin/prednisol ac) OINTMENT	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT
TOBRADEX (tobramycin/dexamethasone) OINTMENT	neomycin/bacitracin/polymyxin b/hydrocortisone ointment
	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT

Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 5-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Drops

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACUVAIL (ketorolac) DROPS	ACULAR (ketorolac) DROPS
ALREX (loteprednol) DROPS	ACULAR LS (ketorolac) DROPS
diclofenac sodium drops	bromfenac sodium drops
DUREZOL (difluprednate) DROPS – *Brand Required*	BROMSITE (bromfenac sodium) DROPS
FLAREX (fluorometholone) DROPS	dexamethasone sodium phosphate drops
fluorometholone drops	difluprednate drops
flurbiprofen sodium drops	EYSUVIS (loteprednol) DROPS
FML FORTE (fluorometholone) DROPS	INVELTYS (loteprednol) DROPS
ILEVRO (nepafenac) DROPS	FML (fluorometholone) DROPS
ketorolac tromethamine 0.4% drops	LOTEMAX SM (loteprednol) DROPS
ketorolac tromethamine 0.5% drops	loteprednol eye drops
LOTEMAX (loteprednol) DROPS – *Brand Required*	loteprednol gel eye drops
LOTEMAX (loteprednol) GEL DROPS – *Brand Required*	PRED FORTE 1% (prednisolone acetate) DROPS
MAXIDEX (dexamethasone) DROPS	PROLENSA (bromfenac) DROPS
NEVANAC (nepafenac) DROPS	
PRED MILD 0.12% (prednisolone acetate) DROPS	
prednisolone acetate 1% drops	
prednisolone sodium phosphate 1% drops	

Ointment

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FML S.O.P. (fluorometholone) OINTMENT	
LOTEMAX (loteprednol) OINTMENT	

Dry Eye Syndrome

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 14-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Cequa, Restasis Multidose**
  - The member must have had a 30-day trials of Xiidra, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the member is unable to use all other products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
RESTASIS (cyclosporine)	CEQUA (cyclosporine)***
	RESTASIS MULTIDOSE (cyclosporine)***
	XIIDRA (lifitegrast)

Glaucoma

Alpha Adrenergic

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The member must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The member must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

ALPHAGAN P 0.1% (brimonidine) DROPS	brimonidine 0.15% drops
ALPHAGAN P 0.15% (brimonidine) DROPS – *Brand Required*	
apraclonidine 0.5% drops	
brimonidine 0.2% drops	
COMBIGAN (brimonidine/timolol) DROPS	
IOPIDINE (apraclonidine) 1% DROPS	
LUMIFY (brimonidine) 0.03% DROPS	
SIMBRINZA (brinzolamide/brimonidine) DROPS	

Beta Blockers

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of at least 2 preferred ophthalmic beta blocker products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BETOPTIC S (betaxolol) 0.25% DROPS	betaxolol 0.5% drops
carteolol drops	BETIMOL (timolol) DROPS
COMBIGAN (brimonidine/timolol) DROPS	COSOPT (dorzolamide/timolol) PF DROPS
dorzolamide/timolol drops	ISTALOL (timolol maleate) DROPS ONCE DAILY
levobunolol drops	timolol drops once daily
timolol maleate drops	timolol gel forming solution
timolol maleate/PF drops	TIMOPTIC (timolol maleate) DROPS
TIMOPTIC OCUDOSE 0.25% (timolol) PF DROPS	TIMOPTIC OCUDOSE 0.5% (timolol) PF DROPS
	TIMOPTIC-XE (timolol gel forming solution)

Prostaglandins

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of at least 2 preferred ophthalmic prostaglandin products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
latanoprost	bimatoprost 0.03%
LUMIGAN (bimatoprost) 0.01%	travoprost
ROCKLATAN (netarsudil/Latanoprost)	VYZULTA (latanoprostene)
TRAVATAN Z (travoprost) - *Brand Required*	XALATAN (latanoprost)
ZIOPTAN (tafluprost)	XELPROS (latanoprost)

Other

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The member must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The member must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AZOPT (brinzolamide) – *Brand Required*	brinzolamide
dorzolamide	COSOPT (dorzolamide/timolol)
PHOSPHOLINE (Echothiophate Iodide)	ISOPTO CARPINE (pilocarbine)
pilocarpine	TRUSOPT (dorzolamide)
RHOPRESSA (netarsudil)	
ROCKLATAN (netarsudil/latanoprost)	
SIMBRINZA (brinzolamide/brimonidine)	

Uveitis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	

Otic

Anti-infectives/Anti-inflammatories – Fluoroquinolones

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 7-day trial of one preferred product in the past 3 months, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CIPRO HC (ciprofloxacin/hydrocortisone)	ciprofloxacin/dexamethasone otic drops
CIPRODEX (ciprofloxacin/dexamethasone) – *Brand Required*	ciprofloxacin/fluocinolone
	OTOVEL (ciprofloxacin/fluocinolone)

Pain

Lidocaine patch

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
lidocaine 4% patch	lidocaine 5% patch
LIDODERM (lidocaine) 5% PATCH – *Brand Required*	
ZTLIDO (lidocaine) 1.8% PATCH	

Lidocaine topical cream

General Prior Authorization Form

Group Criteria:

- The request must be for injection pain from a medically necessary procedure

NSAIDS

Therapeutic Duplication

- One strength of one medication is allowed at a time (topical and oral formulations are not allowed together)
  - **Please call for an override** if all the following circumstances apply by calling provider relations at 1-800-755-2604:
    - Member is prescribed ketorolac and will stop regular NSAID therapy during course of ketorolac

Electronic Diagnosis Verification

- **Mefenamic acid and Meclofenamate:** The member must have diagnosis of dysmenorrhea or endometriosis

Solid Oral Dosage Forms

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have failed a 30-day trial of 3 different oral generic NSAIDs including a COX-2 inhibitor with GI intolerances, as evidenced by paid claims or pharmacy print outs

Product Specific Criteria:

- **Branded NSAIDs and non-preferred strengths**:
  - Clinical justification must be provided explaining why the member is unable to use other NSAID agents (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

celecoxib 50mg, 100mg, 200mg	ARTHROTEC (diclofenac/misoprostol)
diclofenac potassium	celecoxib 400mg
diclofenac sodium 50mg, 75mg	CELEBREX (celecoxib)
etodolac	CONSENSI (amlodipine/celecoxib)
flurbiprofen	DAYPRO (oxaprozin)
ibuprofen	diclofenac sodium ER 100mg
indomethacin	diclofenac sodium 35mg capsule, submicronized
indomethacin ER	diclofenac/misoprostol
ketorolac	DUEXIS (famotidine/ibuprofen)
meclofenamate	etodolac ER
mefenamic acid	FELDENE (piroxicam)
meloxicam	fenoprofen
nabumetone	INDOCIN (indomethacin)
naproxen	ketoprofen
piroxicam	ketoprofen ER 200mg
sulindac	meloxicam, submicronized
VIMOVO (naproxen/esomeprazole) – *Brand Required*	MOBIC (meloxicam)
ZIPSOR (diclofenac)	NALFON (fenoprofen)
	NAPRELAN (naproxen)
	naproxen ER 375 mg, 500mg
	naproxen/esomeprazole
	oxaprozin
	RELAFEN DS (nabumetone)
	tolmetin 200mg
	VIVLODEX (meloxicam, submicronized)
	ZORVOLEX (diclofenac, submicronized)

Non-Solid Oral Dosage Forms

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
ibuprofen suspension	INDOCIN (Indomethacin) SOLUTION
naproxen suspension	

Nasal

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 30-day trials of 2 oral and 1 topical preferred agents, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use another dosage form (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	Ketorolac Nasal Spray
	SPRIX (Ketorolac) NASAL SPRAY

Topical:

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts.

- Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Diclofenac 1.5% Topical Solution	Diclofenac Patch
FLECTOR (diclofenac) PATCH - *Brand Required*	LICART (Diclofenac) PATCH 1.3%
PENNSAID (Diclofenac) 2% PUMP	

Opioid Analgesics – Long Acting

Therapeutic Duplication

- One extended-release product/strength is allowed at a time
- One immediate release product is allowed (single ingredient or combination)
- Nucynta and Nucynta ER are not allowed with other narcotic medications
- Opioid-acetaminophen combination products are not allowed with acetaminophen
- Tramadol immediate release with tramadol extended release
- Methadone is not allowed
- 3A4 Substrates (Fentanyl, methadone, and oxycodone) are not allowed with strong 3A4 inhibitors. Click here for a full listing of medications included.
- Methadone: Not allowed with opioids, benzodiazepines, or opioid use disorder medications
- Opioids are not allowed with:
    - Benzodiazepines: Opioid and Benzodiazepines Concurrent Use Form
        - Due to guidance in The SUPPORT for Members and Communities Act (H.R. 6) on CNS depression, this includes long-acting opioids over 90 MME/day or immediate release opioids over 15 MME/dose in combination with benzodiazepines
        - **Opioids and Benzodiazepines Override Criteria:**
            - The prescriber must attest that they have reviewed the past 3 months of the member's North Dakota PDMP reports.
                - The member has access to Narcan and has been counseled on overdose risk
                - One of the following criteria must be met:
                    - Prescriber must be or be in consult with an oncologist, palliative care specialist, or pain management specialist including a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens)
                    - Member must have taper plan of one or both agents
                - The following criteria is met:
                    - Prescriber(s) of both agents have provided reasons why opioid analgesics and benzodiazepines cannot be avoided, or lower doses be used (subject to clinical review)
                    - Prescriber(s) from both the opioid and benzodiazepine attest to the following:
                        - The member must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.
                        - Opioid dose does not exceed 90 MME/day
                        - The member has an acute condition that cannot be reasonably treated with non-opioid therapy (e.g. surgery)
    - Carisoprodol: The "Holy Trinity" consists of an opioid, a benzodiazepine, and carisoprodol and is a highly abused dangerous combination that can lead to additive CNS depression, overdose, and death. It is not covered.
    - **Opioid use disorder medications override criteria**:
        - Call provider relations at 1-800-755-2604 if all the following circumstances apply:
            - The member has an acute condition that cannot be reasonably treated with non-opioid therapy (e.g. surgery)
            - Prescribers of both opioid and opioid use disorder are aware of each other and agree to opioid therapy
            - Opioid duration is of a one-time occurrence or taper plan is provided

- Morphine is not covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine. Other opioid analgesics are covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine.
    - Morphine may diminish the antiplatelet effect and serum concentrations of P2Y12 Inhibitor antiplatelet agents (clopidogrel, prasugrel, ticagrelor, and ticlopidine).

Underutilization

- Long-acting opioid analgesics must be used compliantly and will reject on point of sale for late fill

Morphine Milligram Equivalents (MME)

Prior Authorization Form – Opioid Analgesics

- A cumulative maximum of 90 MME will be allowed without authorization
- Member must meet Prior Authorization Criteria
- An MME calculator may be found at Opioid Dose Calculator

Prior Authorization Criteria

Prior Authorization Form – Opioid Analgesics

Category Criteria (initial):

- The prescriber must attest that they have reviewed the past 3 months of the member's North Dakota PDMP reports.
- The member must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.).
- The member must have established opioid tolerability by using short acting opioids daily for at least 90 days prior to request for long-acting opioid, as evidenced by paid claims or pharmacy printouts
- The member must have access to Narcan and be counseled on overdose risk
- The prescription must be written by or in consultation with an oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if one of the following:
    - Cumulative daily dose of opioids exceeds 90 MED/day

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the member is unable to use other opioid and non-opioid analgesic agents (subject to clinical review).

Category Criteria (renewal):

- Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

Partial Agonist/Antagonist Opioids

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BELBUCA (buprenorphine)	buprenorphine patches
butorphanol	
BUTRANS (buprenorphine) PATCHES - *Brand Required*	

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

Prior Authorization Form – Opioid Analgesics

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NUCYNTA ER (tapentadol)	ARYMO ER (morphine)
OXYCONTIN (oxycodone) – *Brand Required*	CONZIP (tramadol ER) CAPSULES
tramadol ER Tablets	hydrocodone ER tablets
	HYSINGLA ER (hydrocodone)
	levorphanol
	methadone
	MORPHABOND ER (morphine)
	tramadol ER Capsules
	XTAMPZA ER (oxycodone)

Full Agonist Opioids Without Abuse Deterrent Formulations

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Fentanyl Patch:**

- Member must meet one of the following criteria:
  - The member has an indication of cancer pain or palliative care pain
  - The member requires a long-acting narcotic and cannot tolerate an oral dosage form
- Member must have a BMI ≥17
- **Fentanyl Patch 12 mcg/hr**:
  - Member must meet one of the following (A or B):

A. The member must be receiving a total daily opioid dose less than or equal to 60 Morphine Equivalent Dose (MED), as evidenced by paid claims or pharmacy printouts

B. The member must be continuously tapering off opioids from a higher strength Fentanyl patch

Full Agonist Opioids Without Abuse Deterrent Formulations	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
fentanyl 12 mcg/hr	EXALGO (hydromorphone)
fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr	fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr
morphine ER tablets	hydrocodone ER capsules
	hydromorphone ER tablets
	KADIAN (morphine)
	morphine ER capsules
	MS CONTIN (morphine)
	oxycodone ER
	oxymorphone ER tablets
	ZOHYDRO ER (hydrocodone)

Opioid Analgesic – Short Acting

First Fill

- Short acting opioid analgesics must be filled with a 7-day supply if no previous fill within past 34 days
  - If member is filling prescription less than every 34 days due to decreased utilization, please get a new prescription for a lower quantity that reflects actual utilization within a 34-day window.

Prior Authorization Criteria

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Subsys, Fentanyl Citrate Buccal Tablet, Lazanda, Actiq, and Abstral:**
  - The member's age must be within label recommendations
  - The member must have a diagnosis of cancer pain
  - The member must currently be on around-the-clock opioid therapy for at least a week, as evidenced by paid claims or pharmacy printouts
    - The around the clock opioid therapy must be equivalent to 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily, or equianalgesic dose of another opioid daily
- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Initial):**
  - The member must have required around-the-clock pain relief for the past 90 days, as evidenced by paid claims or pharmacy printouts
  - The prescriber must attest that they have reviewed the past 3 months of the member's North Dakota PDMP reports
  - The member must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)
  - The prescription must be written by or in consultation with an oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens)
- **Oxycodone IR**
  - The "ALL Other Non-Preferred Short-Acting Opioid Analgesics" above Initial Criteria must be met
  - The member must currently be on a long-acting opioid analgesic that provides a daily Morphine Equivalent Dose (MED) which meets requirements below (based on requested strength), as evidenced by paid claims or pharmacy printouts (Please use an Opioid Dose Calculator to find the MED for specific products):
    - **Oxycodone 15 mg tablet:** long-acting opioid must provide ≥150 mg MED per day
    - **Oxycodone 20 mg tablet:** long-acting opioid must provide ≥200 mg MED per day
    - **Oxycodone 30 mg tablet:** long-acting opioid must provide ≥300 mg MED per day
- **Meperidine, butalbital-codeine products:**

- The above Initial Criteria must be met
- Clinical justification must be provided explaining why the member is unable to use other opioid and non-opioid analgesic products (subject to clinical review).

- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Renewal):**
  - Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
acetaminophen-codeine solution	ABSTRAL (fentanyl) SUBLINGUAL TABLET
acetaminophen-codeine tablets	ACTIQ (fentanyl) LOZENGE
benzhydrocodone-acetaminophen	butalbital-codeine
codeine tablets	CONZIP (tramadol) CAPSULE
hydrocodone-acetaminophen 7.5-325/15ml Solution	DEMEROL (meperidine)
hydrocodone-acetaminophen 5-325 MG	DILAUDID (hydromorphone)
hydrocodone-acetaminophen 7.5-325 MG	ENDOCET (oxycodone-acetaminophen)
hydrocodone-acetaminophen 10-325 MG	FENTORA (fentanyl) EFFERVESCENT TABLET
hydrocodone-ibuprofen 7.5mg-200mg	fentanyl citrate buccal tablet
hydromorphone liquid	fentanyl lozenge
hydromorphone tablet	hydrocodone-acetaminophen 5-163mg/7.5mL solution
meperidine	hydrocodone-acetaminophen 2.5-325 MG
morphine tablets	hydrocodone-acetaminophen 10MG-300MG
morphine solution	hydrocodone-acetaminophen 5 MG-300MG
NUCYNTA (tapentadol) TABLETS	hydrocodone-acetaminophen 7.5-300 MG
oxycodone 5mg, 10mg tablets	hydrocodone-ibuprofen 5mg-200mg and 10mg-200mg
oxycodone solution	LAZANDA (fentanyl) SPRAY
oxycodone-acetaminophen 5-325 MG	LORCET (hydrocodone-acetaminophen)
oxycodone-acetaminophen 10 -325 MG	LORTAB (hydrocodone-acetaminophen) SOLUTION
oxymorphone tablets	NALOCET (oxycodone-acetaminophen)
tramadol 50mg tablets	NORCO (hydrocodone-acetaminophen)
tramadol-acetaminophen tablets	OPANA (oxymorphone)
	OXAYDO (oxycodone)
	oxycodone 15mg, 20mg, 30mg
	oxycodone-acetaminophen 2.5-325 MG
	oxycodone-acetaminophen 7.5-325 MG
	PERCOCET (oxycodone/acetaminophen)
	PRIMLEV (oxycodone/acetaminophen)
	PROLATE (oxycodone/acetaminophen)
	QDOLO (tramadol) ORAL SOLUTION
	ROXICODONE (oxycodone)
	ROXYBOND (oxycodone)
	SUBSYS (fentanyl) SPRAY
	tramadol 100mg tablets
	ULTRACET (tramadol/acetaminophen)
	ULTRAM (tramadol)
	VICODIN (hydrocodone/acetaminophen)

Skeletal Muscle Relaxants

Therapeutic Duplication

- One strength of one medication is allowed at a time
  - **Please call for an override** if all the following circumstances apply by calling provider relations at 1-800-755-2604:
    - Member has cerebral palsy or another chronic spastic disorder
    - Prescriber is a physiatrist
    - Requested combination is baclofen and tizanidine
- Carisoprodol is not allowed with opioids, benzodiazepines, or opioid use disorder medications

- The "Holy Trinity" consists of an opioid, a benzodiazepine, and carisoprodol and is a highly abused dangerous combination that can lead to additive CNS depression, overdose, and death. It is not covered.

- Tizanidine is not allowed with:
  - Antipsychotics: visual hallucinations being reported in 3% of members receiving tizanidine, psychosis has also been reported.
  - Other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa) as tizanidine is also an alpha 2 agonist

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 12 months*

- The member must have failed two 30-day trials of other skeletal muscle relaxants, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria

- **Metaxalone:** *Approval Duration = 12 months*
  - One of the required 30-day trials must be methocarbamol, as evidenced by paid claims or pharmacy printouts.
- **Carisoprodol:** *Approval Duration = 1 week*
  - The member must be undergoing dose tapering

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
baclofen	AMRIX (cyclobenzaprine) TAB 24HR
chlorzoxazone 500mg	chlorzoxazone 375mg and 750mg
cyclobenzaprine 5mg and 10mg	cyclobenzaprine 7.5mg
dantrolene	cyclobenzaprine ER
methocarbamol	carisoprodol
orphenadrine ER	carisoprodol-aspirin
tizanidine tablets	carisoprodol-aspirin-codeine
	DANTRIUM (dantrolene)
	FEXMID (cyclobenzaprine)
	LORZONE (chlorzoxazone)
	METAXALL (metaxalone)
	metaxalone
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)
	OZOBAX (baclofen) SOLUTION
	ROBAXIN (methocarbamol)
	SKELAXIN (metaxalone)
	SOMA (carisoprodol)
	tizanidine capsules
	ZANAFLEX (tizanidine)

Psychiatry

ADHD Agents

Therapeutic Duplication

- **For all stimulants:**
  - The following are not payable:
    - Multiple strengths of a single medication
    - Amphetamine Agent + Methylphenidate Agent
    - Multiple Long-Acting Agents
    - Multiple Short Acting Agents
    - Non-Solid dosage + Solid dosage forms

- These long acting products are not allowed with short acting products:
  - Aptensio XR (Methylphenidate)
  - Adhansia XR (Methylphenidate)
  - Cotempla XR-ODT (Methylphenidate)
  - Daytrana (Methylphenidate)
  - Adderall XR (Mixed Salts of a Single-Entity Amphetamine Product)
  - Adzenys XR ODT (Amphetamine Suspension, Extended Release)
  - Adzenys ER (Amphetamine Suspension, Extended Release)
  - Dyanavel XR (amphetamine suspension, Extended Release)
  - Mydayis (Mixed Salts of a Single-Entity Amphetamine Product)
  - Vyvanse (Lisexamfetamine)
  - Vyvanse Chewable (Lisexamfetamine)

- Amphetamines: One product will be allowed at a time. The following are not payable regimens:
  - Dextroamphetamine/Amphetamine ER with Proton Pump Inhibitors
    - Proton Pump Inhibitors increase blood levels and potentiate the action of amphetamine. Co-administration of Adderall XR and gastrointestinal or urinary alkalizing agents should be avoided
  - Concurrent use of Mydayis and Adhansia XR with benzodiazepines or sedatives
    - Members reporting insomnia should use a shorter acting product that does not reach steady state.

