CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Aralast NP, Glassia, Prolastin C, Zemaira (alpha$_1$-proteinase inhibitor [human])
BILLING CODE	J0256 (J0257 for Glassia)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Products) QUANTITY LIMIT— See "Dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Aralast NP, Glassia, Prolastin C, and Zemaira are **non-preferred** products and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ALPHA$_1$-ANTITRYPSIN DEFICIENCY (AATD)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist; AND
3. Member has a diagnosis of clinically evident emphysema due to severe AATD; AND
4. Member is a never-smoker or has been a non-smoker for at least 3 months; AND
5. Member is in compliance with any prescribed supportive therapy (at least one)[1,4] (e.g., bronchodilators, pulmonary rehabilitation, oxygen); AND
6. Chart notes must include lab reports showing ALL of the following[1]:
   a) Pre-treatment alpha$_1$-antitrypsin (AAT) serum level less than 11micromol/L or equivalent;
   b) High risk genotype (e.g. Pi*ZZ, Pi*ZNull, Pi*NullNull);
   c) Pre-treatment FEV_1 is 30-65%[5] of predicted or has declined at a rate of 100mL/yr or more.
7. **Dosage allowed:** 60mg/kg IV once weekly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member continues to abstain from smoking; AND
2. At least ONE of the following:
   a) AAT level at or above protective threshold (11 micromol/L);
   b) Slowed rate of FEV_1 decline per spirometry results;
   c) CT densitometry report or high resolution computed tomography (HRCT) demonstrates slowed progression of anatomic lung disease.[3,4]

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers alpha$_1$-proteinase inhibitor not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/14/2020	Transferred to new template; revised and updated content.

References:

1. Stoller JK. Treatment of alpha-1-antitrypsin deficiency. *UpToDate*. http://www.uptodate.com. Updated July 13, 2020. Accessed July 13,2020.
2. Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global Strategy for the Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease: 2020 Report. www.goldcopd.org (Accessed on July 14, 2020).
3. Miravitlles M, Dirksen A, Ferrarotti I, et al. European Respiratory Society statement: diagnosis and treatment of pulmonary disease in α1-antitrypsin deficiency. Eur Respir J 2017; 50: 1700610 [https://doi.org/10.1183/13993003.00610-2017].
4. Marciniuk DD, Hernandez P, Balter M, et al. Alpha-1 antitrypsin deficiency targeted testing and augmentation therapy: a Canadian Thoracic Society clinical practice guideline [published correction appears in Can Respir J. 2012 Jul-Aug;19(4):272]. *Can Respir J*. 2012;19(2):109-116. doi:10.1155/2012/920918
5. Sandhaus RA, Turino G, Brantly ML, et al. The Diagnosis and Management of Alpha-1 Antitrypsin Deficiency in the Adult. *Chronic Obstructive Pulmonary Diseases: Journal of the COPD Foundation*. 2016;3(3):668-682. doi:10.15326/jcopdf.3.3.2015.0182
6. Gøtzsche PC, Johansen HK. Intravenous alpha-1 antitrypsin augmentation therapy for treating patients with alpha-1 antitrypsin deficiency and lung disease. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD007851. DOI: 10.1002/14651858.CD007851.pub3.

Effective date: 10/1/2021
Revised date: 07/14/2020

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Abecma (idecabtagene vicleucel)
BILLING CODE	J3490/J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Inpatient/Outpatient
STATUS	Prior Authorization Required

Abecma is a B-cell maturation antigen (BCMA)-directed, autologous chimeric antigen receptor T-cell (CAR-T) immunotherapy. A patient's own T cells are harvested and genetically modified outside of the body. The re-engineered cells are injected back into the patient and will recognize the BCMA on the malignant plasma cells to target and kill them. Abecma was approved in March 2021 and is indicated for the treatment of relapsed or refractory multiple myeloma after 4 or more prior therapies. Multiple myeloma is a cancer of the plasma cells in the bone marrow. Abecma is the first CAR-T therapy approved for multiple myeloma and the first to target the BCMA protein, whereas existing products target the CD19 protein.

Abecma (idecabtagene vicleucel) will be considered for coverage when the following criteria are met:

Multiple Myeloma

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Healthcare facility/provider has enrolled in the Abecma REMS program; AND
3. Member has a diagnosis of relapsed or refractory multiple myeloma (RRMM); AND
4. Member has persistent disease after treatment with 4 or more prior lines of therapy, including ALL the following:
   a) An immunomodulatory agent (e.g. Revlimid),
   b) A proteasome inhibitor (e.g. Velcade), and
   c) An anti-CD38 monoclonal antibody (e.g. Darzalex); AND
5. Member does not have history of an allogeneic hematopoietic stem cell transplantation (HSCT) or treatment with any gene therapy-based therapeutic for cancer; AND
6. Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).
7. **Dosage allowed/Quantity limit:** A single infusion of 300 to 460 × 10^6 CAR-positive T cells.

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:

1. Abecma will not be reauthorized for continued therapy.

CareSource considers Abecma (idecabtagene vicleucel) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
04/22/2021	New policy for Abecma created.

References:

1. Abecma [package insert] Summit, NJ: Celgene Corporation, a Bristol-Myers Squibb Company; 2021.
2. National Comprehensive Cancer Network. Multiple Myeloma (Version 6.2021). https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed April 22, 2021.
3. Munshi NC, Anderson LD Jr, Shah N, et al. Idecabtagene Vicleucel in Relapsed and Refractory Multiple Myeloma. N Engl J Med. 2021;384(8):705-716. doi:10.1056/NEJMoa2024850

Effective date: 10/1/2021
Revised date: 04/22/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Actemra (tocilizumab)
BILLING CODE	For medical - J3262 (1 unit = 1 mg) For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Outpatient/Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 3200 units per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Actemra (tocilizumab) is a **preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

GIANT CELL ARTERITIS (GCA)

For **initial** authorization:

1. Member must be 50 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a diagnosis of GCA based on at least one of the following:
   a) Temporal artery biopsy revealing features of GCA;
   b) Evidence of large-vessel vasculitis by angiography;
   c) Imaging (i.e. ultrasound, MRI, CT or PET-CT); AND
4. Member demonstrates typical signs and symptoms of active GCA such as elevated erythrocyte sedimentation rate (ESR) or C - reactive protein (CRP), new-onset persistent localized headache, visual symptoms, polymyalgia rheumatica, claudication, weight loss or fever; AND
5. Member has developed or has an increased risk of glucocorticoid side effects OR member has relapsed on glucocorticoids; AND
6. Actemra will be used in adjunct with a tapering course of glucocorticoids; AND
7. Member has tested negative for tuberculosis (TB) within the past 12 months.
8. **Dosage allowed:** 162 mg subQ once weekly in combination with a tapering course of glucocorticoids. A dose of 162 mg subQ every other week in combination with a tapering course of glucocorticoids may also be considered.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must demonstrate improvement such as absence of flare or relapse, normalization of CRP (<1 mg/dL), or reduced glucocorticoid dose.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

JUVENILE IDIOPATHIC ARTHRITIS (JIA) – systemic (SJIA) and polyarticular (PJIA)

For **initial** authorization:

1. Member must be 2 years of age or older with moderate to severe active PJIA or SJIA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist; AND
4. Member must have an inadequate response to methotrexate or inability to tolerate methotrexate; AND
5. Member must have least 6 months of active disease AND at least **one** of the following signs or symptoms:
   a) Four or fewer joints involved with an inadequate response to glucocorticoid injection and methotrexate or leflunomide and NSAID treatment for at least 12 weeks;
   b) Five or more joints involved and an inadequate response to methotrexate or leflunomide for at least 12 weeks.
6. **Dosage allowed:** For PJIA intravenously every 4 weeks: body weight < 30 kg - 10 mg per kg; body weight ≥ 30 kg - 8 mg per kg. For PJIA subcutaneously: body weight < 30 kg - 162 mg once every three weeks; body weight ≥ 30 kg - 162 mg once every two weeks. For SJIA intravenously every 2 weeks: Body weight < 30 kg - 12 mg per kg; body weight ≥ 30 kg - 8 mg per kg. For SJIA subcutaneously: body weight < 30 kg - 162 mg every two weeks; body weight ≥ 30 kg - 162 mg every week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. **Dosage allowed:**
   a) Subcutaneously: for body weight < 100 kg: 162 mg every other week, followed by an increase to every week (based on clinical response); for body weight ≥ 100 kg: 162 mg every week.
   b) Intravenously: the recommended starting dose is 4 mg/kg every 4 weeks, followed by an increase to 8 mg/kg every 4 weeks based on clinical response. Max dose is 800 mg per infusion.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSc-ILD)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist or rheumatologist; AND
3. Member has a diagnosis of active systemic sclerosis; AND
4. Presence of interstitial lung disease has been confirmed by high-resolution computed tomography (HRCT); AND
5. Documentation of baseline forced vital capacity (FVC), which must be 55% or greater[14]; AND
6. Member's lung disease has progressed despite at least a 6 month trial of an immunosuppressant (e.g. cyclophosphamide, mycophenolate mofetil) unless contraindicated or intolerable; AND
7. Member is a non-smoker or has been educated regarding smoking cessation; AND
8. Member has tested negative for tuberculosis (TB) within the past 12 months.
9. **Dosage allowed:** 162mg subQ once weekly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must demonstrate a slowed rate of pulmonary function decline, as evidenced by stabilized FVC or repeat HRCT.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Actemra (tocilizumab) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Actemra created. Policy SRx-0042 archived. For diagnosis of JIA: length of active disease added. For diagnosis of RA: list of non-biologic DMARDS added. List of diagnoses considered not medically necessary added.
08/30/2017	New diagnosis of GCA was added. For diagnosis of JIA (PJIA and SJIA) leflunomide was added as a treatment option.
10/13/2017	Option to approve under the pharmacy benefit was added.
02/26/2019	Dosing changed for GCA, PJIA and SJIA. ESR and CRP rates expanded for members on glucocorticoid (prednisone) therapy. Actual or recent myocardial infarction (within the last 3 months) criterion removed from GCA. Exception of temporal artery biopsy or other biopsy related to diagnosing GCA was added in criterion on surgical procedures within 8 weeks. References updated. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed.

11/23/2020	Updates for RA section: Removed repeat TB test. Updated references. Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors.
03/17/2021	Added criteria for new indication of SSc-ILD. GCA: Updated references. Re-ordered criteria. Removed list of restrictions. Added ultrasound as an option. Combined signs and symptoms into one general criterion addressing key features. Added glucocorticoid rule (per EULAR). Re-wrote renewal criteria and removed repeat TB test. Reduced initial approval to 6 months.

References:

1. Actemra [package insert]. South San Francisco, CA: Genentech, Inc.; 2021.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
3. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
4. Ringold S, Weiss PF, Beukelman T, et al. 2013 Update of the 2011 American College of Rheumatology Recommendations for the Treatment of Juvenile Idiopathic Arthritis. Recommendations for the Medical Therapy of Children With Systemic Juvenile Idiopathic Arthritis and Tuberculosis Screening Among Children Receiving Biologic Medications Vol. 65, No. 10, October 2013, pp 2499–2512.
5. Hoffmann-La Roch. An Efficacy and Safety Study of Tocilizumab (RoActemra/Actemra) in Participants With Giant Cell Arteritis (GCA). Available from: https://clinicaltrials.gov/ct2/show/NCT01791153?term=WA28119&rank=2. NLM identifier: NCT01791153. Accessed August 2, 2017.
6. Turnier JL, et al. Tocilizumab for treating juvenile idiopathic arthritis. Expert Opin Biol Ther. 2016;16(4):559-66.
7. Brunner HI, et al. Efficacy and safety of tocilizumab in patients with polyarticular-course juvenile idiopathic arthritis: results from a phase 3, randomised, double-blind withdrawal trial. Annals of the Rheumatic Diseases. 2015;74:1110-1117.
8. Yokota S, et al. Tocilizumab in systemic juvenile idiopathic arthritis in a real-world clinical setting: results from 1 year of postmarketing surveillance follow-up of 417 patients in Japan. Annals of the Rheumatic Diseases. 2016;75:1654-1660.
9. Scott LJ, et al. Tocilizumab: A Review in Rheumatoid Arthritis. Drugs. 2017 Nov;77(17):1865-1879.
10. Kaneko A. Tocilizumab in rheumatoid arthritis: efficacy, safety and its place in therapy. Ther Adv Chronic Dis. 2013 Jan; 4(1): 15–21.
11. Jones G, et al. Five-year Efficacy and Safety of Tocilizumab Monotherapy in Patients with Rheumatoid Arthritis Who Were Methotrexate- and Biologic-naive or Free of Methotrexate for 6 Months: the AMBITION Study. The Journal of Rheumatology. 2017 Feb;44(2):142-146.
12. Khanna D, Lin CJF, Furst DE, et al. Tocilizumab in systemic sclerosis: a randomised, double-blind, placebo-controlled, phase 3 trial [published correction appears in Lancet Respir Med. 2020 Oct;8(10):e75] [published correction appears in Lancet Respir Med. 2021 Mar;9(3):e29]. *Lancet Respir Med*. 2020;8(10):963-974. doi:10.1016/S2213-2600(20)30318-0
13. Hoffmann-Vold AM, Maher TM, Philpot EE, Ashrafzadeh A, Distler O. Assessment of recent evidence for the management of patients with systemic sclerosis-associated interstitial lung disease: a systematic review. *ERJ Open Res*. 2021;7(1):00235-2020. Published 2021 Feb 22. doi:10.1183/23120541.00235-2020
14. Stone JH, Tuckwell K, Dimonaco S, et al. Trial of Tocilizumab in Giant-Cell Arteritis. *N Engl J Med*. 2017;377(4):317-328. doi:10.1056/NEJMoa1613849
15. Mackie SL, Dejaco C, Appenzeller S, et al. British Society for Rheumatology guideline on diagnosis and treatment of giant cell arteritis: executive summary. *Rheumatology (Oxford)*. 2020;59(3):487-494. doi:10.1093/rheumatology/kez664
16. Hellmich B, Agueda A, Monti S, et al. 2018 Update of the EULAR recommendations for the management of large vessel vasculitis. *Ann Rheum Dis*. 2020;79(1):19-30. doi:10.1136/annrheumdis-2019-215672

Effective date: 01/01/2022
Revised date: 3/17/21

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Acthar Gel (repository corticotropin injection)
BILLING CODE	Medical - J0800 Pharmacy - Must use valid NDC
BENEFIT TYPE	Pharmacy or Medical
SITE OF SERVICE ALLOWED	Home, Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 3 vials (15 mL total) per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Acthar Gel (repository corticotropin injection) is a **non-preferred** product and will only be considered for coverage under the **pharmacy or medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

INFANTILE SPASMS (West syndrome, X-linked infantile spasms syndrome)

For **initial** authorization:

1. Member is an infant or a child under 2 years of age; AND
2. Medication must be prescribed by a pediatric neurologist or an epileptologist; AND
3. Member has documented diagnosis of infantile spasms in chart notes; AND
4. Member's body surface area (BSA, m^2) or height and weight have been provided to determine the appropriate dosage.
5. **Dosage allowed:** The recommended regimen is a maximum daily dose of 150 U/m^2 (divided into twice daily injections of 75 U/m^2) for 2 weeks. After 2 weeks of treatment, dosing should be gradually tapered and discontinued over a 2-week period. The dosing calculator is available on Acthar's website.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:

1. Member must be under 2 years of age; AND
2. Chart notes demonstrate clinical benefit from the initial use of medication (e.g., suppression of spasm symptoms); AND
3. Member experienced a relapse in spasm symptoms after Acthar was discontinued.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 1 month.

CareSource considers Acthar Gel (repository corticotropin injection) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Corticosteroid-responsive conditions (e.g., systemic lupus erythematosus, multiple sclerosis, Stevens-Johnson's syndrome, ophthalmic diseases, rheumatic disorders, serum sickness, and symptomatic

sarcoidosis) as it has not been proven to be any more effective than corticosteroids for these indications

- All other uses of Acthar Gel are considered experimental/investigational

DATE	ACTION/DESCRIPTION
10/08/2018	New policy for H.P.Acthar created. Policy placed in the new format.
01/22/2021	Changed name to Acthar. Increased the quantity limit to 3 vials (15 mL) per 28 days. Adjusted specialist name. Added that BSA or height/weight must be provided to calculate quantity. Reworded reauth requirement to be more specific. Added member must be under 2 years of age for reauth. Added that member must experience relapse in spasm symptoms after Acthar was discontinued. Updated references.

References:

1. H.P. Acthar Gel [package insert]. Hazelwood, MO: Mallinckrodt ARD Inc.; March, 2019.
2. AAN/CNS evidence-based guideline update on medical treatment of infantile spasms. Neurology 2012: 78 (24): 1974 – 80. doi: 10.1212/WNL.0b013e318259e2cf.
3. Wilmshurst JM, Gaillard WD, Vinayan KP, et al. Summary of recommendations for the management of infantile seizures: Task Force Report for the ILAE Commission of Pediatrics. *Epilepsia*. 2015;56(8):1185-1197. doi:10.1111/epi.13057.
4. Nelson GR. Management of infantile spasms. *Transl Pediatr*. 2015;4(4):260-270. doi:10.3978/j.issn.2224-4336.2015.09.01.
5. Gold Standard, Inc. Corticotropin ACTH. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc; 2012. Available from: http://www.clinicalpharmacology.com.
6. Management and prognosis of infantile spasms. Daniel G Glaze. UpToDate [online database]. Available from: http://www.uptodate.com
7. Milanese C, La Mantia L, Salmaggi A, et al. Double-blind randomized trial of ACTH versus dexamethasone versus methylprednisolone in multiple sclerosis bouts. Clinical, cerebrospinal fluid and neurophysiological results. Eur Neurol. 1989; 29 (1): 10 – 14.
8. Thompson AJ, Kennard C, Swash M, et al. Relative efficacy of intravenous methylprednisolone and ACTH in the treatment of acute relapse in MS. Neurology. 1989; 39 (7): 969 – 971.

Effective date: 07/01/2021
Revised date: 01/22/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Adakveo (crizanlizumab-tmca)
BILLING CODE	J0791 (1 unit = 5 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital/Office/Infusion Site
COVERAGE REQUIREMENTS	Prior authorization required (Non-preferred product) Alternative product includes hydroxyurea QUANTITY LIMIT – Weight based dosing
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Adakveo (crizanlizumab-tmca) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SICKLE CELL DISEASE

For **initial** authorization:

1. Member must be 16 years of age or older; AND
2. Medication must be prescribed by or in consultation with a hematologist or a physician who has experience in treating sickle cell disease; AND
3. Chart notes have been provided with documentation of at least TWO vaso-occlusive pain crises in the past 12 months; AND
4. Member has tried and failed 90-day of hydroxyurea, unless contraindicated or intolerant; AND
5. Medication will not be used concurrently with Oxbryta (voxelotor) therapy.
6. **Dosage allowed**: 5 mg/kg intravenously at week 0, week 2, and every 4 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided to show that the member has experienced a reduction in frequency of vaso-occlusive crises since starting treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Adakveo (crizanlizumab-tmca) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/17/2020	New policy for Adakveo created.
06/18/2020	New J Code added
08/21/2020	Removed Endari from trial requirement.

References:

1. Adakveo [Package Insert]. East Hanover, NJ: Novartis; November 2019.

2. Ataga KI, Kutlar A, Kanter J, et al. Crizanlizumab for the prevention of pain crises in sickle cell disease. *N Engl Med*. 2017;376(5):429-439.
3. Evidence-Based Management of Sickle Cell Disease. US Department of Health and Human Services. 2014.
4. Niihara Y, Miller ST, Kanter J, et al. A phase 3 trial of L-glutamine in sickle cell disease. *N Engl Med*. 2018;379:226-235.
5. Reprixys Pharmaceutical Corporation. Study to Assess Safety and Impact of SelG1 With or Without Hydroxyurea Therapy in Sickle Cell Disease Patients With Pain Crises (SUSTAIN). NLM Identifier: NCT01895361.
6. Kutlar A, Kanter J, Liles DK, et al. Effect of crizanlizumab on pain crises in subgroups of patients with sickle cell disease: A SUSTAIN study analysis. Am. 2019;94(1):55-61.
7. Bradt P, Spackman E, Synnott PG, Chapman R, Beinfeld M, Rind DM, Pearson SD.
8. Crizanlizumab, Voxelotor, and L-Glutamine for Sickle Cell Disease: Effectiveness and Value. Institute for Clinical and Economic Review, January 23, 2020. https://icer-review.org/material/sickle-cell-disease-draft-evidence-report/.
9. Voskaridou E, Christoulas D, Bilalis A, et al. The effect of prolonged administration of hydroxyurea on morbidity and mortality in adult patients with sickle cell syndromes: results of a 17-year, single-center trial (LaSHS). *Blood*. 2010;115(12):2354-2363.
10. Rodgers GP, George A. Hydroxyurea use in sickle cell disease. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on August 21, 2020).

Effective date: 10/1/2020
Revised date: 08/21/2020

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Aduhelm (aducanumab-avwa)
BILLING CODE	J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Aduhelm, a monoclonal antibody that targets amyloid plaque buildup in the brain, was initially approved by the FDA in June 2021. It is indicated for Alzheimer's disease patients with mild cognitive impairment or mild dementia stage of disease. Aduhelm is the first drug approved to slow the progression of Alzheimer's. There has been significant controversy surrounding the accelerated approval of this product, including conflicting results from the phase 3 clinical trials EMERGE and ENGAGE, and concerns regarding safety outcomes.

Aduhelm (aducanumab) will be considered for coverage when the following criteria are met:

Alzheimer's Disease

For **initial** authorization:

1. Member is at least 50 years of age; AND
2. Medication must be prescribed by or in consultation with a neurologist or geriatrician; AND
3. Member has a diagnosis of Alzheimer's disease with mild cognitive impairment or mild dementia as evidenced by ALL of the following assessments:
   a) MMSE score[10] of at least 21, and
   b) CDR-GS score equal to 0.5, and
   c) At least one of the following:
      i) MoCA score of at least 18,
      ii) QDRS score between 2 and 5,
      iii) RBANS score of 85 or less; AND
4. Member's Alzheimer's disease is of confirmed beta amyloid pathology as evidenced by ONE of the following:
   a) A positive amyloid PET scan interpreted by a radiologist or nuclear medicine specialist, or
   b) Amyloid is detected in CSF from a lumbar puncture; AND
5. Member has had a brain MRI within the past 12 months that does NOT show ANY of the following:
   a) Pre-treatment localized superficial siderosis,
   b) 10 or more brain microhemorrhages,
   c) A brain hemorrhage greater than 1 cm; AND
6. Member has undergone a complete physical and neurological exam to comprehensively rule out all other possible causes of neurocognitive decline including but not limited to:
   a) Any medication potentially causing cognitive impairment must have been stopped for at least 4 weeks with continued cognitive symptoms,
   b) Currently uncontrolled psychiatric condition (including alcohol or substance abuse),
   c) Parkinson's disease,
   d) Lewy body dementia,
   e) Vascular dementia (such as from a stroke); AND
7. Member is not taking any blood thinners (exception: low dose aspirin).

8. **Dosage allowed/Quantity limit:** After initial titration (see below), the recommended maintenance dose is 10 mg/kg every 4 weeks as an IV infusion.

IV Infusion (every 4 weeks)	ADUHELM Dosage (administered over approximately one hour)
Infusion 1 and 2	1 mg/kg
Infusion 3 and 4	3 mg/kg
Infusion 5 and 6	6 mg/kg
Infusion 7 and beyond	10 mg/kg

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has had a follow up assessment to determine that they have not progressed to moderate/severe dementia, as concluded by at least two of the following cognitive tests:
   a) MMSE score of at least 19,
   b) CDR-GS score of 1.0 or less,
   c) CDR-SB score of 9.0 or less,
   d) MoCA score of at least 18,
   e) QDRS score of 12 or less; AND
2. Prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg), repeat MRI must be completed to evaluate for amyloid related imaging abnormalities-edema (ARIA-E), which can be observed on MRI as brain edema, and amyloid related imaging abnormalities-hemosiderin deposition (ARIA-H), which includes microhemorrhage. Discontinuation is warranted in those with severe symptomatic ARIA[10], radiographically severe ARIA-H, and as otherwise outlined in the prescribing information.

If all the above requirements are met, the medication will be approved for an additional 6 months.

CareSource considers Aduhelm (aducanumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/13/2021	New policy for Aduhelm created.

References:

1. Aduhelm (aducanumab) [package insert]. Cambridge, MA; Biogen Inc.; Revised 7/2021.
2. IPD analytics. Accessed 7/13/21.
3. Petersen RC, Lopez O, Armstrong MJ, et al. Practice guideline update summary: Mild cognitive impairment: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. *Neurology*. 2018;90(3):126-135. doi:10.1212/WNL.0000000000004826
4. Knopman DS, Jones D, GreiciusMD. Failure to demonstrate efficacy of aducanumab: An analysis of the EMERGE and ENGAGE trials as reported by Biogen, December 2019. Alzheimer's Dement. 2021;17:696–701. https://doi.org/10.1002/alz.12213
5. Alexander GC, Emerson S, Kesselheim AS. Evaluation of Aducanumab for Alzheimer Disease: Scientific Evidence and Regulatory Review Involving Efficacy, Safety, and Futility. *JAMA*. 2021;325(17):1717-1718. doi:10.1001/jama.2021.3854
6. Haeberlein SB, von Hehn C, Tian Y, Chalkias S, et al. EMERGE and ENGAGE Topline Results: Two Phase 3 Studies to Evaluate Aducanumab in Patients With Early Alzheimer's Disease. Presented at: Clinical Trials on Alzheimer's Disease - 12th Conference (CTAD 2019). Dec 4th - Dec 7th, 2019; San Diego, CA, USA.

7. Sevigny J, Chiao P, Bussière T, et al. The antibody aducanumab reduces Aβ plaques in Alzheimer's disease. *Nature*. 2016;537(7618):50-56. doi:10.1038/nature19323
8. Lin GA, Whittington MD, Synnott PG, McKenna A, Campbell J, Pearson SD, Rind DM. Aducanumab for Alzheimer's Disease: Effectiveness and Value; Draft Evidence Report. Institute for Clinical and Economic Review, May 5, 2021. https://icer.org/assessment/alzheimersdisease-2021/.
9. Ackley SF, Zimmerman SC, Brenowitz WD, et al. Effect of reductions in amyloid levels on cognitive change in randomized trials: instrumental variable meta-analysis. *BMJ*. 2021;372:n156. Published 2021 Feb 25. doi:10.1136/bmj.n156
10. Cummings, J., Aisen, P., Apostolova, L.G. et al. Aducanumab: Appropriate Use Recommendations. *J Prev Alzheimers Dis* (2021). https://doi.org/10.14283/jpad.2021.41

Effective date: 01/01/2022
Revised date: 08/13/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Aimovig (erenumab-aooe)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— up to 140 mg per month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Aimovig (erenumab-aooe) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHRONIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years of age or older with a history of migraine attacks with or without aura; AND
2. Medication is being prescribed for the prevention of chronic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≥ 15 headache days per month for at least 3 months;
   b) ≥ 8 migraine days per month for at least 3 months; AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed 2 quarterly injections (6 months) of onabotulinumtoxinA (Botox); OR
5. Member has tried and failed or unable to tolerate **two** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
6. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
7. Medication is not being used in combination with botulinum toxin therapy or any other prophylactic CGRP product (e.g. Emgality, Ajovy, or Vyepti); AND
8. Member does **not** have ANY of the following:
   a) Medication overuse headache;
   b) Pregnant or nursing female;
   c) History of cluster or hemiplegic headache;
   d) Cardiac or hepatic disease;
   e) Member was older than 50 years of age at migraine onset.
9. **Dosage allowed:** 70 mg subcutaneous injection once a month. Some patients may benefit from a dosage of 140 mg once monthly. The 140 mg dose is administered once monthly as two consecutive injections of 70 mg each.

Note: Aimovig is considered experimental and investigational as combination therapy with Botox, Vyepti, Ajovy or Emgality because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

EPISODIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years of age or older with a history of migraine attacks with or without aura; AND
2. Medication is being prescribed for prevention of episodic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≤ 14 headache days per month for at least 3 months;
   b) 4 or more migraine days per month for at least 3 months that cause significant impairment to quality of life (i.e. requiring bed rest, missed school/work); AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed or unable to tolerate **three** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
5. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
6. Medication is not being used in combination with botulinum toxin therapy or any other prophylactic CGRP product (e.g. Emgality, Ajovy, or Vyepti); AND
7. Member does **not** have ANY of the following:
   a) Medication overuse headache;
   b) Pregnant or nursing female;
   c) History of cluster or hemiplegic headache;
   d) Cardiac or hepatic disease;
   e) Member was older than 50 years of age at migraine onset.
8. **Dosage allowed:** 70 mg subcutaneous injection once a month. Some patients may benefit from a dosage of 140 mg once monthly. The 140 mg dose is administered once monthly as two consecutive injections of 70 mg each.

Note: Aimovig is considered experimental and investigational as combination therapy with Botox, Vyepti, Ajovy or Emgality because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Aimovig (erenumab-aooe) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Cluster or hemiplegic migraine headache

DATE	ACTION/DESCRIPTION
08/03/2018	New policy for Aimovig created.
03/05/2019	Criterion on pregnant or nursing females added. Initial authorization length increased to 6 months and reauthorization length increased to 12 months.
06/05/2020	Diagnosis of episodic migraine headache prophylaxis added. Definition of chronic migraine simplified to just frequency of migraine and headache days. Requirement of no botox in the past 4 months removed. No concurrent use with Botox and other CGRP agents added. Trial of Botox added as an additional option under chronic migraine prophylaxis. Length of prophylactic and abortive trials reduced to 2 months/trial.
11/19/2021	Annual review, no changes

References:

1. Aimovig [package insert]. Thousand Oaks, CA: Amgen Inc.; May 2018.
2. ClinicalTrials.gov. Identifier: NCT 03096834. A Study Evaluating the Effectiveness of AMG 334 Injection in Preventing Migraines in Adults Having Failed Other Therapies (LIBERTY). Available: https://clinicaltrials.gov/ct2/show/NCT03096834?term=NCT03096834&rank=1.
3. ClinicalTrials.gov. Identifier: NCT 02456740. Study to Evaluate the Efficacy and Safety of AMG 334 in Migraine Prevention (STRIVE). Available at: https://clinicaltrials.gov/ct2/show/NCT02456740?term=NCT+02456740&rank=1.
4. ICHD-3 The International Classification of Headache Disorders. www.ichd-3.org.
5. Katsarava Z, Buse DC, Manack AN, Lipton RB. Defining the Differences Between Episodic Migraine and Chronic Migraine. Current Pain and Headache Reports. 2012;16(1):86-92. doi:10.1007/s11916-011-0233-z.
6. ClinicalTrials.gov. Identifier: NCT 02066415. A Study to Evaluate the Efficacy and Safety of AMG 334 in Chronic Migraine Prevention. Available at: https://clinicaltrials.gov/ct2/show/NCT02066415?term=NCT+02066415&rank=1.
7. Tepper S, et al. Safety and efficacy of erenumab for preventive treatment of chronic migraine: a randomized, double-blind, placebo-controlled phase 2 trial. The Lancet Neurology. 2017;16(6): 425-434.
8. The American Headache Society Position Statement on Integrating New Migraine Treatments into Clinical Practice. Headache: The Journal of Head and Face Pain. 2019;59: 1-18.
9. Silberstein SD, Holland S, Freitag F, et al. Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults. Neurology Apr 2012, 78 (17) 1337-1345.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ajovy (fremanezumab-vfrm)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ajovy (fremanezumab-vfrm) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHRONIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years of age or older with a history of migraine attacks with or without aura; AND
2. Medication is being prescribed for the prevention of chronic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≥ 15 headache days per month for at least 3 months;
   b) ≥ 8 migraine days per month for at least 3 months; AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed 2 quarterly injections (6 months) of onabotulinumtoxinA (Botox); OR
5. Member has tried and failed or unable to tolerate **two** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
6. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
7. Medication is not being used in combination with botulinum toxin therapy or any other prophylactic CGRP product (e.g. Emgality, Aimovig, or Vyepti); AND
8. Member does **not** have ANY of the following:
   a) Medication overuse headache;
   b) Member was older than 50 years of age at migraine onset.
9. **Dosage allowed:** Subcutaneously 225 mg monthly, or 675 mg every 3 months (quarterly).

Note: Ajovy is considered experimental and investigational as combination therapy with Botox, Vyepti, Aimovig or Emgality because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

EPISODIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:
1. Member is 18 years of age or older with a history of migraine attacks with or without aura; AND
2. Medication is being prescribed for prevention of episodic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≤ 14 headache days per month for at least 3 months;
   b) 4 or more migraine days per month for at least 3 months that cause significant impairment to quality of life (i.e. requiring bed rest, missed school/work); AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed or unable to tolerate **three** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
5. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
6. Medication is not being used in combination with botulinum toxin therapy or any other prophylactic CGRP product (e.g. Emgality, Aimovig or Vyepti); AND
7. Member does **not** have ANY of the following:
   a) Medication overuse headache;
   b) Member was older than 50 years of age at migraine onset.
8. **Dosage allowed:** Subcutaneously 225 mg monthly, or 675 mg every 3 months (quarterly).

Note: Ajovy is considered experimental and investigational as combination therapy with Botox, Vyepti, Aimovig or Emgality because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ajovy (fremanezumab-vfrm) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
03/05/2019	New policy for Ajovy created.

06/05/2020	Diagnosis of episodic migraine headache prophylaxis added. Definition of chronic migraine simplified to just frequency of migraine and headache days. No concurrent use with other CGRP agents added. Trial of Botox added as an additional option under chronic migraine prophylaxis. Criteria pregnancy, psychiatric issues, CV disease, cancer, infection were removed from excluded list. Length of prophylactic and abortive trials reduced to 2 months/trial.
11/19/2021	Annual review, no changes

References:

1. Ajovy [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc; January 2019.
2. ICHD-3 The International Classification of Headache Disorders. www.ichd-3.org.
3. Katsarava Z, Buse DC, Manack AN, Lipton RB. Defining the Differences Between Episodic Migraine and Chronic Migraine. Current Pain and Headache Reports. 2012;16(1):86-92. doi:10.1007/s11916-011-0233-z.
4. ClinicalTrials.gov. Identifier: NCT 02621931. Comparing Efficacy and Safety of 2 Dose Regimens of Subcutaneous Administration of TEV-48125 Versus Placebo for the Preventive Treatment of Chronic Migraine. Available at: https://clinicaltrials.gov/ct2/show/NCT02621931?term=02621931&rank=1.
5. ClinicalTrials.gov. Identifier: NCT02629861. Efficacy and Safety of 2 Dose Regimens of TEV-48125 Versus Placebo for the Preventive Treatment of Episodic Migraine. Available at: https://clinicaltrials.gov/ct2/show/NCT02629861?term=02629861&rank=1.
6. The American Headache Society Position Statement on Integrating New Migraine Treatments into Clinical Practice. Headache: The Journal of Head and Face Pain. 2019;59: 1-18.
7. Silberstein SD, Holland S, Freitag F, et al. Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults. Neurology Apr 2012, 78 (17) 1337-1345.
8. Oakes TM, Kovacs R, Rosen N, et al. Evaluation of Cardiovascular Outcomes in Adult Patients With Episodic or Chronic Migraine Treated With Galcanezumab: Data From Three Phase 3, Randomized, Double-Blind, Placebo-Controlled EVOLVE-1, EVOLVE-2, and REGAIN Studies. Headache. 2020;60(1):110-123. doi:10.1111/head.13684

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Aldurazyme (laronidase)
BILLING CODE	J1931
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Aldurazyme is an enzyme replacement therapy that was approved by the FDA in 2003 for the treatment of Mucopolysaccharidosis type I (MPS I), including patients with Hurler syndrome, Hurler-Scheie syndrome, and Scheie syndrome with moderate to severe symptoms. The risks and benefits of treating mildly affected patients with Scheie syndrome have not been established. MPS I is a rare genetic lysosomal storage disease, with Hurler syndrome being the most severe and most common subtype and Scheie syndrome as the rarest and mildest of the attenuated forms. Pathogenic mutations of the IDUA gene cause the enzyme alpha-L-iduronidase (IDUA) to be deficient or absent. Normally this lysosomal enzyme breaks down glycosaminoglycans (GAGs) (previously known as mucopolysaccharides) but when it is reduced in MPS I, the GAG substrates heparan sulfate (HS) and dermatan sulfate (DS) accumulate throughout the body leading to widespread cellular, tissue, and organ dysfunction. Aldurazyme provides an exogenous form of the deficient enzyme.

Aldurazyme (laronidase) will be considered for coverage when the following criteria are met:

Mucopolysaccharidosis I (MPS I)

For **initial** authorization:

1. Member is at least 6 months of age; AND
2. Medication must be prescribed by or in consultation with a geneticist, metabolic specialist, or pediatrician experienced with managing mucopolysaccharidoses; AND
3. Member has a documented diagnosis of ONE of the following forms of MPS I:
   a) Hurler syndrome,
   b) Hurler-Scheie syndrome, or
   c) Scheie syndrome with moderate to severe symptoms; AND
4. Member's clinical diagnosis of MPS I has been confirmed by at least one of the following:
   a) Low IDUA enzyme activity (less than 10%), and/or
   b) Molecular genetic testing identifies pathogenic IDUA gene mutation; AND
5. Documentation of elevated baseline urinary GAG (uGAG) level.
6. **Dosage allowed/Quantity limit:** 0.58 mg/kg IV infusion once weekly

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as improved functional capacity (e.g. 6-minute walk test, forced vital capacity (FVC)) compared to baseline, reduced liver size, and/or reduced uGAG levels.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Aldurazyme (laronidase) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/26/2021	New policy for Aldurazyme created.

References:

1. Aldurazyme [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; 2019.
2. Wraith JE, Clarke LA, Beck M, et al. Enzyme replacement therapy for mucopolysaccharidosis I: a randomized, double-blinded, placebo-controlled, multinational study of recombinant human alpha-L-iduronidase (laronidase). *J Pediatr*. 2004;144(5):581-588. doi:10.1016/j.jpeds.2004.01.046
3. Wang RY, Bodamer OA, Watson MS, Wilcox WR; ACMG Work Group on Diagnostic Confirmation of Lysosomal Storage Diseases. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. *Genet Med*. 2011;13(5):457-484. doi:10.1097/GIM.0b013e318211a7e1
4. Jameson E, Jones S, Remmington T. Enzyme replacement therapy with laronidase (Aldurazyme®) for treating mucopolysaccharidosis type I. *Cochrane Database Syst Rev*. 2019;6(6):CD009354. Published 2019 Jun 18. doi:10.1002/14651858.CD009354.pub5
5. Clarke LA. Mucopolysaccharidosis Type I. 2002 Oct 31 [Updated 2021 Feb 25]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2021. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1162/
6. Martins AM, Dualibi AP, Norato D, et al. Guidelines for the management of mucopolysaccharidosis type I. *J Pediatr*. 2009;155(4 Suppl):S32-S46. doi:10.1016/j.jpeds.2009.07.005
7. de Ru MH, Boelens JJ, Das AM, et al. Enzyme replacement therapy and/or hematopoietic stem cell transplantation at diagnosis in patients with mucopolysaccharidosis type I: results of a European consensus procedure. *Orphanet J Rare Dis*. 2011;6:55. Published 2011 Aug 10. doi:10.1186/1750-1172-6-55
8. Kubaski F, de Oliveira Poswar F, Michelin-Tirelli K, et al. Mucopolysaccharidosis Type I. *Diagnostics (Basel)*. 2020;10(3):161. Published 2020 Mar 16. doi:10.3390/diagnostics10030161

Effective date: 01/01/2022
Revised date: 07/26/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Amevive (alefacept)
BILLING CODE	J0215 (1 unit = 0.5 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Cosentyx, Enbrel, Humira QUANTITY LIMIT— 60 mg per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Amevive (alefacept) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by a rheumatologist or dermatologist; AND
3. Member's CD4 count is documented in chart notes, and it is greater than 250 cells/microliter; AND
4. Member has moderate to severe chronic PsO for one year or over, and it involves 10% or more of the body surface area (BSA); AND
5. Member's baseline of Psoriasis Area and Severity Index (PASI) score documented in chart notes; AND
6. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments; tanning beds emit mostly UVA light and therefore would not meet this criteria);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene); AND
7. Member has tried and failed to respond to treatment with traditional first-line oral/systemic therapies (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
8. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Humira, Otezla and Siliq. Treatment failure requires at least for 12 weeks of therapy with each drug.
9. **Dosage allowed:** IV: 7.5 mg once weekly for 12 weeks; IM: 15 mg once weekly for 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improving signs and symptoms of disease; AND
3. Member's CD4 count is greater than 250 cells/microliter; AND
4. PASI score improvement of 50% from baseline documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for additional 12 months.

CareSource considers Amevive (alefacept) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Active infections
- Ankylosing spondylitis
- Asthma
- Cellulitis
- Crohn's Disease
- Dissecting scalp cellulitis
- For use in combination with other TNF-inhibitors (i.e., Humira, Kineret, Enbrel, Remicade)
- Giant-cell arteritis
- Infectious uveitis
- Lupus perino
- Osteoarthritis
- Psoriatic arthritis
- Recurrent pregnancy loss
- Relapsing polychondritis
- Rheumatoid arthritis
- Sarcoidosis
- Sciatica
- Spondyloarthritis (other than ankylosing spondylitis)
- Takayasu's arteritis
- Vogt-Koyanagi

DATE	ACTION/DESCRIPTION
07/18/2017	New policy for Amevive created.
02/26/2019	Humira trial removed from criteria; Cimzia, Cosentyx, Otezla and Siliq added to trial agents list. "Immunosuppressant therapies" changed to "treatment of traditional first-line oral/systemic" therapies.
01/19/2020	Updated alternative preferred products and trial agents to match Ohio Department of Medicaid Unified Preferred Drug List.
11/17/2021	Annual review, no changes

References:

1. Amevive [package insert]. Astellas Pharma US, Inc: Deerfield, IL; May, 2011.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: Case-based presentations and evidence-based conclusions. Journal of the American Academy of Dermatology, Volume 65, Issue 1, 137 – 174.
3. Hsu S, Papp KA, Lebwohl MG, et al. Consensus guidelines for the management of plaque psoriasis. Arch Dermatol. 2012 Jan;148(1):95-102.
4. Amevive. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 24, 2017.

5. Krueger GG, Papp KA, Stough DB, et al. A randomized, double-blind, placebo-controlled phase III study evaluating efficacy and tolerability of 2 courses of alefacept in patients with chronic plaque psoriasis. J Am Acad Dermatol 2002;47:821-833.
6. Lebwohl M, Christophers E, Langley R, et al. An international, randomized, double-blind, placebo controlled phase 3 trial of intramuscular alefacept in patients with chronic plaque psoriasis. Arch Dermatol 2003;139(6):791-793.
7. Gottlieb AB, et al. Safety observations in 12095 patients with psoriasis enrolled in an international registry (PSOLAR): experience with infliximab and other systemic and biologic therapies. J Drugs Dermatol. 2014 Dec;13(12):1441-8.
8. Sbidian E, et al. Systemic pharmacological treatments for chronic plaque psoriasis: a network metaanalysis. Cochrane Database Syst Rev. 2017;12:CD011535.
9. Nast A, et al. European S3-Guideline on the systemic treatment of psoriasis vulgaris – Update Apremilast and Secukinumab - EDF in cooperation with EADV and IPC. J Eur Acad Dermatol Venereol. 2017;31(12):1951.
10. Smith CH, et al. British Association of Dermatologists guidelines for biologic therapy for psoriasis 2017. Br J Dermatol. 2017;177(3):628.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Amondys 45 (casimersen)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Amondys 45 (casimersen) is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of DMD gene that is amenable to exon 45 skipping. This is the first FDA-approved treatment for patients with this specific type of mutation. This indication was approved based on an increase in dystrophin production in skeletal muscle observed in patients treated with Amondys 45. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.

Amondys 45 (casimersen) will be considered for coverage when the following criteria are met:

DUCHENNE MUSCULAR DYSTROPHY (DMD)

For **initial** authorization:

1. Member has a diagnosis of DMD with confirmed mutation of DMD gene that is amenable to exon 45 skipping (genetic testing results required); AND
2. Medication is being prescribed by or in consultation with a DMD specialist (i.e., neurologist); AND
3. Member is currently stable on corticosteroid for at least 6 months prior to starting therapy with Amondys 45, unless not tolerated or contraindicated; AND
4. Chart notes have been provided to show that the member is able to walk independently without assistive devices.
5. **Dosage allowed/Quantity limit:** 30 mg/kg IV once weekly.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show stability or slowed rate of decline of the member's motor function compared to baseline; AND
2. Chart notes confirm that member remains able to walk independently without assistive devices.

If all the above requirements are met, the medication will be approved for an additional 6 months.

CareSource considers Amondys 45 (casimersen) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
03/17/2021	New policy for Amondys 45 (casimersen) created.

References:

1. Amondys 45 [package insert]. Cambridge, MA; Sarepta Therapeutics, Inc. February 2021.
2. ClinicalTrials.gov. Study of SRP-4045 and SRP-4053 in DMD Patients (ESSENCE). NCT02500381. Available at https://clinicaltrials.gov/ct2/show/NCT02500381.
3. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management [published correction appears in Lancet Neurol. 2018 Apr 4;:]. Lancet Neurol. 2018;17(3):251-267.
4. Gloss D, Moxley RT 3rd, Ashwal S, Oskoui M. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2016;86(5):465-472.

Effective date: 10/1/2021
Revised date: 03/17/2021

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Dalfampridine (generic for Ampyra)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 60 tabs for 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Dalfampridine (generic for Ampyra) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SYMPTOM MANAGEMENT: WALKING (GAIT) DIFFICULTIES

For **initial** authorization:
If request is for brand name Ampyra, please follow policy "Medical Necessity for DAW" on CareSource webpage.

1. Member must be age 18 or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Member has been on a disease modifying agent (Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone (glatiramer acetate), Extavia (interferon beta-1b), Glatopa (glatiramer actate), Plegridy (peginterferon beta-1a), Rebif (interferon beta-1a), Aubagio (teriflunomide), Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Lemtrada (alemtuzumab), Novantrone (mitoxantrone), Tysabri (natalizumab), Ocrevus (ocrelizumab), Mayzent (simponimod) or Mavenclad (cladribine)) for at least the last 90 days; AND
4. Member is ambulatory and has documented baseline of the timed 25 foot walk (T25FW) between 8 and 45 seconds.
5. **Dosage allowed:** 10 mg every 12 hours.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Documentation of member's increase in walking speed submitted with chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Dalfampridine (generic for Ampyra) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute spinal cord injury

- Disorder of neuromuscular transmission

DATE	ACTION/DESCRIPTION
07/18/2017	New policy for Ampyra created. Not covered diagnosis added.
05/16/2019	Policy modified to Dalfampridine (generic for Ampyra). Mayzent and Mavenclad added to the list of disease modifying agents; Zinbryta was removed due to market recall.

References:

1. Ampyra [package insert]. Ardsley, NY: Acorda Therapeutics, Inc.; October, 2016.
2. Ampyra. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 16, 2017.
3. Goodman AD, Brown TR, Edwards KR, Krupp LB, Schapiro RT, Cohen R, Marinucci LN, Blight AR; MSF204 Investigators. A phase 3 trial of extended release oral dalfampridine in multiple sclerosis. Ann Neurol. 2010 Oct; 68(4):494-502.
4. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.

Effective date: 01/01/2022
Revised date: 05/16/2019

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Aranesp (darbepoetin alfa)
BILLING CODE	For Medical - J0881 (non-ESRD) For Pharmacy - Must use valid NDC code
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office, Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— vary per diagnosis
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Aranesp (darbepoetin alfa) is a **preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANEMIA

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Member has documented diagnosis of anemia due to **one** of the following:
   a) Myelodysplastic syndrome;
   b) Chronic Kidney Disease (GFR below 60 mL/min/1.73 m^2);
   c) The effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy; AND
3. Member's individual iron status reveals **both** of the following:
   a) Transferrin saturation is at least 20%;
   b) Ferritin is at least 100 mcg/L; AND
4. Member is on supplemental iron therapy (unless serum ferritin level > 800 mcg/L); AND
5. Member's labs show hemoglobin ≤10 g/dL for adults (≤11 g/dL for children) within the last 14 days for initial therapy OR ≤10.5 g/dL for adults (≤11.5 g/dL for children) currently receiving therapy.
6. **Dosage allowed:** Recommended starting dose for adult members with CKD on dialysis - 0.45 mcg/kg IV or SQ weekly, or 0.75 mcg/kg IV or SQ every 2 weeks. IV route is recommended for patients on hemodialysis. Recommended starting dose for members with CKD not on dialysis - 0.45 mcg/kg IV or SQ at 4 week intervals. Recommended starting dose for pediatric members with CKD: 0.45 mcg/kg IV or SQ weekly, members with CKD not on dialysis may also be initiated at 0.75 mcg/kg every 2 weeks. Recommended starting dose for members with cancer on chemotherapy: 2.25 mcg/kg subcutaneously weekly, or 500 mcg subcutaneously every 3 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's hemoglobin increased, stayed the same and not decreased further (baseline labs and current labs required); AND
2. Red blood cells transfusions are not required or the number of the transfusions has decreased.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Aranesp (darbepoetin alfa) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- In members with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy
- In members with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure
- In members with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion
- In members scheduled for surgery who are willing to donate autologous blood
- As a substitute for RBC transfusions in patients who require immediate correction of anemia

DATE	ACTION/DESCRIPTION
10/04/2018	New policy for Aransep created. Hemoglobin requirement expanded. Endogenous serum erythropoietin level requirement removed.
09/16/2021	Annual review, no changes

References:

1. Aranesp [package insert]. Thousand Oaks, CA: Amgen; July, 2015.
2. National comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Myelodysplastic syndrome. V.1.2018. Available at https://www.nccn.org/professionals/physician_gls/pdf/mds.pdf on January 30, 2018.
3. Wolters Kluwer. Facts & Comparisons. www.factsandcomparisons.com, 2011. (May 11, 2011).
4. YOUNG. D. CMS Anemia Drugs Proposal: Bad for Amgen, Good for Patients, 17 May 2007.
5. New risk management program for erythropoiesis-stimulating agents. Aranesp, Procrit, and Epogen Article; Pharmacist's Letter; April 2010; Vol: 26 Hematology / Oncology.
6. Singh AK, Szczech L, Tang KL, et al. Correction of Anemia with Epoetin Alfa in Chronic Kidney Disease, N Engl j Med. 2006; 355:2085-98.
7. Bohlius J, Wilson J, Seidenfeld J, et al., Recombinant Human Erythropoietins and Cancer Patients: Updated Meta-Analysis of 57 Studies Including 9353 Patients. J Natl Cancer Inst. 2006; 98:708-14.
8. Erythropoiesis-stimulating agents in oncology: a study-level meta-analysis of survival and other safety outcomes.
9. Glaspy J, Crawford J, Vansteenkiste J, Henry D, Rao S, Bowers P, Berlin JA, Tomita D, Bridges K, Ludwig H Br J Cancer. 2010;102(2):301. American Society of Clinical Oncology/American Society of Hematology clinical practice guideline update on the use of epoetin and darbepoetin in adult patients with cancer.
10. Rizzo JD, Brouwers M, Hurley P, Seidenfeld J, Arcasoy MO, Spivak JL, Bennett CL, Bohlius J, Evanchuk D, Goode MJ, Jakubowski AA, Regan DH, Somerfield MR, American Society of Clinical Oncology, American Society of Hematology; J Clin Oncol. 2010;28(33):4996. National Comprehensive Cancer Network (NCCN) guidelines www.nccn.org. Accessed September 3, 2015.
11. Aliment Pharmacol Ther. 2010 May;31(9):929-37. Epub 2010 Feb 18.Review article: optimizing SVR and management of the haematological side effects of peginterferon/ribavirin antiviral therapy for HCV - the role of epoetin, G-CSF and novel agents.

12. Definition and management of anemia in patients infected with hepatitis C virus. McHutchison JG, Manns MP, Longo DL Liver Int. 2006;26(4):389 MCG 20th edition, 2016.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Arcalyst (Rilonacept)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Arcalyst is an interleukin 1 (IL-1) antagonist indicated for Cryopyrin-Associated Periodic Syndromes (CAPS), Deficiency of IL-1 Receptor Antagonist (DIRA), and recurrent pericarditis.
CAPS refer to rare genetic syndromes generally caused by mutations in the NLRP-3 [Nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]). Mutations in NLRP-3 result in an overactive inflammasome leading to an excessive release of activated IL-1β that drives inflammation.
DIRA is an auto-inflammatory, autosomal recessive disorder caused by loss of function mutations in the IL1RN gene, which encodes IL-1 receptor antagonist (IL-1ra), resulting in unopposed signaling of the proinflammatory cytokines IL-1α and IL-1β through the IL-1 receptor.
Interleukin-1 (IL-1) is a key cytokine that mediates the pathophysiology of many inflammatory processes, and it has also been implicated as a causative factor in pericarditis.

Arcalyst (Rilonacept) will be considered for coverage when the following criteria are met:

Cryopyrin-Associated Periodic Syndromes (CAPS)

For **initial** authorization:
1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or other specialist familiar with CAPS; AND
3. Member has a diagnosis of Familial Cold Auto-Inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS); AND
4. Member has elevated inflammatory markers (e.g. serum levels of amyloid A, C-reactive protein, erythrocyte sedimentation rate); AND
5. Member displays symptoms of CAPS (e.g. skin rash, musculoskeletal pain, central nervous system manifestations, hearing loss, conjunctivitis, cold/stress-triggered flares); AND
6. Member has had a negative tuberculosis test within the past 12 months.
7. **Dosage allowed/Quantity limit:**
   Adults: loading dose, 320 mg SUBQ (160 mg at 2 different sites); then 160 mg SUBQ once weekly.
   Pediatric: (12 to 17 years of age) loading dose, 4.4 mg/kg SUBQ (MAX of 320 mg) as 1 or 2 injections with a MAX volume of 2 mL (if administered as 2 injections, then administer at 2 different sites); then 2.2 mg/kg (MAX 160 mg) SUBQ once weekly.
   Quantity limit: 8 vials per 28 days (4 doses). Note: Each vial is 220 mg.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes demonstrate positive clinical response including decreased inflammatory marker values and symptom improvement.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Deficiency of IL-1 Receptor Antagonist (DIRA)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a rheumatologist, dermatologist, or geneticist; AND
2. Member has a diagnosis of DIRA confirmed by ALL of the following:
   a) Genetic testing shows IL1RN mutation,
   b) Member has baseline symptoms of skin and/or bone inflammation,
   c) Inflammatory markers (erythrocyte sedimentation rate [ESR], C-reactive protein [CRP]) are elevated at baseline; AND
3. Member has had a negative tuberculosis test within the past 12 months.
4. **Dosage allowed/Quantity limit:**
   Adults: 320 mg (160 mg at 2 different sites on the same day) subQ once weekly
   Pediatric patients weighing 10 kg or more: 4.4 mg/kg subQ once weekly in 1 or 2 injections (if 2 injections, administer at 2 different sites on the same day); MAX dosage, 320 mg
   Quantity limit: 8 vials per 28 days (4 doses). Note: Each vial is 220 mg.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Must demonstrate sustained positive clinical response to therapy such as inflammatory remission, resolution of skin and/or bone symptoms, normalization of ESR and/or CRP.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Recurrent Pericarditis

For **initial** authorization:
1. Member is 12 years of age or older; AND
2. Drug is prescribed by or in consultation with a cardiologist; AND
3. Member has a diagnosis of recurrent pericarditis, presenting with at least the 3rd episode of acute pericarditis; AND
4. Member's C-reactive protein [CRP] level is equal to or greater than 1 mg/dL; AND
5. Member has tried and failed Nonsteroidal Anti-inflammatory Drugs (NSAIDs) and colchicine (or corticosteroids if both are contraindicated); AND
6. Member has had a negative tuberculosis test within the past 12 months.
7. **Dosage allowed/Quantity limit:**
   Adults: Loading dose, 320 mg SUBQ (160 mg at 2 different sites); then 160 mg SUBQ once weekly
   Pediatrics: (12 to 17 years) Loading dose, 4.4 mg/kg SUBQ (MAX of 320 mg) as 1 or 2 injections with a MAX volume of 2 mL (if administered as 2 injections, then administer at 2 different sites); then 2.2 mg/kg (MAX 160 mg) SUBQ once weekly.
   Quantity limit: 8 vials per 28 days (4 doses). Note: Each vial is 220 mg.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has a documented clinical response to treatment such as significantly improved chest pain and normalized inflammatory markers (e.g. CRP).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Arcalyst (Rilonacept) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
6/11/21	New policy for Arcalyst created.

References:

1. Arcalyst (Rilonacept) [package insert]. London, UK; Kiniksa Pharmaceuticals (UK), Ltd.; Revised 03/2021.
2. Aksentijevich I, Masters SL, Ferguson PJ, et al. An autoinflammatory disease with deficiency of the interleukin-1-receptor antagonist. *N Engl J Med*. 2009;360(23):2426-2437. doi:10.1056/NEJMoa0807865
3. Bonilla FA, Khan DA, Ballas ZK, et al. Practice parameter for the diagnosis and management of primary immunodeficiency. *J Allergy Clin Immunol*. 2015;136(5):1186-205.e2078. doi:10.1016/j.jaci.2015.04.049
4. Garg M, de Jesus AA, Chapelle D, et al. Rilonacept maintains long-term inflammatory remission in patients with deficiency of the IL-1 receptor antagonist. *JCI Insight*. 2017;2(16):e94838. Published 2017 Aug 17. doi:10.1172/jci.insight.94838
5. Welzel T, Kuemmerle-Deschner JB. Diagnosis and Management of the Cryopyrin-Associated Periodic Syndromes (CAPS): What Do We Know Today?. *J Clin Med*. 2021;10(1):128. Published 2021 Jan 1. doi:10.3390/jcm10010128
6. Hoffman HM, Throne ML, Amar NJ, et al. Efficacy and safety of rilonacept (interleukin-1 Trap) in patients with cryopyrin-associated periodic syndromes: results from two sequential placebo-controlled studies. *Arthritis Rheum*. 2008;58(8):2443-2452. doi:10.1002/art.23687
7. Hoffman HM, Throne ML, Amar NJ, et al. Long-term efficacy and safety profile of rilonacept in the treatment of cryopryin-associated periodic syndromes: results of a 72-week open-label extension study. *Clin Ther*. 2012;34(10):2091-2103. doi:10.1016/j.clinthera.2012.09.009
8. Klein AL, Imazio M, Cremer P, et al. Phase 3 Trial of Interleukin-1 Trap Rilonacept in Recurrent Pericarditis. *N Engl J Med*. 2021;384(1):31-41. doi:10.1056/NEJMoa2027892
9. Adler Y, Charron P, Imazio M, et al. 2015 ESC Guidelines for the diagnosis and management of pericardial diseases: The Task Force for the Diagnosis and Management of Pericardial Diseases of the European Society of Cardiology (ESC)Endorsed by: The European Association for Cardio-Thoracic Surgery (EACTS). *Eur Heart J*. 2015;36(42):2921-2964. doi:10.1093/eurheartj/ehv318
10. Chiabrando JG, Bonaventura A, Vecchié A, et al. Management of Acute and Recurrent Pericarditis: JACC State-of-the-Art Review. *J Am Coll Cardiol*. 2020;75(1):76-92. doi:10.1016/j.jacc.2019.11.021

Effective date: 01/01/2022
Revised date: 06/11/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Aubagio (teriflunomide)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 30 tabs for 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Aubagio (teriflunomide) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member must be between 18 and 65 years of age; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis based on McDonald Diagnostic Criteria.
4. **Dosage allowed:** 7 or 14 mg orally once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Aubagio (teriflunomide) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Aubagio created. Not covered diagnosis added.
09/16/2021	Annual review, no changes

References:

1. Aubagio [package insert]. Cambridge, MA; Genzyme, Inc. November 2016.

2. Aubagio. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 16, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Austedo (deutetrabenazine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— up to 48 mg per day
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Austedo (deutetrabenazine) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE

For **initial** authorization:

1. Member must be at least 18 years and older and medication is prescribed by neurologist or psychiatrist or nurse practitioner within a psychiatric or neurologic practice; AND
2. Member must have diagnosis of Huntington's disease with chorea symptoms; AND
3. Documented consultation on risks of suicidal ideation or behavior while on Austedo is submitted with member's chart notes (Austedo is contraindicated in patients who are suicidal, and in patients with untreated or inadequately treated depression); AND
4. Member's baseline Total Maximal Chorea Score (of the Unified Huntington's Disease Rating Scale (UHDRS)) is submitted with chart notes.
5. **Dosage allowed:** Starting dose of 6 mg once daily with weekly titration by 6 mg per day up to maximum dosage of 48 mg (24 mg twice daily).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member must have documentation of improvement of Total Maximal Chorea Scores after week 12.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

TARDIVE DYSKINESIA (TD)

For **initial** authorization:

1. Member is 18 years of age and older and medication is prescribed by neurologist or psychiatrist or nurse practitioner within a psychiatric or neurologic practice; AND
2. Member has clinical diagnosis of Tardive Dyskinesia documented in chart notes; AND
3. Member must try and fail at least 1 other guideline recommended treatments first (e.g., clonazepam, ginkgo biloba, etc.); AND
4. Chart notes confirming that member does **not** have risk for suicidal or violent behavior and has stable psychiatric symptoms; AND

5. If member has a history of substance use disorder, chart notes confirming that member is in remission for **at least** 3 months must be provided; AND
6. Member's The Abnormal Involuntary Movement Scale (AIMS) score is documented in chart notes; AND
7. Member does **not** have ANY of the following:
   a) History of hepatic impairment;
   b) History of renal impairment;
   c) Allergy, hypersensitivity, or intolerance to tetrabenazine.
8. **Dosage allowed:** Starting dose of 12 mg once daily with weekly titration by 6 mg per day up to maximum dosage of 48 mg (24 mg twice daily).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member must have documentation of improvement of AIMS score.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Austedo (deutetrabenazine) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/16/2017	New policy for Austedo created.
11/01/2017	New diagnosis of Tardive Dyskinesia was added.
02/08/2018	Criterion requirement of clinical diagnoses of Tardive Dyskinesia for at least 3 months was removed. Length of initial authorization increased to 3 months. Criterion on guidelines recommended treatment was revised. Substance use disorder remission length requirement changed. New provider's specialty was added for both diagnosis.
05/06/2019	The guideline recommended treatment criterion changed from two to one medication to try as a trial.
09/16/2021	Annual review, no changes

References:

1. Austedo [package insert]. North Wales, PA; Teva Pharmaceuticals, Inc. August, 2017.
2. Huntington Study group. Effect of deutetrabenazine on chorea among patients with huntington disease: a randomized clinical trial. JAMA. 2016; 316(1):40-50. doi: 10.1001/jama.2016.8655.
3. Claassen DO, Carroll B, De Boer LM, et al. Indirect tolerability comparison of deutetrabenazine and tetrabenazine for huntington disease. J Clin Mov Dis 2017(4):3. doi: 10.1186/s40734-017-0051-5.
4. ClinicalTrials.gov. Bethesda (MD): National Library of Medicine (US). 2017. Identifier NCT02291861, Addressing Involuntary Movements in Tardive Dyskinesia (AIM-TD); 2017 [cited 2017 Nov 1]. Available from: https://clinicaltrials.gov/ct2/show/NCT02291861?term=deutetrabenazine&recrs=e&rank=5.
5. ClinicalTrials.gov. Bethesda (MD): National Library of Medicine (US). 2017. Identifier NCT02195700, Aim to Reduce Movements in Tardive Dyskinesia (ARM-TD); 2017 [cited 2017 Nov 1]. Available from: https://clinicaltrials.gov/ct2/show/NCT02195700?term=deutetrabenazine&recrs=e&rank=2.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Avonex (interferon beta-1a)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred product includes Rebif QUANTITY LIMIT— 120 mcg per month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Avonex (interferon beta-1a) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
2. Chart notes have been provided confirming diagnosis of Multiple Sclerosis.
3. **Dosage allowed:** 30 mcg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member has documented biological response to treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Avonex (interferon beta-1a) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/13/2017	New policy for Avonex created. Not covered diagnosis added.
12/06/2017	Confirmation of diagnosis based on McDonald criteria is no longer required.
09/16/2021	Annual review, no changes

References:

1. Avonex [package insert]. Cambridge, MA: Biogen Inc.; March 2016.

2. Avonex. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 16, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Bafiertam (monomethyl fumarate)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 120 capsules per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Bafiertam (monomethyl fumarate) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a confirmed diagnosis of relapsing multiple sclerosis, including clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS), and active secondary progressive disease (SPMS); AND
4. Member's relapse rate and/or number of lesions prior to starting treatment are documented in chart notes; AND
5. Member does NOT have concurrent use with another disease-modifying agent for MS.
6. **Dosage allowed:** 95 mg (1 capsule) twice per day orally for 7 days of titration. Maintenance dose is 190 mg (2 capsules of 95 mg) twice daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing stability or improvement in signs and symptoms of disease (e.g., fewer relapses, slowed disability progression, reduced number or volume of brain lesions).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Bafiertam (monomethyl fumarate) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/25/2020	New policy for Bafiertam created.
09/16/2021	Annual review, no changes

References:

1. Bafiertam [package insert]. High Point, NC; Banner Life Sciences LLC, April 2020.
2. Rae-Grant A, Day GS, Marrie RA, et al. Comprehensive systematic review summary: Disease-modifying therapies for adults with multiple sclerosis. *Neurology 2018*;90:789-800.
3. ClinicalTrials.gov. Identifier NCT02294058. Phase 3 study of RPC1063 in relapsing MS. Available at https://clinicaltrials.gov/ct2/show/NCT02294058.
4. ClinicalTrials.gov. Identifier NCT02047734. Efficacy and safety study of ozanimod in relapsing multiple sclerosis (Radiance study). Available at https://clinicaltrials.gov/ct2/show/NCT02047734.
5. Finkelsztejn A. Multiple sclerosis: overview of disease-modifying agents. *Perspect Medicin Chem*. 2014;6:65-72. Published 2014 Oct 5.

Effective date: 01/01/2022
Revised date: 09/16/20/21

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Benlysta (belimumab)
BILLING CODE	For medical - J0490 For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Benlysta (belimumab) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

For **initial** authorization:

1. Member is 5 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has autoantibody-positive SLE as confirmed by documentation of anti-nuclear antibody (ANA) titer ≥1:80 or anti-double-stranded DNA (anti-dsDNA) ≥ 30 IU/mL; AND
4. Member has documented moderately active disease or SELENA-SLEDAI score of 6 or greater; AND
5. Member has tried and failed all the following (unless contraindicated):
   a) Hydroxychloroquine (or chloroquine), and
   b) Corticosteroid, and
   c) A non-steroid immunosuppressant (methotrexate, azathioprine, mycophenolate mofetil, cyclophosphamide) for at least 12 weeks.
6. **Dosage allowed:**
   IV (Adult or Pediatric): 10mg/kg every 2 weeks for 3 doses and every 4 weeks thereafter
   subQ (Adult only): 200 mg once weekly [limit of 4 syringes/28 days]

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document at least a 4-point improvement of the SELENA-SLEDAI score (or low disease activity as measured by another validated activity score) since starting Benlysta, OR
2. Documented reduction in corticosteroid use.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

LUPUS NEPHRITIS

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a nephrologist or rheumatologist; AND
3. Member has a diagnosis of lupus nephritis class III, IV, and/or V as confirmed by kidney biopsy; AND
4. Medication must be prescribed in combination with standard therapy such as mycophenolate mofetil (MMF) or cyclophosphamide; AND
5. Chart notes must document baseline eGFR and urine protein creatinine ratio (UPCR); AND
6. eGFR is at least 30 mL/min/1.73m^2; AND
7. Member is not on dialysis and has not had a kidney transplant.
8. **Dosage allowed:**
   IV: 10mg/kg every 2 weeks for 3 doses and every 4 weeks thereafter
   subQ: 400 mg (as two 200 mg injections) once weekly for 4 doses, then 200 mg once weekly thereafter [limit of 8 syringes/28 days for the first fill, then 4 syringes/28 days going forward]

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has a reduced UPCR from baseline (goal is 0.5 mg/mg or less); AND
2. eGFR is at least 60mL/min/1.73m^2 OR has stabilized (not declined).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Benlysta (belimumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Severe active central nervous system lupus

DATE	ACTION/DESCRIPTION
10/18/2017	New policy for Benlysta created. Length of approval was increased, system involvement limitations were removed and improvement of SELENA-SLEDAI score was added in reauthorization.
07/28/2019	Age coverage expanded from adult population (18 years old and older) to pediatric population of 5 years old and older.
04/13/2021	Added criteria for new indication of lupus nephritis. SLE: Updated references and added current treatment guidelines. Removed the mandate for daily corticosteroid dependence and replaced with a general trial and failure of corticosteroid. Emphasized that a non-steroid immunosuppressive must also be tried first. Added “moderately active disease.” Removed IV cyclophosphamide restriction. Specified 4-point improvement or reduced steroid use for renewal and removed other renewal criteria.

References:

1. Benlysta [package insert]. Research Triangle Park, NC: GlaxoSmithKline LLC; March 2021.

2. Furie R, Petri M, Zamani O, et al. A phase III, randomized, placebo-controlled study of belimumab, a monoclonal antibody that inhibits B lymphocyte stimulator, in patients with systemic lupus erythematosus. Arthritis Rheum. 2011; 63 (12): 3918 – 30.
3. Navarra SV, Guzman RM, Gallacher AE, et al. Efficacy and safety of belimumab in patients with active systemic lupus erythematosus: a randomized, placebo-controlled, phase 3 trial. Lancet. 2011; 26 (377): 721 – 31.
4. Wallace DJ, Sohl W, Furie RA, et al, A phase II, randomized, double-blind, placebo-controlled, dose-ranging study of belimumab in patients with active systemic lupus erythematosus. Arthritis Rheum. 2009; 61 (9): 1168 – 78.
5. American College of Rheumatology Ad Hoc Committee on Systemic Lupus Erythematosus Response Criteria. The American College of Rheumatology response criteria for systemic lupus erythematosus clinical trials: measures of overall disease activity. Arthritis Rheum. 2004; 50 (11): 3418 – 26.
6. Petri M. Disease activity assessment in SLE: do we have the right instruments? Ann Rheum Dis. 2007; 66 (suppl III):iii61 – iii64.
7. ClinicalTrials.gov. Identifier: NCT01649765. Pediatric Lupus Trial of Belimumab Plus Background Standard Therapy (PLUTO). Available at: https://clinicaltrials.gov/ct2/show/NCT01649765?term=01649765&rank=1.
8. Hahn BH, McMahon MA, Wilkinson A, et al. American College of Rheumatology guidelines for screening, treatment, and management of lupus nephritis. *Arthritis Care Res (Hoboken)*. 2012;64(6):797-808. doi:10.1002/acr.21664
9. Fanouriakis A, Kostopoulou M, Cheema K, et al. 2019 Update of the Joint European League Against Rheumatism and European Renal Association-European Dialysis and Transplant Association (EULAR/ERA-EDTA) recommendations for the management of lupus nephritis. *Ann Rheum Dis*. 2020;79(6):713-723. doi:10.1136/annrheumdis-2020-216924
10. Tice JA, Mandrik O, Thokala P, Fotheringham J, Agboola F, HerronSmith S, Chapman R, Pearson SD. Voclosporin and Belimumab for Lupus Nephritis: Effectiveness and Value; Evidence Report. Institute for Clinical and Economic Review, March 12, 2021. https://icer.org/wp-content/uploads/2020/11/ICER_Lupus-Nephritis_Evidence-Report_031221.pdf
11. Furie R, Rovin BH, Houssiau F, et al. Two-Year, Randomized, Controlled Trial of Belimumab in Lupus Nephritis. *N Engl J Med*. 2020;383(12):1117-1128. doi:10.1056/NEJMoa2001180
12. Rovin BH, Caster DJ, Cattran DC, et al. Management and treatment of glomerular diseases (part 2): conclusions from a Kidney Disease: Improving Global Outcomes (KDIGO) Controversies Conference. *Kidney Int*. 2019;95(2):281-295. doi:10.1016/j.kint.2018.11.008
13. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus. *Ann Rheum Dis*. 2019;78(6):736-745. doi:10.1136/annrheumdis-2019-215089
14. Blair HA, Duggan ST. Belimumab: A Review in Systemic Lupus Erythematosus. *Drugs*. 2018;78(3):355-366. doi:10.1007/s40265-018-0872-z
15. Belimumab for treating active autoantibody-positive systemic lupus erythematosus. NICE guidance. https://www.nice.org.uk/guidance/ta397. Published June 22, 2016. Accessed April 21, 2021.
16. Aringer M, Costenbader K, Daikh D, et al. 2019 European League Against Rheumatism/American College of Rheumatology Classification Criteria for Systemic Lupus Erythematosus. *Arthritis Rheumatol*. 2019;71(9):1400-1412. doi:10.1002/art.40930
17. Kleinmann JF, Tubach F, Le Guern V, et al. International and multidisciplinary expert recommendations for the use of biologics in systemic lupus erythematosus. *Autoimmun Rev*. 2017;16(6):650-657. doi:10.1016/j.autrev.2017.04.011
18. Collins CE, Cortes-Hernández J, Garcia MA, et al. Real-World Effectiveness of Belimumab in the Treatment of Systemic Lupus Erythematosus: Pooled Analysis of Multi-Country Data from the OBSErve Studies. *Rheumatol Ther*. 2020;7(4):949-965. doi:10.1007/s40744-020-00243-2
19. Singh JA, Shah NP, Mudano AS. Belimumab for systemic lupus erythematosus. *Cochrane Database Syst Rev*. 2021;2:CD010668. Published 2021 Feb 25. doi:10.1002/14651858.CD010668.pub2
20. Gordon C, Amissah-Arthur MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults. *Rheumatology (Oxford)*. 2018;57(1):e1-e45. doi:10.1093/rheumatology/kex286

Effective date: 10/1/2021
Revised date: 04/13/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Beovu (brolucizumab)
BILLING CODE	J0179
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
STATUS	Prior Authorization Required

Beovu was approved by the FDA in 2019 for the treatment of neovascular (wet) age-related macular degeneration (AMD). There are 2 forms of AMD, dry and wet (neovascular). Wet AMD is less common but progresses more quickly. Neovascular in the context of AMD means growth of new blood vessels under the macula which can lead to loss of central vision. The goal of AMD treatment is to preserve visual function. Beovu is a vascular endothelial growth factor (VEGF) inhibitor administered by intravitreal injection. VEGF inhibitors suppress endothelial cell proliferation, neovascularization, and vascular permeability. In the Phase 3 studies HAWK and HARRIER, Beovu was noninferior to another VEGF inhibitor, Eylea (aflibercept), in the primary endpoint measuring change in best corrected visual acuity (BCVA).

Beovu (brolucizumab) will be considered for coverage when the following criteria are met:

Neovascular (Wet) Age-related Macular Degeneration (AMD)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a confirmed diagnosis of neovascular (wet) age-related macular degeneration (AMD); AND
4. Member has tried and failed bevacizumab intravitreal injection; AND
5. Documentation of best-corrected visual acuity (BCVA); AND
6. Member does NOT have any of the following:
   a) Active infection or inflammation around or in the affected eye(s)
   b) Uncontrolled glaucoma
   c) Recent eye surgery
   d) Concurrent use with another vascular endothelial growth factor (e.g., Eylea, Avastin, Macugen, or Lucentis)
7. **Dosage allowed/Quantity limit:** 6 mg by intravitreal injection monthly for the first 3 doses, then 6 mg once every 8-12 weeks.
   (Note: Each single dose vial provides 6 mg of drug).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must include documentation of improved or stabilized visual acuity.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Beovu (brolucizumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
04/24/2020	New policy for Beovu created.
10/20/2021	Transferred to new template. Updated references. Added baseline BCVA. Specified visual acuity in renewal criteria.

References:

1. Beovu [package insert]. East Hanover, NJ. Novartis Pharmaceuticals Corporation: Revised October 2019.
2. Dugel, Pravin U. et al. HAWK and HARRIER: Phase 3, Multicenter, Randomized, Double-Masked Trials of Brolucizumab for Neovascular Age-Related Macular Degeneration. Ophthalmology, Volume 127, Issue 1, 72 – 84
3. Holekamp, Nanvy M. Review of Neovascular Age-Related Macular Degeneration Treatment Options. Am J Manag Care. July 2019; 25:-S0
4. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P1-P65. doi:10.1016/j.ophtha.2019.09.024
5. Solomon SD, Lindsley K, Vedula SS, Krzystolik MG, Hawkins BS. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. *Cochrane Database Syst Rev*. 2019;3(3):CD005139. Published 2019 Mar 4. doi:10.1002/14651858.CD005139.pub4

Effective date: 04/01/2022
Revised date: 10/20/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Berinert (C1 esterase inhibitor (human))
BILLING CODE	J0597
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 8 vials per fill
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Berinert (C1 esterase inhibitor (human)) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
2. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
3. Medication is being prescribed for the treatment of acute HAE attacks; AND
4. Medication is not being used in combination with another on-demand therapy (e.g. Kalbitor, Firazyr, Ruconest).
5. **Dosage allowed:** 20 International Units (IU) per kg body weight by IV injection.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improvement such as faster time to symptom relief or resolution of attack.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Berinert (C1 esterase inhibitor (human)) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/25/2017	New policy for Berinert created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks were added.
01/15/2021	Updated references. Removed age limit. Removed hematology as specialist. Simplified the diagnostic criteria. Removed specific body locations from indication, per clinical guidelines. Removed log book requirement. Reworded the renewal criteria. Extended

	initial approval duration to 6 months and renewal to 12 months. Removed statement about causative meds. Deleted monthly quantity limit.

References:

1. Berinert [package insert]. Kankakee, IL: CSL Behring LLC; 2020.
2. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
3. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384
4. Craig TJ, Levy RJ, Wasserman RL, et al. Efficacy of human C1 esterase inhibitor concentrate compared with placebo in acute hereditary angioedema attacks. *J Allergy Clin Immunol*. 2009;124(4):801-808. doi:10.1016/j.jaci.2009.07.017

Effective date: 10/1/2021
Revised date: 01/15/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Betaseron (interferon beta-1b)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Extavia QUANTITY LIMIT— 14 mL per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Betaseron (interferon beta-1b) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
2. Chart notes have been provided confirming diagnosis of Multiple Sclerosis; AND
3. Documentation of trial and failure of or contraindication to Avonex, Copaxone/Glatopa, Extavia, or Rebif for at least 90 days submitted with chart notes.
4. **Dosage allowed:** Start 0.0625 mg (0.25 mL) subcutaneously every other day for week 1 and 2; then 0.125 mg (0.5 mL) subcutaneously every other day for week 3 and 4; then 0.1875 mg (0.75 mL) subcutaneously every other day week 5 and 6; then 0.25 mg (1 mL) subcutaneously every other day for week 7 and thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member has documented biological response to treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Betaseron (interferon beta-1b) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/13/2017	New policy for Betaseron created. Not covered diagnosis added.
12/06/2017	Confirmation of diagnosis based on McDonald criteria is no longer required.

11/17/2021	Annual review, no changes

References:

1. Betaseron [package insert]. Whippany, NJ; Bayer HealthCare Pharmaceuticals Inc.: Revised April 2016.
2. Betaseron. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed April 7, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Bethkis (tobramycin inhalation solution)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization (Non-Preferred Product) Alternative preferred products include generic tobramycin inhalation solution QUANTITY LIMIT — 224 mL per 56 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Bethkis (tobramycin inhalation solution) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Member has a diagnosis of cystic fibrosis and has a positive culture for Pseudomonas aeruginosa documented in chart notes; AND
3. Member is not colonized with Burkholderia cepacia; AND
4. Medication is prescribed by a pulmonologist or an infectious disease specialist; AND
5. Member has documented forced expiratory volume in 1 second (FEV1) > 40% or < 80% predicted; AND
6. Member has tried and failed generic tobramycin inhalation solution and ineffectiveness, intolerance or contraindication is documented in chart notes.
7. **Dosage allowed:** 300 mg twice daily by oral inhalation in repeated cycles of 28 days on drug, followed by 28 days off drug.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Evidence of disease stability or disease improvement
   a) Note: Disease improvement is evidenced by chart notes with any of the following:
      i) Improved FEV1 and/or other lung function tests;
      ii) Improvement in sweat chloride;
      iii) Decrease in pulmonary exacerbations;
      iv) Decrease in pulmonary infections;
      v) Increase in weight-gain;
      vi) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Bethkis (tobramycin inhalation solution) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Bethkis created. Not covered diagnosis added.
12/29/2020	Quantity limit changed to 56 days from 28 days. Reauthorization criteria updated to ask for evidence of disease stability or improvement. Diagnosis of cystic fibrosis added to initial criteria. Kitabis removed as preferred option. Exclusion criteria updated to a simplified statement.
11/17/2021	Annual review, no changes

References:

1. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. [cited 2016 Dec 19]. Available: https://www.guideline.gov..
2. Bethkis [package insert]. Woodstock, IL: Cornerstone Therapeutics, Inc.; 2012.
3. Bethkis. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Bleeding Disorder Agents
BILLING CODE	See Table A
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— see package insert for each individual drug
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

All antihemophilic agents will only be considered for coverage under the medical benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEMOPHILIA A (FACTOR VIII DEFICIENCY)

For **initial** authorization:

1. Member has diagnosis of Hemophilia A (congenital Factor VIII deficiency); AND
2. For Jivi, member must be 12 years of age or older; AND
3. Medication is being prescribed by or in consultation with a hematologist; AND
4. Medication will be used for applicable situations listed in Table A or for Immune Tolerance Induction (ITI); AND
5. If request is for ITI, member must have severe hemophilia (factor level < 1%) with inhibitors (FVIII titre > 0.6 BU), and meet one of the following:
   a) Inhibitor titre < 10 BU/mL or titre fails to fall below 10 BU/mL within a year;
   b) Member is having severe or life-threatening bleeding;
   c) Member is having frequent bleeding and is being considered for bypassing agent prophylaxis; AND
6. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review.
7. **Dosage allowed:** Per package insert of individual drug. For ITI, dosages may range from 50 IU/kg three times weekly to 200 IU/kg daily depending on titre inhibitor levels.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:

1. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes; AND
4. For ITI, chart notes have been provided to show both of the following:
   a) Member continues to need ITI (e.g., inhibitor is detectable (> 0.6 BU), FVIII recovery < 66% of expected, FVIII half-life is < 7 hours); AND

b) Member has shown at least 20% decline in the inhibitor titre level since the previous approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

HEMOPHILIA B (FACTOR IX DEFICIENCY)

For **initial** authorization:

1. Member has diagnosis of Hemophilia B (congenital Factor IX deficiency); AND
2. For Ixnity, member must be 12 years of age or older; AND
3. For AlphaNine, member must be 17 years of age or older; AND
4. Medication is being prescribed by or in consultation with a hematologist; AND
5. Medication will be used for applicable situations listed in Table A or for Immune Tolerance Induction (ITI); AND
6. If request is for ITI, member must have inhibitors (FIX titre ≥ 0.3 BU) and prescriber must attest that benefit outweighs the risk of starting therapy; AND
7. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review.
8. **Dosage allowed:** Per package insert of individual drug.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:

1. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

FEIBA (anti-inhibitor coagulant complex)

For **initial** authorization:

1. Member has a diagnosis of Hemophilia A or B with confirmed inhibitors (FVIII titre > 0.6 BU for hemophilia A or FIX titre ≥ 0.3 BU for hemophilia B); AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Medication will be used in one of the following situations:
   a) On-demand treatment of acute bleeding episodes;
   b) Perioperative management of bleeding;
   c) Routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
4. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
5. If member is using Hemlibra, must have a clinical reason why a recombinant activated factor VII (rFVIIa) such as NovoSevenRT or Sevenfact cannot be used.
6. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:

1. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

NOVOSEVEN RT (Recombinant Factor VIIa)

For **initial** authorization:

1. Medication is being prescribed by or in consultation with a hematologist; AND
2. Medication is being used for the treatment of bleeding episodes OR perioperative management for one of the following diagnoses:
   a) Hemophilia A or B with confirmed inhibitors (FVIII titre > 0.6 BU for hemophilia A or FIX titre ≥ 0.3 BU for hemophilia B);
   b) Acquired hemophilia;
   c) Congenital Factor VII (FVII) deficiency;
   d) Glanzmann's Thrombasthenia and platelet transfusion was either ineffective or contraindicated; AND
3. Member's recent weight (kg), history of bleeds, and inhibitor status (if applicable) have been provided for review.
4. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:

1. Member's recent weight (kg), history of bleeds, and inhibitor status (if applicable) have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

SEVENFACT (Recombinant Factor VIIa)

For **initial** authorization:

1. Member is 12 years of age or older; AND
2. Member has a diagnosis of Hemophilia A or B with confirmed inhibitors (FVIII titre > 0.6 BU for hemophilia A or FIX titre ≥ 0.3 BU for hemophilia B); AND
3. Medication is being prescribed by or in consultation with a hematologist; AND
4. Medication will be used as on-demand treatment of acute bleeding episodes; AND
5. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review.
6. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:
1. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

HEMLIBRA (emicizumab-kxwh)

For **initial** authorization:
1. Member has diagnosis of Hemophilia A, with congenital factor VIII deficiency confirmed by blood coagulation testing; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Member's recent weight (kg), history of bleeds, and inhibitor status have been provided for review; AND
4. For member with factor VIII inhibitors, member must meet the following:
   a) Chart notes with documented positive test for inhibitors (titer > 0.6 BU/mL [Bethesda unit per milliliter]); OR
5. For member without factor VIII inhibitors, member must have severe hemophilia A (Factor VIII level <1%) AND meet **one** of the following:
   a) Poor and/or frequent venous access AND risk outweighs benefit for obtaining a port or an alternative route of administration;
   b) Clinical documentation that prior prophylaxis with factor VIII (e.g., Advate, Adynovate, Eloctate, etc.) was ineffective for the prevention of bleeding episodes;
   c) Prescriber attested that member is not a candidate for factor VIII and the clinical rationale is strongly supported by chart notes; AND
6. Bypassing agents (e.g., Feiba, NovoSeven RT, Sevenfact) are discontinued the day before starting Hemlibra (if applicable); AND
7. Prophylactic use of factor replacements are discontinued after loading dose period is finished. Note: Factor VIII may be used as on-demand therapy for breakthrough bleeding.
8. **Dosage allowed:** 3 mg/kg subQ once weekly for the first 4 weeks, followed by a maintenance dose of 1.5 mg/kg once every week, OR 3mg/kg once every 2 weeks, OR 6 mg/kg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

Note: Approval will be for the lowest number of vials to achieve requested dosage.

For **reauthorization**:
1. Member's recent weight in kilograms is documented on medication prior authorization request; AND
2. Chart notes have been provided showing that the member experienced a reduction in bleeding episodes compared to baseline.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

VON WILLEBRAND DISEASE (VWD)

For **initial** authorization:
1. Member has a diagnosis of Von Willebrand Disease (VWD); AND
2. For Vonvendi, member must be 18 years of age or older; AND
3. Medication is being prescribed by or in consultation with a hematologist; AND

4. Medication will be used for applicable situations listed in Table A; AND
5. Member has severe vWD (except Alphanate) OR Member has mild or moderate vWD and the use of desmopressin is known or suspected to be ineffective or contraindicated; AND
6. Member's recent weight (kg) and history of bleeds have been provided for review.
7. **Dosage allowed:** Per package insert of individual drug.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management, or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:
1. Member's recent weight (kg) and history of bleeds have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

MISCELLANEOUS FACTORS (Obizur, Coagadex, Corifact, Tretten, Fibryga, RiaSTAP)

For **initial** authorization:
1. For Obizur, member must be 18 years of age or older; AND
2. Member has an FDA approved indication for use as listed in Table A; AND
3. Medication is being prescribed by or in consultation with a hematologist; AND
4. Member's recent weight (kg), history of bleeds, and fibrinogen level (if available, Fibryga and RiaSTAP only) have been provided for review.
5. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 30 days for perioperative management or 6 months for all other cases.

Note: Approval will be for requested dosage, but no more than +/- 5-10% of prescribed assays.

For **reauthorization**:
1. Member's recent weight (kg) and history of bleeds have been provided for review; AND
2. Member has experienced positive clinical response from the use of factor; AND
3. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

ANTI-CLOTTING PRODUCTS (ATryn, Ceprotin)

For **initial** authorization:
1. Member has an FDA approved indication for use as listed in Table A; AND
2. Medication is being prescribed by or in consultation with a hematologist; AND
3. Member's recent weight (kg) and chart notes supporting diagnosis have been provided for review.
4. **Dosage allowed:** Per package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's recent weight (kg) and documentation of positive clinical response have been submitted for review; AND
2. If request is for a dosage increase, provider must submit a clinical rationale supported by chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

Table A

Drug Class	Drug Name	Indications	J Code
Recombinant Factor VIII (Hemophilia A)	Advate	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7192
	Afstyla	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7210
	Helixate FS	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7192
	Kogenate FS	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7192
	Kovaltry	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7211
	Novoeight	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7182
	Nuwiq	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7209
	Recombinate	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7192
	Xyntha	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7185
Extended Half-Life Recombinant Factor VIII (Hemophilia A)	Adynovate	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7207
	Eloctate	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7205
	Esperoct	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7204
	Jivi	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7208
Plasma-Derived Factor VIII (Hemophilia A)	Hemofil M	• Prevention and control of hemorrhagic episodes	J7190
	Koate	• Prevention and control of bleeding episodes	J7190
Non-Factor (Hemophilia A)	Hemlibra	• Routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and pediatric patietns with **hemophilia A with or without factor VIII inhibitors**	J7170

Recombinant Factor IX (Hemophilia B)	Benefix	**Hemophilia B** (congenital factor IX deficiency) for: • On-demand treatment and control of bleeding episodes • Perioperative management of bleeding • Routine prophylaxis to reduce the frequency of bleeding episodes	J7195
	Ixinity	Adults and children ≥ 12 years of age with **hemophilia B** for: • On-demand treatment and control of bleeding episodes • Perioperative management Adults with **hemophilia B** for: • Routine prophylaxis to reduce the frequency of bleeding episodes	J7195
	Rixubis	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7200
Extended Half-Life Recombinant Factor IX (Hemophilia B)	Alprolix	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7201
	Idelvion	• On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7202
	Rebinyn	• On-demand treatment and control of bleeding episodes • Perioperative management	J7203
Plasma-Derived Factor IX (Hemophilia B)	AlphaNine SD	• Prevention and control of bleeding episodes	J7193
Factor IX Complex (Hemophilia B)	Profilnine SD	• Prevention and control of bleeding episodes	J7194
von Willebrand Factor/Coagulation Factor VIII Complex (Human)	Alphanate	• Control and prevention of bleeding in patients with **hemophilia A** • Surgical and/or invasive procedures in adult and pediatric patients with **von Willebrand Disease** in whom desmopressin (DDAVP) is either ineffective or contraindicated. Not indicated for patients with severe VWD (Type 3) undergoing major surgery	J7186
	Humate-P	**Hemophilia A** • Treatment and prevention of bleeding in adults **Von Willebrand disease** • Treatment of spontaneous and trauma-induced bleeding episodes • Perioperative management	J7187
	Wilate	Children and adults with **von Willebrand disease** for: • On-demand treatment and control of bleeding episodes • Perioperative management Adolescents and adults with **hemophilia A** for: • On-demand treatment and control of bleeding episodes • Routine prophylaxis to reduce the frequency of bleeding episodes	J7183
vonWillebrand Recombinant Factor	Vonvendi	Adults with **von Willebrand disease** for: • On-demand treatment and control of bleeding episodes • Perioperative management	J7179
Bypassing Agent	Feiba	**Hemophilia A and B with inhibitors** for: • On-demand treatment and control of bleeding episodes • Perioperative management • Routine prophylaxis to reduce the frequency of bleeding episodes	J7198
	NovoSeven RT	• Treatment of bleeding episodes and peri-operative management in adults and children with **hemophilia A or B with inhibitors** • **Congenital Factor VII (FVII) deficiency** • **Glanzmann's thrombasthenia** with refractoriness to platelet transfusions, with or without antibodies to platelets • Treatment of bleeding episodes and peri-operative management in adults with **acquired hemophilia**	J7189
	SevenFact	• On-demand treatment of bleeding episodes in adults and adolescents with **hemophilia A or B with inhibitors**	J7212
Miscellaneous Factor	Obizur	• On-demand treatment of bleeding episodes in adults with **acquired hemophilia A**	J7188

	Coagadex	**Hereditary Factor X deficiency** for: • Routine prophylaxis to reduce the frequency of bleeding episodes • On-demand treatment and control of bleeding episodes • Perioperative management of bleeding in patients with mild and moderate hereditary Factor X deficiency	J7175
	Corifact	• Routine prophylactic treatment and peri-operative management of surgical bleeding in patients with **congenital Factor XIII deficiency**	J7180
	Tretten	• Prophylaxis of bleeding in patients with **congenital Factor XIII A-Subunit deficiency**	J7181
	Fibryga	• Treatment of acute bleeding episodes in adults and children with **congenital fibrinogen deficiency**, including afibrinogenemia and hypofibrinogenemia	J7177
	RiaSTAP	• Treatment of acute bleeding episodes in adults and children with **congenital fibrinogen deficiency**, including afibrinogenemia and hypofibrinogenemia	J7178
Antithrombin	ATryn	• Prevention of peri-operative and peri-partum thromboembolic events in patients with **hereditary antithrombin deficiency**	J7196
Protein C Concentrate	Ceprotin	• Treatment and prevention of venous thrombosis and purpura fulminans in patients with **severe congenital Protein C deficiency**	J2724

CareSource considers antihemophilic agents not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
12/15/2016	Policy issued.
06/12/2018	Policy placed in a new format. Initial authorization length increased to 6 months.
10/05/2018	New drug Jivi added to the list of antihemophilic agents.
08/06/2019	New drug Esperoct added to the list of antihemophilic agents.
10/19/2019	Policy updated to include Hemlibra criteria.
08/01/2020	Hemlibra criteria updated to include hematologist. Requirement changed for members without Factor VIII inhibitors to align better with current practice and clinical trials.
04/02/2021	Title updated to encompass all bleeding disorder products. Table A created for all products, indications, and J codes. Added separate criteria set for hemophilia A, hemophilia B, Feiba, NovoSevenRT, Sevenfact, Von Willebrand Disease, miscellaneous factors, and anti-clotting products (previously only had one set of criteria for hemophilia factor replacement). Updated Hemlibra's weight requirement, reauth criteria, and dosage allowed section. Added approval instruction note for the factors and Hemlibra. Updated initial approval duration for all agents.

References:

1. Srivastava A, Santagostino E, Dougall A, et al. WFH Guidelines for the Management of Hemophilia, 3rd edition. *Haemophilia*. 2020;26 Suppl 6:1-158. doi:10.1111/hae.14046
2. Advate [package insert]. Westlake Village, CA: Baxalta US Inc; Nov 2016.
3. Adynovate [package insert]. Westlake Village, CA: Baxalta US Inc; March 2017.
4. Afstyla [package insert]. Kankakee, IL: CSL Behring LLC; Sept 2017.
5. Alphanate [package insert]. Los Angeles, CA: Grifols Biologicals Inc.; June 2014.
6. Alphanine SD [package insert]. Los Angeles, CA: Grifols Biologicals Inc.; March 2017.
7. Alprolix [package insert]. Cambridge, MA: Biogen Inc.; November 2017.
8. ATryn [package insert]. Framingham, MA: rEVO Biologics, Inc.; December 2013.
9. Benefix [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals Inc.; June 2017.
10. Ceprotin [package insert]. Lexington, MA: Baxalta US Inc.; December 2018.
11. Coagadex [package insert]. Durham, NC: Bio Products Laboratory USA, Inc.; No date.

12. Corifact [package insert]. Kankakee, IL: CSL Behring LLC; Sept 2017.
13. Eloctate [package insert]. Waltham, MA: Bioverativ Therapeutics Inc.; Dec 2017.
14. Esperoct [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; February, 2019.
15. Feiba [package insert]. Westlake Village, CA: Baxter Healthcare Corporation.; Nov 2013.
16. Fibryga [package insert]. Paramus, NJ: Octapharma USA, Inc. December 2020.
17. Helixate FS [package insert]. Kankakee, IL: CSL Behring LLC.; May 2014.
18. Hemlibra [package insert]. South San Francisco, CA: Genentech, Inc.; Nov 2017
19. Hemofil M [package insert]. Westlake Village, CA: Baxter Healthcare Corporation.; April 2012.
20. Humate-P [package insert]. Kankakee, IL: CSL Behring LLC.; Aug 2013.
21. Idelvion [package insert]. Kankakee, IL: CSL Behring LLC.; March 2016.
22. Ixinity [package insert]. Berwyn, PA: Aptevo BioTherapeutics LLC; April 2018.
23. Jivi [package insert]. Whippany, NJ: Bayer HealthCare LLC; August 2018.
24. Koate-DVI [package insert]. Los Angeles, CA: Grifols Biologicals Inc.; Aug 2012.
25. Kogenate FS [package insert]. Tarrytown, NY: Bayer Healthcare; May 2014.
26. Kovaltry [package insert]. Whippany, NJ: Bayer HealthCare LLC; March 2016.
27. Novoeight [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; June 2018.
28. Novoseven RT [package insert]. Bagsvaerd, Denmark: Novo Nordisk A/S.; May 2014.
29. NuwiQ [package insert]. Hoboken, NJ: Octapharma USA Inc.; Sept 2015.
30. Obizur [package insert]. Westlake Village, CA: Baxter Healthcare Corporation.; Oct 2014
31. Profilnine [package insert]. Los Angeles, CA: Grifols Biologicals Inc.; Aug 2010.
32. Rebinyn [package insert]. Plainsboro, NJ: Novo Nordisk Inc.; May 2017.
33. Recombinate [package insert] Westlake Village, CA: Baxter Healthcare Corporation.; Dec 2010.
34. RiaSTAP [package insert] Kankakee, IL: CSL Behring LLC.; July 2020.
35. Rixubis [package insert]. Westlake Village, CA: Baxalta US Inc.; Sept 2014.
36. Sevenfact [package insert]. Les Ulis, France. HEMA Biologics. April, 2020.
37. Tretten [package insert]. Bagsvaerd, Denmark: Novo Nordisk A/S.; Apr 2014.
38. VonVendi [package insert]. Westlake Village, CA: Baxalta US Inc.; Dec 2015.
39. Wilate [package insert]. Hoboken, NJ: Octapharma USA Inc.; Aug 2010.
40. Xyntha [package insert]. Philadelphia, PA: Wyeth Pharmaceuticals Inc.; Oct 2014.
41. Oldenburg J. Optimal treatment strategies for hemophilia: achievements and limitations of current prophylactic regimens. *Blood*. 2015;125(13):2038-2044.
42. Hay CR. Immune tolerance induction: current status. *Hematology Education*. 2013;7:87-92
43. DiMichele DM, Hoots WK, Pipe SW, Rivard GE, Santagostino E. International workshop on immune tolerance induction: consensus recommendations. *Haemophilia*. 2007;13 Suppl 1:1-22.
44. Brackmann HH, White GC 2nd, Berntorp E, Andersen T, Escuriola-Ettingshausen C. Immune tolerance induction: What have we learned over time?. *Haemophilia*. 2018;24 Suppl 3:3-14.
45. Valentino LA, Kempton CL, Kruse-Jarres R, et al. US Guidelines for immune tolerance induction in patients with haemophilia a and inhibitors. *Haemophilia*. 2015;21(5):559-567.
46. ClinicalTrials.gov Identifier: NCT02847637. A Clinical Trial to Evaluate Prophylactic Emicizumab Versus no Prophylaxis in Hemophilia A Participants Without Inhibitors (HAVEN 3). Available at: https://clinicaltrials.gov/ct2/show/NCT02847637.
47. Ng HJ, Lee LH. Recombinant activated clotting factor VII (rFVIIa) in the treatment of surgical and spontaneous bleeding episodes in hemophilic patients. *Vasc Health Risk Manag*. 2006;2(4):433–440. doi:10.2147/vhrm.2006.2.4.433.
48. Mahlangu J, Oldenburg J, Paz-Patel I, et al. Emicizumab prophylaxis in patients who have hemophilia A without inhibitors [supplementary appendix appears online]. N Engl J Med 2018;379:811-822. https://www.nejm.org/doi/pdf/10.1056/NEJMoa1803550.
49. Pipe S. Emicizumab subcutaneous dosing every 4 weeks is safe and efficacious in the control of bleeding in persons with haemophilia A with and without inhibitors – Results from the phase 3 HAVEN 4 study. Presented at the World Federation of Hemophila World Congress in Glasgow, Scotland; May 20–24, 2018. WFH Oral Presentation.
50. Protocol for Haven 3 Trial: Emicizumab prophylaxis in patients who have hemophilia A without inhibitors. 2018. Available at https://www.nejm.org/doi/suppl/10.1056/NEJMoa1803550/suppl_file/nejmoa1803550_protocol.pdf.
51. Thornburg CD. How I approach: Previously untreated patients with severe congenital hemophilia A. Pediatric blood & cancer. 2018;65(12):e27466. doi:10.1002/pbc.27466.
52. Yada K, Nogami K. Spotlight on emicizumab in the management of hemophilia A: patient selection and special considerations. J Blood Med. 2019;10:171-181. Published 2019 Jul 2. doi:10.2147/JBM.S175952.

53. National Hemophilia Foundation (NHF). Recommendation on the Use and Management of Emicizumab-kxwh (Hemlibra) for Hemophilia A with and without Inhibitors. December 6, 2018.
54. Connell NT, Flood VH, Brignardello-Petersen R, et al. ASH ISTH NHF WFH 2021 guidelines on the management of von Willebrand disease. *Blood Adv*. 2021;5(1):301-325. doi:10.1182/bloodadvances.2020003264

Effective date: 10/1/2021
Revised date: 04/02/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Botox (onabotulinumtoxinA)
BILLING CODE	J0585
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office, Outpatient
STATUS	Prior Authorization Required

Botox is a neurotoxin produced from Clostridium botulinum serotype A. It works through the inhibition of acetylcholine release from peripheral nerve endings, causing neuromuscular blockage and muscle paralysis. There are seven types of botulinum toxin serotypes. Only serotypes A and B are used for medicinal purposes. Botox was initially approved in 1989 by the FDA for the treatment of Blepharospasm. Today, Botox is FDA-approved for additional therapeutic indications, such as overactive bladder, urinary incontinence, cervical dystonia, axillary hyperhidrosis, migraine prevention, strabismus and blepharospasm.

Botox (onabotulinumtoxinA) will be considered for coverage when the following criteria are met:

PRIMARY AXILLARY HYPERHIDROSIS

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has a diagnosis of severe axillary hyperhidrosis, including documentation in the chart notes of visible, excessive sweating of at least 6 months duration which significantly impairs daily activities; AND
4. Secondary causes of hyperhidrosis (e.g., hyperthyroidism) have been ruled out; AND
5. Member has tried and failed topical prescription-strength aluminum chloride (e.g. Xerac) for at least 60 days.
6. **Dosage allowed:** 50 Units per axilla.

Note: Medication will not be covered for treatment of hyperhidrosis in body areas other than axillary.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show improvement of signs and symptoms (i.e. reduced axillary sweat production).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

BLEPHAROSPASM

For **initial** authorization:
1. Member is 12 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or ophthalmologist; AND
3. Member has a diagnosis of blepharospasm, characterized by spasms inducing narrowing or closure of the eyelids.

4. **Dosage allowed:** The cumulative dose of Botox treatment for blepharospasm in a 30-day period should not exceed 200 Units. Treatment may be repeated every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. lessening of involuntary contraction).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a neurologist or other specialist experienced with treating cervical dystonia; AND
2. Member has a documented diagnosis of moderate to severe cervical dystonia as evidenced by involuntary contractions of neck muscles, leading to abnormal movements or postures; AND
3. Symptoms affect quality of life and daily functions.
4. **Dosage allowed:** Up to 300 units every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. severity of abnormal head position, neck pain).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ESOPHAGEAL ACHALASIA

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has a diagnosis of achalasia confirmed by high resolution esophageal manometry; AND
4. Chart notes must document that the member is NOT a candidate for ALL of the following: Laparoscopic Heller myotomy, pneumatic dilation, and peroral endoscopic myotomy (POEM); AND
5. Other esophageal motility disorders and malignancy have been ruled out.
6. **Dosage allowed:** 100 units every 6 months (off label).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes must show the member had symptomatic improvement of dysphagia and/or regurgitation.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication is being prescribed for the prevention of chronic migraine, with **both** of the following documented in chart notes:
   a) ≥ 15 headache days per month for at least 3 months;
   b) ≥ 8 migraine days per month for at least 3 months; AND
3. Medication must be prescribed by a neurologist or a headache specialist; AND
4. Member has tried and failed or unable to tolerate **two** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
5. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
6. Medication is not being used in combination with another prophylactic CGRP product (e.g., Emgality, Aimovig, Ajovy, or Vyepti); AND
7. Member does **not** have medication-overuse headaches.
8. **Dosage allowed:** 155 Units every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

OVERACTIVE BLADDER (OAB)

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a urologist or gynecologist; AND
3. Member has a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency; AND
4. Member has tried and failed at least TWO prior pharmacologic therapies for at least 30 days each (e.g. oxybutynin, solifenacin, Myrbetriq); AND
5. Member does not have a urinary tract infection.
6. **Dosage allowed:** 100 Units every 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show decreased symptoms of urge urinary incontinence, urgency, and frequency.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SPASTICITY

For **initial** authorization:
1. Member is 2 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or other specialist experienced with treating spasticity (e.g., PM&R); AND
3. Member has a documented diagnosis of upper or lower limb spasticity that affects daily functioning and quality of life; AND
4. Spasticity is secondary to a neurologic condition such as cerebral palsy, stroke, or brain or spinal cord injury; AND
5. Member has tried or is unable to try one conventional treatment modality such as physical therapy or oral medication (e.g. baclofen, tizanidine).
6. **Dosage allowed:** Adult: Not to exceed 400 total units every 12 weeks (given intramuscularly as a divided dose among affected muscles). Pediatric: Not to exceed 340 total units or 10 units per kg (whichever is lower) every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. decrease in severity of increased muscle tone, increased functional ability or range of motion).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

STRABISMUS

For **initial** authorization:
1. Member is 12 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or ophthalmologist; AND
3. Member has a diagnosis of a strabismus type with binocular potential, unlikely to spontaneously resolve.
4. **Dosage allowed:** See package insert.[1]

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing that the member's ocular alignment has improved.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

URINARY INCONTINENCE (associated with neurologic condition)

For **initial** authorization:
1. Member is 5 years of age or older; AND
2. Medication is prescribed by or in consultation with a urologist, neurologist, or gynecologist; AND
3. Member has a diagnosis of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g. brain or spinal cord injury, stroke, multiple sclerosis, Parkinson's, spina bifida); AND
4. Member has tried and failed at least one anticholinergic medication for 30 days (e.g. oxybutynin, solifenacin, tolterodine); AND
5. Member does not have a urinary tract infection.
6. **Dosage allowed:** For adults and pediatric patients weighing 34kg or more: 200 units per treatment, no sooner than every 12 weeks. If weight is less than 34kg: 6mg/kg, no sooner than every 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show decreased frequency of urinary incontinence.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Botox (onabotulinumtoxinA) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/03/2018	Criterion "no infection at proposed injection site" removed from Blepharospasm and Cervical Dystonia diagnosis. Age limitation removed from Cervical Dystonia; pain and abnormal head position requirements clarified and medications trial added. On diagnosis of Urinary Incontinence criterion "Surgical treatment or balloon sphincter dilatation is not indicated, has been refused, or has failed" was removed. On diagnosis of Spasticity rehabilitation program is not required anymore. Strabismus diagnosis got criteria expanded. Lower Limb Spasticity is combined into Spasticity diagnosis. For diagnosis of Migraine Headache Prophylaxis trial length for abortive therapeutic options decreased.
01/19/2020	Updated Overactive Bladder criteria from three to two trials of an adequately titrated overactive bladder medication.
08/17/2020	Removed criteria for upper extremity focal dystonia/writer's cramp (off label). Hyperhidrosis: added specialist requirement, changed re-auth duration, changed dx title to match drug label, changed the ordering, removed sweat quantification requirement and changed diagnostic phrase to match guidelines. Added reference. Blepharospasm: Extend re-auth duration to 12 mo, added specialist, re-phrased dose, revised diagnostic phrasing. Added reference. Strabismus: Added specialist, referred dose to PI, simplified diagnostic wording. Added reference. Cervical dystonia: Added specialist. Re-worded the diagnosis requirement. Removed trial of oral medication. Removed exclusions. Added frequency to dose. Extended re-auth duration. Added references. Achalasia (off label use): added age and specialist, changed initial auth duration from 12 mo to 6mo. Removed requirement for oral therapy (not effective). Specified high resolution manometry per guideline. Included surgical procedures per guideline. Removed redundancy. Simplified other causes. Added frequency to dose. Added references. Migraine: removed symptoms and duration of migraine episode from diagnostic requirement; trial length reduced to 2 months/trial; added one of the abortive trials must be a triptan; added no concurrent use with prophylactic CGRP; removed statement about episodic migraine because not an FDA approved indication. OAB: added frequency to dose. Added specialist. Amended dx per drug label. Specified length of alternate drug trials. Added examples of drugs. Added reference. Urinary incontinence: added specialist, added frequency to dose, edited dx to match fda label wording, changed initial auth duration. Changed order of criteria to match others. Removed statement about urinary retention. Expanded examples of neurologic disease, added examples of anticholinergic, specified length of trial. Added reference. Spasticity: Add age and specialist. Update to match latest drug label. Generalized list of co-existing conditions. Added trial of conventional treatment. Extended initial auth duration. Edited dose allowed. Added reference. All: specified type of symptom improvement to look for at re-auth.

11/23/2020	Hyperhidrosis: Replaced “Drysol” with “Xerac” and changed trial length to 60 days.
02/15/2021	Per label change: Updated age to 5 yrs old for urinary incontinence due to detrusor overactivity assoc. with neurologic condition; added spina bifida to list of examples; added dosing for peds.
08/10/2021	Transferred to new template. Allowing additional specialists for cervical dystonia and spasticity indications.

References:

1. Botox [package insert]. Madison, NJ: Allergan USA, Inc.; February 2021.
2. Brashear A, Lew MF, Dykstra DD, et al. “Safety and Efficacy of NeuroBloc (Botulinum Toxin Type B) in Type A-Responsive Cervical Dystonia,” Neurology, 1999, 53(7):1439-46.
3. Clinical Use of Botulinum Toxin,” Arch Neurol, 1991, 48(12):1294-8.
4. Benecke R, Jost WH, Kanovsky P, et al. “A New Botulinum Toxin Type A Free of Complexing Proteins for Treatment of Dystonia,” Neurology, 2005, 64(11):1949-51.
5. Borodic GE and Pearce LB, “New Concepts in Botulinum Toxin Therapy,” Drug Saf, 1994, 11(3):145-52. Jankovic J and Brin MF, “Therapeutic Uses of Botulinum Toxin,” N Engl J Med,1991, 324(17):1186-94.
6. Naumann M and Jankovic J, "Safety of Botulinum Toxin Type A: A Systematic Review and Meta-Analysis," Curr Med Res Opin, 2004, 20(7):981-90.
7. Russman, BS, Tilton, A, Gormley ME. Jr. Cerebral palsy; a rational approach to a treatment protocol, and the role of botulinum toxin in treatment, Muscle Nerve Suppl 1997; 6:S181.
8. Fishman LM, Anderson C, Rosner B. Botox and physical therapy in the treatment of Piriformis syndrome Am J Phys Med Rehabil. 2002 Dec;81(12):936-42.
9. Assessment: botulinum neurotoxin for the treatment of movement disorders (an evidence-based review). Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. http://www.guideline.gov/content.aspx?id=12947(March11, 2011).
10. Simpson DM, et al. Assessment: Botulinum neurotoxin for the treatment of movement disorders (an evidence-based review). Report of the Therapeutics and Technology Subcommittee of the American Academy of Neurology. Neurology. 2008;70(19):1699-706.
11. Neumann M, et al. Assessment: Botulinum neurotoxin in the treatment of autonomic disorders and pain. Report of the Therapeutics and Technology Subcommittee of the American Academy of Neurology. Neurology. 2008; 70:1707-14.
12. Keam SJ, Muir VJ, Deeks ED. Botulinum toxin A (Dysport): in dystonias and focal spasticity. Drugs 2011;71(8):1043-58.
13. Ondo WG, Hunter C, Moore W. A double-blind placebo-controlled trial of botulinum toxin B for sialorrhea in Parkinson’s disease. Neurology. 2004;62(1):37-40.
14. Koivusalo A.I., Pakarinen M.P., Rintala R.J. Botox injection treatment for anal outlet obstruction in patients with internal anal sphincter achalasia and Hirschsprung’s disease. *Pediatr Surg Int* (2009) 25: 873. https://doi.org/10.1007/s00383-009-2438-3.
15. Pasricha, P.J., Ravich, W.J., Hendrix, T.R., et al. M.D. Intrasphincteric Botulinum Toxin for the Treatment of Achalasia. *N Engl J Med* (1995); 332:774-778. March 23, 1995. DOI: 10.1056/NEJM199503233321203
16. Storr M, Born P, Frimberger E, et al. Treatment of achalasia: the short-term response to botulinum toxin injection seems to be independent of any kind of pretreatment. *BMC Gastroenterology*. 2002;2:19. doi:10.1186/1471-230X-2-19.
17. Staskin D., Martin M.C. Understanding Dose Titration: Overactive Bladder Treatment With Fesoterodine as an Example. European Association of Urology. 10(2011): 8-13. DOI:10.1016/j.eursup.2011.01.004.
18. Fock J, Galea MP, Stillman BC, et al. Functional outcome following Botulinum toxin A injection to reduce spastic equinus in adults with traumatic brain injury. Brain Inj. 2004;18(1):57-63.
19. Biglan AW, Burnstine RA, Rogers GL, Saunders RA. Management of strabismus with botulinum A toxin. Ophthalmology. 1989;96(7):935-943.
20. Rowe FJ, Noonan CP. Botulinum toxin for the treatment of strabismus. Cochrane Database Syst Rev. 2012;2:CD006499.
21. Tremor, myoclonus, focal dystonias, and tics. In: Adams and Victor's Principles of Neurology. 7th ed. M Victor, AH Ropper, eds., New York, NY: McGraw-Hill; 2001; Ch. 6: 99-120.
22. Munksgaard SB, et al. Medication overuse headache. Headache. 2014 Jul-Aug;54(7):1251-7.
23. Gómez-Caravaca MT, et al. The use of botulinum toxin in the treatment of sialorrhea in parkinsonian disorders. Neurol Sci. 2015 Feb;36(2):275-9.
24. International Headache Society. Available at: www.ichd-3.org.

25. Hornberger J, Grimes K, Naumann M, et al. Recognition, diagnosis, and treatment of primary focal hyperhidrosis. *J Am Acad Dermatol*. 2004;51(2):274-286. doi:10.1016/j.jaad.2003.12.029
26. Simpson DM, Hallett M, Ashman EJ, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(19):1818-1826. doi:10.1212/WNL.0000000000002560
27. Defazio G, Hallett M, Jinnah HA, Berardelli A. Development and validation of a clinical guideline for diagnosing blepharospasm. *Neurology*. 2013;81(3):236-240. doi:10.1212/WNL.0b013e31829bfdf6
28. Rowe FJ, Noonan CP. Botulinum toxin for the treatment of strabismus. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD006499. DOI: 10.1002/14651858.CD006499.pub4.
29. Cervical Dystonia. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/cervical-dystonia/. Published July 19, 2019. Accessed July 17, 2020.
30. Dressler D, Altenmueller E, Bhidayasiri R, et al. Strategies for treatment of dystonia. *Journal of Neural Transmission*. 2015;123(3):251-258. doi:10.1007/s00702-015-1453-x
31. Khashab MA, Vela MF, Thosani N, et al. ASGE guideline on the management of achalasia. *Gastrointest Endosc*. 2020;91(2):213-227.e6. doi:10.1016/j.gie.2019.04.231
32. Zaninotto G, Bennett C, Boeckxstaens G, et al. The 2018 ISDE achalasia guidelines. *Dis Esophagus*. 2018;31(9):10.1093/dote/doy071. doi:10.1093/dote/doy071
33. Vaezi MF, Pandolfino JE, Vela MF. ACG clinical guideline: diagnosis and management of achalasia. *Am J Gastroenterol*. 2013;108(8):1238-1250. doi:10.1038/ajg.2013.196
34. The American Headache Society Position Statement on Integrating New Migraine Treatments into Clinical Practice. Headache: The Journal of Head and Face Pain. 2019;59: 1-18.
35. Gormley EA, Lightner DJ, Faraday M, Vasavada SP; American Urological Association; Society of Urodynamics, Female Pelvic Medicine. Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline amendment. *J Urol*. 2015;193(5):1572-1580. doi:10.1016/j.juro.2015.01.087
36. Groen J, Pannek J, Castro Diaz D, et al. Summary of European Association of Urology (EAU) Guidelines on Neuro-Urology. *Eur Urol*. 2016;69(2):324-333. doi:10.1016/j.eururo.2015.07.071
37. Lindsay C, Kouzouna A, Simcox C, Pandyan AD. Pharmacological interventions other than botulinum toxin for spasticity after stroke. Cochrane Database of Systematic Reviews 2016, Issue 10. Art. No.: CD010362. DOI: 10.1002/14651858.CD010362.pub2.

Effective date: 01/01/2022
Revised date: 08/10/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Breyanzi (lisocabtagene maraleucel)
BILLING CODE	J3490/J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Inpatient/Outpatient
STATUS	Prior Authorization Required

Breyanzi is a CD19-directed chimeric antigen receptor (CAR)T-cell therapy for the treatment of relapsed or refractory large B-cell lymphoma after 2 or more lines of systemic therapy. Lymphoma is a cancer of the lymphatic system and white blood cells. Competitor products include Kymriah and Yescarta. Breyanzi was approved in February 2021.

Breyanzi (lisocabtagene maraleucel) will be considered for coverage when the following criteria are met:

Large B-Cell Lymphoma

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Healthcare facility/provider has enrolled in the Breyanzi REMS; AND
3. Member has a diagnosis of relapsed or refractory large B-cell lymphoma including any of the following:
   a) Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma);
   b) High grade B-cell lymphoma;
   c) Primary mediastinal large B-cell lymphoma;
   d) Follicular lymphoma grade 3B; AND
4. Member has been treated with 2 or more lines of systemic therapy, including treatment with an anthracycline and rituximab (or other CD20-targeted agent); AND
5. Member has an Eastern cooperative oncology group (ECOG) performance status of 0 or 1; AND
6. Member does not have any of the following:
   a) Primary central nervous system (CNS) lymphoma;
   b) Prior CAR T-cell or other genetically-modified T-cell therapy (e.g. Yescarta, Kymriah);
7. Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).
8. **Dosage allowed/Quantity limit:** 50 to 110 × 10^6 CAR-positive viable T cells (consisting of 1:1 CAR-positive viable T cells of the CD8 and CD4 components), with each component supplied separately in one to four single-dose vials

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:

1. Breyanzi will not be reauthorized for continued therapy.

CareSource considers Breyanzi (lisocabtagene maraleucel) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/20/2021	New policy for Breyanzi created.

References:

1. Breyanzi (lisocabtagene maraleuce) [package insert]. Bothell, WA; Juno Therapeutics, Inc.; Revised 02/2021.
2. National Comprehensive Cancer Network. B-Cell Lymphomas (Version 4.2021). https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed May 20, 2021.
3. Abramson JS, Palomba ML, Gordon LI, et al. Lisocabtagene maraleucel for patients with relapsed or refractory large B-cell lymphomas (TRANSCEND NHL 001): a multicentre seamless design study. *Lancet*. 2020;396(10254):839-852. doi:10.1016/S0140-6736(20)31366-0
4. Abramson JS. Anti-CD19 CAR T-Cell Therapy for B-Cell Non-Hodgkin Lymphoma. *Transfus Med Rev*. 2020;34(1):29-33. doi:10.1016/j.tmrv.2019.08.003

Effective date: 10/1/2021
Revised date: 05/20/2021

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Brineura (cerliponase alfa)
BILLING CODE	J3590 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 600 mg every 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Brineura (cerliponase alfa) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

INFANTILE NEURONAL CEROID LIPOFUSCINOSIS TYPE 2 (CLN2), aka tripeptidyl peptidase 1 (TPP1) deficiency

For **initial** authorization:

1. Medication is being used to slow the loss of ambulation in symptomatic pediatric patients 3 years of age and older with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency; AND
2. Member is between the ages 3 and 16 years old; AND
3. Member has mild to moderate disease documented by a two-domain score of 3-6 on motor and language domains of the Hamburg Scale, with a score of at least 1 in each of these two domains; AND
4. Member does not have a score of 0 points on the combined motor and language components of the Hamburg CLN2 rating scale; AND
5. Member does not have another neurological illness that may have caused cognitive decline (e.g. trauma, meningitis, or hemorrhage); AND
6. Member does not require ventilation support; AND
7. Member does not have generalized motor status epilepticus within 4 weeks of first dose.
8. **Dosage allowed:** 300 mg administered once every other week as an intraventricular infusion followed by infusion of Intraventricular Electrolytes over approximately 4.5 hours.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member's loss of ambulation slowed and it is documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Brineura (cerliponase alfa) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/17/2017	New policy for Brineura created.

References:

1. ClinicalTrials.gov. BMN 190. Available at: https://clinicaltrials.gov/ct2/results?term=bmn+190&Search=Search. Accessed January 1, 2017.
2. ClinicalTrials.gov. A phase 2 open-label study to evaluate safety, tolerability, and efficacy of intracerebroventricular BMN 190 in patients with CLN2 disease. Available at: https://clinicaltrials.gov/ct2/show/NCT02485899?term=bmn+190&rank=3. Accessed January 8, 2017.
3. Brineura [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; April, 2017.
4. FDA.gov. FDA approves first treatment for a form of Batten disease. https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm555613.htm. Accessed May 17, 2017.

Effective date: 07/01/2017
Revised date: 05/17/2017

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Bunavail (buprenorphine and naloxone) buccal film
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include generic buprenorphine/naloxone sublingual tablets QUANTITY LIMIT— 30-day supply at a time only
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Strength	Quantity Limit
2.1 mg – 0.3 mg	1 film per day
4.2 mg – 0.7 mg	2 films per day
6.3 mg – 1 mg	2 films per day

Bunavail (buprenorphine and naloxone) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID DEPENDENCE

For **initial** authorization:

1. All of the following:
   a) The individual has failed an adequate trial of the preferred generic buprenorphine/naloxone sublingual tablets within the previous 120 days (*Note:* Adequate trial is defined as at least 28 days of treatment); AND
   b) One of the following:
      i) The member experienced therapeutic failure with the preferred generic buprenorphine/naloxone sublingual tablets (*Note:* Brand and non-preferred buprenorphine agents will not be approved for members who report lesser efficacy as compared to the preferred generic buprenorphine sublingual tablets unless it would be clinically inappropriate to address efficacy with dose adjustment); OR
      ii) Generic sublingual tablets caused adverse outcome; AND
   c) The prescriber has provided a copy and confirmation of a MedWatch form submission to the FDA documenting the therapeutic failure or adverse outcome experienced by the member (*Note*: The MedWatch form is available at https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf)

OR

2. Both of the following:
   a) The individual has a hypersensitivity reaction to an inactive ingredient in the preferred generic buprenorphine sublingual tablets; AND
   b) The hypersensitivity reaction(s) is clearly documented in the member's medical record.
3. **Dosage allowed:** The maintenance dose of Bunavail buccal film is generally in the range of 2.1/0.3 mg buprenorphine/naloxone to 12.6/2.1 mg buprenorphine/naloxone per day. Dosages higher than this have not been demonstrated to provide any clinical advantage.

Additional Notes:

- GI upset or irritation is not generally considered an allergy or failed treatment. Members should be referred to their physician or pharmacist for advice on dose adjustment, and/or other options to reduce GI upset/irritation.
- Common documented side effects attributed to the drug (i.e., headache, nausea, blurred vision, fatigue, muscle aches) are not considered an allergy and would be expected to occur at the same level in both the generic and brand agent.
- Drug hypersensitivity symptoms may include skin rash, hives, itching, fever, swelling, shortness of breath, wheezing, runny nose, itchy and/or watery eyes, and in severe cases, anaphylaxis.

If member meets all the requirements listed above, the medication will be approved for lifetime.

CareSource considers Bunavail (buprenorphine and naloxone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/03/2019	New policy for Bunavail created.
03/11/2021	Annual review, no changes

References:

1. MedWatch: The FDA Safety Information and Adverse Event Reporting Program. Available at http://www.fda.gov/safety/medwatch/default.htm.
2. Bunavail [package insert]. Raleigh, NC: BioDelivery Sciences International, Inc.; 2002.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Bylvay (odevixibat)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Bylvay, approved by the FDA in July 2021, is indicated for the treatment of pruritus in patients 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC). It is the first drug approved for PFIC and is available as oral pellets or capsules, taken once daily.
PFIC is an ultra-rare group of genetic disorders that disrupt bile formation in the liver. It usually presents during infancy and is characterized by cholestasis, jaundice, and intense itching. Most patients will eventually require biliary diversion surgery or liver transplant. PFIC types 1, 2, and 3 are the most common and types 1 and 2 are the most severe. PFIC1 involves extrahepatic manifestations while PFIC2 does not. However, PFIC2 can be complicated by hepatocellular carcinoma. Less is known about the other PFIC subtypes.
In cholestatic liver disease, biliary substances aren't eliminated from the liver, thus they re-enter circulation. Cholestatic itch is thought to be related to the accumulation of bile acids in the skin. Bylvay is a reversible inhibitor of the ileal bile acid transporter (IBAT). Inhibiting IBAT decreases reuptake of bile salts, as observed by a decrease in serum bile acids, which helps improve pruritis. The pivotal clinical trials PEDFIC1 and PEDFIC2 met both primary endpoints of improving pruritis and reducing serum bile acids (sBA).

Bylvay (odevixibat) will be considered for coverage when the following criteria are met:

Progressive familial intrahepatic cholestasis (PFIC)

For **initial** authorization:

1. Member is at least 3 months of age; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist or hepatologist; AND
3. Member has a diagnosis of PFIC type 1 or 2 confirmed by genetic testing identifying pathogenic mutations of the ATP8B1 or ABCB11 genes (results must be provided for review); AND
4. Member has significant pruritis not attributed to another cause; AND
5. Documentation of serum bile acid level ≥ 100 µmol/L; AND
6. Documentation of baseline liver tests (e.g., ALT, AST, bilirubin, INR); AND
7. Trial and failure of ursodiol (may also continue concurrently); AND
8. Member does NOT have any of the following:
   a) Decompensated cirrhosis
   b) Variants of the ABCB11 gene (PFIC type 2) that code for non-functional or complete absence of the bile salt export pump (BSEP-3) protein (per submitted genetic test result)
   c) Biliary diversion surgery in the past 6 months
   d) Liver transplant
9. **Dosage allowed/Quantity limit:** 40 mcg/kg orally once daily. If no improvement after 3 months, may increase in 40 mcg/kg increments up to 120 mcg/kg. Max dose per day 6 mg.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement of pruritis compared to baseline; AND
2. Chart notes must show reduced serum bile acid from baseline; AND
3. Member has NOT experienced portal hypertension or a hepatic decompensation event (e.g., variceal hemorrhage, ascites, hepatic encephalopathy) while being treated with Bylvay.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Bylvay (odevixibat) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/17/2021	New policy for created for Bylvay.

References:

1. Bylvay [prescribing information]. Albireo Pharma, Inc.; 2021.
2. Baumann U, Sturm E, Lacaille F, et al. Effects of odevixibat on pruritus and bile acids in children with cholestatic liver disease: Phase 2 study. *Clin Res Hepatol Gastroenterol*. 2021;45(5):101751. doi:10.1016/j.clinre.2021.101751
3. Deeks ED. Odevixibat: First Approval [published correction appears in Drugs. 2021 Sep 23;:]. *Drugs*. 2021;81(15):1781-1786. doi:10.1007/s40265-021-01594-y
4. Kamath BM, Stein P, Houwen RHJ, Verkade HJ. Potential of ileal bile acid transporter inhibition as a therapeutic target in Alagille syndrome and progressive familial intrahepatic cholestasis. *Liver Int*. 2020;40(8):1812-1822. doi:10.1111/liv.14553
5. Gunaydin M, Bozkurter Cil AT. Progressive familial intrahepatic cholestasis: diagnosis, management, and treatment. *Hepat Med*. 2018;10:95-104. Published 2018 Sep 10. doi:10.2147/HMER.S137209
6. Siddiqi I, Tadi P. Progressive Familial Intrahepatic Cholestasis. [Updated 2021 Sep 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK559317/
7. Baker A, Kerkar N, Todorova L, Kamath BM, Houwen RHJ. Systematic review of progressive familial intrahepatic cholestasis [published correction appears in Clin Res Hepatol Gastroenterol. 2020 Feb;44(1):115]. *Clin Res Hepatol Gastroenterol*. 2019;43(1):20-36. doi:10.1016/j.clinre.2018.07.010
8. Srivastava A. Progressive familial intrahepatic cholestasis. *J Clin Exp Hepatol*. 2014;4(1):25-36. doi:10.1016/j.jceh.2013.10.005
9. Squires RH, Ng V, Romero R, et al. Evaluation of the pediatric patient for liver transplantation: 2014 practice guideline by the American Association for the Study of Liver Diseases, American Society of Transplantation and the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. *Hepatology*. 2014;60(1):362-398. doi:10.1002/hep.27191

Effective date: 04/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Cabenuva (cabotegravir/rilpivirine)
BILLING CODE	J0741
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
STATUS	Prior Authorization Required

Cabenuva is a co-packaged product consisting of 2 different injectable drugs: cabotegravir, an integrase strand transfer inhibitor (INSTI), and rilpivirine, a non-nucleoside reverse transcriptase inhibitor (NNRTI). Both are once-monthly intramuscular injections given separately at the same time. Cabenuva is indicated as a complete regimen for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically suppressed. Prior to initiating treatment with Cabenuva, oral lead-in dosing (available at no-charge) should be used for approximately 1 month to assess tolerability of cabotegravir and rilpivirine.

Cabenuva (cabotegravir/rilpivirine) will be considered for coverage when the following criteria are met:

HUMAN IMMUNODEFICIENCY VIRUS TYPE-1 (HIV-1)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an HIV specialist; AND
3. Member has a diagnosis of HIV-1; AND
4. Member is currently virologically suppressed (HIV-1 RNA < 50 copies/mL) for at least 3 months; AND
5. Member is stable on a complete oral antiretroviral therapy (ART) regimen and there is a documented clinical reason for switching to Cabenuva; AND
6. Member does NOT have any of the following:
   a) Baseline resistance to either cabotegravir (Vocabria) or rilpivirine (Edurant);
   b) Prior virologic failure with any antiretroviral therapy;
   c) Active hepatitis B virus (HBV) infection.
7. **Dosage allowed/Quantity limit:** prior to initiating treatment with Cabenuva, oral lead-in should be used for at least 28 days to assess tolerability of cabotegravir and rilpivirine. Initiate injections (600 mg of cabotegravir and 900 mg of rilpivirine) on the last day of oral lead-in and continue with injections (400 mg of cabotegravir and 600 mg of rilpivirine) every month thereafter.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must demonstrate that member remains virologically suppressed (HIV-1 RNA < 50 copies/mL) after initiation of treatment.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Cabenuva (cabotegravir/rilpivirine) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
03/17/2021	New policy for Cabenuva (cabotegravir/rilpivirine) created.
11/16/2021	Added J code. Changed to medical benefit only.

References:

1. Cabenuva [package insert]. Research Triangle Park, NC; GlaxoSmithKline. January 2021.
2. Vocabria [package insert]. Research Triangle Park, NC; GlaxoSmithKline. January 2021.
3. 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 March 17, 2021.
4. Swindells S, Andrade-Villanueva JF, Richmond GJ, et al. Long-Acting Cabotegravir and Rilpivirine for Maintenance of HIV-1 Suppression. *N Engl J Med*. 2020;382:1112-1123.
5. Orkin C, Arasteh K, Hernández-Mora MG, et al. Long-Acting Cabotegravir and Rilpivirine after Oral Induction for HIV-1 Infection. *N Engl J Med*. 2020;382:1124-1135.
6. Rizzardini G, Overton ET, Orkin C, et al. Long-Acting Injectable Cabotegravir + Rilpivirine for HIV Maintenance Therapy: Week 48 Pooled Analysis of Phase 3 ATLAS and FLAIR Trials. *J Acquir Immune Defic Syndr*. 2020;85(4):498-506.
7. Overton ET, Richmond GJ, Rizzardini G, et al. Long-acting cabotegravir and rilpivirine dosed every 2 months in adults with HIV-1 infection (ATLAS-2M), 48-week results: a randomised, multicentre, open-label, phase 3b, non-inferiority study. *Lancet*. 2020;396(10267):1994-2005.

Effective date: 04/01/2022
Revised date: 03/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Cablivi (caplacizumab-yhdp)
BILLING CODE	Must use valid NDC, or J3590
BENEFIT TYPE	Medical or pharmacy
SITE OF SERVICE ALLOWED	Home/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT—30 vials/30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Cablivi (caplacizumab-yhdp) is a **non-preferred** product and will only be considered for coverage under the **medical** or **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (aTTP)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a hematologist; AND
3. Member has known or highly likely diagnosis of severe aTTP with ALL of the following:
   a) Lab results showing platelet count less than 100,000[4,5];
   b) Microangiopathic hemolytic anemia (MAHA) confirmed by presence of schistocytes on blood smear;
   c) Documentation of a PLASMIC score between 5 and 7 (intermediate to high risk)[6];
   d) Testing shows an ADAMTS13 activity level less than 10%, OR test has been ordered and results are pending; AND
4. Cablivi was initiated inpatient with plasma exchange and will be continued in combination with immunosuppressive therapy (i.e. glucocorticoids, rituximab) as indicated.
   Note: Rituximab requires prior authorization.
5. **Dosage allowed:** 11mg once daily[1]

If member meets all the requirements listed above, the medication will be approved for 30 days.

For **reauthorization**:

1. Platelet count normalized (at least 150,000) for at least 2 days during treatment; AND
2. ADAMTS13 activity remains less than 20%; AND
3. Member has not experienced more than 2 recurrences (need to restart plasma exchange) of aTTP during treatment (within the same episode or acute event).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 28 days.

CareSource considers Cablivi (caplacizumab-yhdp) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/15/2020	New policy for Cablivi created.
11/17/2021	Annual review, no changes

References:

1. Cablivi [package insert]. Cambridge, MA: Genzyme Corporation; 2019.
2. George JN, Cuker A.Acquired TTP: Initial treatment. *UpToDate*. http://www.uptodate.com. Updated September 30, 2019. Accessed July 15, 2020.
3. ISTH Guideline for the Diagnosis and Management of Thrombotic Thrombocytopenic Purpura. https://cdn.ymaws.com/www.isth.org/resource/resmgr/guidance_and_guidelines/ttp_guideline/isth_ttp_guideline_september.pdf. Accessed 7/15/2020.
4. Scully M, Cataland SR, Peyvandi F, et al. Caplacizumab Treatment for Acquired Thrombotic Thrombocytopenic Purpura. *N Engl J Med*. 2019;380(4):335-346. doi:10.1056/NEJMoa1806311
5. Peyvandi F, Scully M, Kremer Hovinga JA, et al. Caplacizumab for Acquired Thrombotic Thrombocytopenic Purpura. *N Engl J Med*. 2016;374(6):511-522. doi:10.1056/NEJMoa1505533
6. Coppo P, Cuker A, George JN. Thrombotic thrombocytopenic purpura: Toward targeted therapy and precision medicine. *Res Pract Thromb Haemost*. 2018;3(1):26-37. Published 2018 Nov 16. doi:10.1002/rth2.12160
7. Assessment report (Cablivi dossier). European Medicines Agency. https://www.ema.europa.eu/en/documents/assessment-report/cablivi-epar-public-assessment-report_en.pdf. Published 2018. Accessed August 20, 2020.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Cayston (aztreonam inhalation solution)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT—84 vials per 56 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Cayston (aztreonam inhalation solution) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 7 years of age or older; AND
2. Member has a diagnosis of cystic fibrosis and has a positive culture for Pseudomonas aeruginosa documented in chart notes; AND
3. Medication prescribed by a pulmonologist or an infectious disease specialist; AND
4. Member has documented forced expiratory volume in 1 second (FEV1) > 25% or < 75% predicted (Documented in chart notes and submitted with prior authorization request); AND
5. Member is not colonized with *Burkholderia cepacia.*
6. **Dosage allowed:** 75 mg 3 times daily for 28 days in repeated cycles of 28 days on drug, followed by 28 days off drug.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.
2. Evidence of disease stability or disease improvement
   a) Disease improvement evidenced by chart notes with any of the following:
      i) Improved FEV1 and/or other lung function tests;
      ii) Improvement in sweat chloride;
      iii) Decrease in pulmonary exacerbations;
      iv) Decrease in pulmonary infections;
      v) Increase in weight-gain;
      vi) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Cayston (aztreonam inhalation solution) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Cayston created. Not covered diagnosis added.
12/30/2020	Quantity limit changed to 56 days from 28 days. Reauthorization criteria updated to ask for evidence of disease stability or improvement. Diagnosis of cystic fibrosis added to initial criteria. Exclusion criteria updated to a simplified statement.
11/17/2021	Annual review, no changes

References:

1. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. [cited 2016 Dec 19]. Available: https://www.guideline.gov.
2. Cayston [package insert]. Foster City, CA: Gilead Sciences Inc; 2014.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Cerdelga (eliglustat)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Cerdelga is a substrate reduction therapy, FDA approved in 2014 for the treatment of Gaucher disease type 1. Gaucher disease is a rare, inherited, lysosomal storage disorder. In Gaucher disease, mutations of the GBA gene cause deficiency of the enzyme glucocerebrosidase (acid beta-glucosidase), resulting in the accumulation of glucocerebroside (glucosylceramide [GLC]) in the lysosomes of macrophages to form "Gaucher cells," especially in the bone marrow, spleen, and liver. Prominent symptoms include hepatosplenomegaly, anemia, thrombocytopenia, and skeletal problems. Type 1 Gaucher disease is the most common form and does not affect the central nervous system. In contrast to standard of care enzyme replacement therapy (ERT), Cerdelga reduces synthesis of the accumulating substrate to compensate for its impaired degradation.

Cerdelga (eliglustat) will be considered for coverage when the following criteria are met:

Gaucher disease type 1 (GD1)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a geneticist, hematologist, or metabolic specialist; AND
3. Member has a diagnosis of Gaucher disease type 1 confirmed by documentation of at least one of the following:
   a) Deficiency of glucocerebrosidase activity by enzyme assay (0 to 15% of normal), and/or
   b) Molecular genetic test documenting mutation of the GBA gene; AND
4. CYP2D6 genotype analysis shows the member is an extensive, intermediate, or poor metabolizer; AND
5. Member exhibits at least one of the following as a result of Gaucher disease:
   a) Anemia,
   b) Thrombocytopenia,
   c) Spleen and/or liver enlargement; AND
6. Member does NOT have any of the following:
   a) Neurologic symptoms suggestive of type II or III Gaucher disease (i.e., supranuclear gaze palsy, cognitive decline, epilepsy, myoclonus and/or ataxia),
   b) CYP2D6 ultra-rapid or indeterminate metabolizer status,
   c) Pre-existing cardiac disease, long QT syndrome, or in combination with Class IA (e.g., quinidine, procainamide) or Class III (e.g., amiodarone, sotalol) antiarrhythmic medications,
   d) Concomitant use with Zavesca (miglustat) or ERT.
7. **Dosage allowed/Quantity limit:**
   Recommended dosing is based on CYP2D6 metabolizer status:

CYP2D6 Metabolizer Status	CERDELGA Dosage
EMs	84 mg twice daily
IMs	
PMs	84 mg once daily

NOTE: Dose adjustments may be needed based on other medications the member is taking. Consult the complete prescribing information from the manufacturer.
QL: 56 capsules per 28 days.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes must document improvement in one or more of the following parameters compared to baseline:
   a) Hemoglobin level
   b) Platelet count
   c) Spleen and/or liver volumes
   d) Bone outcomes

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Cerdelga (eliglustat) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/04/2021	New policy for Cerdelga created.

References:

1. Cerdelga [package insert]. Waterford, Ireland: Genzyme Ireland, Ltd.; 7/2021.
2. Mistry PK, Lukina E, Ben Turkia H, et al. Effect of oral eliglustat on splenomegaly in patients with Gaucher disease type 1: the ENGAGE randomized clinical trial. *JAMA*. 2015;313(7):695-706. doi:10.1001/jama.2015.459
3. Lukina E, Watman N, Arreguin EA, et al. A phase 2 study of eliglustat tartrate (Genz-112638), an oral substrate reduction therapy for Gaucher disease type 1. *Blood*. 2010;116(6):893-899. doi:10.1182/blood-2010-03-273151
4. Lukina E, Watman N, Dragosky M, et al. Outcomes after 8 years of eliglustat therapy for Gaucher disease type 1: Final results from the Phase 2 trial. *Am J Hematol*. 2019;94(1):29-38. doi:10.1002/ajh.25300
5. Cox TM, Drelichman G, Cravo R, et al. Eliglustat maintains long-term clinical stability in patients with Gaucher disease type 1 stabilized on enzyme therapy. *Blood*. 2017;129(17):2375-2383. doi:10.1182/blood-2016-12-758409
6. Belmatoug N, Di Rocco M, Fraga C, et al. Management and monitoring recommendations for the use of eliglustat in adults with type 1 Gaucher disease in Europe. *Eur J Intern Med*. 2017;37:25-32. doi:10.1016/j.ejim.2016.07.011
7. Balwani M, Burrow TA, Charrow J, et al. Recommendations for the use of eliglustat in the treatment of adults with Gaucher disease type 1 in the United States. *Mol Genet Metab*. 2016;117(2):95-103. doi:10.1016/j.ymgme.2015.09.002

Effective date: 01/01/2022
Revised date: 08/04/2021

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Cimzia (certolizumab pegol)
BILLING CODE	For medical – J0717 (1 unit = 1 mg) Must use valid NDC code for self-administered product
BENEFIT TYPE	Pharmacy or Medical
SITE OF SERVICE ALLOWED	Outpatient/Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 400 mg per 28 days (after loading doses)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Cimzia (certolizumab pegol) is a **preferred** product and will only be considered for coverage under the **pharmacy or medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS) or NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (nr-axSpA)

Note: Diagnosis of axial spondyloarthritis (axSpA) is also accepted. SpA comprises of 2 subtypes – ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA).

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Member has a documented diagnosis of active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA); AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Member shows at least one of the following signs or symptoms of Spondyloarthritis:
   a) Elevated serum C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR);
   b) Positive HLA-B27 test;
   c) Sacroiliitis; AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response.
8. **Dosage allowed:** 400 mg (two injections of 200 mg) once a week at weeks 0, 2, and 4, followed by 200 mg every other week or 400 mg every four weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CROHN'S DISEASE (CD)

For **initial** authorization:
1. Member is 18 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by **one** of the following:
   a) Extensive small bowel disease involving more than 100 cm;
   b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
   c) Fistulizing disease.
6. **Dosage allowed:** 400 mg (two injections of 200 mg) once a week at weeks 0, 2, and 4, followed by 400 mg every four weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks.

7. **Dosage allowed:** 400 mg (two injections of 200 mg) every other week. For members with weight 90 kg or less, may consider 400 mg (two injections of 200 mg) once a week at weeks 0, 2, and 4, followed by 200 mg every other week .

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life).
6. **Dosage allowed:** 400 mg (two injections of 200 mg) once a week at weeks 0, 2, and 4, followed by 200 mg every other week or 400 mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:
1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately.

Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).

5. **Dosage allowed:** 400 mg (two injections of 200 mg) once a week at weeks 0, 2, and 4, followed by 200 mg every other week or 400 mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Cimzia (certolizumab pegol) not medically necessary for the treatment of the diseases that are not listed in this document

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Cimzia created. Policies SRx-0041 and SRx-0042 achieved. New diagnosis of AS with criteria was added. For diagnosis of CD: TNF inhibitor Humira and corticosteroids trials were added. For PsA: TNF inhibitors Humira and Enbrel were listed as required trials. For RA: non-biologic DMARDS were listed, and TNF inhibitors Humira and Enbrel were listed as required trials. List of diagnoses considered not medically necessary was added.
08/15/2018	Exception to pregnant member or those who are planning on becoming pregnant or are currently breastfeeding was added to each diagnosis in TNF requirement criterion. New indication of Plaque Psoriasis added. A requirement to have documented radiographic change involving the sacroiliac joints for diagnosis of AS was removed, and criteria of increased occiput to wall distance and post rest stiffness were added. Drug trials length were clarified as 4 weeks in length with each NSAID and 12 weeks in length with each Enbrel and Humira.
02/26/2019	Status changed to preferred. Humira and Enbrel trials removed from criteria; references edited. Initial authorization length increased to 12 months for PsO. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate. “Immunosuppressant therapies” changed to “treatment of traditional first-line oral/systemic” therapies. Reauthorization criteria on documented member’s PASI score improvement incorporated into general chart noted documentation requirements.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. Updated quantity limit to 400 mg per 28 days (after loading doses). AS/nr-axSpA: Specified that diagnosis can be AS or nr-axSpA. Simplified list of spondyloarthritis symptoms/signs. Removed peripheral arthritis requirement – not relevant for this diagnosis. CD: Specified length of trials for conventional therapies. For severe disease, removed esophageal/gastroduodenal disease, specified that history of colonic resection must also be high risk for recurrence. PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement.

	PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors.
11/17/2021	Annual review, no changes

References:

1. Cimzia [prescribing information]. Smyrna, GA: UCB, Inc.; September 2019.
2. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
7. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
8. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
9. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
10. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
11. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
12. ClinicalTrials.gov. Identifier: NCT02326298. An Efficacy and Safety Study of Two Dose Levels of Certolizumab Pegol (CZP) in Subjects With Plaque Psoriasis (PSO) (CIMPASI-1). Available at: https://clinicaltrials.gov/ct2/show/NCT02326298?term=NCT02326298&rank=1.
13. ClinicalTrials.gov. Identifier: NCT02326272. A Study to Evaluate the Efficacy and Safety of Two Dose Levels of Certolizumab Pegol (CZP) in Subjects With Plaque Psoriasis (PSO) (CIMPASI-2). Available at: https://clinicaltrials.gov/ct2/show/NCT02326272?term=NCT02326272&rank=1.
14. ClinicalTrials.gov. Identifier: NCT02346240. Efficacy and Safety Study of Certolizumab Pegol (CZP) Versus Active Comparator and Placebo in Subjects With Plaque Psoriasis (PSO) (CIMPACT). Available at: https://clinicaltrials.gov/ct2/show/NCT02346240?term=NCT02346240&rank=1.
15. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
16. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
17. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
18. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
19. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
20. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.

21. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
22. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
23. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
24. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Cinqair (reslizumab)
BILLING CODE	J2786 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see dosage allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Cinqair (reslizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SEVERE ASTHMA

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist, immunologist or allergist; AND
3. Member has a blood eosinophil count of at least 300 cells/μL or at least 150 cells/ μL if taking maintenance oral corticosteroids (OCS); AND
4. Member has at least two documented severe asthma exacerbations requiring oral corticosteroids (OCS), or at least one requiring hospitalization, within last year; AND
5. Member's asthma has been inadequately controlled after 3 months of conventional treatment on medium to high doses of inhaled corticosteroids (ICS) and long acting beta 2-agonists (LABA); AND
6. Medication is being used as add-on maintenance treatment to conventional therapies for asthma (i.e. ICS, LABA, etc.); AND
7. Medication is not used in conjunction with any other biologic therapy for asthma.
8. **Dosage allowed:** 3 mg/kg once every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 16 weeks.

For **reauthorization**:

1. Medication not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
    a) Decreased frequency of emergency department visits or hospitalizations due to asthma exacerbations; OR
    b) Increase in percent predicted FEV1 from pretreatment baseline; OR
    c) Improved functional ability (i.e. decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
    d) Decreased utilization of rescue medications or oral corticosteroids.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Cinqair (reslizumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/18/2017	New policy for Cinqair created. Lab for blood eosinophil count required within 4 weeks of dosing. Leukotriene receptor antagonists and corticosteroids on exacerbations taken out from criteria.
11/25/2020	Eosinophil count was updated to be consistent with guidelines; exacerbation number was updated to be consistent with guidelines (2 requiring OCS or 1 requiring hospitalization in the last year); changed from not to be used with Nucala to not to be used with any other asthma biologic.

References:

1. Cinqair [package insert]. Frazer, PA: Teva Respiratory LLC; 2020.
2. Castro M, Zangrilli J, Wechsler ME, et al. Reslizumab for inadequately controlled asthma with elevated blood eosinophil counts: Results from two multicentre, parallel, double-blind, randomised, placebo-controlled, phase 3 trials. Lancet Respir Med. 2015;3(5):355-366.
3. Walford HH, Doherty TA. Diagnosis and management of eosinophilic asthma: a US perspective. J Asthma Allergy. 2014;7:53–65.
4. Difficult-To-Treat & Severe Asthma in Adolescent and Adult Patients: Diagnosis and Management. Global Initiative For Asthma (GINA); Apr. 2019. Available at: https://ginasthma.org/wp-content/uploads/2018/11/GINA-SA-FINAL-wms.pdf.
5. Kostikas K, Brindicci C, Patalano F. Blood Eosinophils as Biomarkers to Drive Treatment Choices in Asthma and COPD. *Curr Drug Targets*. 2018;19(16):1882-1896. doi:10.2174/1389450119666180212120012
6. 2020 Focused Updates To The Asthma Management Guidelines. National Institute of Health; Dec 2020. Available at: https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates.

Effective date: 10/1/2021
Revised date: 11/25/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Cinryze (C1 esterase inhibitor (human))
BILLING CODE	J0598
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product: Haegarda QUANTITY LIMIT— 20 vials (500 IU/vial) per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Cinryze (C1 esterase inhibitor (human)) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Chart notes must document the member's baseline frequency of HAE attacks; AND
5. Member is inadequately controlled with on-demand treatment alone; AND
6. Cinryze is being prescribed for ongoing prophylaxis and will not be used to treat acute attacks; AND
7. Member has a trial and failure of or contraindication to Haegarda.
8. **Dosage allowed:**
   Age 12+: 1000 units IV infusion every 3 or 4 days; if no adequate response, doses up to 2,500 units (not exceeding 100 units/kg) every 3 or 4 days.
   Age 6-11: 500 units IV infusion every 3 or 4 days ; if no adequate response, doses up to 1000 units IV every 3 or 4 days may be considered.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must be provided that show a reduced frequency or number of acute attacks since starting treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Cinryze (C1 esterase inhibitor (human)) not medically necessary for the treatment of the following disease states based on a lack of

robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acquired angioedema (AAE)
- Treatment of acute HAE attacks

DATE	ACTION/DESCRIPTION
08/25/2017	New policy for Cinryze created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks were added.
07/27/2018	Medication is now approved for 6 years old and older.
01/14/2021	Updated and revised all content; consistent with other HAE prophylactics. Updated references. Greatly simplified the diagnostic confirmation criteria. Removed minimum required number of attacks, per guidelines; will just ask for baseline measure. Removed the statement about causative medications. Added that they must try on-demand treatment first. Rewrote the renewal criteria and removed log book requirement. Extended initial auth duration to 6 mo and renewal to 12 mo. Edited dosing information.

References:

1. Cinryze [package insert]. Exton, PA; ViroPharma Biologics, Inc.; 2020.
2. Lumry W. Management and Prevention of Hereditary Angioedema Attacks. Am J Manag Care. 2013;19:S111-S118.
3. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
4. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384
5. Zuraw BL, Busse PJ, White M, et al. Nanofiltered C1 inhibitor concentrate for treatment of hereditary angioedema. *N Engl J Med*. 2010;363(6):513-522. doi:10.1056/NEJMoa0805538
6. Lumry W, Manning ME, Hurewitz DS, et al. Nanofiltered C1-esterase inhibitor for the acute management and prevention of hereditary angioedema attacks due to C1-inhibitor deficiency in children. *J Pediatr*. 2013;162(5):1017-22.e222. doi:10.1016/j.jpeds.2012.11.030

Effective date: 10/1/2021
Revised date: 01/14/2021

CareSource

PHARMACY POLICY STATEMENT
Georgia Marketplace

DRUG NAME	Continuous Glucose Monitors
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— Product Specific, see Quantity allowed below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

FreeStyle Libre and FreeStyle Libre 2 are **preferred** products, Dexcom, Guardian Sensor 3, and Eversense are **non-preferred** products, and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

FreeStyle Libre

For **initial** authorization:

1. Diagnosis of Diabetes (type 1 or type 2)
2. Currently utilizing 3 or more injections of insulin per day
3. Age 18 years and older
4. One or more of the following:
   a) Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
   b) Hypoglycemic unawareness
   c) Poor glycemic control despite at least 4 finger-sticks per day
   d) Hypoglycemia overnight
   e) Recurring diabetic ketoacidosis (DKA)
   f) Insulin pump usage with poor control
   g) Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic
5. **Quantity allowed:** 1 reader per lifetime, 10-day sensors: 3 sensors per 30 days, 14-day sensors: 2 sensors per 28 days.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Documentation showing member benefit or clinical improvement (ex. decrease in hypoglycemic events, decrease in HbA1c or glucose readings)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

FreeStyle Libre 2

For **initial** authorization:

1. Diagnosis of Diabetes (type 1 or type 2)
2. Currently utilizing 3 or more injections of insulin per day
3. Age 4 years and older
4. One or more of the following:
   a) Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
   b) Hypoglycemic unawareness
   c) Poor glycemic control despite at least 4 finger-sticks per day
   d) Hypoglycemia overnight
   e) Recurring diabetic ketoacidosis (DKA)
   f) Insulin pump usage with poor control
   g) Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic
5. **Quantity allowed:** 1 reader per lifetime, 2 sensors per 28 days

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

2. Documentation showing member benefit or clinical improvement (ex. decrease in hypoglycemic events, decrease in HbA1c or glucose readings)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

Dexcom

For **initial** authorization:

1. For age 2-3 years:
   a) Diagnosis of Diabetes (type 1 or type 2)
   b) Currently utilizing 3 or more injections of insulin per day
   c) One or more of the following:
      i) Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
      ii) Hypoglycemic unawareness
      iii) Poor glycemic control despite at least 4 finger-sticks per day
      iv) Hypoglycemia overnight
      v) Recurring diabetic ketoacidosis (DKA)
      vi) Insulin pump usage with poor control
      vii) Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic
2. For age 4 years and older:
   a) Clinical reason why Freestyle Libre or Freestyle Libre 2 cannot be used
   b) Diagnosis of Diabetes (type 1 or type 2)
   c) Currently utilizing 3 or more injections of insulin per day
   d) One or more of the following:
      i) Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
      ii) Hypoglycemic unawareness
      iii) Poor glycemic control despite at least 4 finger-sticks per day
      iv) Hypoglycemia overnight
      v) Recurring diabetic ketoacidosis (DKA)
      vi) Insulin pump usage with poor control
      vii) Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic

3. **Quantity allowed:** 1 receiver per lifetime, 3 sensors per month, 1 transmitter per 90 days

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Documentation showing member benefit or clinical improvement (ex. decrease in hypoglycemic events, decrease in HbA1c or glucose readings)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

Guardian Sensor 3

For **initial** authorization:

1. Clinical reason why Freestyle Libre or Freestyle Libre 2 cannot be used
2. Diagnosis of Diabetes (type 1 or type 2)
3. Age 7 years and older
4. Currently utilizing 3 or more injections of insulin per day
5. One or more of the following:
   a) Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
   b) Hypoglycemic unawareness
   c) Poor glycemic control despite at least 4 finger-sticks per day
   d) Hypoglycemia overnight
   e) Recurring diabetic ketoacidosis (DKA)
   f) Insulin pump usage with poor control
   g) Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic
6. **Quantity allowed:** 5 sensors per 35 days

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Documentation showing member benefit or clinical improvement (ex. decrease in hypoglycemic events, decrease in HbA1c or glucose readings)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

Eversense

For **initial** authorization:

1. Clinical reason why Freestyle Libre or Freestyle Libre 2 cannot be used
2. Diagnosis of Diabetes (type 1 or type 2)
3. Age 18 years and older
4. Currently utilizing 3 or more injections of insulin per day
5. One or more of the following:
   a) Recurring episodes of at least moderately severe hypoglycemia (<50mg/dl)
   b) Hypoglycemic unawareness
   c) Poor glycemic control despite at least 4 finger-sticks per day
   d) Hypoglycemia overnight
   e) Recurring diabetic ketoacidosis (DKA)
   f) Insulin pump usage with poor control
   g) Specific cases where CGM use led to improvement in control and the clinician feels that prolonged monitoring is needed for an insulin dependent diabetic

6. **Quantity allowed:** 1 smart transmitter per year, 1 sensor per 90 days

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Documentation showing member benefit or clinical improvement (ex. decrease in hypoglycemic events, decrease in HbA1c or glucose readings)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Continuous Glucose Monitoring not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
8/27/2021	New policy for Continuous Glucose Monitors created.

References:

1. American Diabetes Association. 7. Diabetes technology: Standards of Medical Care in Diabetes – 2021. Diabetes Care 2021;44(Suppl. 1):S85-S99.
2. Battelino T, Danne T, Bergenstal RM, et al. Clinical Targets for Continuous Glucose Monitoring Data Interpretation: Recommendations From the International Consensus on Time in Range. Diabetes Care. 2019;42(8):1593-1603. doi:10.2337/dci19-0028
3. Beck RW, Riddlesworth TD, Ruedy K, et al.; DIAMOND Study Group. Continuous glucose monitoring versus usual care in patients with type 2 diabetes receiving multiple daily insulin injections: a randomized trial. Ann Intern Med 2017;167:365-374.
4. Bolinder J, Antuna R, Geelhoed-Duijvestijn P, Kroger J, Weitgasser R. novel glucose-sensing technology and hypoglycaemia in type 1 diabetes: a multicentre, non-masked, randomized controlled trial. Lancet 2016;388:2254-2263.
5. Haak T, Hanaire H, Ajjan R, Hermanns N, Riveline J-P, Rayman G. Flash glucose-sensing technology as a replacement for blood glucose monitoring of the management of insulin-treated type 2 diabetes: a multicenter, open-label randomized controlled trial. Diabetes Ther 2017;8:55-73.
6. Evans M, Welsh Z, Ells S, Seibold A. The Impact of Flash Glucose Monitoring on Glycaemic Control as Measured by HbA1c: A Meta-analysis of Clinical Trials and Real-World Observational Studies. Diabetes Ther. 2020;11(1):83-95. doi:10.1007/s13300-019-00720-0

Effective date: 10/01/2021
Revised date: 08/27/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Cosentyx (secukinumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 2 injections per 28 days (after loading dose)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Cosentyx (secukinumab) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS) or NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (nr-axSpA)

Note: Diagnosis of axial spondyloarthritis (axSpA) is also accepted. SpA comprises of 2 subtypes – ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA).

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Member has a documented diagnosis of active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA); AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Member shows at least one of the following signs or symptoms of Spondyloarthritis:
   a) Elevated serum C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR);
   b) Positive HLA-B27 test;
   c) Sacroiliitis; AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response.
8. **Dosage allowed:**
   a) AS: 150 mg at Week 0, 1, 2, 3, and 4 and every 4 weeks thereafter (with loading dose) OR 150 mg every 4 weeks (no loading dose), may increase dose to 300 mg every 4 weeks if needed.
   b) nr-axSpA: 150 mg at Week 0, 1, 2, 3, and 4 and every 4 weeks thereafter (with loading dose) OR 150 mg every 4 weeks (no loading dose). Max dose 150 mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks.
7. **Dosage allowed:** 300 mg (2 injections of 150 mg) by subcutaneous injection at Weeks 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:

i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life).

6. **Dosage allowed:** With a loading dosage is 150 mg at weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter; without a loading dosage is 150 mg every 4 weeks. May increase to 300 mg every 4 weeks if PsA is still active.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Cosentyx (secukinumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Cosentyx created. Policies SRx-0043 achieved. New diagnoses of AS and PsA with criteria were added. For diagnosis of PsO: immunosuppressive criterion was separated from phototherapies and topical agents trials; TNF inhibitors Humira and Enbrel were listed as required trials; Psoriasis Area and Severity Index (PASI) score requirement was added. List of diagnoses considered not medically necessary was added.
02/26/2019	Status changed to preferred. Trials of Humira and Enbrel removed from criteria. Clarifications entered for AS and PsA on NSAIDs trial length. References updated. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate. "Immunosuppressant therapies" changed to "treatment of traditional first-line oral/systemic" therapies. Reauthorization criteria on documented member's PASI score improvement incorporated into general chart noted documentation requirements.
09/25/2020	For AS: Modified to include the new indication nr-axSpA. Modified signs/symptoms to only include inflammatory markers or sacroiliitis. Removed peripheral arthritis requirement – not relevant for this diagnosis. For PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. For PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). Removed repeat TB test for reauth for all diagnoses.
11/19/2021	Annual review, no changes

References:

1. Cosentyx [package insert]. East Hanover, NJ:Novartis Pharmaceuticals Corporation; June 2020.
2. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
3. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.

4. ClinicalTrials.gov. Study of Efficacy and Safety of Secukinumab in Patients With Non-radiographic Axial Spondyloarthritis (PREVENT). Identifier: NCT02696031. Available at: https://www.clinicaltrials.gov/ct2/show/NCT02696031.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
7. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
8. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
9. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
10. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201
11. Bissonnette R, et al. Secukinumab demonstrates high sustained efficacy and a favorable safety profile through 5 years of treatment in moderate to severe psoriasis. *J Eur Acad Dermatol Venereol*. 2018 Sep;32(9):1507-1514.
12. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
13. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
14. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
15. McInnes IB, et al. Secukinumab, a human anti-interleukin-17A monoclonal antibody, in patients with psoriatic arthritis (FUTURE 2): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2015;386(9999):1137-1146.
16. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of Psoriatic Arthritis. *Arthritis Rheumatol*. 2019 Jan;71(1):5-32.
17. Mease PJ, et al. Secukinumab Provides Sustained Improvements in the Signs and Symptoms of Active Psoriatic Arthritis through 3 Years: Efficacy and Safety Results from a Phase 3 Trial. *Ann Rheum Dis*. 2017;76:952-953.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Crysvita (burosumab-twza)
BILLING CODE	J0584
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "dosage allowed" sections

Crysvita (burosumab-twza) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

X-LINKED HYPOPHOSPHATEMIA (XLH)

For **initial** authorization:

1. Member is 6 months old or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist, nephrologist, or rheumatologist; AND
3. Member has a diagnosis of XLH confirmed by **at least one** of the following:
   a) PHEX (Phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation per genetic testing;
   b) Family history positive for XLH (first-degree relative);
   c) Elevated plasma levels of intact fibroblast growth factor 23 (FGF23); AND
4. Lab results show fasting serum phosphorus level BELOW the reference range for age; AND
5. Member has chart notes documenting the following:
   a) Pediatric: Radiographic evidence of active bone disease including rickets and/or lower extremity bowing;
   b) Adult: Persistent bone and/or joint pain due to XLH and/or osteomalacia that limits daily activities; pseudofractures or osteomalacia-related fractures; AND
6. Member is refractory to or develops complications from conventional treatment with phosphate and active vitamin D (e.g., calcitriol, paricalcitol, doxercalciferol, calcifediol); AND
7. Member does not have ANY of the following:
   a) Concurrent use of oral phosphate and active vitamin D analogs;
   b) Severe renal impairment or ESRD.
8. **Dosage allowed:** Adult XLH (18 years of age and older): 1 mg/kg to the nearest 10 mg up to a maximum dose of 90 mg subQ every four weeks.

   Pediatric XLH (6 months to 17 years): For members who weigh < 10 kg, starting dose is 1 mg/kg to the nearest 1 mg, subQ every two weeks. For members who weigh 10 kg or greater, starting dose is 0.8 mg/kg to the nearest 10 mg, subQ every two weeks. The minimum starting dose is 10 mg up to a maximum dose of 90 mg.
   Dose may be increased up to approximately 2 mg/kg (maximum 90 mg), every two weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Lab results show an improved serum phosphorus level compared to baseline; AND
2. Chart notes have been provided that show the member has improvement of signs and symptoms of disease (e.g. severity of rickets, linear growth, reduced pain/stiffness, fracture healing, physical function [6MWT]); AND
3. Member is not taking oral phosphate or active vitamin D analogs; AND
4. Member does not have severe renal impairment or ESRD.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

TUMOR-INDUCED OSTEOMALACIA (TIO)

For **initial** authorization:
1. Member is 2 years old or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist, nephrologist, or rheumatologist; AND
3. Member has chart notes showing a diagnosis of FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO); AND
4. The tumor is not amenable to surgical excision or cannot be located; AND
5. Chart notes show elevated fibroblast growth factor 23 (FGF23); AND
6. Lab results show fasting serum phosphorus level BELOW the reference range for age; AND
7. Member does not have ANY of the following:
   a) Concurrent use of oral phosphate and active vitamin D analogs (eg, calcitriol, paricalcitol, doxercalciferol, calcifediol);
   b) Severe renal impairment or ESRD.
8. **Dosage allowed:** See package insert for titration details. Adult= Starting dosage: 0.5 mg/kg, rounded to nearest 10 mg, up to a max of 180mg subQ every 4 weeks; Maximum dosage: 2 mg/kg not to exceed 180 mg every 2 weeks. Pediatric= Starting dosage: 0.4 mg/kg, rounded to nearest 10 mg, up to 180mg subQ every 2 weeks; Maximum dosage: 2 mg/kg not to exceed 180 mg every 2 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Lab results show an improved serum phosphorus level compared to baseline; AND
2. Chart notes demonstrate improvement of signs and symptoms of disease compared to baseline (e.g. bone pain, muscle weakness, fractures); AND
3. Member is not taking oral phosphate or active vitamin D analogs; AND
4. Member does not have severe renal impairment or ESRD.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Crysvita (burosumab-twza) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/16/2018	New policy for Crysvita created.
09/26/2019	Kainos assay requirement for XLH diagnosis was removed. RSS score requirement was replaced with clinical finding requirement. Criteria about HIV presence, presence of hypocalcemia or hypercalcemia were removed.
09/21/2020	Added criteria for new indication of TIO. Revised XLH criteria: added rheumatology as an acceptable specialist, edited diagnostic confirmation to match clinical guideline by Haffner et al (added FGF23),

	simplified/summarized the section on radiologic and clinical findings, added trial of conventional therapy per guideline, changed exclusions to match TIO section, simplified and made slight correction to dosing, changed initial auth duration to be 6 months, modified the re-auth criteria to more closely match TIO.

References:

1. Crysvita [package insert]. Novato, CA: Ultragenyx Pharmaceutical Inc.; June 2020.
2. ClinicalTrials.gov. Identifier: NCT 02163577. Study of KRN23, a Recombinant Fully Human Monoclonal Antibody Against FGF23, in Pediatric Subjects With X-linked Hypophosphatemia (XLH). Available at: https://clinicaltrials.gov/ct2/show/NCT02163577?term=02163577&rank=1.
3. ClinicalTrials.gov. Identifier: NCT 02750618. Study of the Safety, Pharmacodynamics (PD) and Efficacy of KRN23 in Children From 1 to 4 Years Old With X-linked Hypophosphatemia (XLH). Available at: https://clinicaltrials.gov/ct2/show/NCT02750618?term=02750618&rank=1.
4. ClinicalTrials.gov. Identifier: NCT 02526160. Study of KRN23 in Adults With X-linked Hypophosphatemia (XLH). Available at: https://clinicaltrials.gov/ct2/show/NCT02526160?term=02526160&rank=1.
5. ClinicalTrials.gov. Identifier: NCT 02537431. Open Label Study of KRN23 on Osteomalacia in Adults With X-linked Hypophosphatemia (XLH). Available at: https://clinicaltrials.gov/ct2/show/NCT02537431?term=02537431&rank=1.
6. Carpenter TO, Whyte MP, Imel EA, et al. Burosumab Therapy in Children with X-Linked Hypophosphatemia. N Engl J Med 2018; 378:1987-1998. DOI: 10.1056/NEJMoa1714641.
7. Linglart A, Biosse-Duplan M, Briot K, et al. Therapeutic management of hypophosphatemic rickets from infancy to adulthood. Endocr Connect. 2014;3(1):R13-R30. doi:10.1530/EC-13-0103
8. Carpenter TO. New perspectives on the biology and treatment of X-linked hypophosphatemic rickets. [Review] [109 refs]. Pediatr Clin North Am. 1997;44(2):443-466.
9. Foster BL, Ramnitz MS, Gafni RI, et al. Rare Bone Diseases and Their Dental, Oral, and Craniofacial Manifestations. J Dent Res. 2014;93(7):7S-19S. doi:10.1177/0022034514529150
10. Linglart A, Dvorak-Ewell M, Marshall A, Martin JS, Skrinar A. Impaired mobility and pain significantly impact the quality of life of children with X-linked hypophosphatemia (XLH). Int Conf Child Bone Heal. 2015:P198. doi:10.1530/boneabs.4.P198
11. Skrinar A, Marshall A, Martin JS, Dvorak-Ewell M. X-Linked hypophosphatemia (XLH) impairs skeletal health outcomes and physical function in affected adults. Endocr Soc Meet. 2015:SAT-244. doi:doi:10.1210/endo-meetings.2015.BCHVD.11.SAT-244
12. Veilleux LN, Cheung M, Amor M Ben, Rauch F. Abnormalities in muscle density and muscle function in hypophosphatemic rickets. J Clin Endocrinol Metab. 2012;97(8). doi:10.1210/jc.2012-1336
13. Looser zones. Radiopaedia Website. https://radiopaedia.org/articles/looser-zones-1. Accessed October 9, 2017.
14. Ultragenyx Pharmaceutical Inc. UX023-CL201. Study of KRN23, a Recombinant Fully Human Monoclonal Antibody Against Fibroblast Growth Factor 23 (FGF23), in Pediatric Subjects With X-linked Hypophosphatemia (XLH) [NCT02163577]. https://clinicaltrials.gov/ct2/show/NCT02163577.
15. Ultragenyx Pharmaceutical Inc. UX023-CL301. Efficacy and Safety of KRN23 Versus Oral Phosphate and Active Vitamin D Treatment in Pediatric Patients With X Linked Hypophosphatemia (XLH) [NCT02915705]. https://clinicaltrials.gov/ct2/show/NCT02915705.
16. Beck-Nielsen SS, Mughal Z, Haffner D, et al. FGF23 and its role in X-linked hypophosphatemia-related morbidity. Orphanet J Rare Dis. 2019;14(1):58. doi:10.1186/s13023-019-1014-8.
17. Linglart A, Biosse-Duplan M, Briot K, et al. Therapeutic management of hypophosphatemic rickets from infancy to adulthood. Endocr Connect. 2014;3(1). doi:10.1530/EC-13-0103.
18. FDA approval documentation. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/nda/2018/761068Orig1s000MultidisciplineR.pdf. Accessed 11/16/19.
19. Study of Burosumab (KRN23) in Adults With Tumor-Induced Osteomalacia (TIO) or Epidermal Nevus Syndrome (ENS). Clinicaltrials.gov identifier: NCT02304367. Updated August 10, 2020. Accessed September 21, 2020. https://www.clinicaltrials.gov/ct2/show/NCT02304367.
20. A Study of KRN23 in Subjects With Tumor-Induced Osteomalacia or Epidermal Nevus Syndrome. Clinicaltrials.gov identifier: NCT02722798. Updated September 3, 2020. Accessed September 21, 2020. https://clinicaltrials.gov/ct2/show/NCT02722798.
21. Oncogenic osteomalacia. Genetic and Rare Diseases Information Center. https://rarediseases.info.nih.gov/diseases/9652/tumor-induced-osteomalacia. Published October 19, 2017. Accessed September 22, 2020.