- Methylphenidates: The following are not payable regimens
  - Concurrent use of dexmethylphenidate and methylphenidate

- **For all non-stimulants:**
  - One strength of one medication is allowed at a time except for Guanfacine 4mg IR and ER which may be combined Guanfacine IR and ER, respectively, to form dosages up to 7mg per day
  - Clonidine, guanfacine are not allowed with each other or other alpha 2 agonists (clonidine/chlorthalidone, methyldopa, or tizanidine)
    - Methyldopa and tizanidine are also alpha 2 agonists

First Fill

- Long-Acting ADHD medications (stimulants and guanfacine ER) must be filled with a 14-day supply (or less) if no previous fill within past 99 days

Electronic Step Care and Concurrent Medication

*** **Clonidine ER:** A total of 30 days of clonidine IR must be paid within 40 days prior to clonidine ER

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 10-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Non-Stimulants

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
atomoxetine	INTUNIV (guanfacine ER)
clonidine	KAPVAY (clonidine ER)***
clonidine ER***	STRATTERA (atomoxetine
guanfacine	
guanfacine ER	
QELBREE (viloxazine)	

Stimulants

Stimulants - Methylphenidates	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Solid Dosage Forms	
CONCERTA (methylphenidate) – *Brand Required*	dexmethylphenidate ER

Stimulants - Methylphenidates	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
dexmethylphenidate	FOCALIN (dexmethylphenidate)
FOCALIN XR (dexmethylphenidate) – *Brand Required*	METADATE ER (methylphenidate)
methylphenidate CD 30-70	methylphenidate ER tablet (generic Concerta)
methylphenidate tablet	methylphenidate LA capsules - 50-50 (generic Ritalin LA)
methylphenidate ER tablet 10mg, 20mg	RITALIN (methylphenidate)
RITALIN LA (methylphenidate LA capsules - 50-50)– *Brand Required*	
High Cost Options	
ADHANSIA XR (methylphenidate)	methylphenidate ER 72 mg
AZSTARYS (serdexmethylphenidate/dexmethylphenidate)	methylphenidate ER capsule
JORNAY PM (methylphenidate)	
Non-Solid Dosage Forms	
DAYTRANA (methylphenidate)	METHYLIN (methylphenidate) chew tablets
methylphenidate chew tablet	METHYLIN (methylphenidate) solution
methylphenidate solution	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
High Cost Options	
APTENSIO XR (methylphenidate) – *Brand Required*	
COTEMPLA XR - ODT (methylphenidate)	

Stimulants - Amphetamines	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Solid Dosage Forms	
ADDERALL XR (dextroamphetamine/amphetamine) – *Brand Required*	ADDERALL (dextroamphetamine/amphetamine)
amphetamine	DEXEDRINE ER (dextroamphetamine)
DESOXYN (methamphetamine) – *Brand Required*	dextroamphetamine/amphetamine ER
dextroamphetamine	EVEKEO (amphetamine)
dextroamphetamine ER	methamphetamine
dextroamphetamine/amphetamine	ZENZEDI (dextroamphetamine)
VYVANSE (lisdexamfetamine)	
High Cost Options	
MYDAYIS (dextroamphetamine/amphetamine)	
Non-Solid Dosage Forms	
DYANAVEL XR (amphetamine)	dextroamphetamine 5 mg/5 ml
EVEKEO ODT (amphetamine)	
PROCENTRA (dextroamphetamine) – *Brand Required*	
High Cost Options	
ADZENYS XR - ODT (amphetamine)	ADZENYS ER (amphetamine) SOLUTION
amphetamine ER solution	
VYVANSE (lisdexamfetamine) CHEW TABLET	

Atypical Antipsychotics

Electronic Age Verification

- FDA or compendia supported age is required

Electronic Diagnosis Verification

- FDA or compendia supported indications is required

Therapeutic Duplication

Multiple Antipsychotic Override Request Form

- **For all antipsychotics:** One strength of one medication is payable with the following exceptions:
  - risperidone 0.25mg, 0.5mg and 1mg are allowed with other strengths of risperidone.

    - quetiapine 25mg and 50mg are allowed with other strengths of quetiapine IR.
    - quetiapine 50mg ER is allowed with other strengths of quetiapine ER.
    - olanzapine 2.5mg is allowed with 10mg, 15mg, and 20mg
    - olanzapine 5mg is allowed with 7.5mg and 20mg
    - olanzapine 7.5mg is allowed with 5mg
    - olanzapine 10mg, 15mg, and 20mg are allowed with 2.5mg
- Tizanidine is not allowed with antipsychotics due to visual hallucinations being reported in 3% of members receiving tizanidine, psychosis has also been reported. Please use an alternate muscle relaxant.
- Lybalvi: Lybalvi is not allowed with any other antipsychotic or opioid analgesics. Please call for an override to allow olanzapine with Lybalvi for dose titrations.

Additional information on olanzapine:
- Quantity limit is 1 tablet per day due to the 30-hour half-life of the medication.
- Pharmacokinetic studies show that olanzapine tablets and olanzapine ODT are bioequivalent.

Additional information on quetiapine:
- Quetiapine is not covered for sleep. For sleep indications, please use a sleeping medication indicated for insomnia.
- **For an override** for therapeutic duplication with quetiapine: Please call provider relations at 1-800-755-2604 if all of the following circumstances apply:
    - Nighttime akathisia (e.g. nighttime dosing with risperidone) or daytime sedation (e.g. Seroquel XR dosed at nighttime) must prevent ability to titrate to effective dose with monotherapy.
    - Other sleeping medications must be trialed. Primary use for insomnia will not be approved.

Oral

Electronic Step Care and Concurrent Medication

- Start Vraylar with Initiation pack or 7 days of 1.5 mg tablets prior to continuing therapy with doses of 3 mg or more
    - Vraylar requires titration from 1.5 mg dose at initiation.

Underutilization

- Caplyta, Fanapt, Latuda, Paliperidone ER, Rexulti, Saphris, Sacuado, and Vraylar must be used compliantly and will reject on point of sale for late fill

First Fill

- Caplyta, Fanapt, Latuda, Paliperidone ER, Rexulti, Saphris, Sacuado, and Vraylar must be filled with a 10-day supply if no previous fill within past 99 days

Prior Authorization Criteria

Non-Preferred Agents Criteria:
- **Branded non-preferred agents:** The member must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The member must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:
- ***olanzapine/fluoxetine**: Clinical justification must be provided explaining why the member is unable to use the preferred, individual products separately (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Solid Dosage Forms	
aripiprazole	ABILIFY (aripiprazole)
clozapine	asenapine
FANAPT (iloperidone)	CLOZARIL (clozapine)
INVEGA ER (paliperidone) – *Brand Required*	GEODON (ziprasidone)
LATUDA (lurasidone)	paliperidone ER
olanzapine	RISPERDAL (risperidone)
quetiapine	SEROQUEL (quetiapine)
quetiapine ER	SEROQUEL XR (quetiapine)
risperidone	ZYPREXA (olanzapine)

ziprasidone	
High Cost Options	
CAPLYTA (lumateperone)	olanzapine/fluoxetine***
LYBALVI (olanzapine/samidorphan)	
REXULTI (brexpiprazole)	
VRAYLAR (cariprazine)	
Non-Solid Dosage Forms	
clozapine ODT	RISPERDAL (risperidone) ORAL SOLUTION
olanzapine ODT	RISPERDAL M-TAB (risperidone)
risperidone ODT	ZYPREXA ZYDIS (olanzapine)
risperidone oral solution	
SAPHRIS (asenapine) – *Brand Required*	
High Cost Options	
aripiprazole solution	ABILIFY DISCMELT (aripiprazole)
aripiprazole ODT	
SECUADO (asenapine)	

Long Acting Injectable

Electronic Step Care and Concurrent Medication

- Oral formulations must be used prior to injectable formulations to establish tolerability and achieve steady state.
    - Please call for exception if there is a history of tolerability to active ingredient and no requirement for oral overlap for missed dose / initiation of long-acting injectable antipsychotic.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
INVEGA HAFYERA (paliperidone)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
ZYPREXA RELPREVV (olanzapine)	

Sedatives/Hypnotics

Therapeutic Duplication

- One strength of one medication is allowed at a time
    - Benzodiazepines indicated only for insomnia are not covered with other non-barbiturate insomnia medications or other benzodiazepines
- Sedative/hypnotics are not covered with:
    - Xyrem
    - Mydayis
        - Insomnia has been reported in 25-56% of members receiving Mydayis. Members reporting insomnia should use a shorter acting product that does not reach steady state.
    - Long-Acting Benzodiazepines due to CNS depression
        - Belsomra and Dayvigo are not covered with short or long-acting benzodiazepines
- Ramelteon is a 1A2 Substrate and is not covered with Fluvoxamine, a strong 1A2 inhibitor
- Mirtazapine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
    - Mirtazapine is also an alpha 2 agonist
- Benzodiazepines are not covered with Opioids: Override Criteria Available

Electronic Step Care and Concurrent Medications

- Zolpidem: Initiation with trial of 5 mg must be used for 7 days within 90 days prior to 10 mg tablets
    - Zolpidem is recommended to be used at lowest dose possible.
- Belsomra: The member must have had a 25- day trial of eszopiclone within the past 90 days

Prior Authorization Criteria

General Prior Authorization Form

Product Specific Criteria (Initial): *Approval Duration = 1 month*

- **temazepam, zolpidem SL, Dayvigo:**
  - The member's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The member must have had the following 25-day trials with the most recent failure within the last 90 days, as evidenced by paid claims or pharmacy printouts
    - eszopiclone
    - zolpidem ER
    - Belsomra
- **Edluar (zolpidem):**
  - The member's insomnia must be characterized by difficulty with sleep onset
  - The member must have had the following 25-day trials with the most recent failure within the last 90 days, as evidenced by paid claims or pharmacy printouts
    - zolpidem IR
    - zaleplon
    - eszopiclone
- **triazolam, fluazepam, estazolam, seconal sodium**
  - Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review)

Product Specific Criteria (Renewal): *Approval Duration = 6 months (2 weeks for b*enzodiazepines)

- **ALL Agents:**
  - The prescriber has provided confirmation that other conditions causing sleep issues have been ruled out
- **benzodiazepines (temazepam, triazolam, flurazepam, estazolam):**
  - The member must be undergoing dose tapering

Insomnia

Non-DEA scheduled (non-addictive) medications:

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
doxepin – labeler 44183	doxepin – labeler 00228, 00378
hydroxyzine	ramelteon
mirtazapine	SILENOR (doxepin)
ROZEREM (ramelteon) – *Brand Required*	
trazodone	

DEA scheduled (addictive) medications:

PREFERRED AGENTS (NO PA REQUIRED)	ELECTRONIC STEP MEDICATIONS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
eszopiclone	BELSOMRA (suvorexant)	AMBIEN (zolpidem)
zaleplon	zolpidem 10mg	AMBIEN CR (zolpidem)
zolpidem 5mg		DAYVIGO (lemborexant)
zolpidem ER		EDLUAR (zolpidem)
		estazolam
		flurazepam
		LUNESTA (eszopiclone)
		SECONAL SODIUM (secobarbital)
		temazepam
		triazolam
		zolpidem SL tab

Non-24 Hour Sleep-Wake Disorder

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The member must meet criteria as outlined in prescribing information (PI) including recommendations for diagnosis and age.

- The prescriber is a specialist, or the prescriber has consulted with a specialist in sleep disorders
- The member must have had a 30-day trial of Rozerem (ramelteon), as evidenced by paid claims or pharmacy printouts.
- One of the following must be met:
  - Member must be unable to perceive light in either eye
  - Sighted members must confirm diagnosis by documentation submitted of self-reported sleep diaries or actigraphy for at least 14 days demonstrating a gradual daily drift (typically later) in rest-activity patterns not better explained by sleep hygiene, substance or medication use, or other neurological or mental disorders.

- **Renewal Criteria**: *Approval Duration = 12 months*
  - The member must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ROZEREM (ramelteon) – *Brand Required*	HETLIOZ (tasimelteon)
	ramelteon

Pulmonology

Asthma/COPD

Therapeutic Duplication

- One medication from each class is allowed at time (nebulizers and inhalers are not payable together)
  - One inhaled steroid
  - Long-acting anticholinergic
  - Leukotriene pathway inhibitor
  - One long-acting beta agonist
  - One short acting beta agonist
    - Inhalers and Nebulizers work equally well whether used at home, in school, or otherwise outside of the home. If member receives multiple forms of rescue medication, the risk of unidentified uncontrolled asthma and rescue inhaler dependence is increased.
    - **Please call for an override** if any of the following circumstances apply by calling provider relations at 1-800-755-2604:
      - Maximally treated members (compliance with inhaled steroid, long-acting beta agonist, long-acting muscarinic antagonist, and Daliresp) with end-stage COPD will be allowed an ongoing override
      - Acutely ill children will be allowed a one-time override
      - Members with cystic fibrosis will be allowed an ongoing override
- Anticholinergic medications are not covered with Acetylcholinesterase Inhibitors (Aricept, Exelon, Razadyne, Pyridostigmine). Click here for a full listing of medications included.
- The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other, and the therapeutic effect of both products is diminished.

Concurrent Medication and Step Care

- Daliresp
  - A total of 90 days of an inhaled short or long-acting anticholinergic must be paid within 110 days prior to Daliresp's date of service.
    - According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, Daliresp is a recommended add-on therapy to members experiencing exacerbations while on antimuscarinic therapy.

Albuterol/ Levalbuterol Rescue Inhalers

References:

2. Albuterol Overuse: A Marker of Psychological Distress? Joe K. Gerald, Tara F. Carr, Christine Y. Wei, Janet T. Holbrook, Lynn B. Gerald. J Allergy Clin Immunol Pract. 2015 Nov-Dec; 3(6): 957–962. Published online 2015 Sep 1. doi: 10.1016/j.jaip.2015.06.021. PMCID: PMC4641773
3. Global Initiative for Asthma. Global strategy for asthma management and prevention. 2019 GINA Main Report. Available from: www.ginasthma.org. (Accessed February 5, 2020)
4. National Asthma Education and Prevention Program, Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda (MD): National Healrth, Lung, and Blood Institute (US); 2007 Aug. Available from: https://www.ncbi.nlm.nih.gov/books/NBK7232

5. High-Dose Albuterol by Metered-Dose Inhaler Plus a Spacer Device Versus Nebulization in Preschool Children With Recurrent Wheezing: A Double-Blind, Randomized Equivalence Trial Dominique Ploin, François R. Chapuis, Didier Stamm, Jacques Robert, Louis David, Pierre G. Chatelain, Guy Dutau and Daniel Floret Pediatrics. August 2000, 106 (2) 311-317; DOI: https://doi.org/10.1542/peds.106.2.311

Concurrent Medication and Step Care

- Ventolin HFA
  - A total of 30 days of steroid inhaler must be paid within 40 days prior to Ventolin HFA or ProAir Respiclick's date of service. The quantity limit for ProAir HFA is set to 2 canisters per 6 months (2 puffs per day). If more is needed, member must switch to Ventolin HFA and be on a steroid inhaler to control asthma.
    - According to the GINA guidelines:
      - A low dose ICS should be taken whenever SABA taken for step 1 control of asthma.
      - Dispensing ≥ 3 canisters per year is associated with higher risk of emergency department presentations
      - Dispensing ≥ 12 canisters per year is associated with higher risk of death
  - **Please call for an override:** if the following circumstance applies by calling provider relations at 1-800-755-2604:
    - If primary insurance will only pay for Ventolin HFA or ProAir Respiclick and member is well-controlled without steroid inhaler (i.e., uses less than 2 canisters per 6 months).
- Xopenex HFA
  - A total of 30 days of albuterol HFA must be paid within 180 days prior to Xopenex HFA's date of service

Prior Authorization

General Prior Authorization Form
MedWatch Form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PROAIR (albuterol) HFA – *Brand Required*	albuterol HFA
PROAIR RESPICLICK (albuterol)	levalbuterol HFA
VENTOLIN (albuterol) HFA– *Brand Required*	PROAIR (albuterol) DIGIHALER
	PROVENTIL (albuterol) HFA
	XOPENEX (levalbuterol) HFA

Anticholinergics/Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of 2 preferred, combination anticholinergic/long-acting beta agonist products, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Duaklir Pressair:**
  - The member must have had 30-day trials of Bevespi Aerosphere, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
albuterol/ipratropium	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)
ANORO ELLIPTA (umeclidinium/vilanterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)***
COMBIVENT RESPIMAT (albuterol/ipratropium)	DUONEB (albuterol/ipratropium)
STIOLTO RESPIMAT (tiotropium/olodaterol)	

Biologics

General Prior Authorization Form

Category Criteria (Initial): *Approval Duration = 3 months*

- The member must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, a pulmonologist or allergist/immunologist

- The member must have had at least 1 asthma exacerbation requiring use of oral corticosteroids in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the member has achieved a significant reduction in asthma exacerbations and utilization of rescue medications since treatment initiation

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)	

Corticosteroids - Inhaled

Electronic Duration Verification:

- Budesonide Suspension 1mg/2mL is payable for 30 days every 75 days. Guidelines recommend that once control is achieved, dose should be titrated down to minimum dose required to maintain control. For doses 1.5mg per day or lower, please use 0.5mg/2mL strength.
- For diluted nasal rinses, please use 0.5mg/2mL instead of 1mg/2mL for doses 1mg per day or higher.

Prior Authorization

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of each preferred inhaler of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Alvesco, Armonair Digihaler**:
  - Member must have had a 30-day trial of Asmanex HFA, as evidenced by pharmacy claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ASMANEX (mometasone) TWISTHALER	ALVESCO (ciclesonide)***
budesonide Suspension	ARMONAIR DIGIHALER (fluticasone)***
FLOVENT DISKUS (fluticasone)	ARNUITY ELLIPTA (fluticasone)
FLOVENT HFA (fluticasone)	ASMANEX HFA (mometasone)
PULMICORT FLEXHALER (budesonide)	PULMICORT RESPULES (budesonide)
	QVAR REDIHALER (beclomethasone)

Long-Acting Anticholinergics

Electronic Diagnosis Verification

- Spiriva Respimat 1.25mg: Member must have a diagnosis of asthma
- All other long-acting anticholinergics must have a diagnosis of COPD

Concurrent Medication and Step Care

- Spiriva Respimat 1.25mg
  - A total of 30 days of a long-acting beta agonist (in combination or alone) must be paid within 40 days prior to Spiriva Respimat 1.25mg's date

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had a 30-day trial of at least 2 preferred long-acting anticholinergic agents, as evidenced by paid claims or pharmacy printouts.
  - Either single ingredient or combination products will count toward trials.

Product Specific Criteria:

- ***Lonhala Magnair**:
  - The member must have had a 30-day trial of Yupelri, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

INCRUSE ELLIPTA (umeclidinium)	LONHALA MAGNAIR (glycopyrrolate)***
SPIRIVA HANDIHALER (tiotropium)	TUDORZA PRESSAIR (aclidinium)
SPIRIVA RESPIMAT 2.5 MCG (tiotropium)	YUPELRI (revefenacin)

Long-Acting Beta Agonists

General Prior Authorization Form

Group Criteria:

- **Generic non-preferred agents:** The member must have had a 10-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BROVANA (arformoterol) – *Brand Required*	arformoterol
PERFOROMIST (formoterol) – *Brand Required*	formoterol
SEREVENT DISKUS (salmeterol)	
STRIVERDI RESPIMAT (olodaterol)	

Steroid/Long-Acting Beta Agonist (LABA) Combination Inhalers

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts
- The member must have a diagnosis of an FDA-approved indication for use and meet the criteria for that diagnosis
    - **For COPD diagnosis:**
        A. The member must currently be taking a long acting antimuscarinic agent
    - **For asthma diagnosis:**
        - The member must have been reviewed for step down therapy for all renewal requests.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ADVAIR DISKUS (fluticasone/salmeterol) – *Brand Required*	AIRDUO DIGIHALER (fluticasone/salmeterol)
ADVAIR HFA (fluticasone/salmeterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)
SYMBICORT (budesonide/formoterol)) – *Brand Required*	budesonide/formoterol
	fluticasone/salmeterol
	WIXELA INHUB (fluticasone/salmeterol)

Steroid/Anticholinergics/Long-Acting Beta Agonists Combinations

General Prior Authorization Form

Group Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- **For COPD diagnosis:** the member must have had two 30-day trials of each of the following (either in combination or as single agents) as part of a maximized triple therapy, as evidenced by paid claims or pharmacy printouts:
    1. Long-Acting Anticholinergics
    2. Long-Acting Beta Agonist
    3. Inhaled Steroid
- **For asthma diagnosis:** the member must have had at least two 30-day trials of each of the following (either in combination or as single agents) in addition to Spiriva Respimat 1.25mg inhaler as part of a maximized triple therapy, as evidenced by paid claims or pharmacy printouts:
    1. Long-Acting Beta Agonist
    2. Inhaled Steroid

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of the preferred product, as evidenced by paid claims or pharmacy printouts:

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)	BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)

Cystic Fibrosis

Cystic Fibrosis - Inhaled Antibiotics

General Prior Authorization Form

Product Specific Criteria:

- ***Tobi Podhaler:**
  - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
  - The member must have had a 28-day trial of a preferred nebulized product, as evidenced by paid claims or pharmacy printouts.
- ***Cayston:**
  - The member must be colonized with *Pseudomonas aeruginosa.*
  - The member must have had a 28-day trial of TOBI Podhaler, as evidenced by paid claims or pharmacy printouts.
- ***Arikayce:**
  - The member must be colonized with *Mycobacterium avium* complex (MAC).
  - The member must have not achieved negative sputum cultures after a minimum duration of 6 consecutive months of background treatment with a macrolide, a rifamycin, and ethambutol.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BETHKIS (tobramycin)	ARIKAYCE (amikacin/nebulizer) ***
KITABIS PAK (tobramycin/nebulizer) - *Brand Required*	CAYSTON (aztreonam)***
TOBI PODHALER (tobramycin) PA***	TOBI (tobramycin) in 0.225% sodium chloride
tobramycin in 0.225% sodium chloride	tobramycin/nebulizer

Cystic Fibrosis – CFTR Modulators

General Prior Authorization Form

Group Criteria: *Approval Duration = 12 months*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have a CFTR mutation that the requested medication is FDA-approved to treat, as evidenced by medical documentation (e.g. chart notes, genetic testing) that is attached to the request

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KALYDECO (ivacaftor)	
ORKAMBI (lumacaftor/ivacaftor)	
SYMDEKO (tezacaftor/ivacaftor)	
TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	

Cystic Fibrosis – Osmotic Agent

Electronic Diagnosis Verification

- The member must have an FDA-approved indication for use

Electronic Age Verification

- The member must be 18 years or older

Prior Authorization

- Documentation of the Bronchitol Tolerance Test must be submitted

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BRONCHITOL (Mannitol) INHALER	

Idiopathic Pulmonary Fibrosis / Interstitial Lung Disease

General Prior Authorization Form

Category Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The prescriber must be, or in consult with, a pulmonologist or rheumatologist.
- The prescriber must submit documentation of the following:
  - The member must have forced vital capacity (FVC) ≥ 40% of predicted within prior 60 days
  - The member must have carbon monoxide diffusing capacity (DLCO, corrected for hemoglobin) of 30% to 79% of predicted.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACTEMRA (tocilizumab)	
ESBRIET (pirfenidone)	
OFEV (nintedanib)	

Rheumatology

Biologics

Electronic Diagnosis Verification

- The member must have an FDA-approved indication for use

Prior Authorization

General Prior Authorization Form

Product Specific Criteria:

- Anti-interleukin (IL)17 antibodies:
  - The member must have a 3-month trial of an Anti-TNF inhibitor, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria:

- The member must have had a 3-month trial of a preferred agent from each class approved for patient's diagnosis, as evidenced by paid claims or pharmacy printouts.