22. Zuo QY, Wang H, Li W, et al. Treatment and outcomes of tumor-induced osteomalacia associated with phosphaturic mesenchymal tumors: retrospective review of 12 patients. *BMC Musculoskelet Disord*. 2017;18(1):403. Published 2017 Sep 21. doi:10.1186/s12891-017-1756-1
23. Ruppe MD. X-Linked Hypophosphatemia. 2012 Feb 9 [Updated 2017 Apr 13]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2020. Available from: https://www.ncbi.nlm.nih.gov/books/NBK83985/
24. Whyte MP, Carpenter TO, Gottesman GS, et al. Efficacy and safety of burosumab in children aged 1-4 years with X-linked hypophosphataemia: a multicentre, open-label, phase 2 trial. *Lancet Diabetes Endocrinol*. 2019;7(3):189-199. doi:10.1016/S2213-8587(18)30338-3
25. Portale AA, Carpenter TO, Brandi ML, et al. Continued Beneficial Effects of Burosumab in Adults with X-Linked Hypophosphatemia: Results from a 24-Week Treatment Continuation Period After a 24-Week Double-Blind Placebo-Controlled Period. *Calcif Tissue Int*. 2019;105(3):271-284. doi:10.1007/s00223-019-00568-3
26. Insogna KL, Briot K, Imel EA, et al. A Randomized, Double-Blind, Placebo-Controlled, Phase 3 Trial Evaluating the Efficacy of Burosumab, an Anti-FGF23 Antibody, in Adults With X-Linked Hypophosphatemia: Week 24 Primary Analysis. *J Bone Miner Res*. 2018;33(8):1383-1393. doi:10.1002/jbmr.3475
27. Imel EA, Glorieux FH, Whyte MP, et al. Burosumab versus conventional therapy in children with X-linked hypophosphataemia: a randomised, active-controlled, open-label, phase 3 trial [published correction appears in *Lancet*. 2019 Jul 13;394(10193):120]. *Lancet*. 2019;393(10189):2416-2427. doi:10.1016/S0140-6736(19)30654-3
28. Haffner D, Emma F, Eastwood DM, et al. Clinical practice recommendations for the diagnosis and management of X-linked hypophosphataemia. *Nature Reviews Nephrology*. 2019;15(7):435-455. doi:10.1038/s41581-019-s0152-5

Effective date: 10/1/2021
Revised date: 09/21/2020

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Procysbi and Cystagon (cysteamine bitartrate); Cystaran and Cystadrops (cysteamine hydrochloride solution)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Products) QUANTITY LIMIT— See "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Procysbi and Cystagon (cysteamine bitartrate), Cystaran and Cystadrops (cysteamine hydrochloride solution) are **non-preferred** products and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NEPHROPATHIC CYSTINOSIS (Procysbi or Cystagon)

For **initial** authorization:

1. Member must be 1 year of age or older if the request is for Procysbi (no limit for Cystagon); AND
2. Medication must be prescribed by or in consultation with a nephrologist; AND
3. Member has a diagnosis of nephropathic cystinosis confirmed by an elevated WBC cystine concentration greater than 2 nmol ½ cystine/mg protein (lab report must include reference values) AND at least **one** of the following:
   a) CTNS gene mutation;
   b) Presence of corneal crystals, as shown by slit lamp exam performed by an ophthalmologist; AND
4. If the request is for Procysbi, all the following must also be documented in the chart notes:
   a) Inability to reach target cystine level despite a minimum of 6 months of compliant therapy with Cystagon at max dose (or highest tolerated dose);
   b) If requesting switch from Cystagon due to intolerance, member must first attempt to temporarily stop therapy, then re-initiate at a lower dose and gradually increase to the proper dose;[2]
   c) If requesting switch from Cystagon due to GI side effects, member must also try taking with a proton pump inhibitor (e.g. omeprazole), in addition to attempting dose adjustment;
   d) NOTE: Any other rationale for switching from Cystagon (aside from inefficacy or intolerance) will be considered on a case by case basis. In general, CareSource does not recognize frequency of dosing or lack of adherence as being indicative of medical necessity.
5. **Dosage allowed:** Refer to product label for initiation, titration, and adjustment. The max dose is 1.95g/m^2/day.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Lab report showing stabilized or decreased cystine levels from baseline; AND
2. Chart notes showing stabilized or improved signs and symptoms of disease or slowed progression.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CYSTINOSIS (Cystaran or Cystadrops)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a nephrologist or ophthalmologist; AND
2. Member has a diagnosis of cystinosis confirmed by an elevated WBC cystine concentration 1 nmol ½ cystine/mg protein or greater; AND
3. Presence of corneal crystal deposits as evidenced by slit lamp exam.
4. **Dosage allowed:** 1 drop in each eye, every waking hour; (up to 4 times a day for Cystadrops).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes have been provided that show improvement of signs and symptoms of disease (e.g. reduction of corneal cystine crystal accumulation, decreased severity of photophobia).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Procysbi and Cystagon (cysteamine bitartrate), Cystaran and Cystadrops (cysteamine hydrochloride solution) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/07/2020	New policy for Procysbi and Cystagon (cysteamine bitartrate), Cystaran and Cystadrops (cysteamine hydrochloride solution) created.
09/16/2021	Annual review, no changes

References:

1. Procysbi (cysteamine bitartrate) [package insert]. Lake Forest, IL: Horizon Therapeutics USA, Inc.; 2020.
2. Cystagon (cysteamine bitartrate) [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc; 2019.
3. Wilmer MJ, Schoeber JP, van den Heuvel LP, Levtchenko EN. Cystinosis: practical tools for diagnosis and treatment. *Pediatr Nephrol*. 2011;26(2):205-215. doi:10.1007/s00467-010-1627-6
4. Elmonem MA, Veys KR, Soliman NA, Dyck MV, Heuvel LPVD, Levtchenko E. Cystinosis: a review. *Orphanet Journal of Rare Diseases*. April 2016. doi:10.1186/s13023-016-0426-y
5. Bäumner S, Weber LT. Nephropathic Cystinosis: Symptoms, Treatment, and Perspectives of a Systemic Disease. *Front Pediatr*. 2018;6:58. Published 2018 Mar 14. doi:10.3389/fped.2018.00058
6. Ahlenstiel-Grunow T, Kanzelmeyer NK, Froede K, et al. Switching from immediate- to extended-release cysteamine in nephropathic cystinosis patients: a retrospective real-life single-center study. *Pediatric Nephrology*. 2016;32(1):91-97. doi:10.1007/s00467-016-3438-x
7. Bäumner S, Weber LT. Conversion from immediate- to extended-release cysteamine may decrease disease control and increase additional side effects. *Pediatric Nephrology*. 2017;32(7):1281-1282. doi:10.1007/s00467-017-3618-3
8. Emma F, Nesterova G, Langman C, et al. Nephropathic cystinosis: an international consensus document. *Nephrol Dial Transplant*. 2014;29 Suppl 4(Suppl 4):iv87-iv94. doi:10.1093/ndt/gfu090

9. Nesterova G, Gahl WA. Cystinosis. 2001 Mar 22 [Updated 2017 Dec 7]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2020. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1400/
10. Cystaran (cysteamine hydrochloride solution) [package insert]. Gaithersburg, MD: Leadiant Biosciences, Inc.; 2020.
11. Cystadrops (cysteamine hydrochloride solution) [package insert]. Lebanon, NJ: Recordati Rare Diseases Inc.; 2020.
12. Kaur S, Sarma P, Kaur H, et al. Efficacy and safety of topical cysteamine in corneal cystinosis: a systematic review and meta- analysis. *American Journal of Ophthalmology*. September 2020. doi:10.1016/j.ajo.2020.07.052
13. Biswas S, Gaviria M, Malheiro L, Marques JP, Giordano V, Liang H. Latest Clinical Approaches in the Ocular Management of Cystinosis: A Review of Current Practice and Opinion from the Ophthalmology Cystinosis Forum. *Ophthalmol Ther*. 2018;7(2):307-322. doi:10.1007/s40123-018-0146-6.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Daklinza (daclatasvir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Mavyret and Sofosbuvir/velpatasvir (generic for Epclusa) QUANTITY LIMIT— 28 for a 28 day supply
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Daklinza (daclatasvir) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEPATITIS C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A))

For **initial** authorization:

1. Member is treatment-naïve or treatment-experienced, without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
2. Member must be 18 years of age or older; AND
3. Member has genotype 1 or 3 (laboratory documentation required); AND
4. Member will be prescribed Daklinza in combination with Sovaldi (prior authorization required); AND
5. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
6. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
7. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
8. Member does not have moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C); AND
9. Member has tried and failed course of treatment with Sofosbuvir/velpatasvir (generic for Epclusa) and with Mavyret (Dates and HCV RNA values must be documented in chart notes); AND
10. Member must have evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless one of the following (fibrosis stage F0-4 covered):
    a) Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
    b) Post liver transplantation;
    c) Extrahepatic disease (i.e., kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
    d) HIV or HBV coinfection.
11. **Dosage allowed:** Daklinza one tablet taken orally once daily for 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:
1. Daklinza will not be reauthorized for continued therapy.

CareSource considers Daklinza (daclatasvir) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
12/17/2018	New policy for Daklinza created. Criteria written based Ohio Department of Medicaid requirements.
05/01/2019	Sofosbuvir/velpatasvir (generic for Epclusa) trial added.
03/11/2021	Annual review, no changes

References:

1. Daklinza [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; November, 2017.
2. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
3. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Diacomit (stiripentol)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Diacomit (stiripentol) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DRAVET SYNDROME

For **initial** authorization:

1. Member is 2 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Medication must be used for the treatment of seizures associated with Dravet syndrome; AND
4. Member's weight must be documented in chart notes for dosing; AND
5. Chart notes must document the member's seizure frequency on current treatment; AND
6. The member has tried and failed, or has contraindication to, valproic acid and clobazam[9,10]; AND
7. Diacomit will be taken in combination with clobazam.
8. **Dosage allowed:** 50 mg/kg/day, in divided doses. Capsule or powder for oral suspension (250 mg and 500 mg strengths) available. Max recommended dose is 3,000mg per day.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has decrease in frequency of seizures.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Diacomit (stiripentol) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/28/2019	New policy for Diacomit created.
07/24/2020	Removed requirement for minimum number of seizures. Edited how the specialist requirement is worded. Added max dose. Changed drug trials to match treatment guidelines. Specified concomitant use. Added that chart notes must include weight and baseline seizure frequency.
09/16/2021	Annual review, no changes

References:

1. Diacomit [prescribing information]. Beauvais, France: BIOCODEX; August 2018.
2. ClinicalTrials.gov Identifier: NCT02607904. An Open-label Extension Trial to Investigate Possible Drug-drug Interactions Between Stiripentol or Valproate and Cannabidiol in Patients With Epilepsy. Available at: https://clinicaltrials.gov/ct2/show/NCT02607904?term=stiripentol&recrs=e&draw=1&rank=2.
3. ClinicalTrials.gov Identifier: NCT02607891. A Study of Possible Drug-drug Interactions Between Stiripentol or Valproate and Cannabidiol in Patients With Epilepsy. Available at: https://clinicaltrials.gov/ct2/show/NCT02607891?term=stiripentol&recrs=e&draw=1&rank=1.
4. Kossoff E. Stiripentol for dravet syndrome: is it worth it?. Epilepsy Curr. 2014;14(1):22–23. doi:10.5698/1535-7597-14.1.22.
5. Rosati A, Boncristiano A, Doccini V, et al. Long-term efficacy of add-on stiripentol treatment in children, adolescents, and young adults with refractory epilepsies: A single center prospective observational study. Epilepsia. 2019 Oct 20. doi: 10.1111/epi.16363.
6. Frampton JE, et al. Stiripentol: A Review in Dravet Syndrome. Drugs. 2019) 1-12.
7. Myers, Kenneth A., et al. Stiripentol efficacy and safety in Dravet syndrome: a 12-year observational study. *Developmental Medicine & Child Neurology.* 60.6 (2018): 574-578.
8. Nickels KC, et al. Stiripentol in the management of epilepsy. CNS drugs. 31.5 (2017): 405-416.
9. Wirrell EC, Laux L, Donner E, et al. Optimizing the Diagnosis and Management of Dravet Syndrome: Recommendations From a North American Consensus Panel. *Pediatric Neurology*. 2017;68:18-34. doi:10.1016/j.pediatrneurol.2017.01.025
10. Knupp KG, Wirrell EC. Treatment Strategies for Dravet Syndrome [published correction appears in CNS Drugs. 2018 Aug;32(8):783. Abstract corrected]. *CNS Drugs*. 2018;32(4):335-350. doi:10.1007/s40263-018-0511-y

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Dojolvi (triheptanoin)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Dojolvi (triheptanoin) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

LONG-CHAIN FATTY ACID OXIDATION DISORDERS (LC-FAOD)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a physician specializing in genetic metabolic disorders; AND
2. Chart notes must show the member has a molecularly confirmed diagnosis of an LC-FAOD (examples include: Very long-chain acylCoA dehydrogenase (VLCAD) Deficiency, Carnitine Palmitoyltransferase 2 (CPT2) Deficiency, Mitochondrial Trifunctional Protein (TFP) Deficiency, Long-chain 3 hydroxyacylCoA dehydrogenase (LCHAD) deficiency); AND
3. Member is symptomatic despite dietary management (e.g. a low-fat diet) and medium-chain triglyceride (MCT) oil for at least 90 days, unless contraindicated; AND
4. Member does not have pancreatic insufficiency; AND
5. Member will discontinue any other medium-chain triglyceride products before starting Dojolvi.
6. **Dosage allowed:** See package insert for titration details and equation for dose calculations based on individual's daily caloric intake (DCI). Increase up to a total daily dose of 35% DCI.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement per 1 or more of the following parameters:
   a) Reduced frequency or severity of major clinical events related to hypoglycemia, cardiomyopathy, and/or rhabdomyolysis.
   b) Increased endurance and/or exercise tolerance (e.g. 6-minute walk test).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Dojolvi (triheptanoin) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/25/2020	New policy for Dojolvi created.

11/17/2021	Annual review, no changes

References:

1. Dojolvi (triheptanoin) [package insert]. Novato, CA: Ultragenyx Pharmaceutical Inc.; 2020.
2. Vockley J, Burton B, Berry G, et al. UX007 for the treatment of long chain-fatty acid oxidation disorders: Safety and efficacy in children and adults following 24 weeks of treatment. *Molecular Genetics and Metabolism*. 2017;120(4):370-377. doi:10.1016/j.ymgme.2017.02.005
3. Vockley J, Burton B, Berry GT, et al. Results from a 78-week, single-arm, open-label phase 2 study to evaluate UX007 in pediatric and adult patients with severe long-chain fatty acid oxidation disorders (LC-FAOD). *J Inherit Metab Dis*. 2019;42(1):169-177. doi:10.1002/jimd.12038
4. Gillingham MB, Heitner SB, Martin J, et al. Triheptanoin versus trioctanoin for long-chain fatty acid oxidation disorders: a double blinded, randomized controlled trial. *J Inherit Metab Dis*. 2017;40(6):831-843. doi:10.1007/s10545-017-0085-8
5. Knottnerus SJG, Bleeker JC, Wüst RCI, et al. Disorders of mitochondrial long-chain fatty acid oxidation and the carnitine shuttle. *Rev Endocr Metab Disord*. 2018;19(1):93-106. doi:10.1007/s11154-018-9448-1
6. Merritt JL 2nd, Norris M, Kanungo S. Fatty acid oxidation disorders. *Ann Transl Med*. 2018;6(24):473. doi:10.21037/atm.2018.10.57
7. Merritt JL, Macleod E, Jurecka A, Hainline B. Clinical manifestations and management of fatty acid oxidation disorders. *Reviews in Endocrine and Metabolic Disorders*. July 2020. doi:10.1007/s11154-020-09568-3
8. Vockley J, Burton B, Berry G, et al. Effects of triheptanoin (UX007) in patients with long-chain fatty acid oxidation disorders: Results from an open-label, long-term extension study. *J Inherit Metab Dis*. September 2020. doi:10.1002/jimd.12313

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Doptelet (avatrombopag)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include Promacta QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Doptelet (avatrombopag) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

IMMUNE THROMBOCYTOPENIC PURPURA (ITP)

For **initial** authorization:

1. Member is 18 year of age or older; AND
2. Member has a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) with an insufficient response to a previous treatment; AND
3. Medication must be prescribed by or in consultation with a hematologist; AND
   Member has ONE of the following conditions:
   a) Current platelet count is < 30 $x10^9$/L;
   b) 30 $x10^9$/L to 50 $x10^9$/L with one of the following:
      i) Symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma);
      ii) Have risk factors for bleeding (i.e., on anticoagulant, lifestyle that predisposes member to trauma, comorbidity such as peptic ulcer disease, undergoing medical procedure where blood loss is anticipated); AND
4. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with ONE of the following treatments:
   a) Corticosteroids (prednisone, prednisolone, methylprednisolone, and dexamethasone);
   b) Immunoglobulins;
   c) Splenectomy;
   d) Other medications: cyclosporine A, mycophenolate mofetil, azathioprine, danazol, cyclophosphamide and/or rituximab.
5. **Dosage allowed:** 20 mg (1 tablet) once daily. Adjust the dose or frequency of dosing to maintain platelet count greater than or equal to 50 $x10^9$/L. Do not exceed 40 mg per day.

Note: Discontinue Doptelet if the platelet count does not increase to greater than or equal to 50 $x10^9$/L after 4 weeks of dosing at the maximum dose of 40 mg once daily. Discontinue Doptelet if the platelet count is greater than 400 $x10^9$/L after 2 weeks of dosing at 20 mg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND

2. Chart notes have been provided that show the member has shown improvement in platelet count from baseline; AND
3. Member's platelet count is less than 200 x 10^9/L.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

THROMBOCYTOPENIA (with chronic liver disease)

For **initial** authorization:

1. Member is 18 years of age or older with diagnosis of thrombocytopenia with chronic liver disease and is scheduled to undergo a procedure; AND
2. Medication must be prescribed by or in consultation with a hematologist; AND
3. Member's platelet count is < 50 x10^9/L; AND
4. Member does **not** have ANY of the following:
   a) Thrombosis;
   b) Hematologic disorders;
   c) Significant cardiovascular disease;
   d) Platelet transfusion or receipt of blood products containing platelets within 7 days (exception packed red blood cells);
   e) Heparin, warfarin, NSAID, aspirin, verapamil, and antiplatelet therapy with ticlopidine, glycoprotein iib/iiia antagonists (e.g., tirofiban), or erythropoietin stimulating agents within 7 days;
   f) Interferon use within 14 days;
   g) Estrogen-containing hormonal contraceptive or hormone replacement therapy use within 30 days;
   h) Advanced hepatocellular carcinoma.
5. **Dosage allowed:** Once daily for 5 consecutive days. Begin Doptelet dosing 10-13 days prior to the scheduled procedure. The recommended daily dose of Doptelet is based on the member's platelet count, if platelet count < 40 x10^9/L – 60 mg (3 tabs) once daily for 5 days, if platelet count 40-50 x10^9/L – 40 mg (2 tabs) once daily for 5 days. Member should undergo their procedure 5 to 8 days after the last dose of Doptelet.

Note: Doptelet will not be approved for more than 5 days of treatment.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:

1. Doptelet will not be reauthorized.

CareSource considers Doptelet (avatrombopag) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Thrombocytopenia due to Myelodysplastic syndrome (MDS)

DATE	ACTION/DESCRIPTION
05/06/2019	New policy for Doptelet created.
07/24/2019	New indication of Immune thrombocytopenia (ITP) added. Status changed to preferred.
11/17/2021	Annual Review, no changes

References:

1. Doptelet [package insert]. Durham, NC: Dova Pharmaceuticals, Inc., June, 2019.

2. Terrault et al. Avatrombopag Before Procedures Reduces Need for Platelet Transfusion in Patients With Chronic Liver Disease and Thrombocytopenia. Gastroenterology 2018;155:705–718.
3. ClinicalTrials.gov. Identifier: NCT01976104. Treatment of Thrombocytopenia in Patients With Chronic Liver Disease Undergoing an Elective Procedure. Available at: https://clinicaltrials.gov/ct2/show/NCT01976104?term=avatrombopag&recrs=e&rank=6.
4. ClinicalTrials.gov. Identifier: NCT01972529. Treatment of Thrombocytopenia in Patients With Chronic Liver Disease Undergoing an Elective Procedure. Available at: https://clinicaltrials.gov/ct2/show/NCT01972529?term=avatrombopag&recrs=e&rank=7.
5. NCCN Guidelines. Myelodysplastic Syndromes. V.1.2019.
6. Jurczak W, et al. Phase 3 randomised study of avatrombopag, a novel thrombopoietin receptor agonist for the treatment of chronic immune thrombocytopenia. Br J Haematol. 2018 Nov;183(3):479-490.
7. ClinicalTrials.gov. Identifier: NCT00441090. Study of AKR-501 Tablets Taken Orally Once Daily for 28 Days in Patients With Chronic Idiopathic Thrombocytopenic Purpura (ITP). Available at: https://clinicaltrials.gov/ct2/show/NCT00441090?term=avatrombopag&rank=8.
8. ClinicalTrials.gov. Identifier: NCT01438840. Efficacy and Safety of Oral E5501 Plus Standard of Care for the Treatment of Thrombocytopenia in Adults With Chronic Immune Thrombocytopenia (Amendment 02). Available at: https://www.clinicaltrials.gov/ct2/show/NCT01438840?term=avatrombopag&recrs=e&rank=8.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Dupixent (dupilumab)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Dupixent was originally approved by the FDA in 2017 for the treatment of moderate to severe atopic dermatitis. Since then, it has also been granted approvals for the treatment of moderate to severe asthma and for chronic rhinosinusitis with nasal polyposis. It is administered by subcutaneous injection.
Dupixent is an interleukin (IL) - 4 receptor alpha antagonist monoclonal antibody. It inhibits the signaling of IL-4 and IL-13 to help combat cytokine-induced inflammatory responses.

Dupixent (dupilumab) will be considered for coverage when the following criteria are met:

Atopic Dermatitis

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by a dermatologist, allergist, or immunologist; AND
3. Member has a documented diagnosis of moderate-to-severe atopic dermatitis; AND
4. Member's atopic dermatitis involves 10% or more of the body surface area (BSA) OR involves highly visible or functional areas (e.g., neck, face, genitals, palms) and is significantly impairing quality of life; AND
5. Member has a documented trial and failure of, intolerance, or contraindication to at least one medium to high potency topical corticosteroid for at least 4 weeks. Note: a topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) or Eucrisa may also be acceptable.
6. Member has documented trial and failure of, intolerance, or contraindication to one of the following:
   a) At least 8 weeks of phototherapy treatment (i.e., UV-A, UV-B, a combination of both, psoralen plus UV-A (PUVA), or UV-B1 (narrow-band UV-B));
   b) At least 12 weeks of one oral immunomodulatory agent (e.g., cyclosporine, methotrexate, azathioprine).
7. **Dosage allowed/Quantity limit:**
   Adults: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg given every other week.
   Pediatrics:

Body Weight	Initial Loading Dose	Subsequent Doses
15 to less than 30 kg	600 mg (two 300 mg injections)	300 mg every 4 weeks (Q4W)
30 to less than 60 kg	400 mg (two 200 mg injections)	200 mg every other week (Q2W)
60 kg or more	600 mg (two 300 mg injections)	300 mg every other week (Q2W)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes demonstrate improvement of signs and symptoms such as fewer flares, less itching/erythema, improved quality of life, etc.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Asthma

For **initial** authorization:
1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist, immunologist or allergist; AND
3. Member has **one** of the following:
   a) Severe eosinophilic asthma including:
      i) Blood eosinophil count of at least 150 cells/μL; AND
      ii) At least two documented severe asthma exacerbations requiring oral corticosteroids (OCS), or at least one requiring hospitalization, within last year; OR
   b) Oral corticosteroid (OCS) dependent asthma; AND
4. Member's asthma has been inadequately controlled after 3 months of conventional treatment on medium to high doses of inhaled corticosteroids (ICS) and long acting beta 2-agonists (LABA); AND
5. Medication is being used as the add-on maintenance treatment to conventional therapies for asthma (i.e., ICS, LABA, etc.); AND
6. Medication is not used in conjunction with any other biologic therapy for asthma.
7. **Dosage allowed/Quantity limit:**
   Adults and adolescents 12 years of age and older:

Initial Loading Dose	Subsequent Dose
400 mg (two 200 mg injections)	200 mg every 2 weeks (Q2W)
or	
600 mg (two 300 mg injections)	300 mg every 2 weeks (Q2W)
Dosage for patients with oral corticosteroid-dependent asthma or with co-morbid moderate-to-severe atopic dermatitis or adults with co-morbid chronic rhinosinusitis with nasal polyposis	
600 mg (two 300 mg injections)	300 mg every 2 weeks (Q2W)

   Pediatric age 6-11 years:

Body Weight	Initial[a] and Subsequent Doses
15 to less than 30 kg	100 mg every other week (Q2W) or 300 mg every four weeks (Q4W)
≥30 kg	200 mg every other week (Q2W)

   *No loading dose for this age group

If all the above requirements are met, the medication will be approved for 16 weeks.

For **reauthorization**:
1. Medication is not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
   a) Decreased frequency of emergency department visits or hospitalizations due to asthma exacerbations; OR
   b) Increase in percent predicted FEV1 from pretreatment baseline; OR
   c) Improved functional ability (i.e., decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
   d) Decreased utilization of rescue medications or oral corticosteroids.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

For **initial** authorization:
1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with allergist, immunologist, or otorhinolaryngologist (ENT); AND
3. Member has a diagnosis of severe CRSwNP with at least two of the following symptoms for 12 weeks or more:
   a) Nasal blockage/obstruction/congestion;
   b) Nasal discharge;
   c) Facial pain/pressure;
   d) Reduction in smell; AND
4. Chart notes must show documentation of bilateral nasal polyps by direct examination, endoscopy, or sinus CT scan; AND
5. Member has symptoms of chronic rhinosinusitis after at least a 4-week trial with an intranasal corticosteroid (e.g., mometasone, fluticasone) in combination with nasal saline irrigation AND ALL of the following:
   a) Prior sinonasal surgery;
   b) Systemic corticosteroids (unless not tolerated or contraindicated); AND
6. Medication is used as an add-on maintenance treatment in combination with intranasal corticosteroid, unless not tolerated or contraindicated; AND
7. Member does not have ANY of the following:
   a) Nasal polyp removal surgery within the past 6 months.
   b) Combination use with Xolair or Nucala;
   c) Allergic Fungal rhinosinusitis (AFRS)
8. **Dosage allowed/Quantity limit:** 300 mg every other week.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Medication is to be used as add-on maintenance therapy in combination with intranasal corticosteroids, unless not tolerated or contraindicated; AND
3. Chart notes have been provided showing improvement of nasal congestion/obstruction symptoms, and/or reduced nasal polyp size.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Dupixent (dupilumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Dupixent created.
05/22/2019	New indication of Moderate-to-Severe Persistent Asthma added. For Atopic Dermatitis: age requirements expanded (covered for 12 years old members and older); topical corticosteroids use required for at least 3 months; clarification on tanning beds for UV exposure entered; step therapy for topical calcineurin inhibitors revised.
10/14/2019	New diagnosis of Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP) was added.
06/05/2020	Age lowered to 6 years old for atopic dermatitis and pediatric dosing table added.
01/12/2021	Persistent Asthma: eosinophil count was updated to be consistent with guidelines; exacerbation number was updated to be consistent with guidelines (2 requiring OCS or 1 requiring hospitalization in the last year); ICS + LTRA treatment removed; requirements despite adherence to therapy removed (i.e. intubation, urgent care visit or hospital admin); changed from not to be used with Nucala, Cinqair, or Fasenra to not to be used with any other asthma biologic. CRSwNP: removed documentation of severity/amount of polyposis; removed "use in the past 2 years" for systemic steroid. Specified 4 weeks of trial for intranasal steroid and added that it must be used with nasal saline. Specified that Dupixent must be used as add-on treatment with intranasal steroid for initial and reauth. Removed list of symptoms of sinusitis. Removed Hep B & C requirement. Specified what improvement looks like for reauth. Reduced the list of exclusion to only ask that member does not have AFRS. Atopic Dermatitis: removed EASI score requirement. Added diagnosis of AD. Added that AD involvement that significantly affects QoL also qualifies for moderate to severe. Reduced topical trials to just one trial of steroid for 4 weeks. Made Eucrisa and TCI optional if member cannot use steroid. Reduced phototherapy trial to 8 weeks. Changed from phototherapy and immunosuppressant to phototherapy OR immunosuppressant. Removed requirement of combination with another biologic. Updated reauth to require specific signs and symptoms of AD improvements. Increased reauth length to 12 months. Updated references.
11/16/2021	Transferred to new template. For asthma, amended minimum age from 12 years to 6 years per recent label update and added dosing information for the new age group.

References:

1. Dupixent [package insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.: October 2021.
2. Atopic dermatitis clinical guideline (2017). In American Academy of Dermatology. Retrieved from https://www.aad.org/practicecenter/quality/clinical-guidelines/atopic-dermatitis.
3. Eichenfield LF, Tom WL, Chamlin SL et al. Guidelines of care for the management of atopic dermatitis: section 1. Diagnosis and assessment of atopic dermatitis. J Am Acad Dermatol. 2014; 70(1):338-51.
4. Eichenfield LF, Tom WL, Berger TG, et al. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. *J Am Acad Dermatol*. 2014;71(1):116-132.
5. Sidbury R, Davis DM, Cohen DE, et al. Guidelines of care for the management of atopic dermatitis: Section 3. Management and treatment with phototherapy and systemic agents. J Am Acad Dermatol. 2014 Aug;71(2):327-49.
6. Deleanu D, Nedelea I. Biological therapies for atopic dermatitis: An update. *Exp Ther Med*. 2019;17(2):1061-1067.
7. Eichenfield LF, Boguniewicz M, Simpson EL, et al. Translating Atopic Dermatitis Management Guidelines Into Practice for Primary Care Providers. *Pediatrics*. 2015;136(3):554-565.

8. Wollenberg A, Beck LA, Blauvelt A, et al. Laboratory safety of dupilumab in moderate-to-severe atopic dermatitis: results from three phase III trials (LIBERTY AD SOLO 1, LIBERTY AD SOLO 2, LIBERTY AD CHRONOS). *Br J Dermatol*. 2020;182(5):1120-1135.
9. Wong ITY, Tsuyuki RT, Cresswell-Melville A, Doiron P, Drucker AM. Guidelines for the management of atopic dermatitis (eczema) for pharmacists. *Can Pharm J (Ott)*. 2017;150(5):285-297.
10. Boguniewicz M, Alexis AF, Beck LA, et al. Expert Perspectives on Management of Moderate-to-Severe Atopic Dermatitis: A Multidisciplinary Consensus Addressing Current and Emerging Therapies. *J Allergy Clin Immunol Pract.* 2017;5(6):1519-1531.
11. Patrizi A, Raone B, Ravaioli GM. Management of atopic dermatitis: safety and efficacy of phototherapy. *Clin Cosmet Investig Dermatol*. 2015;8:511-520.
12. Thaçi D, L Simpson E, Deleuran M, et al. Efficacy and safety of dupilumab monotherapy in adults with moderate-to-severe atopic dermatitis: a pooled analysis of two phase 3 randomized trials (LIBERTY AD SOLO 1 and LIBERTY AD SOLO 2). *J Dermatol Sci*. 2019;94(2):266-275.
13. Simpson EL, Akinlade B, Ardeleanu M. Two Phase 3 Trials of Dupilumab versus Placebo in Atopic Dermatitis. *N Engl J Med*. 2017;376(11):1090-1091.
14. Mayer Knutsen R. Novartis aims to bring first oral asthma drug to market in two decades. Medical Marketing & Media. 2017 Mar 22. http://www. mmm-online.com/pipeline/novartis-nvs-first-to-market-oral-asthma-respiratory-drug-in-two-decades/article/645364.
15. IPD Analytics. New Drug Approval. Dupixent (dupilumab). Available at: http://www.ipdanalytics.com.
16. Difficult-To-Treat & Severe Asthma in Adolescent and Adult Patients: Diagnosis and Management. Global Initiative For Asthma (GINA); Apr. 2019. Available at: https://ginasthma.org/wp-content/uploads/2018/11/GINA-SA-FINAL-wms.pdf
17. 2020 Focused Updates To The Asthma Management Guidelines. National Institute of Health; Dec 2020. Available at: https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates
18. Stevens WW, Schleimer RP, Kern RC. Chronic Rhinosinusitis with Nasal Polyps. *J Allergy Clin Immunol Pract*. 2016;4(4):565-572. doi:10.1016/j.jaip.2016.04.012.
19. Peters AT, Spector S, Hsu J, et al. Diagnosis and management of rhinosinusitis: a practice parameter update. *Ann Allergy Asthma Immunol*. 2014;113(4):347-85. DOI: 10.1016/j.anai.2014.07.025.
20. Sedaghat AR. Chronic rhinosinusitis. *Am Fam Physician*. 2017;96(8):500.506.
21. Ly K, Smith MP, Thibodeaux Q, et al. Dupilumab in patients with chronic hepatitis B on concomitant entecavir. *JAAD Case Rep*. 2019;5(7):624-626. DOI: 10.1016/j.jdcr.2019.05.007.
22. Bachert C, Han JK, Desrosiers M, et al. Efficacy and safety of dupilumab in patients with severe chronic rhinosinusitis with nasal polyps (LIBERTY NP SINUS-24 and LIBERTY NP SINUS-52): results from two multicentre, randomised, double-blind, placebo-controlled, parallel-group phase 3 trials [published correction appears in Lancet. 2019 Nov 2;394(10209):1618]. *Lancet*. 2019;394(10209):1638-1650. doi:10.1016/S0140-6736(19)31881-1.
23. Laidlaw TM, Buchheit KM. Biologics in chronic rhinosinusitis with nasal polyposis. *Ann Allergy Asthma Immunol*. 2020;124(4):326-332. doi:10.1016/j.anai.2019.12.001.
24. Orlandi RR, Kingdom TT, Hwang PH, et al. International consensus statement of allergy and rhinology: rhinosinusitis. *Int Forum Allergy Rhinol*. 2016 Feb;6 Suppl 1:S22-209. doi: 10.1002/alr.21695.
25. Fokkens WJ, Lund V, Bachert C, et al. EUFOREA consensus on biologics for CRSwNP with or without asthma. *Allergy*. 2019 Dec;74(12):2312-2319. doi: 10.1111/all.13875.

Effective date: 04/01/2022
Revised date: 11/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Durolane (sodium hyaluronate)
BILLING CODE	J7318
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include Gelsyn-3, Supartz FX QUANTITY LIMIT— 1 injection (60 mg) = 1 unit
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Durolane (sodium hyaluronate) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions.
7. **Dosage allowed:** Inject 60 mg every 6 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Durolane (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/15/2018	New policy for Durolane created.

References:

1. Durolane [package insert]. Durham, NC: Bioventus LLC; 2017.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
11. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Durysta (bimatoprost intracameral implant)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT—1 implant per eye per lifetime
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Durysta (bimatoprost) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPEN-ANGLE GLAUCOMA (OAG) OR OCULAR HYPERTENSION (OHT)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a diagnosis of OAG or OHT, including documentation of elevated intraocular pressure (IOP); AND
4. Chart notes must document inadequate IOP reduction following trials of no less than 30 days of at least 1 prostaglandin analog eye drop (e.g. latanoprost, travoprost) as monotherapy, and in combination with an eye drop from another drug class (e.g. timolol, brimonidine, dorzolamide); AND
5. Member must not have had prior Durysta administration to the affected eye(s).
6. **Dosage allowed:** 10 mcg per eye.

If member meets all the requirements listed above, the medication will be approved 1 time only. (The approval will be active for 30 days).

For **reauthorization**: Not applicable.

CareSource considers Durysta (bimatoprost) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/10/2020	New policy for Durysta created.

References:

1. Durysta [package insert]. Madison, NJ: Allergan; 2020.
2. Prum BE, Rosenberg LF, Gedde SJ, et al. Primary Open-Angle Glaucoma Preferred Practice Pattern® Guidelines. *Ophthalmology*. 2015;123(1):41-111. doi:10.1016/j.ophtha.2015.10.053
3. Recommendations: Glaucoma: diagnosis and management: Guidance. NICE. https://www.nice.org.uk/guidance/ng81/chapter/Recommendations. Published November 1, 2017. Accessed July 10, 2020.

Effective date: 10/1/2021
Revised date: 07/10/2020

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Dysport (abobotulinumtoxinA)
BILLING CODE	J0586
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office, Outpatient
STATUS	Prior Authorization Required

Dysport is a neurotoxin produced from Clostridium botulinum serotype A. It works through the inhibition of acetylcholine release from peripheral nerve endings, causing neuromuscular blockage and muscle paralysis. Dysport was initially approved by the FDA in 2009 for the treatment of adults with cervical dystonia. Cervical dystonia (also known as spasmodic torticollis) involves the involuntary contractions of the neck that cause abnormal movements and postures of the neck and head. Dysport is the first botulinum toxin approved for both upper and lower spasticity in pediatric patients.

Dysport (abobotulinumtoxinA) will be considered for coverage when the following criteria are met:

CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or other specialist experienced with treating cervical dystonia; AND
3. Member has a documented diagnosis of moderate to severe cervical dystonia as evidenced by involuntary contractions of neck muscles, leading to abnormal movements or postures; AND
4. Symptoms affect quality of life and daily functions.
5. **Dosage allowed:** Up to 1000 units every 12 weeks, divided among affected muscles.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. severity of abnormal head position, neck pain).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SPASTICITY

For **initial** authorization:

1. Member is 2 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or other specialist experienced with treating spasticity (e.g., PM&R); AND
3. Member has a documented diagnosis of upper or lower limb spasticity that affects daily functioning and quality of life; AND

4. Spasticity is secondary to a neurologic condition such as cerebral palsy, stroke, or brain or spinal cord injury; AND
5. Member has tried or is unable to try one conventional treatment modality such as physical therapy or oral medication (e.g. baclofen, tizanidine).
6. **Dosage allowed:** Adult: Not to exceed 1500 total units every 12 weeks (given intramuscularly as a divided dose among affected muscles). Pediatric: Not to exceed 1000 total units or 30 units per kg (whichever is lower) every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. decrease in severity of increased muscle tone).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Dysport (abobotulinumtoxinA) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/06/2018	New policy for Dysport created. Diagnoses of Blepharospasm and Upper extremity dystonia (e.g. writer's cramp) are no longer covered. Diagnoses of Spasticity and Lower Limb spasticity combined, patient weight and age are no longer required. Criterion "no infection at proposed injection site" removed from Cervical Dystonia diagnosis. Age limitation removed from Cervical Dystonia; pain and abnormal head position requirements clarified and medications trial added.
08/17/2020	Cervical dystonia: Added age limit and specialist requirement. Re-worded the diagnosis requirement. Removed trial of oral medication. Removed exclusions. Corrected the dose. Extended re-auth duration. Updated references. Spasticity: Add age and specialist. Update to match latest drug label. Relaxed list of co-existing conditions. Added trial of conventional treatment. Extended initial auth duration. Added reference.
08/10/2021	Transferred to new template. Allowing additional specialists for cervical dystonia and spasticity indications.

References:

1. Dysport [package insert]. Basking Ridge, NJ: Ipsen Biopharmaceuticals, Inc.; 2020.
2. MCG 20th Edition, 2016.
3. U.S. Drug and Food Administration Safety Data. http://www.accessdata.fda.gov/drugsatfda_docs/label/2005/125036s044lbl.pdf (March 6, 2011).
4. Wolters Kluwer. Facts &Comparisons. www.factsandcomparisons.com, 2011. (March 6, 2011).
5. Brashear A, Lew MF, Dykstra DD, et al, "Safety and Efficacy of NeuroBloc (Botulinum Toxin Type B) in Type A-Responsive Cervical Dystonia," Neurology, 1999, 53(7):1439-46.
6. Clinical Use of Botulinum Toxin," Arch Neurol, 1991, 48(12):1294-8.
7. Benecke R, Jost WH, Kanovsky P, et al, "A New Botulinum Toxin Type A Free of Complexing Proteins for Treatment of Dystonia," Neurology, 2005, 64(11):1949-51.
8. Borodic GE and Pearce LB, "New Concepts in Botulinum Toxin Therapy," Drug Saf, 1994, 11(3):145-52. Jankovic J and BrinMF, "Therapeutic Uses of Botulinum Toxin," N Engl J Med,1991, 324(17):1186-94.
9. Naumann M and Jankovic J, "Safety of Botulinum Toxin Type A: A Systematic Review and Meta-Analysis," Curr Med Res Opin, 2004, 20(7):981-90.
10. Russman, BS, Tilton, A, Gormley ME. Jr. Cerebral palsy; a rational approach to a treatment protocol, and the role of botulinum toxin in treatment, Muscle Nerve Suppl 1997; 6:S181.
11. Fishman LM, Anderson C, Rosner B. Botox and physical therapy in the treatment of Piriformis syndrome Am J Phys Med Rehabil. 2002 Dec;81(12):936-42.

12. Assessment: botulinum neurotoxin for the treatment of spasticity (an evidence-based review). Report of the Therapeutics and Technology Assessment Subcommittee of the American Academyof Neurology. http://www.guideline.gov/content.aspx?id=12942(March112011).
13. Simpson DM, et al. Assessment: Botulinum neurotoxin for the treatment of movement disorders (an evidence-based review). Report of the Therapeutics and Technology Subcommittee of the American Academy of Neurology. Neurology. 2008;70(19):1699-706.
14. Neumann M, et al. Assessment: Botulinum neurotoxin in the treatment of autonomic disorders and pain. Report of the Therapeutics and Technology Subcommittee of the American Academy of Neurology. Neurology. 2008; 70:1707-14.
15. Keam SJ, Muir VJ, Deeks ED. Botulinum toxin A (Dysport): in dystonias and focal spasticity. Drugs 2011;71(8):1043-58.
16. Ondo WG, Hunter C, Moore W. A double-blind placebo-controlled trial of botulinum toxin B for sialorrhea in Parkinson's disease. Neurology. 2004;62(1):37-40.
17. Cervical Dystonia. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/cervical-dystonia/. Published July 19, 2019. Accessed July 17, 2020.
18. Simpson DM, Hallett M, Ashman EJ, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache. *Neurology*. 2016;86(19):1818-1826. doi:10.1212/wnl.0000000000002560
19. Dressler D, Altenmueller E, Bhidayasiri R, et al. Strategies for treatment of dystonia. *Journal of Neural Transmission*. 2015;123(3):251-258. doi:10.1007/s00702-015-1453-x
20. Lindsay C, Kouzouna A, Simcox C, Pandyan AD. Pharmacological interventions other than botulinum toxin for spasticity after stroke. Cochrane Database of Systematic Reviews 2016, Issue 10. Art. No.: CD010362. DOI: 10.1002/14651858.CD010362.pub2.

Effective date: 01/01/2022
Revised date: 08/10/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Egrifta SV (tesamorelin)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Tesamorelin is an analog of human growth hormone (GH)-releasing factor, indicated to reduce excess abdominal fat in HIV-infected patients with lipodystrophy. The original formulation, Egrifta, has been replaced with Egrifta SV, a more concentrated product allowing for reduced injection volume. Lipodystrophy can exist as lipoatrophy (loss of subcutaneous fat), lipohypertrophy (fat accumulated as excess visceral adipose tissue), or a mix of both. In contrast, obesity is an increase in subcutaneous fat. Tesamorelin has a weight neutral effect and should not be prescribed for obesity. It has a selective effect to reduce visceral fat but does not reduce subcutaneous fat. Tesamorelin should not be continued beyond 6 months in the absence of treatment response.

Egrifta SV (tesamorelin) will be considered for coverage when the following criteria are met:

Lipodystrophy

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an infectious disease specialist or endocrinologist; AND
3. Member has a diagnosis of HIV-associated lipodystrophy with excess abdominal fat (visceral adipose tissue); AND
4. Member has attempted to switch from taking any causative anti-retroviral drugs (i.e. stavudine, zidovudine) to an alternate regimen, or is unable to switch; AND
5. Medication is not being prescribed for simple obesity or weight loss; AND
6. Member does not have active malignancy.
7. **Dosage allowed/Quantity limit:** 1.4mg subQ once daily

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show there has been a reduction of excess visceral adipose tissue from baseline, as measured by waist circumference.

If all the above requirements are met, the medication will be approved for an additional 1 year.

CareSource considers Egrifta SV (tesamorelin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
12/08/2020	New policy for Egrifta SV created.
03/11/2021	Annual review, no changes

References:

1. Egrifta SV [package insert]. Montreal, Quebec, Canada: Theratechnologies Inc; 2020.
2. Glesby MJ. Treatment of HIV-associated lipodystrophy. UpToDate. https://www-uptodate-com. Updated April 17, 2020. Accessed December 9, 2020.
3. Falutz J, Mamputu JC, Potvin D, et al. Effects of tesamorelin (TH9507), a growth hormone-releasing factor analog, in human immunodeficiency virus-infected patients with excess abdominal fat: a pooled analysis of two multicenter, double-blind placebo-controlled phase 3 trials with safety extension data. *J Clin Endocrinol Metab*. 2010;95(9):4291-4304. doi:10.1210/jc.2010-0490
4. Falutz J, Potvin D, Mamputu JC, et al. Effects of tesamorelin, a growth hormone-releasing factor, in HIV-infected patients with abdominal fat accumulation: a randomized placebo-controlled trial with a safety extension. *J Acquir Immune Defic Syndr*. 2010;53(3):311-322. doi:10.1097/QAI.0b013e3181cbdaff
5. Lake JE, Stanley TL, Apovian CM, et al. Practical Review of Recognition and Management of Obesity and Lipohypertrophy in Human Immunodeficiency Virus Infection [published correction appears in Clin Infect Dis. 2017 Oct 15;65(8):1431-1433]. *Clin Infect Dis*. 2017;64(10):1422-1429. doi:10.1093/cid/cix178
6. 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 12/30/2020.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Elaprase (idursulfase)
BILLING CODE	J1743
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Elaprase is an enzyme replacement therapy that was approved by the FDA in 2006 for the treatment of Mucopolysaccharidosis type II, also known as MPS II or Hunter syndrome. MPS II is a rare, X-linked lysosomal storage disease mostly affecting males, which distinguishes it from the other MPS types which are autosomal recessive. Hunter syndrome can be classified as either severe or attenuated. Pathogenic mutations of the iduronate 2-sulfatase (IDS or I2S) gene cause the enzyme iduronate 2-sulfatase to be deficient or absent. Normally this lysosomal enzyme breaks down glycosaminoglycans (GAGs) (previously known as mucopolysaccharides) but when reduced in MPS II, the GAG substrates heparan sulfate (HS) and dermatan sulfate (DS) accumulate throughout the body causing chronic progressive damage. Elaprase has been shown to improve somatic manifestations but does not impact neurologic symptoms because it does not penetrate the blood-brain barrier. MPS I and II are the MPS types that display both somatic and neurologic symptoms. MPS I progresses faster than MPS II.

Elaprase (idursulfase) will be considered for coverage when the following criteria are met:

Hunter syndrome (Mucopolysaccharidosis II, MPS II)

For **initial** authorization:

1. Member is at least 16 months of age; AND
2. Medication must be prescribed by or in consultation with a geneticist, metabolic specialist, or pediatrician experienced with managing mucopolysaccharidoses; AND
3. Member has a diagnosis of MPS II confirmed by at least one of the following:
   a) Low iduronate 2-sulfatase enzyme activity AND normal activity of a second sulfatase (to exclude Multiple Sulfatase Deficiency), and/or
   b) Molecular genetic testing identifies pathogenic IDS gene mutation; AND
4. Documentation of baseline urinary GAG (uGAG) level; AND
5. Member does NOT have severe neurologic impairment (such as being in a vegetative state or fed by gastrostomy due to inability to swallow).
6. **Dosage allowed/Quantity limit:** 0.5 mg/kg IV infusion once weekly

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as improved functional capacity (e.g., 6-minute walk test, forced vital capacity (FVC)) compared to baseline, reduced liver and spleen volumes, and/or reduced uGAG levels.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Elaprase (idursulfase) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/22/2021	New policy for Elaprase created.

References:

1. Elaprase [package insert]. Lexington, MA: Shire Human Genetic Therapies, Inc.; 2018.
2. da Silva EM, Strufaldi MW, Andriolo RB, Silva LA. Enzyme replacement therapy with idursulfase for mucopolysaccharidosis type II (Hunter syndrome). *Cochrane Database Syst Rev*. 2016;2(2):CD008185. Published 2016 Feb 5. doi:10.1002/14651858.CD008185.pub4
3. Muenzer J, Wraith JE, Beck M, et al. A phase II/III clinical study of enzyme replacement therapy with idursulfase in mucopolysaccharidosis II (Hunter syndrome) [published correction appears in Genet Med. 2006 Sep;8(9):599. Wendt, Suzanne [corrected to Wendt, Susanne]; Puga, Antonio [corrected to Puga, Ana Cristina]; Conway, Ann Marie [corrected to Conway, Anne Marie]]. *Genet Med*. 2006;8(8):465-473. doi:10.1097/01.gim.0000232477.37660.fb
4. Wang RY, Bodamer OA, Watson MS, Wilcox WR; ACMG Work Group on Diagnostic Confirmation of Lysosomal Storage Diseases. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. *Genet Med*. 2011;13(5):457-484. doi:10.1097/GIM.0b013e318211a7e1
5. Giugliani R, Federhen A, Rojas MV, et al. Mucopolysaccharidosis I, II, and VI: Brief review and guidelines for treatment. *Genet Mol Biol*. 2010;33(4):589-604. doi:10.1590/S1415-47572010005000093
6. Scarpa M. Mucopolysaccharidosis Type II. 2007 Nov 6 [Updated 2018 Oct 4]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2021. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1274/
7. Scarpa M, Almássy Z, Beck M, et al. Mucopolysaccharidosis type II: European recommendations for the diagnosis and multidisciplinary management of a rare disease. *Orphanet J Rare Dis*. 2011;6:72. Published 2011 Nov 7. doi:10.1186/1750-1172-6-72
8. Wraith JE, Scarpa M, Beck M, et al. Mucopolysaccharidosis type II (Hunter syndrome): a clinical review and recommendations for treatment in the era of enzyme replacement therapy. *Eur J Pediatr*. 2008;167(3):267-277. doi:10.1007/s00431-007-0635-4
9. Nan H, Park C, Maeng S. Mucopolysaccharidoses I and II: Brief Review of Therapeutic Options and Supportive/Palliative Therapies. *Biomed Res Int*. 2020;2020:2408402. Published 2020 Dec 4. doi:10.1155/2020/2408402
10. Muenzer J, Bodamer O, Burton B, et al. The role of enzyme replacement therapy in severe Hunter syndrome-an expert panel consensus. *Eur J Pediatr*. 2012;171(1):181-188. doi:10.1007/s00431-011-1606-3

Effective date: 01/01/2022
Revised date: 07/22/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Emflaza (deflazacort)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Prednisone QUANTITY LIMIT— 6 mg tablets - 60 per 30 days 18 mg tablets - 30 per 30 days 30 mg tablets - 90 per 30 days 36 mg tablets - 90 per 30 days 22.75 mg/mL suspension – 9 bottles (117 mL) per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Emflaza (deflazacort) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DUCHENNE MUSCULAR DYSTROPHY (DMD)

For **initial** authorization:

1. Member must be 2 years of age or older; AND
2. Medication is being prescribed by or in consultation with a DMD specialist (i.e., neurologist); AND
3. Member has a confirmed diagnosis of Duchenne Muscular Dystrophy (DMD) with evidence of dystrophin gene mutation (genetic testing result required); AND
4. Member has documented trial and failure of prednisone for at least 6 months.
5. **Dosage allowed:** 0.9 mg/kg/day once daily.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes must show stability or slowed rate of decline of the member's motor function and muscle strength.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Emflaza (deflazacort) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/15/2017	New policy for Emflaza created.
07/25/2019	Age coverage expanded from 5 years of age and older to 2 years of age and older.

01/15/2021	Added quantity limit for oral suspension. Removed serum CK requirement. Removed onset of weakness before 5 years of age, added must have genetic testing to confirm dystrophin gene mutation. Removed MRC score requirement in initial and reauth. Added that member must show stability or slowed rate of decline of motor function/muscle strength for reauth.
11/17/2021	Annual review, no changes

References:

1. Emflaza [package insert]. Northbrook, IL; Marathon Pharmaceuticals, LLC: June, 2019.
2. Griggs RC, Miller JP, Greenberg CR, et al. Efficacy and safety of deflazacort vs prednisone and placebo for Duchenne muscular dystrophy. *Neurology*. 2016;87(20):2123-2131.
3. McDonald CM, Henricson EK, Abresch RT, et al. Long-term effects of glucocorticoids on function, quality of life, and survival in patients with Duchenne muscular dystrophy: a prospective cohort study. *Lancet*. 2018;391(10119):451-461.
4. Bello L, Gordish-Dressman H, Morgenroth LP, et al. Prednisone/prednisolone and deflazacort regimens in the CINRG Duchenne Natural History Study. *Neurology*. 2015;85(12):1048-1055.
5. Gloss D, Moxley RT 3rd, Ashwal S, Oskoui M. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(5):465-472.
6. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management [published correction appears in Lancet Neurol. 2018 Apr 4;:]. Lancet Neurol. 2018;17(3):251-267.
7. Ciafaloni E, Kumar A, Liu K, et al. Age at onset of first signs or symptoms predicts age at loss of ambulation in Duchenne and Becker Muscular Dystrophy: Data from the MD STARnet. *J Pediatr Rehabil Med*. 2016;9(1):5-11.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Emgality (galcanezumab-gnlm)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage Allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Emgality (galcanezumab-gnlm) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHRONIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years of age or older with a history of migraine attacks with or without aura; AND
2. Medication is being prescribed for the prevention of chronic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≥ 15 headache days per month for at least 3 months;
   b) ≥ 8 migraine days per month for at least 3 months; AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed 2 quarterly injections (6 months) of onabotulinumtoxinA (Botox); OR
5. Member has tried and failed or unable to tolerate **two** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
6. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
7. Medication is not being used in combination with botulinum toxin therapy or any other prophylactic CGRP product (e.g. Aimovig, Ajovy, or Vyepti); AND
8. Member does **not** have ANY of the following:
   a) Medication overuse headache;
   b) History of hemiplegic headache, ophthalmoplegic migraine, and migraine with brainstem aura (basilar-type migraine);
   c) Member was older than 50 years of age at migraine onset.
9. **Dosage allowed:** Subcutaneously, 240 mg loading dose (administered as two consecutive injections of 120 mg each), followed by monthly doses of 120 mg.

Note: Emgality is considered experimental and investigational as combination therapy with Botox, Ajovy, Aimovig, or Vyepti because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

EPISODIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years of age or older with a history of migraine attacks with or without aura; AND
2. Medication is being prescribed for prevention of episodic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≤ 14 headache days per month for at least 3 months;
   b) 4 or more migraine days per month for at least 3 months that cause significant impairment to quality of life (i.e. requiring bed rest, missed school/work); AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed or unable to tolerate **three** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
5. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month); AND
6. Medication is not being used in combination with botulinum toxin therapy or any other prophylactic CGRP product (e.g. Aimovig, Ajovy, or Vyepti); AND
7. Member does **not** have ANY of the following:
   a) Medication overuse headache;
   b) History of hemiplegic headache, ophthalmoplegic migraine, and migraine with brainstem aura (basilar-type migraine);
   c) Member was older than 50 years of age at migraine onset.
8. **Dosage allowed:** Subcutaneously, 240 mg loading dose (administered as two consecutive injections of 120 mg each), followed by monthly doses of 120 mg.

Note: Emgality is considered experimental and investigational as combination therapy with Botox, Ajovy, Aimovig, or Vyepti because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

2. Member has improvement in prevention of migraines documented in chart notes (e.g., reduced migraine frequency, reduced use of medication for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

EPISODIC CLUSTER HEADACHE TREATMENT (ABORTIVE)

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has documented episodic cluster headache defined as **all** of the following:
   a) At least two cluster periods lasting 7 days to 1 year, separated by pain-free remission periods of at least 3 months;
   b) Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15-180 minutes (when untreated);
   c) Has one headache every other day or up to 8 per day; AND
3. Medication must be prescribed by neurologist or a headache specialist; AND
4. Member has tried and failed or unable to tolerate **two** of the following prophylactic medications for 2 months per trial:
   a) Verapamil
   b) Glucocorticoids (e.g. prednisone) - trial does not need to be 2 months
   c) Anticonvulsant medications (e.g. topiramate or divalproex); AND
5. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options for 2 months per trial: ergotamine, triptans, intranasal lidocaine or capsaicin; AND
6. Medication is not being used in combination with any other prophylactic CGRP product (e.g. Aimovig, Ajovy, or Vyepti).
7. **Dosage allowed:** Administer 300mg (3 injections of 100mg) subcutaneously once per month until cluster period ends.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes have been provided showing a reduction in the number of cluster headache attacks and its severity.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Emgality (galcanezumab-gnlm) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Chronic cluster headache
- Hemiplegic migraine headache

DATE	ACTION/DESCRIPTION
03/05/2019	New policy for Emgality created.
06/05/2020	New diagnoses added: episodic migraine prophylaxis and episodic cluster headache treatment. Pregnancy exclusion was removed. Definition of chronic migraine simplified to just frequency and headache days. Trial of Botox added as an additional option under chronic migraine. CGRP products added as exclusion of concurrent use. Length of prophylactic and abortive trials reduced to 2 months/trial.
09/16/2021	Annual Review, no changes

References:

1. Emgality [package insert]. Indianapolis, IN: Eli Lilly and Company; September, 2018.
2. ICHD-3 The International Classification of Headache Disorders. www.ichd-3.org.

3. Katsarava Z, Buse DC, Manack AN, Lipton RB. Defining the Differences Between Episodic Migraine and Chronic Migraine. Current Pain and Headache Reports. 2012;16(1):86-92. doi:10.1007/s11916-011-0233-z.
4. ClinicalTrials.gov. Identifier: NCT02614183. Evaluation of Galcanezumab in the Prevention of Episodic Migraine- the EVOLVE-1 Study (EVOLVE-1). Available at: https://clinicaltrials.gov/ct2/show/NCT02614183?term=NCT02614183&rank=1.
5. ClinicalTrials.gov. Identifier: NCT02614196. Evaluation of Efficay & Safety of Galcanezumab in the Prevention of Episodic Migraine- the EVOLVE-2 Study (EVOLVE-2). Available at: https://clinicaltrials.gov/ct2/show/NCT02614196?term=NCT02614196&rank=1.
6. Detke HC, et al. Galcanezumab in chronic migraine: The randomized, double-blind, placebo-controlled REGAIN study. Neurology. 2018;91(24):e2211-e2221.
7. Beck E, Sieber WJ, Trejo R. Management of cluster headache. Am Fam Physician. 2005 Feb 15;71(4):717-724.
8. ClinicalTrials.gov. Identifier: NCT02397473. A Study of Galcanezumab in Participants with Episodic Cluster Headache. Available at: https://clinicaltrials.gov/ct2/show/NCT02397473.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Empaveli (pegcetacoplan)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Empaveli is the first and only FDA-approved drug for PNH that controls both intravascular and extravascular hemolysis. In contrast to Soliris and Ultomiris, C5 inhibitors which only impact intravascular hemolysis, Empaveli is a C3 inhibitor. The phase 3 PEGASUS study concluded Empaveli was superior to Soliris in terms of improving hemoglobin levels and freedom from transfusion.
PNH is a hematopoietic stem cell disorder in which activation of the complement system destroys red blood cells because of an acquired mutation in the PIGA gene. Common manifestations can include hemolytic anemia and fatigue. Thrombosis and bone marrow suppression may also occur.

Empaveli (pegcetacoplan) will be considered for coverage when the following criteria are met:

Paroxysmal nocturnal hemoglobinuria (PNH)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a hematologist/oncologist; AND
3. Member has a diagnosis of PNH as confirmed by flow cytometry; AND
4. Member has a lactate dehydrogenase (LDH) level >1.5x upper limit of normal (ULN); AND
5. If member is switching from Soliris, it must be discontinued 4 weeks after starting Empaveli; AND
6. Member has been vaccinated against encapsulated bacteria (Streptococcus pneumoniae, Neisseria meningitidis types A, C, W, Y, and B, and Haemophilus influenzae type B) at least 2 weeks prior to the first dose unless the risks of delaying therapy outweigh the risks of developing a serious infection.
7. **Dosage allowed/Quantity limit:** 1080 mg by subQ infusion twice weekly (via commercially available infusion pump). [QL 8 vials per 28 days]
   Note: May be adjusted to 1080 mg every 3 days if LDH is more than 2x greater than ULN.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Clinical evidence of positive response to therapy such as increased hemoglobin level, decreased need for transfusions, normalized LDH levels, improved fatigue.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Empaveli (pegcetacoplan) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/28/2021	New policy for Empaveli created.

References:

1. Empaveli [package insert]. Waltham, MA: Apellis Pharmaceuticals, Inc.; 2021.
2. Hillmen P, Szer J, Weitz I, et al. Pegcetacoplan versus Eculizumab in Paroxysmal Nocturnal Hemoglobinuria. *N Engl J Med*. 2021;384(11):1028-1037. doi:10.1056/NEJMoa2029073
3. Parker CJ. Update on the diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Hematology Am Soc Hematol Educ Program*. 2016;2016(1):208-216. doi:10.1182/asheducation-2016.1.208
4. Patriquin CJ, Kiss T, Caplan S, et al. How we treat paroxysmal nocturnal hemoglobinuria: A consensus statement of the Canadian PNH Network and review of the national registry. *Eur J Haematol*. 2019;102(1):36-52. doi:10.1111/ejh.13176
5. Devos T, Meers S, Boeckx N, et al. Diagnosis and management of PNH: Review and recommendations from a Belgian expert panel. *Eur J Haematol*. 2018;101(6):737-749. doi:10.1111/ejh.13166

Effective date: 01/01/2022
Revised date: 05/28/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Enbrel (etanercept)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 8 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Enbrel (etanercept) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response.
8. **Dosage allowed:** Inject 50 mg subcutaneously once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (pJIA)

For **initial** authorization:

1. Member must be 2 years of age or older with moderately to severely active pJIA; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had an adequate trial and failure of a non-biologic DMARD (e.g., methotrexate, leflunomide, etc.) for 8 weeks, unless not tolerated or contraindicated.

5. **Dosage allowed:** weight < 63 kg (138 lbs): 0.8 mg/kg once weekly; weight 63 kg (138 lbs) or more: 50 mg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:
1. Member must be 4 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks.
7. **Dosage allowed:**
   a) Adults: 50 mg twice weekly for 3 months then once weekly thereafter.
   b) Pediatrics: weight < 63 kg (138 lbs): 0.8 mg/kg once weekly; weight 63 kg (138 lbs) or more: 50 mg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND

5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life).
6. **Dosage allowed:** 50 mg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:
1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately.
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. **Dosage allowed:** 50 mg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Enbrel (etanercept) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Enbrel created. Policies SRx-0042 and SRx-00423 achieved. For diagnosis of PsO: immunosuppressive drug criterion was separated from phototherapies and topical agents' trials; Psoriasis Area and Severity Index (PASI) score requirement was added; age was adjusted for pediatric indication. For RA: non-biologic DMARDS were listed. List of diagnoses considered not medically necessary was added.
02/26/2019	Pediatric dosing added to PsO indication. Clarifications entered for AS and PsA on NSAIDs trial length. References added. TB test allowed to be done within 12 months prior to

	initiation of therapy; chest x-ray option removed. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate. “Immunosuppressant therapies” changed to “treatment of traditional first-line oral/systemic” therapies. Reauthorization criteria on documented member’s PASI score improvement incorporated into general chart noted documentation requirements.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. JIA: Changed trials to require one non-biologic DMARD. Renamed diagnosis to be polyarticular JIA. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors.
11/17/2021	Annual review, no changes

References:

1. Enbrel [prescribing information]. Thousand Oaks, CA: Immunex Corporation; August, 2020.
2. Lui Y, et al. Etanercept in the treatment of ankylosing spondylitis: A systematic review and metaanalysis. *Exp Ther Med*. 2014 Nov;8(5):1585–1592.
3. Baraliakosm X, et al. Long-term outcome of patients with active ankylosing spondylitis with etanercept-sustained efficacy and safety after seven years. *Arthritis Res Ther*. 2013;15(3):R67.
4. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
5. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
6. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
7. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
8. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guidelines for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care Res* (Hoboken). 2019 Jun;71(6):717-734.
9. Puig L. Etanercept in the treatment of psoriatic arthritis. *Actas Dermosifiliogr*. 2015 May;106(4):252-9.
10. Mease PJ, et al. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blind, randomized, placebo-controlled trial. *Arthritis Rheum*. 2005; 52:3279.
11. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
12. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
13. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
14. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
15. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.

16. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
17. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
18. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
19. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
20. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
21. Zhao S, et al. Etanercept for the treatment of rheumatoid arthritis. *Immunotherapy*. 2018 Feb 27;10(6).
22. Lau AN, et al. Effectiveness Of Etanercept In Elderly Patients With Rheumatoid Arthritis: A Single Center Retrospective Study. *American College of Rheumatology*. Meeting Abstract Number: 1476.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Endothelin Receptor Antagonists for Pulmonary Arterial Hypertension: Letairis (ambrisentan), Opsumit (macitentan), Tracleer (bosentan)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Pulmonary Arterial Hypertension is a rare but serious condition characterized by elevated pulmonary arterial resistance. Letairis, Opsumit and Tracleer are endothelin receptor antagonists approved for the treatment of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1. Letairis is indicated to improve exercise ability and delay clinical worsening in PAH. It can also be used in combination with tadalafil to reduce the risks of disease progression and hospitalization for worsening PAH, and to improve exercise ability. Opsumit is indicated for the treatment of PAH to reduce the risks of disease progression and hospitalization. Tracleer is indicated in adults to improve exercise ability and to decrease clinical worsening for PAH. It can also be used in pediatric patients with idiopathic or congenital PAH to improve pulmonary vascular resistance.

Endothelin Receptor Antagonists will be considered for coverage when the following criteria are met:

Pulmonary Arterial Hypertension [WHO Group 1]

For **initial** authorization:

1. Tracleer: Member is at least three years of age or older;
   Letairis and Opsumit: Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization;
4. Member must have documentation pulmonary arterial pressures are not adequately controlled, confirmed by **one** of the following:
   a) Patient had an acute response to vasodilator testing AND has tried a calcium channel blocker (CCB) for at least 3 months; OR
   b) Patient did not have a response to vasodilator testing; OR
   c) Patient cannot undergo vasodilator testing; OR
   d) Patient cannot take CCB therapy
5. **Dosage allowed/Quantity limit:**
   Opsumit: 10 mg once daily
   Letairis: Initiate treatment at 5 mg once daily; Increase to 10mg once daily every 4 weeks as tolerated;
   Tracleer: **Patients 12 years and older**: Initially 62.5 mg PO BID for 4 weeks, then increased to 125 mg PO BID (maximum 250 mg/day); **Patients 12 years and younger**: initial and maintenance dosing is weight-based:
   ≥ 4-8 kg: 16 mg twice daily
   > 8-16 kg: 32 mg twice daily
   > 16-24 kg: 48 mg twice daily

> 24-40 kg: 64 mg twice daily

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
Endothelin Receptor Antagonists will be reauthorized when chart notes show at least one of the following:
1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in WHO functional class (see appendix)
   b) Stabilization or improvement in 6MWD [6-minute walk distance]
   c) Reduction in PAH-related hospitalizations

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Endothelin Receptor Antagonists not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/15/2011	Pulmonary Arterial Hypertension policy creation.
05/13/2014	Combined all PAH agents into one policy
07/09/2015	Revised guidelines for therapy aligning with CMS
08/18/2015	Revised guidelines to include diagnosis criteria
10/13/2021	Separated PAH agents by drug class; Updated guidelines; Added provider specialty

References:

1. Letairis [package insert]. Foster City, CA: Gilead Sciences, Inc; August 2019
2. Opsumit [package insert]. San Francisco, CA: Actelion Pharmaceuticals US, Inc.; February 2020
3. Tracleer [package insert]. San Francisco, CA: Actelion Pharmaceuticals US, Inc.; May 2019
4. Coons, J.C., Pogue, K., Kolodziej, A.R. et al. Pulmonary Arterial Hypertension: a Pharmacotherapeutic Update. Curr Cardiol Rep. 2019; 21(141)
5. Klinger JR, Elliott CG et al. Therapy for Pulmonary Arterial Hypertension in Adults; Chest Journal. March 2019; 155(3): 565-586
6. Galie N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension: The Joint Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS): Endorsed by: Association for European Paediatric and Congenital Cardiology (AEPC), International Society for Heart and Lung Transplantation (ISHLT). European heart journal. 2016;37(1):67–119

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

World Health Organization Functional Assessment Classification	
Class I	Patients with PAH but without resulting limitation of physical activity. Ordinary physical activity does not cause undue dyspnea, fatigue, chest pain or near syncope.
Class II	Patients with PAH resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity increases dyspnea, fatigue, chest pain, or near syncope.
Class III	Patients with PAH resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity increases dyspnea, fatigue, chest pain, or near syncope.
Class IV	Patients with PAH unable to carry out any physical activity without symptoms. These patients may have signs of right-heart failure. Dyspnea and/or fatigue may even be present at rest. Discomfort is increased by any physical activity.

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Enspryng (satralizumab-mwge)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 1 syringe per 28 days (maintenance)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Enspryng (satralizumab) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of NMOSD and is seropositive for aquaporin-4 (AQP4) IgG antibodies (documentation required); AND
4. Member has had 1 or more relapses within the past year; AND
5. Member has tried and failed at least one of the following for 6 months or longer: azathioprine, mycophenolate, rituximab[2,3,4] (requires prior auth); AND
6. Member has tested negative for hepatitis B and tuberculosis within the past year.
7. **Dosage allowed:** 120mg subQ at weeks 0, 2, and 4, then 120mg every 4 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document disease stabilization, symptom improvement, and/or reduced frequency of relapses.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Enspryng (satralizumab) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/16/2020	New policy for Enspryng created.
11/19/2021	Annual review, no changes

References:

1. Enspryng (satralizumab-mwge) [package insert]. South San Francisco, CA: Genentech, Inc.; 2020.

2. Kessler RA, Mealy MA, Levy M. Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic. *Curr Treat Options Neurol*. 2016;18(1):2. doi:10.1007/s11940-015-0387-9
3. Weinshenker B. Neuromyelitis Optica Spectrum Disorder. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/neuromyelitis-optica/. Published August 25, 2020. Accessed October 2, 2020.
4. Mealy MA, Wingerchuk DM, Palace J, Greenberg BM, Levy M. Comparison of relapse and treatment failure rates among patients with neuromyelitis optica: multicenter study of treatment efficacy. *JAMA Neurol*. 2014;71(3):324-330. doi:10.1001/jamaneurol.2013.5699
5. IPD Analytics. Accessed October 2, 2020.
6. Yamamura T, Kleiter I, Fujihara K, et al. Trial of Satralizumab in Neuromyelitis Optica Spectrum Disorder. *N Engl J Med*. 2019;381(22):2114-2124. doi:10.1056/NEJMoa1901747
7. Traboulsee A, Greenberg BM, Bennett JL, et al. Safety and efficacy of satralizumab monotherapy in neuromyelitis optica spectrum disorder: a randomised, double-blind, multicentre, placebo-controlled phase 3 trial. *Lancet Neurol*. 2020;19(5):402-412. doi:10.1016/S1474-4422(20)30078-8

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Entyvio (vedolizumab)
BILLING CODE	J3380 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product for Crohn's Disease includes Cimzia; for Ulcerative Colitis - Xeljanz QUANTITY LIMIT— 300 units/mg per infusion
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Entyvio (vedolizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 18 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate. Note: Trial is not required if member is switching from another biologic agent; AND
4. Member has tried and failed at least 12 weeks of an anti-TNF agent (e.g., Cimzia, Humira, or Remicade), unless not tolerated or contraindicated.
5. **Dosage allowed:** 300 mg IV infusion at 0, 2, and 6 weeks, and every 8 weeks thereafter.

Note: Therapy should be discontinued in members who show no evidence of therapeutic benefit by week 14.

If member meets all the requirements listed above, the medication will be approved for 4 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:

1. Member is 18 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member must have a documented trial and inadequate response with **one** of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of Corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
4. **Dosage allowed:** 300 mg intravenously at 0, 2, and 6 weeks, then 300 mg intravenously every 8 weeks thereafter.

Note: Therapy should be discontinued in patients who show no evidence of therapeutic benefit by week 14.

If member meets all the requirements listed above, the medication will be approved for 4 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Entyvio (vedolizumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Entyvio created. Policy SRx-0041 archived. For both diagnoses CD and UC: TNF inhibitor Humira was listed as required trial. List of diagnoses considered not medically necessary was added.
02/26/2019	Humira removed from required trials. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Initial authorization length increased to 12 months. Inadequate response to trial agents combined under member's history; CDAI and Mayo scoring requirement added; severity factors for CD removed from requirements.
11/23/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. Removed TB requirements (not necessary for this drug). CD: Removed CDAI score requirement. Specified length of trials for conventional therapies, previously not specified. Added a trial of TNF inhibitor in accordance with guidelines. Reduced initial auth approval to 4 months (must discontinue if no benefit observed after 14 weeks). UC: Removed Mayo score and endoscopy subscore requirements. Specified length of trials for conventional therapies. Reduced initial auth approval to 4 months (must discontinue if no benefit observed after 14 weeks).

References:

1. Entyvio [package insert]. Deerfield, IL: Takeda Pharmaceuticals America, Inc.; March 2020.
2. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
3. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

4. Feagan, BG, Rutgeerts, P, Sands, BE, et al. Vedolizumab as induction and maintenance therapy for ulcerative colitis. *N Engl J Med* 2013; 369:699-710.
5. Sands, BE, Feagan, BG, Rutgeerts, P, et al. Effects of Vedolizumab Induction Therapy for Patients With Crohn's Disease in Whom Tumor Necrosis Factor Antagonist Treatment Had Failed. *Gastroenterology*. 2014 May 21.
6. Sandborn, WJ, Feagan, BG, Rutgeerts, P, et al. Vedolizumab as induction and maintenance therapy for Crohn's disease. *N Engl J Med* 2013; 369(8):711-21.
7. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
8. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
9. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
10. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
11. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
12. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.

Effective date: 04/01/2019
Revised date: 02/26/2019

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	ENZYME REPLACEMENT THERAPY (ERT) FOR GAUCHER DISEASE: Cerezyme (imiglucerase), Elelyso (taliglucerase alfa), Vpriv (velaglucerase alfa)
BILLING CODE	J1786 (Cerezyme); J3060 (Elelyso); J3385 (Vpriv)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Gaucher disease is a rare, inherited, lysosomal storage disorder. In Gaucher disease, mutations of the GBA gene cause deficiency of the enzyme glucocerebrosidase (acid beta-glucosidase), resulting in the accumulation of glucocerebroside (glucosylceramide [GLC]) in the lysosomes of macrophages to form "Gaucher cells," especially in the bone marrow, spleen, and liver. Prominent symptoms include hepatosplenomegaly, anemia, thrombocytopenia, and skeletal problems (e.g., bone pain, osteopenia, osteonecrosis, fracture, deformity).
Type 1 Gaucher disease is the most common form and does not affect the central nervous system. Type 2 and 3 Gaucher disease are characterized by the presence of primary neurologic disease. Type 2 has an onset before age two years and is rapidly progressive with death by age two to four years. Individuals with type 3 often have a more slowly progressive course. Available treatments are indicated for Type 1 Gaucher disease and include enzyme replacement therapy (ERT) or substrate reduction therapy (SRT). Individuals with type 2 Gaucher disease are not likely to respond to ERT or SRT. This policy focuses on ERT.
Cerezyme was the first ERT product approved by the FDA for Gaucher disease, approved in 1994. Notably, Gaucher disease was the first lysosomal storage disorder for which an effective ERT was developed.

Enzyme replacement therapy for Gaucher disease will be considered for coverage when the following criteria are met:

Gaucher Disease

For **initial** authorization:

1. Member meets the labeled age requirement:
   a) Cerezyme: At least 2 years of age
   b) Elelyso: At least 4 years of age
   c) Vpriv: At least 4 years of age; AND
2. Medication must be prescribed by or in consultation with a geneticist, hematologist, or metabolic specialist; AND
3. Member has a diagnosis of Gaucher disease Type 1 or Type 3 confirmed by documentation of at least one of the following:
   a) Reduced activity of glucocerebrosidase via enzyme assay (0 to 15% of normal), and/or
   b) Molecular genetic test documenting mutation of the GBA gene; AND
4. Member has at least one of the following as a result of Gaucher disease:
   a) Anemia
   b) Thrombocytopenia
   c) Bone symptoms
   d) Enlarged spleen or liver; AND

5. Member does NOT have any of the following:
   a) Type 2 Gaucher disease,
   b) Severe or rapidly progressing neurological complications,
   c) Concomitant use of miglustat or eliglustat.
6. **Dosage allowed/Quantity limit:**
   Type 1 Gaucher disease: 60 Units/kg every other week IV infusion
   Type 3 Gaucher disease: Based on clinical literature and physician expertise.

NOTE: Treatment of Type 3 Gaucher disease is off label.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes must show improvement from baseline in at least one of the following signs or symptoms:
   a) Hemoglobin level
   b) Platelet count
   c) Reduced liver and/or spleen volume(s)
   d) Skeletal manifestations (e.g., less bone pain, fewer bone crises, etc.)

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Cerezyme (imiglucerase), Elelyso (taliglucerase alfa), Vpriv (velaglucerase alfa) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/02/2021	New policy for ERT for Gaucher disease created.

References:

1. Cerezyme [package insert]. Cambridge, MA: Genzyme Corporation; Revised 2018.
2. Elelyso [package insert]. NY, NY: Pfizer Inc.; Revised 2021.
3. Vpriv [package insert]. Lexington, MA: Shire Human Genetic Therapies, Inc.; Revised 2020.
4. Martins AM, Valadares ER, Porta G, et al. Recommendations on diagnosis, treatment, and monitoring for Gaucher disease. *J Pediatr*. 2009;155(4 Suppl):S10-S18. doi:10.1016/j.jpeds.2009.07.004
5. Shemesh E, Deroma L, Bembi B, et al. Enzyme replacement and substrate reduction therapy for Gaucher disease. *Cochrane Database Syst Rev*. 2015;(3):CD010324. Published 2015 Mar 27. doi:10.1002/14651858.CD010324.pub2
6. Puri RD, Kapoor S, Kishnani PS, et al. Diagnosis and Management of Gaucher Disease in India - Consensus Guidelines of the Gaucher Disease Task Force of the Society for Indian Academy of Medical Genetics and the Indian Academy of Pediatrics. *Indian Pediatr*. 2018;55(2):143-153.
7. Wang RY, Bodamer OA, Watson MS, Wilcox WR; ACMG Work Group on Diagnostic Confirmation of Lysosomal Storage Diseases. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. *Genet Med*. 2011;13(5):457-484. doi:10.1097/GIM.0b013e318211a7e1
8. Pastores GM, Hughes DA. Gaucher Disease. 2000 Jul 27 [Updated 2018 Jun 21]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2021. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1269/
9. El-Beshlawy A, Tylki-Szymanska A, Vellodi A, et al. Long-term hematological, visceral, and growth outcomes in children with Gaucher disease type 3 treated with imiglucerase in the International Collaborative Gaucher Group Gaucher Registry. *Mol Genet Metab*. 2017;120(1-2):47-56. doi:10.1016/j.ymgme.2016.12.001
10. Mistry PK, Cappellini MD, Lukina E, et al. A reappraisal of Gaucher disease-diagnosis and disease management algorithms. *Am J Hematol*. 2011;86(1):110-115. doi:10.1002/ajh.21888
11. Stone WL, Basit H, Master SR. Gaucher Disease. [Updated 2021 Feb 18]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448080/

12. Stirnemann J, Belmatoug N, Camou F, et al. A Review of Gaucher Disease Pathophysiology, Clinical Presentation and Treatments. *Int J Mol Sci*. 2017;18(2):441. Published 2017 Feb 17. doi:10.3390/ijms18020441
13. Weinreb N, Taylor J, Cox T, Yee J, vom Dahl S. A benchmark analysis of the achievement of therapeutic goals for type 1 Gaucher disease patients treated with imiglucerase. *Am J Hematol*. 2008;83(12):890-895. doi:10.1002/ajh.21280

Effective date: 01/01/2022
Revised date: 08/02/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Epclusa (Sofosbuvir/velpatasvir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Epclusa is indicated for the treatment of adults and pediatric patients 3 years of age and older with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis. It is also indicated for the treatment of adults and pediatric patients 3 years of age and older with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection with decompensated cirrhosis for use in combination with ribavirin.

Epclusa is a fixed-dose combination of sofosbuvir and velpatasvir. Sofosbuvir is a HCV nucleotide analog NS5B polymerase inhibitor that prevents hepatitis C viral replication through RNA chain termination. Velpatasvir prevents viral replication through inhibition of NS5A protein.

Epclusa (Sofosbuvir/velpatasvir) will be considered for coverage when the following criteria are met:

HEPATITIS C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A))

For **initial** authorization:

1. Member is treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
2. Member must be 3 years of age or older;
3. Member has genotype 1, 2, 3, 4, 5 or 6 (laboratory documentation required); AND
4. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists
5. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
6. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required).
7. **Dosage allowed/Quantity limit:** One tablet once daily for 12 weeks.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

Epclusa will be reauthorized when chart notes show at least one of the following:

1. Sofosbuvir/velpatasvir (generic for Epclusa) will not be reauthorized for continued therapy.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Hepatitis C with Decompensated Cirrhosis (Child-Turcotte-Pugh Class B or C)

For **initial** authorization:

1. Member is treatment-naïve or treatment-experienced with decompensated cirrhosis (Child-Turcotte-Pugh Class B or C) who may or may not be a candidate for liver transplantation, including those with hepatocellular carcinoma; AND
2. Member must be 3 years of age or older; AND
3. Member has genotype 1, 2, 3, 4, or 6 (laboratory documentation required); AND
4. Member will be prescribed sofosbuvir/velpatasvir (generic for Epclusa) in combination with ribavirin (if ribavirin ineligible must submit documentation of **one** of the following results obtained within the past month: neutrophils < 750 cells/mm^3; hemoglobin < 10 g/dL; platelets < 50 000 cells/ mm^3; OR documented hypersensitivity to drugs used to treat HCV); AND
5. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
6. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
7. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required).
8. **Dosage allowed/Quantity limit**: One tablet once daily for 12 weeks. If member is ribavirin ineligible and request is for genotype 1, 3, 4 or 6 sofosbuvir/velpatasvir (generic for Epclusa) may be approved for additional 12 weeks, not to exceed the total of 24 weeks treatment duration.

If all the above requirements are met, the medication will be approved for 12 months.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

For **reauthorization**:

Epclusa will be reauthorized when chart notes show at least one of the following:

1. Sofosbuvir/velpatasvir (generic for Epclusa) will not be reauthorized for continued therapy.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Epclusa (sofosbuvir/velpatasvir) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/09/2017	New policy for Epclusa created
06/08/2017	Fibrosis stage 2 and above covered.
11/22/2017	Medication status changed to non-preferred. Substance abuse program information is no longer required. Trial of preferred agent is required for members without cirrhosis or with compensated cirrhosis only
12/07/2017	Criterion of "life expectancy not less than one year due to non-liver related comorbidities" removed from criteria and added in a form of the note. Hepatitis B testing is no longer required.
12/21/2017	Fibrosis score requirement was removed.
05/01/2019	Policy modified to Sofosbuvir/velpatasvir (generic for Epclusa); status changed to preferred product. Trial of Mavyret removed.
04/26/2020	Age requirement criterion changed from 18 years old to 6 years old or weighing 17 kg (37 lbs) for both diagnoses.

11/18/2021	Updated age requirement to 3 years and older; Updated reference section; Transferred to new policy template

References:

1. Epclusa [package insert]. Foster City, CA: Gilead Sciences Inc.; June 2021.
2. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31).
3. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607

Effective date: 04/01/2022
Creation date: 11/18/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Epidiolex (cannabidiol)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— See "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Epidiolex (cannabidiol) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DRAVET SYNDROME

For **initial** authorization:

1. Member is 1 year of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Medication must be used for the treatment of seizures associated with Dravet syndrome; AND
4. Member has serum transaminases (ALT and AST) and total bilirubin baseline levels submitted with prior authorization request prior to starting treatment; AND
5. Member's weight must be documented in chart notes for dosing; AND
6. Chart notes must document the member's seizure frequency on current treatment; AND
7. The member has tried and failed (or has contraindication to) ALL of the following first and second line drugs[8,11] for at least 30 days (alone or in combination):
   a) First line: valproic acid AND clobazam;
   b) Second line: Diacomit (requires prior authorization) OR topiramate.
8. **Dosage allowed:** See package insert for titration schedule.[1] The maximum recommended maintenance dosage is 10 mg/kg twice daily (20 mg/kg/day).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes have been provided that show the member has decrease in frequency of seizures.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

LENNOX-GASTAUT SYNDROME (LGS)

For **initial** authorization:

1. Member is 1 year of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Medication must be used for the treatment of seizures associated with Lennox-Gastaut syndrome; AND
4. Member has serum transaminases (ALT and AST) and total bilirubin baseline levels submitted with prior authorization request prior to starting treatment; AND

5. Chart notes must show trial and failure of at least 2 of the following: valproate, lamotrigine, topiramate, clobazam, felbamate, rufinamide (Banzel).[9,10]
6. **Dosage allowed:** See package insert for titration schedule.[1] The maximum recommended maintenance dosage is 10 mg/kg twice daily (20 mg/kg/day).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes have been provided that show the member has decrease in frequency of seizures.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

TUBEROUS SCLEROSIS COMPLEX (TSC)

For **initial** authorization:

1. Member is 1 year of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Medication is being used for the treatment of seizures associated with TSC; AND
4. Member has serum transaminases (ALT and AST) and total bilirubin baseline levels submitted with prior authorization request prior to starting treatment; AND
5. Chart notes must show trial and failure of at least one first-line antiepileptic drug for TSC-related seizure (variable depending on seizure type).
6. **Dosage allowed:** See package insert for titration schedule.[1] The recommended maintenance dosage is 12.5 mg/kg twice daily (25 mg/kg/day).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes have been provided that show the member has decrease in frequency of seizures.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Epidiolex (cannabidiol) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/31/2018	New policy for Epidiolex created.
08/11/2020	Simplified dosing information. Fixed grammatical errors. Added specialist requirement. Added that they must include weight and baseline/current seizure frequency in chart notes. Removed minimum number of seizures. Changed DS and LGS drug trial criteria to align with clinical literature. Added criteria for new TSC indication. Expanded age approved for DS and LGS.
09/16/2021	Annual Review, no changes

References:

1. Epidiolex [package insert]. Carlsbad, CA: Greenwich Biosciences, Inc.; July 2020.
2. ClinicalTrials.gov Identifier: NCT02091375. Antiepileptic Efficacy Study of GWP42003-P in Children and Young Adults With Dravet Syndrome (GWPCARE1). Available at: https://clinicaltrials.gov/ct2/show/NCT02091375. Accessed on July 26, 2018.
3. ClinicalTrials.gov Identifier: NCT02224560. A Study to Investigate the Efficacy and Safety of Cannabidiol (GWP42003-P; CBD) as Adjunctive Treatment for Seizures Associated With Lennox-Gastaut Syndrome in

Children and Adults (GWPCARE3). Available at: https://clinicaltrials.gov/ct2/show/NCT02224560?term=NCT02224560&rank=1. Accessed on July 26, 2018.
4. ClinicalTrials.gov Identifier: NCT02224690. A Study to Investigate the Efficacy and Safety of Cannabidiol (GWP42003-P; CBD) as Adjunctive Treatment for Seizures Associated With Lennox-Gastaut Syndrome in Children and Adults (GWPCARE4). Available at: https://clinicaltrials.gov/ct2/show/NCT02224690?term=GWPCARE4&cond=Lennox+Gastaut+Syndrome&rank=1. Accessed on July 26, 2018.
5. Devinsky O, Patel AD, Cross JH, et al. Effect of Cannabidiol on Drop Seizures in the Lennox–Gastaut Syndrome. *N Engl J Med* 2018;378:1888-97.
6. Thiele EA, Marsh ED, French JA, et al. Cannabidiol in patients with seizures associated with Lennox-Gastaut syndrome (GWPCARE4): a randomised, double-blind, placebo-controlled phase 3 trial. *The Lancet*. Published online January 24, 2018 http://dx.doi.org/10.1016/S0140-6736(18)30136-3.
7. Devinsky O, Cross JH, et al. Trial of Cannabidiol for Drug-Resistant Seizures in the Dravet Syndrome. N Engl J Med 2017;376:2011-20.
8. Wirrell EC, Laux L, Donner E, et al. Optimizing the Diagnosis and Management of Dravet Syndrome: Recommendations From a North American Consensus Panel. *Pediatric Neurology*. 2017;68:18-34. doi:10.1016/j.pediatrneurol.2017.01.025
9. Hancock EC, Cross JH. Treatment of Lennox-Gastaut syndrome. Cochrane Database Syst Rev. 2013;2013(2):CD003277. Published 2013 Feb 28. doi:10.1002/14651858.CD003277.pub3
10. Arzimanoglou A, French J, Blume WT, et al. Lennox-Gastaut syndrome: a consensus approach on diagnosis, assessment, management, and trial methodology. Lancet Neurol. 2009;8(1):82-93. doi:10.1016/S1474-4422(08)70292-8
11. Knupp KG, Wirrell EC. Treatment Strategies for Dravet Syndrome [published correction appears in CNS Drugs. 2018 Aug;32(8):783. Abstract corrected]. *CNS Drugs*. 2018;32(4):335-350. doi:10.1007/s40263-018-0511-y
12. ClinicalTrials.gov. NCT02544763 [Internet]. Bethesda, MD: U.S. National Library of Medicine; [Accessed on: August 11. 2020]. Available from: https://clinicaltrials.gov/show/NCT02544763.
13. Hess EJ, Moody KA, Geffrey AL, et al. Cannabidiol as a new treatment for drug-resistant epilepsy in tuberous sclerosis complex. *Epilepsia*. 2016;57(10):1617-1624. doi:10.1111/epi.13499
14. Curatolo P, Nabbout R, Lagae L, et al. Management of epilepsy associated with tuberous sclerosis complex: Updated clinical recommendations. *Eur J Paediatr Neurol*. 2018;22(5):738-748. doi:10.1016/j.ejpn.2018.05.006

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Epogen (epoetin alfa)
BILLING CODE	For Medical - J0885 (Non-ESRD) For Pharmacy - Must use valid NDC code
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office, Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— vary per diagnosis
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Epogen (epoetin alfa) is a **preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANEMIA

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Member has documented diagnosis of anemia due to **one** of the following:
   a) Myelodysplastic syndrome;
   b) Chronic Kidney Disease (GFR below 60 mL/min/1.73 m2);
   c) Concomitant Zidovudine treatment in member with HIV-infection;
   d) The effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy; AND
3. Member's individual iron status reveals **both** of the following:
   a) Transferrin saturation is at least 20%;
   b) Ferritin is at least 100 mcg/L; AND
4. Member is on supplemental iron therapy (unless serum ferritin level > 800 mcg/L); AND
5. Member's labs show hemoglobin ≤10 g/dL for adults (≤11 g/dL for children) within the last 14 days for initial therapy, OR ≤10.5 g/dL for adults (≤11.5 g/dL for children) currently receiving therapy.
6. **Dosage allowed:** Members with CKD - 50 to 100 Units/kg 3 times weekly (adults) as initial dose and 50 Units/kg 3 times weekly (pediatric patients). Individualize maintenance dose. Intravenous route recommended for members on hemodialysis. Members on Zidovudine due to HIV-infection -100 Units/kg 3 times weekly. Members with cancer - 40,000 Units weekly or 150 Units/kg 3 times weekly (adults); 600 Units/kg intravenously weekly (pediatric patients ≥5 years).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's hemoglobin increased, stayed the same and not decreased further (baseline labs and current labs required); AND
2. Red blood cells transfusions are not required or the number of the transfusions has decreased.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource

REDUCTION OF ALLOGENEIC RBC TRANSFUSIONS

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Medication is being used for reduction of allogeneic RBC transfusions in member undergoing elective, non-cardiac, nonvascular high-risk surgery at increased risk of or intolerant to transfusions; AND
3. Member's labs show hemoglobin ≤13 g/dL.
4. **Dosage allowed:** 300 Units/kg per day daily for 15 days or 600 Units/kg weekly.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Medication will not be reauthorized.