ANKYLOSING SPONDYLITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-TNF Inhibitors	
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	SIMPONI (golimumab)
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti–interleukin (IL) 17 Antibodies	
TALTZ (ixekizumab)***	COSENTYX (secukinumab)
BEHCET'S SYNDROME	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-TNF Inhibitors	
HUMIRA (adalimumab)	
Phosphodiesterase 4 (PDE4) Inhibitor	
OTEZLA (apremilast)	
GIANT CELL ARTERITIS (TEMPORAL ARTERITIS)	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-Interleukin-6 (IL-6) Receptor Inhibitors	
ACTEMRA (tocilizumab)	
JUVENILE IDIOPAHIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-TNF Inhibitors	
ENBREL (etanercept)	
HUMIRA (adalimumab)	
NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-TNF Inhibitors	
HUMIRA (adalimumab)	CIMZIA (certolizumab)
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti–interleukin (IL) 17 Antibodies	
TALTZ (ixekizumab)***	COSENTYX (secukinumab)
POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**

Anti-Interleukin-6 (IL-6) Receptor Inhibitors	
	ACTEMRA (tocilizumab)
Cytotoxic T Lymphocyte Antigen Immunoglobulin (CTLA-4 Ig)	
	ORENCIA (abatacept)
Janus Kinase (JAK) Inhibitors	
XELJANZ (tofacitinib)	
XELJANZ (tofacitinib) ORAL SOLUTION	
XELJANZ XR (tofacitinib)	
PSORIATIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-TNF Inhibitors	
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	SIMPONI (golimumab)
Phosphodiesterase 4 (PDE4) Inhibitor	
OTEZLA (apremilast)	
Janus Kinase (JAK) Inhibitors	
XELJANZ (tofacitinib)	XELJANZ XR (tofacitinib)
Cytotoxic T Lymphocyte Antigen Immunoglobulin (CTLA-4 Ig)	
	ORENCIA (abatacept)
Anti – Interleukin (IL) 23 Antibodies	
	STELARA (ustekinumab)
	TREMFYA (guselkumab)
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti – Interleukin (IL) 17 Antibodies	
TALTZ (ixekizumab)***	COSENTYX (secukinumab)
RHEUMATOID ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-TNF Inhibitors	
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	SIMPONI (golimumab)
Janus Kinase (JAK) Inhibitors	
XELJANZ (tofacitinib)	OLUMIANT (baricitinib)
	RINVOQ (upadacitinib)
	XELJANZ XR (tofacitinib)
Anti-Interleukin-1 (IL-1) Receptor Inhibitors	
KINERET (anakinra)	
Anti – Interleukin 17 (IL) 17 Antibodies	
	COSENTYX (secukinumab)
Anti-Interleukin-6 (IL-6) Receptor Inhibitors	
	ACTEMRA (tocilizumab)
	KEVZARA (sarilumab)
Cytotoxic T Lymphocyte Antigen Immunoglobulin (CTLA-4 Ig)	
	ORENCIA (abatacept)
SYSTEMIC ONSET JUVENILE CHRONIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Anti-Interleukin-6 (IL-6) Receptor Inhibitors	
ACTEMRA (tocilizumab)	

Osteoporosis

Electronic Diagnosis Verification

- Risedronate 30mg requires FDA indication of Paget's Disease of the bone and is not indicated for osteoporosis

Oral Bisphosphonates

Prior Authorization Form - Osteoporosis

- The member must have a current BMD T-score ≤ -2.5 OR new fracture (as evidenced by submitted documentation) after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Alendronate or Risedronate

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
alendronate	ACTONEL (risedronate)
alendronate oral solution	ATELVIA (risedronate DR)
ibandronate	FOSAMAX (alendronate)
risedronate IR	risedronate DR

Non-Oral Bisphosphonates

Prior Authorization Form - Osteoporosis

Non-Preferred Agents Criteria (Initial): *Approval Duration = 2 years*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have a current BMD T-score ≤ -2.5 OR new fracture (as evidenced by submitted documentation) after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    - alendronate or risedronate
    - teriparatide
- Member must be at high risk of fracture, confirmed by documentation of at least one of the following:
    - The member with a history of hip or vertebral fracture
    - The member with a T-score of −2.5 or lower at the femoral neck or spine
    - The member has a T-score of between −1.0 and −2.5 at the femoral neck or spine and a ten-year hip fracture risk of ≥3% as assessed with the FRAX
    - 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
calcitonin, salmon nasal spray	EVISTA (raloxifene)
MIACALCIN (calcitonin, salmon)	FORTEO (teriparatide)
raloxifene	TYMLOS (abaloparatide)
teriparatide	

Substance Use

Nicotine / Tobacco Dependence Treatment

Concurrent Medication and Step Care

- A total of 14 days of Nicotine patch, Chantix, or Zyban must be paid within 40 days prior to Nicotrol Nasal Spray, nicotine lozenge, nicotrol inhaler, or nicotine gum's date of service.
    - Better outcomes are associated with concurrent use of short acting and long-acting tobacco cessation products.
- A total of 14 days of Nicotine patch, gum, lozenge, inhaler, or spray must be paid within 40 days prior to Zyban's date of service.
    - Better outcomes are associated with concurrent use of short acting and long-acting tobacco cessation products. Nicotine products can help bridge treatment until Zyban becomes effective.

Electronic Duration Verification

- A total of 12 consecutive weeks will be covered for all other products, every 6 months
    - Chantix:
      Please call for an override if the following conditions apply by calling provider relations at 1-800-755-2604:
        - Patent is abstinent from tobacco
        - Treatment duration is requested to be extended to 24 consecutive weeks

Therapeutic Duplication

- nicotine gum, lozenge, inhaler, and spray will not be paid concurrently

- Zyban will not be paid with other forms of bupropion

Underutilization

- Nicotine Patch, Chantix, and Bupropion must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The member must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
bupropion SR	NICODERM CQ (nicotine) PATCH
CHANTIX (varenicline)	NICORETTE (nicotine polacrilex) GUM
nicotine lozenge	ZYBAN (bupropion SR)
nicotine patch	
nicotine polarcrilex gum	
NICOTROL (nicotine polacrilex) INHALER	
NICOTROL (nicotine polacrilex) SPRAY	

Opioid Dependence Treatment

Lucemyra

General Prior Authorization Form

Group Criteria:

- The member must have a diagnosis of an FDA-approved indication for use
- The member must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
clonidine	LUCEMYRA (lofexidine)
guanfacine	

Opioid Antagonist

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
VIVITROL (Naltrexone Microspheres)	

Naloxone Rescue Medications

Please call for an override by calling provider relations at 1-800-755-2604:
The following information will need to be submitted as a follow up for the override by either emailing medicaidpharmacy@nd.gov or documenting on General Prior Authorization Form:

- The provider must attest that it is known that the previous dose was taken by the member (and not diverted or given to another member)
- One of the following criteria must be met (A, B, or C)
    A. The previous dose has expired
    B. The dose was used by member for illicit drug use
    C. The member is currently taking opioids and meets one of the following criteria:
        - The opioid dose must have been decreased
        - The provider has provided medical justification why the opioid dose as not been Decreased

Non-Preferred Agents Criteria:

- The provider has provided medical justification explaining why the member cannot use Narcan Nasal Spray or injectable naloxone.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KLOXXADO (naloxone) NASAL SPRAY	
Naloxone injection	
NARCAN (naloxone) NASAL SPRAY	

Opioid Partial Agonist

Therapeutic Duplication

- One strength of one medication is allowed at a time
- Opioid Partial Agonists are not allowed with:
  - Methadone
  - Carisoprodol
  - Opioid Analgesics
    - **For an override,** please call provider relations at 1-800-755-2604 if all the following circumstances apply:
      - The member has an acute condition that cannot be reasonably treated with non-opioid therapy (e.g. surgery)
      - Prescribers of both opioid and opioid use disorder are aware of each other and agree to opioid therapy
      - Opioid duration is of a one-time occurrence or taper plan is provided

Underutilization

- Buprenorphine and buprenorphine/naloxone must be used compliantly and will reject on point of sale for late fill
- To request an override, submit a Opioid Dependence Underutilization Form. Both the 1st and 2nd pages must be filled out.

Prior Authorization Criteria

General Prior Authorization Form

Product Specific Criteria:

- *** **Buprenorphine tablets**: The member must be pregnant or breastfeeding, and estimated delivery date/duration of need for breastfeeding must be provided.

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of buprenorphine-naloxone SL tablets, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the member is unable to use the preferred products (subject to clinical review).
- A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request
- DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Agonist Group PA Criteria.

Oral Agents

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
buprenorphine-naloxone tablets	BUNAVAIL FILM (buprenorphine/naloxone)
buprenorphine tablets[PA***]	buprenorphine/naloxone film
	SUBOXONE FILM (buprenorphine/naloxone)
	ZUBSOLV (buprenorphine/naloxone)

Non-Oral Agents

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
SUBLOCADE (buprenorphine)	

Obstetrics/Gynecology

Estrogens

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA approved or compendia supported indication
- The member must have failed 30-day trials of at least two preferred products, as evidenced by paid claims or pharmacy printouts.

Injectable

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DELESTROGEN (estradiol valerate) INJECTION – *Brand Preferred*	DEPO-ESTRADIOL (estradiol cypionate) INJECTION
PREMARIN (estrogens, conjugated) INJECTION	estradiol valerate injection

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
estradiol tablet	ACTIVELLA (estradiol-norethindrone) TABLET
estradiol-norethindrone tablet	AMABELZ (estradiol-norethindrone) TABLET
FEMHRT (norethindrone-ethyl estradiol) TABLET	BIJUVA (estradiol-progesterone) CAPSULE
norethindrone-ethinyl estradiol tablet	ESTRACE (estradiol) TABLET
PREMARIN (estrogens, conjugated) TABLET	FYAVOLV (norethindrone-ethinyl estradiol) TABLET
PREMPHASE (estrogen, conj.,m-progest) TABLET	JINTELI (norethindrone-ethinyl estradiol) TABLET
PREMPRO (estrogen, conj.,m-progest) TABLET	LOPREEZA (estradiol-norgestimate) TABLET
	MENEST (estrogens, esterified) TABLET
	MIMVEY (estradiol-norgestimate) TABLET
	PREFEST (estradiol-norgestimate) TABLET

Topical Cream/Gel/Spray

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELESTRIN (estradiol) GEL	DIVIGEL (estradiol) GEL
EVAMIST (estradiol) SPRAY	

Topical Patch

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALORA (estradiol) PATCH TWICE WEEKLY - *Brand Required*	CLIMARA (estradiol) PATCH WEEKLY
CLIMARA PRO (estradiol-levonorgestrel) PATCH	DOTTI (estradiol) PATCH TWICE WEEKLY
COMBIPATCH (estradiol- norethindrone)	estradiol patch twice weekly
MENOSTAR (estradiol) PATCH	estradiol patch weekly
MINIVELLE (estradiol) PATCH TWICE WEEKLY - *Brand Required*	LYLLANA (estradiol) PATCH
VIVELLE-DOT (estradiol) PATCH TWICE WEEKLY - *Brand Required*	

Vaginal

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ESTRING (estradiol)	ESTRACE (estradiol) CREAM
FEMRING (estradiol)	estradiol vaginal cream
PREMARIN (estrogens, conjugated) VAGINAL CREAM	estradiol vaginal tablet
VAGIFEM (estradiol) VAGINAL TABLET – *Brand Required*	YUVAFEM (estradiol) VAGINAL TABLET

Mifepristone

Prior Authorization Form - Mifeprex

Criteria for coverage: *Approval Duration = 1 month*

- Gestational age must be less than or equal to 70 days
- One of the following criteria must be met (A or B):
    - A. **Pregnancy must have resulted from an act of rape or incest, and one of the following (I or II)**
        - I. The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
        - II. The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.
    - B. **Both of the following must be met (I and II)**
        - I. The woman must suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a provider, place the woman in danger of death unless an abortion is performed
        - II. The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Nausea/Vomiting

Pregnancy

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 3 months or until due date*

- Member must have diagnosis of nausea and vomiting of pregnancy
- Member's due date must be provided
- The prescriber must submit medical justification explaining why the member cannot use a preferred product (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DICLEGIS (doxylamine/vitamin B6) – *Brand Required*	BONJESTA (doxylamine/vitamin B6)
meclizine	doxylamine/vitamin B6
metoclopramide	
ondansetron	

Uterine Fibroids

Electronic Diagnosis Verification

- The member must have an FDA approved indication

Electronic Age Verification

- The member must be 18 years of age or older

Prior Authorization Form

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 12 months*
  - The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - The member must not be pregnant
  - The provider must attest that the member does not have any contraindications to treatment with Oriahnn
- The member must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts (may be concurrent use):
  - A. A 3-menstual cycle trial of mefenamic acid or meclofenamate, celecoxib, ibuprofen 1800mg/day or equivalent high dose NSAID
  - B. A 3-menstual cycle trial of an oral estrogen-progestin or progestin contraceptives
- **Renewal Criteria:** *Approval Duration = 12 months*
  - The member must not have received ≥24 months of Oriahnn, as evidenced by paid claims or pharmacy printouts
  - The provider must attest that the member does not have any contraindications to treatment with Oriahnn
  - The member must have experienced and maintained clinical benefit since starting treatment with Oriahnn, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
MYFEMBREE (relugolix, estradiol, and norethindrone acetate)	
ORIAHNN (elagolix, estradiol, and norethindrone acetate)	

Orilissa

General Prior Authorization Form

Initial Criteria: *Approval Duration = 6 months*

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The member must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts:
  - A. A 3-menstual cycle trial of mefenamic acid or meclofenamate, celecoxib, ibuprofen 1800mg/day or equivalent high dose NSAID
  - B. A 3-menstual cycle trial of an oral estrogen-progestin or progestin contraceptives

Renewal Criteria: *Approval Duration = 18 months*

- Prescriber must submit documentation of improvement in pain score from baseline

- Request must be for maintenance dosing (150 mg strength).

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ORILISSA (Elagolix)	

Progesterone

Prior Authorization Form - Makena

Category Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The week of pregnancy and due date must be indicated on request (must be 20 weeks or greater).
- Clinical justification must be provided explaining why medication is medically necessary

Non-Preferred Agents Criteria:

- The member must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
MAKENA (hydroxyprogesterone caproate) – *Brand Required*	hydroxyprogesterone caproate

Vaginal Anti-Infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The member must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The member must have had 30-day trials of 3 preferred vaginal anti-infective agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AVC (sulfanilamide)	clindamycin cream
CLEOCIN (clindamycin) SUPPOSITORY	CLEOCIN (clindamycin) CREAM
CLINDESSE (clindamycin) CREAM	GYNAZOLE 1 (butoconazole) CREAM
clotrimazole	METROGEL-VAGINAL (metronidazole)
metronidazole gel	MICONAZOLE 3 (miconazole) SUPPOSITORY
NUVESSA (metronidazole) GEL	terconazole suppository
SOLOSEC (secnidazole)	VANDAZOLE (metronidazole) GEL
terconazole cream	
tinidazole	

Preferred Dosage Forms List:

General Prior Authorization Form

Criteria for coverage:

- Clinical justification must be provided explaining why the member is unable to use the preferred agents (subject to clinical review).
- The member must have a diagnosis of an FDA-approved indication for use
- The member must not have any contraindication to the requested product
- The member must have failed* a therapeutic course** of each preferred agent (listed in boxes below) within the past 2 years, as evidenced by paid claims or pharmacy printouts.

**: A failure is defined as product was not effective at maximum tolerated dose or member has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the member*

***: Trials must have been at least 30 days in duration unless otherwise indicated*

Amoxicillin ER

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
amoxicillin IR	amoxicillin ER

Antihistamines

Therapeutic Duplication

- One strength of one medication is allowed at a time

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
cetirizine chew tablet	desloratadine ODT
cetirizine Solution	levocetirizine solution
cetirizine tablet	
desloratadine tablet	
levocetirizine tablet	
loratadine solution	
loratadine tablet	

Bactroban

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Bactroban ointment	Bactroban cream

Belladonna Alkaloids/Phenobarbital

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
belladonna alkaloids/phenobarbital tablets	belladonna alkaloids/phenobarbital elixir

Bowel Prep Agents

Required trial duration: 1 complete dose

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE
MOVIPREP	GOLYTELY 236-22.74G
OSMOPREP	GAVILYTE-C
PEG-3350 AND ELECTROLYTES 236-22.74G	GAVILYTE-N
	NULYTELY
	PEG 3350-ELECTROLYTE 240-22.72G
	PEG 3350-ELECTROLYTE 420 G
	PEG 3350/SOD SUL/NACL/KCL/ASB/C
	PLENVU
	SUPREP
	SUTAB
	TRILYTE

Brisdelle (paroxetine)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
paroxetine tablets	paroxetine mesylate 7.5mg capsules

butalbital-acetaminophen-caffeine

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
butalbital-acetaminophen-caffeine tablets	butalbital-acetaminophen-caffeine capsules
	ESGIC (butalbital-acetaminophen-caffeine) CAPSULES
	VANATOL LQ (butalbital-acetaminophen-caffeine) SOLUTION
	VANATOL S (butalbital-acetaminophen-caffeine) SOLUTION
	ZEBUTAL (butalbital-acetaminophen-caffeine) CAPSULES

cyanacobalamin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
cyanocobalamin Injection	NASCOBAL (cyanocobalamin) NASAL SPRAY

Daxbia (cephalexin)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
cephalexin	Daxbia (cephalexin)

gabapentin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
gabapentin	GRALISE (gabapentin)
gabapentin	HORIZANT (gabapentin)
pramipexole	
ropinirole	

Jadenu (deferasirox)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
deferasirox tablet for suspension	EXJADE (deferasirox tablet for suspension)
	deferasirox tablets
	JADENU (deferasirox) SPRINKLE
	JADENU (deferasirox) TABLETS

Kits

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FDA approved products prescribed separately	CAMPHOTREX 4%-10% ROLL-ON G (menthol/camphor)
	CICLOPIROX (ciclopirox/urea/camphor/methol)
	CICLODAN (ciclopirox/urea/camphor/methol)
	CICLODAN (ciclopirox/skin cleanser 28)
	CLINDACIN ETZ (clindamycin phos/skin clnsr 19)
	CLINDACIN PAC (clindamycin phos/skin clnsr 19)
	CLINDAVIX (clindamycin/dimethacone/zinc oxide)
	CLOBETEX (clobetasol/desloratadine)
	CYCLOPAK (cyclobenzaprine/lidocaine/prilocaine/glycerine)
	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX LEXITRAL PHARMAP (diclofenac/capsicum oleoresin)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAPAK (triamcinolone/dimeth/silicone)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	DERMACINRX SURGICAL PHARMAP (mupirocin/chlorhexidine/dimeth)
	DERMACINRX THERAZOLE PAK (clotrimazole/betameth dip/zinc)
	DERMACINRX ZRM PAK (lidocaine/dimethicone)
	DERMALID 5% PATCH (lidocaine/elastic bandage)
	ELLZIA PAK (triamcinolone/dimethicone)
	ESOMEP-EZS KIT (esomeprazole mag/glycerin)
	ECONASIL (econazole/gauze/silicone)
	FLUOPAR (fluocinonide/dimethacone)
	FLUOVIX PLUS (fluocinonide/silicone,adhesive)
	GABACAINE KIT (gabapentin/lidocaine)
	INAVIX (diclofenac/capsaicin)
	INFAMMACIN (diclofenac/capsicum)
	KETODAN (ketoconazole/skin cleanser 28)
	LIDOPURE PATCH 5% COMBO PAC (lidocaine/kinesiology tape)
	LIDOTIN (gabapentin/lidocaine/silicone)
	LIPRITIN (gabapentin/lidocaine/prilocaine/dressing)
	LOPROX (ciclopirox/skin cleanser No. 40)
	MIGRANOW KIT (sumatriptan/menthol/camphor)
	MORGIDOX (Doxycycline/skin cleanser No. 19)
	NOPIOID-TC KIT (cyclobenzaprine/lidocaine/menthaine)
	NUVAKAAN KIT (lidocaine/prilocaine/silicone)
	NUSURGEPAK (mupirocin/chlorhexidine/dimethacone)
	NUTRIARX (Triamcinolone/dimethacone/silicone)
	PRILO PATCH KIT (lidocaine/prilocaine)
	PRIZOTRAL II (lidocaine/prilocaine/lidocaine)

	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SALEX (salicylic acid/ceramide comb 1) CREAM KIT
	SALEX (salicylic acid/ceramide comb 1) LOTION KIT
	SILAZONE-II KIT (triamcinolone aceton/silicones)
	SOLARAVIX (Diclofenac/silicone, adhesive)
	SUMADAN KIT (sulfacetamide/sulfur/cleansr23)
	SUMAXIN CP KIT (sulfacetamide/sulfur/cleansr23)
	TICANASE KIT (fluticasone/sodium chloride/sodium bicarbonate)
	TRIVIX (Triamcinolone/dimethacone/silicone)
	TRIXYLITRAL (diclofenac/lidocaine/tape)
	XRYLIX 1.5% KIT (diclofenac/kinesiology tape)
	ZILACAINE PATCH 5% COMBO PA (lidocaine/silicone, adhesive)

metformin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Metformin ER	FORTAMET (metformin)
	GLUMETZA (metformin)
	RIOMET (metformin) ORAL SOLUTION
	RIOMET ER (metformin) ORAL SOLUTION

methotrexate

Required trial duration: 6 weeks

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
methotrexate	OTREXUP (methotrexate)
	RASUVO (methotrexate)
	REDITREX (methotrexate)
	TREXALL (methotrexate)

montelukast

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
montelukast chewable tablets	montelukast granules
montelukast tablets	

mupirocin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
mupirocin Ointment	mupirocin calcium cream

nitroglycerin spray

Required trial duration: 1 dose while on preventative medication

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
nitroglycerin sublingual tablets	GONITRO (nitroglycerin) SUBLINGUAL PACKET
	nitroglycerin spray
	NITROLINGUAL (nitroglycerin) SPRAY

Nocdurna (desmopressin)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
desmopressin	Nocdurna (desmopressin)

Onmel (itraconazole)

Required trial duration: 12 weeks with 6 months outgrow following treatment for onychomycosis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Itraconazole capsule	ONMEL (itraconazole) TABLET
terbinafine	

penicillamine

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

DEPEN (penicillamine) TITRATAB – *Brand Required*	CUPRIMINE (penicillamine) CAPSULE
	penicillamine capsule
	penicillamine tablet

potassium

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
potassium tablets	potassium solution
	potassium powder for solution

Procysbi (cysteamine)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CYSTAGON (cysteamine)	PROCYSBI (cysteamine)
	PROCYSBI GRANULES (cysteamine)

Siklos (hydroxyurea)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DROXIA (hydroxyurea capsule)	SIKLOS (hydroxyurea tablet)
hydroxyurea capsule	

Steroids - Oral

Additional Criteria for coverage of Emflaza: See Emflaza Criteria on this document
Rayos required trial duration: 12 weeks with 2AM dosing of prednisone

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
budesonide 3mg EC capsules	ALKINDI (hydrocortisone) SPRINKLE CAPSULE
cortisone	budesonide 9 mg ER tablet
dexamethasone	DEXPAK (dexamethasone)
hydrocortisone	DXEVO (dexamethasone)
methylprednisone	EMFLAZA (deflazacort)
prednisolone sodium phosphate 5mg/5ml, 15mg/5ml, 25mg/5ml	HEMADY (dexamethasone)
prednisone solution	MILLIPRED (prednisolone)
prednisone tablets	ORTIKOS (budesonide)
	prednisone intensol
	prednisolone sodium phosphate ODT
	prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
	RAYOS (prednisone)
	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

tacrolimus

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
tacrolimus	ASTAGRAF XL (tacrolimus)
	ENVARSUS ER (tacrolimus)

Tiglutik (riluzole)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
riluzole	RILUTEK (riluzole)
	TIGLUTIK (riluzole) ORAL SUSPENSION

Tirosint (levothyroxine)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
levothyroxine tablet	levothyroxine capsules
TIROSINT (levothyroxine) 13 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg 100 mcg 112 mcg, 125 mcg, 137 mcg, and 150 mcg capsule – *Brand Required*	SYNTHROID (levothyroxine) TABLET
	THYQUIDITY (levothyroxine) ORAL SOLUTION
	TIROSINT (levothyroxine) 175 mcg and 200 mcg capsule

	TIROSINT (levothyroxine) solution

Tussicaps

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
hydrocodone/chlorpheniramine ER suspension	TUSSICAPS (hydrocodone/chlorpheniramine)
promethazine/codeine	
ZODRYL AC (chlorpheniramine/codeine)	

ursodiol

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ursodiol capsule	RELTONE (ursodiol) CAPSULE
ursodiol tablet	URSO 250 (ursodiol) TABLET
	URSODIOL AVPAK (ursodiol) CAPSULE
	URSO FORTE (ursodiol) TABLET

General
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires members to meet specific diagnosis and step-therapy requirements for some medications. Criteria for agents requiring prior authorization can be found at the following location:

- The Preferred Drug List (PDL) is available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf
- ***Completed Medwatch form(s) must be attached to this request for failed trial(s) in which the active ingredient of the failed product is the same as the requested product***

Part I: TO BE COMPLETED BY PRESCRIBER

Member Name		Member Date of Birth	Member Medicaid ID Number
Prescriber Name		Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI		Telephone Number	Fax Number
Member Weight	Member Adjusted Weight	BMI	**Reason for PA request:**
Requested Drug and Dosage:		**Diagnosis for this request:**	
List all failed medications:		**Start Date:**	**End Date:**

Additional Qualifications for Coverage:

☐ Member is pregnant: Due Date

☐ Member has primary insurance requiring requested product

☐ Member is unable to use preferred dosage form (please provide medical justification below– e.g. contraindication, feeding tube, permanent disability, temporary restriction, swallow study, etc.)