CareSource considers Epogen (epoetin alfa) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- In members with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy
- In members with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure
- In members with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion
- In members scheduled for surgery who are willing to donate autologous blood
- In members undergoing cardiac or vascular surgery
- As a substitute for RBC transfusions in patients who require immediate correction of anemia

DATE	ACTION/DESCRIPTION
10/04/2018	New policy for Epogen created. Hemoglobin requirement expanded. Endogenous serum erythropoietin level requirement removed.

References:

1. Epogen [package insert]. Thousand Oaks, CA: Amgen, Inc.; September, 2017.
2. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology; Cancer- and Chemotherapy- Induced Anemia. V.2.2018. Available at https://www.nccn.org/professionals/physician_gls/pdf/anemia.pdf. Accessed January 30, 2018.
3. Wolters Kluwer. Facts & Comparisons. www.factsandcomparisons.com, 2011. (May 11, 2011).
4. Young. D. CMS Anemia Drugs Proposal: Bad for Amgen, Good for Patients, 17 May 2007.
5. New risk management program for erythropoiesis-stimulating agents. Aranesp, Procrit, and Epogen Article; Pharmacist's Letter; April 2010; Vol: 26 Hematology / Oncology.
6. Singh AK, Szczech L, Tang KL, et al. Correction of Anemia with Epoetin Alfa in Chronic Kidney Disease, N Engl j Med. 2006; 355:2085-98.
7. Mueller BU, Jacobsen RN, Jarosinski P, et al. Erythropoietin for zidovudine-associated anemia in children with HIV infection.
8. Pediatr AIDS and HIV Infect: Fetus to Adolesc. 1994;5:169-173.
9. Bohlius J, Wilson J, Seidenfeld J, et al., Recombinant Human Erythropoietins and Cancer Patients: Updated Meta-Analysis of 57 Studies Including 9353 Patients. J Natl Cancer Inst. 2006; 98:708-14.
10. Erythropoiesis-stimulating agents in oncology: a study-level meta-analysis of survival and other safety outcomes.

11. Glaspy J, Crawford J, Vansteenkiste J, Henry D, Rao S, Bowers P, Berlin JA, Tomita D, Bridges K, Ludwig H Br J Cancer. 2010;102(2):301. American Society of Clinical Oncology/American Society of Hematology clinical practice guideline update on the use of epoetin and darbepoetin in adult patients with cancer.
12. Rizzo JD, Brouwers M, Hurley P, Seidenfeld J, Arcasoy MO, Spivak JL, Bennett CL, Bohlius J, Evanchuk D, Goode MJ, Jakubowski AA, Regan DH, Somerfield MR, American Society of Clinical Oncology, American Society of Hematology; J Clin Oncol. 2010;28(33):4996. National Comprehensive Cancer Network (NCCN) guidelines www.nccn.org. Accessed September 3, 2015.
13. Aliment Pharmacol Ther. 2010 May;31(9):929-37. Epub 2010 Feb 18.Review article: optimizing SVR and management of the haematological side effects of peginterferon/ribavirin antiviral therapy for HCV - the role of epoetin, G-CSF and novel agents.
14. Definition and management of anemia in patients infected with hepatitis C virus. McHutchison JG, Manns MP, Longo DL Liver Int. 2006;26(4):389 MCG 20th edition, 2016.

Effective date: 10/19/2018
Revised date: 10/04/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Esbriet (pirfenidone)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 90 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Esbriet (pirfenidone) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

IDIOPATHIC PULMONARY FIBROSIS (IPF)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist; AND
3. Member has diagnosis of IPF confirmed by high resolution computed tomography (HRCT) or lung biopsy (results must be submitted for review)[3]; AND
4. Documentation of member's baseline forced vital capacity (FVC) must be equal to or greater than 50% predicted;[7,8] AND
5. Member does not have severe hepatic impairment (Child Pugh Class C); AND
6. Member is not a current smoker and provider attests the member will not smoke during treatment.
7. **Dosage allowed:** Titrate as follows, to max of 801mg three times per day (2403mg/day total).

Treatment days	Dosage
Days 1 through 7	267 mg three times daily (801 mg/day)
Days 8 through 14	534 mg three times daily (1602 mg/day)
Days 15 onward	801 mg three times daily (2403 mg/day)

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member continues to abstain from smoking; AND
2. Chart notes must demonstrate reduced rate of FVC decline[7,8].

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Esbriet (pirfenidone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/22/2020	New policy for Esbriet created; split off from combined IPF policy with Ofev.
11/17/2021	Annual review, no changes

References:

1. Esbriet [package insert]. South San Francisco, CA: Genentech, Inc; 2020.
2. Pirfenidone. Greenwood Village, CO: Truven Health Analytics. http://micromedex.com/. Updated May 7, 2020. Accessed June 23, 2020.
3. Raghu G, Collard HR, Egan JJ, et al. An Official ATS/ERS/JRS/ALAT Statement: Idiopathic Pulmonary Fibrosis: Evidence-based Guidelines for Diagnosis and Management. *American Journal of Respiratory and Critical Care Medicine*. 2011;183(6):788-824. doi:10.1164/rccm.2009-040gl
4. Raghu G, Rochwerg B, Zhang Y, et al. An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline: Treatment of Idiopathic Pulmonary Fibrosis. An Update of the 2011 Clinical Practice Guideline. *American Journal of Respiratory and Critical Care Medicine*. 2015;192(2). doi:10.1164/rccm.201506-1063st
5. Canestaro WJ, Forrester SH, Raghu G, Ho L, Devine BE. Drug Treatment of Idiopathic Pulmonary Fibrosis. *Chest*. 2016;149(3):756-766. doi:10.1016/j.chest.2015.11.013
6. Rogliani P, Calzetta L, Cavalli F, Matera MG, Cazzola M. Pirfenidone, nintedanib and N-acetylcysteine for the treatment of idiopathic pulmonary fibrosis: A systematic review and meta-analysis. *Pulmonary Pharmacology & Therapeutics*. 2016;40:95-103. doi:10.1016/j.pupt.2016.07.009
7. Noble PW, Albera C, Bradford WZ, et al. Pirfenidone in patients with idiopathic pulmonary fibrosis (CAPACITY): two randomised trials. *Lancet*. 2011;377(9779):1760-1769. doi:10.1016/S0140-6736(11)60405-4
8. King TE Jr, Bradford WZ, Castro-Bernardini S, et al. A phase 3 trial of pirfenidone in patients with idiopathic pulmonary fibrosis [published correction appears in N Engl J Med. 2014 Sep 18;371(12):1172]. *N Engl J Med*. 2014;370(22):2083-2092. doi:10.1056/NEJMoa1402582

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Euflexxa (sodium hyaluronate)
BILLING CODE	J7323
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 3 injections (3 units)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Euflexxa (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
8. **Dosage allowed:** Inject 20 mg (2 mL) once weekly for 3 weeks (total of 3 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource

CareSource considers Euflexxa (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Euflexxa created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.

References:

1. Euflexxa [package insert]. Parisippany, NJ: Ferring Pharmaceuticals, Inc.; July 2016.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Christensen R, Bartels EM, Astrup A, Bliddal H. Effect of weight reduction in obese patients diagnosed with knee osteoarthritis: a systematic review and meta-analysis. Ann Rheum Dis. 2007: 66(4):433-9.
11. Altman RD, Rosen JE, Bloch DA, Hatoum HT. Safety and efficacy of retreatment with a bioengineered hyaluronate for painful osteoarthritis of the knee: results of the open-label Extension Study of the FLEXX Trial. Osteoarthritis Cartilage. 2011;19(10):1169-1175.
12. Kirchner M, Marshall D. A double-blind randomized controlled trial comparing alternate forms of high molecular weight hyaluronan for the treatment of osteoarthritis of the knee. Osteoarthritis Cartilage. 2006;14(2):154-162.
13. Altman RD, Rosen JE, Bloch DA, Hatoum HT, Korner P. A double-blind, randomized, saline-controlled study of the efficacy and safety of EUFLEXXA for treatment of painful osteoarthritis of the knee, with an open-label safety extension (the FLEXX Trial). Semin Arthritis Rheum. 2009;39(1):1-9.
14. Euflexxa. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
15. Euflexxa. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
16. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.

17. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Evenity (romosozumab-aqqg)
BILLING CODE	J3111
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include alendronate, risedronate, ibandronate tablet and zoledronic acid QUANTITY LIMIT— 1 injection (210 mg) per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Evenity (romosozumab-aqqg) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOPOROSIS

For **initial** authorization:

1. Member is a postmenopausal woman with osteoporosis, as evidenced by **one** of the following[2]:
   a) Bone mineral density (BMD) T-score –2.5 or below in the lumbar spine, femoral neck, total proximal femur, or 1/3 radius;
   b) Low-trauma spine or hip fracture (regardless of BMD);
   c) Osteopenia (T-score between –1 and –2.5) with a fragility fracture of proximal humerus, pelvis, or distal forearm;
   d) Osteopenia (T-score between –1 and –2.5) with FRAX fracture probability of ≥ 20% for major osteoporotic fracture or ≥ 3% for hip fracture; AND
2. Member meets **one** of the following conditions:
   a) Member has had an inadequate response to at least 12 months of an oral bisphosphonate (e.g., alendronate, risedronate);
   b) If oral bisphosphonate is not tolerated or contraindicated or if member has very high risk for fracture, must have a trial with IV bisphosphonate (e.g., zoledronic acid (Reclast), ibandronate) or Prolia (prior authorization required); AND
      Note: very high fracture risk is defined as having multiple fractures, T score -3.5 or below, T-score -2.5 or below plus fractures, fractures while taking osteoporosis drug, FRAX > 30% for major osteoporosis fracture or 4.5% for hip fracture[2,4].
3. Member does **not** have ANY of the following:
   a) Uncorrected hypocalcemia;
   b) Prior heart attack (myocardial infarction) or stroke within the last year;
   c) Concurrent use with a parathyroid hormone analog (e.g., Forteo, Tymlos) or Prolia.
4. **Dosage allowed:** 210 mg monthly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
Evenity will not be reauthorized for continued therapy.

CareSource considers Evenity (romosozumab-aqqg) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Bone metastases from solid tumors
- Giant Cell Tumor of Bone
- Multiple Myeloma
- Paget's disease

DATE	ACTION/DESCRIPTION
08/01/2019	New policy for Evenity created.
07/31/2020	Osteoporosis definition was updated to accurately reflect current guidelines. Removed dental disease and history of hip fracture from excluded list. Added prior attack or stroke to excluded list per black box warning. Removed list of contraindications for oral bisphosphonates. Removed risk factor appendix. Specified length of oral bisphosphonate trial for 12 months. Specified 2nd line trials to be any IV bisphosphonate or Prolia. Added no concurrent use with PTH or Prolia.

References:

1. Evenity [prescribing information]. Thousand Oaks, CA: Amgen Inc.; April, 2020.
2. Camacho PM, Petak SM, Binkley N, et al. American Association of Clinical Endocrinologists and American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis – 2020. *Endocr Pract*. 2020 May;26(5):564-570.
3. ClinicalTrials.gov. Identifier: NCT01575834. Efficacy and Safety of Romosozumab Treatment in Postmenopausal Women With Osteoporosis (FRAME). Available at: https://clinicaltrials.gov/ct2/show/NCT01575834?term=NCT01575834&rank=1.
4. Shoback D, Rosen CJ, Black DM, Cheung AM, Murad MH, Eastell R. Pharmacological Management of Osteoporosis in Postmenopausal Women: An Endocrine Society Guideline Update. *J Clin Endocrinol Metab*. 2020;105(3):dgaa048.
5. Cosman, F., de Beur, S.J., LeBoff, M.S. et al. Clinician's Guide to Prevention and Treatment of Osteoporosis. Osteoporos Int 25, 2359–2381 (2014).
6. Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. *Arch Osteoporos*. 2017;12(1):43. doi:10.1007/s11657-017-0324-5.

Effective date: 10/1/2021
Revised date: 07/31/2020

CareSource Rx Innovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Evkeeza (evinacumab-dgnb)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Evkeeza (evinacumab-dgnb) is an ANGPTL3 (angiopoietin-like 3) inhibitor indicated as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, aged 12 years and older, with homozygous familial hypercholesterolemia (HoFH).

Evkeeza (evinacumab-dgnb) will be considered for coverage when the following criteria are met:

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH)

For **initial** authorization:

1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with a lipid specialist or a cardiologist; AND
3. Member has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by **one** of the following:
   a) Genetic testing confirmation of two mutant alleles in the LDLR, Apo-B, PCSK9, or LDLRAP1 gene locus; OR
   b) LDL-C > 500 mg/dL before any treatment or LDL-C > 300 mg/dL if treated with a lipid-lowering drug AND **one** of the following:
      i) Xanthoma before 10 years of age; OR
      ii) Evidence of heterozygous familial hypercholesterolemia (HeFH) (i.e., total cholesterol > 250 mg/dL) in both parents; AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days prior to therapy; AND
5. Member is unable to achieve LDL-C goal (see Note below) after trials with **both** of the following:
   a) 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe;
   b) 90-day trial with Repatha or Praluent (prior authorization required); AND
6. Evkeeza will be used as an adjunct to other lipid-lowering treatments (e.g., statins, ezetimibe, LDL apheresis), unless contraindicated or intolerant; AND
7. Prescriber attests that the member will adhere to a low-fat diet and exercise regimen; AND
8. If member is adding Evkeeza to current Juxtapid therapy, must have a 6 month trial and failure of Evkeeza with maximized statin, ezetimibe, or PCSK9 (without Juxtapid) AND a strong clinical reason why Evkeeza must be used together with Juxtapid.
9. **Dosage allowed/Quantity limit:** 15 mg/kg administered by intravenous infusion once monthly.

Note: The LDL-C goals are <100 mg/dL for adults 18 years or older, < 135 mg/dL for children, and < 70 mg/dL for adults with clinical ASCVD.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Evkeeza (evinacumab-dgnb) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
03/23/2021	New policy for Evkeeza (evinacumab-dgnb) created.

References:

1. Evkeeza [package insert]. Tarrytown, NY; Regeneron Pharmaceuticals, Inc. February 2021.
2. Raal FJ, Rosenson RS, Reeskamp LF, et al. Evinacumab for Homozygous Familial Hypercholesterolemia. *N Engl J Med*. 2020;383(8):711-720.
3. Cuchel M, Bruckert E, Ginsberg HN, et al. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. *Eur Heart J*. 2014;35(32):2146-2157.
4. Doggrell SA. Will evinacumab become the standard treatment for homozygous familial hypercholesterolemia?. *Expert Opin Biol Ther*. 2021;21(3):299-302.

Effective date: 10/1/2021
Revised date: 03/23/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Evrysdi (risdiplam)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— see "Dosage Allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Evrysdi (risdiplam) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SPINAL MUSCULAR ATROPHY (SMA)

For **initial** authorization:

1. Member is 2 months of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a confirmed diagnosis of 5q-autosomal recessive spinal muscular atrophy (SMA) Type 1, 2, or 3 as evidenced by genetic testing results showing **both** of the following;
   a) Mutation or deletion in SMN1 genes with **one** of the following:
      i) Homozygous deletion of SMN1 genes (zero copies of SMN1 genes);
      ii) Homozygous mutation in SMN1 genes;
      iii) Compound heterozygous mutation in SMN1 genes (deletion of one SMN1 gene and mutation of another SMN1 gene; AND
   b) 2 to 4 copies of SMN2; AND
4. Member has documentation of a baseline evaluation of current clinical status or motor function (e.g., Hammersmith Functional Motor Scale Expanded (HFMSE), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Hammersmith Infant Neurological Exam (HINE), Revised Upper Limb Module (RULM), Motor Function Measure 32 (MFM32), 6 minute walk test, etc.); AND
5. Member does not have prior treatment with Zolgensma; AND
6. Medication will not be used together with Spinraza. Any current use must be discontinued prior to starting treatment with Evrysdi; AND
7. Member does not require the use of invasive ventilation or tracheostomy as a result of advanced SMA disease.
8. **Dosage allowed:** 2 months to < 2 years of age: 0.2 mg/kg once daily; 2 years of age and older weighing < 20 kg: 0.25 mg/kg once daily; 2 years of age or older weighing 20 kg or more: 5 mg once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Documentation has been provided showing that member has had improvement or stabilization in clinical status and motor function since baseline; AND
2. Medication will not be used together with Spinraza or Zolgensma.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Evrysdi (risdiplam) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/16/2020	New policy for Evrysdi created.
11/17/2021	Annual review, no changes

References:

1. Evrysdi [package insert]. South San Francisco, CA: Genetech, Inc.; August 2020.
2. Mercuri E, Finkel RS, Muntoni F, et al. Diagnosis and management of spinal muscular atrophy: Part 1: Recommendations for diagnosis, rehabilitation, orthopedic and nutritional care. *Neuromuscul Disord*. 2018;28(2):103-115. doi:10.1016/j.nmd.2017.11.005.
3. Dangouloff T, Servais L. Clinical Evidence Supporting Early Treatment Of Patients With Spinal Muscular Atrophy: Current Perspectives. *Ther Clin Risk Manag*. 2019;15:1153-1161. Published 2019 Oct 2. doi:10.2147/TCRM.S172291.
4. Wang CH, Finkel RS, Bertini ES, et al. Consensus statement for standard of care in spinal muscular atrophy. *J Child Neurol*. 2007;22(8):1027-1049. doi:10.1177/0883073807305788.
5. ClinicalTrials.gov. A study to investigate the safety, tolerability, pharmacokinetics, pharmacodynamics and efficacy of risdiplam (RO7034067) in Type 2 and Type 3 Spinal Muscular Atrophy (SMA) participants (SUNFISH). Identifier: NCT02908685. Available at: https://clinicaltrials.gov/ct2/show/NCT02908685.
6. ClinicalTrials.gov. Investigate safety, tolerability, PK, PD, and efficacy of risdiplam (RO7034067) in infants with Type 1 Spinal Muscular Atrophy (FIREFISH). Identifier: NCT02913482. Available at: https://clinicaltrials.gov/ct2/show/NCT02913482.
7. CureSMA. The genetics of spinal muscular atrophy. www.cureSMA.org. Elk Grove Village, IL. Accessed on Sep 16, 2020.
8. Finkel RS, Mercuri E, Darras BT, et al. Nusinersen versus Sham Control in Infantile-Onset Spinal Muscular Atrophy. *N Engl J Med*. 2017;377(18):1723-1732. doi:10.1056/NEJMoa1702752.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Exondys 51 (eteplirsen)
BILLING CODE	J1428 (1 unit = 10 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see dosage allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Exondys 51 (eteplirsen) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DUCHENNE MUSCULAR DYSTROPHY (DMD)

For **initial** authorization:

1. Member has a diagnosis of DMD with confirmed mutation of DMD gene that is amenable to exon 51 skipping (genetic testing results required); AND
2. Medication is being prescribed by or in consultation with a DMD specialist (i.e., neurologist); AND
3. Member is currently stable on corticosteroid for at least 6 months prior to starting therapy, unless not tolerated or contraindicated; AND
4. Chart notes have been provided to show that the member is able to walk independently without assistive devices.
5. **Dosage allowed:** 30 mg per kg of body weight once weekly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show stability or slowed rate of decline of the member's motor function compared to baseline; AND
2. Chart notes confirm that member remains able to walk independently without assistive devices.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Exondys 51 (eteplirsen) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/29/2016	Last revision of the policy.
10/16/2017	Policy converted into new format. No changes in criteria.
05/20/2019	Criteria on member's ambulatory status and independent walking ability added to initial authorization and reauthorization parts of the policy.
06/23/2020	Length of corticosteroid trial specified to be at least 3 months.
01/14/2021	Added prescriber requirement. Simplified ambulatory requirement. Added requirement of stability or slowed rate of decline of motor function in reauth section.

04/06/2021	Increased duration of steroid trial to 6 months.

References:

1. Exondys 51 [Package Insert]. Cambridge, MA: Sarepta Therapeutics, Inc.; July 2020.
2. Sarepta Therapeutics. An Open-Label, Multi-Center Study to Evaluate the Safety and Tolerability of Eteplirsen in Patients With Advanced Stage Duchenne Muscular Dystrophy. NLM Identifier: NCT02286947.
3. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management [published correction appears in Lancet Neurol. 2018 Apr 4;:]. *Lancet Neurol*. 2018;17(3):251-267.
4. Gloss D, Moxley RT 3rd, Ashwal S, Oskoui M. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(5):465-472.

Effective date: 10/1/2021
Revised date: 04/06/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Extavia (interferon beta-1b)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 14 mL in 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Extavia (interferon beta-1b) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
2. Chart notes have been provided confirming diagnosis of Multiple Sclerosis.
3. **Dosage allowed:** Start 0.0625 mg (0.25 mL) subcutaneously every other day for week 1 and 2; then 0.125 mg (0.5 mL) subcutaneously every other day for week 3 and 4; then 0.1875 mg (0.75 mL) subcutaneously every other day week 5 and 6; then 0.25 mg (1 mL) subcutaneously every other day for week 7 and thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member has documented biological response to treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Extavia (interferon beta-1b) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/13/2017	New policy for Extavia created. Not covered diagnosis added.
12/06/2017	Confirmation of diagnosis based on McDonald criteria is no longer required.
09/16/2021	Annual review, no changes

References:

1. Extavia [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corporation: Revised May 2016.

2. Extavia. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed April 7, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Eylea (aflibercept)
BILLING CODE	J0178
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
STATUS	Prior Authorization Required

Eylea was approved by the FDA in 2011. It is indicated for the treatment of 4 different ophthalmic conditions. Eylea is a vascular endothelial growth factor (VEGF) inhibitor for intravitreal use. VEGF inhibitors suppress endothelial cell proliferation, neovascularization, and vascular permeability.
There are 2 forms of age-related macular degeneration (AMD), dry and wet (neovascular). Eylea is approved for the treatment of Wet AMD which is less common but progresses more quickly. Neovascular in the context of AMD means growth of new blood vessels under the macula which can lead to loss of central vision.
Diabetic eye disease includes diabetic retinopathy (DR) and diabetic macular edema (DME). DR affects blood vessels in the retina at the back of the eye. DME is a consequence of DR that occurs in about half of DR patients. It causes fluid build-up in the macula part of the retina.
Retinal Vein Occlusion (RVO) occurs when there is a partial or complete obstruction of a retinal vein. Macular edema is a complication of RVO and can lead to vision loss. It is treated first-line with anti-VEGF drugs.

Eylea (aflibercept) will be considered for coverage when the following criteria are met:

Retinal Disease

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a confirmed diagnosis of one of the following conditions:
   a) Neovascular (Wet) Age-Related Macular Degeneration (AMD)
   b) Macular Edema Following Retinal Vein Occlusion (RVO)
   c) Diabetic Macular Edema (DME)
   d) Diabetic Retinopathy (DR); AND
4. Member has tried and failed bevacizumab intravitreal injection (Exception: not required for diagnosis of DME when visual acuity is worse than 20/50); AND
5. Documentation of best-corrected visual acuity (BCVA); AND
6. Member does NOT have active infection or inflammation in or around the eye(s) to be treated.
7. **Dosage allowed/Quantity limit:**
   AMD: 2 mg every 4 weeks for 3 months, then 2 mg every 8 weeks.
   RVO: 2 mg every 4 weeks.
   DME or DR: 2 mg every 4 weeks for the first 5 injections, then 2 mg every 8 weeks.
   Note: Eylea is supplied as a 2 mg/0.05 mL single-dose vial or pre-filled syringe.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must include documentation of improved or stabilized visual acuity.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Eylea (aflibercept) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/22/2021	New policy for Eylea created.

References:

1. Eylea [prescribing information]. Regeneron Pharmaceuticals, Inc.; 2021.
2. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P1-P65. doi:10.1016/j.ophtha.2019.09.024
3. Holekamp, Nanvy M. Review of Neovascular Age-Related Macular Degeneration Treatment Options. Am J Manag Care. July 2019; 25:-S0
4. Flaxel CJ, Adelman RA, Bailey ST, et al. Retinal Vein Occlusions Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(2):P288-P320. doi:10.1016/j.ophtha.2019.09.029
5. Shalchi Z, Mahroo O, Bunce C, Mitry D. Anti-vascular endothelial growth factor for macular oedema secondary to branch retinal vein occlusion. *Cochrane Database Syst Rev*. 2020;7(7):CD009510. Published 2020 Jul 7. doi:10.1002/14651858.CD009510.pub3
6. Flaxel CJ, Adelman RA, Bailey ST, et al. Diabetic Retinopathy Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P66-P145. doi:10.1016/j.ophtha.2019.09.025
7. Virgili G, Parravano M, Evans JR, Gordon I, Lucenteforte E. Anti-vascular endothelial growth factor for diabetic macular oedema: a network meta-analysis. *Cochrane Database Syst Rev*. 2018;10(10):CD007419. Published 2018 Oct 16. doi:10.1002/14651858.CD007419.pub6
8. Diabetic Retinopathy Clinical Research Network, Wells JA, Glassman AR, et al. Aflibercept, bevacizumab, or ranibizumab for diabetic macular edema. *N Engl J Med*. 2015;372(13):1193-1203. doi:10.1056/NEJMoa1414264

Effective date: 04/01/2022
Revised date: 10/22/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Fabrazyme (agalsidase beta)
BILLING CODE	J0180
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Fabrazyme is an enzyme replacement therapy (ERT) indicated for the treatment of confirmed Fabry disease, to replace the enzyme alpha-galactosidase A (alpha-Gal A). Fabry disease, a lysosomal storage disorder, is a rare genetic disease caused by certain mutations of the GLA gene resulting in deficient alpha-Gal A. Normally this enzyme breaks down certain lipids in lysosomes, such as globotriaosylceramide (GL-3). Without it, GL-3 accumulates in blood vessels, the kidneys, heart, nerves, and other organs. The continuous build-up of GL-3 results in progressive cell damage and subsequent symptoms and manifestations in the affected organ systems.

Fabrazyme (agalsidase beta) will be considered for coverage when the following criteria are met:

Fabry Disease

For **initial** authorization:

1. Member is at least 2 years of age; AND
2. Medication must be prescribed by or in consultation with a medical geneticist, nephrologist, cardiologist, neurologist, or metabolic specialist; AND
3. Member has a diagnosis of Fabry disease confirmed by genetic testing which identifies a mutation of the GLA gene; AND
4. Member displays symptoms of Fabry disease (e.g. neuropathic pain, renal disease, cardiac disease, abdominal pain, impaired sweating); NOTE: Exception-- Males 8 years of age or older with "classic" gene variants do not need to be symptomatic to qualify for treatment. Males with "non-classic" gene variants and asymptomatic females may be treated if there is documentation of symptoms noted above that warrant treatment with ERT; AND
5. Fabrazyme will not be used in combination with Galafold.
6. **Dosage allowed/Quantity limit:** 1 mg/kg body weight infused every two weeks as an IV infusion.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show positive clinical response such as stabilized kidney function (e.g. GFR, proteinuria), reduced plasma or tissue GL-3 levels, or improved symptoms.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Fabrazyme (agalsidase beta) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/17/2021	New policy for Fabrazyme created.

References:

1. Fabrazyme (agalsidase beta) [package insert]. Cambridge, MA; Genzyme Corporation; Revised 03/2021.
2. Laney DA, Bennett RL, Clarke V, et al. Fabry disease practice guidelines: recommendations of the National Society of Genetic Counselors. *J Genet Couns*. 2013;22(5):555-564. doi:10.1007/s10897-013-9613-3
3. Hopkin RJ, Jefferies JL, Laney DA, et al. The management and treatment of children with Fabry disease: A United States-based perspective. *Mol Genet Metab*. 2016;117(2):104-113. doi:10.1016/j.ymgme.2015.10.007
4. Banikazemi M, Bultas J, Waldek S, et al. Agalsidase-beta therapy for advanced Fabry disease: a randomized trial. *Ann Intern Med*. 2007;146(2):77-86. doi:10.7326/0003-4819-146-2-200701160-00148
5. Eng CM, Guffon N, Wilcox WR, et al. Safety and efficacy of recombinant human alpha-galactosidase A replacement therapy in Fabry's disease. *N Engl J Med*. 2001;345(1):9-16. doi:10.1056/NEJM200107053450102
6. Lenders M, Brand E. Fabry Disease: The Current Treatment Landscape. *Drugs*. 2021;81(6):635-645. doi:10.1007/s40265-021-01486-1

Effective date: 01/01/2022
Revised date: 06/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Fasenra (benralizumab)
BILLING CODE	J0517
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1 syringe or 1 pen/month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Fasenra (benralizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SEVERE ASTHMA

For **initial** authorization:

1. Member must be 12 years of age or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist, immunologist or allergist; AND
3. Member has a blood eosinophil count of at least 300 cells/μL or at least 150 cells/ μL if taking maintenance oral corticosteroids (OCS); AND
4. Member has at least two documented severe asthma exacerbations requiring oral corticosteroids (OCS), or at least one requiring hospitalization, within last year; AND
5. Member's asthma has been inadequately controlled after 3 month of conventional treatment of medium to high doses of inhaled corticosteroids (ICS) and long acting beta 2-agonists (LABA); AND
6. Medication is being used as add-on maintenance treatment to conventional therapies for asthma (i.e., ICS, LABA, etc.); AND
7. Medication is not used in conjunction with any other biologic therapy for asthma.
8. **Dosage allowed:** 30 mg every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 16 weeks.

For **reauthorization**:

1. Medication not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
   a) Decreased frequency of emergency department visits or hospitalizations due to asthma exacerbations; OR
   b) Increase in percent predicted FEV1 from pretreatment baseline; OR
   c) Improved functional ability (i.e. decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
   d) Decreased utilization of rescue medications or oral corticosteroids.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

CareSource considers Fasenra (benralizumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
12/01/2017	New policy for Fasenra created.
05/12/2018	Baseline (pre-benralizumab treatment) peripheral blood eosinophil level was changed from 300 to ≥ 150 cells/μL within the past 6 weeks.
11/25/2020	Eosinophil count was updated to be consistent with guidelines; exacerbation number was updated to be consistent with guidelines (2 requiring OCS or 1 requiring hospitalization in the last year); changed from not to be used with Nucala or Cinqair to not to be used with any other asthma biologic.

References:

1. Fasenra [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals; October 2019.
2. ClinicalTrials.gov web site. U.S. National Library of Medicine. Identifier NCT01914757 Efficacy and Safety Study of Benralizumab in Adults and Adolescents Inadequately Controlled on Inhaled Corticosteroid Plus Long-acting β2 Agonist. Available at: https://clinicaltrials.gov/ct2/show/NCT01914757?term=benralizumab&recrs=e&draw=1&rank=6.
3. Walford HH, Doherty TA. Diagnosis and management of eosinophilic asthma: a US perspective. J Asthma Allergy. 2014;7:53–65.
4. ClinicalTrials.gov web site. U.S. National Library of Medicine. Identifier NCT02075255. Efficacy and Safety Study of Benralizumab to Reduce OCS Use in Patients With Uncontrolled Asthma on High Dose Inhaled Corticosteroid Plus LABA and Chronic OCS Therapy. Available at: https://clinicaltrials.gov/ct2/show/NCT02075255?term=benralizumab&recrs=e&draw=1&rank=7.
5. Goldman M, Hirsch I, Zangrilli JG, et al. The association between blood eosinophil count and benralizumab efficacy for patients with severe, uncontrolled asthma: subanalyses of the Phase III SIROCCO and CALIMA studies. Curr Med Res Opin. 2017 Sep;33(9):1605-1613.
6. Difficult-To-Treat & Severe Asthma in Adolescent and Adult Patients: Diagnosis and Management. Global Initiative For Asthma (GINA); Apr. 2019. Available at: https://ginasthma.org/wp-content/uploads/2018/11/GINA-SA-FINAL-wms.pdf.
7. Kostikas K, Brindicci C, Patalano F. Blood Eosinophils as Biomarkers to Drive Treatment Choices in Asthma and COPD. *Curr Drug Targets*. 2018;19(16):1882-1896. doi:10.2174/1389450119666180212120012
8. 2020 Focused Updates To The Asthma Management Guidelines. National Institute of Health; Dec 2020. Available at: https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates.

Effective date: 10/1/2021
Revised date: 11/25/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Fensolvi (leuprolide acetate)
BILLING CODE	J1950 (1 unit = 3.75 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Lupron PED QUANTITY LIMIT— 12 units every 6 months
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Fensolvi (leuprolide acetate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CENTRAL PRECOCIOUS PUBERTY (CPP)

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Member developed pubertal symptoms before age of 8 for female or 9 for male; AND
3. Member has confirmed diagnosis of central precocious puberty, as evidenced by **both** of the following:
   a) Pubertal response to a gonadotropin releasing hormone (GnRH) stimulation test OR pubertal levels of basal luteinizing hormones (LH) and estradiol or testosterone hormones;
   b) Bone age is advanced by at least one year greater than chronological age; AND
4. Medication must be prescribed by or in consultation with an endocrinologist; AND
5. Member's baseline LH level, sex steroid level (estradiol or testosterone), and height are submitted with chart notes.
6. **Dosage allowed:** 1 subcutaneous injection (45mg) every 6 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. If member is 11 years or older for females or 12 years or older for males, prescriber must provide a clinical reason for continuing medication beyond the recommended age for resuming puberty; AND
2. Chart notes have been provided showing efficacy of response (e.g., slowed growth rate, slowed bone age advancement, LH and sex steroid hormone levels have been suppressed or reduced from baseline).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Fensolvi (leuprolide acetate) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/22/2020	New policy for Fensolvi created.

References:

1. Fensolvi [package insert]. Fort Collins, CO: Tolmar, Inc.; May, 2020.
2. ClinicalTrials.gov. Study of leuprolide acetate injectable suspension in the treatment of central precocious puberty. Identifier: NCT02452931. Available at: https://clinicaltrials.gov/ct2/show/NCT02452931.
3. Chen M, Eugster EA. Central Precocious Puberty: Update on Diagnosis and Treatment. *Paediatr Drugs*. 2015;17(4):273-281.
4. Carel JC, Eugster EA, Rogol A, et al; ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123(4).
5. Creo AL, Schwenk WF. Bone age: a handy tool for pediatric providers. *Pediatrics*. Dec 2017, 140 (6) e20171486.
6. Klein KO. Precocious puberty: who has it? Who should be treated?. *J Clin Endocrinol Metab*. 1999;84(2):411-414.

Effective date: 10/1/2021
Revised date: 07/22/2020

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Fintepla (fenfluramine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT – See "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Fintepla (fenfluramine) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DRAVET SYNDROME

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of seizures associated with Dravet Syndrome; AND
4. Member's weight must be documented in chart notes for dosing; AND
5. Chart notes must document the member's seizure frequency on current treatment; AND
6. Chart notes must show that an electrocardiogram (ECG) has been done or will be done before starting treatment; AND
7. The member has tried and failed (or has contraindication to) ALL of the following drugs (alone or in combination):[2,3,5]
   a) First line: valproic acid AND clobazam;
   b) Second line: Diacomit (requires prior authorization) OR topiramate.
8. **Dosage allowed:** See package insert for titration schedule[1]
   a) Without Diacomit (stiripentol): 0.35mg/kg twice daily, up to 26mg/day.
   b) Concomitant Diacomit (stiripentol) and clobazam: 0.2mg/kg twice daily, up to 17mg/day.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes must document a reduction in convulsive seizure frequency since starting Fintepla.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Fintepla (fenfluramine) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/28/2020	New policy for Fintepla created.
09/16/2021	Annual review, no changes

References:

1. Fintepla [package insert]. Emeryville, CA: Zogenix, Inc; 2020.
2. IPD analytics. Accessed 7/21/20.
3. Wirrell EC, Laux L, Donner E, et al. Optimizing the Diagnosis and Management of Dravet Syndrome: Recommendations From a North American Consensus Panel. *Pediatric Neurology*. 2017;68:18-34. doi:10.1016/j.pediatrneurol.2017.01.025
4. Wirrell EC, Nabbout R. Recent Advances in the Drug Treatment of Dravet Syndrome. *CNS Drugs*. 2019;33(9):867-881. doi:10.1007/s40263-019-00666-8
5. Knupp KG, Wirrell EC. Treatment Strategies for Dravet Syndrome [published correction appears in CNS Drugs. 2018 Aug;32(8):783. Abstract corrected]. *CNS Drugs*. 2018;32(4):335-350. doi:10.1007/s40263-018-0511-y
6. Cross JH, Caraballo RH, Nabbout R, Vigevano F, Guerrini R, Lagae L. Dravet syndrome: Treatment options and management of prolonged seizures. *Epilepsia*. 2019;60 Suppl 3:S39-S48. doi:10.1111/epi.16334
7. Lagae L, Sullivan J, Knupp K, et al. Fenfluramine hydrochloride for the treatment of seizures in Dravet syndrome: a randomised, double-blind, placebo-controlled trial. *Lancet*. 2019;394(10216):2243-2254. doi:10.1016/S0140-6736(19)32500-0
8. Nabbout R, Mistry A, Zuberi S, et al. Fenfluramine for Treatment-Resistant Seizures in Patients With Dravet Syndrome Receiving Stiripentol-Inclusive Regimens: A Randomized Clinical Trial [published online ahead of print, 2019 Dec 2]. *JAMA Neurol*. 2019;77(3):300-308. doi:10.1001/jamaneurol.2019.4113

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Firazyr (icatibant)
BILLING CODE	J1744
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior-Authorization Required (Preferred Product) QUANTITY LIMIT— 6 syringes per fill (18 mL)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Firazyr (icatibant) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Medication is being prescribed for the treatment of acute HAE attacks; AND
5. Medication is not being used in combination with another on-demand therapy (e.g. Kalbitor, Berinert, Ruconest); AND
6. The member is not taking an ACE inhibitor.
7. **Dosage allowed:** 30 mg subQ; may repeat at 6-hour intervals if response is inadequate. Max of 3 doses in 24 hours.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improvement such as faster time to symptom relief or resolution of attack.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Firazyr (icatibant) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/25/2017	New policy for Firazyr created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks added.

01/20/2021	Updated references. Removed hematology as a specialist. Simplified the diagnostic criteria. Removed log book requirement. Removed statement about causative meds. Added ACE inhibitor interaction. Reworded renewal criteria. Extended initial auth duration to 6 mo and renewal to12 mo. Amended the quantity limit to say 6 syringes instead of 6 mL.

References:

1. Firazyr [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc; 2020.
2. Frank MM, Zuraw B, Banerji A, et al. Management of children with hereditary angioedema due to C1 inhibitor deficiency. Pediatrics. 2016 Nov;138(5). pii: e20160575.
3. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
4. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384
5. Lumry WR, Farkas H, Moldovan D, et al. Icatibant for Multiple Hereditary Angioedema Attacks across the Controlled and Open-Label Extension Phases of FAST-3. *Int Arch Allergy Immunol*. 2015;168(1):44-55. doi:10.1159/000441060

Effective date: 10/1/2021
Revised date: 01/20/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Firdapse (amifampridine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes pyridostigmine QUANTITY LIMIT— 240 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Firdapse (amifampridine) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)

For **initial** authorization:

1. Member 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by documentation of diagnostic test results including one of the following:
   a) Repetitive nerve stimulation (RNS) testing showing reproducible post-exercise increase in compound muscle action potential (CMAP) amplitude of at least 60 percent compared with pre-exercise baseline value or a similar increment on high-frequency repetitive nerve stimulation without exercise; AND
   b) Positive anti-P/Q type voltage-gated calcium channel antibody test; AND
4. Member must have a documented baseline ECG in the last 12 months demonstrating QT interval < 450 milliseconds; AND
5. Member must have documented baseline Quantitative Myasthenia Gravis (QMG) testing; AND
6. Member does NOT have any of the following:
   a) History of seizures;
   b) Active brain metastases;
   c) Unable to ambulate;
   d) Currently pregnant or lactating.
7. **Dosage allowed:** The recommended starting dosage is 15 mg to 30 mg daily taken orally in divided doses (3 to 4 times daily); dosage can be increased by 5 mg daily every 3 to 4 days. Not to exceed 80 mg/day. The maximum single dose is 20 mg.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member meets all initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Firdapse (amifampridine) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Myasthenia gravis (MG)

DATE	ACTION/DESCRIPTION
05/20/2019	New policy for Firdapse created.
11/19/2021	Annual review, no changes

References:

1. Firdapse (amifampridine) [prescribing information]. Coral Gables, FL: Catalyst Pharmaceuticals, Inc. 2018 Nov.
2. ClinicalTrials.gov. Identifier: NCT02970162. Phase 3 study to evaluate efficacy of amifampridine phosphate in Lambert-Eaton myasthenic syndrome (LEMS). Available: clinicaltrials.gov/ct2/show/NCT02970162.
3. ClinicalTrials.gov. Identifier: NCT01377922. Phase 3 study of amifampridine phosphate in patients with Lambert-Eaton myasthenic syndrome (LEMS). Available: clinicaltrials.gov/ct2/show/NCT01377922.
4. Kesner VG, et al. Lambert-Eaton myasthenic syndrome. Neurologic clinics. 2018;36(2):379-394.
5. Harper MC, et al. Lambert-Eaton syndrome. Myasthenia Gravis and Related Disorders. Humana Press, Cham. 2018. 221-237.
6. Sanders DB, et al. 3, 4-diaminopyridine base effectively treats the weakness of Lambert-Eaton myasthenia. Muscle & nerve. 2018;57(4):561-568.
7. Khadilkar SV, et al. Lambert–Eaton Myasthenic Syndrome. Neuromuscular Disorders. Springer, Singapore. 2018. 261-272.
8. Schoser B, et al. Amifampridine Phosphate in patients with Lambert-eaton myasthenic syndrome (lems): a phase 3, multicentre, double-blind, placebo-controlled trial: p31181. European Journal of Neurology. 2016;23: 690-691.
9. Oh SJ, et al. Amifampridine phosphate (Firdapse®) is effective and safe in a phase 3 clinical trial in LEMS. Muscle & nerve. 2016;53(5):717-725.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Forteo (teriparatide)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include alendronate, risedronate, ibandronate tablet, and zoledronic acid QUANTITY LIMIT— 600 mcg/2.4 mL (1 pen) per month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Forteo (teriparatide) injection is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOPOROSIS

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is being used for treatment of **one** the following:
   a) Osteoporosis in postmenopausal women;
   b) Primary or hypogonadal osteoporosis in men;
   c) Glucocorticoid-induced osteoporosis in men and women who have been taking ≥ 5 mg of prednisone (or equivalent) daily for ≥ 3 months; AND
3. Member is at high-risk for fracture as evidenced by **one** of the following:
   a) Bone mineral density (BMD) T-score –2.5 or below in the lumbar spine, femoral neck, proximal femur, 1/3 radius, or total hip;
   b) History of vertebral (spine) or hip fracture;
   c) T-score between –1 and –2.5 with a fragility fracture of proximal humerus, pelvis, or distal forearm;
   d) T-score between –1 and –2.5 with FRAX score of ≥ 20% for major osteoporotic fracture or ≥ 3% for hip fracture;
   e) Member is taking prednisone ≥ 30 mg/day and a cumulative dose of > 5 gm in the past year;
   f) Member is taking prednisone ≥ 7.5mg/day AND having greater than 10% BMD loss per year or a Z score < -3 at hip or spine; AND
4. Member meets **one** of the following drug trials:
   a) Member has had an inadequate response to at least 12 months of an oral bisphosphonate (e.g., alendronate, risedronate);
   b) If oral bisphosphonate is not tolerated or contraindicated or if member has very high risk for fracture, must have a trial with IV bisphosphonate (e.g., zoledronic acid (Reclast), ibandronate) or Prolia (prior authorization required); AND
      **Note*: very high fracture risk is defined as having multiple fractures, T score of -3.5 or below, fracture while taking osteoporosis drug, FRAX > 30% for major osteoporosis fracture or 4.5% for hip fracture[2].
5. The total length of treatment for parathyroid hormone analogs (abaloparatide, teriparatide) has not exceeded 24 months in the member's lifetime.

6. **Dosage allowed:** 20 mcg subcutaneously once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Treatment length has not exceeded 24 months in lifetime; AND
2. Chart notes have been provided showing stable or increase in bone mineral density, with no evidence of new fractures or vertebral fracture progression.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Forteo (teriparatide injection) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Bone metastases from solid tumors
- Giant Cell Tumor of Bone
- Hypercalcemic disorder
- Multiple Myeloma
- Paget's disease
- Pediatric and young adult members with open epiphyses
- Prior external beam or implant radiation involving the skeleton
- Skeletal malignancies

DATE	ACTION/DESCRIPTION
08/02/2019	New policy for Forteo created.
07/31/2020	Removed uncorrected hypocalcemia and dental disease. Removed list of reasons oral bisphosphonates cannot be used. Removed risk factor appendix. Removed calcium and vitamin D requirements. Modified osteoporosis definitions to include GC-induced high-risk groups. Specified length of oral bisphosphonate trial for 12 months. Added age requirement. Specified 2nd line trials to be any IV bisphosphonate or Prolia. Added no more than 2 years of treatment to initial and reauth. Changed length of initial approval to 12 months. Changed reauth language to say stable or increase BMD with no evidence of new fractures.
03/11/2021	Annual review, no changes

References:

1. Forteo [prescribing information]. Indianapolis, IN: Lilly USA, LLC; April, 2020.
2. Camacho PM, Petak SM, Binkley N, et al. American Association of Clinical Endocrinologists and American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis – 2020. *Endocr Pract*. 2020 May;26(5):564-570.
3. Cosman, F., de Beur, S.J., LeBoff, M.S. et al. Clinician's Guide to Prevention and Treatment of Osteoporosis. Osteoporos Int 25, 2359–2381 (2014).
4. Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. *Arch Osteoporos*. 2017;12(1):43. doi:10.1007/s11657-017-0324-5.
5. Leder BZ. Optimizing Sequential and Combined Anabolic and Antiresorptive Osteoporosis Therapy. *JBMR Plus*. 2018;2(2):62-68. Published 2018 Feb 27.
6. Buckley L, Guyatt G, Fink HA, et al. 2017 American college of rheumatology guideline for the prevention and treatment of glucocorticoid-induced osteoporosis. *Arthritis Rheumatol*. 2017 Aug;69(8):1521-1537.
7. Rao SS, Budhwar N, Ashfaque A. Osteoporosis in men. *Am Fam Physician*. 2010 Sep 1;82(5):503-8.

CareSource

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Fulphila (pegfilgrastim-jmdb)
BILLING CODE	Q5108
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Neulasta QUANTITY LIMIT— 12 mg per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Fulphila (pegfilgrastim-jmdb) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:

1. Member has a non-myeloid malignancy; AND
2. Medication will not be administered less than 14 days before OR less than 24 hours after chemotherapy; AND
3. Chart notes with length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the day of the cycle on which the Fulphila will be administered, are submitted with prior authorization request; AND
4. Member has a documented history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
5. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (> 20%, see Appendix for description) for incidence of febrile neutropenia; OR
6. Member is receiving myelosuppressive anti-cancer drugs associated with at intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Bone marrow involvement with tumor;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (bilirubin > 2.0);
   f) Renal dysfunction (creatinine clearance < 50);
   g) Age > 65 years receiving full chemotherapy dose intensity.
7. **Dosage allowed:** Up to 6 mg per chemotherapy cycle, beginning at least 24 hours after completion of chemotherapy.

Note: Fulphila is not indicated for hematopoietic syndrome of acute radiation syndrome.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Fulphila (pegfilgrastim-jmdb) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Hematopoietic syndrome of acute radiation syndrome
- Mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplant

DATE	ACTION/DESCRIPTION
07/25/2018	New policy for Fulphila (pegfilgrastim-jmdb) created.
11/08/2019	Appendix updated to the most recent NCCN guidelines chemotherapy regimens.

References:

1. Fulphila [package insert]. Rockford, IL: Mylan Institutional LLC.; June 2018.
2. U.S. Food and Drug Administration. Media release. FDA approved first biosimilar to Nulasta to help reduce the risk of infection during cancer treatment. Available at: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm609805.htm. Accessed on July 25, 2018.
3. National Comprehensive Cancer Network. (2016). NCCN Drugs & Biologics Compendium™. Pegfilgrastim. Retrieved November 22, 2016 from the National Comprehensive Cancer Network.

Effective date: 04/01/2020
Revised date: 11/08/2019

CareSource

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (> 20%).

This list is not comprehensive. There are other regimens that have a high risk for the development of febrile neutropenia. See NCCN guidelines for treatment by cancer site for details.

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	Dose-dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
Bone Cancer	VAI (vincristine, doxorubicin or dactinomycin, ifosfamide)
	VDC-IE (vincristine, doxorubicin or dactinomycin, and cyclophosphamide alternating with ifosfamide and etoposide)
	VIDE (vincristine, ifosfamide. doxorubicin or dactinomycin, etoposide)
Breast Cancer	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel)
	TAC (docetaxel, doxorubicin, cyclophosphamide)
	TC (docetaxel, cyclophosphamide)
	TCH (docetaxel, carboplatin, trastuzumab)
Head and Neck Squamous Cell Carcinoma	TPF (docetaxel, cisplatin, 5-fluorouracil)
Hodgkin Lymphoma	Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine)
	Escalated BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)
	ICE (ifosfamide, carboplatin, etoposide)
	Dose-dense CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone)
	MINE (mesna, ifosfamide, mitoxantrone, etoposide)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine)
	HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone)
Melanoma	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Multiple Myeloma	DT-PACE (dexamethasone/thalidomide/ cisplatin/doxorubicin/cyclophosphamide/etoposide) ± bortezomib (VTD-PACE)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Ovarian Cancer	Topotecan
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)

	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	Topotecan
Testicular cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% - 20%)

Cancer Histology	**Regimen**
Occult primary - Adenocarcinoma	Gemcitabine/docetaxel
Bone Cancer	Cisplatin/doxorubicin
	VDC (vincristine, doxorubicin or dactinomycin, cyclophosphamide)
Breast cancer	Docetaxel
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (taxane portion only)
	Paclitaxel every 21 days
Cervical Cancer	Cisplatin/topotecan
	Paclitaxel/cisplatin
	Topotecan
	Irinotecan
Colorectal	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Non-Hodgkin's lymphomas	GDP (gemcitabine, dexamethasone, cisplatin/carboplatin)
	CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) including regimens with pegylated liposomal doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel
	Cisplatin/vinorelbine
	Cisplatin/docetaxel
	Cisplatin/etoposide
	Carboplatin/paclitaxel
	Docetaxel
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX

Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
	BEP (bleomycin, etoposide, cisplatin)
Uterine Sarcoma	Docetaxel

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Galafold (migalastat)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Galafold is a pharmacologic chaperone that can be used instead of enzyme replacement therapy (ERT) for the treatment of Fabry disease. Fabry disease is an X-linked lysosomal storage disorder caused by mutations in the GLA gene that cause deficiency of the alpha-galactosidase A (alpha-Gal A) lysosomal enzyme. Normally this enzyme breaks down certain lipids in lysosomes, such as globotriaosylceramide (GL-3). Without it, GL-3 accumulates in blood vessels, the kidneys, heart, nerves, and other organs.
Unlike ERT with Fabrazyme, Galafold can be taken orally and is only indicated for adult patients. Importantly, Galafold is only indicated in patients with certain amenable gene variants. It is estimated that the amenable variants are present in 35-50% of the Fabry disease patient population.

Galafold (migalastat) will be considered for coverage when the following criteria are met:

Fabry Disease

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a medical geneticist, nephrologist, cardiologist, neurologist, or metabolic specialist; AND
3. Member has a confirmed diagnosis of Fabry disease and an amenable galactosidase alpha gene (GLA) variant (refer to package insert) based on in vitro assay data documented in chart notes; AND
4. Member does NOT have severe renal impairment or end-stage renal disease requiring dialysis; AND
5. Galafold will NOT be used in combination with Fabrazyme.
6. **Dosage allowed/Quantity limit:** 123 mg orally every other day. (Limit: 14 capsules per 28 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must show positive clinical response such as stabilized kidney function (e.g. GFR, proteinuria), reduced plasma or tissue GL-3 levels, reduced left ventricular mass index, or symptom improvement.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Galafold (migalastat) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION

05/20/2019	New policy for Galafold created.
06/18/2021	Transferred to new template. Updated references. Added neurology to specialists. Removed baseline GL-3 level. Removed exclusions except renal impairment and combination therapy. Increased initial approval duration to 6 months and renewal to 12 months. Revised renewal criteria; removed % reductions.

References:

1. Galafold [prescribing information]. Philadelphia, PA: Amicus Therapeutics US, LLC; February 2021.
2. Desnick R, et al. Fabry disease, an under-recognized multisystemic disorder: expert recommendations for diagnosis, management, and enzyme replacement therapy. Annals of internal medicine. 2003 Feb 18;138(4):338 46.
3. Ellaway C. Paediatric fabry disease. Transl pediatr. 2016; 5(1): 37-42.
4. Hopkin R, et al. The management and treatment of children with Fabry disease: A United States-based perspective. Molecular genetics and metabolism. 2016 Feb 1;117(2):104-13.
5. Ortiz A, et al. Fabry disease revisited: management and treatment recommendations for adult patients. Molecular genetics and metabolism. 2018 Apr 1;123(4):416-27.
6. Wang R, et al. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. Genetics in Medicine. 2011 May;13(5):457.
7. Wanner C, et al. European expert consensus statement on therapeutic goals in Fabry disease. Molecular genetics and metabolism. 2018 Jun 12.
8. Germain D, et al. Treatment of Fabry's disease with the pharmacologic chaperone migalastat. New England Journal of Medicine. 2016 Aug 11;375(6):545-55.
9. Hughes D, et al. Oral pharmacological chaperone migalastat compared with enzyme replacement therapy in Fabry disease: 18-month results from the randomised phase III ATTRACT study. Journal of medical genetics. 2017 Apr 1;54(4):288-96.
10. National institute for health and care excellence. Migalastat for treating Fabry disease. 2017 Feb. Available from: nice.org.uk/guidance/hst4/chapter/1-Recommendations.
11. Laney DA, Bennett RL, Clarke V, et al. Fabry disease practice guidelines: recommendations of the National Society of Genetic Counselors. *J Genet Couns*. 2013;22(5):555-564. doi:10.1007/s10897-013-9613-3
12. Feldt-Rasmussen U, Hughes D, Sunder-Plassmann G, et al. Long-term efficacy and safety of migalastat treatment in Fabry disease: 30-month results from the open-label extension of the randomized, phase 3 ATTRACT study. *Mol Genet Metab*. 2020;131(1-2):219-228. doi:10.1016/j.ymgme.2020.07.007

Effective date: 01/01/2022
Revised date: 06/18/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Gamifant (emapalumab-lzsg)
BILLING CODE	J9210
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include dexamethasone, etoposide, methotrexate, hydrocortisone, etc. QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Gamifant (emapalumab-lzsg) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS (HLH)

For **initial** authorization:

1. Member has diagnosis of primary HLH with either refractory, recurrent, or progressive disease during conventional HLH therapy (e.g., dexamethasone, etoposide, methotrexate, hydrocortisone, etc.) or who were intolerant of conventional HLH therapy (Documentation required); AND
2. HLH diagnosis confirmed by ONE of the following:
   a) Genetic testing;
   b) Chart notes indicating family history consistent with primary HLH;
   c) Five out of 8 criteria fulfilled:
      i) Fever;
      ii) Splenomegaly;
      iii) Cytopenias affecting 2 of 3 lineages in the peripheral blood (hemoglobin < 9, platelets < 100 x 10^9/L, neutrophils < 1 x 10^9/L);
      iv) Hypertriglyceridemia (fasting triglycerides > 3 mmol/L or ≥ 265 mg/dL) and/or hypofibrinogenemia (≤ 1.5 g/L);
      v) Hemophagocytosis in bone marrow, spleen or lymph nodes with no evidence of malignancy;
      vi) Low or absent NK-cell activity;
      vii) Ferritin ≥ 500 mcg/L;
      viii) Soluble CD25 ≥ 2400 U/mL; AND
3. Medication must be prescribed by or in consultation with a hematologist; AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Medication must be administered concomitantly with dexamethasone at a dose of at least 5 mg/m^2; AND
6. Member does not have ANY of the following:
   a) Diagnosis of secondary HLH consequent to a proven rheumatic or neoplastic disease;
   b) Body weight < 3 kg;
   c) Active Mycobacteria, Histoplasma Capsulatum, Shigella, Salmonella, Campylobacter and Leishmania infections;

d) Presence of malignancy;
e) Concomitant disease or malformation severely affecting the cardiovascular, pulmonary, liver or renal function; AND

7. Member has received vaccines or prophylaxis for Herpes Zoster, Pneumocystis jiroveccii, and fungal infections (Documentation required).
8. **Dosage allowed:** Up to a maximum of 10 mg/kg as an intravenous infusion twice per week. See prescribing information for dose titration criteria.

If member meets all the requirements listed above, the medication will be approved for 8 weeks.

For **reauthorization**:

1. Member has documented chart notes indicating ONE of the following:
   a) Partial response, defined as normalization of ≥ 3 HLH abnormalities;
   b) Complete response, defined as normalization of all HLH abnormalities (i.e., no fever, no splenomegaly, neutrophils > $1x10^9$ /L, platelets > $100x10^9$ /L, ferritin < 2,000 μg/L, fibrinogen > 1.50 g/L, D-dimer < 500 ug/L, normal CNS symptoms, no worsening of soluble CD25 > 2-fold baseline); OR
   c) HLH improvement, defined as ≥ 3 HLH abnormalities improved by at least 50% from baseline; AND
2. Member has not received a hematopoietic stem cell transplant since receiving initial authorization.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Gamifant (emapalumab-lzsg) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/23/2019	New policy for Gamifant created.

References:

1. McClain K. Treatment and prognosis of hemophagocytic lymphohistiocytosis. UpToDate [serial on the Internet] 2018 Dec 14 [cited 2019 Sept 9]. Available at: https://www.uptodate.com/contents/treatment-and-prognosis-of-hemophagocytic-lymphohistiocytosis.
2. Gamifant [prescribing information]. Waltham, MA: Sobi Inc.; November 2018.
3. ClinicalTrials.gov Identifier: NCT01818492. A Study to Investigate the Safety and Efficacy of an Anti-IFNγ mAb in Children Affected by Primary Haemophagocytic Lymphohistiocytosis. Available at: https://clinicaltrials.gov/ct2/show/NCT01818492?term=NCT01818492&rank=1.
4. McClain KL, Newburger P, Rosmarin AG. Treatment and prognosis of hemophagocytic lymphohistiocytosis. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com/contents/treatment-and-prognosis-of-hemophagocytic-lymphohistiocytosis?search=hemophagocytic%20lymphohistiocytosis%20(HLH)&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2. Accessed September 23, 2019.

Effective date: 04/01/2020
Revised date: 09/23/2019

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Gattex (teduglutide)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "dosage allowed" below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Gattex (teduglutide) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SHORT BOWEL SYNDROME (SBS)

For **initial** authorization:

1. Member is 1 year of age or older (must weigh at least 10kg or 22 pounds); AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has a diagnosis of short bowel syndrome and is dependent on parenteral support, defined by one of the following: [3,5]
   a) 18 years of age and over: At least 12 months of dependence, requiring support 3 or more times per week
   b) 17 years of age and under: At least 3 months of dependence, providing at least 30% of caloric/fluid needs; AND
4. Chart notes must document the baseline weekly volume of parenteral support; AND
5. Members 18 years old or older must have a colonoscopy within the past 6 months; AND
6. Member does not have colorectal cancer.
7. **Dosage allowed:** 0.05mg/kg once daily. Weight must be included in chart notes.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has not developed an active gastrointestinal malignancy; AND
2. Chart notes have been provided that show at least a 20% reduced volume of parenteral support need since treatment initiation.[3,4]

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Gattex (teduglutide) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/29/2020	New policy for Gattex created.
06/10/2021	Annual review, no changes

References:

1. Gattex [package insert]. Lexington, MA: Shire-NPS Pharmaceuticals Inc; 2019.
2. Pironi L, Arends J, Bozzetti F, et al. ESPEN guidelines on chronic intestinal failure in adults. *Clinical Nutrition*. 2016;35(2):247-307. doi:10.1016/j.clnu.2016.01.020
3. Jeppesen PB, Pertkiewicz M, Messing B, et al. Teduglutide Reduces Need for Parenteral Support Among Patients With Short Bowel Syndrome With Intestinal Failure. *Gastroenterology*. 2012;143(6):1473-1481. doi:10.1053/j.gastro.2012.09.007
4. Kocoshis SA, Merritt RJ, Hill S, et al. Safety and Efficacy of Teduglutide in Pediatric Patients With Intestinal Failure due to Short Bowel Syndrome: A 24-Week, Phase III Study. *Journal of Parenteral and Enteral Nutrition*. 2019;44(4):621-631. doi:10.1002/jpen.1690
5. Carter BA, Cohran VC, Cole CR, et al. Outcomes from a 12-Week, Open-Label, Multicenter Clinical Trial of Teduglutide in Pediatric Short Bowel Syndrome. *The Journal of Pediatrics*. 2017;181:102-111. doi:10.1016/j.jpeds.2016.10.027
6. Iyer KR, Kunecki M, Boullata JI, et al. Independence From Parenteral Nutrition and Intravenous Fluid Support During Treatment With Teduglutide Among Patients With Intestinal Failure Associated With Short Bowel Syndrome. *Journal of Parenteral and Enteral Nutrition*. 2016;41(6):946-951. doi:10.1177/0148607116680791

Effective date: 01/01/2022
Revised date: 06/10/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Gel-One (sodium hyaluronate)
BILLING CODE	J7326
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 1 injection (1 unit)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Gel-One (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions;
7. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
8. **Dosage allowed:** Inject 30 mg (3 mL) once.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Gel-One (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy - Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/17/2017	New policy for Gel-One created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed.
05/15/2018	Changed to non-preferred status. Trial of Supartz FX or Gel-One or Durolane added to criteria.

References:

1. Gel-One [package insert]. Warsaw, IN: Zimmer, Inc.; May, 2011.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Chevalier X, Jerosch J, Goupille P, et al. Single, intra-articular treatment with 6 ml hylan G-F 20 in patients with symptomatic primary osteoarthritis of the knee: a randomized, multicenter, double-blind, placebo controlled trial. Ann Rheum Dis. 2010 Jan;69(1):113-9.
5. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
6. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
7. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
8. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
9. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
10. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
11. Petrella RJ, Wakeford C. Pain relief and improved physical function in knee osteoarthritis patients receiving ongoing hylan G-F 20, a high-molecular-weight hyaluronan, versus other treatment options: data from a large real-world longitudinal cohort in Canada. Drug Des Devel Ther. 2015;9:5633-40.
12. Christensen R, Bartels EM, Astrup A, Bliddal H. Effect of weight reduction in obese patients diagnosed with knee osteoarthritis: a systematic review and meta-analysis. Ann Rheum Dis. 2007: 66(4):433-9.
13. Gel-One. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
14. Gel-One. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
15. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
16. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Gelsyn-3 (sodium hyaluronate)
BILLING CODE	J7328
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include Durolane, Supartz FX QUANTITY LIMIT— 3 injection (504 units) - 168 billing units per 2 mL injection
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Gelsyn-3 (sodium hyaluronate) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions.
7. **Dosage allowed:** Inject 16.8 mg (2 mL) once weekly for 3 weeks (total of 3 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Gelsyn-3 (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Gelsyn-3 created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Product status changed to preferred. Trial of Supartz FX or Gel-One removed.

References:

1. Gelsyn-3 [package insert]. Durham, NC: Bioventus; 2016.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Gelsyn-3. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
11. Gelsyn-3. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
12. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 09/01/2017
Revised date: 08/04/2017

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Gender–Affirming Hormone Therapy
BILLING CODE	Must use valid NDC or J code (see Table 1)
BENEFIT TYPE	Medical or Pharmacy (see Table 1)
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Gender dysphoria is a condition of feeling one's emotional and psychological identity as male or female to be incongruent to one's assigned sex at birth. Gender-affirming hormone therapy can be used to allow different degrees of masculinization or feminization tailored to the patient's needs. For example, masculinizing hormone therapy includes medications that will increase testosterone levels to cause masculinizing changes to occur. In contrast, feminizing hormone therapy includes medications that reduce testosterone levels while raising estrogen level to allow feminizing changes to occur. Patient's may also identify as non-binary and require flexible interventions. As a result, hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone treatment is not recommended for prepubertal gender-dysphoric individuals.

Gender-affirming hormone therapy will be considered for coverage when the following criteria are met:

Gender Dysphoria

For **initial** authorization:

1. Member is at least 16 years of age; AND
2. Medication must be prescribed by or in consultation with a mental health provider or a pediatric endocrinologist who has experience in providing gender-affirming hormone therapy; AND
3. Member has a diagnosis of gender dysphoria with all of the following:
   a) Persistent, well-documented gender dysphoria;
   b) If member is under 18 years of age, puberty has started (Tanner stage 2 or greater); AND
4. If medication requires a step therapy, must have a trial and failure of, or contraindication to the preferred step therapy product; AND
5. Provider attests that member has sufficient mental capacity to make a fully informed decision and to consent for treatment; AND
6. If significant medical or mental health concerns are present, they must be reasonably well controlled before starting hormone therapy.
7. **Dosage allowed/Quantity limit:** See Table 1 for dosing suggestions.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show that member is experiencing clinical benefit from the use of gender-affirming hormone therapy.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource Rxinnovations

CareSource considers Gender-Affirming Hormone Therapy not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
04/24/2021	New policy for Gender-Affirming Hormone Therapy created.

References:

1. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2017;102(11):3869-3903.
2. Unger CA. Hormone therapy for transgender patients. *Transl Androl Urol*. 2016;5(6):877-884. doi:10.21037/tau.2016.09.04.
3. UCSF Transgender Care, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at transcare.ucsf.edu/guidelines.
4. Hashemi L, Weinreb J, Weimer AK, Weiss RL. Transgender Care in the Primary Care Setting: A Review of Guidelines and Literature. *Fed Pract*. 2018;35(7):30-37.
5. World Professional Association for Transgender Health. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Conforming People [7th Version].
6. Cocchetti C, Ristori J, Romani A, et al. Hormonal Treatment Strategies Tailored to Non-Binary Transgender Individuals. *J Clin Med*. 2020 May 26;9(6):1609. doi: 10.3390/jcm9061609.

Table 1

Please note that this is not a comprehensive list of all available hormone therapy options. The dosing regimens listed below are generally accepted dosing regimens in current guidelines. Actual dosing of medications might vary for certain patients to achieve hormonal goal levels.

Gender-Affirming Hormone Therapy	Dosing Regimen
Testosterone Therapy	
Testosterone transdermal gel 1%, 1.62%, 2%	50 – 100 mg/day
Testosterone transdermal patch (AndroDerm)	2.5 - 7.5 mg/day
Testosterone enanthate or cypionate	100 – 200 mg every 2 weeks OR 50 – 100 mg every week
Testosterone undecanoate (Aveed)	1000 mg every 12 weeks
Estrogen/Progesterone Therapy	
Estradiol oral	2 - 6 mg daily
Estradiol transdermal patch	0.025 – 0.2 mg patch twice weekly
Estradiol valerate (Delestrogen)	5 – 30 mg every 2 weeks
Estradiol cypionate (Depo-Estradiol)	2 – 10 mg every week
Progesterone	20 - 60 mg daily
Medroxyprogesterone acetate (Depo-Provera)	150 mg every 3 months
GnRH Agonist	
Leuprolide (Lupron Depot, Lupron Depot-PED, Eligard, Fensolvi)	3.75 - 7.5 mg monthly OR 11.25 mg every 3 months
Goserelin (Zoladex) implant	3.6 mg monthly
Anti-androgens	
Spironolactone	100 - 300 mg daily

Effective date: 10/1/2021
Revised date: 05/18/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	GenVisc 850 (sodium hyaluronate)
BILLING CODE	J7320
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 5 injections (125 units) - 25 billing units per injection
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

GenVisc 850 (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
8. **Dosage allowed:** Inject 25 mg (2.5 mL) once weekly for 5 weeks (total of 5 injections); some patients may benefit from a total of 3 injections.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers GenVisc 850 (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for GenVisc 850 created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.

References:

1. GenVisc 850 [package insert]. Doylestown, PA: OrthogenRx. N.D.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. *Cochrane Database Syst Rev.* 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Genvisc. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
11. Genvisc. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
12. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Gilenya (fingolimod)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Gilenya was initially approved by the FDA in 2010. It is indicated for the treatment of relapsing forms of multiple sclerosis (MS). It was the first oral drug approved for MS and later became the first drug approved for MS in the pediatric population. MS is a chronic autoimmune disease of the central nervous system that disrupts communication in the brain and between the brain and body. Gilenya was the first sphingosine-1-phosphate (S1P) receptor modulator. It requires all patients to be monitored for 6 hours after the first dose is given due to the potential for bradycardia.

Gilenya (fingolimod) will be considered for coverage when the following criteria are met:

Multiple Sclerosis (MS)

For **initial** authorization:

1. Member is at least 10 years of age; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of a relapsing form of MS (i.e., clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease); AND
4. The following baseline assessments have been completed (or are scheduled):
   a) A complete blood count (CBC)
   b) An ophthalmic evaluation
   c) Baseline QTc interval is less than 500 msec
   d) Baseline liver function tests; AND
5. The risk of progressive multifocal leukoencephalopathy (PML) has been discussed; AND
6. Member has not experienced any of the following in the past 6 months: Myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure; AND
7. Member does not have Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker; AND
8. Gilenya will not be used concomitantly with any other disease modifying drugs for MS.
9. **Dosage allowed/Quantity limit:**
   Adults and pediatrics 10 years of age and older weighing more than 40 kg: 0.5 mg once daily
   Pediatrics 10 years of age and older weighing less than or equal to 40 kg: 0.25 mg once daily

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as fewer relapses or no new or enlarging lesions on MRI.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Gilenya (fingolimod) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Gilenya created. Not covered diagnosis added. Contraindications added in criteria. Baseline QTc interval required
12/06/2017	Age coverage expanded. Confirmation of diagnosis based on McDonald criteria is no longer required.
09/13/2018	Age coverage expanded into pediatric population. CBC baseline and suggested discussion with member about PML risks prior to treatment were added to criteria.
10/12/2021	Transferred to new template. General changes to language for consistency with related drugs. Updated references. Removed CIS from exclusion list and added to criteria. Moved ophthalmic note into the criteria. Added baseline LFT's. Added note regarding concomitant use. Added pediatric dosing. Added renewal criteria. Removed anti-arrhythmic exclusion, could be ok if they have cardiac consult.

References:

1. Gilenya [package insert]. East Hanover, NJ; Novartis Pharmaceuticals, Inc., 2019.
2. Kappos L, et al. A placebo-controlled trial of oral fingolimod in relapsing multiple sclerosis. N Engl J Med. 2010 Feb 4;362(5):387-401.
3. Cohen JA, et al. Oral fingolimod or intramuscular interferon for relapsing multiple sclerosis. N Engl J Med. 2010 Feb 4;362(5):402-15.
4. Calabresi PA, et al. Safety and efficacy of fingolimod in patients with relapsing-remitting multiple sclerosis (FREEDOMS II): a double-blind, randomised, placebo-controlled, phase 3 trial. Lancet Neurol. 2014 Jun;13 (6):545-56.
5. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology [published correction appears in Neurology. 2019 Jan 8;92(2):112]. *Neurology*. 2018;90(17):777-788. doi:10.1212/WNL.0000000000005347
6. National Multiple Sclerosis Society. The Use of Disease-Modifying Therapies in Multiple Sclerosis: Principles and Current Evidence. A Consensus Paper by the Multiple Sclerosis Coalition; 2019. Available from: https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/DMT_Consensus_MS_Coalition.pdf. Accessed August 18, 2021.
7. Thompson AJ, Banwell BL, Barkhof F, et al. Diagnosis of multiple sclerosis: 2017 revisions of the McDonald criteria. *Lancet Neurol*. 2018;17(2):162-173. doi:10.1016/S1474-4422(17)30470-2
8. Roy R, Alotaibi AA, Freedman MS. Sphingosine 1-Phosphate Receptor Modulators for Multiple Sclerosis. *CNS Drugs*. 2021;35(4):385-402. doi:10.1007/s40263-021-00798-w
9. Chitnis T, Arnold DL, Banwell B, et al. Trial of Fingolimod versus Interferon Beta-1a in Pediatric Multiple Sclerosis. *N Engl J Med*. 2018;379(11):1017-1027. doi:10.1056/NEJMoa1800149
10. La Mantia L, Tramacere I, Firwana B, Pacchetti I, Palumbo R, Filippini G. Fingolimod for relapsing-remitting multiple sclerosis. *Cochrane Database Syst Rev*. 2016;4:CD009371. Published 2016 Apr 19. doi:10.1002/14651858.CD009371.pub2
11. Tramacere I, Del Giovane C, Salanti G, D'Amico R, Filippini G. Immunomodulators and immunosuppressants for relapsing-remitting multiple sclerosis: a network meta-analysis. *Cochrane Database Syst Rev*. 2015;(9):CD011381. Published 2015 Sep 18. doi:10.1002/14651858.CD011381.pub2

12. Filippini G, Del Giovane C, Clerico M, et al. Treatment with disease-modifying drugs for people with a first clinical attack suggestive of multiple sclerosis. *Cochrane Database Syst Rev*. 2017;4(4):CD012200. Published 2017 Apr 25. doi:10.1002/14651858.CD012200.pub2

Effective date: 04/01/2022
Revised date: 10/12/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Givlaari (givosiran)
BILLING CODE	J3490 (1 unit = 1 mL)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— based on weight
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Givlaari (givorisan) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE HEPATIC PORPHYRIA (AHP)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist, a hepatologist, or a physician who has experience with treating acute hepatic porphyria; AND
3. Member has a confirmed diagnosis of Acute Hepatic Porphyria with one of the following types: Acute Intermittent Porphyria, Hereditary Corproporhyria, Variegate Porphyria, aminolevulinic acid (ALA) dehydratase deficient porphyria; AND
4. Member has had at least 2 porphyria attacks within the last 6 months documented in chart notes (Note: attacks are defined as requiring hospitalization, urgent care visit, or intravenous hemin administration at home); AND
5. Member does not have ANY of the following:
   a) Prior or anticipated liver transplant;
   b) Active HIV infection;
   c) Active Hepatitis B or C virus; AND
6. Member will not be receiving prophylactic treatment with intravenous Panhematin (IV hemin) while taking Givlaari (Note: acute use of Panhematin for the treatment of an attack is allowed).
7. **Dosage allowed:** 2.5mg/kg via subcutaneous injection once monthly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has not been using prophylactic Panhematin while taking Givlaari; AND
2. Member is in compliance with all other initial criteria; AND
3. Chart notes have been provided to show the member has had a reduction in the number of porphyria attacks.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Givlaari (givosiran) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/23/2020	New policy for Givlaari created.
11/17/2021	Annual review, no changes

References:

1. Givlaari [package insert]. Summit, NJ: Celgene Corporation, November 2019.
2. ENVISION: A Study to Evaluate the Efficacy and Safety of Givosiran (ALN-AS1) in Patients With Acute HepaticPorphyrias (AHP). Clinicaltrials.gov. Accessed April 23, 2020.
3. Balwani M, Wang B, Anderson KE, et al. Acute hepatic porphyrias: Recommendations for evaluation and long-term management. Hepatology. 2017;66(4):1314–1322. doi:10.1002/hep.29313.
4. Givlaari Drug Approval Package - Multi-Discipline Review, Application Number 212194. Food and Drug Administration Center for Drug Evaluation and Research. Accessed April 23, 2020.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Granix (tbo-filgrastim)
BILLING CODE	For medical - J1447 For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Zarxio QUANTITY LIMIT— N/A
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Granix (tbo-filgrastim) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:

1. Member is 18 years of age or older with a non-myeloid malignancy; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication will not be administered within 24 hours of myelosuppressive chemotherapy and will be administered for at least 5 days until neutrophil recovery (ANC ≥1,000/mm^3) up to a maximum of 14 days; AND
4. Chart notes with length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the day of the cycle on which Granix will be administered, are submitted with prior authorization request; AND
5. Member has a documented history of febrile neutropenia following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
6. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (>20%, see Appendix for description) for incidence of febrile neutropenia; OR
7. Member is receiving myelosuppressive anti-cancer drugs associated with at intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Bone marrow involvement with tumor;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (bilirubin >2.0);
   f) Renal dysfunction (creatinine clearance <50);
   g) Age >65 years receiving full chemotherapy dose intensity.
8. **Dosage allowed:** 5 mcg/kg per day administered as a subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Granix therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Granix (tbo-filgrastim) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute myeloid leukemia
- Hematopoietic Subsyndrome of Acute Radiation Syndrome
- Mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplant
- Myeloid recovery following autologous or allogenic bone marrow transplant
- Nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant
- Severe chronic neutropenia

DATE	ACTION/DESCRIPTION
10/19/2017	New policy for Granix created. Criteria coverage for Prevention of Febrile Neutropenia was expanded. List of not covered diagnoses was added.

References:

1. Granix (tbo-filgrastim) [prescribing information]. North Wales, PA: Teva; February 2017.
2. Del Giglio A, Eniu A, Ganea-Motan D, Tupozov E, Lubenau H. XM02 is superior to placebo and equivalent to Neupogen in reducing the duration of severe neutropenia and the incidence of febrile neutropenia in cycle I in breast cancer patients receiving docetaxel/doxorubicin in chemotherapy. *BMC Cancer*. 2008;8:332-339. Doi: 10.1186/1471-2407-8-332.

Effective date: 11/08/2017
Revised date: 10/19/2017

CareSource

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (>20%)

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) (neoadjuvant, adjuvant, metastatic)
Breast Cancer	Docetaxel + trastuzumab (metastatic or relapsed)
	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel) (adjuvant)
	TAC (docetaxel, doxorubicin, cyclophosphamide) (adjuvant)
Esophageal and Gastric Cancers	Docetaxel/cisplatin/fluorouracil
Hodgkin Lymphoma	BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	ICE (ifosfamide, carboplatin, etoposide) (diffuse large B-cell lymphoma [DLBCL], peripheral T-cell lymphomas [PTCL], 2nd line)
	RICE (rituximab, ifosfamide, carboplatin, etoposide)
	CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone) + rituximab
	MINE (mesna, ifosfamide, novantrone, etoposide) (DLBCL, 2nd line, refractory)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine (Ara-C)) (DLBCL, PTCL, 2nd line, recurrent)
	HyperCVAD + rituximab (cyclophosphamide, vincristine, doxorubicin, dexamethasone + rituximab)
Melanoma	Dacarbazine-based combination (dacarbazine, cisplatin, vinblastine) (advanced, metastatic, or recurrent)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha) (advanced, metastatic, or recurrent)
Ovarian Cancer	Topotecan
	Paclitaxel
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)
	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	topotecan
Testicular cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	BEP (bleomycin, etoposide, cisplatin)

	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% to 19%)

Cancer Histology	**Regimen**
Occult primary - adenocarcinoma	Gemcitabine/docetaxel
Breast cancer	Docetaxel every 21 days
	CMF classic (cyclophosphamide, methotrexate, fluorouracil) (adjuvant)
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (adjuvant) (taxane portion only)
	AC + sequential docetaxel + trastuzumab (adjuvant)
	FEC (fluorouracil, epirubicin, cyclophosphamide) + sequential docetaxel
	TC (docetaxel, cyclophosphamide)
Cervical Cancer	Cisplatin/topotecan (recurrent or metastatic)
	Paclitaxel/cisplatin
	Topotecan (recurrent or metastatic)
	Irinotecan (recurrent or metastatic)
Colorectal	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Multiple myeloma	DT-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophoaphamide/etoposide)
	DT-PACE + bortezomib (VTD-PACE)
Non-Hodgkin's lymphomas	EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) (AIDS-related NHL, Burkitt lymphoma, recurrent, otherr NHL subtypes)
	EPOCH-IT chemotherapy (AIDS-related NHL, DLBCL, recurrent)
	GDP (gemcitabine, dexamethasone, cisplatin) (DLBCL, PTCL, 2nd line)
	GDP (gemcitabine, dexamethasone, cisplatin) + rituximab (DLBCL, 2nd line, Burkitt lymphoma, other NHL subtypes)
	FMR (fludarabine, mitoxantrone, rituximab)
	CHOP + rituximab (cyclophosphamide, doxorubicin, vincristine, prednisone, rituximab) including regimens with pegylated liposomal doxorubicin or mitoxantrone substituted for doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel (advanced/metastatic)
	Cisplatin/vinorelbine (adjuvant, advanced/metastatic)
	Cisplatin/docetaxel (adjuvant, advanced/metastatic)
	Cisplatin/etoposide (adjuvant, advanced/metastatic)

	Carboplatin/paclitaxel (adjuvant, advanced/metastatic)
	Docetaxel (advanced/metastatic)
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX
Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
Uterine Sarcoma	Docetaxel (advanced or metastatic)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Haegarda (C1 esterase inhibitor (human))
BILLING CODE	J0599
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Haegarda (C1 esterase inhibitor (human)) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Chart notes must document the member's baseline frequency of HAE attacks; AND
5. Member is inadequately controlled with on-demand treatment alone; AND
6. Haegarda is being prescribed for ongoing prophylaxis and will not be used to treat acute attacks.
7. **Dosage allowed:** 60 units/kg subQ twice weekly (every 3 or 4 days).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must be provided that show a reduced frequency or number of acute attacks since starting treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Haegarda (C1 esterase inhibitor (human)) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acquired angioedema (AAE)
- Treatment of acute HAE attacks

DATE	ACTION/DESCRIPTION
08/25/2017	New policy for Haegarda created.

01/14/2021	Updated and revised all content; consistent with other HAE prophylactics. Added specific J code. Changed age limit to 6 per recent label change. Updated references. Greatly simplified the diagnostic confirmation criteria. Removed minimum required number of attacks, per guidelines; will just ask for baseline measure. Removed the statement about causative medications. Added that they must try on-demand treatment first. Rewrote the renewal criteria and removed log book requirement. Extended initial auth duration to 6 mo and renewal to 12 mo. Inserted the word “esterase” in front of “inhibitor” in the drug name.

References:

1. ClinicalTrials.gov web site. Bethesda, MD. U.S. National Institutes of Health. Identifier NCT02584959, Study to Evaluate the Clinical Efficacy and Safety of Subcutaneously Administered C1 Esterase Inhibitor for the Prevention of Angioedema Attacks in Adolescents and Adults With Hereditary Angioedema; October 20, 2015. Available at: https://clinicaltrials.gov/ct2/show/NCT02584959.
2. Haegarda (C1 Esterase Inhibitor [Human]) [prescribing information]. Kankakee, IL: CSL Behring LLC; 2020.
3. Longhurst H, Cicardi M, Craig T, et al. Prevention of Hereditary Angioedema Attacks with a Subcutaneous C1 Inhibitor. N Engl J Med. 2017;376(12):1131-1140.
4. Lumry W. Management and Prevention of Hereditary Angioedema Attacks. Am J Manag Care. 2013;19:S111-S118.
5. Lumry WR, Martinez-Saguer I, Yang WH, et al. Fixed-Dose Subcutaneous C1-Inhibitor Liquid for Prophylactic Treatment of C1-INH-HAE: SAHARA Randomized Study. *J Allergy Clin Immunol Pract*. 2019;7(5):1610-1618.e4. doi:10.1016/j.jaip.2019.01.021
6. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
7. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384

Effective date: 10/1/2021
Revised date: 01/14/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Harvoni (ledipasvir/sofosbuvir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Mavyret and Sofosbuvir/velpatasvir (generic Epclusa) QUANTITY LIMIT— 28 for a 28 day supply
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Harvoni (ledipasvir/sofosbuvir) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEPATITIS C

For **initial** authorization:

1. Member must be 3 years of age or older; AND
2. Member is treatment-naïve or treatment-experienced with genotype 1, 4, 5 or 6 (laboratory documentation required); AND
3. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
4. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
5. Member must meet **one** of the following drug trial requirements based on eligible age/weight (*dates of previous trials and viral loads must be documented in chart notes*):
   a) No trial required for 3-5 years old AND weigh below 17 kg (37 lbs); OR
   b) Member who is 6-11 years old OR weighs at least 17 kg (37 lbs) must have a trial of Sofosbuvir/velpatasvir (generic for Epclusa); OR
   c) Member who is 12 years of age and older OR weighs at least 45 kg (99 lbs) must have a trial with either Sofosbuvir/velpatasvir or Mavyret; AND
6. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required).
7. **Dosage allowed:** One tablet once daily for 12-24 weeks, see Appendix below for details.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

If member meets all the requirements listed above, the medication will be approved for 12-24 weeks, see Appendix below.

For **reauthorization**:
Harvoni will not be reauthorized for continued therapy.