☐ Other: (please fill out below)

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Benzodiazepine + Opioid Concurrent Use Prior Authorization Form

Fax Completed Form to: 855-207-0250 For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving both an opioid analgesic and a benzodiazepine must meet the following criteria:

-Member must have tried all treatment alternatives without achievement of therapeutic goal (please provide details on trial and outcome, or reason alternative cannot be attempted)

- Either a tapering plan must be included, or given the CDC guidelines and FDA black box warnings, clinical justification must be provided to explain:
  - Reason opioid analgesic cannot be avoided in this member currently receiving a benzodiazepine
  - Reason the member cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER OF THE OPIOID ANALGESIC

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Pain, Palliative Care, or Oncology/Hematology Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Opioid Analgesic:	**Diagnosis for use of opioid(s) in this member:**	
Plan to taper: (dose and length of treatment)	**Clinical justification for concurrent opioid and benzodiazepine treatment and/or reason opioid dose cannot be reduced:**	
Treatment Alternatives: ☐ NSAIDs ☐ TCAs ☐ SNRIs ☐ Corticosteroids ☐ Weight Loss ☐ Physical Therapy ☐ Cognitive Behavioral Therapy ☐ Other	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:

Does provider routinely check the PDMP?	☐ YES ☐NO
Has the provider established a realistic treatment plan with the member, addressing expected outcomes and limitations of therapy in totally eliminating pain?	☐ YES ☐NO
Will opioid therapy be routinely evaluated for effectiveness?	☐ YES ☐NO
Does the patient undergo routine drug screens?	☐ YES ☐NO
Has the provider discussed and counseled the patient on the known risks of utilizing opioid analgesics in combination with benzodiazepines and other CNS depressing medications/conditions?	☐ YES ☐NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

☐ Patient's treatment/tapering plan including an evaluation of effectiveness and plans for continuation/discontinuation
☐ Clinical documentation of previously tried and failed non-opioid therapies.

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Benzodiazepine + Opioid Concurrent Use Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving both an opioid analgesic and a benzodiazepine must meet the following criteria:

- Member must have tried all treatment alternatives without achievement of therapeutic goal (please provide details on trial and outcome, or reason alternative cannot be attempted)
- Either a tapering plan must be included, or given the CDC guidelines and FDA black box warnings, clinical justification must be provided to explain:
  - Reason opioid analgesic cannot be avoided in this patient currently receiving a benzodiazepine
  - Reason the member cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER OF THE BENZODIAZEPINE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Benzodiazepine:	**Diagnosis for use of a benzodiazepine in this member:**	
Plan to taper: (dose and length of treatment)	**Clinical justification for concurrent opioid and benzodiazepine treatment and/or reason opioid dose cannot be reduced:**	
List all failed treatments: ☐ **SSRIs** ☐ **SNRIs** ☐ **Buspirone** ☐ **Lyrica** ☐ **Mirtazapine** ☐ **Exercise Therapy** ☐ **Cognitive Behavioral Therapy** ☐ Relaxation and Breath Training ☐ **Other**	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:	
Does provider routinely check the PDMP?	☐ YES ☐NO
Has the provider established an appropriate treatment plan with the member, addressing the delayed onset of effectiveness of their maintenance therapy?	☐ YES ☐NO
Will the benzodiazepine therapy be routinely evaluated for continued necessity?	☐ YES ☐NO
Does the member undergo routine drug screens?	☐ YES ☐NO
Has the provider discussed and counseled the member on the known risks of utilizing benzodiazepines in combination with opioid analgesics and other CNS depressing medications/conditions?	☐ YES ☐NO

Please confirm that all of the following is attached to the request, along with any other relevant documentation:

☐ Member's treatment plan including an evaluation of effectiveness and plans for continuation/discontinuation
☐ Clinical documentation of previously tried and failed non-benzodiazepine therapies.

Prescriber (or Staff) / Pharmacy Signature**	Date

Multiple Antipsychotics Override Request
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for multiple antipsychotics to meet specific clinical criteria for coverage. Criteria for coverage for multiple antipsychotics can be found in the following location:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**

What non-antipsychotic mood stabilizers have been trialed or ruled out for treatment and justification for that decision?

Is clozapine an option for duplicate antipsychotic for unresolved symptoms? ☐ **Yes** ☐ **No**

Is hydroxyzine an option for sleep and/or anxiety? ☐ **Yes** ☐ **No**

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Multiple Antipsychotic Override Requests	
When are the breakthrough symptoms occurring (e.g. timeframe from injection)? Any other contributing factors (non-pharmacological) and how addressed, if so?	
At what point, would the first medication be considered a failure / other treatment would be considered?	
What is the anticipated benefit of another medication (vs. increasing dose or switching medication)?	
Why is one antipsychotic unable to be maximized to treat all targeted symptoms?	
What symptoms are being targeted with each antipsychotic?	
For injections:	What would be the tapering goal for oral antipsychotic if symptoms abate as long-term supplemental use of oral with injectable safety/efficacy data lacking?
	What is the site of administration?
For duplicate quetiapine requests:	If sedation/anxiety is part of a reason for the quetiapine treatment, which medications have been trialed? • A hydroxyzine trial is required for sedation/anxiety • Primary use for insomnia will not be approved

Dupixent
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a new prescription for Dupixent must meet criteria for coverage, as stated in the PA Criteria page of the North Dakota Medicaid Prior Authorization website http://www.hidesigns.com/ndmedicaid or directly at the following link: www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug:	**Diagnosis for this request:**	

For atopic dermatitis:	**Is the affected area on the face, groin, axilla, or under occlusion?** ☐ YES ☐ NO
For asthma:	**Has the member had at least 1 asthma exacerbation requiring use of oral corticosteroids in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts?** ☐ YES ☐ NO
For nasal polyps:	**Does the member have bilateral polyps confirmed by sinus CT, sinus MRI, or nasal endoscopy?** ☐ YES ☐ NO
	Has the member had a 12-week trial of intranasal or oral corticosteroid? ☐ YES ☐ NO

List all failed medications:	**Start Date:**	**End Date:**

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Emflaza
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a new prescription for Emflaza must meet the criteria for use available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	
List all failed medications:	**Start Date:**	**End Date:**
• **Member's serum creatinine kinase activity prior to initiating treatment:**		
• **Member's current motor milestone score** (provide score and assessment used):		
• **Did the member experience onset of weakness before 5 years of age?**		☐ YES ☐ NO

INITIAL: **Member has experienced the following significant intolerable adverse effects*** (select all that apply)
- ☐ Cushingoid appearance
- ☐ Central (truncal) obesity
- ☐ Severe behavioral adverse effect
- ☐ Undesirable weight gain (>10% of body weight gain increase over 6-month period)
- ☐ Diabetes and/or hypertension that is difficult to manage

• *RENEWAL*: **Member has experienced an improvement from adverse effects experienced on prednisone***	☐ YES ☐ NO

Documentation of experienced adverse events or improvement on Emflaza must be provided with this request

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Empaveli

Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for Empaveli (pegcetacoplan) to meet specific clinical criteria for coverage. Criteria for coverage for Empaveli can be found the following location:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:** ☐ PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH) ☐ OTHER:

Qualifications for coverage:

Does the member have transfusion dependent anemia?	☐ YES ☐ NO
Does the member have symptoms of thromboembolic complications (abdominal pain, shortness of breath, chest pain, end-organ damage, fatigue)?	☐ YES ☐ NO
Has the member received one of the following? • A full course of meningococcal, pneumococcal, and Hib vaccines at least 2 weeks prior to starting treatment • A test for antibodies against encapsulated bacteria at least 2 weeks prior to starting treatment • Prophylactic antibiotics against encapsulated bacteria prior to starting treatment	☐ YES ☐ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

☐ Documentation of lab results confirming a diagnosis of PNH
☐ (Renewal ONLY): Documentation supporting that the member has experienced and/or maintained a clinical benefit since starting treatment with Empaveli, as evidenced by medical documentation (e.g. reduced fatigue, decrease in transfusions, increase in Hb levels, or normalization of LDH).

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Evrysdi

Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for Evrysdi must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

- Please complete this form in its entirety and provide all required documentation (if available)

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this request:** ☐ SMA Type 1 ☐ SMA Type 2 ☐ SMA Type 3
Member Weight	**Requested Dose**
Neuromuscular Clinic Contact Information:	**Date of last Visit:**

Has the member required continuous intubation for greater than 3 weeks?	☐ YES	☐ NO
Is the member receiving/has the member received treatment with Zolgensma?	☐ YES	☐ NO
Is the member symptomatic (ex. loss of reflexes, motor delay/weakness, abnormal EMG/neuromuscular ultrasound)?	☐ YES	☐ NO

Please confirm that all of the following is attached to the request, if applicable, along with any other documentation required, as stated in the PDL:

☐ Documentation of the member's current motor function from at least 2 of the approved assessments
☐ Documentation of genetic testing confirming bi-allelic deletions or mutations of SMN1 gene
☐ Documentation of genetic testing confirming the number of the patient's SMN2 gene copies

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Growth Hormone
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving preferred growth hormone meet one of the criteria below (member's receiving a non-preferred growth hormone product must be switched to a preferred agent):

- Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
- Turner's syndrome
- SHOX syndrome
- Noonan syndrome
- Chronic renal insufficiency
- Prader–Willi syndrome
- See growth hormone criteria for additional information – www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	

Qualifications for coverage:

Does the member have any active malignancy?	☐ YES ☐NO
Has the member attained epiphyseal closure?	☐ YES ☐NO
Does the member consult with a dietician to maintain a nutritious diet?	☐ YES ☐NO
Is growth hormone needed to maintain proper blood glucose *(endogenous GH deficiency only)*?	☐ YES ☐NO
Does the member have multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary Disease *(endogenous GH deficiency only)*?	☐ YES ☐NO
Has the member received a renal transplant *(chronic renal insufficiency only)?*	☐ YES ☐NO
Has a diagnosis of sleep apnea been ruled out in this member *(Prader-Willi syndrome only)*?	☐ YES ☐NO
Are all lab values stated as required in the criteria attached to this request?	☐ YES ☐NO

Member's current BMI (Prader-Willi syndrome only):

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Treatments
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for hepatitis C treatments must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf
Please complete this form in its entirety and provide any and all required documentation (if available)

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dose:	**Duration requested:**	**Member's liver fibrosis score:** ☐ F0-F1 ☐ F3-F4
Diagnosis: ☐ HCV ☐ OTHER:	**Genotype:**	**Member's Child–Pugh Class:** ☐ A ☐ B ☐ C ☐ N/A

Please list any previous treatments the member has failed for chronic HCV: ☐ N/A	Regimen:	Dates of treatment:	Response:

Has the member remained drug (illicit use by injection) and alcohol free for the past 3 months?	☐ YES ☐ NO
Does the member have a diagnosis of alcohol use disorder?	☐ YES ☐ NO
Does the member have a history of illicit use of drugs by injection?	☐ YES ☐ NO
Has the member completed or is currently in a treatment program from an enrolled addiction medicine/chemical dependency provider (or buprenorphine waived provider if history of IV drug use)? Approximate Dates of Treatment:	☐ YES ☐ NO Attested by: ☐ PROVIDER ☐ PATIENT
Please provide the name of the enrolled addiction medicine/chemical dependency treatment provider/facility name, if applicable:	
Does the member have Hepatitis B?	☐ YES ☐ NO
If the member has Hepatitis B, has it been treated or will it be closely monitored during treatment?	☐ YES ☐ NO
Is the member post-liver transplant?	☐ YES ☐ NO
Is the member's life expectancy greater than one year?	☐ YES ☐ NO
Does the member attend scheduled visits with no more than 1 no-show and fill maintenance medications on time?	☐ YES ☐ NO
Does the member have any contraindications to therapy with the requested agent?	☐ YES ☐ NO
Is the member going to take Ribavirin alongside treatment?	☐ YES ☐ NO

Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:

- o Baseline HCV RNA
- o ≥ 2 drug and alcohol tests dated at least 3 months apart
- o Patient & Prescriber attestation forms
- o Chart notes addressing member's alcohol and drug free status over the past year
- o Documentation of member's fibrosis score if available (e.g. APRI, Fibroscan, Fibrotest)

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Patient Consent Form

I, ¸ have been counseled by my healthcare provider on the following:

I am planning to live in North Dakota during the entire treatment period. I will complete the entire course of treatment, attend office visits, and have laboratory tests as ordered by my healthcare provider during the treatment period.

I will notify my chosen pharmacy of a need to refill one week prior to running out of medication. I understand I must take my medication each day as directed for the entire course of treatment. If the medication does not work due to missed doses, I may not be approved for re-treatment.

I understand to keep my liver healthy, I must not drink alcohol or use illicit injectable drugs prior to, during, or after my treatment. If indicated, I will participate in a treatment program to remain abstinent.

I understand that after treatment, I can be re-infected with Hepatitis C. My provider has educated me on routes of Hepatitis C transmission, and I will avoid or modify high risk activities to avoid re-infection.

I understand that medications that treat Hepatitis C may be harmful to unborn babies. I will use methods to avoid getting pregnant or another person pregnant during treatment and when advised by my provider or pharmacist, for at least 6 months after treatment is complete.

Patient Signature_____Date __/__/____

Pharmacy or Prescriber Representative:

Signature _____Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient

Hepatitis C Prescriber Agreement Form

I agree that I will counsel my patient on how, where, and when to obtain refills on their hepatitis C medications.

I agree that I will have intermittent telephone check-ins with my patient, at minimum at 2 weeks and 6 weeks of treatment. I will assess continued adherence with medication, labs, and office visits, treatment tolerability, as well as medication changes that may affect treatment.

I have reviewed my patient's medications for drug interactions that would make Hepatitis C medications less effective or cause other adverse effects.

I have reviewed the treatment plan with my patient including medications, lab, vaccinations, and follow-up visits.

I have assessed my patient's readiness for treatment and believe they are ready and willing to comply with the treatment plan. I have assessed social and psychological stability, substance use abstinence, compliance to follow up visits and medications, pregnancy status, and concurrent health risks.

I understand that ND Medicaid tracks refill history and may contact me to provide additional information in the event of a dropped or late refill.

I have a dedicated individual or team which may include pharmacy and nursing support to fulfill the elements of this form and have listed key members contact information below.

Name: Location:

Phone #: _____ _____

Name: _____ Location:

Phone #: _____ _____

Pharmacy or Prescriber Representative:

Signature _____ **Date** __/__/____

Makena
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for Makena to meet criteria confirming the medication is being used according to its FDA-approved indication. Please fill out the following form in its entirety.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Member's Estimated Date of Delivery or Gestational Age of Current Pregnancy (weeks and days):			
Does the member have a history of singleton spontaneous preterm birth? ☐ YES ☐ NO			
Is the member currently pregnant with singleton? ☐ YES ☐ NO			
Additional Qualifications for Coverage (*if applicable*)			
☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Mifeprex
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a new prescription for Mifeprex must meet the following criteria:

- **Member must have an FDA approved indication for the medication requested.**
- **Prescriber must provide signed written statement as listed in the Mifeprex Prior Authorization Criteria at** www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

- **Is the member terminating a pregnancy before 70 days of gestation? □ YES □ NO**
- **Is the member resulting from an act of rape or incest? □ YES □ NO** (If yes, please attach written statements as outlined in section 1 below)
- **Does the woman suffer from a physical disorder that would place the woman in danger of death unless abortion is performed? □ YES □ NO** (If yes, please attach a written statement as outlined in section 2 below)

Section 1:

- The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
- The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.

Section 2:

- The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Migraine Prophylaxis/Treatment Prior Authorization Form

Fax Completed Form to: 855-207-0250 For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for migraine prophylaxis/treatment must meet the following criteria:

Prophylaxis Initial Requests:

- Member must experience 3 or more migraine days per month.
- Member must submit documentation of treatment failure of a 2-month trial of two preferred agents from different therapeutic classes. Documentation must include clinical notes regarding failure to reduce migraine frequency.

Prophylaxis Renewal Requests: Member must experience a reduction in migraines of at least 50%

Treatment Initial Requests:

- Member must have had 30-day trials of two triptans (5HT-1 agonists) within the past 2 years

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Number of experienced migraine days per month:			
How will the requested product be used? ☐ Prophylaxis ☐ Treatment			
List all failed medications:	**Start Date:**	**End Date:**	
Additional Qualifications for Coverage (e.g. medical justification explaining inability to meet required trials)			
☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Nuedexta
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a new prescription for Nuedexta must meet the following criteria:

Initial Criteria

- Member must be 18 years of age or older
- Member must not have a prolonged QT interval, heart failure, or complete atrioventricular block
- Member's baseline CNS-LS and weekly PBA episode count must be provided
- Member must have a diagnosis of PBA due to one of the following conditions: ALS, MS, Alzheimer's disease, or stroke

For PBA due to Alzheimer's disease or stroke

- Neurologic condition must have been stable for at least 3 months
- Member must have failed a 3-month trial of one medication from BOTH classes listed: SSRIs (sertraline, fluoxetine, citalopram, and paroxetine) and Tricyclic Antidepressants (nortriptyline or amitriptyline)
  - A PBA episode count and CNS-LS score must be provided for before and after each trial

Renewal Criteria

- Benefit of renewal must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode count must be a 75 percent decrease from baseline

For PBA due to Alzheimer's disease or stroke

- Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
- Current CNS-LS score must be a 30% decrease from baseline

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request (include cause of PBA):**	
List all failed medications:	**Start Date (PBA Count at Start):**	**End Date (PBA Count at End):**

Does the member have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block?	☐ YES ☐ NO
Has the neurologic condition been stable for at least 3 months?	☐ YES ☐ NO

Baseline CNS-LS:	Baseline weekly PBA episode count:	Current CNS-LS:	Current weekly PBA episode count:

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Opioid Analgesics
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a long-acting opioid analgesic must meet the following criteria:

- Member must have required around-the-clock pain relief for the past 90 days
- The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.
- Member must be in consult with oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if:
  - Cumulative daily dose of narcotics exceed 90 MED/day
  - Member is using benzodiazepine concurrently with narcotic medication
- Member must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)

  *** For additional and agent-specific criteria, please see criteria for coverage in the Preferred Drug List at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Pain, Palliative Care, or Oncology/Hematology Specialist involved in therapy (if not treating prescriber):		
Prescriber NPI	Telephone Number	Fax Number	
Requested Opioid Analgesic:	**Diagnosis for use of opioid(s) in this member:**		
List All Failed/Current Medications: ☐ NSAIDs ☐ TCAs ☐ SNRIs ☐ Corticosteroids ☐ Weight Loss ☐ Physical Therapy ☐ Cognitive Behavioral Therapy ☐ Other:	**Dose and Frequency:**	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:

Have the past 3 months of North Dakota PDMP reports been reviewed by the prescriber?	☐ YES ☐ NO
Has the provider established a realistic treatment plan with the member, addressing expected outcomes and limitations of therapy in eliminating pain?	☐ YES ☐ NO
Does the patient undergo routine drug screens?	☐ YES ☐ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

☐ Member's treatment plan including an evaluation of effectiveness and plans for continuation/discontinuation
☐ Clinical documentation of previously tried and failed non-opioid therapies.

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Palforzia
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for Palforzia to meet criteria confirming the medication is being used according to its FDA-approved indication. Please fill out the following form in its entirety.

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	

Does the member have uncontrolled asthma?	☐ YES	☐ NO
Has the member experienced severe or life-threatening anaphylaxis in the 60 days?	☐ YES	☐ NO
Does the member have a history of eosinophilic esophagitis or another eosinophilic GI disease?	☐ YES	☐ NO
Has the member/caregiver been educated on appropriate use of epinephrine?	☐ YES	☐ NO
RENEWAL ONLY: Does the member continue to have a peanut allergy and has been/is being monitored for resolution of their allergy?	☐ YES	☐ NO
RENEWAL ONLY: Has the member been able to tolerate the maintenance dose of Palforzia (300	☐ YES	☐ NO

Additional Qualifications for Coverage (*if applicable*)

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Phenylketonuria Agents
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a new prescription for a phenylketonuria agent must meet the following criteria:

- **Member must have hyperphenalaninemia.**
- **Member must be following a PHE restricted diet.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		**Recipient Date of Birth**	Recipient Medicaid ID Number
Prescriber Name			
Prescriber NPI		Telephone Number	Fax Number
Address		City	State / Zip Code
Requested Drug and Dosage:	**PHE level:**	**Diagnosis for this Request:**	**Member's weight:**

Has the member been known to have two null mutations in TRANS?	☐ YES	☐ NO
Are baseline PHE levels attached?	☐ YES	☐ NO
Is the member of child-bearing potential?	☐ YES	☐ NO
Is this a renewal request?	☐ YES	☐ NO
Has the member been compliant with diet and medications for past 6 months?	☐ YES	☐ NO

☐ I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Sedative/Hypnotic
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a sedative/hypnotic must meet the agent criteria located on the Preferred Drug List (PDL), located on the North Dakota Department of Human Services Prior Authorization website at http://www.hidesigns.com/ndmedicaid.