CareSource

CareSource considers Harvoni (ledipasvir/sofosbuvir) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/09/2017	New policy for Harvoni created. Criteria coverage was adjusted for age, alternative products were indicated. Hep B test requirement was added. Drug and alcohol screens for 3 consecutive months required for all regardless of abuse history. Evidence of liver fibrosis exceptions was expanded. Reauthorization requirement of 2 consecutive values of HCV RNA ≥ 25 IU per mL during the post-treatment period and documented reason of treatment failure were added.
06/08/2017	Fibrosis stage 2 and above covered.
11/22/2017	Substance abuse program information is no longer required. Criterion on absence of moderate to severe liver impairment was added.
12/07/2017	Criterion of "life expectancy not less than one year due to non-liver related comorbidities" removed from criteria and added in a form of the note. Hepatitis B testing is no longer required.
12/21/2017	Fibrosis score requirement was removed.
05/01/2019	Sofosbuvir/velpatasvir (generic for Epclusa) trial added for adult members; Mavyret trial added for members 12-17 years of age.
4/26/2020	Harvoni's age indication expanded to include age 3 or older. Criteria were adjusted for age and drug trials accordingly.
05/04/2021	Updated treatment appendix. Reworded the trial requirements to be more clear (neutral change). Removed requirement that member does not have severe hepatic impairment (child-pugh B and C). Removed reauthorization criteria and replaced with "Harvoni will not be reauthorized".

References:

1. Harvoni [package Insert]. Foster City, CA: Gilead Sciences, Inc.; November, 2017.
2. Mavyret [Package insert]. North Chicago, IL: AbbVie Inc.; August 2017.
3. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
4. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
5. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 01/01/2022
Revised date: 05/04/2021

CareSource

Appendix. Treatment Duration

Genotype	Patient Population	Regimen and Duration
Genotype 1	Treatment-naïve without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Harvoni 12 weeks
	Treatment-experienced without cirrhosis	Harvoni 12 weeks
	Treatment-experienced with compensated cirrhosis (Child-Pugh A)	Harvoni 24 weeks
	Treatment-naïve and treatment-experienced with decompensated cirrhosis (Child-Pugh B or C)	Harvoni + ribavirin 12 weeks
Genotype 1 or 4	Treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A)	Harvoni + ribavirin 12 weeks
Genotype 4, 5, or 6	Treatment-naïve and treatment-experienced, without cirrhosis or with compensated cirrhosis (Child-Pugh A)	Harvoni 12 weeks

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Humira (adalimumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz QUANTITY LIMIT— 4 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Humira (adalimumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
8. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia and Cosentyx. Treatment failure requires at least 12 weeks of therapy with each drug.
9. **Dosage allowed:** 40 mg subcutaneously every other week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 6 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by **one** of the following:
   a) Extensive small bowel disease involving more than 100 cm;
   b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
   c) Fistulizing disease.
6. **Dosage allowed:**
   a) Adults: 160 mg subcutaneously on day one, then 80 mg 2 week later (day 15), then 40 mg every other week beginning on day 29;
   b) Pediatrics:
      i. 17 kg (37 lbs) to < 40 kg (88 lbs): Induction: 80 mg on day 1 and 40 mg two weeks later (day 15); maintenance: 20 mg every other week;
      ii. ≥ 40 kg (88 lbs.): Induction: 160 mg on day 1 and 80 mg two weeks later (day 15); maintenance: 40 mg every other week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

HIDRADENITIS SUPPURATIVA (HS)

For **initial** authorization:

1. Member is 12 years of age or older with a diagnosis of moderately to severely HS as defined by The Physicians Global Assessment Tool (Hurley Stage II or III); AND
2. Medication must be prescribed by a dermatologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has made documented lifestyle changes that would promote weight loss if member's body mass index (BMI) is greater than 25; AND
5. Member has a documented negative Urine Nicotine Test; AND
6. Member has tried at least a **four** week trial and has failed to respond to **both** of the following treatments:
   a) Topical clindamycin and systemic tetracycline; AND
   b) Systemic clindamycin and systemic rifampicin.
7. **Dosage allowed:** 160 mg initial dose, then 80 mg 2 weeks later (day 15), then 40 mg every week beginning on day 29.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (pJIA)

For **initial** authorization:
1. Member must be 2 years of age or older with moderately to severely active pJIA; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had an adequate trial and failure of a non-biologic DMARD (e.g., methotrexate, leflunomide, etc.) for 8 weeks, unless not tolerated or contraindicated; AND
5. Member must have tried and failed treatment with **both** Enbrel and Actemra. Treatment failure requires at least 12 weeks of therapy with each drug.
6. **Dosage allowed:** 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg subcutaneously every other week;
   15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg subcutaneously every other week;
   ≥ 30 kg (66 lbs): 40 mg subcutaneously every other week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq. Treatment failure requires at least 12 weeks of therapy with each drug.

8. **Dosage allowed:** 80 mg initial dose, then 40 mg every other week starting 1 week after the initial dose.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated dose AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** 40 mg subcutaneously every other week.

If member meets all the requirements listed above, the medication will be approved** for **12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:
1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).

5. Member has tried and failed treatment with at least **two** of the following: Actemra, Cimzia, Enbrel, Kevzara, Olumiant and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
6. **Dosage allowed:** 40 mg subcutaneously every other week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:
1. Member is 5 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a documented trial and inadequate response with **one** of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of Corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
5. **Dosage allowed:**
   a) Adults (18 or older): 160 mg subcutaneously on day 1, then 80 mg 2 weeks later (day 15), then 40 mg every other week beginning on day 29.
   b) Pediatric 20 kg (44 lbs) to less than 40 kg (88 lbs): 80 mg subcutaneously on day 1, 40 mg on day 8, 40 mg on day 15. Starting on day 29, give 40 mg every other week or 20 mg every week.
   c) Pediatric 40 kg (88 lbs) and greater: 160 mg subcutaneously on day 1, 80 mg on day 8, 80 mg on day 15. Starting on day 29, give 80 mg every other week or 40 mg every week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

UVEITIS (noninfectious, chronic)

For **initial** authorization:
1. Medication must be prescribed by an ophthalmologist that is a uveitis specialist or an ocular immunologist; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Member has loss of visual acuity or has evidence of retinal involvement; AND
4. Member has tried at least a 4-week trial and has failed to respond to at least **one** of the following treatments:
   a) Corticosteroids (prednisone, methylprednisolone, cortisone, etc.);

b) Systemic immunosuppresants (azathioprine, cyclosporine, etc.).

5. **Dosage allowed:** 80 mg as a single subcutaneous dose, then 40 mg every other week beginning 1 week after the initial dose.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Humira (adalimumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/08/2017	New policy for Humira created. Policies SRx-0041, SRx-0042, and SRx-0043 archived. For diagnosis of CD: Remicade was removed from criteria requirements. For HS diagnosis: prescribed by a dermatologist requirement was added. For diagnosis of PP: immunosuppressive drug criterion was separated from phototherapies and topical agents' trials; Psoriasis Area and Severity Index (PASI) score requirement was added. For diagnosis of RA: non-biologic DMARDS were listed and criterion was added to use drug in combination with methotrexate, or if intolerant to methotrexate, use another immunosuppressant. List of diagnoses considered not medically necessary was added.
02/26/2019	Medication status changed to non-preferred. Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. References added. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
11/13/2019	Age coverage for diagnosis of HS expanded; it's now approved for 12 years old and older.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. CD: Specified length of trials for conventional therapies, previously not specified. For severe disease, removed esophageal/gastroduodenal disease, specified that history of colonic resection must also be high risk for recurrence. JIA: Changed trials to require one non-biologic DMARD. Specified name to be pJIA. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. Removed concurrent use with methotrexate. UC: Specified the length of trials for conventional therapies (previously not specified).
05/04/2021	For Ulcerative Colitis (UC), age limit expanded to 5 years of age or older (previously 18 or older). Dosage allowed section updated.

References:

1. Humira [prescribing information]. North Chicago, IL; AbbVie Inc.: February, 2021.

2. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
7. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
8. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
9. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
10. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
11. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
12. Lovell DJ, et al. Adalimumab with or without methotrexate in juvenile rheumatoid arthritis. *N Engl J Med*. 2008; 359:810.
13. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guidelines for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care Res* (Hoboken). 2019 Jun;71(6):717-734.
14. Mease PJ, et al. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blind, randomized, placebo-controlled trial. *Arthritis Rheum*. 2005; 52:3279.
15. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
16. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
17. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
18. Bissonnette R, et al. Efficacy and safety of adalimumab in patients with plaque psoriasis who have shown an unsatisfactory response to etanercept. J Am Acad Dermatol. 2010; 63:228.
19. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
20. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
21. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
22. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
23. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
24. Weinblatt ME, et al. Adalimumab, a fully human anti-tumor necrosis factor alpha monoclonal antibody, for the treatment of rheumatoid arthritis in patients taking concomitant methotrexate: the ARMADA trial. Arthritis Rheum. 2003; 48:35.
25. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.

26. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
27. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
28. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

Effective date: 01/01/2022
Revised date: 05/04/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Hyalgan (sodium hyaluronate)
BILLING CODE	J7321
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 5 injections (5 units)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Hyalgan (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member is not allergic to avian proteins, feathers, and egg products; AND
8. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
9. **Dosage allowed:** Inject 20 mg (2 mL) once weekly for up to 5 weeks (total of 5 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource

CareSource considers Hyalgan (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Hyalgan created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.

References:

1. Hyalgan [package insert]. Parsippany, NJ: Fidia Pharma USA Inc.; May, 2014.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Christensen R, Bartels EM, Astrup A, Bliddal H. Effect of weight reduction in obese patients diagnosed with knee osteoarthritis: a systematic review and meta-analysis. Ann Rheum Dis. 2007: 66(4):433-9.
11. Carraba, M et al. 1991 Hyaluronic acid sodium salt (Hyalgan) in the treatment of patients with osteoarthritis of the knee: a controlled trial versus Orgotein, Final report. April 1991. Data on file.
12. Kotz R, Kolarz G. Intra-articular hyaluronic acid: duration of effect and results of repeated treatment cycles. Am J Ortho 1997(28):5-7.
13. Hyalgan. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
14. Hyalgan. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
15. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
16. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Hymovis (sodium hyaluronate)
BILLING CODE	J7322
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 2 injections (48 units)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Hymovis (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
8. **Dosage allowed:** Inject 24 mg (3 mL) once weekly for 2 weeks (total of 2 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource

CareSource considers Hymovis (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Hymovis created.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.

References:

1. Hymovis [package insert]. Parsippany, NJ; Fidia Pharma USA Inc.; August, 2015. Accessed March 2016.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Hymovis. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
11. Hymovis. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
12. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Ilaris (canakinumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Freestanding facility or clinic
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 2 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ilaris (canakinumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as state.

ADULT-ONSET STILL'S DISEASE (AOSD)

For **initial** authorization:

1. Member must have a confirmed diagnosis of active Adult-Onset Still's Disease supported by chart notes; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has tried and failed, or unable to tolerate **both** of the following (taken together or separately):
   a) A trial of a corticosteroid (prednisone or methylprednisolone);
   b) A 2-month trial of a conventional DMARD (e.g., methotrexate, cyclosporine, leflunomide, etc.).
5. **Dosage allowed:** 4 mg/kg (up to max dose 300 mg) subcutaneously every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS)

For **initial** authorization:

1. Member must be 4 years of age or older; AND
2. Member must be diagnosed with Familial Cold Autoinflammatory Syndrome (FCAS) OR Muckle-Wells Syndrome; AND
3. Prescriber has submitted laboratory evidence of a genetic mutation in the Cold-Induced Auto-Inflammatory Syndrome 1 (CIAS1—sometimes referred to as the NLRP3); AND
4. Medication must be prescribed by a rheumatologist or under recommendation of a rheumatologist or CAPS specialist; AND
5. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy.
6. **Dosage allowed:** 150 mg for body weight > 40 kg; 2 mg/kg for body weight ≥ 15 kg and ≤ 40 kg. For children 15 to 40 kg with an inadequate response, the dose can be increased to 3 mg/kg. Administer subcutaneously every 8 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

FAMILIAL MEDITERRANEAN FEVER (FMF)

For **initial** authorization:

1. Member's Physician's Global Assessment (PGA) Disease Activity score is ≥2 documented in chart notes with key signs and symptoms of FMF: abdominal pain, skin rash, chest pain, arthralgia/arthritis; AND
2. Member's C-reactive protein (CRP) > 10 mg/L is documented in chart notes; AND
3. Member has documentation of at least one flare per month; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy.
5. **Dosage allowed:** Body weight ≤ 40 kg: starting dose is 2 mg/kg every 4 weeks. The dose can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate. Body weight > 40 kg: starting dose is 150 mg every 4 weeks. The dose can be increased to 300 mg every 4 weeks if the clinical response is not adequate.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

HYPERIMMUNOGLOBULIN D SYNDROME (HIDS)/MEVALONATE KINASE DEFICIENCY (MKD)

For **initial** authorization:

1. Member's Physician's Global Assessment (PGA) Disease Activity score is ≥2 documented in chart notes with key signs and symptoms of HIDS/MKD: abdominal pain; lymphadenopathy, aphthous ulcers; AND
2. Member's C-reactive protein (CRP) > 10 mg/L is documented in chart notes; AND
3. Member has documentation of ≥ 3 febrile acute flares within a 6 month period; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy.
5. **Dosage allowed:** Body weight ≤ 40 kg: starting dose is 2 mg/kg every 4 weeks. The dose can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate. Body weight > 40 kg: starting dose is 150 mg every 4 weeks. The dose can be increased to 300 mg every 4 weeks if the clinical response is not adequate.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA)

For **initial** authorization:

1. Member must be 2 years of age or older; AND
2. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by a rheumatologist; AND
4. Member must have active systemic juvenile idiopathic arthritis, as indicated by arthritis involving two or more joints AND **one** or more of the following:
    a) Evanescent erythematous rash;
    b) Fever for at least two weeks
    c) Generalized lymphadenopathy;
    d) Hepatomegaly or splenomegaly;
    e) Pericarditis, pleuritis, or peritonitis; AND
5. Member must have inadequate response to ALL of the following:
    a) Glucocorticoid injection;
    b) Methotrexate;
    c) NSAIDs after a 12-week trial.
6. **Dosage allowed:** 4 mg/kg (with a maximum of 300 mg) for members with a body weight ≥ 7.5 kg. Administer subcutaneously every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

TUMOR NECROSIS FACTOR RECEPTOR ASSOCIATED PERIODIC SYNDROME (TRAPS)

For **initial** authorization:

1. Member's Physician's Global Assessment (PGA) Disease Activity score is ≥ 2 documented in chart notes with key signs and symptoms of TRAPS: abdominal pain, skin rash, musculoskeletal pain, eye manifestations; AND
2. Member's C-reactive protein (CRP) > 10 mg/L is documented in chart notes; AND
3. Member has documentation of at least 6 flares per year; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy.
5. **Dosage allowed:** Body weight ≤ 40 kg: starting dose is 2 mg/kg every 4 weeks. The dose can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate. Body weight > 40 kg: starting dose is 150 mg every 4 weeks. The dose can be increased to 300 mg every 4 weeks if the clinical response is not adequate.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ilaris (canakinumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute coronary syndromes
- Atherosclerosis
- Chronic obstructive pulmonary disease
- Gout/gouty arthritis
- Heart failure
- Inflammatory dermatosis
- Majeed syndrome
- Ocular diseases
- Rheumatoid arthritis
- Schnitzler syndrome
- Type 1 and type 2 diabetes

DATE	ACTION/DESCRIPTION
05/09/2017	New policy for Ilaris created. Policy SRx-0042 archived. For CAPS diagnosis: laboratory evidence requirement of a genetic mutation added. Diagnoses of TRAPS, HIDS/MKD and FMF were added. List of diagnoses considered not medically necessary added.
07/14/2017	Documentation of negative TB test was added to all diagnosis.

03/20/2019	TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed.
09/29/2020	New diagnosis of Adult Onset Still's Disease added. Status corrected.
11/19/2021	Annual review, no changes

References:

1. Ilaris [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; December, 2016
2. Shinkai K, McCalmont TH, Leslie KS. Cryopyrin-associated periodic syndromes and autoinflammation. Clin Exp Dermatol. 2008;33(1):1-9.
3. Lachmann HJ, Kone-Paut I, Kuemmerle-Deschner JB, et al; Canakinumab in CAPS Study Group. Use of canakinumab in the cryopyrin-associated periodic syndrome. N Engl J Med. 2009;360(23):2416-2425.
4. American College of Rheumatology. Guidelines for the management of rheumatoid arthritis: American College of Rheumatology Ad Hoc Committee on Clinical Guidelines. Arthritis Rheuma. 1996;39(5):713-723.
5. Jamilloux Y, Gerfaud-Valentin M, Henry T, Sève P. Treatment of adult-onset Still's disease: a review. *Ther Clin Risk Manag*. 2014;11:33-43. Published 2014 Dec 22.
6. Govoni M, Bortoluzzi A, Rossi D, Modena V. How I treat patients with adult onset Still's disease in clinical practice. *Autoimmun Rev*. 2017;16(10):1016-1023.
7. Kedor C, Listing J, Zernicke J, et al. Canakinumab for Treatment of Adult-Onset Still's Disease to Achieve Reduction of Arthritic Manifestation (CONSIDER): phase II, randomised, double-blind, placebo-controlled, multicentre, investigator-initiated trial. Annals of the Rheumatic Diseases. Published Online First: 13 May 2020.
8. Yamaguchi M, et al. Diagnostic criteria for adult onset Still's disease (AOSD). J Rheumatol. 19:424-30, 1992.
9. Galozzi P, Baggio C, Bindoli S, et al. Development and Role in Therapy of Canakinumab in Adult-Onset Still's Disease. Front Pharmacol. 2018;9:1074. Published 2018 Sep 21. doi:10.3389/fphar.2018.01074.
10. Cavalli G, Tomelleri A, De Luca G, et al. Efficacy of canakinumab as first-line biologic agent in adult-onset Still's disease. Arthritis Res Ther 21, 54 (2019).
11. Junge G, Mason J, Feist E. Adult onset Still's disease – The evidence that anti-interleukin-1 treatment is effective and well-tolerated (a comprehensive literature review). Semin Arthritis Rheum. 2017;47(2):295-302.
12. Aarntzen EHJG, van Riel PLCM, Barrera P. Refractory adult onset Still's disease and hypersensitivity to non-steroidal anti-inflammatory drugs and cyclo-oxygenase-2 inhibitors: are biological agents the solution?. *Annals of the Rheumatic Diseases* 2005;64:1523-1524.
13. Efthimiou P. Adult Onset Still's Disease. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/adult-onset-stills-disease/. Published 2015. Accessed September 29, 2020.
14. Mandl LA, O'Dell JR, Romain PL. Treatment of adult Still's disease. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
15. DeWitt EM, Kimura Y, Beukelman T, et al. Consensus treatment plans for new-onset systemic juvenile idiopathic arthritis. *Arthritis Care Res (Hoboken)*. 2012;64(7):1001-1010.
16. Ringold S, Weiss PF, Beukelman T, et al. 2013 Update of the 2011 American College of Rheumatology Recommendations for the Treatment of Juvenile Idiopathic Arthritis. Recommendations for the Medical Therapy of Children With Systemic Juvenile Idiopathic Arthritis and Tuberculosis Screening Among Children Receiving Biologic Medications Vol. 65, No. 10, October 2013, pp 2499–2512.
17. Ferrara G, Mastrangelo G, Barone P, et al. Methotrexate in juvenile idiopathic arthritis: advice and recommendations from the MARAJIA expert consensus meeting. *Pediatr Rheumatol Online J*. 2018;16(1):46. Published 2018 Jul 11.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Ilumya (tildrakizumab-asmn)
BILLING CODE	J3245 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Cimzia, Cosentyx, Enbrel, Otezla and Siliq QUANTITY LIMIT— 100 mg (1 syringe) every 12 weeks after loading doses
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ilumya (tildrakizumab-asmn) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq. Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:** 100 mg subcutaneously at Weeks 0, 4, and every twelve weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ilumya (tildrakizumab-asmn) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/13/2018	New policy for Ilumya created.
02/26/2019	Humira trial removed from criteria; Cimzia, Cosentyx, Otezla and Siliq added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Reauthorization criteria on documented member's PASI score improvement incorporated into general chart noted documentation requirements. Static Physician's Global Assessment (sPGA) score removed. Ulcerative Colitis added to not covered diagnosis. BSA less than 10% allowed if there is sensitive area involvement.
11/18/2020	Updated J code. Removed rheumatologist from prescriber requirement. Removed PsO 6 months or longer. Removed not going to receive systemic/phototherapy while on Ilumya. Changed BSA to 3% or sensitive areas. Removed PASI score. Removed repeat TB for reauth. Updated references.

References:

1. Ilumya [package insert]. Whitehouse Station, NJ: Merck & Co., Inc., March, 2018.
2. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
3. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
4. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
5. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
6. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
7. ClinicalTrials.gov. Identifier NCT01225731. A Study to Determine the Optimal Dose of Tildrakizumab (SCH 900222/MK-3222) for the Treatment of Moderate-to-severe Chronic Plaque Psoriasis (P05495) (MK-3222-003). Available at: https://clinicaltrials.gov/ct2/show/NCT01225731?term=tildrakizumab&rank=1. Accessed on March 26, 2018.

Effective date: 10/1/2021
Revised date: 11/18/2020

CareSource Rx Innovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Iluvien (fluocinolone acetonide)
BILLING CODE	J7313
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
STATUS	Prior Authorization Required

Iluvien is an intravitreal implant containing 0.19 mg (190 mcg) fluocinolone acetonide in a 36-month sustained-release drug delivery system. It is indicated for the treatment of diabetic macular edema (DME) in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure. DME is a common complication of diabetic retinopathy.

Iluvien (fluocinolone acetonide) will be considered for coverage when the following criteria are met:

Diabetic Macular Edema (DME)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a confirmed diagnosis of diabetic macular edema; AND
4. Member has been previously treated with a course of corticosteroids and did not have a clinically significant increase in intraocular pressure; AND
5. Member has tried and failed Ozurdex; AND
6. Member does not have active or suspected ocular or periocular infection; AND
7. Member does not have glaucoma with a cup to disc ratio greater than 0.8.
8. **Dosage allowed/Quantity limit:** One implant (0.19 mg) per eye
   Limit: 2 implants (1 per eye) per 36 months.

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes must show improved or stabilized visual acuity following treatment; AND
2. At least 36 months have elapsed since the prior treatment (of the same eye).

If all the above requirements are met, the medication will be approved for an additional 3 months.

CareSource considers Iluvien (fluocinolone acetonide) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/27/2021	New policy created for Iluvien.

References:

1. Iluvien [prescribing information]. Alimera Sciences, Inc.; 2016.
2. Flaxel CJ, Adelman RA, Bailey ST, et al. Diabetic Retinopathy Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P66-P145. doi:10.1016/j.ophtha.2019.09.025
3. Virgili G, Parravano M, Evans JR, Gordon I, Lucenteforte E. Anti-vascular endothelial growth factor for diabetic macular oedema: a network meta-analysis. *Cochrane Database Syst Rev*. 2018;10(10):CD007419. Published 2018 Oct 16. doi:10.1002/14651858.CD007419.pub6
4. Grover D, Li TJ, Chong CC. Intravitreal steroids for macular edema in diabetes. *Cochrane Database Syst Rev*. 2008;(1):CD005656. Published 2008 Jan 23. doi:10.1002/14651858.CD005656.pub2
5. Rittiphairoj T, Mir TA, Li T, Virgili G. Intravitreal steroids for macular edema in diabetes. *Cochrane Database Syst Rev*. 2020;11(11):CD005656. Published 2020 Nov 17. doi:10.1002/14651858.CD005656.pub3
6. Zur D, Iglicki M, Loewenstein A. The Role of Steroids in the Management of Diabetic Macular Edema. *Ophthalmic Res*. 2019;62(4):231-236. doi:10.1159/000499540
7. Schmidt-Erfurth U, Garcia-Arumi J, Bandello F, et al. Guidelines for the Management of Diabetic Macular Edema by the European Society of Retina Specialists (EURETINA). *Ophthalmologica*. 2017;237(4):185-222. doi:10.1159/000458539
8. Bailey C, Chakravarthy U, Lotery A, Menon G, Talks J; Medisoft Audit Group. Extended real-world experience with the ILUVIEN® (fluocinolone acetonide) implant in the United Kingdom: 3-year results from the Medisoft® audit study [published online ahead of print, 2021 May 10]. *Eye (Lond)*. 2021;1-7. doi:10.1038/s41433-021-01542-w

Effective date: 04/01/2022
Revised date: 10/27/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Imbruvica (ibrutinib)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Imbruvica is indicated for the treatment of adult patients with chronic graft-versus-host disease (cGVHD) after failure of one or more lines of systemic therapy. GVHD, a common complication following allogenic hematopoietic stem cell transplant (HSCT), occurs in about 50% of HSCT patients. Prednisone is the mainstay of initial therapy but at least half of patients require at least 2 lines of therapy. Clinical guidelines do not come to a consensus regarding optimal 2nd line therapy but describe a variety of options.
Imbruvica is a small molecule inhibitor of Bruton's tyrosine kinase (BTK). BTK is a signaling molecule of the B-cell antigen receptor (BCR) and cytokine receptor pathways. Imbruvica can exert its effects on B cells and T cells, both of which are thought to be involved in cGVHD pathogenesis. Approval was based on a phase 1b/2 study of 42 patients with cGVHD after failure of first line corticosteroid therapy and requiring additional therapy.

Imbruvica (ibrutinib) will be considered for coverage when the following criteria are met:

Chronic Graft-Versus-Host Disease (cGVHD)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a transplant or hematology/oncology specialist; AND
3. Member has a documented diagnosis of active cGVHD that is steroid-dependent or steroid-refractory; AND
4. Member does NOT have a known bleeding disorder or hemophilia.
5. **Dosage allowed/Quantity limit:** 420 mg orally once daily (until progression, recurrence of underlying malignancy, or unacceptable toxicity). QL: 28 tablets per 28 days.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must show improvement of signs and symptoms of disease in at least 1 organ/site, without progression in any other organ/site.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Mantle Cell Lymphoma, Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma, Waldenstrom's Macroglobulinemia, Marginal Zone Lymphoma

Any request for cancer must be submitted through NantHealth/Eviti portal.

CareSource considers Imbruvica (ibrutinib) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/04/2021	New policy created for Imbruvica.

References:

1. Imbruvica [prescribing information]. Pharmacyclics LLC and Janssen Biotech, Inc.; 2020.
2. Miklos D, Cutler CS, Arora M, et al. Ibrutinib for chronic graft-versus-host disease after failure of prior therapy. *Blood*. 2017;130(21):2243-2250. doi:10.1182/blood-2017-07-793786
3. Waller EK, Miklos D, Cutler C, et al. Ibrutinib for Chronic Graft-versus-Host Disease After Failure of Prior Therapy: 1-Year Update of a Phase 1b/2 Study. *Biol Blood Marrow Transplant*. 2019;25(10):2002-2007. doi:10.1016/j.bbmt.2019.06.023
4. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (HCT): Pre-Transplant Recipient Evaluation and Management of Graft-Versus-Host Disease. (Version 5.2021). https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf. Accessed October 4, 2021.
5. Wolff D, Fatobene G, Rocha V, Kröger N, Flowers ME. Steroid-refractory chronic graft-versus-host disease: treatment options and patient management. *Bone Marrow Transplant*. 2021;56(9):2079-2087. doi:10.1038/s41409-021-01389-5
6. Penack O, Marchetti M, Ruutu T, et al. Prophylaxis and management of graft versus host disease after stem-cell transplantation for haematological malignancies: updated consensus recommendations of the European Society for Blood and Marrow Transplantation. *Lancet Haematol*. 2020;7(2):e157-e167. doi:10.1016/S2352-3026(19)30256-X

Effective date: 04/01/2022
Revised date: 10/04/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Imcivree (setmelanotide)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Imcivree, approved by the FDA in 2020, is indicated for chronic weight management in patients with certain types of monogenic obesity confirmed by genetic testing. This group of disorders is incredibly rare. These patients have extreme hunger (hyperphagia) and may become morbidly obese as early as infancy. They may also have endocrine complications. Imcivree is an analog of endogenous melanocortin peptide α-MSH (alpha-melanocyte stimulating hormone) that acts as an agonist at the melanocortin-4 receptor (MC4R), intended to partially or completely restore signaling at the MC4 receptors in the brain, which are involved in regulation of hunger, satiety, and energy expenditure.

Imcivree (setmelanotide) will be considered for coverage when the following criteria are met:

Weight Management in Rare Genetic Obesity Disorders

For **initial** authorization:

1. Member is at least 6 years of age; AND
2. Medication must be prescribed by or in consultation with an endocrinologist or medical geneticist; AND
3. Member has a documented diagnosis of obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing (results must be attached to request); AND
4. Genetic testing demonstrates the variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS); AND
5. Documentation of baseline weight and body mass index (BMI); AND
6. Adult: Member has BMI of 30 or greater, or
   Pediatric: Member's weight is 95th percentile or greater for age on growth chart; AND
7. Member does NOT have any of the following:
   a) Variants in POMC, PCSK1, or LEPR classified as benign or likely benign
   b) Any other type of obesity not related to POMC, PCSK1 or LEPR deficiency, including obesity associated with other genetic syndromes and general (polygenic) obesity
   c) Prior gastric bypass surgery resulting in greater than 10% weight loss durably maintained.
8. **Dosage allowed/Quantity limit:**
   Starting dose for 6-11 years of age: 1 mg subQ once daily
   Starting dose for 12+ years of age: 2 mg subQ once daily
   Maximum maintenance dose (if tolerated): 3 mg subQ once daily.
   See package insert for dose adjustment frequency and titration details.

If all the above requirements are met, the medication will be approved for 16 weeks.

For **reauthorization**:

1. 1st renewal: Chart notes must show one of the following:
   a) At least 5% reduction of baseline body weight OR
   b) At least 5% reduction from baseline BMI for patients with continued growth potential.
2. Subsequent renewals: Chart notes must show at least 10% weight loss from baseline has been achieved and maintained.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Imcivree (setmelanotide) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
09/24/2021	New policy created for Imcivree.

References:

1. Imcivree. (prescribing information). Rhythm Pharmaceuticals, Inc.; 2020.
2. Clément K, van den Akker E, Argente J, et al. Efficacy and safety of setmelanotide, an MC4R agonist, in individuals with severe obesity due to LEPR or POMC deficiency: single-arm, open-label, multicentre, phase 3 trials. *Lancet Diabetes Endocrinol*. 2020;8(12):960-970. doi:10.1016/S2213-8587(20)30364-8

Effective date: 04/01/2022
Revised date: 09/24/2021

CareSource

PHARMACY POLICY STATEMENT **Indiana Marketplace**	
DRUG NAME	**Immune globulin (IVIG and SCIG):** **Intravenous (IVIG)**: Asceniv, Bivigam, Carimune NF, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen **Subcutaneous (SCIG)**: Cutaquig, Cuvitru, Hizentra, HyQvia, Xembify
BILLING CODE	See Appendix C at end of document.
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— Dosing should be based on ideal body weight (IBW) or adjusted body weight (adjBW) rather than actual/total body weight (TBW).
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Immune Globulin will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

AUTOIMMUNE BULLOUS DISEASE

For **initial** authorization:

1. Member has contraindications to, failure of (refractory to), or significant side effects from systemic corticosteroids or immunosuppressive treatment (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil); AND
2. Member has dermatologic condition, as indicated by **one** or more of the following:
   a) Bullous pemphigoid;
   b) Epidermolysis bullosa acquisita;
   c) Linear IgA bullous dermatosis;
   d) Mucous membrane (cicatricial) pemphigoid;
   e) Pemphigoid gestationis;
   f) Pemphigus foliaceus;
   g) Pemphigus vulgaris.
3. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
2. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect is provided with chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

For **initial** authorization:

1. IVIG is prescribed for prophylaxis of bacterial infections; AND
2. Member has a history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization; AND
3. Member has a pretreatment serum IgG level <500 mg/dL (Copy of laboratory report with pre-treatment serum IgG level must be provided with chart notes).
4. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. A reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a neurologist; AND
2. Member has a documented diagnosis of CIDP; AND
3. Symptoms of motor weakness and/or sensory disturbances have been present for at least 2 months; AND
4. Member has moderate to severe functional disability because of symptoms; AND
5. Electrodiagnostic studies must show evidence of demyelination in at least 2 nerves (e.g. reduced nerve conduction velocities, conduction block, abnormal temporal dispersion); AND
6. Member must meet at least one of the following:
   a) Trial and failure of or contraindication to a steroid regimen for at least 12 weeks (e.g. daily oral prednisone, monthly oral dexamethasone, IV methylprednisolone)
   b) Rapidly progressive disease
   c) Pure motor CIDP (no sensory symptoms, e.g. numbness, tingling, prickling).
7. **Dosage allowed:** See dosing information in individual drug package insert (Gammaked, Gamunex-C, Privigen, Hizentra).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member has improvement of neuromuscular disability and impairment, with sustained stability since initiation of therapy; AND
2. Members who are stable on maintenance IVIG should be assessed periodically to determine if the dose and/or frequency can be reduced to the lowest effective and establish the need for continued treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

DERMATOMYOSITIS OR POLYMYOSITIS

For **initial** authorization:

1. Medication must be prescribed by a neurologist, rheumatologist, or dermatologist; AND
2. Member has a diagnosis of dermatomyositis or polymyositis confirmed by muscle biopsy; AND
3. Member has tried and failed or has contraindications to first line treatment with a corticosteroid (e.g. prednisone), and/or with a non-steroid immunosuppressant (e.g. azathioprine, methotrexate, cyclosporine) for at least 4 weeks.
4. **Dosage allowed:** Consult clinical literature. For example, 2g/kg IV over 2-5 days.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member has significantly improved muscle strength sustained since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

FETAL/NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (F/NAIT)

For **initial** authorization:

1. Member is a newborn, and thrombocytopenia persists after transfusion of antigen-negative compatible platelet; OR
2. Member is pregnant and has diagnosis of F/NAIT with **one** or more of the following:
   a) Family history of disease;
   b) Platelet alloantibodies found on screening;
   c) Previously affected pregnancy.
3. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Medication will not be reauthorized for continuous use.

GUILLAIN-BARRE SYNDROME (GBS)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of Guillain-Barre Syndrome; AND
3. Physical mobility is severely affected such that member requires an aid to walk; AND
4. IVIG therapy will be initiated within 2 weeks of symptom onset.
5. **Dosage allowed:** Consult clinical literature. For example, 0.4g/kg/day x 5 days in adults.

If member meets all the requirements listed above, the medication will be approved for 1 month (1 course).

For **reauthorization**:

1. Member responded to initial course of therapy, as evidenced by improved/stabilized disability or weakness; AND
2. Member is experiencing deterioration following initial response to treatment.

If member meets the requirements listed above, the medication will be approved for 1 additional month (1 course). Further renewal will NOT be considered after a total of 2 courses.

CareSource

IDIOPATHIC THROMBOCYTOPENIC PURPURA (IMMUNE THROMBOCYTOPENIA)

For **initial** authorization:

1. Initial therapy (Member diagnosed with ITP within the past 3 months):
   a) Children (< 18 years of age):
      i) Significant bleeding symptoms (mucosal bleeding or other moderate/severe bleeding); OR
      ii) High risk for bleeding* (see Appendix A); OR
      iii) Rapid increase in platelets is required* (e.g., surgery or procedure);
   b) Adults (≥ 18 years of age):
      i) Platelet count < 30,000/mcL; OR
      ii) Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding or rapid increase in platelets is required*; AND
      iii) Corticosteroid therapy is contraindicated and IVIG will be used alone or IVIG will be used in combination with corticosteroid therapy.
2. Chronic/persistent ITP (≥ 3 months from diagnosis) or ITP unresponsive to first-line therapy (i.e., corticosteroids):
   a) Platelet count < 30,000/mcL; OR
   b) Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding* or rapid increase in platelets is required*; AND
   c) Relapse after previous response to IVIG or inadequate response/intolerance/contraindication to corticosteroid or anti-D therapy.
3. Adults with refractory ITP after splenectomy:
   a) Platelet count < 30,000/mcL; OR
   b) Significant bleeding symptoms.
4. ITP in pregnant women: authorization through delivery may be granted to pregnant women with ITP if any **one** or more of the following:
   a) Any bleeding during pregnancy;
   b) Platelet count less than 10,000/mm^3 ($10x10^9$/L) at any time during pregnancy;
   c) Platelet count between 10,000/mm^3 ($10x10^9$/L) and 30,000/mm^3 ($30x10^9$/L) in second or third trimester.
5. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

***** *The member's risk factor(s) for bleeding (see Appendix A) or reason requiring a rapid increase in platelets must be provided*.

If member meets all the requirements listed above, the medication will be approved for 1 months for initial therapy, or for 6 months for chronic/persistent ITP or for adults with refractory ITP after splenectomy.

For **reauthorization**:

1. Medication will not be reauthorized for continuous use.

KAWASAKI SYNDROME

For **initial** authorization:

1. Medication is prescribed by a pediatric cardiologist or pediatrician experienced with diagnosing and treating Kawasaki Syndrome; AND
2. Member has a diagnosis of Kawasaki Syndrome.
3. **Dosage allowed:** 2g/kg as a single dose. If fever recurs or persists after at least 36 hours, a second dose may be given.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:
1. Medication will not be reauthorized for continuous use.

KIDNEY TRANSPLANT

For **initial** authorization:
1. Medication is used for prophylaxis or treatment of acute kidney rejection in conjunction with concomitant immunosuppression (e.g., cyclosporine, mycophenolate mofetil, and corticosteroids).
2. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 12 months.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a neurologist or oncologist; AND
2. Member has a diagnosis of LEMS as confirmed by at least one of the following:
   a) Repetitive nerve stimulation (RNS) study abnormalities
   b) Positive P/Q type anti-voltage gated calcium channel (VGCC) antibody assay; AND
3. Member has progressive proximal muscle weakness; AND
4. Member has tried and failed amifampridine (Firdapse or Ruzurgi; these require prior auth) or pyridostigmine.
5. **Dosage allowed:** Consult clinical literature. Consider 2g/kg given over 2 to 5 days, every 8 weeks.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must document significant improvement in muscle strength and maintenance of improvement since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MULTIFOCAL MOTOR NEUROPATHY (MMN)

For **initial** authorization:
1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of MMN as evidenced by BOTH of the following:
   a) Progressive, focal, asymmetric limb weakness with motor involvement of at least 2 nerves for more than one month, and
   b) No objective sensory abnormalities (e.g. normal sensory nerve conduction study).
3. **Dosage allowed:** Consult clinical literature. (Per Gammagard liquid: 0.5-2.4 g/kg/month IV in adults).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member has improved muscle strength and disability since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MYASTHENIA GRAVIS

For **initial** authorization:
1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of myasthenia gravis and meets one of the following:
   a) For short term use: Member has impending or manifest myasthenic crisis with signs of significant respiratory or bulbar dysfunction and potential airway compromise; OR
   b) For maintenance:
      i) Member has severe, refractory myasthenia gravis that is unchanged or worse after corticosteroids and at least 2 other immunosuppressive therapies (e.g. azathioprine [first line], cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) for an adequate duration, with persistent symptoms or side effects that limit functioning; AND
      ii) Member has a positive serologic test for anti-acetylcholine receptor (AchR) antibodies.
3. **Dosage allowed:** Consult clinical literature. Consider a daily dose of 0.4 g/kg x 5 days or 1g/kg x 2 days.

If member meets the requirements listed above, the medication will be approved for 1 month (1 course) for crisis episode (as defined in 2a) or 12 months for maintenance use (as defined in 2b).

For **reauthorization**:
1. Member must meet initial criteria; AND
2. Chart notes must document clinically significant improvement of muscle weakness with treatment.

If the reauthorization requirements above are met, the medication will be approved for 1 month for crisis episode (as defined in 2a) or 6 months for maintenance use (as defined in 2b).

PARVOVIRUS B19-INDUCED PURE RED CELL APLASIA (PRCA)

For **initial** authorization:
1. Medication is prescribed by or in consultation with a hematologist or infectious disease specialist; AND
2. Member is immunocompromised (e.g. HIV, cancer, transplant); AND
3. Member has severe anemia as evidenced by hemoglobin lab results (i.e. less than 8.0 g/dL); AND
4. Member has tested positive for parvovirus B19 (e.g. by PCR or bone marrow exam).
5. **Dosage allowed:** Consult clinical literature. For example: 2g/kg divided over 5 days (400mg/kg/day).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member is chronically infected with parvovirus B19; AND
2. Hemoglobin level improved from baseline; AND
3. Member relapsed when treatment was stopped.

If the reauthorization requirements above are met, the medication will be approved for an additional 3 months.

PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS)

For **initial** authorization:
1. Member must have a documented diagnosis of moderately severe to severe pediatric acute onset neuropsychiatric syndrome (PANS) in chart notes; AND
2. Other causes of neurological and psychiatric symptoms (such as Sydenham chorea, Tourette's syndrome, toxic effects of drugs, or others) have been comprehensively ruled out; AND
3. IVIG must be prescribed by a pediatric neurologist, immunologist, or psychiatrist; AND
4. Member has failed trial of corticosteroid burst; AND
5. Member must be treated in conjunction with other therapies, including behavioral intervention (such as cognitive behavioral therapy (CBT) and/or medications).

6. **Dosage allowed**: 1 gram per kilogram per day for 2 days; [Note: The typical max dose in the literature is 100g/day (200g over 2 days)].

If member meets all the requirements listed above, the medication will be approved for one month (one course of treatment; 2 doses).

For **reauthorization**:
1. Member is in compliance with initial criteria; AND
2. Member is experiencing a recurrence of symptoms; AND
3. Chart notes show significant improvement resulted from initial course of treatment, and no impairing side effects; AND
4. Dosing may not be repeated more often than monthly and may not exceed 3 courses of treatment.
5.

If member meets all the reauthorization requirements above, the medication will be approved for another month (one course of treatment; 2 doses). Note: Max total number of treatment courses is limited to 3.

PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS)

For **initial** authorization:
1. Member must have a documented and confirmed diagnosis of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) in their chart notes; AND
2. The member experiences onset or exacerbation of obsessive-compulsive disorder (OCD) symptoms and/or tics following a Group-A streptococcus (GAS) infection; AND
3. Member is considered to have moderately severe to severe symptoms such as significant weight loss (>10-15% body mass), irrational fears, extreme impulsivity, suicidal ideation, significant anxiety that have significant interference with daily activities; AND
4. IVIG must be prescribed by a specialist in treating PANDAS; AND
5. Member has received a course of antibiotic and has tried or unable to try a short course of corticosteroid; AND
6. Member must be treated in conjunction with behavioral intervention (such as cognitive behavioral therapy (CBT) and/or medications); AND
7. Member must have tried and failed plasmapheresis or has a clinical reason or contraindication why plasmapheresis cannot be used.
8. **Dosage allowed**: 1 gram per kilogram per day via intravenous infusion for 2 days; max dose 100 grams/day (200 grams over 2 days).

If member meets all the requirements listed above, the medication will be approved for one month (one course of treatment; 2 doses).

For **reauthorization**:
1. Member is in compliance with initial criteria; AND
2. Member is experiencing a recurrence of symptoms; AND
3. Chart notes show significant improvement resulted from initial course of treatment, and no impairing side effects; AND
4. Dosing may not be repeated more often than monthly and may not exceed 3 courses of treatment.

If member meets all the reauthorization requirements above, the medication will be approved for another month (one course of treatment; 2 doses). Note: Max total number of treatment courses is limited to 3.

CareSource

PRIMARY IMMUNODEFICIENCY

For **initial** authorization:
Member must have **one** of the following diagnoses:

1. Severe combined immunodeficiency (SCID) or congenital agammaglobulinemia (e.g., X-linked or autosomal recessive agammaglobulinemia):
   a) Diagnosis confirmed by genetic or molecular testing; OR
   b) Pretreatment IgG level < 200 mg/dL; OR
   c) Absence or very low number of T cells (CD3 T cells < 300/microliter) or the presence of maternal T cells in the circulation (SCID only);
2. Wiskott-Aldrich syndrome, DiGeorge syndrome, or ataxia-telangiectasia (or other non-SCID combined immunodeficiency):
   a) Diagnosis confirmed by genetic or molecular testing (if applicable); AND
   b) History of recurrent bacterial infections (e.g., pneumonia, otitis media, sinusitis, sepsis, gastrointestinal); AND
   c) Impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix B);
3. Common variable immunodeficiency (CVID):
   a) Member is 4 years of age or older; AND
   b) Other causes of immune deficiency have been excluded (e.g., drug induced, genetic disorders, infectious diseases such as HIV, malignancy); AND
   c) Member's pretreatment IgG level < 500 mg/dL or ≥ 2 SD below the mean for age; AND
   d) Member has a history of recurrent bacterial infections; AND
   e) Member has impaired antibody response to pneumococcal polysaccharide vaccine documented in chart notes (see Appendix B);
4. Hypogammaglobulinemia (unspecified), IgG subclass deficiency, selective IgA deficiency, selective IgM deficiency, or specific antibody deficiency:
   a) Member has a history of recurrent bacterial infections; AND
   b) Member has impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix B)
   c) Member has ANY of the following pre-treatment laboratory findings:
      i) Hypogammaglobulinemia: IgG < 500 mg/dL or ≥ 2 SD below the mean for age;
      ii) Selective IgA deficiency: IgA level < 7 mg/dL with normal IgG and IgM levels;
      iii) Selective IgM deficiency: IgM level < 30 mg/dL with normal IgG and IgA levels;
      iv) IgG subclass deficiency: IgG1, IgG2, or IgG3 ≥ 2 SD below mean for age assessed on at least 2 occasions; normal IgG (total) and IgM levels, normal/low IgA levels;
      v) Specific antibody deficiency: normal IgG, IgA and IgM levels;
5. Other predominant antibody deficiency disorders must meet a), b), and c) i) in section 4. above;
6. Other combined immunodeficiency must meet criteria in section 2. above.
7. **Dosage allowed:** Please see dosage and administration information in individual drug package insert. *Note:* Gammagard Liquid, Gamunex-C, and Gammaked may be administered intravenously or subcutaneously for primary immunodeficiency.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. A reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy; AND
2. IgG trough levels are monitored at least yearly and maintained at or above the lower range of normal for age (when applicable for indication); OR
3. The prescriber will re-evaluate the dose of IVIG and consider a dose adjustment (when appropriate).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PROPHYLAXIS OF BACTERIAL INFECTIONS IN BMT/HSCT RECIPIENTS

For **initial** authorization:
1. Member is BMT/HSCT recipient; AND
2. IVIG is prescribed for prophylaxis of bacterial infections; AND
3. Either of the following:
   a) IVIG is requested within the first 100 days post-transplant; OR
   b) Member has a pretreatment serum IgG < 400 mg/dL.
4. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy and documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

PROPHYLAXIS OF BACTERIAL INFECTIONS IN HIV-INFECTED PEDIATRIC PATIENTS

For **initial** authorization:
1. Member with HIV infection and is 18 years of age or younger; AND
2. IVIG is prescribed for **primary** prophylaxis of bacterial infections and pretreatment serum IgG < 400 mg/dL; OR
3. IVIG is prescribed for **secondary** prophylaxis of bacterial infections with ALL of the following:
   a) History of recurrent bacterial infections (> 2 serious bacterial infections in a 1-year period);
   b) Member is not able to take combination antiretroviral therapy;
   c) Antibiotic prophylaxis was tried but was not effective (e.g., trimethoprim-sulfamethoxazole).
4. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy and documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

STIFF-PERSON SYNDROME

For **initial** authorization:
1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of stiff-person syndrome; AND
3. Member has anti-glutamic acid decarboxylase (GAD) antibodies; AND
4. Member has tried and failed both of the following first-line treatments (monotherapy or in combination) for an adequate dose and duration, unless contraindicated or not tolerated:
   a) Benzodiazepine (e.g. diazepam, clonazepam)
   b) Baclofen. (An anticonvulsant is an acceptable alternative; for example, gabapentin, pregabalin, or valproate).

5. **Dosage allowed:** Consult the clinical literature for guidance. A dose of 2 g/kg over 2-5 days has been commonly cited.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must document reduced stiffness, improved gait, fewer falls, and/or improved function with activities of daily living; AND
2. Clinically significant or disabling symptoms return following an attempt to discontinue treatment.

If requirements are met, the medication will be approved for an additional 6 months.

CareSource considers Immune Globulin not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

Acquired hemophilia	Myocarditis, acute
Adrenoleukodystrophy	Neonatal sepsis, prevention
Alzheimer's disease	Neonatal sepsis, treatment
Amyotrophic lateral sclerosis (ALS)	Ocular myasthenia
Antiphospholipid antibody syndrome (APS) in pregnancy	Paraneoplastic cerebellar degeneration, sensory neuropathy, or encephalopathy
Asthma, non-steroid dependent	Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
Atopic dermatitis	POEMS syndrome
Autism spectrum disorders	Postinfectious cerebellar ataxia
Autoimmune liver disease	Postoperative sepsis
Autoimmune neutropenia	Pseudomembranous colitis
Campylobacter species-induced enteritis	Respiratory syncytial virus (RSV) lower respiratory tract infection
Cerebral infarctions with antiphospholipid antibodies	Rheumatic fever, acute
Chronic fatigue syndrome	Sjogren's syndrome
Demyelinative brain stem encephalitis	Spontaneous recurrent abortions, prevention
Demyelinating neuropathy associated with monoclonal IgM	Systemic lupus erythematosus
Dilated cardiomyopathy	Urticaria, chronic
HIV infection or prophylaxis	Vasculitides and antineutrophil antibody syndromes
HTLV-1-associated myelopathy	Routine prophylaxis of Measles, Varicella, and Rubella
Idiopathic dysautonomia, acute	Treatment of Measles, Varicella, and Rubella
Inclusion body myositis	
Isolated IgA deficiency	
Isolated IgG4 deficiency	
Lumbosacral or brachial plexitis	

DATE	ACTION/DESCRIPTION

11/15/2017	New policy for Immune Globulin created. Diagnoses associate with inpatient life-threatening therapies were removed. Diagnoses of CIDP, Dermatomyositis or Polymyositis, ITP, MMN, Primary Immunodeficiency and Stiff-Person Syndrome got criteria expanded. Diagnosis of Acquired red cell aplasia was revised to PRCA with criteria. Length of coverage and reauthorization length were added.
08/21/2019	New medication Xembify added to the list of subcutaneous immune globulins.
6/8/2020	Criteria for PANS/PANDAS added
02/22/2021	Added Panzyga, Asceniv to product list. Removed Thymoglobulin. Added J codes for Cutaquig, Cuvitru and Xembify and moved list of billing codes to an appendix. Added general note about weight-based dosing. Myasthenia Gravis: Updated references. Added specialist requirement. Split between short- and long-term use; replaced short term criteria and created new criteria for long term. Refer to literature for dosing, not package insert; added common dose regimen. Added renewal criteria. Parvovirus B19-induced PRCA: Added references. Revised entire section. Refer to literature for dosing, not package insert. Added specialist requirement. Added that they must be immunocompromised. Added hemoglobin and viral confirmation. Reduced approval duration from 6 months to 3 months. Added renewal criteria. Stiff person syndrome: Added references. Added specialist requirement. Added GAD antibody requirement. Require 2 prior therapies. Refer to literature for dosing, not package insert. Added example dose. Reduced approval duration from 6 months to 3 months. Added renewal criteria. Kawasaki syndrome: Added reference (previously none). Added specialist. Added dosing information. LEMS: Added references. Added specialist requirement. Direct to literature for dosing rather than package insert. Added common dose. Added confirmation of diagnosis. Amended step drugs to more closely align with guidelines in literature. Added progressive proximal muscle weakness. Slightly revised the renewal criteria. Shortened initial auth duration from 12 months to 3 months. GBS: Added reference. Added specialist requirement. Refer to literature for dosing, not package insert. Added example dose. Shortened initial auth duration from 2 mo to 1 mo and added renewal criteria for additional month. CIDP: Added references. Added specialist requirement. Added drug names to dosing section for guidance. Added requirement for steroid unless rapidly progressive or pure motor. Removed CSF protein requirement; added main clinical diagnostic point (symptoms x 2 mo). Elaborated on electrodiagnostic studies. MMN: Added reference. Added specialist. Added example dosing. Rephrased renewal criteria. Amended diagnostic criteria. DM/PM: Added reference. Added specialists. Clarified diagnostic criteria. Rephrased standard therapies and added duration. Added example dose; refer to literature, not package insert. Rephrased renewal criteria.

References:

1. Bivigam [package insert]. Boca Raton, FL: Biotest Pharmaceuticals Corporation; October 2013.
2. Carimune NF [package insert]. Kankakee, IL: CSL Behring LLC; May 2018.
3. Flebogamma 10% DIF [package insert]. Los Angeles, CA: Grifols Biologicals, Inc.; January 2016.
4. Flebogamma 5% DIF [package insert]. Los Angeles, CA: Grifols Biologicals, Inc.; April 2015.
5. Gammagard Liquid [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; April 2014.
6. Gammagard S/D [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; April 2014.
7. Gammagard S/D IgA less than 1 mcg/mL [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; September 2013.
8. Gammaked [package insert]. Fort Lee, NJ: Kedrion Biopharma, Inc.; September 2013.
9. Gammaplex [package insert]. Hertfordshire, United Kingdom: Bio Products Laboratory; July 2015.
10. Gamunex-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; July 2014.

11. Octagam 10% [package insert]. Hoboken, NJ: Octapharma USA, Inc.; April 2015.
12. Octagam 5% [package insert]. Hoboken, NJ: Octapharma USA, Inc.; October 2014.
13. Privigen [package insert]. Kankakee, IL: CSL Behring LLC; November 2013.
14. Cuvitru [package insert]. Westlake Village, CA: Baxalta US Inc.; September 2016.
15. Hizentra [package insert]. Kankakee, IL: CSL Behring LLC; October 2016.
16. HyQvia [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; September 2016.
17. Xembify [prescribing information]. Research Triangle Park, NC: Grifols Therapeutics LLC; July 2019.
18. Amagai M, Ikeda S, Shimizu H, et al. A randomized double-blind trial of intravenous immunoglobulin for pemphigus. J Am Acad Dermatol 2009; 60(4):595-603.
19. Kirtschig G, Middleton P, Bennett C, Murrell DF, Wojnarowska F, Khumalo NP. Interventions for bullous pemphigoid. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD002292.
20. Orange JS, Hossny EM, Weiler CR, et al. Use of intravenous immunoglobulin in human disease: a review of evidence by members of the Primary Immunodeficiency Committee of the American Academy of Allergy, Asthma, and Immunology. J Allergy Clin Immunol. 2006;417(4 Suppl):S525-553.
21. Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/oi_guidelines_pediatrics.pdf. Accessed November 8, 2017.
22. Tomblyn M, Chiller T, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic cell transplant recipients: a global perspective. Biol Blood Marrow Transplant. 2009;15(10):1143-1238.
23. Feasby T, Banwell B, Bernstead T, et al. Guidelines on the use of intravenous immune globulin for neurologic conditions. Transfus Med Rev. 2007;21(2):S57-S107.
24. Donofrio PD, Berger A, Brannagan TH 3rd, et al. Consensus statement: the use of intravenous immunoglobulin in the treatment of neuromuscular conditions report of the AANEM ad hoc committee. Muscle Nerve. 2009;40(5):890-900.
25. Elovaara I, Apostolski S, van Doorn P, et al. EFNS guidelines for the use of intravenous immunoglobulin in treatment of neurological diseases: EFNS task force on the use of intravenous immunoglobulin in treatment of neurological diseases. Eur J Neurol. 2008;15(9):893-908.
26. Patwa HS, Chaudhry V, Katzberg H, et al. Evidence-based guideline: intravenous immunoglobulin in the treatment of neuromuscular disorders: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Neurology. 2012;78(13);1009-1015.
27. Anderson D, Kaiser A, Blanchette V, et al. Guidelines on the use of intravenous immune globulin for hematologic conditions. *Transfus Med Rev*. 2007;21(2):S9-S56.
28. Picard C, Al-Herz W, Bousfiha A, et al. Primary immunodeficiency diseases: an update on the classification from the International Union of Immunological Societies Expert Committee for Primary Immunodeficiency. J Clin Immunol. 2015; 35(8):696-726.
29. Bonilla FA, Khan DA, Ballas ZK, et al. Practice parameter for the diagnosis and management of primary immunodeficiency. J Allergy Clin Immunol. 2015;136(5):1186-205.e1-78.
30. Orange JS, Ballow M, Stiehm ER, et al. Use and interpretation of diagnostic vaccination in primary immunodeficiency: a working group report of the Basic and Clinical Immunology Interest section of the American Academy of Allergy, Asthma and Immunology. J Allergy Clin Immunol. 2012;130:S1-S24.
31. Ameratunga R, Woon ST, Gillis D, Koopmans W, Steele R. New diagnostic criteria for common variable immune deficiency (CVID), which may assist with decisions to treat with intravenous or subcutaneous immunoglobulin. Clin Exp Immunol. 2013;174(2):203-11.
32. Immune Deficiency Foundation. About primary immunodeficiencies. Specific disease types. http://primaryimmune.org/about-primary-immunodeficiencies/specific-disease-types/. Accessed November 8, 2017.
33. Immune Deficiency Foundation. Diagnostic and Clinical Care Guidelines for Primary Immunodeficiency Diseases. 3rd edition. Towson, MD: Immune Deficiency Foundation; 2015. http://primaryimmune.org/wp-content/uploads/2015/03/2015-Diagnostic-and-Clinical-Care-Guidelines-for-PI.pdf. Accessed November 8, 2017.
34. The NCCN Clinical Practice Guidelines in Oncology® B-cell Lymphomas (Version 2.2017). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed November 8, 2017.
35. Van den Bergh PY, Hadden RD, Bouche P, et al. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy: report of a joint task force of the European Federation of Neurological Societies and the Peripheral Nerve Society - first revision. Eur J Neurol. 2010;17(3):356-363.
36. Joint Task Force of the EFNS and the PNS. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of multifocal motor neuropathy. Report of a joint task force of the European

Federation of Neurological Societies and the Peripheral Nerve Society--first revision. *J Peripher Nerv Syst*. 2010;15(4):295-301. doi:10.1111/j.1529-8027.2010.00290.x
37. Dalakas MC. Inflammatory muscle diseases. *N Engl J Med*. 2015;372(18):1734-1747. doi:10.1056/NEJMra1402225.
38. Neunert C, Lim W, Crowther M, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011;117(16):4190-4207.
39. Provan D, Stasi R, Newland AC, et al. International consensus report on the investigation and management of primary immune thrombocytopenia. Blood. 2010;115(2):168-186.
40. Shearer WT, Dunn E, Notarangelo LD, et al. Establishing diagnostic criteria for severe combined immunodeficiency disease (SCID), leaky SCID, and Omenn syndrome: the Primary Immune Deficiency Treatment Consortium experience. J Allergy Clin Immunol. 2014;133(4):1092.
41. Cutaquig [prescribing information]. Paramus, NJ: Octapharma USA, Inc.; July 2020.
42. Panzyga [prescribing information]. Paramus, NJ: Octapharma USA, Inc.; February 2020.
43. Asceniv [prescribing information]. Boca Raton, FL: ADMA Biologics; April 2019.
44. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis: Executive summary. *Neurology*. 2016;87(4):419-425. doi:10.1212/WNL.0000000000002790
45. Sussman J, Farrugia ME, Maddison P, Hill M, Leite MI, Hilton-Jones D. Myasthenia gravis: Association of British Neurologists' management guidelines. *Pract Neurol*. 2015;15(3):199-206. doi:10.1136/practneurol-2015-001126
46. Gajdos P, Chevret S, Toyka KV. Intravenous immunoglobulin for myasthenia gravis. *Cochrane Database Syst Rev*. 2012;12(12):CD002277. Published 2012 Dec 12. doi:10.1002/14651858.CD002277.pub4
47. Balasubramanian SK, Sadaps M, Thota S, et al. Rational management approach to pure red cell aplasia. *Haematologica*. 2018;103(2):221-230. doi:10.3324/haematol.2017.175810
48. Crabol Y, Terrier B, Rozenberg F, et al. Intravenous immunoglobulin therapy for pure red cell aplasia related to human parvovirus b19 infection: a retrospective study of 10 patients and review of the literature. *Clin Infect Dis*. 2013;56(7):968-977. doi:10.1093/cid/cis1046
49. Brown KE, Young NS. Parvovirus B19 infection and hematopoiesis. *Blood Rev*. 1995;9(3):176-182. doi:10.1016/0268-960x(95)90023-3
50. Dalakas MC. The role of IVIg in the treatment of patients with stiff person syndrome and other neurological diseases associated with anti-GAD antibodies. *J Neurol*. 2005;252 Suppl 1:I19-I25. doi:10.1007/s00415-005-1105-4
51. Dalakas MC, Fujii M, Li M, Lutfi B, Kyhos J, McElroy B. High-dose intravenous immune globulin for stiff-person syndrome. *N Engl J Med*. 2001;345(26):1870-1876. doi:10.1056/NEJMoa01167
52. McCrindle BW, Rowley AH, Newburger JW, et al. Diagnosis, Treatment, and Long-Term Management of Kawasaki Disease: A Scientific Statement for Health Professionals From the American Heart Association [published correction appears in Circulation. 2019 Jul 30;140(5):e181-e184]. *Circulation*. 2017;135(17):e927-e999. doi:10.1161/CIR.0000000000000484
53. Titulaer MJ, Lang B, Verschuuren JJ. Lambert-Eaton myasthenic syndrome: from clinical characteristics to therapeutic strategies. *Lancet Neurol*. 2011;10(12):1098-1107. doi:10.1016/S1474-4422(11)70245-9
54. Keogh M, Sedehizadeh S, Maddison P. Treatment for Lambert-Eaton myasthenic syndrome. *Cochrane Database Syst Rev*. 2011;2011(2):CD003279. Published 2011 Feb 16. doi:10.1002/14651858.CD003279.pub3
55. Willison HJ, Jacobs BC, van Doorn PA. Guillain-Barré syndrome. *Lancet*. 2016;388(10045):717-727. doi:10.1016/S0140-6736(16)00339-1
56. van Schaik IN, Bril V, van Geloven N, et al. Subcutaneous immunoglobulin for maintenance treatment in chronic inflammatory demyelinating polyneuropathy (PATH): a randomised, double-blind, placebo-controlled, phase 3 trial [published correction appears in Lancet Neurol. 2018 Jan;17 (1):26] [published correction appears in Lancet Neurol. 2018 Aug;17(8):661]. *Lancet Neurol*. 2018;17(1):35-46. doi:10.1016/S1474-4422(17)30378-2
57. Eftimov F, Winer JB, Vermeulen M, de Haan R, van Schaik IN. Intravenous immunoglobulin for chronic inflammatory demyelinating polyradiculoneuropathy. *Cochrane Database Syst Rev*. 2013;(12):CD001797. Published 2013 Dec 30. doi:10.1002/14651858.CD001797.pub3
58. Oaklander AL, Lunn MP, Hughes RA, van Schaik IN, Frost C, Chalk CH. Treatments for chronic inflammatory demyelinating polyradiculoneuropathy (CIDP): an overview of systematic reviews. *Cochrane Database Syst Rev*. 2017;1(1):CD010369. Published 2017 Jan 13. doi:10.1002/14651858.CD010369.pub2
59. Ryan M, Ryan SJ. Chronic inflammatory demyelinating polyneuropathy: considerations for diagnosis, management, and population health. *Am J Manag Care*. 2018;24(17 Suppl):S371-S379.
60. Hameed S, Cascella M. Multifocal Motor Neuropathy. [Updated 2021 Feb 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www-ncbi-nlm-nih-gov.cedarville.ohionet.org/books/NBK554524/

61. Lundberg IE, Tjärnlund A, Bottai M, et al. 2017 European League Against Rheumatism/American College of Rheumatology classification criteria for adult and juvenile idiopathic inflammatory myopathies and their major subgroups [published correction appears in Ann Rheum Dis. 2018 Sep;77(9):e64]. *Ann Rheum Dis*. 2017;76(12):1955-1964. doi:10.1136/annrheumdis-2017-211468

Effective date: 10/1/2021
Revised date: 2/22/21

APPENDICES

Appendix A: Examples of Risk Factors for Bleeding (not all inclusive)

- Undergoing a medical or dental procedure where blood loss is anticipated
- Comorbidity (e.g., peptic ulcer disease, hypertension)
- Mandated anticoagulation therapy
- Profession or lifestyle predisposes patient to trauma (e.g., construction worker, fireman, professional athlete)

Appendix B: Impaired Antibody Response to Pneumococcal Polysaccharide Vaccine

- Age 6 years and older: antibody levels are not ≥ 1.3 mcg/mL for at least 70% of serotypes in the vaccine
- Age 2 to 5 years: antibody levels are not ≥ 1.3 mcg/mL for at least 50% of serotypes in the vaccine
- Not established for children less than 2 years of age

Appendix C: Billing codes

Product	Code
Asceniv	J1554
Bivigam	J1556
Carimune NF	J1566
Flebogamma DIF	J1572
Gammagard liquid	J1569
Gammagard S/D	J1566
Gammaked	J1561
Gammaplex	J1557
Gamunex-C	J1561
Octagam	J1568
Panzyga	J1559
Privigen	J1459
Cutaquig	J1599
Cuvitru	J1555
Hizentra	J1559
HyQvia	J1575
Xembify	J1558

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	**Immune globulin (IVIG and SCIG):** **Intravenous (IVIG)**: Asceniv, Bivigam, Carimune NF, Flebogamma DIF, Gammagard Liquid, Gammagard S/D, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, Privigen **Subcutaneous (SCIG)**: Cutaquig, Cuvitru, Hizentra, HyQvia, Xembify
BILLING CODE	See Appendix C at end of document.
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— Dosing should be based on ideal body weight (IBW) or adjusted body weight (adjBW) rather than actual/total body weight (TBW).
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Immune Globulin will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

AUTOIMMUNE BULLOUS DISEASE

For **initial** authorization:

1. Member has contraindications to, failure of (refractory to), or significant side effects from systemic corticosteroids or immunosuppressive treatment (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil); AND
2. Member has dermatologic condition, as indicated by **one** or more of the following:
   a) Bullous pemphigoid;
   b) Epidermolysis bullosa acquisita;
   c) Linear IgA bullous dermatosis;
   d) Mucous membrane (cicatricial) pemphigoid;
   e) Pemphigoid gestationis;
   f) Pemphigus foliaceus;
   g) Pemphigus vulgaris.
3. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
2. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect is provided with chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

For **initial** authorization:

1. IVIG is prescribed for prophylaxis of bacterial infections; AND
2. Member has a history of recurrent sinopulmonary infections requiring intravenous antibiotics or hospitalization; AND
3. Member has a pretreatment serum IgG level <500 mg/dL (Copy of laboratory report with pre-treatment serum IgG level must be provided with chart notes).
4. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. A reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a neurologist; AND
2. Member has a documented diagnosis of CIDP; AND
3. Symptoms of motor weakness and/or sensory disturbances have been present for at least 2 months; AND
4. Member has moderate to severe functional disability because of symptoms; AND
5. Electrodiagnostic studies must show evidence of demyelination in at least 2 nerves (e.g. reduced nerve conduction velocities, conduction block, abnormal temporal dispersion); AND
6. Member must meet at least one of the following:
   a) Trial and failure of or contraindication to a steroid regimen for at least 12 weeks (e.g. daily oral prednisone, monthly oral dexamethasone, IV methylprednisolone)
   b) Rapidly progressive disease
   c) Pure motor CIDP (no sensory symptoms, e.g. numbness, tingling, prickling).
7. **Dosage allowed:** See dosing information in individual drug package insert (Gammaked, Gamunex-C, Privigen, Hizentra).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member has improvement of neuromuscular disability and impairment, with sustained stability since initiation of therapy; AND
2. Members who are stable on maintenance IVIG should be assessed periodically to determine if the dose and/or frequency can be reduced to the lowest effective and establish the need for continued treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

DERMATOMYOSITIS OR POLYMYOSITIS

For **initial** authorization:

1. Medication must be prescribed by a neurologist, rheumatologist, or dermatologist; AND
2. Member has a diagnosis of dermatomyositis or polymyositis confirmed by muscle biopsy; AND
3. Member has tried and failed or has contraindications to first line treatment with a corticosteroid (e.g. prednisone), and/or with a non-steroid immunosuppressant (e.g. azathioprine, methotrexate, cyclosporine) for at least 4 weeks.
4. **Dosage allowed:** Consult clinical literature. For example, 2g/kg IV over 2-5 days.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member has significantly improved muscle strength sustained since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

FETAL/NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (F/NAIT)

For **initial** authorization:

1. Member is a newborn, and thrombocytopenia persists after transfusion of antigen-negative compatible platelet; OR
2. Member is pregnant and has diagnosis of F/NAIT with **one** or more of the following:
   a) Family history of disease;
   b) Platelet alloantibodies found on screening;
   c) Previously affected pregnancy.
3. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Medication will not be reauthorized for continuous use.

GUILLAIN-BARRE SYNDROME (GBS)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of Guillain-Barre Syndrome; AND
3. Physical mobility is severely affected such that member requires an aid to walk; AND
4. IVIG therapy will be initiated within 2 weeks of symptom onset.
5. **Dosage allowed:** Consult clinical literature. For example, 0.4g/kg/day x 5 days in adults.

If member meets all the requirements listed above, the medication will be approved for 1 month (1 course).

For **reauthorization**:

1. Member responded to initial course of therapy, as evidenced by improved/stabilized disability or weakness; AND
2. Member is experiencing deterioration following initial response to treatment.

If member meets the requirements listed above, the medication will be approved for 1 additional month (1 course). Further renewal will NOT be considered after a total of 2 courses.

CareSource

IDIOPATHIC THROMBOCYTOPENIC PURPURA (IMMUNE THROMBOCYTOPENIA)

For **initial** authorization:

1. Initial therapy (Member diagnosed with ITP within the past 3 months):
   a) Children (< 18 years of age):
      i) Significant bleeding symptoms (mucosal bleeding or other moderate/severe bleeding); OR
      ii) High risk for bleeding* (see Appendix A); OR
      iii) Rapid increase in platelets is required* (e.g., surgery or procedure);
   b) Adults (≥ 18 years of age):
      i) Platelet count < 30,000/mcL; OR
      ii) Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding or rapid increase in platelets is required*; AND
      iii) Corticosteroid therapy is contraindicated and IVIG will be used alone or IVIG will be used in combination with corticosteroid therapy.
2. Chronic/persistent ITP (≥ 3 months from diagnosis) or ITP unresponsive to first-line therapy (i.e., corticosteroids):
   a) Platelet count < 30,000/mcL; OR
   b) Platelet count < 50,000/mcL and significant bleeding symptoms, high risk for bleeding* or rapid increase in platelets is required*; AND
   c) Relapse after previous response to IVIG or inadequate response/intolerance/contraindication to corticosteroid or anti-D therapy.
3. Adults with refractory ITP after splenectomy:
   a) Platelet count < 30,000/mcL; OR
   b) Significant bleeding symptoms.
4. ITP in pregnant women: authorization through delivery may be granted to pregnant women with ITP if any **one** or more of the following:
   a) Any bleeding during pregnancy;
   b) Platelet count less than 10,000/mm^3 ($10x10^9$/L) at any time during pregnancy;
   c) Platelet count between 10,000/mm^3 ($10x10^9$/L) and 30,000/mm^3 ($30x10^9$/L) in second or third trimester.
5. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

***** *The member's risk factor(s) for bleeding (see Appendix A) or reason requiring a rapid increase in platelets must be provided*.

If member meets all the requirements listed above, the medication will be approved for 1 months for initial therapy, or for 6 months for chronic/persistent ITP or for adults with refractory ITP after splenectomy.

For **reauthorization**:

1. Medication will not be reauthorized for continuous use.

KAWASAKI SYNDROME

For **initial** authorization:

1. Medication is prescribed by a pediatric cardiologist or pediatrician experienced with diagnosing and treating Kawasaki Syndrome; AND
2. Member has a diagnosis of Kawasaki Syndrome.
3. **Dosage allowed:** 2g/kg as a single dose. If fever recurs or persists after at least 36 hours, a second dose may be given.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:
1. Medication will not be reauthorized for continuous use.

KIDNEY TRANSPLANT

For **initial** authorization:
1. Medication is used for prophylaxis or treatment of acute kidney rejection in conjunction with concomitant immunosuppression (e.g., cyclosporine, mycophenolate mofetil, and corticosteroids).
2. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 12 months.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a neurologist or oncologist; AND
2. Member has a diagnosis of LEMS as confirmed by at least one of the following:
   a) Repetitive nerve stimulation (RNS) study abnormalities
   b) Positive P/Q type anti-voltage gated calcium channel (VGCC) antibody assay; AND
3. Member has progressive proximal muscle weakness; AND
4. Member has tried and failed amifampridine (Firdapse or Ruzurgi; these require prior auth) or pyridostigmine.
5. **Dosage allowed:** Consult clinical literature. Consider 2g/kg given over 2 to 5 days, every 8 weeks.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must document significant improvement in muscle strength and maintenance of improvement since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MULTIFOCAL MOTOR NEUROPATHY (MMN)

For **initial** authorization:
1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of MMN as evidenced by BOTH of the following:
   a) Progressive, focal, asymmetric limb weakness with motor involvement of at least 2 nerves for more than one month, and
   b) No objective sensory abnormalities (e.g. normal sensory nerve conduction study).
3. **Dosage allowed:** Consult clinical literature. (Per Gammagard liquid: 0.5-2.4 g/kg/month IV in adults).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member has improved muscle strength and disability since initiation of IVIG therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MYASTHENIA GRAVIS

For **initial** authorization:
1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of myasthenia gravis and meets one of the following:
   a) For short term use: Member has impending or manifest myasthenic crisis with signs of significant respiratory or bulbar dysfunction and potential airway compromise; OR
   b) For maintenance:
      i) Member has severe, refractory myasthenia gravis that is unchanged or worse after corticosteroids and at least 2 other immunosuppressive therapies (e.g. azathioprine [first line], cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) for an adequate duration, with persistent symptoms or side effects that limit functioning; AND
      ii) Member has a positive serologic test for anti-acetylcholine receptor (AchR) antibodies.
3. **Dosage allowed:** Consult clinical literature. Consider a daily dose of 0.4 g/kg x 5 days or 1g/kg x 2 days.

If member meets the requirements listed above, the medication will be approved for 1 month (1 course) for crisis episode (as defined in 2a) or 12 months for maintenance use (as defined in 2b).

For **reauthorization**:
1. Member must meet initial criteria; AND
2. Chart notes must document clinically significant improvement of muscle weakness with treatment.

If the reauthorization requirements above are met, the medication will be approved for 1 month for crisis episode (as defined in 2a) or 6 months for maintenance use (as defined in 2b).

PARVOVIRUS B19-INDUCED PURE RED CELL APLASIA (PRCA)

For **initial** authorization:
1. Medication is prescribed by or in consultation with a hematologist or infectious disease specialist; AND
2. Member is immunocompromised (e.g. HIV, cancer, transplant); AND
3. Member has severe anemia as evidenced by hemoglobin lab results (i.e. less than 8.0 g/dL); AND
4. Member has tested positive for parvovirus B19 (e.g. by PCR or bone marrow exam).
5. **Dosage allowed:** Consult clinical literature. For example: 2g/kg divided over 5 days (400mg/kg/day).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member is chronically infected with parvovirus B19; AND
2. Hemoglobin level improved from baseline; AND
3. Member relapsed when treatment was stopped.

If the reauthorization requirements above are met, the medication will be approved for an additional 3 months.

PRIMARY IMMUNODEFICIENCY

CareSource

For **initial** authorization:
Member must have **one** of the following diagnoses:

1. Severe combined immunodeficiency (SCID) or congenital agammaglobulinemia (e.g., X-linked or autosomal recessive agammaglobulinemia):
   a) Diagnosis confirmed by genetic or molecular testing; OR
   b) Pretreatment IgG level < 200 mg/dL; OR
   c) Absence or very low number of T cells (CD3 T cells < 300/microliter) or the presence of maternal T cells in the circulation (SCID only);
2. Wiskott-Aldrich syndrome, DiGeorge syndrome, or ataxia-telangiectasia (or other non-SCID combined immunodeficiency):
   a) Diagnosis confirmed by genetic or molecular testing (if applicable); AND
   b) History of recurrent bacterial infections (e.g., pneumonia, otitis media, sinusitis, sepsis, gastrointestinal); AND
   c) Impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix B);
3. Common variable immunodeficiency (CVID):
   a) Member is 4 years of age or older; AND
   b) Other causes of immune deficiency have been excluded (e.g., drug induced, genetic disorders, infectious diseases such as HIV, malignancy); AND
   c) Member's pretreatment IgG level < 500 mg/dL or ≥ 2 SD below the mean for age; AND
   d) Member has a history of recurrent bacterial infections; AND
   e) Member has impaired antibody response to pneumococcal polysaccharide vaccine documented in chart notes (see Appendix B);
4. Hypogammaglobulinemia (unspecified), IgG subclass deficiency, selective IgA deficiency, selective IgM deficiency, or specific antibody deficiency:
   a) Member has a history of recurrent bacterial infections; AND
   b) Member has impaired antibody response to pneumococcal polysaccharide vaccine (see Appendix B)
   c) Member has ANY of the following pre-treatment laboratory findings:
      i) Hypogammaglobulinemia: IgG < 500 mg/dL or ≥ 2 SD below the mean for age;
      ii) Selective IgA deficiency: IgA level < 7 mg/dL with normal IgG and IgM levels;
      iii) Selective IgM deficiency: IgM level < 30 mg/dL with normal IgG and IgA levels;
      iv) IgG subclass deficiency: IgG1, IgG2, or IgG3 ≥ 2 SD below mean for age assessed on at least 2 occasions; normal IgG (total) and IgM levels, normal/low IgA levels;
      v) Specific antibody deficiency: normal IgG, IgA and IgM levels;
5. Other predominant antibody deficiency disorders must meet a), b), and c) i) in section 4. above;
6. Other combined immunodeficiency must meet criteria in section 2. above.
7. **Dosage allowed:** Please see dosage and administration information in individual drug package insert. *Note:* Gammagard Liquid, Gamunex-C, and Gammaked may be administered intravenously or subcutaneously for primary immunodeficiency.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. A reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy; AND
2. IgG trough levels are monitored at least yearly and maintained at or above the lower range of normal for age (when applicable for indication); OR
3. The prescriber will re-evaluate the dose of IVIG and consider a dose adjustment (when appropriate).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PROPHYLAXIS OF BACTERIAL INFECTIONS IN BMT/HSCT RECIPIENTS

For **initial** authorization:

1. Member is BMT/HSCT recipient; AND
2. IVIG is prescribed for prophylaxis of bacterial infections; AND
3. Either of the following:
   a) IVIG is requested within the first 100 days post-transplant; OR
   b) Member has a pretreatment serum IgG < 400 mg/dL.
4. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy and documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

PROPHYLAXIS OF BACTERIAL INFECTIONS IN HIV-INFECTED PEDIATRIC PATIENTS

For **initial** authorization:

1. Member with HIV infection and is 18 years of age or younger; AND
2. IVIG is prescribed for **primary** prophylaxis of bacterial infections and pretreatment serum IgG < 400 mg/dL; OR
3. IVIG is prescribed for **secondary** prophylaxis of bacterial infections with ALL of the following:
   a) History of recurrent bacterial infections (> 2 serious bacterial infections in a 1-year period);
   b) Member is not able to take combination antiretroviral therapy;
   c) Antibiotic prophylaxis was tried but was not effective (e.g., trimethoprim-sulfamethoxazole).
4. **Dosage allowed:** Please see dosage and administration information in individual drug package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Reduction in the frequency of bacterial infections has been demonstrated since initiation of IVIG therapy and documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

STIFF-PERSON SYNDROME

For **initial** authorization:

1. Medication is prescribed by or in consultation with a neurologist; AND
2. Member has a diagnosis of stiff-person syndrome; AND
3. Member has anti-glutamic acid decarboxylase (GAD) antibodies; AND
4. Member has tried and failed both of the following first-line treatments (monotherapy or in combination) for an adequate dose and duration, unless contraindicated or not tolerated:
   a) Benzodiazepine (e.g. diazepam, clonazepam)
   b) Baclofen. (An anticonvulsant is an acceptable alternative; for example, gabapentin, pregabalin, or valproate).
5. **Dosage allowed:** Consult the clinical literature for guidance. A dose of 2 g/kg over 2-5 days has been commonly cited.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes must document reduced stiffness, improved gait, fewer falls, and/or improved function with activities of daily living; AND
2. Clinically significant or disabling symptoms return following an attempt to discontinue treatment.

If requirements are met, the medication will be approved for an additional 6 months.

CareSource considers Immune Globulin not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

Acquired hemophilia	Myocarditis, acute
Adrenoleukodystrophy	Neonatal sepsis, prevention
Alzheimer's disease	Neonatal sepsis, treatment
Amyotrophic lateral sclerosis (ALS)	Ocular myasthenia
Antiphospholipid antibody syndrome (APS) in pregnancy	Paraneoplastic cerebellar degeneration, sensory neuropathy, or encephalopathy
Asthma, non-steroid dependent	Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
Atopic dermatitis	POEMS syndrome
Autism spectrum disorders	Postinfectious cerebellar ataxia
Autoimmune liver disease	Postoperative sepsis
Autoimmune neutropenia	Pseudomembranous colitis
Campylobacter species-induced enteritis	Respiratory syncytial virus (RSV) lower respiratory tract infection
Cerebral infarctions with antiphospholipid antibodies	Rheumatic fever, acute
Chronic fatigue syndrome	Sjogren's syndrome
Demyelinative brain stem encephalitis	Spontaneous recurrent abortions, prevention
Demyelinating neuropathy associated with monoclonal IgM	Systemic lupus erythematosus
Dilated cardiomyopathy	Urticaria, chronic
HIV infection or prophylaxis	Vasculitides and antineutrophil antibody syndromes
HTLV-1-associated myelopathy	Routine prophylaxis of Measles, Varicella, and Rubella
Idiopathic dysautonomia, acute	Treatment of Measles, Varicella, and Rubella
Inclusion body myositis	
Isolated IgA deficiency	
Isolated IgG4 deficiency	
Lumbosacral or brachial plexitis	

DATE	ACTION/DESCRIPTION
11/15/2017	New policy for Immune Globulin created. Diagnoses associate with inpatient life-threatening therapies were removed. Diagnoses of CIDP, Dermatomyositis or Polymyositis, ITP, MMN, Primary Immunodeficiency and Stiff-Person Syndrome got criteria

	expanded. Diagnosis of Acquired red cell aplasia was revised to PRCA with criteria. Length of coverage and reauthorization length were added.
08/21/2019	New medication Xembify added to the list of subcutaneous immune globulins.
02/22/2021	Added Panzyga, Asceniv to product list. Removed Thymoglobulin. Added J codes for Cutaquig, Cuvitru and Xembify and moved list of billing codes to an appendix. Added general note about weight-based dosing. Myasthenia Gravis: Updated references. Added specialist requirement. Split between short- and long-term use; replaced short term criteria and created new criteria for long term. Refer to literature for dosing, not package insert; added common dose regimen. Added renewal criteria. Parvovirus B19-induced PRCA: Added references. Revised entire section. Refer to literature for dosing, not package insert. Added specialist requirement. Added that they must be immunocompromised. Added hemoglobin and viral confirmation. Reduced approval duration from 6 months to 3 months. Added renewal criteria. Stiff person syndrome: Added references. Added specialist requirement. Added GAD antibody requirement. Require 2 prior therapies. Refer to literature for dosing, not package insert. Added example dose. Reduced approval duration from 6 months to 3 months. Added renewal criteria. Kawasaki syndrome: Added reference (previously none). Added specialist. Added dosing information. LEMS: Added references. Added specialist requirement. Direct to literature for dosing rather than package insert. Added common dose. Added confirmation of diagnosis. Amended step drugs to more closely align with guidelines in literature. Added progressive proximal muscle weakness. Slightly revised the renewal criteria. Shortened initial auth duration from 12 months to 3 months. GBS: Added reference. Added specialist requirement. Refer to literature for dosing, not package insert. Added example dose. Shortened initial auth duration from 2 mo to 1 mo and added renewal criteria for additional month. CIDP: Added references. Added specialist requirement. Added drug names to dosing section for guidance. Added requirement for steroid unless rapidly progressive or pure motor. Removed CSF protein requirement; added main clinical diagnostic point (symptoms x 2 mo). Elaborated on electrodiagnostic studies. MMN: Added reference. Added specialist. Added example dosing. Rephrased renewal criteria. Amended diagnostic criteria. DM/PM: Added reference. Added specialists. Clarified diagnostic criteria. Rephrased standard therapies and added duration. Added example dose; refer to literature, not package insert. Rephrased renewal criteria.

References:

1. Bivigam [package insert]. Boca Raton, FL: Biotest Pharmaceuticals Corporation; October 2013.
2. Carimune NF [package insert]. Kankakee, IL: CSL Behring LLC; May 2018.
3. Flebogamma 10% DIF [package insert]. Los Angeles, CA: Grifols Biologicals, Inc.; January 2016.
4. Flebogamma 5% DIF [package insert]. Los Angeles, CA: Grifols Biologicals, Inc.; April 2015.
5. Gammagard Liquid [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; April 2014.
6. Gammagard S/D [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; April 2014.
7. Gammagard S/D IgA less than 1 mcg/mL [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; September 2013.
8. Gammaked [package insert]. Fort Lee, NJ: Kedrion Biopharma, Inc.; September 2013.
9. Gammaplex [package insert]. Hertfordshire, United Kingdom: Bio Products Laboratory; July 2015.
10. Gamunex-C [package insert]. Research Triangle Park, NC: Grifols Therapeutics Inc.; July 2014.
11. Octagam 10% [package insert]. Hoboken, NJ: Octapharma USA, Inc.; April 2015.
12. Octagam 5% [package insert]. Hoboken, NJ: Octapharma USA, Inc.; October 2014.
13. Privigen [package insert]. Kankakee, IL: CSL Behring LLC; November 2013.
14. Cuvitru [package insert]. Westlake Village, CA: Baxalta US Inc.; September 2016.