Note:

- **Requires step therapy. See Sedative/Hypnotic PA criteria for more information.**
  - Zolpidem: Initiation with trial of 5 mg must be used for 7 days within 90 days prior to 10 mg tablets
  - Belsomra: The member must have had a 25- day trial of eszopiclone within the past 90 days

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name		
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	
Qualifications for coverage:		
List all failed medications:	**Start Date:**	**End Date:**

Have other conditions causing sleep issues been ruled out?	☐ YES ☐ NO
Does the member require dose tapering?	☐ YES ☐ NO
Is the member's insomnia characterized by difficulty with sleep maintenance?	☐ YES ☐ NO
Is the member's insomnia characterized by difficulty with sleep initiation?	☐ YES ☐ NO
Is the member's insomnia characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep?	☐ YES ☐ NO
Is the member blind in both eyes? (For non-24 hour sleep-wake disorder)	☐ YES ☐ NO

☐ I *confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Tardive Dyskinesia Agents
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a new prescription for Austedo, Ingrezza, or tetrabenazine must meet the following criteria:

Category Criteria

- The member must be 18 years of age or older.
- The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).
- The member must have a diagnosis of tardive dyskinesia, including the following:
  - Involuntary athetoid or choreiform movements
  - History of treatment with dopamine receptor blocking agent (DRBA)
  - Symptom duration lasting longer than 4-8 weeks
- The member must not be taking monoamine oxidase inhibitor (MAOI)
- The member is not pregnant or breastfeeding

Product Specific Criteria: * Austedo/tetrabenazine:**

- The member must have a diagnosis of Huntington's disease or Tardive Dyskinesia.
- The member must not have hepatic impairment

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name		
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**FDA approved indication for this request:**	
List all failed medications (drug name, date of trial, reason for failure):		
Qualifications for coverage:		
Does the member's diagnosis include athetoid or choreiform movements?		☐ YES ☐ NO
Has the symptom duration lasted longer than 4-8 weeks?		☐ YES ☐ NO
Is the member pregnant or breastfeeding?		☐ YES ☐ NO
Prescriber (or Staff) / Pharmacy Signature**		Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

REVIEW OF KIDNEY DISEASE

Kidney disease currently affects 37 million adults in the United States. Chronic kidney disease (CKD) is defined as kidney damage/decreased function for three months or greater. Any duration less would be considered acute kidney injury (AKI). Kidney damage is described as urinary albumin excretion ≥30 mg/day, and decreased kidney function is defined as estimated glomerular filtration rate (eGFR) <60 mL/min/1.73 m2. High blood pressure and diabetes are the main causes of CKD, and it is estimated that 50% of patients with CKD also have diabetes or cardiovascular disease.

Table 1. Classification of Chronic Kidney Disease (KDIGO 2012)

Stage	Description	Kidney Function (eGFR, mL/min/1.73 m²)	Albuminuria (mg/g)		
			<30	30–300	>300
Stage 1	Normal kidney function	>90	Low risk	Moderate risk	High risk
Stage 2	Mild loss of kidney function	60–89	Low risk	Moderate risk	High risk
Stage 3a	Mild to moderate loss of kidney function	45–59	Moderate risk	High risk	Very high risk
Stage 3b	Moderate to severe loss of kidney function	30–44	High risk	Very high risk	Very high risk
Stage 4	Severe loss of kidney function	15–29	Very high risk		
Stage 5 (ESRD)	Complete kidney failure	<15	Very high risk		

Source: KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. *Kidney Int Suppl.* 2013;3(1). https://kdigo.org/wp-content/uploads/2017/02/KDIGO_2012_CKD_GL.pdf

Abbreviations: eGFR, estimated glomerular filtration rate; ESRD, end-stage renal disease; KDIGO, Kidney Disease: Improving Global Outcomes

Place in Therapy/Guidelines

There is currently no cure for CKD; therefore, the goals of treatment include:

- Treating reversible causes of CKD
- Preventing or slowing the progression of disease
- Treating complications of kidney failure

CKD Treatment
All patients
• Treatment with an ACEi or ARB titrated to the highest approved, tolerated dose • Treating complications of kidney failure (e.g., volume overload, hyperkalemia, anemia) and ESRD (e.g., malnutrition, neuropathy).
Patients with Type 2 diabetes
• Treatment with metformin • Treatment with a SGLT-2 inhibitor (Farxiga or Invokana) OR with Kerendia Although not currently recommended or studied, triple therapy with an ACE inhibitor or ARB plus an SGLT2 inhibitor plus Kerendia could help target all possible mechanisms responsible for kidney damage in CKD: ▪ ACE inhibitors and ARBs generally target reduction in blood pressure control and glomerular hypertension ▪ SGLT2 inhibitors additionally target glycemic control and cardiovascular risk reduction ▪ Nonsteroidal MRAs (e.g. Kerendia) add an additional anti-inflammatory and antifibrotic effect
Patients with Type 2 diabetes who have not achieved glycemic targets despite use of metformin and SGLT2i, or who are unable to use those medications
• Treatment with a long-acting GLP-1 RA

General Dosing and FDA Indications

Farxiga (dapagliflozin propanediol)	
Mechanism of Action	Sodium-glucose linked transporter 2 (SGLT2) inhibitor
Dosing	• (eGFR 25 mL/min/1.73 m(2) or greater): 10 mg orally once daily. • (eGFR less than 25 mL/min/1.73 m(2)): Do not initiate therapy; may continue established dapagliflozin therapy at 10 mg orally once daily
Indications	• CKD, (At risk of progression) • Disorder of cardiovascular system; Prophylaxis – T2DM • HF, (NYHA class II to IV, reduced EF) to reduce risk of CV death and hospitalization
Invokana (canagliflozin)	
Mechanism of Action	Sodium-glucose linked transporter 2 (SGLT2) inhibitor
Dosing	<u>Diabetic nephropathy, With Albuminuria – T2DM:</u> • (eGFR 60 mL/min/1.73 m(2) or greater): 100 mg PO Qday, taken before the first meal of the day; may increase to 300 mg Qday for additional glycemic control. • (eGFR 30 to less than 60 mL/min/1.73 m(2)): 100 mg PO Qday, taken before the first meal of the day. • (eGFR less than 30 mL/min/1.73 m(2)): Do not initiate therapy in this population, however if albuminuria is greater than 300 mg/day may continue with 100 mg PO Qday, taken before the first meal of the day. <u>Disorder of cardiovascular system; Prophylaxis – T2DM:</u> • (eGFR 60 mL/min/1.73 m(2) or greater): 100 mg PO Qday, taken before the first meal of the day; may increase to 300 mg PO Qday for additional glycemic control. • (eGFR 30 to less than 60 mL/min/1.73 m(2)): 100 mg PO Qday, taken before the first meal of the day. • (eGFR less than 30 mL/min/1.73 m(2)): Do not initiate therapy in this population, however if albuminuria is greater than 300 mg/day may continue with 100 mg PO Qday, taken before the first meal of the day.
Indications	• Diabetic nephropathy, With Albuminuria – T2DM • Disorder of cardiovascular system; Prophylaxis – T2DM • T2DM
Kerendia (finerenone)	
Mechanism of Action	Selective mineralocorticoid receptor antagonist
Dosing	• (eGFR 60 mL/min/1.73 m(2) or greater) Initial, 20 mg PO Qday; titration, measure serum potassium 4 weeks after initiating treatment and maintain 20 mg daily for serum potassium up to 5.5 mEq/L; adjust dose as needed based on serum potassium obtained 4 weeks after a dose adjustment, and periodically. • (eGFR 25 to less than 60 mL/min/1.73 m(2)) Initial, 10 mg PO Qday; titration, measure serum potassium 4 weeks after initiating treatment and increase dose to 20 mg daily for serum potassium 4.8 mEq/L or less. Maintain 10 mg daily dose for serum potassium greater than 4.8 to 5.5 mEq/L. For serum potassium 4.8 mEq/L or less with eGFR decrease by more than 30% over previous measurement, maintain 10 mg/day dosage. Adjust dose as needed based on serum potassium obtained 4 weeks after a dose adjustment, and periodically. • Serum potassium 5.5 mEq/L or greater: Withhold finerenone. For patients who were receiving the 20 mg/day dose, restart at 10 mg Qday when serum potassium is 5 mEq/L or less. For patients who were receiving the 10 mg/day dose, consider restarting at 10 mg daily when serum potassium is 5 mEq/L or lower.
Indications	• CKD- T2DM

Approval Status and Special Designations

Drugs@FDA: FDA-Approved Drugs
Fast Track, Breakthrough Therapy, Accelerated Approval, Priority Review | FDA
The Drug Development Process | FDA

Drug Name	Approval Letter Post Marketing Trial and Reporting Requirements
Farxiga	Approved in 04/30/2021 – New Indication
Invokana	Approved in 09/27/2019- New Indication
Kerendia	Approved NDA in 07/09/2021

Therapeutically Important Adverse Effects/Advantages

Farxiga

- Approved for treatment of T2DM, heart failure, and kidney disease.
- ADEs: UTIs, nasopharyngitis, genital infection

Invokana

- Approved for treatment of T2DM and kidney disease in patients with T2DM.
- ADEs: Polyuria, UTIs, hypovolemia

Kerendia

- Currently only approved for kidney disease in patients with T2DM.
- ADEs: hypotension, hyponatremia, hyperkalemia

Cost

Drug	Strength	Package Size	WAC Pkg Price	Cost/day*	Cost/month*	Cost/year*
Farxiga	5mg, 10mg	7, 30 count	$532.84	$17.76	$532.84	$6,394.08
Invokana	100mg, 300mg	30, 90 count	$543.43	$18.11	$543.43	$6,521.16
Kerendia	10mg, 20mg	7, 30, 90 count	$569.10	$18.97	$569.10	$6,829.20

*Based on lowest per unit WAC cost

Current Utilization

ND Medicaid Utilization (9/01/2020 – 08/31/2021)		
Label Name	**Rx Number**	**Total Reimbursement Amt**
Farxiga	583	$277,535.82
Invokana	229	$112,467.50
Kerendia	0	0

Kerendia Clinical Trials:

- FIDELIO-DKD, a Phase 3, randomized, double-blind, placebo-controlled study, evaluated daily finerenone in patients with CKD and type-2 diabetes vs. placebo with all patients were receiving ACE or ARB. Patients with heart failure with reduced ejection fraction were excluded from the study.
    - Primary endpoint was time to first occurrence of the composite endpoint of onset of kidney failure, a sustained decrease of eGFR of at least 40% from baseline over at least 4 weeks or renal death after 2 years. This occurred in 17.8% of the finerenone group vs. 21.5% in the placebo group (HR 0.82, 95% CI; p=0.001) - showing an 18% risk reduction in finerenone vs. placebo. Patients treated with finerenone saw lower risk of CKD progression and cardiovascular events vs. placebo.

- FIGARO-DKD is an additional phase 3 study that investigated the drug's efficacy and safety versus placebo in addition to an ACE inhibitor or ARB in the reduction of cardiovascular morbidity and mortality in an additional 7437 patients with CKD and T2D. Compared with FIDELIO-DKD, FIGARO-DKD includes more patients at earlier stages of CKD (eGFR >60 mL/min).
    - Kerendia met its primary composite endpoint of time to first occurrence of CV death or nonfatal CV events with a 13% relative risk reduction over a median duration of 3.4 years when added to ACE/ARB therapy. This reduction was primarily driven by a decrease in hospitalization due to heart failure.
    - Safety and tolerability were similar to the FIDELIO-DKD study with hyperkalemia more common in the Kerendia group (10.8%) versus 5.3% in the placebo group.

- FINEARTS-HF (n=5500) is a phase 3 study in patients with heart failure with preserved ejection fraction. The study started in September 2020 and is expected to be completed in 2024 with a primary composite outcome of heart failure events (first and recurrent).

Comparison of Trials for SGLT-2 inhibitors and Kerendia					
	Invokana	**Farxiga**	**Jardiance**	**Kerendia**	
Manufacturer	Janssen/Vifor	AstraZeneca	Boehringer Ingelheim/ Eli Lilly	Bayer	
Renal Trial(s)	CREDENCE	DAPA-CKD	EMPA-KIDNEY (Phase 3)	FIDELIO-DKD	FIGARO-DKD
Patient population	T2DM with CKD (n = 4401)	CKD with or without DM (n = 4303)	CKD with or without DM (n = 6609)	T2DM with CKD (n = 5734)	T2DM with CKD (n = 7437)
eGFR Inclusion criteria (mL/min/1.73m^2)	30 to <90	≥25 to 75	≥20 to <90	≥25 to <75	≥25 to <90
CKD	Approved in T2DM	Approved	In Phase 3	Approved in T2DM	

References:

Product Information: JARDIANCE(R) oral tablets, empagliflozin oral tablets. Boehringer Ingelheim Pharmaceuticals Inc (per FDA), Ridgefield, CT, 2021.
Product Information: FARXIGA(R) oral tablets, dapagliflozin oral tablets. AstraZeneca Pharmaceuticals LP (per manufacturer), Wilmington, DE, 2021.
Product Information: INVOKANA(R) oral tablets, canagliflozin oral tablets. Janssen Pharmaceuticals Inc (per FDA), Titusville, NJ, 2020.
Product Information: KERENDIA(R) oral tablets, finerenone oral tablets. Bayer HealthCare Pharmaceuticals Inc (per manufacturer), Whippany, NJ, 2021.
Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group. KDIGO 2020 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease. Kidney Int. 2020;98(4S):S1–S115.

LUPUS

Lupus is an autoimmune disease that can affect many organ systems, most commonly, the heart and kidneys. There are four different types of lupus: Systemic lupus erythematosus (SLE), cutaneous lupus erythematosus, drug-induced lupus erythematosus, and neonatal lupus. SLE is the most common and most serious form of the disease. The cause of SLE is unknown, but it is thought to develop in response to many factors, including hormones, genetics, and external environmental factors. SLE can range in severity and can have phases of alternating symptoms. Lupus can cause severe inflammation in the kidneys which is called lupus nephritis. Additionally, lupus can affect the nervous system, brain, and arteries. The prevalence of SLE in the U.S. is believed to be close to 200,000 with women of childbearing age being more at risk for developing the disease. Lupus nephritis develops in approximately 40% of patients with SLE with 10% of those patients eventually developing end-stage renal disease (ESRD). The prevalence of lupus nephritis, however, is more common in men than in women.

Place in Therapy/Guidelines

There is currently no cure for lupus, but there are treatment options available to help minimize organ damage.

<table>
<tr><th>SLE Treatment</th><th>Lupus Nephritis Treatment</th></tr>
<tr><td>Mild (i.e. skin, joint, and mucosal involvement)</td><td>Induction therapy</td></tr>
<tr><td>• Hydroxychloroquine or chloroquine
• With or without NSAIDs
• With or without short term use of low-dose glucocorticoids</td><td>• Cyclophosphamide or mycophenolate mofetil (MMF) with steroids</td></tr>
<tr><td>Moderate (i.e. constitutional, cutaneous, musculoskeletal, or hematologic)</td><td>Maintenance therapy</td></tr>
<tr><td>• Hydroxychloroquine or chloroquine
• PLUS 5mg – 15mg of prednisone (or equivalent) per day. Prednisone is usually tapered once hydroxychloroquine or chloroquine has taken effect.
• A steroid-sparing immunosuppressive agent (e.g., azathioprine or methotrexate) is often required to control symptoms.</td><td rowspan="3">• Azathioprine, MMF, or calcineurin inhibitor (e.g., Lupkynis) and a low- dose steroid
• Most patients should receive maintenance therapy for at least 1 year before tapering
• The average length of immunosuppression in lupus nephritis can be ≥3 years, with up to 60% of patients with lupus nephritis never reaching full remission with current therapies</td></tr>
<tr><td>Severe (i.e. Renal and central nervous system)</td></tr>
<tr><td>• Intensive immunosuppressive therapy (induction therapy) to control the disease and halt tissue injury.
• High dose systemic glucocorticoids alone or in combination with immunosuppressant agents
• Immunosuppressant agents include Mycophenolate, Azathioprine, Cyclophosphamide, and Rituximab</td></tr>
<tr><td colspan="2">Biologics are recommended in patients with an inadequate response to standard therapies
• Benlysta (SLE and LN)
• Saphnelo (SLE only)</td></tr>
</table>

General Dosing and FDA Indications

Benlysta (belimumab)	
Mechanism of Action	B-lymphocyte stimulator inhibitor
Dosing	SLE IV: 10 mg/kg IV every 2 weeks for 3 doses, then every 4 weeks thereafter SubQ: 200mg every week Lupus Nephritis IV: 10 mg/kg IV every 2 weeks for 3 doses, then every 4 weeks thereafter SubQ: 400mg once weekly for first 4 doses, then 200mg once weekly thereafter
Indications	Active, autoantibody-positive SLE in patients ≥ 5 years of age receiving standard therapy Lupus nephritis in adult patients receiving standard therapy
Lupkynis (voclosporin)	
Mechanism of Action	Calcineurin inhibitor
Dosing	Oral: 23.7 mg twice daily with eGFR-based dosing modifications in combination with mycophenolate mofetil and corticosteroids
Indications	Lupus nephritis in adult patients receiving a background immunosuppressive therapy regimen
Saphnelo (anifrolumab)	
Mechanism of Action	Type I interferon (IFN) inhibitor
Dosing	IV: 300mg every 4 weeks
Indications	Adult patients with moderate to severe SLE who are receiving standard therapy

Approval Status and Special Designations

Drugs@FDA: FDA-Approved Drugs
Fast Track, Breakthrough Therapy, Accelerated Approval, Priority Review | FDA
The Drug Development Process | FDA

Drug Name	Approval Letter Post Marketing Trial and Reporting Requirements
Benlysta	Approved BLA on 03/09/2011 – SLE Approved on 12/16/2020 – Lupus Nephritis (New Indication)
Lupkynis	Approved NDA on 01/22/2021
Saphnelo	Approved BLA on 07/30/2021

Therapeutically Important Adverse Effects/Advantages

Benlysta

- Can be utilized in SLE and LN
- Can be given as an infusion or administered subcutaneously
- Weekly (SC) or monthly (IV) dosing
- Indicated in adults and pediatrics (5 years and older)

Lupkynis

- Only indicated for LN
- Taken orally
- Most expensive treatment

Saphnelo

- Only FDA indicated for SLE
- Once a month infusion

Cost

Drug	Strength	Package Size	WAC Pkg Price	Cost/day*	Cost/month*	Cost/year*
Benlysta	120mg/vial, 200mg/mL, 400mg/vial	4 single dose 1 mL autoinjectors, 1 vial	$995.78	$132.77	$3,983.12	$47,797.44
Lupkynis	7.9 mg	60-count	$3,949.99	$394.98	$11,849.40	$142,192.80
Saphnelo	300 mg/2 mL	2 mL vial	$4,600.54	$153.36	$4,600.54	$55,206.48

*Based on lowest per unit WAC cost

Current Utilization

ND Medicaid Utilization (9/01/2020 – 08/31/2021)

Label Name	Rx Number	Total Reimbursement Amt
Benlysta	5	$19,977.90
Lupkynis	0	0
Saphnelo	0	0

Clinical Trials:

Benlysta

- The Phase 3 BLISS-LN trial studied the efficacy and safety of intravenous (IV) belimumab versus placebo when added to standard therapy in adults with active lupus nephritis. In the primary endpoint analysis, significantly more patients who received belimumab had a renal response at Week 104 versus placebo (43% versus. 32%). In addition, more participants in the belimumab group reached a renal response earlier (Week 52) than the placebo group, which was sustained through Week 104. Other secondary endpoints found that the risk of a renal-related event or death was lower in the belimumab group versus placebo (hazard ratio [HR] 0.5). Adverse effects between the groups were similar; the most common adverse events were upper respiratory tract (12% treatment versus 11% placebo) and urinary tract infections (7% treatment versus 6% placebo).

Lupkynis

- The Phase 3 AURORA trial studied the efficacy and safety of oral voclosporin 23.7 mg twice daily vs. placebo, in addition to mycophenolate mofetil 2 g/day and tapered low dose corticosteroids. Voclosporin met its primary endpoint of renal response at week 52 (40.8% voclosporin vs. 22.5% placebo; OR 2.65, $p<0.001$). Voclosporin also achieved all secondary endpoints, including: renal response at week 24, partial renal response at week 24, and week 52, time to UPCR ≤0.5, time to 50% reduction in UPCR. Adverse effects were similar between groups with infection reported most commonly (10.1% voclosporin group vs. 11.2% placebo group).

Saphnelo

- Saphnelo's efficacy and safety data were evaluated in 3 trials: MUSE (Trial 1; NCT01438489), TULIP-1 (Trial 2; NCT02446912), and TULIP-2 (Trial 3; NCT02446899). All 3 studies were randomized, double-blind, placebo-controlled trials in patients ≥18 years of age diagnosed with SLE according to the American College of Rheumatology (ACR) classification criteria and who were receiving standard therapy (at least one of the following: oral corticosteroids (OCSs), antimalarials, and immunosuppressants [methotrexate, azathioprine, or mycophenolate mofetil]). Results from the trials were inconsistent: although MUSE and TULIP-2 met the primary endpoints, TULIP-1 failed to do so.