15. Hizentra [package insert]. Kankakee, IL: CSL Behring LLC; October 2016.
16. HyQvia [package insert]. Westlake Village, CA: Baxter Healthcare Corporation; September 2016.
17. Xembify [prescribing information]. Research Triangle Park, NC: Grifols Therapeutics LLC; July 2019.
18. Amagai M, Ikeda S, Shimizu H, et al. A randomized double-blind trial of intravenous immunoglobulin for pemphigus. J Am Acad Dermatol 2009; 60(4):595-603.
19. Kirtschig G, Middleton P, Bennett C, Murrell DF, Wojnarowska F, Khumalo NP. Interventions for bullous pemphigoid. Cochrane Database of Systematic Reviews 2010, Issue 10. Art. No.: CD002292.
20. Orange JS, Hossny EM, Weiler CR, et al. Use of intravenous immunoglobulin in human disease: a review of evidence by members of the Primary Immunodeficiency Committee of the American Academy of Allergy, Asthma, and Immunology. J Allergy Clin Immunol. 2006;417(4 Suppl):S525-553.
21. Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/oi_guidelines_pediatrics.pdf. Accessed November 8, 2017.
22. Tomblyn M, Chiller T, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic cell transplant recipients: a global perspective. Biol Blood Marrow Transplant. 2009;15(10):1143-1238.
23. Feasby T, Banwell B, Bernstead T, et al. Guidelines on the use of intravenous immune globulin for neurologic conditions. Transfus Med Rev. 2007;21(2):S57-S107.
24. Donofrio PD, Berger A, Brannagan TH 3rd, et al. Consensus statement: the use of intravenous immunoglobulin in the treatment of neuromuscular conditions report of the AANEM ad hoc committee. Muscle Nerve. 2009;40(5):890-900.
25. Elovaara I, Apostolski S, van Doorn P, et al. EFNS guidelines for the use of intravenous immunoglobulin in treatment of neurological diseases: EFNS task force on the use of intravenous immunoglobulin in treatment of neurological diseases. Eur J Neurol. 2008;15(9):893-908.
26. Patwa HS, Chaudhry V, Katzberg H, et al. Evidence-based guideline: intravenous immunoglobulin in the treatment of neuromuscular disorders: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Neurology. 2012;78(13);1009-1015.
27. Anderson D, Kaiser A, Blanchette V, et al. Guidelines on the use of intravenous immune globulin for hematologic conditions. *Transfus Med Rev*. 2007;21(2):S9-S56.
28. Picard C, Al-Herz W, Bousfiha A, et al. Primary immunodeficiency diseases: an update on the classification from the International Union of Immunological Societies Expert Committee for Primary Immunodeficiency. J Clin Immunol. 2015; 35(8):696-726.
29. Bonilla FA, Khan DA, Ballas ZK, et al. Practice parameter for the diagnosis and management of primary immunodeficiency. J Allergy Clin Immunol. 2015;136(5):1186-205.e1-78.
30. Orange JS, Ballow M, Stiehm ER, et al. Use and interpretation of diagnostic vaccination in primary immunodeficiency: a working group report of the Basic and Clinical Immunology Interest section of the American Academy of Allergy, Asthma and Immunology. J Allergy Clin Immunol. 2012;130:S1-S24.
31. Ameratunga R, Woon ST, Gillis D, Koopmans W, Steele R. New diagnostic criteria for common variable immune deficiency (CVID), which may assist with decisions to treat with intravenous or subcutaneous immunoglobulin. Clin Exp Immunol. 2013;174(2):203-11.
32. Immune Deficiency Foundation. About primary immunodeficiencies. Specific disease types. http://primaryimmune.org/about-primary-immunodeficiencies/specific-disease-types/. Accessed November 8, 2017.
33. Immune Deficiency Foundation. Diagnostic and Clinical Care Guidelines for Primary Immunodeficiency Diseases. 3rd edition. Towson, MD: Immune Deficiency Foundation; 2015. http://primaryimmune.org/wp-content/uploads/2015/03/2015-Diagnostic-and-Clinical-Care-Guidelines-for-PI.pdf. Accessed November 8, 2017.
34. The NCCN Clinical Practice Guidelines in Oncology® B-cell Lymphomas (Version 2.2017). © 2017 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed November 8, 2017.
35. Van den Bergh PY, Hadden RD, Bouche P, et al. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy: report of a joint task force of the European Federation of Neurological Societies and the Peripheral Nerve Society - first revision. Eur J Neurol. 2010;17(3):356-363.
36. Joint Task Force of the EFNS and the PNS. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of multifocal motor neuropathy. Report of a joint task force of the European Federation of Neurological Societies and the Peripheral Nerve Society--first revision. *J Peripher Nerv Syst*. 2010;15(4):295-301. doi:10.1111/j.1529-8027.2010.00290.x
37. Dalakas MC. Inflammatory muscle diseases. *N Engl J Med*. 2015;372(18):1734-1747. doi:10.1056/NEJMra1402225.

38. Neunert C, Lim W, Crowther M, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011;117(16):4190-4207.
39. Provan D, Stasi R, Newland AC, et al. International consensus report on the investigation and management of primary immune thrombocytopenia. Blood. 2010;115(2):168-186.
40. Shearer WT, Dunn E, Notarangelo LD, et al. Establishing diagnostic criteria for severe combined immunodeficiency disease (SCID), leaky SCID, and Omenn syndrome: the Primary Immune Deficiency Treatment Consortium experience. J Allergy Clin Immunol. 2014;133(4):1092.
41. Cutaquig [prescribing information]. Paramus, NJ: Octapharma USA, Inc.; July 2020.
42. Panzyga [prescribing information]. Paramus, NJ: Octapharma USA, Inc.; February 2020.
43. Asceniv [prescribing information]. Boca Raton, FL: ADMA Biologics; April 2019.
44. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis: Executive summary. *Neurology*. 2016;87(4):419-425. doi:10.1212/WNL.0000000000002790
45. Sussman J, Farrugia ME, Maddison P, Hill M, Leite MI, Hilton-Jones D. Myasthenia gravis: Association of British Neurologists' management guidelines. *Pract Neurol*. 2015;15(3):199-206. doi:10.1136/practneurol-2015-001126
46. Gajdos P, Chevret S, Toyka KV. Intravenous immunoglobulin for myasthenia gravis. *Cochrane Database Syst Rev*. 2012;12(12):CD002277. Published 2012 Dec 12. doi:10.1002/14651858.CD002277.pub4
47. Balasubramanian SK, Sadaps M, Thota S, et al. Rational management approach to pure red cell aplasia. *Haematologica*. 2018;103(2):221-230. doi:10.3324/haematol.2017.175810
48. Crabol Y, Terrier B, Rozenberg F, et al. Intravenous immunoglobulin therapy for pure red cell aplasia related to human parvovirus b19 infection: a retrospective study of 10 patients and review of the literature. *Clin Infect Dis*. 2013;56(7):968-977. doi:10.1093/cid/cis1046
49. Brown KE, Young NS. Parvovirus B19 infection and hematopoiesis. *Blood Rev*. 1995;9(3):176-182. doi:10.1016/0268-960x(95)90023-3
50. Dalakas MC. The role of IVIg in the treatment of patients with stiff person syndrome and other neurological diseases associated with anti-GAD antibodies. *J Neurol*. 2005;252 Suppl 1:I19-I25. doi:10.1007/s00415-005-1105-4
51. Dalakas MC, Fujii M, Li M, Lutfi B, Kyhos J, McElroy B. High-dose intravenous immune globulin for stiff-person syndrome. *N Engl J Med*. 2001;345(26):1870-1876. doi:10.1056/NEJMoa01167
52. McCrindle BW, Rowley AH, Newburger JW, et al. Diagnosis, Treatment, and Long-Term Management of Kawasaki Disease: A Scientific Statement for Health Professionals From the American Heart Association [published correction appears in Circulation. 2019 Jul 30;140(5):e181-e184]. *Circulation*. 2017;135(17):e927-e999. doi:10.1161/CIR.0000000000000484
53. Titulaer MJ, Lang B, Verschuuren JJ. Lambert-Eaton myasthenic syndrome: from clinical characteristics to therapeutic strategies. *Lancet Neurol*. 2011;10(12):1098-1107. doi:10.1016/S1474-4422(11)70245-9
54. Keogh M, Sedehizadeh S, Maddison P. Treatment for Lambert-Eaton myasthenic syndrome. *Cochrane Database Syst Rev*. 2011;2011(2):CD003279. Published 2011 Feb 16. doi:10.1002/14651858.CD003279.pub3
55. Willison HJ, Jacobs BC, van Doorn PA. Guillain-Barré syndrome. *Lancet*. 2016;388(10045):717-727. doi:10.1016/S0140-6736(16)00339-1
56. van Schaik IN, Bril V, van Geloven N, et al. Subcutaneous immunoglobulin for maintenance treatment in chronic inflammatory demyelinating polyneuropathy (PATH): a randomised, double-blind, placebo-controlled, phase 3 trial [published correction appears in Lancet Neurol. 2018 Jan;17 (1):26] [published correction appears in Lancet Neurol. 2018 Aug;17(8):661]. *Lancet Neurol*. 2018;17(1):35-46. doi:10.1016/S1474-4422(17)30378-2
57. Eftimov F, Winer JB, Vermeulen M, de Haan R, van Schaik IN. Intravenous immunoglobulin for chronic inflammatory demyelinating polyradiculoneuropathy. *Cochrane Database Syst Rev*. 2013;(12):CD001797. Published 2013 Dec 30. doi:10.1002/14651858.CD001797.pub3
58. Oaklander AL, Lunn MP, Hughes RA, van Schaik IN, Frost C, Chalk CH. Treatments for chronic inflammatory demyelinating polyradiculoneuropathy (CIDP): an overview of systematic reviews. *Cochrane Database Syst Rev*. 2017;1(1):CD010369. Published 2017 Jan 13. doi:10.1002/14651858.CD010369.pub2
59. Ryan M, Ryan SJ. Chronic inflammatory demyelinating polyneuropathy: considerations for diagnosis, management, and population health. *Am J Manag Care*. 2018;24(17 Suppl):S371-S379.
60. Hameed S, Cascella M. Multifocal Motor Neuropathy. [Updated 2021 Feb 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available from: https://www-ncbi-nlm-nih-gov.cedarville.ohionet.org/books/NBK554524/
61. Lundberg IE, Tjärnlund A, Bottai M, et al. 2017 European League Against Rheumatism/American College of Rheumatology classification criteria for adult and juvenile idiopathic inflammatory myopathies and their major subgroups [published correction appears in Ann Rheum Dis. 2018 Sep;77(9):e64]. *Ann Rheum Dis*. 2017;76(12):1955-1964. doi:10.1136/annrheumdis-2017-211468

Effective date: 10/1/2021
Revised date: 2/22/21

APPENDICES

Appendix A: Examples of Risk Factors for Bleeding (not all inclusive)

- Undergoing a medical or dental procedure where blood loss is anticipated
- Comorbidity (e.g., peptic ulcer disease, hypertension)
- Mandated anticoagulation therapy
- Profession or lifestyle predisposes patient to trauma (e.g., construction worker, fireman, professional athlete)

Appendix B: Impaired Antibody Response to Pneumococcal Polysaccharide Vaccine

- Age 6 years and older: antibody levels are not ≥ 1.3 mcg/mL for at least 70% of serotypes in the vaccine
- Age 2 to 5 years: antibody levels are not ≥ 1.3 mcg/mL for at least 50% of serotypes in the vaccine
- Not established for children less than 2 years of age

Appendix C: Billing codes

Product	Code
Asceniv	J1554
Bivigam	J1556
Carimune NF	J1566
Flebogamma DIF	J1572
Gammagard liquid	J1569
Gammagard S/D	J1566
Gammaked	J1561
Gammaplex	J1557
Gamunex-C	J1561
Octagam	J1568
Panzyga	J1559
Privigen	J1459
Cutaquig	J1599
Cuvitru	J1555
Hizentra	J1559
HyQvia	J1575
Xembify	J1558

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Increlex (mecasermin)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Increlex (mecasermin) is indicated for the treatment of growth failure in pediatric patients 2 years of age and older with severe primary IGF-1 deficiency or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. It is administered subcutaneously. Growth hormone deficiency involves inadequate secretion of growth hormone from the pituitary gland.

Increlex (mecasermin) will be considered for coverage when the following criteria are met:

Pediatric Growth Failure

For **initial** authorization:

1. Member is at least two years of age or older;
2. Medication must be prescribed by a pediatric endocrinologist; AND
3. Member has a diagnosis of Severe Primary Insulin-like Growth Factor-1 Deficiency (IGFD) confirmed by all of the following:
   a) Height standard deviation score ≤ –3.0;
   b) Basal IGF-1 standard deviation score ≤ –3.0;
   c) normal or elevated growth hormone (GH); OR
4. Member has documentation of GH gene deletion who have developed neutralizing antibodies to GH; AND
5. Documentation the bone epiphyses are open;
6. Member is not treated with other growth hormone therapy
7. **Dosage allowed/Quantity limit:** Initial dose of 0.04 to 0.08 mg/kg (40 to 80 micrograms/kg) twice daily. If well-tolerated for at least one week, the dose may be increased by 0.04 mg/kg per dose, to the maximum dose of 0.12 mg/kg given twice daily

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

Increlex will be reauthorized when chart notes show all of the following:

1. Member has a growth rate of at least 2 cm/year;
2. Documentation the bone epiphyses are open; AND
3. Member is not treated with other growth hormone therapy

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Increlex (mecasermin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/18/2021	Increlex policy creation

References:

1. Increlex [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc.; December 2019
2. Grimberg A, DiVall SA, Polychronakos C, et al. Guidelines for growth hormone and insulilike growth factor-1 treatment in children and adolescents: growth hormone deficiency, idiopathic short stature, and primary insulin-like growth factor-1 deficiency. *Hormone Research in Paediatrics* 2016;361-397
3. Rosenfeld RG. The IGF system: new developments relevant to pediatric practice. *Endocrine Development* 2005;9:1-10
4. Clark RG. Recombinant human insulin-like growth factor I (IGF-I): risks and benefits of normalizing blood IGF-I concentrations. *Frontiers of Hormone Research* 2004; 62 Suppl 1:93-100
5. Roelfsema V, Clark RG. The growth hormone and insulin-like growth factor axis: its manipulation for the benefit of growth disorders in renal failure. *Journal of the American Society of Nephrology* 2001 Jun;12(6):1297-306

Effective date: 04/01/2022
Creation date: 10/18/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Inflectra (infliximab-dyyb)
BILLING CODE	Q5103 (1 unit = 10 mg or 1 x 100 mg vial = 10 units)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Taltz, Enbrel, Humira, and Xeljanz 5 mg tablet QUANTITY LIMIT— 1200 mg (120 units per dose)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Inflectra (infliximab-dyyb) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
8. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Humira, or Taltz. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) that is indicated for AS, then the trial can be accepted.
9. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 6 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by **one** of the following:
   a) Extensive small bowel disease involving more than 100 cm;
   b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
   c) Fistulizing disease.
6. **Dosage allowed:** 5mg/kg at 0, 2, and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Humira, Enbrel, or Taltz. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) that is indicated for PsO, then the trial can be accepted.
8. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member has tried and failed treatment with at least **two** of the following: Humira, Enbrel, Taltz, or Xeljanz 5mg tablet. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) that is indicated for PsA, then the trial can be accepted.
7. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:
1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND

Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Medication is being given in combination with methotrexate or with another non-biologic DMARD if unable to tolerate methotrexate; AND
6. Member has tried and failed treatment with at least **two** of the following: Humira, Enbrel, Taltz, or Xeljanz 5mg tablet. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) or JAK inhibitor (e.g., Kevzara) that is indicated for RA, then the trial can be accepted.
7. **Dosage allowed:** 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:
1. Member is 6 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a documented trial and inadequate response with **one** of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
5. **Dosage allowed:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Inflectra (infliximab-dyyb) not medically necessary for the treatment of the following disease that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/03/2019	New policy for Inflectra created.
05/03/2021	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. Updated list of preferred agents and drug trials for all diagnoses to match Ohio Department of Medicaid Unified Preferred Drug List. Added that if member previously

	tried a non-preferred option in the same drug class as preferred options, the trial is accepted. AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. CD: Removed PCDAI and CDAI score requirements. Specified length of trials for conventional therapies, previously not specified. Those with severe disease can skip the drug trial. Changed initial approval to 6 months to observe efficacy. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. UC: Removed PUCAI and Mayo score requirements. Specified the length of trials for conventional therapies (previously not specified).

References:

1. Inflectra [prescribing information]. New York, NY: Pfizer, Inc.; June 2019.
2. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
7. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
8. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
9. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
10. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
11. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
12. Lofberg R. Treatment of fistulas in Crohn's disease with infliximab. *Gut*. 1999;45(5):642-643.
13. Ricart E, Sandborn WJ. Infliximab for the treatment of fistulas in patients with Crohn's disease. *Gastroenterology*. 1999;117(5):1247-1248.
14. Sands BE, Anderson FH, Bernstein CN et al. A randomized controlled trial of infliximab maintenance therapy for fistulizing Crohn's disease (ACCENT II). *N Engl J Med*. 2004;350:876-885.
15. Mease PJ, et al. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blind, randomized, placebo-controlled trial. *Arthritis Rheum*. 2005; 52:3279.
16. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
17. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
18. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.

19. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
20. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
21. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
22. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
23. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
24. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
25. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
26. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
27. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

Effective date: 10/1/2021
Revised date: 05/03/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Ingrezza (valbenazine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 30 capsules per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ingrezza (valbenazine) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

TARDIVE DYSKINESIA (TD)

For **initial** authorization:

1. Member is 18 years of age and older and medication is prescribed by neurologist or psychiatrist or nurse practitioner within a psychiatric or neurologic practice; AND
2. Member has clinical diagnosis of moderate to severe neuroleptic-induced TD as determined by clinical observation and documented in chart notes; AND
3. Member must try and fail at least 1 other guideline recommended treatments (e.g., clonazepam, ginkgo biloba, etc.); AND
4. Chart notes confirming that member does **not** have risk for suicidal or violent behavior and has stable psychiatric symptoms; AND
5. If member has a history of substance use disorder, chart notes confirming that member is in remission for **at least** 3 months must be provided; AND
6. Member's The Abnormal Involuntary Movement Scale (AIMS) score is documented in chart notes; AND
7. Member does **not** have ANY of the following:
   a) History of neuroleptic malignant syndrome;
   b) History of long QT syndrome or cardiac arrhythmia;
   c) Allergy, hypersensitivity, or intolerance to tetrabenazine.
8. **Dosage allowed:** 40 mg once daily. After one week, increase the dose to the recommended dose of 80 mg once daily.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Documentation that the member's TD symptoms have improved due to Ingrezza use as evidenced by AIMS score showing reduction of score from baseline.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ingrezza (valbenazine) not medically necessary for the treatment of the following disease states based on a lack of robust clinical

controlled trials showing superior efficacy compared to currently available treatments:

- Treatment of Huntington disease, Chorea – Huntington's disease
- Treatment of Tourette syndrome

DATE	ACTION/DESCRIPTION
08/29/2017	New policy for Ingrezza created.
12/14/2017	Criterion revised in collaboration with Indiana Medicaid DUR Board. Criterion requirement of clinical diagnoses of Schizophrenia or Schizoaffective Disorder, or Mood Disorder for at least 3 months was removed. Length of initial authorization increased to 3 months. Criterion on guidelines recommended treatment was revised.
12/28/2017	Criterion on negative drug test revised. Substance use disorder remission length requirement changed.
02/08/2018	New provider's specialty was added: nurse practitioner within a psychiatric or neurologic practice.
05/06/2019	The guideline recommended treatment criterion changed from two to one medication to try as a trial. Criterion on negative urine drug test or positive drug test result due to current prescriptions was removed.
12/21/2020	Updated quantity limit from 60 per 30 days to 30 per 30 days because a new strength (80mg) is now available.
11/19/2021	Annual review, no changes

References:

1. Ingrezza [package insert]. San Diego, CA; Neurocrine Biosciences, Inc.: April, 2017.
2. Kang N-R, Kim M-D. Tardive Dyskinesia: Treatment with Aripiprazole. Clinical Psychopharmacology and Neuroscience. 2011;9(1):1-8. doi:10.9758/cpn.2011.9.1.1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3568649/.
3. ClinicalTrials.gov. Bethesda (MD): National Library of Medicine (US). 2017 Jun 9 - . Identifier NCT02274558, A Phase 3 Study of NBI-98854 for the Treatment of Tardive Dyskinesia (KINECT 3); 2017 Jun 9 [cited 2017 Jul 31]. Available from: https://clinicaltrials.gov/ct2/show/NCT02736955?cond=ingrezza&rank=1.
4. American Academy of Neurology. Summary of Evidence-based Guideline for PATIENTS and their FAMILIES. Treating and managing tardive syndromes. https://www.aan.com/Guidelines/Home/GetGuidelineContent/614.
5. Hauser RA, Factor SA, Marder SR, Knesevich MA, et al. KINECT 3: A Phase 3 Randomized, Double-Blind, Placebo-Controlled Trial of Valbenazine for Tardive Dyskinesia. American Journal of Psychiatry 2017 174:5, 476-484.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Inhaled Prostacyclins for Pulmonary Arterial Hypertension: Tyvaso (treprostinil), Ventavis (iloprost)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Pulmonary Arterial Hypertension is a rare but serious condition characterized by elevated pulmonary arterial resistance. Ventavis and Tyvaso are approved for the treatment of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1. Ventavis is approved to increase exercise tolerance, improve symptoms (NYHA Class), and delay deterioration for PAH. Tyvaso is indicated to improve exercise ability for adults with PAH. It is also indicated for the treatment of pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) to improve exercise ability.

Inhaled Prostacyclins will be considered for coverage when the following criteria are met:

Pulmonary Arterial Hypertension [WHO Group 1]

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization; AND
4. Member has tried and failed one oral medication from one of the following three categories: phosphodiesterase type 5 inhibitor (ie. Sildenafil, Tadalafil), endothelin receptor antagonist (ie. Ambrisentan, Bosentan, Macitentan), or Soluble Guanylate Cyclase Stimulator (ie. Adempas) OR WHO functional class IV symptoms (for Ventavis only – see appendix);
5. Member must have documentation pulmonary arterial pressures are not adequately controlled, confirmed by **one** of the following:
   a) Patient had an acute response to vasodilator testing AND has tried a calcium channel blocker (CCB) for at least 3 months; OR
   b) Patient did not have a response to vasodilator testing; OR
   c) Patient cannot undergo vasodilator testing; OR
   d) Patient cannot take CCB therapy
6. **Dosage allowed/Quantity limit:**
   Tyvaso: Initiate 3 breaths (18 mcg) per treatment session; Titrate to target maintenance dosage of 9 to 12 breaths per treatment session, 4 times daily.
   Ventavis: Initiate 2.5 mcg per treatment session; Titrate to target maintenance dose of 6 to 9 doses (inhalations) per day (minimum of 2 hours between doses during waking hours).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
Inhaled Prostacyclins will be reauthorized when chart notes show at least one of the following:
1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in functional class symptoms or quality of life
   b) Stabilization or improvement in 6MWD [6-minute walk distance]

If all the above requirements are met, the medication will be approved for an additional 12 months.

Pulmonary hypertension associated with interstitial lung disease [WHO Group 3] – TYVASO ONLY

For **initial** authorization:
1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 3 pulmonary hypertension with interstitial lung disease (PH-ILD) confirmed by right heart catheterization; AND
4. Member has evidence of diffuse parenchymal lung disease on computed tomography (CT) imaging of the chest;
5. **Dosage allowed/Quantity limit:**
   Tyvaso: Initiate 3 breaths (18 mcg) per treatment session; Titrate to target maintenance dosage of 9 to 12 breaths per treatment session, 4 times daily.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
Tyvaso will be reauthorized when chart notes show at least one of the following:
1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in functional class symptoms or quality of life
   b) Stabilization or improvement in 6MWD [6-minute walk distance]

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Inhaled Prostacyclins not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/15/2011	Pulmonary Arterial Hypertension policy creation.
05/13/2014	Combined all PAH agents into one policy
07/09/2015	Revised guidelines for therapy aligning with CMS
08/18/2015	Revised guidelines to include diagnosis criteria
10/13/2021	Separated PAH agents by drug class; Updated guidelines; Added provider specialty; Added PH-ILD; WHO Group 3 indication for Tyvaso

References:

1. Tyvaso [package insert]. Research Triangle Park, NC: United Therapeutics Corp; March 2021
2. Ventavis [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; December 2019
3. Coons, J.C., Pogue, K., Kolodziej, A.R. et al. Pulmonary Arterial Hypertension: a Pharmacotherapeutic Update. Curr Cardiol Rep. 2019; 21(141)
4. Klinger JR, Elliott CG et al. Therapy for Pulmonary Arterial Hypertension in Adults; Chest Journal. March 2019; 155(3): 565-586

5. Galie N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension: The Joint Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS): Endorsed by: Association for European Paediatric and Congenital Cardiology (AEPC), International Society for Heart and Lung Transplantation (ISHLT). European heart journal. 2016;37(1):67–119

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

New York Heart Association Functional Classification	
Class 1	Cardiac Disease, but no symptoms and no limitation in ordinary physical activity, e.g. shortness of breath when walking, climbing stairs, etc.
Class 2	Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
Class 3	Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (20-100 m). Comfortable only at rest.
Class 4	Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients

World Health Organization Functional Assessment Classification	
Class I	Patients with PAH but without resulting limitation of physical activity. Ordinary physical activity does not cause undue dyspnea or fatigue, chest pain or near syncope.
Class II	Patients with PAH resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity causes undue dyspnea or fatigue, chest pain, or near syncope.
Class III	Patients with PAH resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes undue dyspnea or fatigue, chest pain, or near syncope.
Class IV	Patients with PAH with inability to carry out any physical activity without symptoms. These patients manifest signs of right-heart failure. Dyspnea and/or fatigue may even by present at rest. Discomfort is increased by any physical activity.

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Injectable Prostacyclins for Pulmonary Arterial Hypertension: Flolan/Veletri (epoprostenol), Remodulin (treprostinil), Uptravi (selexipag)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Pulmonary Arterial Hypertension is a rare but serious condition characterized by elevated pulmonary arterial resistance. Flolan/Veletri, Remodulin and Uptravi are approved for the treatment of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1. Flolan/Veletri is indicated to improve exercise capacity in adults with PAH. Remodulin is indicated to improve exercise capacity as well as reduce the rate of deterioration in patients who require transition from epoprostenol. Uptravi is approved to delay disease progression and reduce the risk of hospitalization for PAH.

Injectable Prostacyclins will be considered for coverage when the following criteria are met:

Pulmonary Arterial Hypertension [WHO Group 1]

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization; AND
4. Member has tried and failed one oral medication from one of the following three categories: phosphodiesterase type 5 inhibitor (ie. Sildenafil, Tadalafil), endothelin receptor antagonist (ie. Ambrisentan, Bosentan, Macitentan), or Soluble Guanylate Cyclase Stimulator (ie. Adempas) OR WHO functional class IV symptoms (see appendix);
5. Member must have documentation pulmonary arterial pressures are not adequately controlled, confirmed by **one** of the following:
   a) Patient had an acute response to vasodilator testing AND has tried a calcium channel blocker (CCB) for at least 3 months; OR
   b) Patient did not have a response to vasodilator testing; OR
   c) Patient cannot undergo vasodilator testing; OR
   d) Patient cannot take CCB therapy
6. Uptravi IV only: A clinical reason why the member cannot take Uptravi tablets;
7. Remodulin IV only**:** A clinical reason why the member cannot take Remodulin subcutaneous infusion;
8. **Dosage allowed/Quantity limit:**
   Flolan/Veletri**:** Initiate at 2 ng/kg/min. Increase infusion by 1- to 2-ng/kg/min increments every 15 minutes
   Remodulin: Initiate 1.25 ng/kg/min per week for the first 4 weeks of treatment, then 2.5 ng/kg/min per week for the remaining duration of the infusion
   Uptravi: Injection dose is determined by the patient's current dose of Uptravi tablets; Administer by intravenous infusion twice daily; Refer to below table:

Oral dose	Equivalent IV dose
200 mcg twice daily	225 mcg twice daily
400 mcg twice daily	450 mcg twice daily
600 mcg twice daily	675 mcg twice daily
800 mcg twice daily	900 mcg twice daily
1,000 mcg twice daily	1,125 mcg twice daily
1,200 mcg twice daily	1,350 mcg twice daily
1,400 mcg twice daily	1,575 mcg twice daily
1,600 mcg twice daily	1,800 mcg twice daily

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
Injectable Prostacyclins will be reauthorized when chart notes show at least one of the following:

1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in functional class symptoms or quality of life
   b) Stabilization or improvement in 6MWD [6-minute walk distance]

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Injectable Prostacyclins not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/15/2011	Pulmonary Arterial Hypertension policy creation.
05/13/2014	Combined all PAH agents into one policy
07/09/2015	Revised guidelines for therapy aligning with CMS
08/18/2015	Revised guidelines to include diagnosis criteria
10/13/2021	Separated PAH agents by drug class; Updated guidelines; Added provider specialty

References:

1. Uptravi [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; October 2021
2. Flolan [package insert]. Research Triangle Park, NC: GlaxoSmithKline; August 2021
3. Veletri [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; December 2018
4. Remodulin [package insert]. Research Triangle Park, NC: United Therapeutics Corporation; February 2021
5. Coons, J.C., Pogue, K., Kolodziej, A.R. et al. Pulmonary Arterial Hypertension: a Pharmacotherapeutic Update. Curr Cardiol Rep. 2019; 21(141)
6. Klinger JR, Elliott CG et al. Therapy for Pulmonary Arterial Hypertension in Adults; Chest Journal. March 2019; 155(3): 565-586
7. Galie N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension: The Joint Task Force for the Diagnosis and Treatment of Pulmonary

Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS): Endorsed by: Association for European Paediatric and Congenital Cardiology (AEPC), International Society for Heart and Lung Transplantation (ISHLT). European heart journal. 2016;37(1):67–119

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

New York Heart Association Functional Classification	
Class 1	Cardiac Disease, but no symptoms and no limitation in ordinary physical activity, e.g. shortness of breath when walking, climbing stairs, etc.
Class 2	Mild symptoms (mild shortness of breath and/or angina) and slight limitation during ordinary activity.
Class 3	Marked limitation in activity due to symptoms, even during less-than-ordinary activity, e.g. walking short distances (20-100 m). Comfortable only at rest.
Class 4	Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients

World Health Organization Functional Assessment Classification	
Class I	Patients with PAH but without resulting limitation of physical activity. Ordinary physical activity does not cause undue dyspnea or fatigue, chest pain or near syncope.
Class II	Patients with PAH resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity causes undue dyspnea or fatigue, chest pain, or near syncope.
Class III	Patients with PAH resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes undue dyspnea or fatigue, chest pain, or near syncope.
Class IV	Patients with PAH with inability to carry out any physical activity without symptoms. These patients manifest signs of right-heart failure. Dyspnea and/or fatigue may even by present at rest. Discomfort is increased by any physical activity.

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Injectable somatostatin analogs (First generation): Sandostatin (octreotide), Sandostatin LAR (octreotide), Somatuline depot (lanreotide), Bynfezia Pen (octreotide)
BILLING CODE	J2354/ J2353/ J1930/ NDC
BENEFIT TYPE	Medical, except Bynfezia is a pharmacy benefit
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— See "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Somatuline depot (lanreotide) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit; Sandostatin (octreotide) and Sandostatin LAR (octreotide) are **non-preferred** products and will only be considered for coverage under the **medical** benefit; Bynfezia is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit, when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACROMEGALY

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has diagnosis of uncontrolled acromegaly confirmed by insulin-like growth factor (IGF-1) elevation above normal level (lab report required); AND
4. Member had an inadequate response to surgery or radiation, or member is ineligible for these treatments (documentation required); AND
5. If IGF-1 elevation is 1.5x upper limit of normal or less, member must have a trial of, or contraindication or intolerance to cabergoline.[3]
6. For Somatuline Depot only: Must have a trial and failure of Sandostatin LAR.
7. For Bynfezia only:
   a) Baseline thyroid function testing is required; AND
   b) Trial and failure of short acting octreotide (generic Sandostatin).
8. **Dosage allowed:**
   Octreotide: Initial 50mcg subQ/IV 3 times daily, titrate as indicated, usual maintenance dose 100mcg 3 times daily, max 500mcg 3 times daily. NOTE: Doses in excess of 300mcg per day seldom confer additional benefit.
   Sandostatin LAR: Start at 20mg IM every 4 weeks for 3 months, then adjust according to GH and IGF-1 per package insert, no more than 40mg every 4 weeks.
   Somatuline depot: Start at 90mg subQ every 4 weeks for 3 months, then adjust according to GH and IGF-1 per package insert, no more than 120mg every 4 weeks.
   Bynfezia Pen: Initial 50mcg subQ 3 times daily, titrate as indicated, usual maintenance dose 100mcg 3 times daily, max 500mcg 3 times daily. NOTE: Doses in excess of 300mcg per day seldom confer additional benefit.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes/lab report must show normalized or improved (decreased) IGF-1.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NOTE to Reviewer: A short-acting product may be used concurrently with a long-acting product.

CARCINOID SYNDROME

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an oncologist or gastroenterologist; AND
3. Member has a neuroendocrine tumor, including carcinoid tumor or vasoactive intestinal peptide tumor (VIPoma); AND
4. Member is experiencing flushing and/or diarrhea symptoms associated with carcinoid syndrome (or VIPoma syndrome), not attributed to another cause.
5. For Somatuline Depot only: Must have a trial and failure of Sandostatin LAR.
6. For Bynfezia only:
   a) Baseline thyroid function testing is required; AND
   b) Trial and failure of short acting octreotide (generic Sandostatin).
7. **Dosage allowed:**
   Octreotide: 100mcg-750mcg per day subQ/IV in divided doses.
   Sandostatin LAR: 10mg to 30mg IM every 4 weeks.
   Somatuline depot: 120mg subQ every 4 weeks.
   Bynfezia: 100-750mcg per day subQ in divided doses.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. For short-acting products (octreotide, Bynfezia): Chart notes must document symptomatic improvement of flushing and/or diarrhea episodes.
2. For long-acting products (Sandostatin LAR, Somatuline Depot): Chart notes must document reduced frequency of short-acting somatostatin analog rescue therapy for symptom control.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NOTE to Reviewer: A short-acting product may be used concurrently with a long-acting product.

GASTROENTEROPANCREATIC NEUROENDOCRINE TUMORS (GEP-NETs)

Any request for **cancer** must be submitted through NantHealth/Eviti portal.

CareSource considers Sandostatin (octreotide) Sandostatin LAR (octreotide), Somatuline depot (lanreotide), Bynfezia (octreotide) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/03/2020	New policy for injectable somatostatin analogs created.

03/11/2021	Annual review, no changes

References:

1. Somatuline Depot (lanreotide acetate) [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc; 2019.
2. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2014;99(11):3933-3951. doi:10.1210/jc.2014-2700
3. Melmed S, Bronstein MD, Chanson P, et al. A Consensus Statement on acromegaly therapeutic outcomes. *Nature Reviews Endocrinology*. 2018;14(9):552-561. doi:10.1038/s41574-018-0058-5
4. Zahr R, Fleseriu M. Updates in Diagnosis and Treatment of Acromegaly. *Eur Endocrinol*. 2018;14(2):57-61. doi:10.17925/EE.2018.14.2.57
5. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary*. October 2020. doi:10.1007/s11102-020-01091-7
6. Vinik AI, Wolin EM, Liyanage N, Gomez-Panzani E, Fisher GA; ELECT Study Group *. EVALUATION OF LANREOTIDE DEPOT/AUTOGEL EFFICACY AND SAFETY AS A CARCINOID SYNDROME TREATMENT (ELECT): A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL. Endocr Pract. 2016 Sep;22(9):1068-80. doi: 10.4158/EP151172.OR. Epub 2016 May 23.
7. Pavel M, Öberg K, Falconi M, Krenning EP, Sundin A, Perren A, Berruti A; ESMO Guidelines Committee. Electronic address: clinicalguidelines@esmo.org. Gastroenteropancreatic neuroendocrine neoplasms: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol. 2020 Jul;31(7):844-860. doi: 10.1016/j.annonc.2020.03.304. Epub 2020 Apr 6.
8. Strosberg JR, Halfdanarson TR, Bellizzi AM, Chan JA, Dillon JS, Heaney AP, Kunz PL, O'Dorisio TM, Salem R, Segelov E, Howe JR, Pommier RF, Brendtro K, Bashir MA, Singh S, Soulen MC, Tang L, Zacks JS, Yao JC, Bergsland EK. The North American Neuroendocrine Tumor Society Consensus Guidelines for Surveillance and Medical Management of Midgut Neuroendocrine Tumors. Pancreas. 2017 Jul;46(6):707-714. doi: 10.1097/MPA.0000000000000850.
9. Cook R, Hendifar AE. Evidence-Based Policy in Practice: Management of Carcinoid Syndrome Diarrhea. P T. 2019;44(7):424-427.
10. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors. (Version 2.2020). https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed November 3, 2020.
11. Pandit S, Annamaraju P, Bhusal K. Carcinoid Syndrome. [Updated 2020 Jun 25]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448096/

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Isturisa (osilodrostat)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 180 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Isturisa (osilodrostat) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CUSHING'S DISEASE

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has a diagnosis of Cushing's disease, with an elevated urinary free cortisol (UFC) level (lab report required); AND
4. Member had pituitary surgery and it was not curative OR member is not a candidate for surgery (documentation required); AND
5. Member has tried ketoconazole for at least 3 months with inadequate response.
6. **Dosage allowed:** Max recommended dose is 30mg (as three 10mg tablets), twice daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Labs must show UFC level within normal range; AND
2. Chart notes must show the member has improved signs and symptoms of disease (e.g. weight, fasting glucose, blood pressure, or tumor size).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Isturisa (osilodrostat) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/30/2020	New policy for Isturisa created.
03/11/2021	Annual review, no changes

References:

1. Isturisa [package insert]. Lebanon, NJ: Recordati Rare Diseases Inc; 2020.
2. Recordati Rare Diseases: Isturisa(R) (osilodrostat) Phase III LINC-4 Trial Meets Its Primary Endpoint in Cushing's Disease. Barron's. https://www.barrons.com/press-release/recordati-rare-diseases-isturisa-r-osilodrostat-phase-iii-linc-4-trial-meets-its-primary-endpoint-in-cushing-s-disease-01592380982?tesla=y. Published June 17, 2020. Accessed June 30, 2020.
3. Nieman, LK. Medical therapy of hypercortisolism (Cushing's syndrome). *UpToDate*. https://www.uptodate.com. Updated 6/29/20. Accessed 6/30/20.
4. IPD analytics. Accessed 6/30/20.
5. Nieman LK, Biller BM, Findling JW, et al. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. J Clin En*docrinol Metab*. 2015;100(8):2807-2831. doi:10.1210/jc.2015-1818
6. Fleseriu M, Pivonello R, Young J, et al. Osilodrostat, a potent oral 11β-hydroxylase inhibitor: 22-week, prospective, Phase II study in Cushing's disease. *Pituitary*. 2015;19(2):138-148. doi:10.1007/s11102-015-0692-z
7. Biller BM, Newell-Price J, Fleseriu M, et al. OR16-2 Osilodrostat Treatment in Cushing's Disease (CD): Results from a Phase III, Multicenter, Double-Blind, Randomized Withdrawal Study (LINC 3). *Journal of the Endocrine Society*. 2019;3(Supplement_1).

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Jakafi (ruxolitinib)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Jakafi, a janus kinase inhibitor (JAK1 and JAK2), is approved for use in both acute and chronic graft-versus-host disease (GVHD), myelofibrosis, and polycythemia vera. JAK1 and JAK2 mediate signaling of cytokines and growth factors important for hematopoiesis and immune function. Prominent side effects of Jakafi are thrombocytopenia and anemia.
GVHD is a common complication following allogenic hematopoietic stem cell transplant (HSCT). It occurs when immune cells transplanted from a non-identical donor (graft) recognize the transplant recipient (host) as foreign, initiating an immune response. Acute GVHD typically occurs within the first 100 days and mainly affects the skin, gastrointestinal system, and liver. Chronic GVHD affects a wider variety of systems and is less well understood. Steroids are the mainstay of treatment but are only effective for about 50% of patients.

Jakafi (ruxolitinib) will be considered for coverage when the following criteria are met:

Acute Graft-Versus-Host Disease (aGVHD)

For **initial** authorization:
1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with a transplant or hematology/oncology specialist; AND
3. Member has a documented diagnosis of grade II-IV acute graft-versus host disease following allogeneic hematopoietic cell transplantation (HCT); AND
4. Member is refractory to treatment with glucocorticoid (such as methylprednisolone 2mg/kg/day), defined as progression by day 3-5, non-response by day 7, or inability to taper.
5. **Dosage allowed/Quantity limit**: Starting dose is 5 mg orally twice daily; consider increasing to 10 mg twice daily. (60 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 30 days.

For **reauthorization**:
1. Member is being monitored for side effects (e.g., cytopenias) and has not experienced any life-threatening adverse events; AND
2. Chart notes must demonstrate improved signs and symptoms of disease.

If all the above requirements are met, the medication will be approved for an additional 6 months.

Chronic Graft-Versus-Host Disease (cGVHD)

For **initial** authorization:
1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with a transplant or hematology/oncology specialist; AND

3. Member has a documented diagnosis of moderate to severe cGVHD; AND
4. Member's condition is steroid refractory or dependent (with or without a calcineurin inhibitor): Lack of response or disease progression after at least 1 week (e.g., on prednisone 1mg/kg/day), persistence without improvement after at least 4 weeks, or at least 2 failed taper attempts.
5. **Dosage allowed/Quantity limit:** 10 mg twice daily. (60 tablets per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must show improvement of signs and symptoms of disease in at least 1 organ/site, without progression in any other organ/site.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Myelofibrosis

Any request for cancer must be submitted through NantHealth/Eviti portal.

Polycythemia Vera

Any request for cancer must be submitted through NantHealth/Eviti portal.

CareSource considers Jakafi (ruxolitinib) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/08/2020	New policy for Jakafi for acute GVHD.
09/30/2021	Transferred to new template. New section added for chronic GVHD. Reviewed aGVHD section: Changed "progression by day 3" to "progression by day 3-5."

References:

1. Jakafi [package insert]. Wilmington, DE: Incyte Corporation; 2021.
2. Chao, NJ. Treatment of acute graft-versus-host disease. UpToDate. https://www.uptodate.com/contents/treatment-of-acute-graft-versus-host-disease. Updated May 15, 2020. Accessed June 5, 2020.
3. Zeiser R, Bubnoff NV, Butler J, et al. Ruxolitinib for Glucocorticoid-Refractory Acute Graft-versus-Host Disease. *New England Journal of Medicine*. 2020;382(19):1800-1810. doi:10.1056/nejmoa1917635
4. Zeiser R, Burchert A, Lengerke C, et al. Ruxolitinib in corticosteroid-refractory graft-versus-host disease after allogeneic stem cell transplantation: a multicenter survey. *Leukemia*. 2015;29(10):2062-2068. doi:10.1038/leu.2015.212
5. Jagasia M, Perales M-A, Schroeder MA, et al. Ruxolitinib for the treatment of steroid-refractory acute GVHD (REACH1): a multicenter, open-label phase 2 trial. *Blood*. 2020;135(20):1739-1749. doi:10.1182/blood.2020004823
6. Zeiser R, Burchert A, Lengerke C, et al. Long-Term Follow-up of Patients with Corticosteroid-Refractory Graft-Versus-Host Disease Treated with Ruxolitinib. *Blood*. 2016;128(22):4561-4561. doi:10.1182/blood.v128.22.4561.4561
7. Zeiser R, Polverelli N, Ram R, et al. Ruxolitinib for Glucocorticoid-Refractory Chronic Graft-versus-Host Disease. *N Engl J Med*. 2021;385(3):228-238. doi:10.1056/NEJMoa2033122
8. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (HCT): Pre-Transplant Recipient Evaluation and Management of Graft-Versus-Host Disease. (Version 5.2021). https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf. Accessed October 4, 2021.

9. Wolff D, Fatobene G, Rocha V, Kröger N, Flowers ME. Steroid-refractory chronic graft-versus-host disease: treatment options and patient management. *Bone Marrow Transplant*. 2021;56(9):2079-2087. doi:10.1038/s41409-021-01389-5
10. Penack O, Marchetti M, Ruutu T, et al. Prophylaxis and management of graft versus host disease after stem-cell transplantation for haematological malignancies: updated consensus recommendations of the European Society for Blood and Marrow Transplantation. *Lancet Haematol*. 2020;7(2):e157-e167. doi:10.1016/S2352-3026(19)30256-X

Effective date: 04/01/2022
Revised date: 09/30/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Juxtapid (lomitapide)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative products include Repatha and Praluent QUANTITY LIMIT— 30 capsules per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Juxtapid (lomitapide) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a cardiologist or a lipid specialist; AND
3. Member has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by **one** of the following:
   a) Genetic testing confirmation of two mutant alleles in the LDLR, Apo-B, PCSK9, or LDLRAP1 gene locus; OR
   b) LDL-C > 500 mg/dL before any treatment or LDL-C > 300 mg/dL if treated with a lipid-lowering drug AND **one** of the following:
      i) Xanthoma before 10 years of age; OR
      ii) Evidence of heterozygous familial hypercholesterolemia (HeFH) (i.e., total cholesterol > 250 mg/dL) in both parents; AND
4. Chart notes must include documentation of baseline cholesterol lab levels, taken within the past 90 days prior to therapy; AND
5. Member is unable to achieve LDL-C goal (see Note) after trials with **both** of the following:
   a) 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe;
   b) 90-day trial with Repatha or Praluent (prior authorization required); AND
6. Juxtapid will be used as an adjunct to other lipid-lowering treatments (e.g., statins, ezetimibe, LDL apheresis, etc.), unless contraindicated or intolerant; AND
7. If request is for adding Juxtapid to current Evkeeza therapy, must have a 6 month trial and failure of Juxtapid with maximized statin, ezetimibe, or PCSK9 (without Evkeeza) AND a strong clinical reason why Juxtapid must be used together with Evkeeza; AND
8. Prescriber attests that the member will be on a low-fat diet during treatment.
9. **Dosage allowed:** up to 60 mg daily or 1 capsule by mouth daily.

NOTE: The LDL-C goals are <100 mg/dL for adults 18 years or older, < 135 mg/dL for children, and < 70 mg/dL for adults with clinical ASCVD.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes along with recent labs have been provided showing a meaningful reduction of cholesterol levels (LDL-C, total cholesterol, apolipoprotein B, etc.) from baseline OR all cholesterol levels are at goal.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Juxtapid (lomitapide) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/22/2020	New policy for Juxtapid created.
04/05/2021	Added Praluent to list of alternative products. Changed trials to include Praluent in addition to Repatha and increased trial length to 90 days. Added a trial requirement for concomitant request of Juxtapid and Evkeeza. Updated genetic testing requirement to ask for specific alleles (previously not specified). Updated atorvastatin high-intensity requirement to reflect pediatric vs. adult dosing.

References:

1. Juxtapid [Package insert]. Cambridge, MA: Aegerion Pharmaceuticals, Inc; December 2012.
2. Cuchel M, Bruckert E, Ginsberg HN, et al. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. Eur Heart J. 2014;35(32):2146-2157.
3. Alonso R, Cuevas A, Mata P. Lomitapide: a review of its clinical use, efficacy, and tolerability. *Core Evid*. 2019;14:19-30. Published 2019 Jul 1.

Effective date: 01/01/2022
Revised date: 04/05/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Jynarque (tolvaptan)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 60 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Jynarque (tolvaptan) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a nephrologist; AND
3. Member has progressive autosomal dominant polycystic kidney disease (ADPKD) confirmed by genetic testing or imaging (e.g. ultrasound, CT scan, or MRI scan) and documented in chart notes; AND
4. Member is at high risk for rapidly declining kidney function, defined as having at least **one** of the following:
   a) Mayo classification 1C, 1D or 1E;
   b) A total kidney volume (TKV) of ≥ 750 mL by MRI or a TKV increase >5% on repeated imaging;
   c) A confirmed eGFR decline of ≥5 ml/min per 1.73 m^2 in 1 year;
   d) A confirmed eGFR decline of ≥2.5 ml/min per 1.73 m^2 per year over a period of 5 years;
   e) Average kidney length > 16.5cm in a patient < 45 years old;
   f) PROPKD score > 6 in patients with genetic data available; AND
5. Member does NOT have any of the following:
   a) eGFR < 25 mL/min/1.73m^2;
   b) Concurrent use with a diuretic agent (e.g. thiazide, furosemide);
   c) Prior kidney transplant and/or dialysis.
6. **Dosage allowed:** Initial dose: 45 mg in the morning and 15mg 8 hours later. Titrate to 60mg + 30mg then to 90mg + 30mg per day based on tolerability at least weekly intervals between titrations.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided that show slower decline in kidney function and improvement of symptoms (such as slowing of cyst growth and/or rate of eGFR decline, less kidney pain, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Jynarque (tolvaptan) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/09/2020	New policy for Jynarque created.
11/17/2021	Annual review, no changes

References:

1. Jynarque [Package Insert]. Rockville, MD: Otsuka Pharmaceutical Co., Ltd.; January 2020.
2. ClinicalTrials.gov. Efficacy and safety of tolvaptan in subjects with chronic kidney disease between late stage 2 to early stage 4 due to autosomal dominant polycystic kidney disease. NCT02160145.
3. ClinicalTrials.gov. Tolvaptan phase 3 efficacy and safety study in autosomal dominant polycystic kidney disease (ADPKD) (TEMPO3:4). NCT00428948.
4. Srivastava A, Patel N. Autosomal dominant polycystic kidney disease. *Am Fam Physician*. 2014;90(5):303-307.
5. Chebib FT, Perrone RD, Chapman AB, et al. A practical guide for treatment of rapidly progressive ADPKD with tolvaptan. JASN Oct 2018, 29 (10) 2458-2470.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kalbitor (ecallantide)
BILLING CODE	J1290
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior-Authorization Required (Non-Preferred Product) Alternative preferred products include Berinert and Firazyr QUANTITY LIMIT—12 vials (4 cartons) per fill
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kalbitor (ecallantide) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 12 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Medication is being prescribed for the treatment of acute HAE attacks; AND
5. Member has documented trial and failure of or contraindication to both Firazyr and Berinert (Chart notes required); AND
6. Medication is not being used in combination with another on-demand therapy (e.g. Berinert, Firazyr, Ruconest).
7. **Dosage allowed:** 30mg subQ (as three 10mg (1 mL) injections); may repeat once within 24-hour period if the attack persists.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improvement such as faster time to symptom relief or resolution of attack.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kalbitor (ecallantide) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/28/2017	New policy for Kalbitor created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks added.
01/20/2021	Updated references. Removed hematology as a specialist. Simplified the diagnostic criteria. Removed log book requirement. Reworded the renewal criteria. Extended initial auth duration to 6 mo and renewal to 12 mo. Removed statement about causative meds. Clarified the dosing. Adjusted quantity limit to allow for repeat doses per label.

References:

1. Kalbitor [package insert]. Burlington, MA; Dyax Corp.; September 2014.
2. Frank MM, Zuraw B, Banerji A, et al. Management of children with hereditary angioedema due to C1 inhibitor deficiency. Pediatrics. 2016 Nov;138(5). pii: e20160575.
3. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
4. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384
5. Cicardi M, Levy RJ, McNeil DL, et al. Ecallantide for the treatment of acute attacks in hereditary angioedema. *N Engl J Med*. 2010;363(6):523-531. doi:10.1056/NEJMoa0905079

Effective date: 10/1/2021
Revised date: 01/20/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kalydeco (ivacaftor)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 150 mg tablets - 60 per 30 days 50 mg & 75 mg granules - 56 per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kalydeco (ivacaftor) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 6 months of age or older; AND
2. Medication must be prescribed by a pulmonologist or an infectious disease specialist; AND
3. Member has had genetic testing documented in chart notes with one of the following mutations in the CFTR gene: 2789+5G→A, 3272-26A→G, 3849+10kbC→T, 711+3A→G, A1067T, A455E, D110E, D110H, D1152H, D1270N, D579G, E193K, E56K, E831X, F1052V, F1074L, G1069R, G1244E, G1349D, G178R, G551D, G551S, K1060T, L206W, P67L, R1070Q, R1070W, R117C, R117H, R347H, R352Q, R74W, S1251N, S1255P, S549N, S549R, S945L, or S977F.
4. **Dosage allowed:** Up to 150 mg every 12 hours. See package insert for details on dosing.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member's adherence to medication is confirmed by claims history.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kalydeco (ivacaftor) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Kalydeco created.
10/05/2018	New CFTD gene mutations added. Age coverage expanded (approved for 12 months old members and older).
05/16/2019	Age coverage expanded (approved for 6 months old members and older).
11/17/2021	Annual review, no changes

References:

1. Kalydeco [package insert]. Boston, MA: Vertex Pharmaceuticals Inc; April, 2019.
2. Kalydeco. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 6, 2017.
3. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. Available: https://www.atsjournals.org/doi/full/10.1164/rccm.201207-1160OE. Accessed November 27, 2018.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kanuma (sebelipase alfa)
BILLING CODE	J2840
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— up to 3 mg/kg once weekly
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kanuma (sebelipase alfa) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY

For **initial** authorization:

1. Member has lab confirmed diagnosis of LAL deficiency; AND
2. Medication must be prescribed by endocrinologist, cardiologist, or hepatologist or other or other specialist in the area of the member's disease; AND
3. Member is > 8 months but < 4 years of age with at least **one** of the following documented clinical manifestations of LALD:
   a) Dyslipidemia;
   b) Elevated transaminases (ALT ≥1.5x ULN);
   c) Impaired growth;
   d) Suspected malabsorption;
   e) Other clinical manifestation of LALD; OR
4. Member is ≥ 4 years of age with at least **one** of the following documented clinical manifestations of LALD:
   a) Evidence of advanced liver disease;
   b) Histologically confirmed disease recurrence in members with past liver or hematopoietic transplant;
   c) Persistent dyslipidemia;
   d) Suspected malabsorption;
   e) Other clinical manifestation of LALD.
5. **Dosage allowed:** 1 mg/kg administered once weekly as an IV infusion. For members with rapidly progressive LAL deficiency presenting within the first 6 months of life and who do not achieve an optimal clinical response, increase to 3 mg/kg once weekly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kanuma (sebelipase alfa) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/11/2018	New policy for Kanuma created.

References:

1. Kanuma [package inset]. New Haven, CT: Alexion Pharmaceuticals Inc.; December, 2015.
2. linicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). Identifier NCT02112994. Safety and Efficacy Study of Sebelipase Alfa in Patients With Lysosomal Acid Lipase Deficiency. February 14, 2018. Available at: https://clinicaltrials.gov/ct2/show/NCT02112994?term=sebelipase+alfa&recrs=e&rank=1.
3. Hoffman EP, et al. Lysosomal acid lipase deficiency. In: ed. Adam MP, et al. GeneReviews [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2018. 2015 Jul 30 [Updated 2016 Sep 1].
4. Desai NK, et al. Lysosomal acid lipase deficiency. In: ed. De Groot LJ, et al. Endotext [Internet]. South Dartmouth (MA): MDText.com, Inc.; 2000-. [Updated 2016 Jun 22].

Effective date: 09/21/2018
Revised date: 04/11/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kesimpta (ofatumumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1 prefilled pen/30 days*
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

*may approve 2 additional pens during initial month of treatment

Kesimpta (ofatumumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a confirmed diagnosis of relapsing multiple sclerosis, including clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS), and active secondary progressive disease (SPMS); AND
4. Member's baseline relapse rate or number of lesions prior to starting treatment are documented in chart notes; AND
5. Member has documented trial and failure or contraindication to at least **two** preferred multiple sclerosis agents; AND
6. Member does NOT have any of the following:
   a) Active Hepatitis B as evidenced by a negative HBV screening;
   b) Concurrent use with another disease-modifying agent for MS.
7. **Dosage allowed:** 20 mg administered by subcutaneous injection at week 0, 1, and 2, followed by 20 mg once monthly starting at week 4.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing an improvement or stabilization in signs and symptoms of disease (e.g., fewer relapses, slowed disability progression, stable or reduced number or volume of brain lesions).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kesimpta (ofatumumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/16/2020	New policy for Kesimpta (ofatumumab) created.
09/16/2021	Annual review, no changes

References:

1. Kesimpta [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corporation. August 2020.
2. Bar-Or A, Grove RA, Austin DJ, et al. Subcutaneous ofatumumab in patients with relapsing-remitting multiple sclerosis: The MIRROR study [published correction appears in Neurology. 2018 Sep 11;91(11):538]. Neurology. 2018;90(20):e1805-e1814. doi:10.1212/WNL.0000000000005516
3. Hauser SL, Bar-Or A, Cohen JA, et al. Ofatumumab versus Teriflunomide in Multiple Sclerosis. N Engl J Med. 2020;383(6):546-557. doi:10.1056/NEJMoa1917246
4. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology [published correction appears in Neurology. 2019 Jan 8;92(2):112]. Neurology. 2018;90(17):777-788
5. Montalban, Xavier, et al. "Ofatumumab Reduces Disability Progression Independent of Relapse Activity in Patients with Relapsing Multiple Sclerosis (1845)." (2020).

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kevzara (sarilumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 2 injections every 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kevzara (sarilumab) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately.
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. **Dosage allowed:** 200 mg once every two weeks given as a subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kevzara (sarilumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/20/2017	New policy for Kevzara created.
02/26/2019	Status changed to preferred. Humira and Enbrel trials removed from criteria. Initial and reauthorization length placed for 12 months. ANC level requirement removed. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed.

11/19/2020	Fixed quantity limit from 1 injection to 2 injections every 28 days. Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. Removed repeated TB test in reauth. Replaced the list of excluded diagnoses with the generic statement. Updated references.
11/17/2021	Annual review, no changes

References:

1. Kevzara [package insert]. Bridgewater, NJ: SANOFI-AVENTIS U.S. LLC; April 2018.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
3. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
4. Genovese MC. Sarilumab Plus Methotrexate in Patients With Active Rheumatoid Arthritis and Inadequate Response to Methotrexate: Results of a Phase III Study. Arthritis Rheumatol. 2015 Jun;67(6):1424-37.
5. United States Food and Drug Administration. Kevzara (sarilumab) injection. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/nda/2017/761037Orig1s000TOC.cfm. Accessed on 2/13/19.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kineret (anakinra)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Actemra, Enbrel, Cimzia, Kevzara, Olumiant and Xeljanz for RA QUANTITY LIMIT— 28 syringes per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kineret (anakinra) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS)

For **initial** authorization:

1. Member must be diagnosed with Neonatal-Onset Multisystem Inflammatory Disease (NOMID); AND
2. Prescriber has submitted laboratory evidence of a genetic mutation in the Cold-Induced Auto-Inflammatory Syndrome 1 (CIAS1—sometimes referred to as the NLRP3); AND
3. Medication must be prescribed by a rheumatologist or under recommendation of a rheumatologist or CAPS specialist; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy.
5. **Dosage allowed:** Initial dose: Inject 1-2 mg/kg subcutaneously once daily in 1 or 2 divided doses; adjust dose in 0.5-1 mg/kg increments as needed. Usual maintenance dose: 3-4 mg/kg once daily (maximum of 8 mg/kg per day).

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Must have been retested for TB with a negative result within the past 12 months; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Member has tried and failed treatment with at least **two** of the following: Actemra, Enbrel, Cimzia and Kevzara, Olumiant and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
6. **Dosage allowed:** Inject 100 mg subcutaneously once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kineret (anakinra) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Ankylosing Spondylitis
- Anterior cruciate ligament injury
- Diabetes mellitus (type 1 and type 2)
- Familial Mediterranean fever
- Fatigue associated with Sjogren's syndrome
- Gout
- Heart failure (prevention of heart failure after acute MI)
- Inflammatory bowel disease
- Kawasaki disease
- Lupus arthritis
- Myopathy/myositis
- Non-neuropathic hereditary familial amyloidosis
- Osteoarthritis
- Pyoderma gangraenosum
- Reactive arthritis
- Systemic lupus erythematosus

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Kineret created. Policy SRx-0042 archived. List of diagnoses considered not medically necessary was added.
02/26/2019	Humira was removed from criteria; Actemra, Cimzia, Kevzara, Olumiant and Xeljanz for RA added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Referenced added.
11/23/2020	Updates for RA section: Removed repeat TB test. Updated references. Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors.
11/17/2021	Annual review, no changes

References:

1. Kineret [package insert]. Stockholm, Sweden: Swedish Orphan Biovitrum AB; May, 2016.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
3. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
4. Ringold S, Weiss PF, Beukelman T, et al. 2013 Update of the 2011 American College of Rheumatology Recommendations for the Treatment of Juvenile Idiopathic Arthritis. Recommendations for the Medical Therapy of Children With Systemic Juvenile Idiopathic Arthritis and Tuberculosis Screening Among Children Receiving Biologic Medications Vol. 65, No. 10, October 2013, pp 2499–2512.
5. Shinkai K, McCalmont TH, Leslie KS. Cryopyrin-associated periodic syndromes and autoinflammation. Clin Exp Dermatol. 2008;33(1):1-9.
6. Scott IC, et al. A randomised trial evaluating anakinra in early active rheumatoid arthritis. Clin Exp Rheumatol. 2016 Jan-Feb;34(1):88-93.
7. Fleischmann RM, et al. Safety of extended treatment with anakinra in patients with rheumatoid arthritis. Ann Rheum Dis. 2006;65(8):1006-12.
8. Galloway JB, et al. The risk of serious infections in patients receiving anakinra for rheumatoid arthritis: results from the British Society for Rheumatology Biologics Register. Rheumatology (Oxford). 2011 Jul;50(7):1341-2.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kitabis Pak (tobramycin inhalation solution)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes generic tobramycin inhalation solution QUANTITY LIMIT — 280 mL per 56 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kitabis Pak (tobramycin inhalation solution) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Member has a diagnosis of cystic fibrosis and has a positive culture for Pseudomonas aeruginosa documented in chart notes; AND
3. Member is not colonized with Burkholderia cepacia; AND
4. Medication is prescribed by a pulmonologist or an infectious disease specialist; AND
5. Member has documented forced expiratory volume in 1 second (FEV1) > 25% or < 75% predicted; AND
6. Member has tried and failed generic tobramycin inhalation solution, and ineffectiveness, intolerance or contraindication is documented in chart notes.
7. **Dosage allowed:** 300 mg every 12 hours; administer in repeated cycles of 28 days on drug followed by 28 days off drug.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.
2. Evidence of disease stability or disease improvement
   a) Note: Disease improvement is evidenced by chart notes with any of the following:
      i) Improved FEV1 and/or other lung function tests;
      ii) Improvement in sweat chloride;
      iii) Decrease in pulmonary exacerbations;
      iv) Decrease in pulmonary infections;
      v) Increase in weight-gain;
      vi) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kitabis Pak (tobramycin inhalation solution) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Kitabis Pak created. Not covered diagnosis added.
12/30/2020	Quantity limit changed to 56 days from 28 days. Corrected status to non-preferred. Reauthorization criteria updated to ask for evidence of disease stability or improvement. Diagnosis of cystic fibrosis added to initial criteria. Exclusion criteria updated to a simplified statement.
11/17/2021	Annual review, no changes.

References:

1. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. [cited 2016 Dec 19]. Available: https://www.guideline.gov.
2. Kitabis Pak [package insert]. Midlothian, VA: Catalent Pharma Solutions LLC; 2014.
3. Kitabis Pak. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com.

Effective date: 01/01/2022
Revised date: 11/17/2021

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Korlym (mifepristone)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include ketoconazole, cabergoline QUANTITY LIMIT— 120 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Korlym (mifepristone) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CUSHING'S SYNDROME

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has diagnoses of endogenous Cushing's syndrome AND type 2 diabetes or glucose intolerance (baseline labs required); AND
4. Member failed surgery or is not a candidate for surgery (documentation required); AND
5. Member has tried and failed ketoconazole and/or cabergoline for at least 3 months[2,5]; AND
6. Female members with reproductive potential must have a negative pregnancy test.
7. **Dosage allowed:** Up to 1200mg (4 tablets) once daily

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes documenting sustained improvement of glucose control compared to pre-treatment (i.e. decreased HbA1c and/or fasting glucose from baseline, reduced use of antidiabetic medications)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Korlym (mifepristone) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/01/2020	New policy for Korlym created.
03/11/2021	Annual review, no changes

References:

1. Korlym [package insert]. Menlo Park, CA: Corcept Therapeutics; 2020.
2. Nieman LK, Biller BM, Findling JW, et al. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2015;100(8):2807-2831. doi:10.1210/jc.2015-1818
3. Fleseriu M, Biller BM, Findling JW, et al. Mifepristone, a glucocorticoid receptor antagonist, produces clinical and metabolic benefits in patients with Cushing's syndrome. *J Clin Endocrinol Metab*. 2012;97(6):2039-2049. doi:10.1210/jc.2011-3350
4. Mazziotti G, Gazzaruso C, Giustina A. Diabetes in Cushing syndrome: basic and clinical aspects. *Trends Endocrinol Metab*. 2011;22(12):499-506. doi:10.1016/j.tem.2011.09.001
5. Scaroni C, Zilio M, Foti M, Boscaro M. Glucose Metabolism Abnormalities in Cushing Syndrome: From Molecular Basis to Clinical Management. *Endocrine Reviews*. 2017;38(3):189-219. doi:10.1210/er.2016-1105

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Korsuva (difelikefalin)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
STATUS	Prior Authorization Required

Korsuva is an injectable kappa opioid receptor (KOR) agonist which targets the peripheral nervous system. It is the first FDA-approved treatment for moderate-to-severe pruritus (itching) associated with chronic kidney disease (CKD-aP) in adults on hemodialysis. Uremic pruritis is thought to affect between 40 and 50% of CKD patients on dialysis. Moderate to severe uremic pruritus is associated with decreased quality of life, higher probability of depression, and poor sleep quality. The approval of Korsuva was largely based on data from 2 pivotal Phase 3 clinical trials, KALM-1and KALM-2, which compared Korsuva 0.5 mg/kg to placebo; both were administered 3 times weekly after each dialysis session. Both trials demonstrated patients on Korsuva had at least a 4-point improvement from baseline using the 24-hour Worst Itching Intensity Numeric Rating Scale (WI-NRS) score versus patients receiving placebo at Week 12.

Korsuva (difelikefalin) will be considered for coverage when the following criteria are met:

Uremic Pruritus associated with Chronic Kidney Disease

For **initial** authorization:
1. Member is at least 18 years of age or older; AND
2. Diagnosis of end-stage renal disease (ESRD) receiving hemodialysis 3 times per week for at least 3 months
3. Documentation the moderate-to-severe pruritis is impairing quality of life (e.g. sleep disruptions, fatigue, and depression).
4. Previous trial and failure of gabapentin or pregabalin for at least 4 weeks.
5. **Dosage allowed/Quantity limit:** 0.5 mcg/kg intravenously three times per week

If all the above requirements are met, the medication will be approved for 12 weeks.

For **reauthorization**:
Korsuva will be reauthorized when chart notes show at least one of the following:
1. Documentation of improvement in itch-related quality of life (e.g. sleep disruptions, fatigue, and depression); OR
2. Documentation of significant reduction in itch intensity.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Korsuva (difelikefalin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/07/2021	Korsuva policy creation

References:

1. Korsuva [package insert]. Stamford, CT; Cara Therapeutics; August 2021. Accessed October 2021.
2. Fishbane S, Jamal A, Munera C, Wen W, Menzaghi F, et al. A Phase 3 Trial of Difelikefalin in Hemodialysis Patients with Pruritis; 2020 Jan 16; *New England Journal of Medicine*. 382:222-232.
3. Hercz D, Jiang SH, Webster AC. Interventions for itch in people with advanced chronic kidney disease. Cochrane Database Systemic Review. 2020 Dec 7;12:CD011393.
4. Simonsen B, Komenda P, Lerner B, Shaw J, Tangri N. Rigatto C, et. Al. Treatment of Uremic Pruritis: A Systemic Review. *American Journal of Kidney Diseases*.

Effective date: 04/01/2022
Creation date: 10/07/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Koselugo (selumetinib)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see Table 1 below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Koselugo (selumetinib) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NEUROFIBROMATOSIS TYPE 1 (NF1)

For **initial** authorization:

1. Member is 2 to 21 years of age; AND
2. Medication must be prescribed by or in consultation with a pediatric oncologist or a specialist with experience in treating neurofibromatosis Type 1; AND
3. Member has a confirmed diagnosis of neurofibromatosis type 1 (NF1) disease documented in chart notes; AND
4. Member has at least one measurable plexiform neurofibromas (PN) as evidenced by MRI or PET-CT scans; AND
5. The plexiform neurofibromas (PN) cannot be removed completely by surgery without substantial risks or morbidity due to reasons such as encasement of, or close proximity to, vital structures, invasiveness, or high vascularity of the PN; AND
6. Member has significant morbidity related to PN (e.g. disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment, and bladder/bowel dysfunction, etc.).
7. **Dosage allowed:** 25mg/m^2 by mouth twice daily (see Table 1 below for recommended dosage based on body surface area).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. If the member is older than 21 years of age, therapy must be initiated prior to 21 years old in order to continue treatment; AND
2. Chart notes have been provided showing that the member has had at least a partial response (defined as ≥20% reduction in the PN volume) from baseline and no disease progression.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Koselugo (selumenib) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/14/2020	New policy for Koselugo created.
11/17/2021	Annual review, no changes

References:
1. Koselugo [Package Insert]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; April 2020.
2. Gross AM, Wolters PL, Dombi E, et al. Selumetinib in children with inoperable plexiform neurofibromas. N Engl J Med 2020; 382:1430-1442.
3. Gutmann DH, Aylsworth A, Carey JC, et al. The diagnostic evaluation and multidisciplinary management of neurofibromatosis 1 and neurofibromatosis 2. JAMA 1997; 278:51.
4. Hardin AP, Hackell JM, et al. Age limit of pediatrics. Pediatrics 2017;140.
5. Miller DT, Freedenberg D, Schorry E, et al. Health supervision for children with Neurofibromatosis Type 1. Pediatrics May 2019, 143 (5) e20190660.

Effective date: 01/01/2022
Revised date: 11/17/2021

Table 1 Recommended Dosage Based on Body Suface Area

Body Surface Area*	Recommended Dosage	Quantity Limit
0.55 – 0.69 m^2	20 mg in the morning and 10 mg in the evening	90 capsules/30 days
0.70 – 0.89 m^2	20 mg twice daily	120 capsules/30 days
0.90 – 1.09 m^2	25 mg twice daily	60 capsules/30 days
1.10 – 1.29 m^2	30 mg twice daily	180 capsules/30 days
1.30 – 1.49 m^2	35 mg twice daily	120 capsules/30 days
1.50 – 1.69 m^2	40 mg twice daily	240 capsules/30 days
1.70 – 1.89 m^2	45 mg twice daily	180 capsules/30 days
≥ 1.90 m^2	50 mg twice daily	120 capsules/30 days

* The recommended dosage for patients with a BSA less than 0.55 m^2 has not been established.

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Krystexxa (pegloticase)
BILLING CODE	J2507
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Krystexxa (pegloticase) is a PEGylated uric acid specific enzyme indicated for the treatment of chronic gout in adult patients refractory to conventional therapy. According to the American College of Rheumatology guideline for management of gout, pegloticase should not be a first-line therapy. Pegloticase is recommended for patients with gout for whom xanthine oxidase inhibitor treatment, uricosurics, and other interventions have failed to achieve the serum uric acid target, and who continue to have frequent gout flares or who have non-resolving subcutaneous tophi.

Krystexxa (pegloticase) will be considered for coverage when the following criteria are met:

CHRONIC GOUT

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication is being prescribed by or in consultation with a gout specialist (e.g., rheumatologist, nephrologist, podiatrist, etc.); AND
3. Member has a diagnosis of chronic gout with 2 or more flares per year OR with non-resolving subcutaneous tophi associated with gout; AND
4. Member has had inadequate response (defined as serum uric acid (sUC) level remains above 6 mg/dL), or have contraindication to **both** of the following:
   a) A xanthine oxidase inhibitor (e.g., allopurinol (Zyloprim) or febuxostat (Uloric)) at maximally appropriate dose for 90 days. Note: allopurinol is first-line;
   b) A uricosuric agent (e.g., probenecid) for 90 days; AND
5. Member does not have glucose-6-phosphate dehydrogenase (G6PD) deficiency per screening result.
6. **Dosage allowed/Quantity limit:** 1 single-dose vial (8 mg of uricase protein) given as an intravenous infusion every 2 weeks.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's serum uric acid (sUC) level has maintained below 6 mg/dL; AND
2. Chart notes demonstrate a positive outcome from using medication (e.g. reduction of flares, reduction of tophi).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Krystexxa (pegloticase) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
04/06/2021	New policy for Krystexxa (pegloticase) created.

References:

1. Krystexxa [package insert]. Dublin, Ireland; Horizon Therapeutics Ireland DAC. January 2020.
2. FitzGerald JD, Dalbeth N, Mikuls T, et al. 2020 American College of Rheumatology Guideline for the Management of Gout [published correction appears in Arthritis Care Res (Hoboken). 2020 Aug;72(8):1187] [published correction appears in Arthritis Care Res (Hoboken). 2021 Mar;73(3):458]. *Arthritis Care Res (Hoboken)*. 2020;72(6):744-760.
3. ClinicalTrials.gov. Observational study of the use of pegloticase (Krystexxa) in refractory chronic gout. NCT 01466166.

Effective date: 10/1/2021
Revised date: 04/06/2021

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Kuvan (sapropterin)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Kuvan, a synthetic form of the cofactor tetrahydrobiopterin, is a phenylalanine hydroxylase (PAH) activator approved by the FDA in 2007 for the treatment of tetrahydrobiopterin- (BH4-) responsive phenylketonuria (PKU). It is indicated for pediatric and adult patients, and it is supplied as tablets and powder for oral solution. Patients must also maintain a phenylalanine (Phe) restricted diet as part of treatment. PKU results from a deficiency of PAH, leading to increased concentrations of Phe. If untreated, this excess accumulation causes neuropsychiatric and neurocognitive symptoms.

Kuvan (sapropterin) will be considered for coverage when the following criteria are met:

Phenylketonuria (PKU)

For **initial** authorization:
1. Member is at least 1 month of age; AND
2. Medication must be prescribed by or in consultation with a specialist experienced in metabolic or genetic diseases; AND
3. Member has a diagnosis of phenylketonuria; AND
4. Member has documentation of current Phe level sustained above 360 µmol/L; AND
5. Kuvan will be used in conjunction with a compliant Phe-restricted diet; AND
6. Kuvan will not be prescribed in combination with Palynziq.
7. **Dosage allowed/Quantity limit:** Up to 20 mg/kg once daily. Discontinue after 1 month at this dose if Phe has not decreased.

If all the above requirements are met, the medication will be approved for 2 months.

For **reauthorization**:
1. Chart notes must show at least a 30% reduction of Phe, and/or
2. Neuropsychiatric symptoms have improved, and/or
3. Member has shown an increase in Phe tolerance.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Kuvan (sapropterin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/05/2021	New policy for Kuvan created.

References:

1. Kuvan [prescribing information]. Novato, CA: Biomarin Phermaceutical Inc.; February 2021.
2. Vockley J, Andersson HC, Antshel KM, et al. Phenylalanine hydroxylase deficiency: diagnosis and management guideline [published correction appears in Genet Med. 2014 Apr;16(4):356]. *Genet Med*. 2014;16(2):188-200. doi:10.1038/gim.2013.157
3. van Spronsen FJ, van Wegberg AM, Ahring K, et al. Key European guidelines for the diagnosis and management of patients with phenylketonuria. *Lancet Diabetes Endocrinol*. 2017;5(9):743-756. doi:10.1016/S2213-8587(16)30320-5
4. Camp KM, Parisi MA, Acosta PB, et al. Phenylketonuria Scientific Review Conference: state of the science and future research needs. *Mol Genet Metab*. 2014;112(2):87-122. doi:10.1016/j.ymgme.2014.02.013
5. Somaraju UR, Merrin M. Sapropterin dihydrochloride for phenylketonuria. *Cochrane Database Syst Rev*. 2015;2015(3):CD008005. Published 2015 Mar 27. doi:10.1002/14651858.CD008005.pub4

Effective date: 01/01/2022
Revised date: 05/05/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Kymriah (tisagenlecleucel)
BILLING CODE	Q2042
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Inpatient/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Kymriah (tisagenlecleucel) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE LYMPHOBLASTIC LEUKEMIA (ALL)

For **initial** authorization:

1. Member is 1 to 25 years of age; AND
2. Member has a diagnosis of relapsed or refractory B-cell ALL defined by **one** of the following:
   a) Second or greater relapse;
   b) Relapse after allogeneic stem cell transplantation (SCT);
   c) Primary refractory as defined by not achieving a complete remission (CR) after 2 cycles of a standard chemotherapy regimen or chemorefractory as defined by not achieving a CR after 1 cycle of standard chemotherapy for relapsed leukemia;
   d) Philadelphia chromosome positive (Ph+) ALL and intolerant to or have failed 2 lines of tyrosine kinase inhibitor (TKI) therapy [e.g. imatinib mesylate (Gleevec), dasatinib (Sprycel)];
   e) Ineligible for allogeneic SCT; AND
3. Documentation of CD19 tumor expression; AND
4. Bone marrow with ≥ 5% lymphoblasts by morphologic assessment; AND
5. Member has been pre-screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) prior to collection of cells (negative results must be submitted); AND
6. Healthcare facility/provider has enrolled in the Kymriah REMS program; AND
7. Member does **not** have ANY of the following:
   a) Prior gene or CAR-T cell therapy;
   b) Life expectancy less than 12 weeks.
8. **Dosage allowed:** Weight 50 kg or less: administer 0.2 to 5.0 x 10^6CAR-positive viable T cells per kg body weight intravenously. Weight above 50 kg: administer 0.1 to 2.5 x 10^8 total CAR-positive viable T cells (non-weight based) intravenously.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Kymriah will not be reauthorized for continued therapy.

CareSource

LARGE B-CELL LYMPHOMA

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a diagnosis of relapsed or refractory large B-cell lymphoma including **one** of the following:
   a) Diffuse large B-cell lymphoma (DLBCL) not otherwise specified;
   b) High grade B-cell lymphoma;
   c) DLBCL arising from follicular lymphoma; AND
3. Member has received 2 or more lines of chemotherapy, including rituximab and anthracycline, and relapsed following autologous hematopoietic stem cell transplantation (SCT) or is not eligible for SCT; AND
4. Member has an Eastern cooperative oncology group (ECOG) performance status of 0 or 1; AND
5. Member does **not** have ANY of the following:
   a) Active central nervous system malignancy involvement;
   b) Prior allogenic HSCT;
   c) Prior CAR-T therapy (e.g. Yescarta); AND
6. Member has been pre-screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) prior to collection of cells (negative results must be submitted); AND
7. Healthcare facility/provider has enrolled in the Kymriah REMS program.
8. **Dosage allowed:** Administer 0.6 to 6.0 x 10^8 CAR-positive viable T cells.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Kymriah will not be reauthorized for continued therapy.

CareSource considers Kymriah (tisagenlecleucel) not medically necessary for the treatment of disease states not included in this document.

DATE	ACTION/DESCRIPTION
10/24/2017	New policy for Kymriah created.
08/27/2018	New indication of Large B-cell lymphoma was added. Criteria expanded for ALL diagnosis for member's disease history requirement.
08/18/2020	Updated billing code. Amended criteria for both diagnoses. ALL: changed lower age limit from 3 years to 1 year. Added #3, 4. Removed TKI's that were listed but not relevant in this context. B cell lymphoma: minor changes. Removed criterion for premedication. Removed some of the exclusion cut offs that appeared to be arbitrary to the controlled trial environment but not necessary to mandate from a utilization management perspective for the clinical setting.
05/27/2021	B cell lymphoma: Removed life expectancy restriction. Added ECOG score.

References:

1. Kymriah [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corp., May 2018.
2. The Leukemia & Lymphoma Society (LLS). Ph-Positive ALL Therapy. Available at https://www.lls.org/leukemia/acute-lymphoblastic-leukemia/treatment/ph-positive-all-therapy.
3. ClinicalTrials.gov. Identifier NCT02228096. Study of Efficacy and Safety of CTL019 in Pediatric ALL Patients. Available at https://clinicaltrials.gov/ct2/show/NCT02228096?term=tisagenlecleucel&rank=1. Accessed in October, 2017.
4. Schuster SJ, et al. Primary analysis of Juliet: a global, pivotal, phase 2 trial of CTL019 in adult patients with relapsed or refractory diffuse large B-cell lymphoma. Blood. 2017;130(s1):577 [Abstract 577 from 2017 ASH annual meeting].

5. Maude SL, et al. Tisagenlecleucel in Children and Young Adults with B-Cell Lymphoblastic Leukemia. N Engl J Med. 2018;378(5):439-448. [PubMed 29385370]
6. National Comprehensive Cancer Network. Pediatric Acute Lymphoblastic Leukemia. (Version 2.2020). https://www.nccn.org/professionals/physician_gls/pdf/ped_all.pdf. Accessed August 3. 2020.
7. National Comprehensive Cancer Network. B-Cell Lymphomas. (Version 4.2020). https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed August 18. 2020.
8. Schuster SJ, Bishop MR, Tam CS, et al. Tisagenlecleucel in Adult Relapsed or Refractory Diffuse Large B-Cell Lymphoma. *N Engl J Med*. 2019;380(1):45-56. doi:10.1056/NEJMoa1804980
9. Tilly H, Gomes da Silva M, Vitolo U, et al. Diffuse large B-cell lymphoma (DLBCL): ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2015;26 Suppl 5:v116-v125. doi:10.1093/annonc/mdv304
10. Chaganti S, Illidge T, Barrington S, et al. Guidelines for the management of diffuse large B-cell lymphoma. *British Journal of Haematology*. 2016;174:43-56. doi:10.1111/bjh.14136
11. Halford Z, Anderson MK, Bennett LL, Moody J. Tisagenlecleucel in Acute Lymphoblastic Leukemia: A Review of the Literature and Practical Considerations [published online ahead of print, 2020 Aug 7]. *Ann Pharmacother*. 2020;1060028020948165. doi:10.1177/1060028020948165

Effective date: 10/1/2021
Revised date: 05/27/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Lemtrada (alemtuzumab)
BILLING CODE	J0202
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 60 mg
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Lemtrada (alemtuzumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS (RRMS), SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS (SPMS)

For **initial** authorization:

1. Member must be 17 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis; AND
4. Member has documented trial and failure or contraindication to at least **two** preferred multiple sclerosis agents (two injectable drugs OR two oral drugs OR one injectable and one oral drug).
5. **Dosage allowed:** Initial course 12 mg per day for 5 consecutive days (60 mg total dose).

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Doses of Lemtrada separated by at least 12 months.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Lemtrada (alemtuzumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis
- Autoimmune disease
- Chronic lymphoid leukemia
- Malignant tumor of lymphoid hemopoietic and related tissue
- Primary cutaneous T-cell lymphoma, Relapsed or refractory
- Renal transplant rejection, Induction therapy; Prophylaxis

- T-cell prolymphocytic leukemia

DATE	ACTION/DESCRIPTION
06/13/2017	New policy for Lemtrada created. Not covered diagnosis added. Trials of two formulary agents required.
12/06/2017	Age coverage expanded. Confirmation of diagnosis based on McDonald criteria is no longer required.

References:

1. Lemtrada [package insert]. Cambridge, MA; Genzyme, Inc: June, 2016.
2. Lemtrada. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed April 7, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 12/20/2017
Revised date: 12/06/2017

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Leukine (sargramostim)
BILLING CODE	For medical - J2820 For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product include Zarxio QUANTITY LIMIT— N/A
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Leukine (sargamostim) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE MYELOID LEUKEMIA (AML)

For **initial** authorization:

1. Member is 55 years of age or older and is receiving induction chemotherapy with or without consolidation chemotherapy; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being used to reduce the time to neutrophil recovery and the duration of fever following induction chemotherapy treatment; AND
4. Member has hypoplastic bone marrow (<5% blasts) following chemotherapy; AND
5. Medication is being administered beginning 4 days after completion of induction chemotherapy until neutrophil recovery (ANC >1000/mm^3 for 3 consecutive days) up to a maximum of 42 days.
6. **Dosage allowed:** 250 mcg/m^2 per day.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria.
2. Chart notes have been provided that show the member is stable or has shown improvement on Leukine therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ALLOGENIC BONE MARROW TRANSPLANT (BMT)

For **initial** authorization:

1. Member is 55 years of age or older; AND
2. Member is receiving myeloablative chemotherapy followed by allogenic BMT from an HLA-matched related donor; AND
3. Medication is being used to accelerate myeloid recovery.
4. **Dosage allowed:** 250 mcg/m^2 per day administered as an IV infusion over a 2 hour period.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Leukine therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS BONE MARROW TRANSPLANT (BMT)

For **initial** authorization:
1. Member is 55 years of age or older; AND
2. Member has a diagnosis of non-Hodgkin's lymphoma, acute lymphoblastic leukemia, or Hodgkin's disease and is receiving myeloablative chemotherapy followed by autologous BMT; AND
3. Member must have tried and failed treatment with Zarxio.
4. **Dosage allowed:** 250 mcg/m^2 per day administered as an IV infusion over a 2 hour period.

If member meets all the requirements listed above, the medication will be approved for 3 month.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Leukine therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL (PBPC) MOBILIZATION

For **initial** authorization:
1. Member is 55 years of age or older; AND
2. Medication is being used to mobilize autologous peripheral blood progenitor cells for collection by leukapheresis and to reduce neutropenia following PBPC transplantation; AND
3. Member must have tried and failed treatment with Zarxio; AND
4. Medication is being administered daily until leukapheresis is completed and after leukapheresis until neutrophil recovery (ANC >1000/mm^3).
5. **Dosage allowed:** 250 mcg/m^2 per day administered as an IV infusion over 24 hours or subcutaneous injection once daily.

If member meets all the requirements listed above, the medication will be approved for 3 month.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Leukine therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

BONE MARROW TRANSPLANT (BMT) FAILURE OR ENGRAFTMENT DELAY

For **initial** authorization:

1. Member is 55 years of age or older; AND
2. Member has received autologous or allogenic BMT and is experiencing graft failure or myeloid engraftment delay with **one** of the following:
   a) Absolute neutrophil count (ANC) ≤ 100 cells/mm^3 by day 28 post-transplant;
   b) ANC ≤ 100 cells/mm^3 by day 21 post-transplant with evidence of an active infection;
   c) ANC ≥ 500 cells/mm^3 for at least one week followed by loss of engraftment with ANC < 500 cells/mm^3 for at least one week beyond day 21 post-transplant; AND
3. Medication is being administered for no more than 14 days per course for up to 3 courses of therapy that are separated by at least 7 therapy-free days.
4. **Dosage allowed:** 250 mcg/m^2 per day for the first 2 courses of therapy; 500 mcg/m^2 per day for the third course.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Leukine will not be reauthorized third course of therapy. If another course of therapy needed in a future initial authorization criteria will be applied.

CareSource considers Leukine (sargramostim) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Hematopoietic Subsyndrome of Acute Radiation Syndrome
- Prevention of febrile neutropenia
- Severe chronic neutropenia

DATE	ACTION/DESCRIPTION
10/19/2017	New policy created for Leukine. List of diagnoses covered was expanded. Length of therapy of preferred trial agent was deleted. List of not covered diagnoses was added.
09/16/2021	Annual review, no changes

References:

1. Leukine (sargramostim) [prescribing information]. Bridgewater, NJ: Sanofi-Aventis; April 2013.
2. Rowe JM, Anderson JW, Mazza JJ, et al. A randomized placebo-controlled phase III study of granulocyte-macrophage colony-stimulating factor in adult patients (>55 to 70 years of age) with acute myelogenous leukemia: a study of eastern cooperative oncology group. *Blood*. 1995;86(2):457-462.
3. Nemunaitis J, Rabinowe SN, Singer JW, et al. Recombinant granulocyte-macrophage colony-stimulating factor after autologous bone marrow transplantation for lymphoid cancer. *N Eng J Med*. 1991;324:1773-1778. Doi: 10.1056/NEJM199106203242504.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Livmarli (maralixibat)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
Coverage Requirements	Prior Authorization Required

Livmarli (maralixibat) is an ileal bile acid transport (IBAT) inhibitor initially approved by the FDA in 2021 for the treatment of cholestatic pruritus in patients with Alagille Syndrome (ALGS). ALGS is a rare genetic disorder, occurring 1 in 30,000 to 1 in 45,000 according to NORD, and can lead to progressive liver disease. Livmarli (maralixibat) was granted orphan drug designation for ALGS by the FDA and breakthrough designation for the treatment of pruritis.