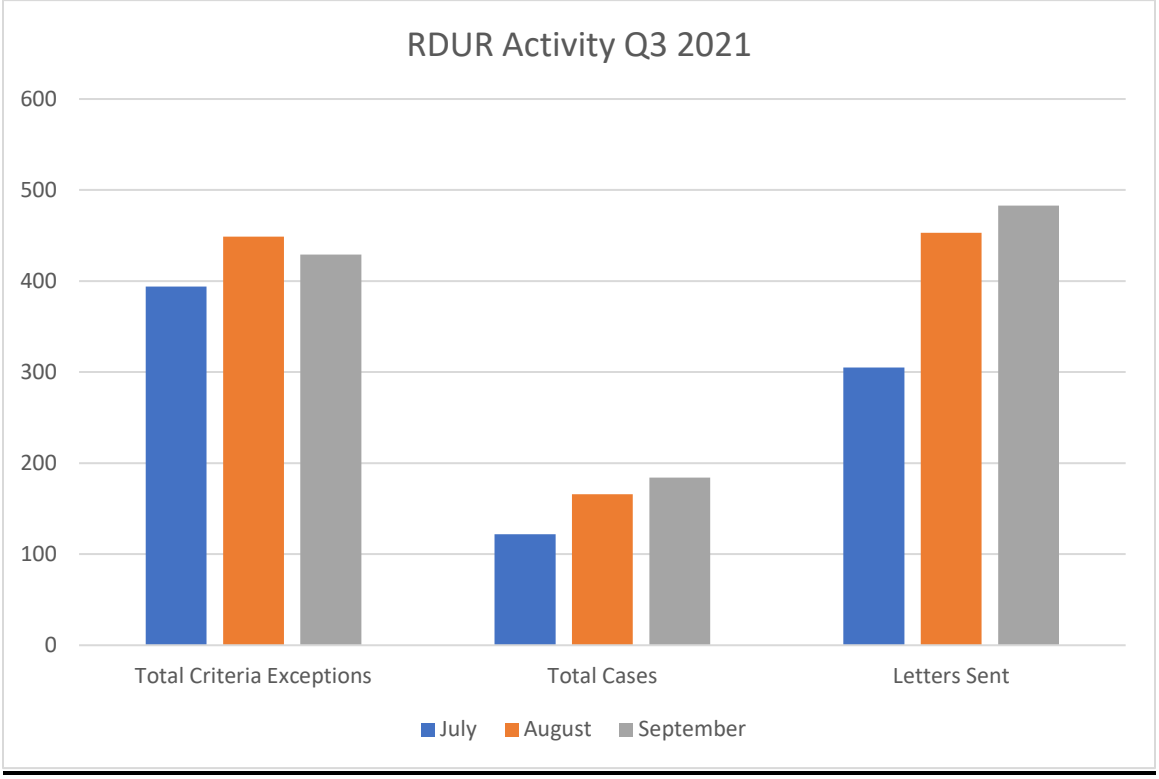
Benlysta vs. Lupkynis		
	Benlysta (belimumab)	**Lupkynis (voclosporin)**
Manufacturer	GlaxoSmithKline	Aurinia
Clinical Trial(s)	Phase 3 NCT01639339 (BLISS-LN) (N=448)	Phase 2 NCT02141672 (AURA-LV) (N=265), Phase 3 NCT03021499 (AURORA) (N=358)
Patient population	• Mean age: 33 years • 88% female • 50% Asian, 33% White, 14% Black	• Mean age: 33 years • 87% female • 38% Asian, 37% White, 8% Black
1-Year Outcome (vs. Placebo)	32.5% complete renal response vs. 25.5%	42.3% complete response (meta-analysis) vs. 23.3%
2-Year Outcome (vs. Placebo)	30% complete renal response vs. 19.7%	Not available

<table>
<tr><th colspan="4">Saphnelo Trials</th></tr>
<tr><th></th><th>Trial 1 (Phase 2) MUSE (NCT01438489)</th><th>Trial 2 (Phase 3) TULIP-1 (NCT02446912)</th><th>Trial 3 (Phase 3) TULIP-2 (NCT02446899)</th></tr>
<tr><td>Manufacturer</td><td colspan="3">MedImmune AstraZeneca</td></tr>
<tr><td>Patient population</td><td colspan="3">• Mean age of 41 years (range = 18-69 years)
• 93% female
• 42% - 70% White, 19%-42% Hispanic/Latino, 12%-14% Black/African American, 5%-17% Asian</td></tr>
<tr><td>Interventions</td><td colspan="3">N = 305
Randomized 1:1:1
Received one of the following in addition to standard therapy:
• Saphnelo IV 300mg
• Saphnelo IV 100mg
• Placebo</td></tr>
<tr><td>Interventions

Primary Endpoints</td><td rowspan="2">N = 305
Randomized 1:1:1
Received one of the following in addition to standard therapy:
• Saphnelo IV 300mg
• Saphnelo IV 100mg
• Placebo
• Combined assessment of SRI-4 and sustained reduction in OCS (10mg/day and ≤OCS dose at week 1, sustained for 12 weeks)</td><td>N = 457
Randomized 1:2:2
Received one of the following in addition to standard therapy:
• Saphnelo IV 150mg
• Saphnelo IV 300mg
• Placebo</td><td>N = 362
Randomized 1:1
Received one in addition to standard therapy:
• Saphnelo IV 300mg
• Placebo</td></tr>
<tr><td colspan="2">During weeks 8-40, patients with a baseline OCS ≥ 10mg/day were required to taper OCS dose to ≤ 7.5 mg/day, unless there was worsening of disease</td></tr>
<tr><td>BICLA Response (300mg)</td><td>54.6% Saphnelo (n=54) vs. 25.8% placebo (n=27)</td><td>Improvement in disease activity evaluated at 52 weeks, measured by SRI-4</td><td>Improvement in disease activity evaluated by 52 weeks, measured by BICLA</td></tr>
<tr><td>SRI-4 Response (300mg)</td><td>62.8% Saphnelo (n=62) vs. 38.8% placebo (n=41)</td><td>47.1% Saphnelo (n=85) vs. 30.2% placebo (n=55)</td><td>47.8% Saphnelo (n=86) vs. 31.5% placebo (n=57)</td></tr>
</table>

References:
Product Information: BENLYSTA(R) intravenous, subcutaneous injection, belimumab intravenous, subcutaneous injection. GlaxoSmithKline (per FDA), Research Triangle Park, NC, 2020.
Product Information: LUPKYNIS(TM) oral capsules, voclosporin oral capsules. Aurinia Pharma US Inc (per manufacturer), Rockville, MD, 2021.
Lupkynis Prescribing information, NCT02141672, NCT03021499
Saphnelo Prescribing Information; NCT01438489 (MUSE); NCT02446912 (TULIP-1); NCT02446899 (TULIP-2).
Product Information: SAPHNELO(TM) intravenous injection, anifrolumab-fnia intravenous injection. AstraZeneca Pharmaceuticals LP (per FDA), Wilmington, DE, 2021.
Fanouriakis A, Kostopoulou M, Alunno A, et al. Ann Rheum Dis 2019;78:736–745.

RDUR Activity Overview: Q3 2021



July Cases by Type of Criteria

Criteria Description	# of Cases	% of Cases
LAMOTRIGINE INTERACTIONS	7	5.74%
TIZANIDINE INTERACTIONS	19	15.6%
CONTRACEPTION AND HEPATIC ENZYME INDUCER INTERACTIONS	7	5.74%
TRAMADOL INTERACTIONS (TCAS, SSRIS, CARBAMAZEPINE)	12	9.84%
TOPIRAMATE INTERACTIONS	10	8.20%
STATIN INTERACTIONS	29	23.78%
CLOBAZAM INTERACTIONS	3	2.46%
CHOLESTYRAMINE INTERACTIONS	2	1.64%
CHOLESTYRAMINE & COLESTIPOL STAGGERING	5	4.10%
MIRABEGRON AND ANTIMUSCARINIC INTERACTION	1	0.82%
TACROLIMUS AND PPI INTERACTIONS	2	1.64%
CYCLOBENZAPRINE AND TCA INTERACTIONS	13	10.66%
DESMOPRESSIN AND DRUGS CAUSING WATER INTOXICATION	12	9.84%

August Cases by Type of Criteria

Criteria Description	# of Cases	% of Cases
ARIPIPRAZOLE INTERACTIONS	6	3.61%
DULPXETINE INTERACTIONS	2	1.20%
DESVENLAFAXINE INTERACTIONS	7	4.22%
CLOPIDOGREL AND PPI INTERACTION	1	0.60%
CONCURRENT OXYCODONE + BENZODIAZEPINE	29	17.47%
OTHER OXYCODONE INTERACTIONS	22	13.25%
CYP INTERACTIONS	36	21.69%
RANOLAZINE + P-GP INHIBITORS	1	0.60%
STIMULANTS + SEROTONERGIC AGENTS	20	12.05%
SGLT-2 INHIBITORS + INSULIN/SULFONYLUREA	10	6.02%
INHALERS + MAOIS/TCA'S/QT PROLONGING MEDS	5	3.01%
METFORMIN + CARBONIC ANHYDRASE INHIBITORS	2	1.20%
TRIPTANS + SSRIS/SNRIS	6	3.61%
DRONEDARONE + POTASSIUM WASTING DIURETICS	1	0.60%
PR AND QT PROLONING MEDICATIONS	4	2.41%
RIVAROXABAN AND NSAIDS	3	1.81%
LEVOMILNACIPRAN/ VORTIOXETINE + COAGULATION DRUGS	6	3.61%
ANTIPSYCHOTIC AND ANTIHYPERTENSIVE INTERACTIONS	5	3.01%

September Cases by Type of Criteria

Criteria Description	# of Cases	% of Cases
ANTI-ULCER AGENTS' LENGTH OF THERAPY	1	0.54%
HYPNOTICS LENGTH OF THERAPY	7	3.80%
SLEEP AGENTS AND ASSESSING FOR UNDERLYING CONDITIONS	6	3.26%
STIMULANTS AND PPIs	7	3.80%
PURE OPIOID AGONISTS/BUPRENORPHINE PAIN + BENZODIAZEPINES	96	52.17%
PURE OPIOID AGONISTS/BUPRENORPHINE PAIN + ANTIPSYCHOTICS	36	19.57%
QUINOLONES AND ANTIHYPERGLYCEMIC AGENTS	7	3.80%
CYP INTERACTIONS	8	4.34%
AGENTS + RENAL IMPAIRMENT	10	5.43%
DISULFURAM + BENZODIAZEPINES HEPATICALLY METABOLIZED	1	0.54%
ZIPRASIDONE + QT PROLONGATION AGENTS	4	2.17%
SOLRIAMFETOL + BP PRESSURE	1	0.54%

NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
4TH QUARTER 2021

Criteria Recommendations ***Approved Rejected***

1. Selpercatinib / Overuse _____ _____
Alert Message: Retevmo (selpercatinib) may be over-utilized. The recommended daily dosage of selpercatinib is based on body weight. Patients weighing 50 kg or greater should receive 160 mg twice daily. Patients weighing less than 50 kg should receive 120 mg twice daily.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Selpercatinib		Cirrhosis
		Hepatic Failure

Max Dose: 320 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

2. Selpercatinib / Overuse – Severe Hepatic Impairment _____ _____
Alert Message: The dose of Retevmo (selpercatinib) should be reduced in patients with severe hepatic impairment [total bilirubin greater than 3 to 10 times the upper limit of normal (ULN) and any AST]. The daily dose of selpercatinib should not exceed 80 mg twice daily in patients with severe hepatic impairment.

Drugs/Diseases

Util A	Util B	Util C (Include)
Selpercatinib		Cirrhosis
		Hepatic Failure

Max Dose: 160 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

3. Selpercatinib / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Retevmo (selpercatinib) for the treatment of non-small cell lung cancer have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C (Include)
Selpercatinib		Malignant Neoplasm of Bronchus and Lung

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

Criteria Recommendations ***Approved Rejected***

4. Selpercatinib / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Retevmo (selpercatinib) have not been established in pediatric patients less than 12 years of age.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib		

Age Range: 0 – 11 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

5. Selpercatinib / Hypertension _____ _____
Alert Message: In clinical studies, hypertension occurred in 35% of patients receiving Retevmo (selpercatinib). Treatment-emergent hypertension was most commonly managed with anti-hypertension medications. Do not initiate selpercatinib in patients with uncontrolled hypertension. Optimize blood pressure prior to initiating selpercatinib. Monitor blood pressure after 1 week, at least monthly thereafter, and as clinically indicated. Initiate or adjust anti-hypertensive therapy as appropriate. Based on the severity of hypertension, withhold, reduce dose, or permanently discontinue selpercatinib.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Selpercatinib	Hypertension	Antihypertensive Medications

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

6. Selpercatinib / Hemorrhage _____ _____
Alert Message: Serious including fatal hemorrhagic events can occur with Retevmo (selpercatinib). Grade ≥ 3 hemorrhagic events occurred in 2.3% of patients treated with selpercatinib, including 3 (0.4%) patients with fatal hemorrhagic events, including one case each of cerebral hemorrhage, tracheostomy site hemorrhage, and hemoptysis. Permanently discontinue selpercatinib in patients with severe or life-threatening hemorrhage.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Intracranial Hemorrhage	
	Gastrointestinal Bleeding	
	Hematuria	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

7. Selpercatinib / Drugs That Prolong QT Interval _____ _____

Alert Message: Retevmo (selpercatinib) is associated with QTc interval prolongation. The concurrent use of selpercatinib with a drug that also increases the QT interval may have an additive effect. Monitor the QT interval with ECGs more frequently in patients who require treatment with concomitant medications known to prolong the QT interval.

Drugs/Diseases

Util A	Util B				Util C
Selpercatinib	Abiraterone	Efavirenz	Lithium	Rilpivirine	
	Alfuzosin	Eliglustat	Lofexidine	Risperidone	
	Amiodarone	Encorafenib	Loperamide	Ritonavir	Amitriptyline
	Entrectinib	Maprotiline	Romidepsin		
	Amoxapine	Eribulin	Methadone	Saquinavir	
	Anagrelide	Erythromycin	Metoclopramide	Sertraline	Aripiprazole
	Escitalopram	Midostaurin	Siponimod		
	Arsenic Trioxide	Ezogabine	Mifepristone	Solifenacin	
	Artemether/Lum	Famotidine	Mirabegron	Sotalol	
	Asenapine	Felbamate	Mirtazapine	Sunitinib	
	Atazanavir	Fingolimod	Moexipril	Tacrolimus	
	Atomoxetine	Flecainide	Moxifloxacin	Tamoxifen	
	Azithromycin	Fluconazole	Nelfinavir	Telavancin	
	Bedaquiline	Fluoxetine	Nilotinib	Tetrabenazine	
	Bortezomib	Fluvoxamine	Nortriptyline	Thioridazine	
	Bendamustine	Foscarnet	Ofloxacin	Tizanidine	
	Bosutinib	Galantamine	Ondansetron	Tolterodine	
	Buprenorphine	Ganciclovir	Osimertinib	Toremifene	
	Ceritinib	Gemifloxacin	Oxaliplatin	Tramadol	
	Chloroquine	Gilteritinib	Paliperidone	Trazodone	
	Chlorpromazine	Glasdegib	Palonosetron	Tranylcypromine	
	Cilostazol	Granisetron	Panobinostat	Trimipramine	
	Ciprofloxacin	Haloperidol	Paroxetine	Valbenazine	
	Citalopram	Hydroxychloroquine	Pasireotide	Vandetanib	
	Clarithromycin	Hydroxyzine	Pazopanib	Vemurafenib	
	Clomipramine	Ibutilide	Pentamidine	Venlafaxine	
	Clozapine	Iloperidone	Pimavanserin	Voriconazole	
	Crizotinib	Imipramine	Pimozide		
	Dabrafenib	Indapamide	Pitolisant		
	Dasatinib	Indinavir	Phenelzine		
	Desipramine	Isocarboxazid	Posaconazole		
	Deutetrabenazine	Itraconazole	Procainamide		
	Diphenhydramine	Ivosidenib	Promethazine		
	Disopyramide	Ivabradine	Propafenone		
	Dofetilide	Ketoconazole	Protriptyline		
	Dolasetron	Lapatinib	Quetiapine		
	Donepezil	Lefamulin	Quinidine		
	Doxepin	Lenvatinib	Quinine		
	Dronedarone	Leuprolide	Ranolazine		

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

8. Selpercatinib / QT Prolongation _____ _____

Alert Message: Retevmo (selpercatinib) can cause concentration-dependent QT interval prolongation. Monitor patients who are at significant risk of developing QTc prolongation, including patients with known long QT syndromes, clinically significant bradyarrhythmias, and severe or uncontrolled heart failure. Assess QT interval, electrolytes, and TSH at baseline and periodically during treatment, adjusting frequency based upon risk factors including diarrhea. Correct hypokalemia, hypomagnesemia, and hypocalcemia prior to initiating selpercatinib and during treatment. Based on the severity of QT prolongation, withhold and dose reduce or permanently discontinue selpercatinib.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Long QT Syndrome	
	Bradyarrhythmia	
	Heart Failure	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

9. Selpercatinib / Proton Pump Inhibitors _____ _____

Alert Message: The coadministration of Retevmo (selpercatinib) with a proton pump inhibitor (PPI) should be avoided. Concomitant use of selpercatinib with acid-reducing agents decreases selpercatinib plasma concentrations, which may reduce selpercatinib anti-tumor activity. If] concurrent use of selpercatinib and a PPI cannot be avoided, take selpercatinib with food when coadministered with a PPI.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Dexlansoprazole	
	Esomeprazole	
	Lansoprazole	
	Omeprazole	
	Pantoprazole	
	Rabeprazole	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

10. Selpercatinib / H2 Receptor Antagonists _____ _____

Alert Message: The coadministration of Retevmo (selpercatinib) with an H2 receptor antagonist should be avoided. Concomitant use of selpercatinib with acid-reducing agents decreases selpercatinib plasma concentrations, which may reduce selpercatinib anti-tumor activity. If concurrent use of selpercatinib and an H2 receptor antagonist cannot be avoided, take selpercatinib 2 hours before or 10 hours after administration of the H2 receptor antagonist.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Cimetidine	
	Famotidine	
	Nizatidine	
	Ranitidine	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

11. Selpercatinib / Locally-Acting Antacids _____ _____

Alert Message: The coadministration of Retevmo (selpercatinib) with a locally-acting antacid should be avoided. Concomitant use of selpercatinib with acid-reducing agents decreases selpercatinib plasma concentrations, which may reduce selpercatinib anti-tumor activity. If concurrent use of selpercatinib and a locally-acting antacid cannot be avoided, take selpercatinib 2 hours before or 2 hours after administration of the locally-acting antacid.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Aluminum Carbonate	
	Calcium Carbonate	
	Magnesium Oxide	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

12. Selpercatinib / Moderate & Strong CYP3A Inhibitors _____ _____

Alert Message: The coadministration of Retevmo (selpercatinib) with a moderate or strong CYP3A inhibitor should be avoided. Selpercatinib is a CYP3A substrate, and concomitant use with a moderate or strong CYP3A inhibitor increases selpercatinib plasma concentrations, which may increase the risk of selpercatinib adverse reactions, including QT interval prolongation. If concurrent use cannot be avoided, reduce the selpercatinib dose according to the approved product labeling, and monitor the QT interval.

Drugs/Diseases

Util A	Util B		Util C
Selpercatinib	Atazanavir	Fosamprenavir	
	Aprepitant	Idelalisib	
	Cimetidine	Indinavir	
	Ciprofloxacin	Itraconazole	
	Clarithromycin	Ketoconazole	
	Clotrimazole	Nefazodone	
	Cobicistat	Nelfinavir	
	Crizotinib	Posaconazole	
	Cyclosporine	Ritonavir	
	Diltiazem	Saquinavir	
	Dronedarone	Tipranavir	
	Erythromycin	Verapamil	
	Fluconazole	Voriconazole	
	Fluvoxamine		

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

13. Selpercatinib / Moderate & Strong CYP3A Inducers _____ _____

Alert Message: The coadministration of Retevmo (selpercatinib) with a moderate or strong CYP3A inducer should be avoided. Selpercatinib is a CYP3A substrate, and concurrent use with a moderate or strong CYP3A inducer decreases selpercatinib plasma concentrations, which may reduce selpercatinib anti-tumor activity.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Apalutamide	
	Bosentan	
	Carbamazepine	
	Efavirenz	
	Etravirine	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifabutin	
	Rifampin	
	Rifapentine	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

14. Selpercatinib / CYP2C8 & CYP3A Substrates _____ _____

Alert Message: Retevmo (selpercatinib) is a moderate CYP2C8 inhibitor and a weak CYP3A inhibitor. Concomitant use of selpercatinib with CYP2C8 and CYP3A substrates increases their plasma concentrations, which may increase the risk of adverse reactions related to these substrates. Avoid coadministration of selpercatinib with CYP2C8 and CYP3A substrates where minimal concentration changes may lead to increased adverse reactions. If coadministration cannot be avoided, follow recommendations for CYP2C8 and CYP3A substrates provided in their approved product labeling.

Drugs/Diseases

Util A	Util B					Util C
Selpercatinib	Avanafil	Eletriptan	Lurasidone	Repaglinide	Ticagrelor	
	Budesonide	Eplerenone	Maraviroc	Rosiglitazone	Tipranavir	
	Buspirone	Everolimus	Midazolam	Selexipag	Tolvaptan	
	Conivaptan	Felodipine	Naloxegol	Simvastatin	Treprostinil	
	Darifenacin	Ibrutinib	Nisoldipine	Sirolimus	Triazolam	
	Darunavir	Lomitapide	Pioglitazone	Sildenafil	Vardenafil	
	Dronedarone	Lovastatin	Quetiapine	Tacrolimus		

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

15. Selpercatinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on findings from animal studies, and its mechanism of action, Retevmo (selpercatinib) can cause fetal harm when administered to a pregnant woman. There are no available data on selpercatinib use in pregnant women to inform of drug-associated risk. Administration of selpercatinib to pregnant rats during the period of organogenesis resulted in embryolethality and malformations at maternal exposures that were approximately equal to the human exposure at the clinical dose of 160 mg twice daily. Advise pregnant women of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Selpercatinib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

16. Selpercatinib / Therapeutic Appropriateness _____ _____

Alert Message: There are no data on the presence of Retevmo (selpercatinib) or its metabolites in human milk or on their effects on the breastfed child or milk production. Because of the potential for serious adverse reactions in breastfed children, advise women not to breastfeed during treatment with selpercatinib and for 1 week after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Selpercatinib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

17. Selpercatinib / Therapeutic Appropriateness _____ _____ Alert Message:

Advise females of reproductive potential to use effective contraception during Retevmo (selpercatinib) treatment and for at least 1 week after the final dose. There are no available data on the use of selpercatinib in pregnant women to inform a drug-associated risk.

Drugs/Disease

Util A	Util B	Util C (Negating)
Selpercatinib		Contraceptives

Gender: Female
Age Rage: 11 – 50 yoa

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

18. Selpercatinib / Therapeutic Appropriateness _____ _____ Alert Message:
Advise males with female partners of reproductive potential to use effective contraception during treatment with Retevmo (selpercatinib) and for at least 1 week after the final selpercatinib dose.

Drugs/Disease
Util A Util B Util C
Selpercatinib

Gender: Male

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan. 2021, Eli Lilly and Company.

19. Selpercatinib / Non-adherence _____ _____
Alert Message: Based on refill history, your patient may be under-utilizing Retevmo (selpercatinib). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs.

Drugs/Diseases
Util A Util B Util C
Selpercatinib

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence with Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.

20. Ponesimod / Overuse _____ _____
Alert Message: Ponvory (ponesimod) may be over-utilized. The recommended maintenance dose of ponesimod is 20 mg orally once daily.

Drugs/Diseases
Util A Util B Util C
Ponesimod

Max Dose: 20 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

21. Ponesimod / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Ponvory (ponesimod) in pediatric patients have not been established.

Drugs/Diseases
Util A Util B Util C
Ponesimod

Age Range: 0 – 17 yoa
References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

22. Ponesimod / Therapeutic Appropriateness _____ _____

Alert Message: Ponvory (ponesimod) is contraindicated in patients who: in the last 6 months, have experienced myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization, or Class III or IV heart failure. Ponesimod is also contraindicated in patients who have the presence of Mobitz type II second-degree, third-degree atrioventricular (AV) block, or sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod		Heart Failure
		Heart Block
		Myocardial Infarction
		Stroke
		Transient Ischemic Attack
		Unstable Angina

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

23. Ponesimod / Infections _____ _____

Alert Message: Ponvory (ponesimod) may increase the susceptibility to infections. Initiation of treatment with ponesimod should be delayed in patients with an active infection until resolution. Effective diagnostic and therapeutic strategies should be employed in patients with symptoms of infection while on ponesimod. Consider interruption of treatment with ponesimod if a patient develops a serious infection.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod	Infections	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

24. Ponesimod / Respiratory Effects _____ _____

Alert Message: Ponvory (ponesimod) should be used with caution in patients with severe respiratory disease (i.e., pulmonary fibrosis, asthma, and chronic obstructive pulmonary disease). Ponesimod has been shown to cause dose-dependent reductions in forced expiratory volume over 1 second (FEV1) and reductions in diffusion lung capacity for carbon monoxide (DLco). There is insufficient information to determine the reversibility of the decrease in FEV1 or FVC after treatment.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ponesimod		Asthma
		Chronic Obstructive Pulmonary
		Pulmonary Fibrosis

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

25. Ponesimod / Liver Injury _____ _____

Alert Message: Ponvory (ponesimod) is not recommended in patients with moderate or severe hepatic impairment (Child-Pugh class B and C, respectively). Patients who develop symptoms suggestive of hepatic dysfunction, such as unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, a rash with eosinophilia, or jaundice and/or dark urine during treatment, should have hepatic enzymes checked. Ponesimod should be discontinued if significant liver injury is confirmed. Obtain transaminase and bilirubin levels, if not recently available (i.e., within the last 6 months) before initiation of ponesimod.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod	Cirrhosis	
	Hepatic Failure	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

26. Ponesimod / Hypertension / Antihypertensives (Negating) _____ _____

Alert Message: Ponvory (ponesimod) can cause hypertension. Blood pressure should be monitored during treatment with Ponvory (ponesimod) and managed appropriately.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ponesimod	Hypertension	Antihypertensives

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

27. Ponesimod /Skin Cancer _____ _____

Alert Message: Cases of basal cell carcinoma and other skin malignancies have been reported in patients treated with S1P receptor modulators, including Ponvory (ponesimod). Providers and patients are advised to monitor for suspicious skin lesions. If a suspicious skin lesion is observed, it should be promptly evaluated.

Drugs/Diseases

Util A	Util B	Util C (Require)
Ponesimod		Skin Cancer

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

28. Ponesimod / Strong CYP3A4 Inducers and UGT1A1 Inducers _____ _____

Alert Message: Coadministration of Ponvory (ponesimod) with strong CYP3A4 and UGT1A1 inducers is not recommended. In vitro assessments and limited clinical data indicated that concomitant use of strong CYP3A4 and UGT1A1 inducers (e.g., rifampin, phenytoin, carbamazepine) may decrease the systemic exposure of ponesimod. It is unclear whether this decrease in ponesimod systemic exposure would be considered of clinical relevance.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

29. Ponesimod / Beta-Blockers _____ _____

Alert Message: Caution should be exercised when Ponvory (ponesimod) is initiated in patients receiving treatment with a beta-blocker because of the additive effects on lowering heart rate; temporary interruption of the beta-blocker treatment may be needed prior to initiation of ponesimod. Beta-blocker treatment can be initiated in patients receiving stable doses of ponesimod.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod	Acebutolol	
	Atenolol	
	Betaxolol	
	Bisoprolol	
	Carvedilol	
	Labetalol	
	Metoprolol	
	Nadolol	
	Nebivolol	
	Pindolol	
	Propranolol	
	Sotalol	
	Timolol	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

30. Ponesimod / QT Prolonging Drugs w/ Arrhythmogenic Properties _____ _____

Alert Message: Because of the potential additive effects on heart rate, treatment with Ponvory (ponesimod) should generally not be initiated in patients who are concurrently treated with QT-prolonging drugs with known arrhythmogenic properties, heart rate lowering calcium channel blockers (e.g., verapamil, diltiazem), or other drugs that may decrease heart rate (e.g., digoxin). If treatment with ponesimod is considered, advice from a cardiologist should be sought.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod	Amiodarone	
	Digoxin	
	Diltiazem	
	Procainamide	
	Quinidine	
	Verapamil	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

31. Ponesimod / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on animal studies, Ponvory (ponesimod) may cause fetal harm. There are no adequate and well-controlled studies of ponesimod in pregnant women. In animal studies, administration of ponesimod during pregnancy produced adverse effects on development, including embryo lethality and fetal malformations, in the absence of maternal toxicity.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ponesimod	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

32. Ponesimod / Therapeutic Appropriateness _____ _____

Alert Message: Because it takes approximately 1 week to eliminate Ponvory (ponesimod) from the body, women of childbearing potential should use effective contraception to avoid pregnancy during and for 1 week after stopping ponesimod treatment. Based on animal studies, ponesimod may cause fetal harm.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ponesimod		Contraceptives

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

33. Ponesimod / Therapeutic Appropriateness _____ _____

Alert Message: There are no data on the presence of Ponvory (ponesimod) in human milk, the effects on the breastfed infant, or the effects of the drug on milk production. When ponesimod was orally administered to female rats during pregnancy and lactation, ponesimod was detected in the plasma of the offspring, suggesting excretion of ponesimod in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ponesimod and any potential adverse effects on the breastfed infant from ponesimod or from the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.

34. Ponesimod / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Ponvory (ponesimod). Nonadherence to the prescribed dosing regimen may result in subtherapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Ponesimod		

References:
Ponvory Prescribing Information, March 2021, Janssen Pharmaceuticals, Inc.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
McKay KA, Tremlett H, Patten SB, et al. Determinants of Non-Adherence to Disease-Modifying Therapies in Multiple Sclerosis: A Cross-Canada Prospective Study. Mult Scler. 2016;23(4):588-596.
Higuera L, Carlin CS, Anderson S. Adherence to Disease-Modifying Therapies for Multiple Sclerosis. J Manag Care Spec Pharm. 2016;22(12):1394-1401.

35. Ozanimod / Overuse _____ _____

Alert Message: Zeposia (ozanimod) may be overutilized. The recommended maximum maintenance dose, after the initial 7-day titration, is 0.92 mg once daily.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod		

Max Dose: 0.92 mg/day

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

Criteria Recommendations ***Approved Rejected***

36. Ozanimod / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Zeposia (ozanimod) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod		

Age Range: 0 – 17 yoa

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

37. Ozanimod / Ozanimod Contraindications _____ _____
Alert Message: Zeposia (ozanimod) is contraindicated in patients who, in the last 6 months, have experienced a myocardial infarction, unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure requiring hospitalization, or Class III or IV heart failure. Ozanimod is also contraindicated in patients who have the presence of Mobitz type II second-degree, third-degree atrioventricular (AV) block, or sick sinus syndrome, or sino-atrial block, unless the patient has a functioning pacemaker.

Drugs/Diseases

Util A	Util B	Util C (Include)
Ozanimod		Heart Failure
		Heart Block
		Myocardial Infarction
		Stroke
		Transient Ischemic Attack
		Unstable Angina

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

38. Ozanimod / Sleep Apnea _____ _____
Alert Message: Zeposia (ozanimod) is contraindicated in patients who have severe untreated sleep apnea.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Sleep Apnea	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

39. Ozanimod / Monoamine Oxidase Inhibitors _____ _____

Alert Message: Zeposia (ozanimod) is contraindicated in patients who taking MAO inhibitors (e.g., selegiline, phenelzine, linezolid). At least 14 days should elapse between discontinuation of ozanimod and initiation of treatment with MAO inhibitors. Metabolites of ozanimod inhibit MAO. The potential for a clinical interaction with MAO inhibitors has not been studied; however, the increased risk of nonselective MAO inhibition may lead to a hypertensive crisis.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Isocarboxazid	
	Linezolid	
	Phenelzine	
	Rasagiline	
	Safinamide	
	Selegiline	
	Tranylcypromine	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

40. Ozanimod / Hepatic Impairment _____ _____

Alert Message: The use of Zeposia (ozanimod) in patients with hepatic impairment is not recommended. Elevations of aminotransferases may occur in patients receiving ozanimod. Patients who develop symptoms suggestive of hepatic dysfunction, such as unexplained nausea, vomiting, abdominal pain, fatigue, anorexia, or jaundice and/or dark urine, should have hepatic enzymes checked, and ozanimod should be discontinued if significant liver injury is confirmed.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Hepatic Impairment	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

41. Ozanimod / Infections _____ _____

Alert Message: Zeposia (ozanimod) may increase the susceptibility to infections, some serious in nature. Life-threatening and rare fatal infections have occurred in patients receiving ozanimod. Consider interruption of treatment with ozanimod if a patient develops a serious infection. Because the elimination of ozanimod after discontinuation may take up to 3 months, continue monitoring for infections throughout this period.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Infections	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

42. Ozanimod / Hypertension / Antihypertensives (Negating) _____ _____

Alert Message: In a clinical study, hypertension was reported as an adverse reaction in patients treated with Zeposia (ozanimod). Blood pressure should be monitored during treatment with ozanimod and managed appropriately.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ozanimod	Hypertension	Antihypertensives

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

43. Ozanimod / Macula Edema _____ _____

Alert Message: Sphingosine 1-phosphate (S1P) receptor modulators, including Zeposia (ozanimod), have been associated with an increased risk of macular edema. An ophthalmic evaluation of the fundus, including the macula, is recommended in all patients at any time if there is any change in vision while taking ozanimod. Continuation of ozanimod therapy in patients with macular edema has not been evaluated. A decision on whether or not ozanimod should be discontinued needs to take into account the potential benefits and risks for the individual patient.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Macula Edema	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

44. Ozanimod / CYP2C8 Inhibitors _____ _____

Alert Message: The co-administration of Zeposia (ozanimod), a CYP2C8 substrate, with a strong CYP2C8 inhibitor may increase the exposure of the active metabolites of ozanimod, which may increase the risk of ozanimod-related adverse reactions. Co-administration of ozanimod with strong CYP2C8 inhibitors (e.g., gemfibrozil) is not recommended.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Gemfibrozil	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

45. Ozanimod / CYP2C8 Inducers _____ _____

Alert Message: The co-administration of Zeposia (ozanimod), a CYP2C8 substrate, with a strong CYP2C8 inducer may decrease the exposure of the active metabolites of ozanimod, which may decrease the ozanimod efficacy. Co-administration of ozanimod with strong CYP2C8 inhibitors (e.g., gemfibrozil) is not recommended.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Rifampin	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

46. Ozanimod / Drugs that Increase Serotonin or Norepinephrine _____ _____

Alert Message: The co-administration of Zeposia (ozanimod) with medications that can increase norepinephrine or serotonin (e.g., opioid drugs, SSRIs, SNRIs, and tricyclics) is not recommended. Ozanimod has an active metabolite that is an MOA-B inhibitor and there is a potential for serious adverse reactions, including hypertensive crisis with coadministration of ozanimod with these medications.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Amphetamines	
	Opioids	
	SNRI's	
	SSRIs	
	Tricyclic Antidepressants	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

47. Ozanimod / Calcium Channel Blockers / Beta Blockers _____ _____

Alert Message: The co-administration of Zeposia (ozanimod) with both a beta-blocker and a calcium channel blocker has not been studied. The triple-drug combination of ozanimod, a beta-blocker, and a calcium channel blocker could potentially have an additive effect on the heart rate. Initiation of ozanimod may result in a transient decrease in heart rate and atrioventricular conduction delays. Treatment with ozanimod should generally not be initiated in patients who are concurrently treated with both a heart rate lowering calcium channel blocker (e.g., verapamil, diltiazem) and beta-blocker. If treatment initiation with ozanimod is considered in patients on both a heart rate lowering calcium channel blocker and beta-blocker, advice from a cardiologist should be sought.

Drugs/Diseases

Util A	Util B	Util C (Include)	
Ozanimod	Diltiazem	Acebutolol	Nadolol
	Verapamil	Atenolol	Nebivolol
		Betaxolol	Pindolol
		Bisoprolol	Propranolol
		Carvedilol	Sotalol
		Labetalol	Timolol
		Metoprolol	

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

48. Ozanimod / QT prolongation Drugs _____ _____

Alert Message: Zeposia (ozanimod) has not been studied in patients taking QT prolonging drugs. Because of the potential additive effects on heart rate, treatment with ozanimod should generally not be initiated in patients who are concurrently treated with QT-prolonging drugs with known arrhythmogenic properties. If treatment initiation with ozanimod is considered in patients on QT-prolonging drugs, advice from a cardiologist should be sought.

Drugs/Diseases

Util A	Util B				Util C
Ozanimod	Abiraterone	Efavirenz	Levofloxacin	Rilpivirine	
	Alfuzosin	Eliglustat	Lithium	Risperidone	
	Amiodarone	Encorafenib	Lofexidine	Ritonavir	Amitriptyline
	Entrectinib	Loperamide	Romidepsin		
	Anagrelide	Eribulin	Maprotiline	Saquinavir	
	Aripiprazole	Erythromycin	Methadone	Sertraline	
	Arsenic Trioxide	Escitalopram	Metoclopramide	Siponimod	
	Asenapine	Ezogabine	Midostaurin	Solifenacin	
	Atazanavir	Famotidine	Mifepristone	Sotalol	
	Atomoxetine	Felbamate	Mirabegron	Sunitinib	
	Azithromycin	Fingolimod	Mirtazapine	Tacrolimus	
	Bedaquiline	Flecainide	Moexipril	Tamoxifen	
	Bortezomib	Fluconazole	Moxifloxacin	Telavancin	
	Bendamustine	Fluoxetine	Nelfinavir	Tetrabenazine	
	Bosutinib	Fluvoxamine	Nilotinib	Thioridazine	
	Buprenorphine	Foscarnet	Nortriptyline	Tizanidine	
	Ceritinib	Galantamine	Ofloxacin	Tolterodine	
	Chloroquine	Ganciclovir	Ondansetron	Toremifene	
	Chlorpromazine	Gemifloxacin	Osimertinib	Tramadol	
	Cilostazol	Gilteritinib	Oxaliplatin	Trazodone	
	Ciprofloxacin	Glasdegib	Paliperidone	Trimipramine	
	Citalopram	Granisetron	Panobinostat	Valbenazine	
	Clarithromycin	Haloperidol	Paroxetine	Vandetanib	
	Clomipramine	Hydroxychloroquine	Pasireotide	Vemurafenib	
	Clozapine	Hydroxyzine	Pazopanib	Venlafaxine	
	Crizotinib	Ibutilide	Pentamidine	Voriconazole	
	Dabrafenib	Iloperidone	Pimavanserin		
	Dasatinib	Imipramine	Pimozide		
	Desipramine	Indapamide	Pitolisant		
	Deutetrabenazine	Indinavir	Posaconazole		
	Diphenhydramine	Ivabradine	Procainamide		
	Disopyramide	Itraconazole	Promethazine		
	Dofetilide	Ivosidenib	Propafenone		
	Dolasetron	Ketoconazole	Quetiapine		
	Donepezil	Lapatinib	Quinidine		
	Doxepin	Lefamulin	Quinine		
	Dronedarone	Lenvatinib	Ranolazine		
	Droperidol	Leuprolide	Ribociclib		

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

49. Ozanimod / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate data on the developmental risk associated with the use of Zeposia (ozanimod) in pregnant women. In animal studies, administration of ozanimod during pregnancy produced adverse effects on development, including embryolethality, an increase in fetal malformations, and neurobehavioral changes, in the absence of maternal toxicity. In rabbits, fetal blood vessel malformations occurred at clinically relevant maternal ozanimod and metabolite exposures. The receptor affected by ozanimod (sphingosine1-phosphate) has been demonstrated to have an important role in embryogenesis, including vascular and neural development.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ozanimod	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

50. Ozanimod / Lactation _____ _____

Alert Message: There are no data on the presence of Zeposia (ozanimod) in human milk, the effects on the breastfed infant, or the effects of the drug on milk production. In animal studies, following oral administration of ozanimod, ozanimod and/or metabolites were detected in the milk of lactating rats at levels higher than those in maternal plasma. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ozanimod and any potential adverse effects on the breastfed infant from ozanimod or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.

51. Ozanimod / Therapeutic Appropriateness _____ _____

Alert Message: Before initiation of Zeposia (ozanimod) treatment, women of childbearing potential should be counseled on the potential for serious risk to the fetus and the need for contraception during treatment with ozanimod. Because of the time it takes to eliminate the drug from the body after stopping treatment, the potential risk to the fetus may persist and women of childbearing age should also use effective contraception for 3 months after stopping ozanimod.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ozanimod		Contraceptives

Gender: Female
Age Range: 11 – 50 yoa

References:
Zeposia Prescribing Information, May 2021, Celgene Corporation.

52. Ozanimod / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Zeposia (ozanimod). Nonadherence to the prescribed dosing regimen may result in subtherapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Ozanimod		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
McKay KA, Tremlett H, Patten SB, et al. Determinants of Non-Adherence to Disease-Modifying Therapies in Multiple Sclerosis: A Cross-Canada Prospective Study. Mult Scler. 2016;23(4):588-596.
Higuera L, Carlin CS, Anderson S. Adherence to Disease-Modifying Therapies for Multiple Sclerosis. J Manag Care Spec Pharm. 2016;22(12):1394–1401.

53. Serdexmethylphenidate/Dexmethylphenidate / Overuse _____ _____

Alert Message: Azstarys (serdexmethylphenidate/dexmethylphenidate) may be over-utilized. The maximum recommended dosage of serdexmethylphenidate/dexmethylphenidate, in patients 6 to 12 years of age is 52.3 mg serdexmethylphenidate /10.4mg dexmethylphenidate once daily.

Drugs/Diseases

Util A	Util B	Util C
Serdexmethylphenidate/dexmethylphenidate		

Age Range: 6 – 12 yoa
Max Dose: 52.3 mg/10.4mg once daily

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Azstarys Prescribing Information, March 2021, Corium, Inc.

54. Serdexmethylphenidate/Dexmethylphenidate / Overuse _____ _____

Alert Message: Azstarys (serdexmethylphenidate/dexmethylphenidate) may be over-utilized. The maximum recommended dosage of serdexmethylphenidate/dexmethylphenidate, in patients 13 years of age and older is 52.3 mg serdexmethylphenidate /10.4mg dexmethylphenidate once daily.

Drugs/Diseases

Util A	Util B	Util C
Serdexmethylphenidate/dexmethylphenidate		

Age Range: ≥13 yoa
Max Dose: 52.3 mg/10.4mg once daily

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Azstarys Prescribing Information, March 2021, Corium, Inc.

55. Serdexmethylphenidate/Dexmethylphenidate / Risperidone _____ _____

Alert Message: When Azstarys (serdexmethylphenidate/dexmethylphenidate) is co-administered with risperidone, and there is a change in dosage of either or both medications, whether an increase or decrease, this may increase the risk of extrapyramidal symptoms (EPS). Monitor patients for signs of EPS.

Drugs/Diseases

Util A	Util B	Util C
Serdexmethylphenidate/dexmethylphenidate	Risperidone	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Azstarys Prescribing Information, March 2021, Corium, Inc.

56. Serdexmethylphenidate/Dexmethylphenidate / Pregnancy _____ _____

Alert Message: There are no available data on Azstarys (serdexmethylphenidate/dexmethylphenidate) use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Serdexmethylphenidate is a prodrug of dexmethylphenidate and dexmethylphenidate is the d-threo enantiomer of racemic methylphenidate. There may be risks to the fetus associated with the use of CNS stimulants use during pregnancy. CNS stimulants, such as serdexmethylphenidate/dexmethylphenidate, can cause vasoconstriction and thereby decrease placental perfusion.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Serdexmethylphenidate/dexmethylphenidate	Pregnancy	Abortion Delivery Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Azstarys Prescribing Information, March 2021, Corium, Inc.

57. Serdexmethylphenidate/Dexmethylphenidate / Lactation _____ _____

Alert Message: The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Azstarys (serdexmethylphenidate/dexmethylphenidate) and any potential adverse effects on the breastfed infant from serdexmethylphenidate/dexmethylphenidate or the underlying maternal condition. There are no available data on the presence of serdexmethylphenidate in human milk, effects on the breastfed infant, or effects on milk production. Dexmethylphenidate is the d-threo enantiomer of racemic methylphenidate, and methylphenidate has been shown to be present in human breast milk.

Drugs/Diseases

Util A	Util B	Util C
Serdexmethylphenidate/dexmethylphenidate	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Azstarys Prescribing Information, March 2021, Corium, Inc.

58. Serdexmethylphenidate/Dexmethylphenidate / MAOIs _____ _____
Alert Message: The safety and effectiveness of Azstarys (serdexmethylphenidate/dexmethylphenidate) in pediatric patients less than 6 years have not been established.

Drugs/Diseases

Util A	Util B	Util C
Serdexmethylphenidate/dexmethylphenidate		

Age Range: 0 - 5 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Azstarys Prescribing Information, March 2021, Corium, Inc.

59. Exenatide ER / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Bydureon Bcise (exenatide extended-release) have not been established in pediatric patients less than 10 years of age.

Drugs/Diseases

Util A	Util B	Util C
Exenatide ER		

Age Range: 0 – 9 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bydureon Bcise Prescribing Information. July 2021, AstraZeneca.

60. Risperidone SubQ / Overuse _____ _____
Alert Message: Perseris (risperidone extended-release subcutaneous injection) may be over-utilized. Initiate subcutaneous risperidone at a dose of 90 mg or 120 mg once monthly. Do not administer more than one dose (90 mg or 120 mg total) per month.

Drugs/Diseases

Util A	Util B	Util C
Risperidone SubQ		

Max Dose: 1 injection/month

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Perseris Prescribing Information, December 2019, Indivior, Inc.

61. Risperidone SubQ / Oral Risperidone / Strong 3A4 Inducers (Negating) _____ _____
Alert Message: Neither a loading dose nor any supplemental oral risperidone is recommended with Perseris (risperidone extended-release subcutaneous injection).

Drugs/Diseases

Util A	Util B	Util C (Negating)	
Risperidone SubQ	Oral Risperidone	Apalutamide	Phenobarbital
		Carbamazepine	Phenytoin
		Enzalutamide	Primidone
		Mitotane	Rifampin

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.

Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Perseris Prescribing Information, December 2019, Indivior, Inc.

Criteria Recommendations ***Approved*** ***Rejected***

62. Risperidone SubQ / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Perseris (risperidone extended-release subcutaneous injection) have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C
Risperidone SubQ		

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Perseris Prescribing Information, December 2019, Indivior, Inc.

63. Risperidone SubQ / Strong CYP34A4 Inducers _____ _____
Alert Message: Concomitant use of Perseris (risperidone extended-release subcutaneous injection) with a strong CYP3A4 inducer may result in decreased risperidone plasma concentrations, which could lead to decreased risperidone efficacy. A risperidone dosage increase may be considered. Refer to the official prescribing information for risperidone dosage modifications.