Livmarli (maralixibat) will be considered for coverage when the following criteria are met:

Cholestatic pruritus in patients with Alagille Syndrome (ALGS)

For **initial** authorization:

1. Member is at least 1 year of age; AND
2. Medication must be prescribed by or in consultation with gastroenterologist OR hepatologist; AND
3. Member has a diagnosis of Alagille syndrome (ALGS) confirmed by the involvement of at least 3 of the following alterations in features for diagnosis:
   a) Hepatic Features (e.g., hyperbilirubinemia or scleral icterus)
   b) Cardiac Features (e.g., lesions confirmed on imaging or murmur)
   c) Facial Features (e.g., inverted triangular face, straight nose with bulbous tip)
   d) Ocular Features (e.g., embryotoxon, optic disk drusen)
   e) Skeletal Features (e.g., vertebral anomalies, osteopenia
   f) Renal Features (e.g., renal dysplasia, renal tubular acidosis)
   g) Vascular Features (e.g., narrowing of internal carotid artery, moyamoya disease)
4. Member must have liver biopsy demonstrating reduced number of the interlobular bile ducts OR confirmed finding of JAG1 or NOTCH2 gene mutation; AND
5. Member has symptoms of moderate to severe pruritus; AND
6. Member does not have ANY of the following:
   a) Previous liver transplant
   b) Previous surgical disruption of enterohepatic circulation (partial external bile diversion or ileal exclusion)
   c) Decompensated cirrhosis
   d) History or presence of other concomitant liver disease
7. The member must have at least a 14-day trial and failure, or contraindication, to two out of three of the following:
   a) Cholestyramine
   b) Ursodiol
   c) Rifampin
8. **Dosage allowed:** Starting dose is 190mcg/kg, titrating up to 380 mcg/kg once daily;
   a) Maximum dose allowed is 28.5 mg per day.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Pruritis has improved in response to therapy with Livmarli

If all the above requirements are met, the medication will be approved for an additional year.

CareSource considers Livmarli (maralixibat) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/15/2021	New policy for Livmarli created.

References:

1. Livmarli. Package insert. Mirum Pharmaceuticals; 2021. Accessed October 13, 2021. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/214662s000lbl.pdf
2. Alagille Syndrome A Guide. Children's Liver Disease Foundation; 2019. Childliverdisease.org
3. ClinicalTrials.gov. Identifier: NCT02160782. Safety and Efficacy Study of LUM001 (Marlixibat) With a Drug Withdrawal Period in Participants With Alagille Syndrome (ALGS) (ICONIC). Available at: https://clinicaltrials.gov/ct2/show/results/NCT02160782
4. ClinicalTrials.gov. Identifier: NCT02057692. Evaluation of LUM001 in the Reduction of Pruritus in Alagille Syndrome (ITCH). Available at: https://clinicaltrials.gov/ct2/show/NCT02057692
5. Shneider BL, Spino C, Kamatha BM, et al. Placebo-Controlled Randomized Trial of an Intestinal Bile Salt Transport Inhibitor for Pruritus in Alagille Syndrome. *Hepatol Commun.* 2018 Oct; 2(10): 1184-1198. Doi 10.1002/hep4.1244
6. Ayoub MD and Kamath BM. Alagille Syndrome: Diagnostic Challenges and Advances in Management. *Diagnostics*. 2020; 10(11):907. https://doi.org/10.3390/diagnostics10110907
7. Lin, Henry. Alagille Syndrome. National Organization for Rare Disorders; updated 2020. Accessed October 12, 2021. https://rarediseases.org/rare-diseases/alagille-syndrome/
8. Alagille Syndrome. Johns Hopkins Medicine. Hopkins Medicine. Accessed October 10, 2021. https://www.hopkinsmedicine.org/health/conditions-and-diseases/alagille-syndrome

Effective date: 04/01/2022
Revised date: 10/15/2021

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Lucentis (ranibizumab)
BILLING CODE	J2778
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
STATUS	Prior Authorization Required

Lucentis was approved by the FDA in 2006. It is indicated for the treatment of several ophthalmic conditions. Lucentis is a vascular endothelial growth factor (VEGF) inhibitor for intravitreal use. VEGF inhibitors suppress endothelial cell proliferation, neovascularization, and vascular permeability.
There are 2 forms of age-related macular degeneration (AMD), dry and wet (neovascular). Lucentis is approved for the treatment of Wet AMD which is less common but progresses more quickly. Neovascular in the context of AMD means growth of new blood vessels under the macula which can lead to loss of central vision.
Diabetic eye disease includes diabetic retinopathy (DR) and diabetic macular edema (DME). DR affects blood vessels in the retina at the back of the eye. DME is a consequence of DR that occurs in about half of DR patients. It causes fluid build-up in the macula part of the retina.
Retinal Vein Occlusion (RVO) occurs when there is a partial or complete obstruction of a retinal vein. Macular edema is a complication of RVO and can lead to vision loss. It is treated first-line with anti-VEGF drugs.
Myopia (nearsightedness) occurs when the eyeball becomes elongated. In pathological myopia, progressive elongation can cause a weakened sclera to bulge at the posterior of the eye which can lead to thinning of the retina and growth of new blood vessels. This can result in vision loss if not treated.

Lucentis (ranibizumab) will be considered for coverage when the following criteria are met:

Retinal Disease

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a confirmed diagnosis of one of the following conditions:
   a) Neovascular (Wet) Age-Related Macular Degeneration (AMD)
   b) Macular Edema Following Retinal Vein Occlusion (RVO)
   c) Diabetic Macular Edema (DME)
   d) Diabetic Retinopathy (DR)
   e) Myopic Choroidal Neovascularization (mCNV); AND
4. Member has tried and failed bevacizumab intravitreal injection; AND
5. Documentation of best-corrected visual acuity (BCVA); AND
6. Member does NOT have active infection or inflammation in or around the eye(s) to be treated.
7. **Dosage allowed/Quantity limit:**
   AMD: 0.5 mg every 28 days (may extend to every 3 months after 4 monthly doses).
   RVO: 0.5 mg every 28 days
   DME or DR: 0.3 mg every 28 days
   CNV: 0.5 mg every 28 days for up to 3 months. Re-treat if needed.
   (Note: Lucentis is supplied as 0.3 mg or 0.5 mg single-use vials or pre-filled syringes).

If all the above requirements are met, the medication will be approved for 6 months (3 months for mCNV).

For **reauthorization**:

1. Chart notes must include documentation of improved or stabilized visual acuity.

If all the above requirements are met, the medication will be approved for an additional 12 months (3 months for mCNV).

CareSource considers Lucentis (ranibizumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/26/2021	New policy for Lucentis created.

References:

1. Lucentis [prescribing information]. Genentech, Inc.; 2018.
2. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P1-P65. doi:10.1016/j.ophtha.2019.09.024
3. Solomon SD, Lindsley K, Vedula SS, Krzystolik MG, Hawkins BS. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. *Cochrane Database Syst Rev*. 2019;3(3):CD005139. Published 2019 Mar 4. doi:10.1002/14651858.CD005139.pub4
4. Holekamp, Nanvy M. Review of Neovascular Age-Related Macular Degeneration Treatment Options. Am J Manag Care. July 2019; 25:-S0
5. Flaxel CJ, Adelman RA, Bailey ST, et al. Retinal Vein Occlusions Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(2):P288-P320. doi:10.1016/j.ophtha.2019.09.029
6. Shalchi Z, Mahroo O, Bunce C, Mitry D. Anti-vascular endothelial growth factor for macular oedema secondary to branch retinal vein occlusion. *Cochrane Database Syst Rev*. 2020;7(7):CD009510. Published 2020 Jul 7. doi:10.1002/14651858.CD009510.pub3
7. Flaxel CJ, Adelman RA, Bailey ST, et al. Diabetic Retinopathy Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P66-P145. doi:10.1016/j.ophtha.2019.09.025
8. Virgili G, Parravano M, Evans JR, Gordon I, Lucenteforte E. Anti-vascular endothelial growth factor for diabetic macular oedema: a network meta-analysis. *Cochrane Database Syst Rev*. 2018;10(10):CD007419. Published 2018 Oct 16. doi:10.1002/14651858.CD007419.pub6
9. Zhu Y, Zhang T, Xu G, Peng L. Anti-vascular endothelial growth factor for choroidal neovascularisation in people with pathological myopia. *Cochrane Database Syst Rev*. 2016;12(12):CD011160. Published 2016 Dec 15. doi:10.1002/14651858.CD011160.pub2
10. Pham B, Thomas SM, Lillie E, et al. Anti-vascular endothelial growth factor treatment for retinal conditions: a systematic review and meta-analysis. *BMJ Open*. 2019;9(5):e022031. Published 2019 May 28. doi:10.1136/bmjopen-2018-022031

Effective date: 04/01/2022
Revised date: 10/26/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Lumizyme (alglucosidase alfa)
BILLING CODE	J0221
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Lumizyme is an enzyme replacement therapy for the treatment of Pompe disease, also known as acid alpha-glucosidase (GAA) deficiency or glycogen storage disease type II. Pompe disease is a rare, genetic lysosomal storage disorder that results in the buildup of glycogen in cell lysosomes causing serious and life-threatening muscle damage and weakness. Lumizyme replaces the deficient GAA enzyme to reduce the glycogen accumulation.
Pompe disease can be broadly classified as infantile-onset within the first few months of life (IOPD) or late-onset beyond infancy (LOPD). Classic IOPD is rapidly progressive with severe cardiomyopathy. Non-classic IOPD progresses slower with less severe cardiomyopathy. LOPD does not typically present with cardiomyopathy and has more variable symptoms, especially skeletal muscle weakness.

Lumizyme (alglucosidase alfa) will be considered for coverage when the following criteria are met:

Pompe disease (acid α-glucosidase [GAA] deficiency)

For **initial** authorization:
1. Medication must be prescribed by or in consultation with a geneticist, cardiologist, neurologist, pulmonologist, or metabolic specialist; AND
2. Member has a diagnosis of Pompe disease confirmed by an enzyme activity assay showing GAA deficiency (0% to 40% of normal); AND
3. Molecular genetic testing shows pathogenic mutation of the GAA gene; AND
4. Members with late onset Pompe disease must show signs or symptoms (i.e., motor weakness, reduced respiratory parameters).
5. **Dosage allowed/Quantity limit:** 20 mg/kg IV infusion every 2 weeks

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes must document positive clinical response such as improved motor function or ambulation, stabilized pulmonary function, or improved cardiomyopathy.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Lumizyme (alglucosidase alfa) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/07/2021	New policy for Lumizyme created.

References:

1. Lumizyme [prescribing information]. Cambridge, MA: Genzyme Corporation; 2020.
2. Chen M, Zhang L, Quan S. Enzyme replacement therapy for infantile-onset Pompe disease. *Cochrane Database Syst Rev*. 2017;11(11):CD011539. Published 2017 Nov 20. doi:10.1002/14651858.CD011539.pub2
3. Schoser B, Stewart A, Kanters S, et al. Survival and long-term outcomes in late-onset Pompe disease following alglucosidase alfa treatment: a systematic review and meta-analysis. *J Neurol*. 2017;264(4):621-630. doi:10.1007/s00415-016-8219-8
4. Wang RY, Bodamer OA, Watson MS, Wilcox WR; ACMG Work Group on Diagnostic Confirmation of Lysosomal Storage Diseases. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. *Genet Med*. 2011;13(5):457-484. doi:10.1097/GIM.0b013e318211a7e1
5. Tarnopolsky M, Katzberg H, Petrof BJ, et al. Pompe Disease: Diagnosis and Management. Evidence-Based Guidelines from a Canadian Expert Panel. *Can J Neurol Sci*. 2016;43(4):472-485. doi:10.1017/cjn.2016.37
6. van der Ploeg AT, Kruijshaar ME, Toscano A, et al. European consensus for starting and stopping enzyme replacement therapy in adult patients with Pompe disease: a 10-year experience. *Eur J Neurol*. 2017;24(6):768-e31. doi:10.1111/ene.13285
7. Cupler EJ, Berger KI, Leshner RT, et al. Consensus treatment recommendations for late-onset Pompe disease. *Muscle Nerve*. 2012;45(3):319-333. doi:10.1002/mus.22329
8. Burton BK, Kronn DF, Hwu WL, Kishnani PS; Pompe Disease Newborn Screening Working Group. The Initial Evaluation of Patients After Positive Newborn Screening: Recommended Algorithms Leading to a Confirmed Diagnosis of Pompe Disease. *Pediatrics*. 2017;140(Suppl 1):S14-S23. doi:10.1542/peds.2016-0280D
9. Kronn DF, Day-Salvatore D, Hwu WL, et al. Management of Confirmed Newborn-Screened Patients With Pompe Disease Across the Disease Spectrum. *Pediatrics*. 2017;140(Suppl 1):S24-S45. doi:10.1542/peds.2016-0280E

Effective date: 01/01/2022
Revised date: 07/07/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Lupaneta Pack (leuprolide acetate, norethindrone acetate)
BILLING CODE	Must use a valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "**Dosage allowed**" below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Lupaneta Pack (leuprolide acetate, norethindrone acetate) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ENDOMETRIOSIS

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Member is having painful symptoms (e.g., pelvic pain, dysmenorrhea, etc.) associated with endometriosis (documentation required); AND
3. Medication must be prescribed by or in consultation with a gynecologist; AND
4. Member has tried and failed to control symptoms after trials with **both** of the following, unless not tolerated or contraindicated:
   a) 30 days of an NSAID;
   b) 3 months of a hormonal contraceptive; AND
5. Member does **not** have any of the following:
   a) Pregnancy or plan to become pregnant while taking medication;
   b) Undiagnosed abnormal uterine bleeding.
6. **Dosage allowed:** 3.75 mg (IM injection) monthly or 11.25 mg every 3 months together with norethindrone acetate 5 mg tablet taken orally once per day for up to 6 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has recurrence of endometriosis symptoms after the first course of treatment; AND
2. Duration of treatment has not exceeded 12 months.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months. Reauthorization will not be allowed after 12 months of therapy.

CareSource considers Lupaneta Pack (leuprolide acetate, norethindrone acetate) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/08/2020	New policy for Lupaneta Pack created.
09/16/2021	Annual review, no changes

References:

1. Lupaneta Pack [package insert]. North Chicago, IL: AbbVie Inc.; June, 2015.
2. Schrager S, Falleroni J, Edgoose J. Evaluation and treatment of endometriosis. *Am Fam Physician*. 2013 Jan 15;87(2):107-13.
3. Hewitt GD, Gerancher KR. Dysmenorrhea and endometriosis in the adolescent. *Obstet Gynecol*. 2018 Dec;132(6):e249-e258.
4. DiVasta AD, Feldman HA, Sadler Gallagher J, et al. Hormonal Add-Back Therapy for Females Treated With Gonadotropin-Releasing Hormone Agonist for Endometriosis: A Randomized Controlled Trial. *Obstet Gynecol*. 2015;126(3):617-627.
5. Armstrong C. ACOG updates guideline on diagnosis and treatment of endometriosis. *Am Fam Physician*. 2011 Jan 1;83(1):84-85.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Lupkynis (voclosporin)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Lupkynis is an oral calcineurin inhibitor (structurally similar to cyclosporine A). It was approved in January 2021 for the treatment of adults with active lupus nephritis (LN), in combination with background immunosuppressive therapy. LN is a complication of systemic lupus erythematosus (SLE) and can progress to end stage renal disease (ESRD). Proteinuria is often the first sign of LN. Diagnosis is confirmed by a kidney biopsy, which reveals the classification of disease and is used to guide treatment. Dosing is based on estimated glomerular filtration rate (eGFR), with most patients likely to be on the higher end of the dose range. Hypertension is a common side effect and blood pressure monitoring is recommended.

Lupkynis (voclosporin) will be considered for coverage when the following criteria are met:

Lupus Nephritis

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a nephrologist or rheumatologist; AND
3. Member has a diagnosis of lupus nephritis class III, IV, and/or V as confirmed by kidney biopsy; AND
4. Medication must be prescribed in combination with an immunosuppressant regimen such as mycophenolate mofetil (MMF) and corticosteroid; AND
5. Chart notes must document baseline eGFR and urine protein creatinine ratio (UPCR); AND
6. eGFR is at least 45 mL/min/1.73m^2 OR it has been determined that the benefit exceeds the risk; AND
7. Member is not on dialysis and has not had a kidney transplant; AND
8. Lupkynis will not be used in combination with cyclophosphamide.
9. **Dosage allowed/Quantity limit:** Up to 23.7 mg (3 capsules) twice daily (total 6 capsules per day; 3 wallets per 30 days). Dosing is based on eGFR as directed in prescribing information.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has a reduced UPCR (goal is 0.5 mg/mg or less); AND
2. eGFR is at least 60mL/min/1.73m^2 OR has stabilized.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Lupkynis (voclosporin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
3/24/21	New policy for Lupkynis created.

References:

1. Lupkynis. [prescribing information]. Rockville, MD: Aurinia Pharma U.S., Inc; 2021.
2. Hahn BH, McMahon MA, Wilkinson A, et al. American College of Rheumatology guidelines for screening, treatment, and management of lupus nephritis. *Arthritis Care Res (Hoboken)*. 2012;64(6):797-808. doi:10.1002/acr.21664
3. Rovin BH, Solomons N, Pendergraft WF 3rd, et al. A randomized, controlled double-blind study comparing the efficacy and safety of dose-ranging voclosporin with placebo in achieving remission in patients with active lupus nephritis. *Kidney Int*. 2019;95(1):219-231. doi:10.1016/j.kint.2018.08.025
4. Fanouriakis A, Kostopoulou M, Cheema K, et al. 2019 Update of the Joint European League Against Rheumatism and European Renal Association-European Dialysis and Transplant Association (EULAR/ERA-EDTA) recommendations for the management of lupus nephritis. *Ann Rheum Dis*. 2020;79(6):713-723. doi:10.1136/annrheumdis-2020-216924

Effective date: 01/01/2022
Revised date: 03/24/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Lupron Depot and Lupron Depot-PED (leuprolide acetate)
BILLING CODE	J1950, J9217, J9218
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Products) QUANTITY LIMIT— see "**Dosage allowed**" below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Lupron Depot and Lupron Depot-PED (leuprolide acetate) are **preferred** products and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CANCER

Any request for **advanced breast cancer** or **advanced prostate cancer** must be submitted through NantHealth/Eviti portal.

CENTRAL PRECOCIOUS PUBERTY (CPP) – Lupron Depot – PED only

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Member has early onset of puberty symptoms before the age of 8 for female or 9 for male; AND
3. Member has confirmed diagnosis of central precocious puberty, as evidenced by **both** of the following:
   a) Pubertal response to a gonadotropin releasing hormone (GnRH) stimulation test OR pubertal levels of basal luteinizing hormones (LH) and estradiol or testosterone hormones;
   b) Bone age is advanced by at least one year greater than chronological age; AND
4. Medication must be prescribed by or in consultation with an endocrinologist; AND
5. Member's baseline LH level, sex steroid level (estradiol or testosterone), height, and weight are submitted with chart notes.
6. **Dosage allowed:** Lupron Depot-PED only – 1 intramuscular (IM) injection once a month (7.5mg, 11.25mg, or 15mg) OR 1 injection every 3 months (11.25mg or 30 mg).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. If member is 11 years or older for females or 12 years or older for males, prescriber must provide a clinical reason for continuing medication beyond the recommended age for resuming puberty; AND
2. Chart notes have been provided showing efficacy of response (e.g., slowed growth rate, slowed bone age advancement, LH and sex steroid hormone levels have been suppressed or reduced from baseline).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

ENDOMETRIOSIS – Lupron Depot only

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Member is having painful symptoms (e.g., pelvic pain, dysmenorrhea, etc.) associated with endometriosis (documentation required); AND
3. Medication must be prescribed by or in consultation with a gynecologist; AND
4. Member has tried and failed to control symptoms after trials with **both** of the following, unless not tolerated or contraindicated:
   a) 30 days of an NSAID;
   b) 3 months of a hormonal contraceptive; AND
5. Member does **not** have any of the following:
   a) Pregnancy or plan to become pregnant while taking medication;
   b) Undiagnosed abnormal uterine bleeding.
6. **Dosage allowed:** Lupron Depot 3.75 mg monthly or 11.25 mg every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member has recurrence of endometriosis symptoms after the first course of treatment; AND
2. Medication must be used concomitantly with norethindrone acetate 5 mg (daily add-back therapy). Retreatment will not be allowed without norethindrone acetate due to risk of bone loss; AND
3. Duration of treatment has not exceeded 12 months.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months. Reauthorization will not be allowed after 12 months of therapy.

UTERINE LEIOMYOMAS (FIBROIDS) – Lupron Depot only

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a gynecologist; AND
3. Member has anemia associated with heavy menstrual bleeding due to uterine fibroid (hemoglobin lab result required);
4. Member's anemia has not improved after a 30 days of supplemental iron therapy; AND
5. Member will be having a surgery to remove fibroid and the proposed surgery date or timeframe is submitted with chart notes; AND
6. Medication must be used concomitantly with iron, unless not tolerated; AND
7. Member does **not** have any of the following:
   a) Pregnancy or plan to become pregnant while taking medication;
   b) Undiagnosed abnormal uterine bleeding.
8. **Dosage allowed:** Lupron Depot 3.75 mg monthly for up to 3 months or Lupron Depot 11.25 (3-month injection) as a single injection. Lupron must be used concomitantly with iron therapy.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

The use of Lupron is limited to 3 months of therapy to improve hemoglobin level prior to fibroid surgery. Therefore, reauthorization is not allowed.

CareSource considers Lupron Depot, Lupron Depot-PED (leuprolide acetate), and Lupaneta Pack (leuprolide acetate, norethindrone acetate) not medically necessary for the treatment of the following disease states based on a lack of

robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Dysfunctional Uterine Bleeding

DATE	ACTION/DESCRIPTION
10/09/2018	New policy for Lupron created. Age requirement for Central Precocious Puberty and diagnostic evaluation assessment were revised. Coverage for Advanced Breast Cancer is specified for hormone receptor-positive breast cancer. "Proposed date of planned fibroid surgery" criterion was added to diagnosis of Uterine Leiomyomas. Diagnosis of Dysfunctional uterine bleeding was removed. The requirement for increased uterine volume from the female criteria in CPP was removed.
07/28/2020	Carved out Advanced Breast Cancer and Advanced Prostate Cancer to Eviti. For central precocious puberty, updated diagnostic requirements to require both: advanced bone age and GnRH stimulation test or pubertal hormone levels; specified baseline LH hormones; removed ruled out diagnoses; removed list of secondary puberty signs and symptoms (redundancy); added requirement for discontinuation of treatment in reauth; added prescriber requirement. Initial approval duration changed from 12 to 6 months.
10/08/2020	For uterine leiomyomas: Added requirement of anemia associated with heavy bleeding due to fibroids to meet diagnosis. Added a 30-day trial of iron therapy in accordance to drug label. Added that Lupron must be used concomitantly with iron therapy. For endometriosis: Removed requirement of norethindone concurrent use in initial auth. Simplified symptoms. Reduced duration of reauth to 6 months from 12 months. Total duration of approval (initial + retreatment) cannot exceed 12 months per drug labeling. Added that member has to be symptomatic to request reauthorization.

References:

1. Lupron Depot [package insert]. North Chicago, IL: AbbVie Inc.; March, 2020.
2. Lupron Depot – PED [package insert]. North Chicago, IL: AbbVie Inc.; April, 2020.
3. American Association of Gynecologic Laparoscopists (AAGL). AAGL practice report: practice guidelines for the diagnosis and management of submucous leiomyomas. *J Minim Invasive Gynecol*. Mar-Apr 2012;19(2):152-71.
4. De La Cruz MS, Buchanan EM. Uterine fibroids: diagnosis and treatment. *Am Fam Physician*. 2017 Jan 15;95(2):100-107.
5. Vilos GA, Allaire C, Laberge PY, et al. The management of uterine leiomyomas. *J Obstet Gynaecol Can*. 2015 Feb;37(2):157-178.
6. Stewart EA. Uterine fibroids (leiomyomas): Treatment overview. In: Barbieri RL, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 30, 2020.
7. Jasonni VM, D'Anna R, Mancuso A, Caruso C, Corrado F, Leonardi I. Randomized double-blind study evaluating the efficacy on uterine fibroids shrinkage and on intra-operative blood loss of different length of leuprolide acetate depot treatment before myomectomy. *Acta Obstet Gynecol Scand*. 2001;80(10):956-958.
8. Schlaff WD, Zerhouni EA, Huth JAM, Chen J, Damewood MD, Rock JA. A placebo-controlled trial of a depot gonadotropin-releasing hormone analogue (leuprolide) in the treatment of uterine leiomyomata. *Obstet Gynecol*. 1989;74(6):856-862.
9. Stovall TG, Muneyyirci-Delale O, Summitt RL Jr, Scialli AR; Leuprolide Acetate Study Group. GnRH agonist and iron versus placebo and iron in the anemic patient before surgery for leiomyomas: a randomized controlled trial. *Obstet Gynecol*. 1995;86(1):65-71.
10. Moroni R, Vieira C, Ferriani R, Candido-Dos-Reis F, Brito L. Pharmacological treatment of uterine fibroids. *Ann Med Health Sci Res*. 2014;4(Suppl 3):S185-S192.
11. Donnez J, Tomaszewski J, Vazquez F, et al; for the PEARL II Study Group. Ulipristal acetate versus leuprolide acetate for uterine fibroids. *N Eng J Med.* 2012;366(5):421-432.
12. Eksioglu AS, et al. Value of pelvic sonography in the diagnosis of various forms of precocious puberty in girls. J *Clin Ultrasound*. 2013 Feb;41(2):84-93.
13. Sathasivam A, et al. Pelvic ultrasonography in the evaluation of central precocious puberty: comparison with leuprolide stimulation test. *J Pediatr*. 2011 Sep;159(3):490-5.

14. Chen M, Eugster EA. Central Precocious Puberty: Update on Diagnosis and Treatment. *Paediatr Drugs*. 2015;17(4):273-281.
15. Carel JC, Eugster EA, Rogol A, et al; ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123(4).
16. Creo AL, Schwenk WF. Bone age: a handy tool for pediatric providers. *Pediatrics*. Dec 2017, 140 (6) e20171486.
17. Klein KO. Precocious puberty: who has it? Who should be treated?. *J Clin Endocrinol Metab*. 1999;84(2):411-414.
18. Schrager S, Falleroni J, Edgoose J. Evaluation and treatment of endometriosis. *Am Fam Physician*. 2013 Jan 15;87(2):107-13.
19. Hewitt GD, Gerancher KR. Dysmenorrhea and endometriosis in the adolescent. *Obstet Gynecol*. 2018 Dec;132(6):e249-e258.
20. DiVasta AD, Feldman HA, Sadler Gallagher J, et al. Hormonal Add-Back Therapy for Females Treated With Gonadotropin-Releasing Hormone Agonist for Endometriosis: A Randomized Controlled Trial. *Obstet Gynecol*. 2015;126(3):617-627.
21. Armstrong C. ACOG updates guideline on diagnosis and treatment of endometriosis. *Am Fam Physician*. 2011 Jan 1;83(1):84-85.

Effective date: 10/1/2021
Revised date: 10/08/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Luxturna (voretigene neparvovec-rzyl) intraocular suspension for subretinal injection
BILLING CODE	TBD
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1 Luxturna carton per eye for lifetime
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Luxturna (voretigene neparvovec-rzyl) intraocular suspension for subretinal injection is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

BIALLELIC RPE65 MUTATION-ASSOCIATED RETINAL DYSTROPHY

For **initial** authorization:

1. Member is 3 years of age or older; AND
2. Medication must be prescribed by ophthalmologist or retinal surgeon; AND
3. Member has confirmed diagnosis of biallelic RPE65 mutation-associated retinal dystrophy by genetic testing in a CLIA-certified laboratory; AND
4. Member has baseline multi-luminance mobility testing (MLMT) score documented in chart notes; AND
5. Member has sufficient viable retinal cells as determined by retinal thickness on spectral domain optical coherence tomography (>100 microns within the posterior pole); AND
6. Member's visual acuity is 20/60 or worse (both eyes) and/or visual field less than 20 degrees in any meridian as measured by a III4e isopter or equivalent (both eyes); AND
7. Member was not previously treated with RPE65 gene therapy.
8. **Dosage allowed:** 1.5×10^{11} vector genomes (vg), administered by subretinal injection in a total volume of 0.3 mL for each eye. Administration of Luxturna to each eye must be performed on separate days within a close interval, but not fewer than 6 days.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Medication will not be reauthorization for continuous use.

CareSource considers Luxturna (voretigene neparvovec-rzyl) intraocular suspension for subretinal injection not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/27/2018	New policy for Luxturna created.

References:

1. Luxturna [package insert]. Philadelphia, PA; Spark Therapeutics, Inc.: 2017.

2. Maguire AM, Simonelli F, Pierce EA, at el. Safety and efficacy of gene transfer for Leber's congenital amaurosis. N Engl J Med. 2008 May 22;358(21):2240-8. doi: 10.1056/NEJMoa0802315. Epub 2008 Apr 27.
3. Bennett J, Wellman J, Marshall KA, at el. Safety and durability of effect of contralateral-eye administration of AAV2 gene therapy in patients with childhood-onset blindness caused by RPE65 mutations: a follow-on phase 1 trial. Lancet. 2016 Aug 13;388(10045):661-72. doi: 10.1016/S0140-6736(16)30371-3. Epub 2016 Jun 30.
4. Russell S, Bennett J, Wellman JA, at el. Efficacy and safety of voretigene neparvovec (AAV2-hRPE65v2) in patients with RPE65-mediated inherited retinal dystrophy: a randomised, controlled, open-label, phase 3 trial. Lancet. 2017 Aug 26;390(10097):849-860. doi: 10.1016/S0140-6736(17)31868-8. Epub 2017 Jul 14.
5. Ameri H. Prospect of retinal gene therapy following commercialization of voretigene neparvovec-rzyl for retinal dystrophy mediated by RPE65 mutation. J Curr Ophthalmol. 2018 Feb 16;30(1):1-2.

Effective date: 09/07/2018
Revised date: 08/27/2018

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	MACI (autologous cultured chondrocytes)
BILLING CODE	J7330
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Inpatient/Outpatient hospital
STATUS	Prior authorization required

MACI® (autologous cultured chondrocytes on porcine collagen membrane) is used for the repair of symptomatic cartilage damage of the knee. It is made up of autologous cells that are collected on biopsy, expanded and proliferated in culture, and seeded onto a collagen membrane that is implanted to the area of defect and absorbed back into the tissue. The amount of MACI applied depends on the size of the cartilage defect (cm^2). The membrane is trimmed by the surgeon to the size and shape of the defect. Implantation is performed via arthrotomy.

MACI (autologous cultured chondrocytes) will be considered for coverage when the following criteria are met:

Cartilage defect of the knee

For **initial** authorization:

1. Member is 15 (with closed growth plates) to 55 years of age; AND
2. Medication must be prescribed by or in consultation with an orthopedic surgeon or PM&R (physiatry) specialist; AND
3. Member has a BMI of 35 or less; AND
4. Member has a diagnosis of single or multiple symptomatic, full-thickness cartilage defects of the knee with or without bone involvement; AND
5. The defect size is greater than 2 cm^2; AND
6. Documentation of disabling knee pain that limits activities of daily living with symptom onset less than 3 years ago; AND
7. Member has tried and failed conservative therapy for at least 2 months, including physical therapy and anti-inflammatory medications; AND
8. The knee has stable alignment with the meniscus intact and normal joint space (per X-ray); AND
9. Documentation that the implantation will be followed by an appropriate, physician-prescribed rehabilitation program to which the member is expected to adhere; AND
10. Member does NOT have any of the following:
    a) Hypersensitivity to gentamicin, other aminoglycosides, or products of porcine or bovine origin
    b) Severe osteoarthritis of the knee or degenerative joint disease
    c) Inflammatory arthritis, inflammatory joint disease, or uncorrected congenital blood coagulation disorders
    d) Knee surgery within the past 6 months (except to procure biopsy or to perform a concurrent procedure with MACI)
    e) Osteochondritis dissecans
11. **Dosage allowed/Quantity limit:** 1 procedure per defect per lifetime.

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:

1. MACI will not be re-authorized. If the request is for a new defect/injury that has not previously been treated with MACI, all initial criteria apply.

CareSource considers MACI (autologous cultured chondrocytes) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/22/2021	New policy created for Maci.

References:

1. MACI. [prescribing information]. Vericel Corporation; 2021.
2. Saris D, Price A, Widuchowski W, et al. Matrix-Applied Characterized Autologous Cultured Chondrocytes Versus Microfracture: Two-Year Follow-up of a Prospective Randomized Trial. *Am J Sports Med*. 2014;42(6):1384-1394. doi:10.1177/0363546514528093
3. Brittberg M, Recker D, Ilgenfritz J, Saris DBF; SUMMIT Extension Study Group. Matrix-Applied Characterized Autologous Cultured Chondrocytes Versus Microfracture: Five-Year Follow-up of a Prospective Randomized Trial. *Am J Sports Med*. 2018;46(6):1343-1351. doi:10.1177/0363546518756976
4. National Institute for Health and Care Excellence. (2017). *Autologous chondrocyte implantation for treating symptomatic articular cartilage defects of the knee* (NICE guideline TA477) Available at https://www.nice.org.uk/guidance/ta477/resources/autologous-chondrocyte-implantation-for-treating-symptomatic-articular-cartilage-defects-of-the-knee-pdf-82604971061701 [Accessed 29 November 2021].
5. Mistry H, Connock M, Pink J, et al. Autologous chondrocyte implantation in the knee: systematic review and economic evaluation. Southampton (UK): NIHR Journals Library; 2017 Feb. (Health Technology Assessment, No. 21.6.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK424075/ doi: 10.3310/hta21060
6. Carey JL, Remmers AE, Flanigan DC. Use of MACI (Autologous Cultured Chondrocytes on Porcine Collagen Membrane) in the United States: Preliminary Experience. *Orthop J Sports Med*. 2020;8(8):2325967120941816. Published 2020 Aug 12. doi:10.1177/2325967120941816
7. Niemeyer P, Albrecht D, Andereya S, et al. Autologous chondrocyte implantation (ACI) for cartilage defects of the knee: A guideline by the working group "Clinical Tissue Regeneration" of the German Society of Orthopaedics and Trauma (DGOU). *Knee*. 2016;23(3):426-435. doi:10.1016/j.knee.2016.02.001
8. Rosa D, Di Donato SL, Balato G, et al. How to Manage a Failed Cartilage Repair: A Systematic Literature Review. *Joints*. 2017;5(2):93-106. Published 2017 Jul 28. doi:10.1055/s-0037-1603900
9. von Keudell A, Han R, Bryant T, Minas T. Autologous Chondrocyte Implantation to Isolated Patella Cartilage Defects. *Cartilage*. 2017;8(2):146-154. doi:10.1177/1947603516654944

Effective date: 04/01/2022
Revised date: 11/22/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Macrilen (macimorelin)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— for weight ≤ 120 kg - 1 pouch >120 kg - 2 pouches
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Macrilen (macimorelin) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DIAGNOSTIC USE FOR GROWTH HORMONE DEFICIENCY

For **initial** authorization:

1. Member is age 18 years or older; AND
2. Medication must be prescribed by an endocrinologist; AND
3. Member's weight is documented on chart notes and member's BMI is ≤ 40 kg/m^2; AND
4. Member must have a contraindication to ALL other diagnostic tests (insulin tolerance test, glucagon stimulation test, arginine, clonidine, levodopa, or arginine combined with levodopa) for growth hormone deficiency.
5. **Dosage allowed:** 0.5 mg/kg as single dose.

If member meets all the requirements listed above, the medication will be approved for a one-time fill and will not be reauthorized.

CareSource considers Macrilen (macimorelin) not medically necessary for the diagnosis or treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/20/2018	New policy for Macrilen created.
03/11/2021	Annual review, no changes

References:

1. Macrilen [prescribing information]. Trevose, PA: Strongbridge US Inc.; Revised January 2018.
2. Garcia JM et al., *J Clin Endocrinol Metab*. 2018 May 31.
3. Diagnosis of growth hormone deficiency in childhood. *Curr Opin Endocrinol Diabetes Obes*. 2012;19(1):47-52.

Effective date: 01/01/2022
Revised date: 03/11/2021

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Macugen (pegaptanib)
BILLING CODE	J2503
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
STATUS	Prior Authorization Required

Macugen was approved by the FDA in 2004 for the treatment of neovascular (wet) age-related macular degeneration (AMD). There are 2 forms of AMD, dry and wet (neovascular). Wet AMD is less common but progresses more quickly. Neovascular in the context of AMD means growth of new blood vessels under the macula which can lead to loss of central vision. The goal of AMD treatment is to preserve visual function. Macugen was the first vascular endothelial growth factor (VEGF) inhibitor approved for intravitreal use. VEGF inhibitors suppress endothelial cell proliferation, neovascularization, and vascular permeability. Macugen is rarely used in clinical practice today due to the availability of newer drugs in this class which have demonstrated better efficacy.

Macugen (pegaptanib) will be considered for coverage when the following criteria are met:

Neovascular (wet) age-related macular degeneration (AMD)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a confirmed diagnosis of wet AMD; AND
4. Member has tried and failed bevacizumab intravitreal injection; AND
5. Documentation of best-corrected visual acuity (BCVA); AND
6. Member does NOT have active infection or inflammation in or around the eye(s) to be treated.
7. **Dosage allowed/Quantity limit:** 0.3 mg once every 6 weeks by intravitreal injection. (Note: Each single-use syringe is pre-filled with 0.3 mg of drug).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must include documentation of improved or stabilized visual acuity.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Macugen (pegaptanib) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/21/2021	New policy for Macugen created.

References:

1. Macugen [prescribing information]. Bausch & Lomb; 2016.
2. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P1-P65. doi:10.1016/j.ophtha.2019.09.024
3. Solomon SD, Lindsley K, Vedula SS, Krzystolik MG, Hawkins BS. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. *Cochrane Database Syst Rev*. 2019;3(3):CD005139. Published 2019 Mar 4. doi:10.1002/14651858.CD005139.pub4
4. Holekamp, Nanvy M. Review of Neovascular Age-Related Macular Degeneration Treatment Options. Am J Manag Care. July 2019; 25:-S0

Effective date: 04/01/2022
Revised date: 10/21/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Mavenclad (cladribine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— based on weight
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Mavenclad (cladribine) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, ACTIVE SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis; AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), an interferon-release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Chart notes submitted with baseline of ALL of the following:
   a) Complete blood count;
   b) Lymphocyte count;
   c) Liver function test; AND
6. Member does **not** have any of the following:
   a) Current malignancy;
   b) HIV infection;
   c) Active chronic infections (e.g., hepatitis or tuberculosis); AND
7. One of the following:
   a) If female, she must:
      i) be post-menopausal or surgically sterilized; OR
      ii) uses a hormonal contraceptive, intra uterine device, diaphragm with spermicide, or condom with spermicide, for the duration of the treatment; AND
      iii) be neither pregnant nor breast-feeding;
   b) If male, he must be willing to use contraception to avoid pregnancies; AND
8. Member has documented trial and failure or contraindication to at least two preferred multiple sclerosis agents (two injectable drugs OR two oral drugs OR one injectable and one oral drug) and one of the following infusions: Lemtrada, Tysabri or Ocrevus.
9. **Dosage allowed:** Cumulative dosage of 3.5 mg/kg administered orally and divided into 2 treatment courses (1.75 mg/kg per treatment course). Each treatment course is divided into 2 treatment cycles. Drug dose in mg and amount of tablets per cycle depend on member's weight, please see prescribing information for details.
   Administration of First Treatment Course:

First Cycle: start any time.
Second Cycle: administer 23 to 27 days after the last dose of First Course/First Cycle.

Administration of Second Treatment Course:
First Cycle: administer at least 43 weeks after the last dose of First Course/Second Cycle.
Second Cycle: administer 23 to 27 days after the last dose of Second Course/First Cycle.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Medication will not be reauthorized since the safety and efficacy of reinitiating Mavenclad more than 2 years after completing 2 treatment courses has not been studied.

CareSource considers Mavenclad (cladribine) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
07/02/2019	New policy for Mavenclad created.
11/19/2021	Annual review, no changes

References:

1. Mavenclad [package insert]. Rockland, MA: EMD Serono, Inc.; April, 2019.
2. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
3. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.
4. FDA News Release: FDA approves new oral treatment for multiple sclerosis. www.fda.gov.
5. ClinicalTrials.gov. Identifier: NCT00725985. Oral Cladribine in Early Multiple Sclerosis (MS) (ORACLE MS). Available at: https://clinicaltrials.gov/ct2/show/NCT00725985?term=cladribine&recrs=e&rank=5.
6. ClinicalTrials.gov. Identifier: NCT00213135. A Safety and Efficacy Study of Oral Cladribine in Subjects With Relapsing-remitting Multiple Sclerosis (RRMS) (CLARITY). Available at: https://clinicaltrials.gov/ct2/show/NCT00213135?term=cladribine&recrs=e&rank=6.
7. Siddiqui, Mohd Kashif, et al. "Systematic literature review and network meta-analysis of cladribine tablets versus alternative disease-modifying treatments for relapsing–remitting multiple sclerosis." Current medical research and opinion 34.8 (2018): 1361-1371.
8. Kalincik, Tomas, et al. "Cladribine versus fingolimod, natalizumab and interferon β for multiple sclerosis." Multiple Sclerosis Journal 24.12 (2018): 1617-1626

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Mavyret (glecaprevir and pibrentasvir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Mavyret is a fixed-dose combination of glecaprevir, a hepatitis C virus (HCV) NS3/4A protease inhibitor, and pibrentasvir, an HCV NS5A inhibitor. It was initially approved by the FDA in 2017 and is indicated for the treatment of adult and pediatric patients 3 years and older with chronic HCV genotype 1, 2, 3, 4, 5 or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A). Mavyret is also indicated for the treatment of adult and pediatric patients 3 years and older with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

Mavyret (glecaprevir and pibrentasvir) will be considered for coverage when the following criteria are met:

HEPATITIS C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A))

For **initial** authorization:

1. Member must be 3 years of age or older; AND
2. Member has ONE of the following statuses:
   a) Treatment-naïve with genotype 1, 2, 3, 4, 5 or 6 (laboratory documentation required); OR
   b) Treatment-experienced with one of the following:
      i) genotype 1, who previously have been treated with a regimen containing an HCV NS5A inhibitor[1] or an NS3/4A protease inhibitor[2], but not both; OR
      ii) genotype 1, 2, 3, 4, 5 or 6 with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A protease inhibitor[2] or NS5A inhibitor[1]; AND
3. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
4. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
5. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
6. Member does not have any of the following:
   a) Moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C);
   b) Currently on atazanavir and rifampin.
7. **Dosage allowed/Quantity limit:** Three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken orally once daily with food.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

[1] NS5A inhibitor regimens includes ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.

[2] NS3/4A protease inhibitor regimens includes simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.

If member meets all the requirements listed above, the medication will be approved for 8 weeks for treatment-naïve members with no cirrhosis or with compensated cirrhosis. If request is for treatment-experienced member, the medication will be approved for 8-16 weeks, see Appendix below.

For **reauthorization**:
1. Medication will not be reauthorized.

CareSource considers Mavyret (glecaprevir and pibrentasvir) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/22/2017	New policy for Mavyret created.
12/07/2017	Criterion of "life expectancy not less than one year due to non-liver related comorbidities" removed from criteria and added in a form of the note. Hepatitis B testing is no longer required.
12/21/2017	Fibrosis score requirement was removed.
05/01/2019	Coverage was adjusted for age; drug covered for members of 12 years of age and older.e was adjusted for age; drug covered for members of 12 years of age and older.
10/28/2019	Mavyret's contraindication updated (contraindicated for both moderate hepatic impairment (Child-Pugh B) and severe hepatic impairment (Child-Pugh C)). Duration of treatment for treatment-naïve members with compensated cirrhosis changed from 12 weeks in length to 8 weeks.
06/15/2020	Criteria changed to match other Hepatitis C Policies, which require viral load within 6 months prior and negative urine drug and alcohol screens for 3 consecutive months.
12/03/2021	Transferred policy to new template; Updated age requirements to include pediatric patients three years of age or older.

References:

1. Mavyret [Package insert]. North Chicago, IL: AbbVie Inc.; June 2021
2. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
3. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 04/01/2022
Revised date: 12/03/2021

Appendix: Treatment Duration for Mavyret for Treatment-Experienced Members Treatment Duration

		Treatment Duration	
HCV Genotype	**Member Previously Treated with a Regimen Containing:**	**No Cirrhosis**	**Compensated Cirrhosis (Child-Pugh A)**
1	An NS5A inhibitor[1] without prior treatment with an NS3/4A protease inhibitor	16 weeks	16 weeks
	An NS3/4A PI[2] without prior treatment with an NS5A inhibitor	12 weeks	12 weeks
1, 2, 4, 5 or 6	Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor	8 weeks	12 weeks
3	Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor	16 weeks	16 weeks

[1] NS5A inhibitor regimens included ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin

[2] NS3/4A protease inhibitor regimens included simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Mayzent (siponimod)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Mayzent was approved by the FDA in 2019 for the treatment of relapsing forms of multiple sclerosis (MS). MS is a chronic autoimmune disease of the central nervous system that disrupts communication in the brain and between the brain and body. Mayzent is a once-daily oral sphingosine-1-phosphate (S1P) receptor modulator with high affinity for S1P receptors 1 and 5. Several assessments must be done before starting Mayzent. For example, a cardiac evaluation is needed to determine if first dose observation will be required. Genotyping is required to determine the appropriate dosage.

Mayzent (siponimod) will be considered for coverage when the following criteria are met:

Multiple Sclerosis (MS)

For **initial** authorization:

1. Member is 18 years of age; AND
2. Medication must be prescribed by, or in consultation with, a neurologist; AND
3. Member has a documented diagnosis of a relapsing form of MS (i.e., clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease); AND
4. Member has tried and failed or is unable to try at least 1 preferred sphingosine-1-phosphate (S1P) receptor modulator; AND
5. The following baseline assessments have been completed (or are scheduled):
   a) A complete blood count (CBC)
   b) An ophthalmic evaluation
   c) Baseline liver function tests
   d) A cardiac evaluation by electrocardiogram (ECG) to determine if first-dose monitoring is required
   e) CYP2C9 genotype determination; AND
6. Member has not experienced any of the following in the past 6 months: Myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure; AND
7. Member does not have Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker; AND
8. Mayzent will not be used concomitantly with any other disease modifying drugs for MS.
9. **Dosage allowed/Quantity limit:**
   See prescribing information for titration details.
   Maintenance dose for CYP2C9 genotype *1/*1, *1/*2, or *2/*2 = 2 mg orally once daily.
   Maintenance dose for CYP2C9 genotype *1/*3 or *2/*3 = 1 mg orally once daily.
   Note: Use in patients with CYP2C9*3/*3 genotype is contraindicated.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as slowed disability progression or fewer relapses.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Mayzent (siponimod) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/07/2019	New policy created for Mayzent.
10/11/2021	Transferred to new template. General changes to language for consistency with related drugs. Updated references. Added trial of preferred alternative. PML education removed. QTc and anti-arrhythmic drug exclusions removed. Added baseline LFT. Added note about *3/*3 genotype. Added concurrent use restriction. Added renewal criteria.

References:

1. Mayzent [package insert]. East Hanover, New Jersey: Novartis Pharmaceuticals Corporation, 2021.
2. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology [published correction appears in Neurology. 2019 Jan 8;92(2):112]. *Neurology*. 2018;90(17):777-788. doi:10.1212/WNL.0000000000005347
3. National Multiple Sclerosis Society. The Use of Disease-Modifying Therapies in Multiple Sclerosis: Principles and Current Evidence. A Consensus Paper by the Multiple Sclerosis Coalition; 2019. Available from: https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/DMT_Consensus_MS_Coalition.pdf. Accessed August 18, 2021.
4. Thompson AJ, Banwell BL, Barkhof F, et al. Diagnosis of multiple sclerosis: 2017 revisions of the McDonald criteria. *Lancet Neurol*. 2018;17(2):162-173. doi:10.1016/S1474-4422(17)30470-2
5. Roy R, Alotaibi AA, Freedman MS. Sphingosine 1-Phosphate Receptor Modulators for Multiple Sclerosis. *CNS Drugs*. 2021;35(4):385-402. doi:10.1007/s40263-021-00798-w

Effective date: 04/01/2022
Revised date: 10/11/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Mepsevii (vestronidase alfa-vjbk)
BILLING CODE	J3397
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Mepsevii is an enzyme replacement therapy (ERT) that was approved by the FDA in 2017 for the treatment of Sly Syndrome, also known as mucopolysaccharidosis type VII (MPS VII). MPS VII is a very rare, progressive inborn error of metabolism. Mutations of the GUSB gene cause deficiency of the enzyme beta glucuronidase. Normally this lysosomal enzyme breaks down glycosaminoglycans (GAGs) (previously known as mucopolysaccharides) but when reduced in MPS VII, the GAG substrates heparan sulfate (HS), dermatan sulfate (DS), and chondroitin sulfate (CS) accumulate throughout the body causing cellular and organ dysfunction. A distinguishing clinical feature of MPS VII is the presence of hydrops fetalis (excess accumulation of fluids in the body) in severe phenotypes.

Mepsevii (vestronidase alfa-vjbk) will be considered for coverage when the following criteria are met:

Sly Syndrome (Mucopolysaccharidosis VII or MPS VII)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a geneticist, metabolic specialist, or pediatrician experienced with managing mucopolysaccharidoses; AND
2. Member has a diagnosis of MPS VII confirmed by at least one of the following:
   a) Low beta-glucuronidase (GUS) enzyme activity, and/or
   b) Molecular genetic testing reveals pathogenic mutation of the GUSB gene; AND
3. Member has elevated urinary glycosaminoglycan (uGAG) excretion at a minimum of 2-fold over the mean normal for age.
4. **Dosage allowed/Quantity limit:** 4 mg/kg administered by intravenous infusion every two weeks

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show reduced uGAG excretion level; AND
2. Improvement or stabilization of at least one of the following compared to baseline: six-minute walk test (6MWT), forced vital capacity (FVC), motor function, visual acuity, hepatosplenomegaly, or fatigue.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Mepsevii (vestronidase alfa-vjbk) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
09/13/2018	New policy for Mepsevii created.
07/27/2021	Transferred to new template. Updated J code. Added home and office to sites of service. Updated references. Added specialist requirement. Clarified diagnosis requirement. Removed baseline multi domain testing. Changed initial approval duration from 12 months to 6 months. Edited renewal criteria to reflect efficacy results from clinical trials. Removed bone marrow/stem cell transplant exclusion.

References:

1. Mepsevii [package insert]. Novato, CA: Ultragenyx Pharmaceutical Inc.; Revised 12/2020.
2. Harmatz P, et al. A novel Blind Start study design to investigate vestronidase alfa for mucopolysaccharidosis VII, an ultra-rare genetic disease. Mol Genet Metab. 2018 Apr;123(4):488-494.
3. Wang RY, da Silva Franco JF, López-Valdez J, et al. The long-term safety and efficacy of vestronidase alfa, rhGUS enzyme replacement therapy, in subjects with mucopolysaccharidosis VII [published correction appears in Mol Genet Metab. 2020 Sep - Oct;131(1-2):285]. *Mol Genet Metab*. 2020;129(3):219-227. doi:10.1016/j.ymgme.2020.01.003
4. Lehman TJ, Miller N, Norquist B, Underhill L, Keutzer J. Diagnosis of the mucopolysaccharidoses. *Rheumatology (Oxford)*. 2011;50 Suppl 5:v41-v48. doi:10.1093/rheumatology/ker390
5. McCafferty EH, Scott LJ. Vestronidase Alfa: A Review in Mucopolysaccharidosis VII [published correction appears in BioDrugs. 2019 Apr 16;:]. *BioDrugs*. 2019;33(2):233-240. doi:10.1007/s40259-019-00344-7
6. Montaño AM, Lock-Hock N, Steiner RD, et al. Clinical course of sly syndrome (mucopolysaccharidosis type VII). *J Med Genet*. 2016;53(6):403-418. doi:10.1136/jmedgenet-2015-103322

Effective date: 01/01/2022
Revised date: 07/27/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Monovisc (sodium hyaluronate)
BILLING CODE	J7327
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 1 injection (1 unit)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Monovisc (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
8. **Dosage allowed:** Inject 88 mg (4 mL) once.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Monovisc (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Monovisc created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.

References:

1. Monovisc [package insert]. Bedford, MA; Anika Therapuetics; 2013.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Monovisc. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
11. Monovisc. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
12. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Mulpleta (lusutrombopag)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Promacta and Doptelet QUANTITY LIMIT— 7 tablets
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Mulpleta (lusutrombopag) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

THROMBOCYTOPENIA (with chronic liver disease)

For **initial** authorization:

1. Member is 18 years of age or older with diagnosis of thrombocytopenia with chronic liver disease and is scheduled to undergo a procedure; AND
2. Medication must be prescribed by or in consultation with a hematologist; AND
3. Member's platelet count is < $50x10^9$/L; AND
4. Member does **not** have ANY of the following:
   a) Thrombosis;
   b) Hematologic disorders;
   c) Significant cardiovascular disease;
   d) History of any of the following: splenectomy, liver transplantation, portal vein embolism or thrombosis, HIV, congenital or acquired thrombotic disease, Budd Chiari syndrome, coagulation factor deficiency or von Willebrand factor deficiency;
   e) Blood transfusion within 14 days;
   f) Any of the following drugs or therapies within 90 days: anticancer drugs, interferon preparations, radiation therapy, exsanguination, other thrombopoietin receptor agonist, any investigational agent;
   g) Pregnancy or lactation.
5. **Dosage allowed:** 3 mg once daily for 7 days. Begin Mulpleta dosing 8-14 days prior to a scheduled procedure. Member should undergo their procedure 2-8 days after the last dose.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:

1. Mulpleta will not be reauthorized.

CareSource considers Mulpleta (lusutrombopag) not medically necessary for the treatment of the following disease states based on a lack of robust clinical

controlled trials showing superior efficacy compared to currently available treatments:

- Thrombocytopenia due to Myelodysplastic syndrome (MDS)
- Hematopoietic tumor
- Aplastic anemia
- Myelofibrosis
- Congenital thrombocytopenia
- Drug-induced thrombocytopenia
- Generalized infection requiring treatment except for viral liver disease
- Immune thrombocytopenia

DATE	ACTION/DESCRIPTION
07/24/2019	New policy for Mulpleta created.
11/17/2021	Annual review, no changes

References:

1. Mulpleta [prescribing information]. Florham Park, NJ: Shionogi Inc.; May, 2019.
2. Terrault et al. Avatrombopag Before Procedures Reduces Need for Platelet Transfusion in Patients With Chronic Liver Disease and Thrombocytopenia. Gastroenterology 2018;155:705–718.
3. ClinicalTrials.gov. Identifier: NCT02389621. Safety and Efficacy Study of Lusutrombopag for Thrombocytopenia in Patients With Chronic Liver Disease Undergoing Elective Invasive Procedures (L-PLUS 2). Available at: https://clinicaltrials.gov/ct2/show/NCT02389621?term=lusutrombopag&rank=1.
4. ClinicalTrials.gov. Identifier: NCT01129024. An Open-label Safety Study of S-888711. Available at: https://clinicaltrials.gov/ct2/show/NCT01129024?term=lusutrombopag&rank=2.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Myalept (metreleptin)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Metreleptin was approved in 2014 to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. The defining feature of lipodystrophy is the selective loss of subcutaneous adipose tissue. Leptin is a hormone secreted by adipose tissue that informs the brain of the status of energy stores in the body. The leptin deficiency resulting from adipose tissue loss contributes to metabolic abnormalities. The replacement of leptin with metreleptin, which mimics native leptin, helps improve metabolic parameters. It must be used as an adjunct to diet, the fundamental treatment for lipodystrophy. It is only available through the Myalept REMS program.

Myalept (metreleptin) will be considered for coverage when the following criteria are met:

Lipodystrophy

For **initial** authorization:

1. Medication must be prescribed by or in consultation with an endocrinologist; AND
2. Member has a diagnosis of congenital or acquired generalized lipodystrophy (CGL or AGL); AND
3. Member has a metabolic abnormality (e.g. diabetes, hypertriglyceridemia, insulin resistance) that has not responded to optimized standard therapy (e.g. metformin, insulin, statins, fibrates);[4] AND
4. Member has failed dietary/lifestyle modifications and medication is prescribed in conjunction with ongoing diet management; AND
5. Member does not have any of the following:
   a) HIV-associated lipodystrophy;
   b) General obesity (without leptin deficiency).
6. **Dosage allowed/Quantity limit:** See package insert for adult and pediatric dosing charts. Max 10mg/day (2mL).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Initial criteria must be met, including continued diet management; AND
2. Chart notes must demonstrate improved signs and symptoms of leptin deficiency, such as reductions in HbA1c, fasting glucose, or triglycerides.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Myalept (metreleptin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
01/08/2021	New policy for Myalept created.

References:

1. Myalept (metreleptin) [package insert]. Dublin, Ireland: Amryt Pharmaceuticals DAC; 2020.
2. Brown RJ, Araujo-Vilar D, Cheung PT, et al. The Diagnosis and Management of Lipodystrophy Syndromes: A Multi-Society Practice Guideline. *J Clin Endocrinol Metab*. 2016;101(12):4500-4511. doi:10.1210/jc.2016-2466
3. Handelsman Y, Oral EA, Bloomgarden ZT, et al. The clinical approach to the detection of lipodystrophy - an AACE consensus statement. *Endocr Pract*. 2013;19(1):107-116. doi:10.4158/endp.19.1.v767575m65p5mr06
4. Meehan CA, Cochran E, Kassai A, Brown RJ, Gorden P. Metreleptin for injection to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. *Expert Rev Clin Pharmacol*. 2016;9(1):59-68. doi:10.1586/17512433.2016.1096772
5. Araújo-Vilar D, Santini F. Diagnosis and treatment of lipodystrophy: a step-by-step approach. *J Endocrinol Invest*. 2019;42(1):61-73. doi:10.1007/s40618-018-0887-z

Effective date: 01/01/2022
Revised date: 01/08/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Mycapssa (octreotide)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 120 capsules per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Mycapssa (octreotide) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACROMEGALY

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has a confirmed diagnosis of acromegaly; AND
4. Member had an inadequate response to surgery or surgery is not an option (documentation required); AND
5. Member has been stabilized on injectable octreotide (preferred) or lanreotide (non-preferred) for at least 3 months, with insulin-like growth factor (IGF-1) lab results demonstrating response to treatment; AND
6. Member has documented rationale for why it is medically necessary to switch to the oral formulation of octreotide (e.g. injection site reactions, ongoing symptoms despite biochemical control).
7. **Dosage allowed:** Initiate at 40mg per day, given as 20mg twice daily. Titrate in 20mg increments, based on IGF-1 levels. Max dose of 80mg per day, given as 40mg twice daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes/lab report must show maintained or normalized IGF-1.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Mycapssa (octreotide) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/19/2020	New policy for Mycapssa created.
03/11/2021	Annual review, no changes

References:

1. Mycapssa (octreotide) [package insert]. Needham, MA: Chiasma, Inc.; 2020.
2. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2014;99(11):3933-3951. doi:10.1210/jc.2014-2700
3. Melmed S, Bronstein MD, Chanson P, et al. A Consensus Statement on acromegaly therapeutic outcomes. *Nature Reviews Endocrinology*. 2018;14(9):552-561. doi:10.1038/s41574-018-0058-5
4. Melmed S, Popovic V, Bidlingmaier M, et al. Safety and efficacy of oral octreotide in acromegaly: results of a multicenter phase III trial [published correction appears in J Clin Endocrinol Metab. 2016 Oct;101(10):3863]. *J Clin Endocrinol Metab*. 2015;100(4):1699-1708. doi:10.1210/jc.2014-4113
5. Samson SL, Nachtigall LB, Fleseriu M, et al. Maintenance of Acromegaly Control in Patients Switching From Injectable Somatostatin Receptor Ligands to Oral Octreotide. *J Clin Endocrinol Metab*. 2020;105(10):dgaa526. doi:10.1210/clinem/dgaa526
6. Zahr R, Fleseriu M. Updates in Diagnosis and Treatment of Acromegaly. *Eur Endocrinol*. 2018;14(2):57-61. doi:10.17925/EE.2018.14.2.57
7. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary*. October 2020. doi:10.1007/s11102-020-01091-7

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Myfembree (relugolix, estradiol, and norethindrone acetate)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Myfembree is a fixed-dose combination of relugolix 40 mg, estradiol 1 mg, and norethindrone acetate 0.5 mg indicated for the management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women. Relugolix is a GnRH receptor antagonist. The addition of the estradiol component may reduce the extent of bone loss from the decreased estrogen concentration resulting from relugolix. The purpose of the norethindrone component is to protect from potential adverse effects of unopposed estrogen. The use of Myfembree must not exceed 24 months due to the risk of bone loss. Myfembree was approved in 2021 and will directly compete with Oriahnn (elagolix, estradiol, norethindrone) which is also an oral GnRH antagonist. Although a head-to-head trial has not been done, there appears to be limited clinical differentiation between the two products. An advantage of Myfembree is that it is taken once daily rather than twice daily.

Myfembree (relugolix, estradiol, and norethindrone acetate) will be considered for coverage when the following criteria are met:

Uterine Fibroids

For **initial** authorization:

1. Member is a premenopausal female at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an OB/GYN; AND
3. Member has a documented diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); AND
4. Member has had no less than a 90-day trial and failure of at least one of the following: Oral contraceptive, levonorgestrel-releasing intrauterine device (IUD), or tranexamic acid; AND
5. Member does not have ANY of the following:
   a) Pregnancy or plan to become pregnant during treatment
   b) Osteoporosis
   c) History or high risk of thrombotic or thromboembolic disorders
   d) Current or history of breast cancer or other hormone-sensitive malignancies.
6. **Dosage allowed/Quantity limit:** 1 tablet once daily (28 tablets per 28 days)

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes must show reduction in menstrual blood loss volume and/or an improvement in hemoglobin level and/or significantly reduced fibroid-related pain.

If all the above requirements are met, the medication will be approved for an additional 12 months. **TOTAL DURATION OF THERAPY NOT TO EXCEED 24 MONTHS**.

CareSource considers Myfembree (relugolix, estradiol, and norethindrone acetate) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/10/2021	New policy for Myfembree created.

References:

1. Myfembree [package insert]. Brisbane, CA: Myovant Sciences, Inc; 2021.
2. Al-Hendy A, Lukes AS, Poindexter AN 3rd, et al. Treatment of Uterine Fibroid Symptoms with Relugolix Combination Therapy. *N Engl J Med*. 2021;384(7):630-642. doi:10.1056/NEJMoa2008283
3. De La Cruz MS, Buchanan EM. Uterine Fibroids: Diagnosis and Treatment. *Am Fam Physician*. 2017;95(2):100-107.
4. Stewart, EA. Uterine fibroids (leiomyomas): Treatment overview. *UpToDate*. Updated August 6, 2021. Accessed August 12, 2021.
5. Vilos GA, Allaire C, Laberge PY, Leyland N; SPECIAL CONTRIBUTORS. The management of uterine leiomyomas. *J Obstet Gynaecol Can*. 2015;37(2):157-178. doi:10.1016/S1701-2163(15)30338-8

Effective date: 01/01/2022
Revised date: 08/10/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Myobloc (rimabotulinumtoxinB)
BILLING CODE	J0587
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office, Outpatient
STATUS	Prior Authorization Required

Myobloc is a neurotoxin produced from Clostridium botulinum. Myobloc works through the inhibition of acetylcholine release from peripheral nerve endings, causing neuromuscular blockage and muscle paralysis. It is the first and only botulinum toxin type B.
Myobloc was initially approved by the FDA in 2000 for the treatment of adults with cervical dystonia. Cervical dystonia (also known as spasmodic torticollis) involves the involuntary contractions of the neck that cause abnormal movements and postures of the neck and head.
Chronic sialorrhea, or excessive drooling, is a common symptom for patients with Parkinson's Disease or other neurological or cognitive impairments. Multicenter, double-blind, placebo-controlled trials displayed a decrease in salivary production and improvement in symptoms from baseline.

Myobloc (rimabotulinumtoxinB) will be considered for coverage when the following criteria are met:

CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS)

For **initial** authorization:
1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or other specialist experienced with treating cervical dystonia; AND
3. Member has a documented diagnosis of moderate to severe cervical dystonia as evidenced by involuntary contractions of neck muscles, leading to abnormal movements or postures; AND
4. Symptoms affect quality of life and daily functions.
5. **Dosage allowed:** Up to 5000 or 10,000 units every 12 to 16 weeks, divided among affected muscles.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. severity of abnormal head position, neck pain).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CHRONIC SIALORRHEA

For **initial** authorization:
1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has diagnosis of chronic sialorrhea impacting quality of life for at least 3 months; AND
4. Member has tried and failed or has a contraindication to at least one anticholinergic drug (e.g. scopolamine, benztropine, glycopyrrolate, amitriptyline).
5. **Dosage allowed:** 1,500 Units to 3,500 Units, divided among the parotid and submandibular glands, every 3 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes have been provided that show the member has improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Myobloc (rimabotulinumtoxinB) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/06/2018	New policy for Myobloc created. Age requirement removed. Criterion “no infection at proposed injection site” removed from Cervical Dystonia diagnosis. Age limitation removed from Cervical Dystonia; pain and abnormal head position requirements clarified and medications trial added.
06/09/2020	Added new diagnosis of chronic sialorrhea and its criteria.
08/17/2020	Cervical Dystonia: Added age limit and specialist requirement. Re-worded the diagnosis requirement. Removed trial of oral medication. Removed exclusions. Corrected the dose. Extended re-auth duration. Updated references.
01/04/2021	For sialorrhea, changed try 2 anticholinergics to try 1 anticholinergic. Added a reference.
08/10/2021	Transferred to new template. Allowing additional specialists for cervical dystonia indication.

References:

1. Myobloc [package insert]. San Francisco, CA: Solstice Neurosciences, Inc.; October 2019.
2. Isaacson S, Ondo W, Jackson C, et al. Safety and Efficacy of RimabotulinumtoxinB for Treatment of Sialorrhea in Adults. *JAMA Neurology.* 2020;77(4), 461. https://pubmed.ncbi.nlm.nih.gov/31930364/?dopt=Abstract.
3. Dashtipour K, Bhidayasiri, R, Chen J, et al. RimabotulinumtoxinB in sialorrhea: systematic review of clinical trials. *Journal of Clinical Movement Disorders.* 2017;4(1). https://clinicalmovementdisorders.biomedcentral.com/track/pdf/10.1186/s40734-017-0055-1.
4. Cervical Dystonia. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/cervical-dystonia/. Published July 19, 2019. Accessed July 17, 2020.
5. Simpson DM, Hallett M, Ashman EJ, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache. *Neurology*. 2016;86(19):1818-1826. doi:10.1212/wnl.0000000000002560
6. Dressler D, Altenmueller E, Bhidayasiri R, et al. Strategies for treatment of dystonia. *Journal of Neural Transmission*. 2015;123(3):251-258. doi:10.1007/s00702-015-1453-x
7. Seppi K, Chaudhuri KR, Coelho M, et al. Update on treatments for nonmotor symptoms of Parkinson's disease—an evidence-based medicine review. *Movement Disorders*. 2019;34(2):180-198. doi:10.1002/mds.27602

Effective date: 01/01/2022
Revised date: 08/10/2021

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Naglazyme (galsulfase)
BILLING CODE	J1458
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Naglazyme is an enzyme replacement therapy that was approved by the FDA in 2005 for treating Mucopolysaccharidosis VI, also known as MPS VI or Maroteaux-Lamy syndrome. MPS VI is a rare, genetic lysosomal storage disease. Pathogenic mutations of the ARSB gene cause the enzyme arylsulfatase B (ASB) (also known as N-acetylgalactosamine-4-sulfatase) to be deficient or absent. Usually this lysosomal enzyme breaks down glycosaminoglycans (GAGs) (previously known as mucopolysaccharides) but when it is reduced in MPS VI, the GAG substrate dermatan sulfate accumulates throughout the body to cause progressive multi-systemic damage and dysfunction. Clinically, Naglazyme has been shown to improve walking and stair-climbing capacity.

Naglazyme (galsulfase) will be considered for coverage when the following criteria are met:

Mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a geneticist, metabolic specialist, or pediatrician experienced with managing mucopolysaccharidoses; AND
2. Member has a diagnosis of MPS VI confirmed by at least one of the following:
   a) ASB enzyme activity is less than 10% of the lower limit of normal AND activity of a second sulfatase is normal (to exclude Multiple Sulfatase Deficiency), and/or
   b) Molecular genetic analysis identifying mutations of the ARSB gene; AND
3. Chart notes must include baseline urinary GAG (uGAG) levels showing elevated dermatan sulfate.
4. **Dosage allowed/Quantity limit:** 1 mg/kg once weekly as an IV infusion

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as improved endurance (e.g. walk test or stair climb) and/or reduced uGAG levels.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Naglazyme (galsulfase) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/09/2021	New policy for Naglazyme created.

References:

1. Naglazyme [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; 2019.
2. Wood T, Bodamer OA, Burin MG, et al. Expert recommendations for the laboratory diagnosis of MPS VI. *Mol Genet Metab*. 2012;106(1):73-82. doi:10.1016/j.ymgme.2012.02.005
3. Akyol MU, Alden TD, Amartino H, et al. Recommendations for the management of MPS VI: systematic evidence- and consensus-based guidance. *Orphanet J Rare Dis*. 2019;14(1):118. Published 2019 May 29. doi:10.1186/s13023-019-1080-y
4. Giugliani R, Harmatz P, Wraith JE. Management guidelines for mucopolysaccharidosis VI. *Pediatrics*. 2007;120(2):405-418. doi:10.1542/peds.2006-2184
5. Brunelli MJ, Atallah ÁN, da Silva EM. Enzyme replacement therapy with galsulfase for mucopolysaccharidosis type VI. *Cochrane Database Syst Rev*. 2016;3:CD009806. Published 2016 Mar 4. doi:10.1002/14651858.CD009806.pub2
6. Harmatz PR, Lampe C, Parini R, et al. Enzyme replacement therapy outcomes across the disease spectrum: Findings from the mucopolysaccharidosis VI Clinical Surveillance Program. *J Inherit Metab Dis*. 2019;42(3):519-526. doi:10.1002/jimd.12079
7. Harmatz P, Shediac R. Mucopolysaccharidosis VI: pathophysiology, diagnosis and treatment. *Front Biosci (Landmark Ed)*. 2017;22:385-406. Published 2017 Jan 1. doi:10.2741/4490

Effective date: 01/01/2022
Revised date: 07/09/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Neulasta (Pegfilgrastim), Neulasta Onpro (Pegfilgrastim on-body injector)
BILLING CODE	For medical - J2505 (1 unit = 6 mg) For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 2 units per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Neulasta (Pegfilgrastim), Neulasta Onpro (Pegfilgrastim on-body injector) are **preferred** products and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME

For **initial** authorization:

1. Medication is prescribed by physician with expertise in treating acute radiation syndrome; AND
2. Documentation of member's suspected or confirmed exposure to radiation levels greater than 2 gray (Gy).
3. **Dosage allowed:** Two doses, 6 mg each, administered one week apart.

If member meets all the requirements listed above, the medication will be approved for 14 days.

For **reauthorization**:

1. Neulasta will not be reauthorized for the same radiation phase after 2 allowed doses. If another round of radiation therapy is needed in the future, the initial authorization criteria will be applied.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:

1. Member has a non-myeloid malignancy; AND
2. Medication will not be administered less than 14 days before OR less than 24 hours after chemotherapy; AND
3. Member has a documented history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
4. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (> 20%, see Appendix for description) for incidence of febrile neutropenia; OR
5. Member is receiving myelosuppressive anti-cancer drugs associated with an intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;

c) Bone marrow involvement with tumor;
d) Recent surgery and/or open wounds;
e) Liver dysfunction (bilirubin > 2.0);
f) Renal dysfunction (creatinine clearance < 50);
g) Age >65 years receiving full chemotherapy dose intensity.

6. **Dosage allowed:** Up to 6 mg per chemotherapy cycle, beginning at least 24 hours after completion of chemotherapy.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Neulasta (Pegfilgrastim) and Neulasta Onpro (Pegfilgrastim on-body injector) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplant

DATE	ACTION/DESCRIPTION
10/19/2017	New Neulasta policy created. Age limits and degree of hematotoxicity were removed; radiation exposure level requirement was decreased. Criteria coverage for Prevention of Febrile Neutropenia was expanded. Chemotherapy regimens with high and intermediate risk of febrile neutropenia were added to the policy's appendix. Not covered diagnosis was added.
2/19/2020	Policy updated to include coverage under pharmacy benefit and requirement for chart notes detailing chemotherapy regimen cycle removed.
3/11/2021	Annual review, no changes

References:

1. Neulasta [package insert]. Thousand Oaks, CA: Amgen Inc; 2016. Accessed March 15, 2017.
2. Neulasta. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed March 15, 2017.
3. Neulasta. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 15, 2017.
4. National Comprehensive Cancer Network. (2016). NCCN Drugs & Biologics Compendium™. Pegfilgrastim. Retrieved November 22, 2016 from the National Comprehensive Cancer Network.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (> 20%)

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) (neoadjuvant, adjuvant, metastatic)
Breast Cancer	Docetaxel + trastuzumab (metastatic or relapsed)
	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel) (adjuvant)
	TAC (docetaxel, doxorubicin, cyclophosphamide) (adjuvant)
Esophageal and Gastric Cancers	Docetaxel/cisplatin/fluorouracil
Hodgkin Lymphoma	BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	ICE (ifosfamide, carboplatin, etoposide) (diffuse large B-cell lymphoma [DLBCL], peripheral T-cell lymphomas [PTCL], 2nd line)
	RICE (rituximab, ifosfamide, carboplatin, etoposide)
	CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone) + rituximab
	MINE (mesna, ifosfamide, novantrone, etoposide) (DLBCL, 2nd line, refractory)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine (Ara-C)) (DLBCL, PTCL, 2nd line, recurrent)
	HyperCVAD + rituximab (cyclophosphamide, vincristine, doxorubicin, dexamethasone + rituximab)
Melanoma	Dacarbazine-based combination (dacarbazine, cisplatin, vinblastine) (advanced, metastatic, or recurrent)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha) (advanced, metastatic, or recurrent)
Ovarian Cancer	Topotecan
	Paclitaxel
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)
	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	Topotecan
Testicular Cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	BEP (bleomycin, etoposide, cisplatin)

	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% to 19%)

Cancer Type	Regimen
Occult Primary Adenocarcinoma	Gemcitabine/docetaxel
Breast Cancer	Docetaxel every 21 days
	CMF classic (cyclophosphamide, methotrexate, fluorouracil) (adjuvant)
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (adjuvant) (taxane portion only)
	AC + sequential docetaxel + trastuzumab (adjuvant)
	FEC (fluorouracil, epirubicin, cyclophosphamide) + sequential docetaxel
	TC (docetaxel, cyclophosphamide)
Cervical Cancer	Cisplatin/topotecan (recurrent or metastatic)
	Paclitaxel/cisplatin
	Topotecan (recurrent or metastatic)
	Irinotecan (recurrent or metastatic)
Colorectal Cancer	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Multiple Myeloma	DT-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophosphamide/etoposide)
	DT-PACE + bortezomib (VTD-PACE)
Non-Hodgkin's Lymphoma	EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) (AIDS-related NHL, Burkitt lymphoma, recurrent, other NHL subtypes)
	EPOCH-IT chemotherapy (AIDS-related NHL, DLBCL, recurrent)
	GDP (gemcitabine, dexamethasone, cisplatin) (DLBCL, PTCL, 2nd line)
	GDP (gemcitabine, dexamethasone, cisplatin) + rituximab (DLBCL, 2nd line, Burkitt lymphoma, other NHL subtypes)
	FMR (fludarabine, mitoxantrone, rituximab)
	CHOP + rituximab (cyclophosphamide, doxorubicin, vincristine, prednisone, rituximab) including regimens with pegylated liposomal doxorubicin or mitoxantrone substituted for doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel (advanced/metastatic)
	Cisplatin/vinorelbine (adjuvant, advanced/metastatic)
	Cisplatin/docetaxel (adjuvant, advanced/metastatic)
	Cisplatin/etoposide (adjuvant, advanced/metastatic)

	Carboplatin/paclitaxel (adjuvant, advanced/metastatic)
	Docetaxel (advanced/metastatic)
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX
Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
Uterine Sarcoma	Docetaxel (advanced or metastatic)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Neupogen (Filgrastim)
BILLING CODE	For medical - J1442 For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Zarxio QUANTITY LIMIT— N/A
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Neupogen (Filgrastim) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE MYELOID LEUKEMIA (AML)

For **initial** authorization:

1. Member has diagnosis of AML documented in chart notes; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being used to reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy treatment; AND
4. Medication is being administered 24 hours after the last dose of chemotherapy until neutrophil recovery (ANC ≥ 1000/mm^3 for 3 consecutive days or ≥ 10,000/mm^3 for 1 day) or for a maximum of 35 days.
5. **Dosage allowed:** 5 mcg/kg/day subcutaneous injection, short intravenous infusion (15 to 30 minutes), or continuous intravenous infusion.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS BONE MARROW TRANSPLANT (BMT)

For **initial** authorization:

1. Member has diagnosis of non-myeloid malignancy and is undergoing myeloablative chemotherapy followed by autologous BMT; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being used to reduce duration of neutropenia following autologous BMT.
4. **Dosage allowed:** 10 mcg/kg/day beginning at least 24 hours after cytotoxic chemotherapy and 24 hours after bone marrow infusion.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL (PBPC) MOBILIZATION

For **initial** authorization:
1. Medication is being used to mobilize autologous peripheral blood progenitor cells for collection by leukapheresis; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being administered for at least 4 days before first leukapheresis and continued until the last leukapheresis (until a sustainable ANC (≥ 1000/mm^3) is reached).
4. **Dosage allowed:** 10 mcg/kg/day subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME

For **initial** authorization:
1. Medication is prescribed by physician with expertise in treating acute radiation syndrome; AND
2. Documentation of member's suspected or confirmed exposure to radiation levels greater than 2 gray (Gy).
3. **Dosage allowed:** 10 mcg/kg/day subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 14 days.

For **reauthorization**:
1. Neupogen will not be reauthorized for the same radiation phase. If another round of radiation therapy needed in the future, the initial authorization criteria will be applied.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:
1. Member must have tried and failed treatment with Zarxio; AND
2. Member has a non-myeloid malignancy; AND
3. Medication will not be administered within 24 hours before or after chemotherapy; AND
4. Member has a documented history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
5. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (> 20%, see Appendix for description) for incidence of febrile neutropenia; OR

6. Member is receiving myelosuppressive anti-cancer drugs associated with an intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Bone marrow involvement with tumor;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (bilirubin > 2.0);
   f) Renal dysfunction (creatinine clearance < 50);
   g) Age > 65 years receiving full chemotherapy dose intensity.
7. **Dosage allowed:** 5 mcg/kg per day.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SEVERE CHRONIC NEUTROPENIA (SCN)

For **initial** authorization:
1. Member must have tried and failed treatment with Zarxio; AND
2. Member has a history of SCN (i.e. congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia) with chart notes confirming **both** of the following:
   a) Absolute neutrophil count (ANC) < 500/mm^3 on three occasions during a 6 month period (or for cyclic neutropenia 5 consecutive days of ANC < 500/mm^3 per cycle); AND
   b) Member must have experienced a clinically significant infection during the previous 12 months.
3. **Dosage allowed:** Idiopathic neutropenia: 3.6 mcg/kg/day; Cyclic neutropenia: 6 mcg/kg/day; Congenital neutropenia: 6 mcg/kg/day divided 2 times per day.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Neupogen (Filgrastim) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Agranulocytosis
- AIDS - Neutropenia
- Aplastic anemia
- Febrile neutropenia, In myeloid malignancies following bone marrow transplant - Prophylaxis
- Infectious disease - Prophylaxis
- Leukemia

- Myelodysplastic syndrome
- Neutropenia - Pre-eclampsia

DATE	ACTION/DESCRIPTION
10/19/2017	New policy for Neupogen created. Age limits and degree of hematotoxicity were removed; radiation exposure level requirement was decreased. Criteria coverage for Prevention of Febrile Neutropenia was expanded. Chemotherapy regimens with high and intermediate risk of febrile neutropenia were added to the policy's appendix. Length of therapy of preferred trial agent was deleted. List of not covered diagnoses was added.
2/19/2020	Requirement for chart notes detailing chemotherapy regimen cycle removed.
3/11/2021	Annual review, no changes

References:

1. Myeloid Cytokines for Acute Exposure to Myelosuppressive Doses of Radiation (Hematopoietic Subsyndrome of ARS). US Department of Health &Human Services. https://www.remm.nlm.gov/Cytokine.pdf.
2. Neupogen (filgrastim) [prescribing information]. Thousand Oaks, CA: Amgen; July 2015.
3. Radiation Emergency Medical Management. Myeloid cytokines for acute exposure to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). U.S. Department of Health and Human Services. Available from https://www.remm.nlm.gov/cytokines.htm. Updated February 22, 2017. Accessed July 27, 2017.
4. Schmitz N, Linch DC. Randomised trial of filgrastim-mobilized peripheral blood progenitor cell transplantation versus autologous bone-marrow transplantation in lymphoma patients. Lancet. 1996;347(8998): 353-358. Doi: 10.1016/S0140-6736(96)90536-X.
5. Crawford J, Becker PS, Armitage JO, et al. Myeloid growth factors. NCCN Clinical Practice Guidelines in Oncology. Available from www.nccn.org. Published April 28, 2017. Accessed July 27, 2017.
6. Filgrastim. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 15, 2017.

Effective date: 01/01/2022
Revised date: 03/11/2021

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (> 20%)

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) (neoadjuvant, adjuvant, metastatic)
Breast Cancer	Docetaxel + trastuzumab (metastatic or relapsed)
	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel) (adjuvant)
	TAC (docetaxel, doxorubicin, cyclophosphamide) (adjuvant)
Esophageal and Gastric Cancers	Docetaxel/cisplatin/fluorouracil
Hodgkin Lymphoma	BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	ICE (ifosfamide, carboplatin, etoposide) (diffuse large B-cell lymphoma [DLBCL], peripheral T-cell lymphomas [PTCL], 2nd line)
	RICE (rituximab, ifosfamide, carboplatin, etoposide)
	CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone) + rituximab
	MINE (mesna, ifosfamide, novantrone, etoposide) (DLBCL, 2nd line, refractory)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine (Ara-C)) (DLBCL, PTCL, 2nd line, recurrent)
	HyperCVAD + rituximab (cyclophosphamide, vincristine, doxorubicin, dexamethasone + rituximab)
Melanoma	Dacarbazine-based combination (dacarbazine, cisplatin, vinblastine) (advanced, metastatic, or recurrent)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha) (advanced, metastatic, or recurrent)
Ovarian Cancer	Topotecan
	Paclitaxel
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)
	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	Topotecan
Testicular Cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)

	BEP (bleomycin, etoposide, cisplatin)
	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% to 19%)

Cancer Type	Regimen
Occult Primary Adenocarcinoma	Gemcitabine/docetaxel
Breast Cancer	Docetaxel every 21 days
	CMF classic (cyclophosphamide, methotrexate, fluorouracil) (adjuvant)
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (adjuvant) (taxane portion only)
	AC + sequential docetaxel + trastuzumab (adjuvant)
	FEC (fluorouracil, epirubicin, cyclophosphamide) + sequential docetaxel
	TC (docetaxel, cyclophosphamide)
Cervical Cancer	Cisplatin/topotecan (recurrent or metastatic)
	Paclitaxel/cisplatin
	Topotecan (recurrent or metastatic)
	Irinotecan (recurrent or metastatic)
Colorectal Cancer	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Multiple Myeloma	DT-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophosphamide/etoposide)
	DT-PACE + bortezomib (VTD-PACE)
Non-Hodgkin's Lymphoma	EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) (AIDS-related NHL, Burkitt lymphoma, recurrent, other NHL subtypes)
	EPOCH-IT chemotherapy (AIDS-related NHL, DLBCL, recurrent)
	GDP (gemcitabine, dexamethasone, cisplatin) (DLBCL, PTCL, 2nd line)
	GDP (gemcitabine, dexamethasone, cisplatin) + rituximab (DLBCL, 2nd line, Burkitt lymphoma, other NHL subtypes)
	FMR (fludarabine, mitoxantrone, rituximab)
	CHOP + rituximab (cyclophosphamide, doxorubicin, vincristine, prednisone, rituximab) including regimens with pegylated liposomal doxorubicin or mitoxantrone substituted for doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel (advanced/metastatic)
	Cisplatin/vinorelbine (adjuvant, advanced/metastatic)
	Cisplatin/docetaxel (adjuvant, advanced/metastatic)

	Cisplatin/etoposide (adjuvant, advanced/metastatic)
	Carboplatin/paclitaxel (adjuvant, advanced/metastatic)
	Docetaxel (advanced/metastatic)
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX
Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
Uterine Sarcoma	Docetaxel (advanced or metastatic)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Nexviazyme (avalglucosidase alfa-ngp)
BILLING CODE	J3490/J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Nexviazyme is an enzyme replacement therapy for the treatment of Pompe disease, also known as acid alpha-glucosidase (GAA) deficiency or glycogen storage disease type II. Pompe disease is a rare, genetic lysosomal storage disorder that results in the buildup of glycogen in cell lysosomes causing serious and life-threatening muscle damage and weakness. Nexviazyme provides an exogenous source of the deficient GAA enzyme to cleave glycogen and reduce its accumulation. In the COMET trial, Nexviazyme was found to be non-inferior to Lumizyme.
Pompe disease can be broadly classified as infantile-onset within the first few months of life (IOPD) or late-onset beyond infancy (LOPD). Classic IOPD is rapidly progressive with severe cardiomyopathy. Non-classic IOPD progresses slower with less severe cardiomyopathy. LOPD does not typically present with cardiomyopathy and has more variable symptoms, especially skeletal muscle weakness. Nexviazyme is only indicated to treat late-onset Pompe disease.

Nexviazyme (avalglucosidase alfa-ngp) will be considered for coverage when the following criteria are met:

Pompe disease (acid α-glucosidase [GAA] deficiency)

For **initial** authorization:
1. Member is at least 1 year of age; AND
2. Medication must be prescribed by or in consultation with a geneticist, neurologist, pulmonologist, or metabolic specialist; AND
3. Member has a diagnosis of late onset Pompe disease confirmed by an enzyme activity assay showing GAA deficiency (2% to 40% of normal); AND
4. Molecular genetic testing shows pathogenic mutation of the GAA gene; AND
5. Member must show signs or symptoms (i.e., motor weakness, reduced respiratory parameters).
6. **Dosage allowed/Quantity limit:**
   Actual body weight 30 kg or greater: 20 mg/kg every 2 weeks
   Actual body weight less than 30 kg: 40mg/kg every 2 weeks

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes must document positive clinical response such as improved or stabilized respiratory muscle strength (i.e., forced vital capacity (FVC)) or functional endurance (e.g., 6-minute walk test).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Nexviazyme (avalglucosidase alfa-ngp) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/20/2021	New policy for Nexviazyme created.