Drugs/Diseases

Util A	Util B		Util C
Risperidone SubQ	Apalutamide	Phenobarbital	
	Carbamazepine	Phenytoin	
	Enzalutamide	Primidone	
	Mitotane	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Perseris Prescribing Information, December 2019, Indivior, Inc.

64. Risperidone SubQ / Strong CYP2D6 Inhibitors _____ _____
Alert Message: Concomitant use of Perseris (risperidone extended-release subcutaneous injection) with a strong CYP2D6 inhibitor may increase risperidone plasma concentrations, increasing the risk of risperidone-related adverse effects. A risperidone dosage adjustment may be considered when a strong CYP2D6 inhibitor is initiated or discontinued. Refer to the official prescribing information for risperidone dosage modifications.

Drugs/Diseases

Util A	Util B	Util C
Risperidone SubQ	Bupropion	
	Dacomitinib	
	Fluoxetine	
	Paroxetine	
	Quinidine	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Facts & Comparisons, 2021 Updates, Wolters Kluwer Health.
Perseris Prescribing Information, December 2019, Indivior, Inc.

65. Risperidone SubQ / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Perseris (risperidone extended-release subcutaneous injection). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Risperidone SubQ		

References:

Higashi k, Medic G, Littlewood K, et al., Medication Adherence in Schizophrenia: Factors Influencing Adherence and Consequences of Nonadherence, A Systemic Literature Review. There Adv Psychopharmacol. 2013 2(4):200-218.
Acsher-Svanum H, Zhu B, Faries DE, et al., The Cost of Relapse and the Predictors of Relapse in the Treatment of Schizophrenia. BMC Psychiatry 2010, 10:2.
Berger A, Edelsbery J, Sanders KN, et al., Medication Adherence and Utilization in Patients with Schizophrenia or Bipolar Disorder Receiving Aripiprazole, Quetiapine, or Ziprasidone at Hospital Discharge: A Retrospective Cohort Study. BMC Psychiatry 2012;12:99.
Stephenson JJ, Tuncelli O, Gu T, et al. Adherence to Oral Second-Generation Antipsychotic Medications in Patients with Schizophrenia and Bipolar Disorder: Physicians' Perceptions of Adherence vs. Pharmacy Claims. Int J Clin Pract. June 2012, 66, 6, 565-573.

66. Elexacaftor/Tezacaftor/Ivacaftor / Hepatic Impairment _____ _____

Alert Message: In clinical studies, the use of Trikafta (elexacaftor/tezacaftor/ivacaftor) in patients with moderate hepatic impairment (Child-Pugh Class B) resulted in a higher AUC and Cmax for each individual. Treatment is not recommended for patients with moderate hepatic impairment. If use is clinically warranted in patients with moderate hepatic impairment, elexacaftor/tezacaftor/ivacaftor should be used with caution at a reduced dose, according to official prescribing information. Liver function tests should be closely monitored in patients with mild and moderate hepatic impairment. No dose modification is recommended for patients with mild hepatic impairment (Child-Pugh Class A).

Drugs/Diseases

Util A	Util B	Util C
Elexacaftor/Tezacaftor/Ivacaftor	Hepatic Impairment	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

67. Elexacaftor/Tezacaftor/Ivacaftor / Severe Hepatic Impairment _____ _____

Alert Message: Trikafta (elexacaftor/tezacaftor/ivacaftor) should not be used in patients with severe hepatic impairment (Child-Pugh Class C). Elexacaftor/tezacaftor/ivacaftor has not been studied in this patient population. In clinical studies, patients with moderate hepatic impairment (Child-Pugh Class B) had increased exposure to all three components of the co-packaged product. Drug exposure is expected to be even higher in patients with severe hepatic impairment.

Drugs/Diseases

Util A	Util B	Util C
Elexacaftor/Tezacaftor/Ivacaftor	Cirrhosis Hepatic Failure	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

68. Elexacaftor/Tezacaftor/Ivacaftor / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Trikafta (elexacaftor/tezacaftor/ivacaftor) in patients with CF younger than 6 years of age have not been established.

Drugs/Diseases

Util A	Util B	Util C
Elexacaftor/Tezacaftor/Ivacaftor		

Age Range: 0 – 5 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

69. Elexacaftor/Tezacaftor/Ivacaftor / CYP3A Inducers _____ _____
Alert Message: Exposure to ivacaftor is significantly decreased and exposure to elexacaftor and tezacaftor are expected to decrease by the concomitant use of strong CYP3A inducers, which may reduce the therapeutic effectiveness of Trikafta (elexacaftor/tezacaftor/ivacaftor). Therefore, co-administration with strong CYP3A inducers is not recommended.

Drugs/Diseases

Util A	Util B	Util C
Elexacaftor/Tezacaftor/Ivacaftor	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

70. Elexacaftor/Tezacaftor/Ivacaftor / Moderate & Strong CYP3A4 Inhibitors _____ _____
Alert Message: Exposure to elexacaftor, tezacaftor, and ivacaftor is increased when co-administered with strong or moderate CYP3A inhibitors. The dose of Trikafta (elexacaftor/tezacaftor/ivacaftor) should be reduced, according to the official prescribing information, when used concomitantly with moderate or strong CYP3A inhibitors.

Drugs/Diseases

Util A	Util B		Util C
Elexacaftor/Tezacaftor/Ivacaftor	Atazanavir	Fosamprenavir	
	Aprepitant	Idelalisib	
	Cimetidine	Indinavir	
	Clarithromycin	Itraconazole	
	Clotrimazole	Ketoconazole	
	Cobicistat	Nefazodone	
	Crizotinib	Nelfinavir	
	Cyclosporine	Posaconazole	
	Diltiazem	Ritonavir	
	Dronedarone	Saquinavir	
	Erythromycin	Tipranavir	
	Fluconazole	Verapamil	
	Fluvoxamine	Voriconazole	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

Criteria Recommendations ***Approved*** ***Rejected***

71. Elexacaftor/Tezacaftor/Ivacaftor / Sensitive P-gp Substrates _____ _____
Alert Message: Caution and appropriate monitoring should be used when Trikafta (elexacaftor/tezacaftor/ivacaftor) is co-administered with a P-gp substrate with a narrow therapeutic index. The ivacaftor component of the co-packaged combination product is a P-gp inhibitor, and concurrent use with a sensitive P-gp substrate may result in increased substrate exposure. Appropriate monitoring should be used when these agents are co-administered.

Drugs/Diseases

Util A	Util B	Util C
Elexacaftor/Tezacaftor/Ivacaftor	Digoxin	
	Cyclosporine	
	Tacrolimus	
	Sirolimus	
	Everolimus	

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

72. Elexacaftor/Tezacaftor/Ivacaftor / Pregnancy / Pregnancy Negating _____ _____
Alert Message: There are limited and incomplete human data from clinical trials on the use of Trikafta (elexacaftor/tezacaftor/ivacaftor) or its individual components in pregnant women to inform a drug-associated risk. Although there are no animal reproduction studies with the concomitant administration of elexacaftor, tezacaftor, and ivacaftor, separate reproductive and developmental studies were conducted with each component in pregnant rats and rabbits. Placental transfer in pregnant rats was observed for each component. No component was found to affect fetal survival or to be teratogenic.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Elexacaftor/Tezacaftor/Ivacaftor	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

73. Elexacaftor/Tezacaftor/Ivacaftor / Lactation _____ _____
Alert Message: There is no information regarding the presence of elexacaftor, tezacaftor, or ivacaftor in human milk, the effects on the breastfed infant, or the effects on milk production. In animal studies, elexacaftor, tezacaftor, and ivacaftor are excreted into the milk of lactating rats. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Trikafta (elexacaftor/tezacaftor/ivacaftor) and any potential adverse effects on the breastfed child from (elexacaftor/tezacaftor/ivacaftor) or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Elexacaftor/Tezacaftor/Ivacaftor	Lactation	

Gender: Female

Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Trikafta Prescribing Information, June 2021, Vertex Pharmaceuticals Inc.

Criteria Recommendations ***Approved*** ***Rejected***

74. Elexacaftor/Tezacaftor/Ivacaftor / Non-adherence _____ _____
Alert Message: Based on refill history, your patient may be under-utilizing Trikafta (elexacaftor/tezacaftor/ivacaftor). Nonadherence to the prescribed dosing regimen may result in subtherapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases
Util A Util B Util C
Elexacaftor/Tezacaftor/Ivacaftor

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
Eakin MN, Bilderback A, Boyle MP, et al., Longitudinal Association Between Medication Adherence and Lung Health in People with Cystic Fibrosis. Jrnl Cyst Fib. 2011:10(4):258-264.
Bishay LC, Sawicki GS., Strategies to Optimize Adherence in Adolescent Patients with Cystic Fibrosis. Adolesc Health, Med & Ther. 2016 Oct21;7:117-124.

75. Monomethyl Fumarate / Overuse _____ _____
Alert Message: Bafiertam (monomethyl fumarate) may be over-utilized. The recommended maintenance dose after 7 days is 190 mg twice a day.

Drugs/Diseases
Util A Util B Util C
Monomethyl Fumarate

Max Dose: 380 mg/day

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

76. Monomethyl Fumarate / Therapeutic Appropriateness _____ _____
Alert Message: The safety and effectiveness of Bafiertam (monomethyl fumarate) in pediatric patients have not been established.

Drugs/Diseases
Util A Util B Util C
Monomethyl Fumarate

Age Range: 0 – 17 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

77. Monomethyl Fumarate / Dimethyl Fumarate & Diroximel Fumarate _____ _____

Alert Message: Coadministration of Bafiertam (monomethyl fumarate) with dimethyl fumarate or diroximel fumarate is contraindicated. Both dimethyl fumarate and diroximel fumarate are metabolized to monomethyl fumarate. Concurrent use of monomethyl fumarate with these drugs may lead to toxic adverse effects. Monomethyl fumarate may be initiated the day following discontinuation of either drug.

Drugs/Diseases

Util A	Util B	Util C
Monomethyl Fumarate	Dimethyl Fumarate	
	Diroximel Fumarate	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

78. Monomethyl Fumarate / Progressive Multifocal Leukoencephalopathy _____ _____

Alert Message: Progressive multifocal leukoencephalopathy (PML) has occurred in patients with MS treated with dimethyl fumarate, the prodrug of Bafiertam (monomethyl fumarate). At the first sign or symptom suggestive of PML, withhold monomethyl fumarate and perform an appropriate diagnostic evaluation. Typical symptoms associated with PML are diverse, progress over days to weeks, and include progressive weakness on one side of the body or clumsiness of limbs, disturbance of vision, and changes in thinking, memory, and orientation leading to confusion and personality changes.

Drugs/Diseases

Util A	Util B	Util C
Monomethyl Fumarate	Visual Disturbances	
	Muscle Weakness	
	Disorientation	
	Altered Mental Status	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

79. Monomethyl Fumarate / Serious Opportunistic Infections _____ _____

Alert Message: Serious opportunistic infections have occurred with dimethyl fumarate, the product of Bafiertam (monomethyl fumarate), including cases of serious viral (herpes simplex virus, West Nile virus, cytomegalovirus), fungal (Candida and Aspergillus), and bacterial (Nocardia, Listeria monocytogenes, Mycobacterium tuberculosis) infections. Patients with symptoms and signs consistent with any of these infections should undergo prompt diagnostic evaluation and receive appropriate treatment. Consider withholding dimethyl fumarate treatment in patients with herpes zoster or other serious infections until the infection has resolved.

Drugs/Diseases

Util A	Util B	Util C
Monomethyl Fumarate	Infections	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

80. Monomethyl Fumarate / Flushing / Aspirin _____ _____

Alert Message: Bafiertam (monomethyl fumarate) may cause flushing (e.g., warmth, redness, itching, and/or burning sensation). Studies with dimethyl fumarate, the prodrug of monomethyl fumarate, show that administration of non-enteric coated aspirin (up to a dose of 325 mg) 30 minutes prior to dosing may reduce the incidence or severity of flushing.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Dimethyl Fumarate	Flushing	Aspirin

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

81. Monomethyl Fumarate / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate data on the developmental risk associated with the use of Bafiertam (monomethyl fumarate) or dimethyl fumarate (the prodrug of monomethyl fumarate) in pregnant women. Monomethyl fumarate may cause fetal harm. In animal studies, adverse effects on offspring survival, growth, sexual maturation, and neurobehavioral function were observed when dimethyl fumarate was administered during pregnancy and lactation at clinically relevant doses.

Drugs/Diseases

Util A	Util B	Util C (Negate)
Monomethyl Fumarate	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

82. Monomethyl Fumarate / Therapeutic Appropriateness _____ _____

Alert Message: There are no data on the presence of Bafiertam (monomethyl fumarate) or dimethyl fumarate (the prodrug of monomethyl fumarate) in human milk. The effects on the breastfed infant and milk production are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for monomethyl fumarate and any potential adverse effects on the breastfed infant from the drug or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Monomethyl Fumarate	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

83. Monomethyl Fumarate / Abnormal Liver Function Studies _____ _____

Alert Message: Clinically significant cases of liver injury have been reported in patients treated with dimethyl fumarate, the prodrug of Bafiertam (monomethyl fumarate, in the postmarketing setting. Obtain serum aminotransferase, alkaline phosphatase (ALP), and total bilirubin levels prior to treatment with monomethyl fumarate and during treatment, as clinically indicated. Discontinue monomethyl fumarate if clinically significant liver injury induced by monomethyl fumarate is suspected.

Drugs/Diseases

Util A	Util B	Util C
Monomethyl Fumarate	Abnormal Results in Liver Function Studies	

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Bafiertam Prescribing Information, May 2021, Banner Life Sciences.

84. Monomethyl Fumarate / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Bafiertam (monomethyl fumarate). Nonadherence to the prescribed dosing regimen may result in subtherapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Monomethyl Fumarate		

References:

Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
McKay KA, Tremlett H, Patten SB, et al. Determinants of Non-Adherence to Disease-Modifying Therapies in Multiple Sclerosis: A Cross-Canada Prospective Study. Mult Scler. 2016;23(4):588-596.
Higuera L, Carlin CS, Anderson S. Adherence to Disease-Modifying Therapies for Multiple Sclerosis. J Manag Care Spec Pharm. 2016;22(12):1394-1401.

85. **Cyclobenzaprine ER / Therapeutic Appropriateness** _____ _____

Alert Message: The safety and effectiveness of Amrix (cyclobenzaprine extended-release) have not been established in pediatric patients.

Drugs/Diseases

Util A	Util B	Util C
Cyclobenzaprine ER		

Age Range: 0 – 17 yoa

References:

Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Retevmo Prescribing Information, Jan.2021, Eli Lilly and Company.

86. Ripretinib / Overuse _____ _____ Alert Message:
Qinlock (ripretinib) may be over-utilized. The manufacturer's recommended maximum daily dosage of ripretinib is 150 mg orally once daily.

Drugs/Disease
Util A Util B Util C
Ripretinib

Max Dose: 150 mg/day

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

87. Ripretinib / Therapeutic Appropriateness _____ _____ Alert Message:
The safety and effectiveness of Qinlock (ripretinib) in pediatric patients have not been established.

Drugs/Disease
Util A Util B Util C
Ripretinib

Age Range: 0 – 17 yoa

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

88. Ripretinib / Therapeutic Appropriateness _____ _____ Alert Message:
Palmar-plantar erythrodysesthesia syndrome (PPES) has occurred in patients who received Qinlock (ripretinib). In clinical trials, PPES led to dose discontinuation in 1.2% of patients, dose interruption in 2.4% of patients, and dose reduction in 1.2% of patients. Based on severity, withhold ripretinib and then resume at the same or reduced dose.

Drugs/Disease
Util A Util B Util C
Ripretinib Localized skin eruption due to drugs and medications taken internally

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

89. Ripretinib / Other Malignancies _____ _____

Alert Message: New primary malignancy (e.g., cutaneous squamous-cell carcinoma, keratoacanthoma, and melanoma) has been reported with Qinlock (ripretinib) therapy. Dermatologic evaluations should be performed prior to starting ripretinib therapy and routinely during treatment. Manage suspicious skin lesions with excision and dermatopathologic evaluation. Continue ripretinib at the same dose.

Drugs/Disease

Util A	Util B	Util C
Ripretinib	Squamous Cell Carcinoma	
	Keratoacanthoma	
	Melanoma	

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

90. Ripretinib / Hypertension _____ _____

Alert Message: Hypertension has been reported with Qinlock (ripretinib) therapy. Do not initiate ripretinib in patients with uncontrolled hypertension. Adequately control blood pressure prior to initiating ripretinib. Monitor blood pressure as clinically indicated during treatment with ripretinib and initiate or adjust antihypertensive therapy as appropriate. Based on severity, withhold ripretinib and then resume at the same or reduced dose or permanently discontinue.

Drugs/Disease

Util A	Util B	Util C (Negating)
Ripretinib	Hypertension	Antihypertensives

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

91. Ripretinib / Cardiovascular Issues _____ _____

Alert Message: Qinlock (ripretinib) should be used with caution in patients with cardiovascular disease. Cardiac dysfunction (including cardiac failure, acute left ventricular failure, diastolic dysfunction, and ventricular hypertrophy) has occurred during ripretinib therapy. Assess ejection fraction by echocardiogram or MUGA scan prior to initiating ripretinib and during treatment, as clinically indicated. Permanently discontinue ripretinib for Grade 3 or 4 left ventricular systolic dysfunction.

Drugs/Disease

Util A	Util B	Util C
Ripretinib	Acute Coronary Syndrome	
	Myocardial Infarction	
	Cardiac Failure	
	Ventricular Hypertrophy	

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

92. Ripretinib / Therapeutic Appropriateness _____ _____

Alert Message: Qinlock (ripretinib) inhibits the vascular endothelial growth factor (VEGF) signaling pathway and may impaired wound healing. Therefore, ripretinib has the potential to adversely affect wound healing. Withhold ripretinib for at least one week prior to elective surgery. Do not administer ripretinib for at least two weeks following major surgery and until adequate wound healing. The safety of resumption of ripretinib after the resolution of wound healing complications has not been established.

Drugs/Disease

Util A	Util B	Util C
Ripretinib		

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

93. Ripretinib / Strong CYP3A Inhibitors _____ _____

Alert Message: The concurrent use of Qinlock (ripretinib), a CYP3A substrate, with a strong CYP3A inhibitor can increase the exposure of ripretinib and its active metabolite (DP-5439), which may increase the risk of adverse reactions. If ripretinib is used concomitantly with a strong CYP3A inhibitor, monitor the patient more frequently for ripretinib-related adverse reactions.

Drugs/Disease

Util A	Util B	Util C
Ripretinib	Clarithromycin	Nelfinavir
	Cobicistat	Posaconazole
	Indinavir	Ritonavir
	Itraconazole	Saquinavir
	Ketoconazole	Voriconazole
	Nefazodone	

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

94. Ripretinib / Strong CYP3A Inducers _____ _____

Alert Message: The concurrent use of Qinlock (ripretinib) with a strong CYP3A inducer should be avoided. Ripretinib is a CYP3A substrate, and the use of ripretinib with strong CYP3A inducers may decrease the exposure of ripretinib and its active metabolite (DP-5439), which may decrease ripretinib anti-tumor activity.

Drugs/Disease

Util A	Util B	Util C
Ripretinib	Apalutamide	
	Carbamazepine	
	Enzalutamide	
	Mitotane	
	Phenobarbital	
	Phenytoin	
	Primidone	
	Rifampin	

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

95. Ripretinib / Moderate CYP3A Inducers _____ _____

Alert Message: The concurrent use of Qinlock (ripretinib) with a moderate CYP3A inducer should be avoided. Ripretinib is a CYP3A substrate, and the use of ripretinib with moderate CYP3A inducers may decrease the exposure of ripretinib and its active metabolite (DP-5439), which may decrease ripretinib anti-tumor activity. If a moderate CYP3A inducer cannot be avoided, increase ripretinib dosing frequency from the recommended dose of 150 mg once daily to 150 mg twice daily during the co-administration period. Monitor the patient for clinical response and tolerability.

Drugs/Disease

Util A	Util B		Util C
Ripretinib	Bosentan	Etravirine	
	Butalbital	Modafinil	
	Efavirenz		

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

96. Ripretinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on findings from animal studies and its mechanism of action, Qinlock (ripretinib) can cause fetal harm when administered to a pregnant patient. There are no available data on the use of ripretinib in pregnant patients to inform a drug-associated risk. Administration of ripretinib to pregnant rats and rabbits during the period of organogenesis resulted in malformations primarily associated with the cardiovascular and skeletal systems, anatomic variations, reduced fetal body weight, and increased post-implantation loss at maternal exposures that were approximately equal to the human exposure at the recommended dose of 150 mg. Advise pregnant patients of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C (Negating)
Ripretinib	Pregnancy	Abortion
		Delivery
		Miscarriage

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

97. Ripretinib / Lactation _____ _____

Alert Message: There are no data regarding the presence of Qinlock (ripretinib) or its metabolites in either human milk or its effects on a breastfed child or milk production. Because of the potential for serious adverse reactions in the breastfed child, advise patients not to breastfeed during treatment with ripretinib and for at least 1 week after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Ripretinib	Lactation	

Gender: Female
Age Range: 11 – 50 yoa

References:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

98. Ripretinib / Therapeutic Appropriateness _____ _____ Alert Message:
Advise females of reproductive potential to use effective contraception during Qinlock (ripretinib) treatment and for at least 1 week after the final dose. There are no available data on the use of ripretinib in pregnant women to inform a drug-associated risk.

Drugs/Disease

Util A	Util B	Util C (Negating)
Ripretinib		Contraceptives

Gender: Female
Age Rage: 11 – 50 yoa

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

99. Ripretinib / Therapeutic Appropriateness _____ _____ Alert Message:
Advise males with female partners of reproductive potential to use effective contraception during treatment with Qinlock (ripretinib) and for at least 1 week after the final ripretinib dose.

Drugs/Disease

Util A	Util B	Util C
Ripretinib		

Gender: Male

Reference:
Clinical Pharmacology, 2021 Elsevier/Gold Standard.
Qinlock Prescribing Information, June 2021, Deciphera Pharmaceuticals, LLC.

100. Ripretinib / Non-adherence _____ _____
Alert Message: Based on refill history, your patient may be under-utilizing Qinlock (ripretinib). Nonadherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Ripretinib		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Ruddy K, Mayer E, Partridge A. Patient Adherence and Persistence with Oral Anticancer Treatment. CA Cancer J Clin 2009;59:56-66.
Barillet M, Prevost V, Joly F, Clarisse B. Oral Antineoplastic Agents: How do We Care About Adherence?. Br J Clin Pharmacol. 2015;80(6):1289–1302. doi:10.1111/bcp.12734
Greer JA, Amoyal N, Nisotel L, et al. Systemic Review of Adherence to Oral Antineoplastic Therapies. The Oncologist. 2016;21:354-376.