References:

1. Nexviazyme [package insert]. Genzyme Corporation; 2021.
2. Tarnopolsky M, Katzberg H, Petrof BJ, et al. Pompe Disease: Diagnosis and Management. Evidence-Based Guidelines from a Canadian Expert Panel. *Can J Neurol Sci*. 2016;43(4):472-485. doi:10.1017/cjn.2016.37
3. Burton BK, Kronn DF, Hwu WL, Kishnani PS; Pompe Disease Newborn Screening Working Group. The Initial Evaluation of Patients After Positive Newborn Screening: Recommended Algorithms Leading to a Confirmed Diagnosis of Pompe Disease. *Pediatrics*. 2017;140(Suppl 1):S14-S23. doi:10.1542/peds.2016-0280D
4. Kronn DF, Day-Salvatore D, Hwu WL, et al. Management of Confirmed Newborn-Screened Patients With Pompe Disease Across the Disease Spectrum. *Pediatrics*. 2017;140(Suppl 1):S24-S45. doi:10.1542/peds.2016-0280E
5. Study to Compare the Efficacy and Safety of Enzyme Replacement Therapies Avalglucosidase Alfa and Alglucosidase Alfa Administered Every Other Week in Patients With Late-onset Pompe Disease Who Have Not Been Previously Treated for Pompe Disease (COMET). ClinicalTrials.gov Identifier: NCT02782741. Updated April 8, 2021. Accessed August 23, 2021. https://clinicaltrials.gov/ct2/show/NCT02782741
6. van der Ploeg AT, Kruijshaar ME, Toscano A, et al. European consensus for starting and stopping enzyme replacement therapy in adult patients with Pompe disease: a 10-year experience. *Eur J Neurol*. 2017;24(6):768-e31. doi:10.1111/ene.13285
7. Wang RY, Bodamer OA, Watson MS, Wilcox WR; ACMG Work Group on Diagnostic Confirmation of Lysosomal Storage Diseases. Lysosomal storage diseases: diagnostic confirmation and management of presymptomatic individuals. *Genet Med*. 2011;13(5):457-484. doi:10.1097/GIM.0b013e318211a7e1
8. Cupler EJ, Berger KI, Leshner RT, et al. Consensus treatment recommendations for late-onset Pompe disease. *Muscle Nerve*. 2012;45(3):319-333. doi:10.1002/mus.22329
9. Kushlaf H, Attarian S, Borges JL, et al. Efficacy and Safety Results of the Avalglucosidase alfa Phase 3 COMET Trial in Late-Onset Pompe Disease Patients (4195). *Neurology*. 2021;96(15 Supplement). https://n.neurology.org/content/96/15_Supplement/4195/tab-article-info

Effective date: 01/01/2022
Revised date: 08/20/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Nivestym (filgrastim-aafi)
BILLING CODE	Must use a valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Zarxio QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Nivestym (filgrastim-aafi) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE MYELOID LEUKEMIA (AML)

For **initial** authorization:

1. Member has diagnosis of AML documented in chart notes; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being used to reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy treatment; AND
4. Medication is being administered 24 hours after the last dose of chemotherapy until neutrophil recovery (ANC ≥ 1000/mm^3 for 3 consecutive days or ≥ 10,000/mm^3 for 1 day) or for a maximum of 35 days; AND
5. Chart notes with the length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the days of the cycle on which Nivestym will be administered are submitted with the prior authorization request.
6. **Dosage allowed:** 5 mcg/kg/day subcutaneous injection, short intravenous infusion (15 to 30 minutes), or continuous intravenous infusion.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS BONE MARROW TRANSPLANT (BMT)

For **initial** authorization:

1. Member has diagnosis of non-myeloid malignancy and is undergoing myeloablative chemotherapy followed by autologous BMT; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being used to reduce duration of neutropenia following autologous BMT.

4. **Dosage allowed:** 10 mcg/kg/day beginning at least 24 hours after cytotoxic chemotherapy and 24 hours after bone marrow infusion.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL (PBPC) MOBILIZATION

For **initial** authorization:
1. Medication is being used to mobilize autologous peripheral blood progenitor cells for collection by leukapheresis; AND
2. Member must have tried and failed treatment with Zarxio; AND
3. Medication is being administered for at least 4 days before first leukapheresis and continued until the last leukapheresis (until a sustainable ANC (≥ 1000/mm^3) is reached).
4. **Dosage allowed:** 10 mcg/kg/day subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:
1. Member must have tried and failed treatment with Zarxio; AND
2. Member has a non-myeloid malignancy; AND
3. Medication will not be administered within 24 hours before or after chemotherapy; AND
4. Chart notes with length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the day of the cycle on which the Nivestym will be administered, are submitted with prior authorization request; AND
5. Member has a documented history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
6. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (> 20%, see Appendix for description) for incidence of febrile neutropenia; OR
7. Member is receiving myelosuppressive anti-cancer drugs associated with at intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Bone marrow involvement with tumor;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (bilirubin > 2.0);

f) Renal dysfunction (creatinine clearance < 50);
g) Age > 65 years receiving full chemotherapy dose intensity.

8. **Dosage allowed:** 5 mcg/kg per day.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SEVERE CHRONIC NEUTROPENIA (SCN)

For **initial** authorization:

1. Member must have tried and failed treatment with Zarxio; AND
2. Member has a history of SCN (i.e. congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia) with chart notes confirming **both** of the following:
   a) Absolute neutrophil count (ANC) < 500/mm^3 on three occasions during a 6 month period (or for cyclic neutropenia 5 consecutive days of ANC < 500/mm^3 per cycle); AND
   b) Member must have experienced a clinically significant infection during the previous 12 months.
3. **Dosage allowed:** Idiopathic neutropenia: 3.6 mcg/kg/day; Cyclic neutropenia: 6 mcg/kg/day; Congenital neutropenia: 6 mcg/kg/day divided 2 times per day.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Neupogen therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Nivestym (filgrastim-aafi) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Agranulocytosis
- AIDS - Neutropenia
- Aplastic anemia
- Febrile neutropenia, In myeloid malignancies following bone marrow transplant - Prophylaxis
- Hematopoietic Syndrome of Acute Radiation Syndrome
- Infectious disease - Prophylaxis
- Leukemia
- Myelodysplastic syndrome
- Neutropenia - Pre-eclampsia

DATE	ACTION/DESCRIPTION
10/11/2019	New policy for Nivestym (filgrastim-aafi) created.
3/11/2021	Annual review, no changes

References:

1. Nivestym (filgrastim-aafi) [prescribing information]. Lake Forest, IL: Hospira, Inc., a Pfizer Company; July 2018.
2. Schmitz N, Linch DC. Randomised trial of filgrastim-mobilized peripheral blood progenitor cell transplantation versus autologous bone-marrow transplantation in lymphoma patients. Lancet. 1996;347(8998): 353-358. Doi: 10.1016/S0140-6736(96)90536-X.
3. National Comprehensive Cancer Network. (2019). NCCN Clinical Practice Guidelines in Oncology. Hematopoietic Growth Factors: Version 2.2019-March 27, 2019.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (> 20%).
This list is not comprehensive. There are other regimens that have a high risk for the development of febrile neutropenia. See NCCN guidelines for treatment by cancer site for details.

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	Dose-dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
Bone Cancer	VAI (vincristine, doxorubicin or dactinomycin, ifosfamide)
	VDC-IE (vincristine, doxorubicin or dactinomycin, and cyclophosphamide alternating with ifosfamide and etoposide)
	VIDE (vincristine, ifosfamide. doxorubicin or dactinomycin, etoposide)
Breast Cancer	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel)
	TAC (docetaxel, doxorubicin, cyclophosphamide)
	TC (docetaxel, cyclophosphamide)
	TCH (docetaxel, carboplatin, trastuzumab)
Head and Neck Squamous Cell Carcinoma	TPF (docetaxel, cisplatin, 5-fluorouracil)
Hodgkin Lymphoma	Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine)
	Escalated BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)
	ICE (ifosfamide, carboplatin, etoposide)
	Dose-dense CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone)
	MINE (mesna, ifosfamide, mitoxantrone, etoposide)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine)
	HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone)
Melanoma	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Multiple Myeloma	DT-PACE (dexamethasone/thalidomide/ cisplatin/doxorubicin/cyclophosphamide/etoposide) ± bortezomib (VTD-PACE)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Ovarian Cancer	Topotecan
	Docetaxel

Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)
	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	Topotecan
Testicular cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% - 20%)

Cancer Histology	**Regimen**
Occult primary - Adenocarcinoma	Gemcitabine/docetaxel
Bone Cancer	Cisplatin/doxorubicin
	VDC (vincristine, doxorubicin or dactinomycin, cyclophosphamide)
Breast cancer	Docetaxel
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (taxane portion only)
	Paclitaxel every 21 days
Cervical Cancer	Cisplatin/topotecan
	Paclitaxel/cisplatin
	Topotecan
	Irinotecan
Colorectal	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Non-Hodgkin's lymphomas	GDP (gemcitabine, dexamethasone, cisplatin/carboplatin)
	CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) including regimens with pegylated liposomal doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel
	Cisplatin/vinorelbine
	Cisplatin/docetaxel
	Cisplatin/etoposide
	Carboplatin/paclitaxel
	Docetaxel
Ovarian Cancer	Carboplatin/docetaxel

Pancreatic Cancer	FOLFIRINOX
Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
	BEP (bleomycin, etoposide, cisplatin)
Uterine Sarcoma	Docetaxel

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Noctiva (desmopressin acetate) intranasal 0.83 mcg/0.1 mL and 1.66 mcg/0.1 mL
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 3.8 g per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Noctiva (desmopressin acetate) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NOCTURIA (DUE TO NOCTURNAL POLYURIA)

For **initial** authorization:

1. Member is 50 years of age or older; AND
2. Member has documented six-month history of at least **two** nocturic episodes per night; AND
3. Member has documentation of at least 6 nights of 24-hour urine frequency/volume chart where night-time urine production exceeding one-third of the total 24-hour urine production; AND
4. Member has documented normal serum sodium concentrations prior to initiating therapy and there is **no** history of hyponatremia per chart notes; AND
5. Member is **not** using Noctiva in combination with loop diuretics or with systemic or inhaled glucocorticoids; AND
6. Member does **not** have ANY of the following:
   a) Congestive heart failure (New York Heart Association Class II to IV);
   b) Uncontrolled hypertension;
   c) Polydipsia;
   d) Renal impairment with an estimated glomerular filtration rate (eGFR) below 50 mL/min/1.73 m^2.
7. **Dosage allowed:** For patients < 65 years of age who are not at increased risk for hyponatremia: Use one spray of 1.66 mcg in either nostril nightly approximately 30 minutes before going to bed. For patients ≥ 65 years of age or younger patients at risk for hyponatremia: Use 0.83 mcg nightly, which can be increased to one spray of 1.66 mcg after at least 7 days, if needed, provided the serum sodium has remained normal.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member has normal serum sodium concentrations labs submitted with chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 3 months.

CareSource considers Noctiva (desmopressin acetate) intranasal not medically necessary for the treatment of the following disease states based on a lack of

robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Nocturnal Enuresis
- Syndrome Of Inappropriate Antidiuretic Hormone Secretion (SIADH)

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Noctiva created.
11/17/2021	Annual review, no changes

References:

1. Noctiva [package insert]. Milford, PA; Serenity Pharmaceuticals, LLC: March, 2017. Accessed on April 24, 2017.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Novantrone (mitoxantrone)
BILLING CODE	J9293 (1 unit = 5 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 5 units per infusion
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Novantrone (mitoxantrone) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS (RRMS), SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS (SPMS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis; AND
4. Member has documented trial and failure or contraindication to at least **two** preferred multiple sclerosis agents (two injectable drugs OR two oral drugs OR one injectable and one oral drug); AND
5. Member has documented Left Ventricular Ejection Fraction (LVEF) of greater than 50% in the chart notes within the last 3 months.
6. **Dosage allowed:** 12 mg/m^2 infusion every 3 months (Maximum cumulative lifetime dose is 140 mg/m^2).

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member has documented biological response to treatment; AND
3. Member has documentation of repeated Left ventricular ejection fraction (LVEF) of greater than 50% in the chart notes (Note: Maximum cumulative lifetime dose is 140 mg/m^2).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Novantrone (mitoxantrone) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute lymphoid leukemia
- Bone marrow transplant

- Breast cancer
- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis
- Head and neck cancer
- Liver carcinoma
- Malignant lymphoma, Indolent
- Non-Hodgkin's lymphoma
- Ovarian cancer
- Primary progressive multiple sclerosis
- Solid tumor

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Novantrone created. Not covered diagnosis added.
12/06/2017	Confirmation of diagnosis based on McDonald criteria is no longer required.

References:

1. Mitoxantrone [package insert]. Lake Zurich, IL; Fresenius Kabi USA, LLC: June, 2015.
2. Mitoxantrone. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 16, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 12/20/2017
Revised date: 12/06/2017

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	NPlate (romiplostim)
BILLING CODE	J2796
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Hospital, Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include immune globulins and Promacta QUANTITY LIMIT— 10 mcg/kg (actual body weight)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

NPlate (romiplostim) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

IMMUNE THROMBOCYTOPENIC PURPURA (ITP)

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP); AND
3. Medication must be prescribed by or in consultation with a hematologist; AND
4. Member has ONE of the following conditions:
   a) Current platelet count is $<30x10^9$/L;
   b) $30x10^9$/L to $50x10^9$/L with one of the following:
      i) Symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma);
      ii) Have risk factors for bleeding (i.e., on anticoagulant, lifestyle that predisposes member to trauma, comorbidity such as peptic ulcer disease, undergoing medical procedure where blood loss is anticipated); AND
5. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with ONE of the following treatments:
   a) Corticosteroids (prednisone, prednisolone, methylprednisolone, and dexamethasone);
   b) Immunoglobulins;
   c) Splenectomy.
6. **Dosage allowed:** Administer 1mcg/kg subcutaneously once weekly, then adjust the weekly dose by increments of 1 mcg/kg until the patient achieves a platelet count ≥ 50 x 10^9/L. Max dose 10 mcg/kg.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement in platelet count from baseline; AND
3. Member's platelet count is less than 400 x 109/L.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers NPlate (romiplostim) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Any cause of thrombocytopenia other than chronic ITP
- Chronic Hepatitis C (CHC) Thrombocytopenia
- ITP with previous documented failure of Nplate
- Severe aplastic anemia
- Thrombocytopenia due to Myelodysplastic syndrome (MDS)

DATE	ACTION/DESCRIPTION
10/04/2018	New policy for NPlate created. Platelets requirement threshold expanded.

References:

1. Nplate [Package Insert]. Thousand Oaks, CA: Amgen, Inc.; October, 2017.
2. Diagnosis and treatment of idiopathic thrombocytopenic purpura: recommendations of the American Society of Hematology. Ann Intern Med. 1997 Feb 15;126(4):319-26.
3. Cooper N, Terrinoni I, Newland A. The efficacy and safety of romiplostim in adult patients with chronic immune thrombocytopenia. Ther Adv Hematol. 2012 Oct; 3(5): 291–298.
4. Bussel JB, Cheng G, Saleh MN, et al. Eltrombopag for the treatment of chronic idiopathic thrombocytopenic purpura. N Engl J Med. 2007; 357:2237.
5. Kuter DJ, et al. Romiplostim or standard of care in patients with immune thrombocytopenia. N Engl J Med. 2010 Nov 11;363(20):1889-99.
6. Kuter DJ, et al. Efficacy of romiplostim in patients with chronic immune thrombocytopenic purpura: a double-blind randomised controlled trial. Lancet. 2008 Feb 2;371(9610):395-403.
7. Kuter DJ, et al. Long-term treatment with romiplostim in patients with chronic immune thrombocytopenia: safety and efficacy. Br J Haematol. 2013 May;161(3):411-23.
8. Neunert C, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011 Apr 21;117(16):4190-207.

Effective date: 10/19/2018
Revised date: 10/04/2018

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Nucala (mepolizumab)
BILLING CODE	J2182
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Nucala is an interleukin-5 (IL-5) antagonist monoclonal antibody (IgG1 kappa) first approved for the treatment of severe asthma in 2015. Since that time, it has been approved for three additional indications - eosinophilic granulomatosis with polyangiitis (EGPA), hypereosinophilic syndrome (HES), and chronic rhinosinusitis with nasal polyps (CRSwNP). All four indications are eosinophilic-driven disease states. Nucala works by blocking IL-5 biding to the alpha chain of the IL-5 receptor complex. This inhibits IL-5 signaling and reduces the production of eosinophils.

Nucala (mepolizumab) will be considered for coverage when the following criteria are met:

CHRONIC RHINOSINUSITIS WITH NASAL POLYPS (CRSwNP)

For **initial** authorization:

1. Member is at least 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist, immunologist or otorhinolaryngologist (ENT); AND
3. Member has a diagnosis of severe CRSwNP with at least two of the following symptoms for 12 weeks or more:
   a) Nasal blockage/obstruction/congestion;
   b) Nasal discharge;
   c) Facial pain/pressure;
   d) Reduction in smell;
4. Chart notes must show documentation of bilateral nasal polyps by direct examination, endoscopy, or sinus CT scan; AND
5. Member has symptoms of chronic rhinosinusitis after at least a 4-week trial with an intranasal corticosteroid (e.g., mometasone, fluticasone) in combination with nasal saline irrigation AND ALL of the following:
   a) Prior sinonasal surgery;
   b) Systemic corticosteroids (unless not tolerated or contraindicated); AND
6. Member will use in combination with an intranasal corticosteroid (INCS), unless not tolerated or contraindicated; AND
7. Member does not have ANY of the following:
   a) Nasal polyp removal surgery within the past 6 months.
   b) Combination use with Xolair or Dupixent;
   c) Allergic Fungal rhinosinusitis (AFRS)
8. **Dosage allowed/Quantity limit:** 100 mg by subcutaneous injection once every 4 weeks.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes have been provided that show the member has demonstrated improvement in signs and symptoms (i.e. reduction in nasal polyp size or nasal obstruction); AND
2. Medication will be used as add-on maintenance therapy in combination with intranasal corticosteroids, unless not tolerated or contraindicated.

If all the above requirements are met, the medication will be approved for an additional 12 months.

HYPEREOSINOPHILIC SYNDROME (HES)

For **initial** authorization:
1. Member is at least 12 years of age or older; AND
2. Medication must be prescribed by or in consultation with an immunologist, allergist, or hematologist; AND
3. Member has a diagnosis of HES; AND
4. Member has a documented blood eosinophil count of > 1500 cells/µL; AND
5. Member has trialed and failed Glucocorticoids for at least one month; AND
6. Member has a history of 2 or more HES flares within the past year defined as worsening of clinical signs and symptoms or increasing eosinophils requiring an escalation in therapy; AND
7. Member does not have ANY of the following:
   a) Identifiable non-hematologic secondary cause (i.e., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy);
   b) FIP1L1-PDGFRα kinase positive HES.
8. **Dosage allowed/Quantity limit:** 300 mg as 3 separate 100-mg injections administered subcutaneously once every 4 weeks.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes have been provided that show the member has demonstrated improvement (i.e. reduction of HES flares, reduction in blood eosinophil count).

If all the above requirements are met, the medication will be approved for an additional 12 months.

EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA/Churg-Strauss Syndrome)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist, immunologist, allergist, or rheumatologist; AND
3. Member has a confirmed diagnosis of EGPA with a history or presence of asthma and documented eosinophilia (>1500 cells/µL and/or >10% of leucocytes); AND
4. Member has trialed and failed glucocorticoids with or without an immunosuppressant (cyclophosphamide, azathioprine, methotrexate, rituximab) for at least 4 weeks; AND
5. Member does not have either of the following: a) Diagnosis of GPA or MPA; b) Organ-threatening or imminently life-threatening EGPA.
6. **Dosage allowed/Quantity limit:** 300 mg as 3 separate 100-mg injections administered subcutaneously once every 4 weeks.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes have been provided that show the member has demonstrated improvement (i.e. reduction in relapse rate, oral corticosteroid (OCS) dose, or blood eosinophil count).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Severe Asthma

For **initial** authorization:
1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist, immunologist or allergist; AND
3. Member has a blood eosinophil count of at least 300 cells/μL or at least 150 cells/μL if taking maintenance oral corticosteroids (OCS); AND
4. Member has at least two documented severe asthma exacerbations requiring oral corticosteroids (OCS), or at least one requiring hospitalization, within last year; AND
5. Member's asthma has been inadequately controlled after 3 months of conventional treatment on medium to high doses of inhaled corticosteroids (ICS) and long acting beta 2-agonists (LABA); AND
6. Medication is being used as add-on maintenance treatment to conventional therapies for asthma (i.e. ICS, LABA, etc.); AND
7. Medication is not used in conjunction with any other biologic therapy for asthma.
8. **Dosage allowed/Quantity limit:** 100 mg by subcutaneous injection once every 4 weeks for patients aged 12 years and older. 40 mg by subcutaneous injection once every 4 weeks for patients aged 6 to 11 years.

If all the above requirements are met, the medication will be approved for 16 weeks.

For **reauthorization**:
1. Chart notes have been provided that show the member has demonstrated improvement (i.e. reduction in relapse rate, oral corticosteroid (OCS) dose, or blood eosinophil count).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Nucala (mepolizumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/18/2017	New policy for Nucala created. Conventional treatment options expanded.
03/16/2018	New indication of Eosinophilic Granulomatosis With Polyangiitis added.
12/28/2020	New indication of Hypereosinophilic Syndrome added. Severe Asthma: changed from 12 yo or older to 6 yo or older; adjusted eosinophil count; added documented exacerbations; removed ICS + LTRA and ICS + theophylline treatments; removed increase in predicted FEV1 from reauthorization section. EGPA: adjusted eosinophil count; removed the list of additional EGPA features; removed definitions of relapsing and refractory EGPA (BVAS not used in practice); removed exclusion criteria (only applicable in clinical trial setting) and replaced with no GPA, MPA, or life threatening EGPA; removed hx of alcohol/substance abuse; changed initial approval period from 12 months to 6 months.
10/29/2021	New indication of CRSwNP added. Changed to new format.

References:

1. Nucala [package insert]. Philadelphia, PA: GlaxoSmithKline LLC; 2020.
2. Walford HH, Doherty TA. Diagnosis and management of eosinophilic asthma: a US perspective. J Asthma Allergy. 2014;7:53–65.
3. Pavord ID, Korn S, Howarth P, et al. Mepolizumab for severe eosinophilic asthma (DREAM): A multicentre, double-blind, placebo-controlled trial. Lancet. 2012;380(9842):651-659.
4. ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). Identifier NCT00287391, A Study to Investigate Mepolizumab in the Treatment of Eosinophilic Granulomatosis With Polyangiitis; 2018 Jan 26. Available at: https://clinicaltrials.gov/ct2/show/NCT02020889?term=mepolizumab&recrs=e&rank=9.
5. Wechsler ME, Akuthota P, Jayne D, et al. EGPA Mepolizumab Study Team. Mepolizumab or Placebo for Eosinophilic Granulomatosis with Polyangiitis. N Engl J Med. 2017 May 18;376(20):1921-1932.
6. Matteson EL. Eosinophilic Granulomatosis with Polyangiitis (EGPA/Churg-Strauss Syndrome). Vascuiltis Foundation. Available at: https://www.vasculitisfoundation.org/education/forms/eosinophilic-granulomatosis-withpolyangiitis-churg-strauss-syndrome/.
7. Wechsler ME, Akuthota P, Jayne D et al. Mepolizumab or Placebo for Eosinophilic Granulomatosis with Polyangiitis. N Engl J Med 2017; Supplementary Appendix.
8. Difficult-To-Treat & Severe Asthma in Adolescent and Adult Patients: Diagnosis and Management. Global Initiative For Asthma (GINA); Apr. 2019. Available at: https://ginasthma.org/wp-content/uploads/2018/11/GINASA-FINAL-wms.pdf.
9. 2020 Focused Updates To The Asthma Management Guidelines. National Institute of Health; Dec 2020. Available at: https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates.
10. Kostikas K, Brindicci C, Patalano F. Blood Eosinophils as Biomarkers to Drive Treatment Choices in Asthma and COPD. Curr Drug Targets. 2018;19(16):1882-1896.
11. Roufosse F, Kahn JE, Rothenberg ME, et al. Efficacy and safety of mepolizumab in hypereosinophilic syndrome: a Phase III, randomized, placebo-controlled trial. Journal of Allergy and Clinical Immunology (2020).
12. Schuster B, Zink A, Eyerich K. Medical algorithm: Diagnosis and treatment of hypereosinophilic syndrome. Allergy. 2020; 75(11): 3003-3006.
13. Shomali W, Gotlib J. World Health Organization-defined eosinophilic disorders: 2019 update on diagnosis, risk stratification, and management. Am J Hematol. 2019 Oct;94(10):1149-1167.
14. Butt NM, Lambert J, Ali S, et al. Guideline for the investigation and management of eosinophilia. Br J Haematol. 2017;176(4):553-572.
15. Valent P, Klion AD, Horny HP, et al. Contemporary consensus proposal on criteria and classification of eosinophilic disorders and related syndromes. J Allergy Clin Immunol. 2012;130(3):607-612.e9.
16. Klion A. Hypereosinophilic syndrome: approach to treatment in the era of precision medicine. Hematology Am Soc Hematol Educ Program. 2018;2018(1):326-331.
17. Greco A, Rizzo MI, De Virgilio A, et al. Churg-Strauss syndrome. Autoimmunity Reviews. 2015; 14(4): 341-348.
18. Raffray L, Guillevin L. Updates for the treatment of EGPA. La Presse Medicale. 2020; 49(3).
19. Groh M, Pagnoux C, Baldini C, et al. Eosinophilic granulomatosis with polyangiitis (Chrug-Strauss) (EGPA) Consensus Task Force recommendations for evaluation and management. European Journal of Internal Medicine. 2015; 26(7): 545-553.
20. Bachert C, et al. Burden of disease in chronic rhinosinusitis with nasal polyps. J Asthma Allergy. 2021;14:127-134.
21. Bachert C, et al. EUFOREA expert board meeting on uncontrolled severe chronic rhinosinusitis with nasal polyps (CRSwNP) and biologics: Definitions and management. J Allergy Clin Immunol. 2021;147(1):29-36
22. Han JK, Bachert C, et al. Mepolizumab for chronic rhinosinusitis with nasal polyps (SYNAPSE): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet. 2021; 9(10):1141-1153.

Effective date: 04/01/2022
Revised date: 10/29/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Nulibry (fosdenopterin)
BILLING CODE	J3490, C9399, or NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Hospital Inpatient, Outpatient, Home
STATUS	Prior Authorization Required

Nulibry (fosdenopterin) is a synthetic substrate replacement therapy indicated for the treatment of molybdenum cofactor deficiency (MoCD) Type A. MoCD Type A is an ultra-rare autosomal recessive, inborn error of metabolism that results in accumulation of a neurotoxic metabolite of sulfite which causes rapid and progressive neurological damage. MoCD type A is caused by mutations in the molybdenum cofactor synthesis 1 gene (MOCS1) and presents shortly after birth.
Nulibry is the first drug to target underlying etiology and reduce the risk of mortality. Prior to Nulibry, treatment had been strictly supportive, such as anticonvulsants for seizures.

Nulibry (fosdenopterin) will be considered for coverage when the following criteria are met:

MOLYBDENUM COFACTOR DEFICIENCY (MoCD) TYPE A

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a neonatologist, geneticist, metabolic specialist, or pediatric neurologist; AND
2. ONE of the following:
   a) Member has a diagnosis of MoCD Type A confirmed by genetic testing (must show mutation in the MOSC1 gene), OR
   b) Member has a presumptive diagnosis of MoCD Type A and genetic testing is to be immediately completed.
   NOTE: If genetic testing does not confirm the diagnosis, Nulibry must be discontinued.
   NOTE: Early presenting characteristics include seizures of unknown origin, strongly positive sulfite dipstick, etc.; AND
3. Documentation of baseline S-sulfocysteine (SSC) level.
4. **Dosage allowed/Quantity limit:**
   Less than 1 year of age: Dosing based on weight per package insert
   Age 1 year or older: 0.9 mg/kg IV once daily

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. If not provided for initial authorization, genetic test result confirming MoCD Type A must be submitted; AND
2. Chart notes must show positive clinical response such as reduced convulsions, normalized biomarkers (urinary S-sulphocysteine (SSC), xanthine, urate), improved neurological or motor function, or achievement of developmental milestones.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Nulibry (fosdenopterin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
6/24/2021	New policy for Nulibry (fosdenopterin) created.

References:

1. Nulibry (fosdenopterin) [package insert]. Charleston SC; Alcami Carolinas Corporation. Revised 2/2021
2. Molybdenum cofactor deficiency. Genetics Home Reference. Accessed June 24, 2021. https://medlineplus.gov/genetics/condition/molybdenum-cofactor-deficiency/
3. Study of ORGN001 (Formerly ALXN1101) in Neonates, Infants and Children With Molybdenum Cofactor Deficiency (MOCD) Type A. ClinicalTrials.gov Identifier: NCT02629393. Updated February 26, 2021. Accessed June 30, 2021. https://clinicaltrials.gov/ct2/show/NCT02629393?term=NCT02629393&draw=2&rank=1
4. Atwal PS, Scaglia F. Molybdenum cofactor deficiency. *Mol Genet Metab*. 2016;117(1):1-4. doi:10.1016/j.ymgme.2015.11.010
5. Schwahn BC, Van Spronsen FJ, Belaidi AA, et al. Efficacy and safety of cyclic pyranopterin monophosphate substitution in severe molybdenum cofactor deficiency type A: a prospective cohort study. *Lancet*. 2015;386(10007):1955-1963. doi:10.1016/S0140-6736(15)00124-5

Effective date: 01/01/2022
Revised date: 06/30/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ocrevus (ocrelizumab)
BILLING CODE	J2350 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— Max 600 mg every 6 months
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ocrevus (ocrelizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PRIMARY PROGRESSIVE MULTIPLE SCLEROSIS (PPMS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of PPMS; AND
4. Member must have documented negative results on Hepatitis B screening (negative results for both HBsAg and anti-HBV). For those who are negative for surface antigen (HBsAg) and positive for HB core antibody (HBcAb+) or are carriers of HBV (HBsAg+), a hepatologist must be consulted; AND
5. Member does not have an active infection; AND
6. Ocrevus is not being used in combination with other multiple sclerosis drugs.
7. **Dosage allowed:** 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion; then 600 mg intravenous infusion every 6 months.

If member meets all the requirements listed above, the medication will be approved 12 months.

For **reauthorization**:

1. Chart notes must indicate positive clinical response such as slowed or stabilized rate of disability progression or MRI outcomes (e.g., volume of lesions, change in brain volume).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RELAPSING FORMS OF MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of relapsing-remitting multiple sclerosis (RRMS), active secondary progressive multiple sclerosis (SPMS), or clinically isolated syndrome (CIS); AND
4. Member has tried and failed at least one preferred disease-modifying MS drug; AND
5. Member must have documented negative results on Hepatitis B screening (negative results for both HBsAg and anti-HBV). For those who are negative for surface antigen (HBsAg) and positive for HB core antibody (HBcAb+) or are carriers of HBV (HBsAg+), a hepatologist must be consulted; AND

6. Member does not have an active infection; AND
7. Ocrevus is not being used in combination with other disease-modifying MS drugs.
8. **Dosage allowed:** 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion; then 600 mg intravenous infusion every 6 months.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes must indicate a positive clinical response such as fewer relapses, slowed or improved disability, or effect on MRI measures (e.g., no new or enlarged brain lesions).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ocrevus (ocrelizumab) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/09/2017	New policy for Ocrevus created.
12/06/2017	Age coverage expanded.
08/16/2021	Updated all references. Removed CIS as an exclusion and added it to RRMS criteria. Changed trial of 2 preferred drugs first for RRMS to trial of 1. Removed incorrect diagnostic requirement from RRMS section. Removed diagnostic specifics for PPMS from outdated McDonald criteria. Removed vaccination details. Removed note about switching products. Simplified HBV phrasing. Revised renewal criteria. Added office as site of care.

References:

1. Ocrevus [package insert]. South San Francisco, CA; Genentech, Inc: March, 2021.
2. Thompson AJ, Banwell BL, Barkhof F, et al. Diagnosis of multiple sclerosis: 2017 revisions of the McDonald criteria. *Lancet Neurol*. 2018;17(2):162-173. doi:10.1016/S1474-4422(17)30470-2
3. Hauser SL, Bar-Or A, Comi G, et al. Ocrelizumab versus Interferon Beta-1a in Relapsing Multiple Sclerosis. *N Engl J Med*. 2017;376(3):221-234. doi:10.1056/NEJMoa1601277
4. Montalban X, Hauser SL, Kappos L, et al. Ocrelizumab versus Placebo in Primary Progressive Multiple Sclerosis. *N Engl J Med*. 2017;376(3):209-220. doi:10.1056/NEJMoa1606468
5. Hauser SL, Kappos L, Arnold DL, et al. Five years of ocrelizumab in relapsing multiple sclerosis: OPERA studies open-label extension. *Neurology*. 2020;95(13):e1854-e1867. doi:10.1212/WNL.0000000000010376
6. Zimmermann M, Brouwer E, Tice JA, et al. Disease-Modifying Therapies for Relapsing-Remitting and Primary Progressive Multiple Sclerosis: A Cost-Utility Analysis. *CNS Drugs*. 2018;32(12):1145-1157. doi:10.1007/s40263-018-0566-9
7. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology [published correction appears in Neurology. 2019 Jan 8;92(2):112]. *Neurology*. 2018;90(17):777-788
8. National Multiple Sclerosis Society. The Use of Disease-Modifying Therapies in Multiple Sclerosis: Principles and Current Evidence. A Consensus Paper by the Multiple Sclerosis Coalition; 2019. Available from: https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/DMT_Consensus_MS_Coalition.pdf. Accessed August 18, 2021.

Effective date: 01/01/2022
Revised date: 08/16/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ofev (nintedanib)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 60 capsules per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ofev (nintedanib) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

IDIOPATHIC PULMONARY FIBROSIS (IPF)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist; AND
3. Member has diagnosis of IPF confirmed by high resolution computed tomography (HRCT) or lung biopsy[3] (results must be submitted for review); AND
4. Documentation of member's baseline forced vital capacity (FVC) must be equal to or greater than 50% predicted; AND
5. Member does not have moderate to severe hepatic impairment; AND
6. Member is not a current smoker and provider attests the member will not smoke during treatment.
7. **Dosage allowed:** 300mg per day (150mg twice daily)

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member continues to abstain from smoking; AND
2. Chart notes must demonstrate reduced rate of FVC decline[7].

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CHRONIC FIBROSING INTERSTITIAL LUNG DISEASES (ILD) WITH A PROGRESSIVE PHENOTYPE

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist or rheumatologist; AND
3. Member has a diagnosis of Progressive Fibrosing ILD presenting with features of diffuse fibrosing lung disease of >10% extent on high-resolution computed tomography (HRCT)[8] (results must be submitted for review); AND
4. Documentation of member's baseline forced vital capacity (FVC) must be equal to or greater than 45% predicted[8]; AND

5. Member does not have moderate to severe hepatic impairment; AND
6. Member is not a current smoker and provider attests the member will not smoke during treatment.
7. **Dosage allowed:** 300mg per day (150mg twice daily)

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member continues to abstain from smoking; AND
2. Chart notes must demonstrate reduced rate of FVC decline[8].

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSc-ILD)

For **initial** authorization:
1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a pulmonologist or rheumatologist; AND
3. Member has a diagnosis of ILD associated with systemic sclerosis, presenting with high-resolution computed tomography (HRCT) showing fibrosis affecting at least 10% of the lungs[12] (results must be submitted for review); AND
4. Documentation of member's baseline forced vital capacity (FVC) must be equal to or greater than 40% predicted[12]; AND
5. Member's lung disease has progressed despite at least a 3 month trial of mycophenolate mofetil (MMF), cyclophosphamide, or azathioprine (MMF preferred)[10,13] unless contraindicated; AND
6. Member does not have moderate to severe hepatic impairment; AND
7. Member is not a current smoker and provider attests the member will not smoke during treatment.
8. **Dosage allowed:** 300mg per day (150mg twice daily)

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member continues to abstain from smoking; AND
2. Chart notes must demonstrate reduced rate of FVC decline[12].

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ofev (nintedanib) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/19/2020	New policy for Ofev created. Previously on IPF policy, now splitting from Esbriet, updating references, and adding new indications PF-ILD and SSc-ILD
11/17/2021	Annual review, no changes

References:

1. Ofev [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc; 2020.
2. Nintedanib. Greenwood Village, CO: Truven Health Analytics. http://micromedex.com/. Updated May 7, 2020. Accessed June 19, 2020.

3. Raghu G, Collard HR, Egan JJ, et al. An Official ATS/ERS/JRS/ALAT Statement: Idiopathic Pulmonary Fibrosis: Evidence-based Guidelines for Diagnosis and Management. *American Journal of Respiratory and Critical Care Medicine*. 2011;183(6):788-824. doi:10.1164/rccm.2009-040gl
4. Raghu G, Rochwerg B, Zhang Y, et al. An Official ATS/ERS/JRS/ALAT Clinical Practice Guideline: Treatment of Idiopathic Pulmonary Fibrosis. An Update of the 2011 Clinical Practice Guideline. *American Journal of Respiratory and Critical Care Medicine*. 2015;192(2). doi:10.1164/rccm.201506-1063st
5. Canestaro WJ, Forrester SH, Raghu G, Ho L, Devine BE. Drug Treatment of Idiopathic Pulmonary Fibrosis. *Chest*. 2016;149(3):756-766. doi:10.1016/j.chest.2015.11.013
6. Rogliani P, Calzetta L, Cavalli F, Matera MG, Cazzola M. Pirfenidone, nintedanib and N-acetylcysteine for the treatment of idiopathic pulmonary fibrosis: A systematic review and meta-analysis. *Pulmonary Pharmacology & Therapeutics*. 2016;40:95-103. doi:10.1016/j.pupt.2016.07.009
7. Richeldi L, Bois RMD, Raghu G, et al. Efficacy and Safety of Nintedanib in Idiopathic Pulmonary Fibrosis. *New England Journal of Medicine*. 2014;370(22):2071-2082. doi:10.1056/nejmoa1402584
8. Flaherty KR, Wells AU, Cottin V, et al. Nintedanib in Progressive Fibrosing Interstitial Lung Diseases. *New England Journal of Medicine*. 2019;381(18):1718-1727. doi:10.1056/nejmoa1908681
9. Cottin V, Hirani NA, Hotchkin DL, et al. Presentation, diagnosis and clinical course of the spectrum of progressive-fibrosing interstitial lung diseases. *European Respiratory Review*. 2018;27(150):180076. doi:10.1183/16000617.0076-2018
10. Cottin V, Wollin L, Fischer A, Quaresma M, Stowasser S, Harari S. Fibrosing interstitial lung diseases: knowns and unknowns. *European Respiratory Review*. 2019;28(151):180100. doi:10.1183/16000617.0100-2018
11. Wells AU, Flaherty KR, Brown KK, et al. Nintedanib in patients with progressive fibrosing interstitial lung diseases-subgroup analyses by interstitial lung disease diagnosis in the INBUILD trial: a randomised, double-blind, placebo-controlled, parallel-group trial. *Lancet Respir Med*. 2020;8(5):453-460. doi:10.1016/S2213-2600(20)30036-9
12. Distler O, Highland KB, Gahlemann M, et al. Nintedanib for Systemic Sclerosis–Associated Interstitial Lung Disease. *New England Journal of Medicine*. 2019;380(26):2518-2528. doi:10.1056/nejmoa1903076
13. Varga J, Montesi S. Treatment and prognosis of interstitial lung disease in systemic sclerosis (scleroderma). *UpToDate.* https://www.uptodate.com/. Updated October 8, 2019. Accessed June 22, 2020.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Olumiant (baricitinib)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 30 tablets for 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Olumiant (baricitinib) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member is 18 year of age or older with moderately to severely active RA who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately.
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA); AND
5. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm^3), lymphopenia (ALC <500 cells/mm^3), or anemia (Hg < 8 g/dL).
6. **Dosage allowed:** 2 mg once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Olumiant (baricitinib) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/31/2018	New policy for Olumiant created.

02/26/2019	Status changed to preferred. Humira and Enbrel trials removed from criteria. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. References added.
11/20/2020	Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. Added that member does not have neutropenia, lymphopenia, or anemia. Removed statement that medication is not being used with other biologic DMARDs. Removed repeated TB test in reauth. Replaced list of excluded diagnoses with the generic statement. Updated references.
11/17/2021	Annual review, no changes

References:

1. Olumiant [package insert]. Indianapolis, IN: Lilly USA, LLC; July 2020.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
3. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
4. Genovese MC, et al. Baricitinib in Patients with Refractory Rheumatoid Arthritis. N Engl J Med. 2016 Mar 31;374(13):1243-52.
5. Taylor PC, et al. Baricitinib versus Placebo or Adalimumab in Rheumatoid Arthritis. N Engl J Med. 2017 Feb 16;376(7):652-662.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Oncology Treatment Regimen Review
BILLING CODE	Must use valid NDC and/or HCPCS code(s)
BENEFIT TYPE	Medical or Pharmacy

All oncology treatments must be submitted to Eviti Connect for review via the NantHealth Eviti Connect portal. Eviti Connect is an online platform that connects CareSource with oncology offices for real-time validation of cancer treatment plans. It is the most efficient way to initiate a treatment plan review and reduces the administrative time involved in requesting authorizations at the drug level by assuring accurate reimbursement at the regimen level.

Oncology treatment regimens are reviewed in their entirety to include supportive care medications and drugs which otherwise would not require prior authorization (PA). Treatment plans that comply with evidence-based medicine will be issued an "Eviti code," meaning that it meets national standards of quality care and the definition of medical necessity. An Eviti code is not an authorization number or guarantee of payment, however, it forwards the authorization request to CareSource for the review process to be completed.

For drugs which may have use in the oncology setting as well as other approved indications and which are not being used as a part of an oncology treatment regimen, review under this policy is not necessary. Any existing drug specific clinical review policies will supersede this oncology treatment regimen review policy.

Oncology treatment regimens are reviewed based on the following criteria:

Cancer (all types)

For **initial** authorization:

1. The oncology drug(s) must be prescribed by an oncologist or hematologist; AND
2. The regimen must have sufficient supporting evidence for use as determined by one or more of the following:
   a) Food and Drug Administration (FDA) approved indication(s);
   b) National Comprehensive Cancer Network (NCCN) evidence categories 1, 2a, or 2b;
   c) Other recommendations within the Eviti evidence-based medical library, such as nationally recognized peer-reviewed medical journal articles or professional society oncology treatment standards and guidelines; AND
3. The dose(s) must not exceed the FDA labeled maximum or what is supported by the above compendia or reference guidelines; AND
4. Medical records, applicable lab results, and/or test results such as to detect a genetic mutation must be provided to confirm the diagnosis and provide baseline information; AND
5. Chart notes must document any and all previous treatments for the member's cancer; AND
6. The member does not have any contraindications to the requested treatment; AND
7. If the request is for a non-preferred/non-formulary drug and a comparable preferred drug is available as determined by the reviewer (e.g. a biosimilar or a drug in the same mechanistic class with similar efficacy and safety), then the member must try the alternative preferred regimen first and show a lack of response before requesting a non-preferred drug, unless not tolerated or contraindicated; AND
8. The request is not for experimental or investigational purposes or for use in a clinical trial.

If all the above requirements are met, the oncology treatment regimen will be authorized for up to 6 months.

For **reauthorization**:

1. Chart notes must document improvement or stabilization of disease based on clinical narrative, imaging, or current clinical biomarker/lab results.

If all the above requirements are met, the oncology regimen will be authorized for up to an additional 12 months.

Scenarios that do not meet the above requirements may be considered on a case by case basis if the provider submits timely clinical literature from a nationally recognized peer-reviewed medical journal(s) that presents clear and compelling data for efficacy and safety.

DATE	ACTION/DESCRIPTION
01/19/2021	New policy for oncology created.

References:

1. NCCN Categories of Evidence and Consensus. https://www.nccn.org/professionals/physician_gls/categories_of_consensus.aspx. Accessed December 16, 2020.
2. Recommendation, Evidence, and Efficacy Ratings. Drug Consult - MICROMEDEX (micromedexsolutions.com). Accessed December 16, 2020.

Effective date: 04/01/2021
Revised date: 01/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Onpattro (patisiran)
BILLING CODE	J0222 (1 unit = 0.1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Onpattro (patisiran) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

POLYNEUROPATHY OF HEREDITARY TRANSTHYRETIN-MEDIATED (hATTR) AMYLOIDOSIS

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of amyloidosis (e.g., hematologist, geneticist, etc.); AND
3. Member has diagnosis of hATTR Amyloidosis with polyneuropathy confirmed by chart notes; AND
4. Member has documented transthyretin (TTR) gene mutation as confirmed through genetic testing (documentation required); AND
5. Documentation of familial amyloid polyneuropathy (FAP) stage 1 (unimpaired ambulation; mostly mild sensory, motor, and autonomic neuropathy in the lower limbs) or stage 2 (assistance with ambulation required; mostly moderate impairment progression to the lower limbs, upper limbs, and trunk). See *Appendix* for details on all stages of FAP for your reference; AND
6. Member does **not** have ANY of the following:
   a) Prior liver transplant;
   b) Known human immunodeficiency virus (HIV) infection;
   c) Hepatitis B virus (HBV) and hepatitis C virus (HCV); AND
7. Member is **not** using Onpattro concomitantly with Tegsedi, Vyndaqel or Vyndamax.
8. **Dosage allowed:** For members weighting less than 100 kg: 0.3 mg/kg every 3 weeks IV. For members weighing 100 kg or more, the recommended dosage is 30 mg every 3 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member continues to have FAP stage 1 or stage 2; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., quality of life and motor function improved, neuropathic pain decreased, serum TTR levels reduced); AND
3. Member is not using Onpattro concomitantly with Tegsedi, Vyndaqel, or Vyndamax.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Onpattro (patisiran) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/05/2019	New policy for Onpattro created.
07/02/2020	Simplified diagnostic requirement of hATTR to just any method of confirmation by chart notes. Separated genetic testing and FAP staging into their own mandatory requirements. Expanded prescriber to include physicians who specialize in treating amyloidosis.

References:

1. Onpattro [prescribing information]. Cambridge, MA: Alnylam Pharmaceuticals, Inc.; August, 2018.
2. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013;8:31.
3. ClinicalTrials.gov Identifier: NCT01960348. APOLLO: The Study of an Investigational Drug, Patisiran (ALN-TTR02), for the Treatment of Transthyretin (TTR)-Mediated Amyloidosis. Available at: https://clinicaltrials.gov/ct2/show/NCT01960348?term=01960348&rank=1.
4. National Institutes of Health (NIH). Transthyretin amyloidosis. Available at: https://ghr.nlm.nih.gov/condition/transthyretin-amyloidosis.

Effective date: 10/1/2021
Revised date: 07/02/2020

Appendix. Stages of FAP.

Stage 0

This is an asymptomatic stage. Patients in this stage do have a mutation in the TTR gene and show evidence of amyloid deposits, but do not show any symptoms of the disease.

Stage 1

Symptoms are mild at this stage, with the functioning of the lower limbs affected but not impaired. This is the stage for early detection of FAP symptoms.

Stage 2

Symptoms turn from mild to moderate in severity in stage 2. Lower limb function is even more affected, with patients possibly requiring walking assistance. Further damage to nerves caused by amyloid deposits is observed.

Stage 3

Symptoms have significantly worsened in stage 3, and the patient needs a wheelchair for mobility. There is no data to support the efficacy of drug therapies at this stage of the disease.

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Oral Prostacyclins for Pulmonary Arterial Hypertension: Orenitram (treprostinil extended-release), Uptravi (selexipag tablets)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Pulmonary Arterial Hypertension is a rare but serious condition characterized by elevated pulmonary arterial resistance. Orenitram and Uptravi are approved for the treatment of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1. Orenitram is indicated to delay disease progression and to improve exercise capacity. Uptravi is approved to delay disease progression and reduce the risk of hospitalization for PAH.

Oral Prostacyclins will be considered for coverage when the following criteria are met:

Pulmonary Arterial Hypertension [WHO Group 1]

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization; AND
4. Member has tried and failed one oral medication from one of the following three categories: phosphodiesterase type 5 inhibitor (ie. Sildenafil, Tadalafil), endothelin receptor antagonist (ie. Ambrisentan, Bosentan, Macitentan), or Soluble Guanylate Cyclase Stimulator (ie. Adempas) OR WHO functional class IV symptoms (for Ventavis only – see appendix); AND
5. Member must have documentation pulmonary arterial pressures are not adequately controlled, confirmed by **one** of the following:
   a) Patient had an acute response to vasodilator testing AND has tried a calcium channel blocker (CCB) for at least 3 months; OR
   b) Patient did not have a response to vasodilator testing; OR
   c) Patient cannot undergo vasodilator testing; OR
   d) Patient cannot take CCB therapy

Dosage allowed/Quantity limit:

Orenitram: Initiate 0.125 mg three times daily or 0.25 mg twice daily; Titrate by 0.125 mg three times daily or by 0.25 mg or 0.5 mg twice daily, not more than every 3 to 4 days as tolerated.
Uptravi: Initiate 200 mcg twice daily; Increase by 200 mcg twice daily usually at weekly intervals (maximum dose of 1600 mcg twice daily).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
Oral Prostacyclins will be reauthorized when chart notes show at least one of the following:

1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in functional class symptoms or quality of life
   b) Stabilization or improvement in 6MWD [6-minute walk distance]

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Oral Prostacyclins not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/15/2011	Pulmonary Arterial Hypertension policy creation.
05/13/2014	Combined all PAH agents into one policy
07/09/2015	Revised guidelines for therapy aligning with CMS
08/18/2015	Revised guidelines to include diagnosis criteria
10/13/2021	Separated PAH agents by drug class; Updated guidelines; Added provider specialty

References:

1. Orenitram [package insert]. Research Triangle Park, NC: United Therapeutics Corp; May 2021
2. Uptravi [package insert]. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; October 2021
3. Coons, J.C., Pogue, K., Kolodziej, A.R. et al. Pulmonary Arterial Hypertension: a Pharmacotherapeutic Update. Curr Cardiol Rep. 2019; 21(141)
4. Klinger JR, Elliott CG et al. Therapy for Pulmonary Arterial Hypertension in Adults; Chest Journal. March 2019; 155(3): 565-586
5. Galie N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension: The Joint Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS): Endorsed by: Association for European Paediatric and Congenital Cardiology (AEPC), International Society for Heart and Lung Transplantation (ISHLT). European heart journal. 2016;37(1):67–119

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

World Health Organization Functional Assessment Classification	
Class I	Patients with PAH but without resulting limitation of physical activity. Ordinary physical activity does not cause undue dyspnea, fatigue, chest pain or near syncope.
Class II	Patients with PAH resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity increases dyspnea, fatigue, chest pain, or near syncope.
Class III	Patients with PAH resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity increases dyspnea, fatigue, chest pain, or near syncope.
Class IV	Patients with PAH unable to carry out any physical activity without symptoms. These patients may have signs of right-heart failure. Dyspnea and/or fatigue may even be present at rest. Discomfort is increased by any physical activity.

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Orencia (abatacept)
BILLING CODE	J0129 (1 unit = 10 mg)—infused product Must have valid NDC for self-administered product
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Outpatient/Office/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Actemra, Enbrel, Cimzia, Kevzara, Olumiant and Xeljanz QUANTITY LIMIT— Infused product 100 units per 28 days Self-administered product 4 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Orencia (abatacept) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (pJIA)

For **initial** authorization:

1. Member must be 2 years of age or older with moderately to severely active pJIA; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had an adequate trial and failure of a non-biologic DMARD (e.g., methotrexate, leflunomide, etc.) for 8 weeks, unless not tolerated or contraindicated; AND
5. Member must have tried and failed treatment with **both** Enbrel and Actemra. Treatment failure requires at least 12 weeks of therapy with each drug.
6. **Dosage allowed:**
   a) Intravenous (6 years and older only): one weight-based IV infusion on week 0, 2, 4, and every 4 weeks thereafter.
      i) Less than 75 kg: 10 mg/kg;
      ii) 75 kg to 100 kg: 750 mg (3 vials);
      iii) More than 100 kg: 1000 mg (4 vials).
   b) Subcutaneous:
      i) 10 kg to < 25 kg: 50 mg once weekly;
      ii) 25 kg to < 50 kg: 87.5 mg once weekly;
      iii) 50 kg or more: 125 mg once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated dose AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless one of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:**
   a) Intravenous: one weight-based IV infusion on week 0, 2, 4, and every 4 weeks thereafter.
      i) Less than 60 kg: 500 mg (2 vials);
      ii) 60 to 100 kg: 750 mg (3 vials);
      iii) More than 100 kg: 1000 mg (4 vials).
   b) Subcutaneous: 125 mg once weekly. IV loading dose is not needed.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and one other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Member has tried and failed treatment with at least two of the following: Actemra, Cimzia, Enbrel, Kevzara, Olumiant and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
6. **Dosage allowed:**
   a) Intravenous: one weight-based IV infusion on week 0, 2, 4, and every 4 weeks thereafter.
      i) Less than 60 kg: 500 mg (2 vials);

ii) 60 to 100 kg: 750 mg (3 vials);
iii) More than 100 kg: 1000 mg (4 vials).

b) Subcutaneous: 125 mg once weekly. If a weight-based IV loading dose is needed, may administer an optional loading dose as a single IV infusion, followed by a subcutaneous injection within one day of the infusion.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Orencia (abatacept) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Orencia created. Policy SRx-0042 archived. Age adjusted for JIA. List of diagnoses considered not medically necessary added.
08/02/2017	New diagnosis of PsA added.
02/26/2019	Humira trial removed from criteria; Actemra, Cimzia, Kevzara, Olumiant, Otezla and Xeljanz added to trial agents. Clarifications entered for PsA on NSAIDs trial length. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. References added.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. Updated dosing sections. JIA: Changed trials to require one non-biologic DMARD. Specified name to be pJIA. Removed 6 months of active disease and 5 or more joints involved. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors.

References:

1. Orencia [package insert]. Princeton, NJ: Bristol-Myers Squibb Company; June, 2020.
2. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guidelines for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care Res* (Hoboken). 2019 Jun;71(6):717-734.
3. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
4. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
5. Kremer JM, et al. Effects of Abatacept in Patients with Methotrexate-Resistant Active Rheumatoid Arthritis: A Randomized Trial. Ann Intern Med. 2006 Jun 20;144(12):865-76.
6. Mease PJ, et al. Efficacy and safety of abatacept, a T-cell modulator, in a randomised, double-blind, placebocontrolled, phase III study in psoriatic arthritis. Ann Rheum Dis. 2017 Sep;76(9):1550-1558.
7. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
8. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.

9. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.

Effective date: 04/01/2019
Revised date: 02/26/2019

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Orfadin (nitisinone) Preferred Options: Nitisinone 2mg, 5mg, 10mg capsules, Orfadin 20mg capsules, Orfadin 4mg/mL suspension
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior authorization required (Preferred product) QUANTITY LIMIT – 2mg/kg/day
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Orfadin (nitisinone) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY TYROSINEMIA TYPE 1 (HT-1)

For **initial** authorization:

If request is for brand name Orfadin 2mg, 5mg, or 10mg capsule strength, please follow policy "Medical Necessity for DAW" on CareSource website.

1. Member has a diagnosis of hereditary tyrosinemia type 1 (HT-1) confirmed by genetic (DNA testing) or biochemical testing (i.e. presence of succinylacetone in the urine or blood); AND
2. Member has a baseline succinylacetone level documented in chart notes; AND
3. Member has an eye exam (e.g. slit-lamp) performed and documented in chart notes prior to initiating treatment; AND
4. Member is using medication in combination with dietary restriction of tyrosine and phenylalanine (commonly found in high-protein food).
5. **Dosage allowed**: up to 1 mg/kg by mouth twice daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must continue a dietary restriction of tyrosine and phenylalanine; AND
2. Chart notes have been provided that show the member has had a positive response (e.g. a reduction in succinylacetone level compared to baseline).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Orfadin (nitisinone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/30/2020	New policy for Orfadin created.
11/19/2021	Annual review, no changes

References:

1. Orfadin [Package Insert]. Waltham, MA: Sobi Inc.; March 2016.
2. Jack RM, Scott CR. Validation of a therapeutic range for nitisinone in patients treated for tyrosinemia type 1 based on reduction of succinylacetone excretion. JIMD reports. 2019;46(1)75-78.
3. Chinsky JM, Singh R, Ficicioglu C, et al. Diagnosis and treatment of tyrosinemia type 1: A US and Canadian consensus group review and recommendations. Genetics in Medicine. 2017;19(12)1380.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Oriahnn (elagolix, estradiol, and norethindrone acetate; elagolix)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 60 capsules per 30 days (max 24 months duration)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Oriahnn (elagolix, estradiol, and norethindrone acetate; elagolix) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

UTERINE LEIOMYOMAS (FIBROIDS)

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a gynecologist; AND
3. Member has heavy menstrual bleeding associated with uterine fibroids (documentation required); AND
4. Member has had a 90-day trial and failure of, or intolerance to **one** of the following: combination estrogen-progestin contraceptive (e.g, estradiol/levonorgestrel), progestins (e.g., Camila, medroxyprogesterone depot, Mirena IUD), or tranexamic acid; AND
5. Member does **not** have any of the following:
   a) Pregnancy or plan to become pregnant while taking medication;
   b) Osteoporosis;
   c) High risk of thrombotic or thromboembolic disorder (e.g., uncontrolled hypertension, smoker over 35 years of age, etc.);
   d) Current or history of breast cancer.
6. **Dosage allowed:** 1 capsule (elagolix 300 mg, estradiol 1 mg, and norethindrone acetate 0.5 mg) in the morning and 1 capsule (elagolix 300 mg) in the evening.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing that member has had improvement in signs and symptoms of disease (e.g. reduction in menstrual bleeding and/or an improvement in hemoglobin level);
3. The duration of treatment has not exceeded 24 months.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months. Total duration of treatment should not exceed 24 months.

CareSource considers Oriahnn (elagolix, estradiol, and norethindrone acetate; elagolix) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/30/2020	New policy for Oriahnn created.
11/19/2021	Annual review, no changes

References:

1. Oriahnn [package insert]. North Chicago, IL; AbbVie Inc, May 2020.
2. American Association of Gynecologic Laparoscopists (AAGL). AAGL practice report: practice guidelines for the diagnosis and management of submucous leiomyomas. *J Minim Invasive Gynecol*. Mar-Apr 2012;19(2):152-71.
3. De La Cruz MS, Buchanan EM. Uterine fibroids: diagnosis and treatment. *Am Fam Physician*. 2017 Jan 15;95(2):100-107.
4. Vilos GA, Allaire C, Laberge PY, et al. The management of uterine leiomyomas. *J Obstet Gynaecol Can*. 2015 Feb;37(2):157-178.
5. Schlaff WD, Ackerman RT, Al-Hendy A, et al. Elagolix for heavy menstrual bleeding in women with uterine fibroids. *N Engl J Med*. 2020 Jan 23;382(4):328-340.
6. Stewart EA. Uterine fibroids (leiomyomas): Treatment overview. In: Barbieri RL, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 30, 2020.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Orilissa (elagolix)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred product includes Lupron QUANTITY LIMIT— up to 200 mg twice daily
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Orilissa (elagolix) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ENDOMETRIOSIS

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a gynecologist; AND
3. Member is having painful symptoms (e.g., pelvic pain, dysmenorrhea, etc.) associated with endometriosis (documentation required); AND
4. Member has tried and failed to control symptoms after trials with **both** of the following, unless not tolerated or contraindicated:
   a) 30 days of an NSAID;
   b) 3 months of a hormonal contraceptive; AND
5. Member does **not** have any of the following:
   a) Pregnancy or plan to become pregnant while taking medication;
   b) Osteoporosis;
   c) Severe hepatic impairment;
   d) Currently using strong OATP1B1 inhibitors (e.g., cyclosporine, gemfibrozil, etc.).
6. **Dosage allowed:** 150 mg once daily for 24 months or 200 mg twice daily for 6 months. 150 mg once daily for 6 months for members with moderate hepatic impairment (Child-Pugh Class B).

If member meets all the requirements listed above, the medication will be approved for 24 months if dose requested is 150 mg and for 6 months if dose requested is 200 mg.

For **reauthorization**:
Orilissa will not be reauthorized for continued therapy.

CareSource considers Orilissa (elagolix) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/20/2018	New policy for Orilissa (elagolix) created.

10/23/2020	Removed requirement of negative pregnancy test or sterilization of partner (changed to no current pregnancy or plan to become pregnant); removed obstetrician as an option for prescriber.
3/11/2021	Annual review, no changes

References:

1. Orilissa [package insert]. North Chicago, IL: AbbVie Inc.; August 2019.
2. Taylor HS, Giudice LC, Lessey BA, et al. Treatment of Endometriosis-Associated Pain with Elagolix, an Oral GnRH Antagonist. *N Engl J Med* 2017;377:28-40.
3. ClinicalTrials.gov Identifier: NCT01620528. A Clinical Study to Evaluate the Safety and Efficacy of Elagolix in Subjects With Moderate to Severe Endometriosis-Associated Pain. Available at: https://clinicaltrials.gov/ct2/show/NCT01620528. Accessed on July 30, 2018.
4. ClinicalTrials.gov Identifier: NCT01931670. A Global Phase 3 Study to Evaluate the Safety and Efficacy of Elagolix in Subjects With Moderate to Severe Endometriosis-Associated Pain. Available at: https://clinicaltrials.gov/ct2/show/NCT01931670. Accessed on July30, 2018.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Orkambi (lumacaftor/ivacaftor)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 112 tablets per 28 days or 56 unit-dose packets per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Orkambi (lumacaftor/ivacaftor) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 2 years of age or older; AND
2. Member has a diagnosis of cystic fibrosis; AND
3. Medication must be prescribed by a pulmonologist or an infectious disease specialist; AND
4. Member has had genetic testing documented in chart notes with two copies (homozygous) of the F508del mutation (F508del/F508del) in their CFTR gene; AND
5. If member is 6 years or older, must have a trial and failure of Symdeko, unless not tolerated or contraindicated.
6. **Dosage allowed:** Adults and pediatric members age 12 years and older: two tablets (each containing lumacaftor 200 mg/ivacaftor 125 mg) taken orally every 12 hours. Pediatric members age 6 through 11 years: two tablets (each containing lumacaftor 100 mg/ivacaftor 125 mg) taken orally every 12 hours. Pediatric members age 2 through 5 years < 14 kg: one packet of granules (each containing lumacaftor 100 mg/ivacaftor 125 mg), ≥ 14 kg or greater: one packet of granules (each containing lumacaftor 150 mg/ivacaftor 188 mg).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member's adherence to medication is confirmed by claims history; AND
3. Chart notes submitted with any of the following:
   a) Improved FEV1 and/or other lung function tests;
   b) Improvement in sweat chloride;
   c) Decrease in pulmonary exacerbations;
   d) Decrease in pulmonary infections;
   e) Increase in weight-gain;
   f) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

CareSource considers Orkambi (lumacaftor/ivacaftor) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Orkambi created. Not covered diagnosis added.
03/14/2019	Age coverage expanded (approved for 2 years old members and older).
12/30/2020	Diagnosis of cystic fibrosis added to initial criteria. Reauthorization criteria updated to ask for evidence of disease improvement. Added trial of Symdeko for members 6 years and older.
11/17/2021	Annual review, no changes

References:

1. Orkambi [package insert]. Boston, MA: Vertex Pharmaceuticals Inc; August, 2018.
2. Orkambi. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com.
3. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. Available: https://www.guideline.gov.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Orladeyo (berotralstat)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Orladeyo is a plasma kallikrein inhibitor approved in December 2020 for the prevention of hereditary angioedema (HAE) attacks. It is the first FDA approved oral drug for HAE attack prophylaxis, taken once daily for long term use. It is not for on-demand use to manage acute attacks. Approval was based on clinical trials showing that Orladeyo reduced the frequency of HAE attacks compared to placebo. Although it may not have the same level of effectiveness as competitor products, the advantage of oral administration may compensate for this difference, depending on patient specific factors such as disease severity. Patients with type 1 or type 2 HAE have deficient or dysfunctional C1 esterase inhibitor, respectively. This leads to an uncontrolled increase in plasma kallikrein activity, which generates excess bradykinin, causing greater vascular permeability that results in angioedema attacks. Type I HAE is the most common.

Orladeyo (berotralstat) will be considered for coverage when the following criteria are met:

Hereditary Angioedema (HAE)

For **initial** authorization:

1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Chart notes must document the member's baseline frequency of HAE attacks; AND
5. Member is inadequately controlled with on-demand treatment alone; AND
6. Orladeyo is being prescribed for ongoing prophylaxis and will not be used to treat acute attacks; AND
7. Member has a trial and failure of or contraindication to Haegarda.
8. **Dosage allowed/Quantity limit:** 150mg once daily (28 capsules per 28 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document a reduced rate of HAE attacks compared to baseline.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Orladeyo (berotralstat) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
01/05/2021	New policy for Orladeyo created.
11/19/2021	Annual review, no changes

References:

1. Orladeyo (berotralstat) [package insert]. Durham, NC: BioCryst Pharmaceuticals, Inc; 2020.
2. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
3. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384
4. Zuraw B, Lumry WR, Johnston DT, et al. Oral once-daily berotralstat for the prevention of hereditary angioedema attacks: A randomized, double-blind, placebo-controlled phase 3 trial [published online ahead of print, 2020 Oct 21]. *J Allergy Clin Immunol*. 2020;S0091-6749(20)31484-6. doi:10.1016/j.jaci.2020.10.015

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Orthovisc (sodium hyaluronate)
BILLING CODE	J7324
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 4 injections (4 units)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Orthovisc (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member is not allergic to avian proteins, feathers, and egg products; AND
8. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
9. **Dosage allowed:** Inject 30 mg (2 mL) once weekly for 3 to 4 weeks (total of 3 to 4 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource

CareSource considers Orthovisc (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Orthovisc created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.

References:

1. Orthovisc [package insert]. Woburn, MA: Anika Therapeutics. N.d.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. *Cochrane Database Syst Rev.* 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Orthovisc. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
11. Orthovisc. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
12. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 07/01/2018
Revised date: 05/15/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Otezla (apremilast)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 60 per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Otezla (apremilast) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ORAL ULCERS ASSOCIATED WITH BEHÇET'S DISEASE

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consult with a rheumatologist or dermatologist; AND
3. Member has a diagnosis of Behçet's disease; AND
4. Member has recurrent oral ulcers with at least 2 active oral ulcers; AND
5. Member has had a trial and failure of a topical corticosteroid and/or colchicine.
6. **Dosage allowed:** Initial: 10 mg in the morning. Titrate upward by additional 10 mg per day on days 2 to 5 as follows: Day 2: 10 mg twice daily; Day 3: 10 mg in the morning and 20 mg in the evening; Day 4: 20 mg twice daily; Day 5: 20 mg in the morning and 30 mg in the evening. Maintenance dose: 30 mg twice daily starting on day 6.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show the member has experienced a decrease in the number of oral ulcers or decrease in pain level associated with oral ulcers.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Member has met a 4-week trial of an NSAID taken at maximally tolerated dose AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.).
5. **Dosage allowed:** Initial: 10 mg in the morning. Titrate upward by additional 10 mg per day on days 2 to 5 as follows: Day 2: 10 mg twice daily; Day 3: 10 mg in the morning and 20 mg in the evening; Day

4: 20 mg twice daily; Day 5: 20 mg in the morning and 30 mg in the evening. Maintenance dose: 30 mg twice daily starting on day 6.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
5. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks.
6. **Dosage allowed:** Initial: 10 mg in the morning. Titrate upward by additional 10 mg per day on days 2 to 5 as follows: Day 2: 10 mg twice daily; Day 3: 10 mg in the morning and 20 mg in the evening; Day 4: 20 mg twice daily; Day 5: 20 mg in the morning and 30 mg in the evening. Maintenance dose: 30 mg twice daily starting on day 6.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Otezla (apremilast) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Otezla created. Policies SRx-0042 and SRx-0043 archived. For diagnosis of PsO: immunosuppressive criterion was separated from phototherapies and topical agents trials; TNF inhibitors Humira and Enbrel were listed as required trials; Psoriasis Area and Severity Index (PASI) score requirement was added. For diagnosis of PsA: TNF inhibitors

	Humira and Enbrel were listed as required trials. List of diagnoses considered not medically necessary was added.
02/26/2019	Status changed to preferred. Humira and Enbrel trials removed from criteria. Clarifications entered for AS and PsA on NSAIDs trial length. Requirements on axial disease type removed from PsA. Physician Global Assessment score removed from diagnosis of PsO. References added. Reauthorization criteria on documented member's PASI score improvement incorporated into general chart noted documentation requirements.
07/28/2019	New diagnosis of Oral Ulcers Associated With Behçet's Disease added.
11/23/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. PsA: Added requirement of diagnosis of PsA. Removed non-axial disease requirement. Specified trials to be 4 weeks of an NSAID AND 3 months of a DMARD. PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement.
02/03/2021	Behcet's disease: Updated references. Changed initial approval duration from 12 months to 6 months. Specified they must have active ulcers. Changed the step drugs to match EULAR guideline recommendations. Made the renewal criteria specific.
11/17/2021	Annual review, no changes

References:

1. Otezla [prescribing information]. Thousand Oaks, CA: Amgen Inc; December 2020.
2. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
3. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
4. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
5. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
6. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
7. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
8. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
9. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
10. ClinicalTrials.gov. Identifier: NCT02307513. A Phase 3 Randomized, Double-blind Study to Evaluate the Efficacy and Safety of Apremilast (CC-10004) in Subjects With Active Behcet's Disease. Available at: https://clinicaltrials.gov/ct2/show/NCT02307513?term=BCT-002&rank=2.
11. Hatemi G, Christensen R, Bang D, et al. 2018 update of the EULAR recommendations for the management of Behçet's syndrome. *Ann Rheum Dis*. 2018;77(6):808-818. doi:10.1136/annrheumdis-2018-213225
12. Hatemi G, Mahr A, Ishigatsubo Y, et al. Trial of Apremilast for Oral Ulcers in Behçet's Syndrome. *N Engl J Med*. 2019;381(20):1918-1928. doi:10.1056/NEJMoa1816594

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Oxbryta (voxelotor)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior authorization required (Non-Preferred product) Alternative preferred product includes hydroxyurea QUANTITY LIMIT – 90 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Oxbryta (voxelotor) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SICKLE CELL DISEASE

For **initial** authorization:

1. Member must be 12 years of age or older; AND
2. Medication is prescribed by or in consultation with a hematologist or a physician who has experience in treating sickle cell disease; AND
3. Member has a confirmed diagnosis of sickle cell disease with at least one vaso-occlusive crisis within the past 12 months; AND
4. Member has a baseline hemoglobin level between 5.5-10.5 g/dL documented in chart notes; AND
5. Member has tried hydroxyurea for at least 3 months and the trial was ineffective or not tolerated; AND
6. Member will not be receiving chronic blood transfusion therapy; AND
7. Medication will not be used concurrently with Adakveo (crizanlizumab-tmca) therapy.
8. **Dosage allowed**: 1,500 mg by mouth daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing an increase in hemoglobin by ≥1 g/dL from baseline.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Oxbryta (voxelotor) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
4/30/2020	New policy for Oxbryta created.
11/17/2021	Annual review, no changes

References:

1. Oxbryta [Package Insert]. South San Francisco, CA: Global Blood Therapeutics, Inc.; November 2019.

2. Vichinsky E, Hoppe CC, Ataga KI, et al; HOPE Trial Investigators. A phase 3 randomized trial of voxelotor in sickle cell disease. N Engl Med. 2019;381(6):509-519.
3. Niihara Y, Miller ST, Kanter J, et al. A phase 3 trial of L-glutamine in sickle cell disease. N Engl Med. 2018;379:226-235.
4. Crizanlizumab, Voxelotor, and L-Glutamine for Sickle Cell Disease: Effectiveness and Value. Institute for Clinical and Economic Review, January 23, 2020. https://icer-review.org/material/sickle-cell-disease-draft-evidence-report/

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Oxervate (cenegermin-bkbj)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 8 kits per eye for 8 weeks (per lifetime)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Oxervate (cenegermin-bkbj) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NEUROTROPHIC KERATITIS

For **initial** authorization:

1. Member must be 2 years of age or older; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist or neurologist; AND
3. Member has a diagnosis of stage 2 (persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis, confirmed by a corneal sensitivity test (documentation required); AND
4. Member has had a trial and failure of preservative-free artificial tears for at least 14 days (with progression of corneal damage); AND
5. Member does NOT have severe corneal thinning (i.e., involving posterior third of the stroma), corneal melting or perforation in the affected eye.
6. **Dosage allowed:** 1 drop to affected eye(s) 6 times per day (2-hour intervals).

If member meets all the requirements listed above, the medication will be approved for 8 weeks.

For **reauthorization**: Not applicable. There is insufficient data to support re-treatment of the same eye.

CareSource considers Oxervate (cenegermin-bkbj) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/16/2020	New policy for Oxervate created.
11/17/2021	Annual review, no changes

References:

1. Oxervate® (cenegermin-bkbj) [package insert]. Boston, MA: Dompe U.S. Inc; 2019.
2. Wells J. Diagnosing and Treating Neurotrophic Keratopathy. *EyeNet Magazine*. 2008. https://www.aao.org/eyenet/article/diagnosing-treating-neurotrophic-keratopathy?julyaugust-2008. Accessed September 18, 2020.

3. Lambiase A, Sacchetti M. Diagnosis and management of neurotrophic keratitis. *Clinical Ophthalmology*. 2014:571-579. doi:10.2147/opth.s45921
4. Evaluation of Safety and Efficacy of rhNGF in Patients With Stage 2 and 3 Neurotrophic Keratitis. (REPARO). ClinicalTrials.gov Identifier: NCT01756456. Updated July 29, 2019. Accessed September 18, 2020. https://clinicaltrials.gov/ct2/show/NCT01756456
5. Sheha H, Tighe S, Hashem O, Hayashida Y. Update On Cenegermin Eye Drops In The Treatment Of Neurotrophic Keratitis. *Clinical Ophthalmology*. 2019:1973-1980. doi:10.2147/opth.s185184
6. Fleeman N, Mahon J, Nevitt S, et al. Cenegermin for Treating Neurotrophic Keratitis: An Evidence Review Group Perspective of a NICE Single Technology Appraisal. *PharmacoEconomics - Open*. 2019;3(4):453-461. doi:10.1007/s41669-019-0138-z
7. Pflugfelder SC, Massaro-Giordano M, Perez VL, et al. Topical Recombinant Human Nerve Growth Factor (Cenegermin) for Neurotrophic Keratopathy. *Ophthalmology*. 2020;127(1):14-26. doi:10.1016/j.ophtha.2019.08.020
8. Deeks ED, Lamb YN. Cenegermin: A Review in Neurotrophic Keratitis. *Drugs*. 2020;80(5):489-494. doi:10.1007/s40265-020-01289-w

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Ohio Medicaid**	
DRUG NAME	Oxlumo (lumasiran)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see Dosage Allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Oxlumo (lumasiran) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

Primary Hyperoxaluria Type 1 (PH1)

For **initial** authorization:

1. Member has a diagnosis of primary hyperoxaluria type 1 as evidenced by **one** of the following:
   a) Genetic testing shows a mutation in the AGXT gene; OR
   b) Lowered AGT catalytic and immunoreactivity in a liver biopsy specimen indicating PH1; AND
2. Member has documentation of elevated oxalate levels; AND
3. Medication must be prescribed by or in consultation with a urologist or nephrologist; AND
4. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with BOTH of the following treatments:
   a) At least a 90-day trial of Vitamin B6 (pyridoxine);
   b) At least a 30-day trial of a calcium oxalate crystallization inhibitor (i.e., potassium citrate, sodium citrate, organophosphates, magnesium oxide); AND
5. Member does not have ESRD (eGFR <30) and is not on dialysis; AND
6. Member has not received a liver transplant.
7. **Dosage allowed:**

Body Weight*	**Loading Dose**	**Maintenance Dose (begin 1 month after the last loading dose)**
Less than 10 kg	6 mg/kg once monthly for 3 doses	3 mg/kg once monthly
10 kg to less than 20 kg	6 mg/kg once monthly for 3 doses	6 mg/kg once every 3 months (quarterly)
20 kg and above	3 mg/kg once monthly for 3 doses	3 mg/kg once every 3 months (quarterly)

***Based on actual body weight**

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been submitted that show the member has:
   a) Decreased excretion of urine oxalate from baseline; OR
   b) Stable or improved kidney function (e.g., improved eGFR or decreased formation of renal stones); AND
3. Member has not received a liver transplant.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Oxlumo (lumasiran) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
12/08/2020	New policy for Oxlumo created.

References:

1. Oxlumo (lumasiran) [prescribing information]. Cambridge, MA: Alnylam Pharmaceuticals Inc; November 2020.
2. Oxlumo (lumasiran) [billing and coding guide]. Cambridge, MA: Alnylam Pharmaceuticals Inc; November 2020.
3. Cochat P, Hulton S, Acquaviva C, et al: Primary hyperoxaluria Type 1: indications for screening and guidance for diagnosis and treatment. *Nephrol Dial Transplant* 2012;27:1729-1736 doi: 10.1093/ndt/gfs078.
4. Danpure CJ. Molecular and clinical heterogeneity in primary hyperoxaluria type 1. *Am J Kidney Dis*. 1991 Apr;17(4):366-9. doi: 10.1016/s0272-6386(12)80624-x. PMID: 2008900.

Effective date: 10/1/2021
Revised date: 12/08/2020

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ozurdex (dexamethasone)
BILLING CODE	J7312
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
STATUS	Prior Authorization Required

Ozurdex is an intravitreal implant containing dexamethasone 0.7 mg. It is indicated for the treatment of retinal vein occlusion (RVO), posterior segment uveitis, and diabetic macular edema (DME).
RVO occurs when there is a partial or complete obstruction of a retinal vein. Macular edema is a complication of RVO and can lead to vision loss. First-line treatment is with anti-vascular endothelial growth factor (anti-VEGF) drugs.
DME is a common consequence of diabetic retinopathy. It is caused by leakage from retinal capillaries and leads to fluid build-up in the macula part of the retina. This can result in loss of central vision. The importance of maintaining glucose control cannot be understated.
Uveitis is an inflammation of the uvea (middle layer of the eye). It can be infectious or non-infectious. Non-infectious uveitis (NIU) is often associated with inflammatory conditions such as rheumatoid arthritis. If the anterior segment of the uvea is affected, it can be treated with topical glucocorticoids. If resistant or affecting the intermediate or posterior segments, more invasive or systemic treatment is needed.

Ozurdex (dexamethasone) will be considered for coverage when the following criteria are met:

Retinal Vein Occlusion (RVO)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a documented diagnosis of macular edema following branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO); AND
4. Trial and failure of or contraindication to an anti-VEGF drug; bevacizumab is the preferred product; AND
5. Member does NOT have any of the following:
   a) Active or suspected ocular or periocular infections
   b) Glaucoma with a cup to disc ratio of greater than 0.8
   c) Torn or ruptured posterior lens capsule
6. **Dosage allowed/Quantity limit:** One implant (0.7 mg) per eye
   Limit: 2 implants (1 per eye) per 6 months

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must include documentation of improved or stabilized visual acuity; AND
2. At least 6 months have elapsed since the prior treatment (of the same eye).

If all the above requirements are met, the medication will be approved for an additional 3 months.

Uveitis

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a documented diagnosis of non-infectious uveitis affecting the posterior segment of the eye; AND
4. Member has tried and failed at least one of the following for at least 3 months:
   a) Systemic corticosteroid (e.g., prednisone)
   b) Non-biologic immunosuppressive (e.g., mycophenolate mofetil, methotrexate, cyclosporine, tacrolimus); AND
5. Member does NOT have any of the following:
   a) Active or suspected ocular or periocular infections
   b) Glaucoma with a cup to disc ratio of greater than 0.8
   c) Torn or ruptured posterior lens capsule.
6. **Dosage allowed/Quantity limit:** One implant (0.7 mg) per eye
   Limit: 2 implants (1 per eye) per 6 months

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must show improved or stabilized visual acuity following treatment and/or an improved vitreous haze score; AND
2. At least 6 months have elapsed since the prior treatment (of the same eye); AND
3. Member has recurrent symptoms.

If all the above requirements are met, the medication will be approved for an additional 3 months.

Diabetic Macular Edema (DME)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a documented diagnosis of diabetic macular edema; AND
4. Member does NOT have any of the following:
   a) Active or suspected ocular or periocular infections
   b) Glaucoma with a cup to disc ratio of greater than 0.8
   c) Torn or ruptured posterior lens capsule.
5. **Dosage allowed/Quantity limit:** One implant (0.7 mg) per eye
   Limit: 2 implants (1 per eye) per 6 months

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must show improved or stabilized visual acuity following treatment; AND
2. At least 6 months have elapsed since the prior treatment (of the same eye).

If all the above requirements are met, the medication will be approved for an additional 3 months.

CareSource considers Ozurdex (dexamethasone) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/03/2021	New policy created for Ozurdex.

References:

1. Ozurdex [prescribing information]. Allergan USA, Inc.; 2020.
2. Tan HY, Agarwal A, Lee CS, et al. Management of noninfectious posterior uveitis with intravitreal drug therapy. *Clin Ophthalmol*. 2016;10:1983-2020. Published 2016 Oct 13. doi:10.2147/OPTH.S89341
3. Flaxel CJ, Adelman RA, Bailey ST, et al. Diabetic Retinopathy Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P66-P145. doi:10.1016/j.ophtha.2019.09.025
4. Grover D, Li TJ, Chong CC. Intravitreal steroids for macular edema in diabetes. *Cochrane Database Syst Rev*. 2008;(1):CD005656. Published 2008 Jan 23. doi:10.1002/14651858.CD005656.pub2
5. Rittiphairoj T, Mir TA, Li T, Virgili G. Intravitreal steroids for macular edema in diabetes. *Cochrane Database Syst Rev*. 2020;11(11):CD005656. Published 2020 Nov 17. doi:10.1002/14651858.CD005656.pub3
6. Zur D, Iglicki M, Loewenstein A. The Role of Steroids in the Management of Diabetic Macular Edema. *Ophthalmic Res*. 2019;62(4):231-236. doi:10.1159/000499540
7. Schmidt-Erfurth U, Garcia-Arumi J, Bandello F, et al. Guidelines for the Management of Diabetic Macular Edema by the European Society of Retina Specialists (EURETINA). *Ophthalmologica*. 2017;237(4):185-222. doi:10.1159/000458539
8. Flaxel CJ, Adelman RA, Bailey ST, et al. Retinal Vein Occlusions Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(2):P288-P320. doi:10.1016/j.ophtha.2019.09.029

Effective date: 04/01/2022
Revised date: 11/03/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Palforzia [Peanut (*Arachis hypogaea*) Allergen Powder-dnfp]
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Office, Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1 dose pack (30 sachets) per 30 days after loading doses (see Dosage Allowed)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Palforzia (Peanut (*Arachis hypogaea*) Allergen Powder) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PEANUT ALLERGY

For **initial** authorization:

1. Member is between 4 and 17 years of age; AND
2. Medication is prescribed and managed by an allergist; AND
3. Documentation must be submitted to confirm presence of peanut allergy, as evidenced by serum IgE >0.35kUa/L OR Skin Prick Test wheal >3mm compared to control; AND
4. Chart notes must show the member does **not** have any of the following:
   a) Anaphylaxis in the last 60 days;
   b) Uncontrolled asthma;
   c) Eosinophilic esophagitis or other eosinophilic gastrointestinal disease;
   d) Cardiovascular disease or uncontrolled hypertension; AND
5. Member has been assessed for ability to comply with daily dosing requirement, and can adhere to the daily dosing schedule; AND
6. Member understands to continue a peanut-avoidant diet.
7. **Dosage allowed:** One initial dose escalation packet (13 caps) for 1 day. One up-dosing packet (pack size varies) for 15 days each x 11 packets (165 days total). Then, maintenance dose of one 300mg sachet once daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. If the member is over 17 years of age, therapy must have been initiated between 4-17 years of age; AND
2. Chart notes must show the member has **not** had worsening of asthma or emergence of eosinophilic gastrointestinal disease; AND
3. Chart notes must show the member tolerates therapy and has **not** had anaphylaxis requiring a higher level of care; AND
4. Member must be compliant with daily dosing regimen.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Palforzia (Peanut (*Arachis hypogaea*) Allergen Powder) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/15/2020	New policy for Palforzia created.
11/17/2021	Annual review, no changes

References:

1. Palforzia [package insert]. Brisbane, CA; Aimmune Therapeutics, Inc.: February, 2020.
2. PALISADE Group of Clinical Investigators, et al. AR101 oral immunotherapy for peanut allergy. *N Engl J Med*. 2018;379(21):1991-2001. doi: 10.1056/NEJMoa1812856.
3. Chu DK, Wood RA, French S, et al. Oral immunotherapy for peanut allergy (PACE): A systematic review and meta-analysis of efficacy and safety.
4. Patrawala, M., Shih, J., Lee, G. and Vickery, B., 2020. Peanut Oral Immunotherapy: a Current Perspective. Current Allergy and Asthma Reports, 20(5).

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Palynziq (pegvaliase-pqpz)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Kuvan QUANTITY LIMIT— up to 40 mg SQ once daily
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Palynziq (pegvaliase-pqpz) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PHENYLKETONURIA

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Member has diagnosis of phenylketonuria and have uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management; AND
3. Member's baseline blood phenylalanine concentration submitted with chart notes before initiating treatment; AND
4. Member does **not** have ANY of the following:
   a) Current use of levodopa;
   b) A positive test for HIV antibody, hepatitis B surface antigen, or hepatitis C antibody;
   c) A history of organ transplantation or on chronic immunosuppressive therapy;
   d) A history of substance abuse (as defined by the Diagnostic and Statistical Manual of Mental Disorders [DSM IV]) in the past 12 months or current alcohol or drug abuse;
   e) Alanine aminotransferase (ALT) concentration > 2 times the upper limit of normal;
   f) Creatinine >1.5 times the upper limit of normal.
5. **Dosage allowed:** The recommended initial dosage is 2.5 mg subcutaneously once weekly for 4 weeks. Titrate the dosage in a step-wise manner over at least 5 weeks based on tolerability to achieve a dosage of 20 mg subcutaneously once daily. Consider increasing the dosage to a maximum of 40 mg subcutaneously once daily in patients who have been on 20 mg once daily continuously for at least 24 weeks and who have not achieved either a 20% reduction in blood phenylalanine concentration from pre-treatment baseline or a blood phenylalanine concentration less than or equal to 600 micromol/L.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member achieved at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline **or** a blood phenylalanine concentration less than or equal to 600 micromol/L after 16 weeks of continuous treatment with the maximum dosage of 40 mg once daily; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Palynziq (pegvaliase-pqpz) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/27/2018	New policy for Palynziq (pegvaliase-pqpz) created.
11/19/2021	Annual review, no changes

References:

1. Palynziq [package insert]. Novato, CA: BioMarin Pharmaceutical Inc.; May, 2018.
2. U.S. Food and Drug Administration. Media release. FDA approves a new treatment for PKU, a rare and serious genetic disease. Available at: https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm608835.htm. Accessed on July 27, 2018.
3. ClinicalTrials.gov Identifier: NCT01819727. An Open-Label Phase 3 Study of BMN 165 for Adults With PKU Not Previously Treated w/ BMN 165 (Prism301). Available at: https://clinicaltrials.gov/ct2/show/NCT01819727?term=NCT01819727&rank=1. Accessed on July 27, 2018.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Pegasys (peginterferon alfa-2a)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 4 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Pegasys (peginterferon alfa-2a) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEPATITIS B

For **initial** authorization:

1. Member is an adult with chronic Hepatitis B (CHB) and compensated liver disease (Child-Pugh A score less than or equal to 6) or a child (3 years of age or older) with non-cirrhotic CHB; AND
2. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist, a physician assistant or a nurse practitioner working with the above specialists; AND
3. Member has two elevated ALT lab values within the past 12 months (> 60 IU/L for men, > 38 IU/L for women) and HBV DNA levels > 20,000 IU/ml; AND
4. Member has tried and failed course of treatment with tenofovir (for ≥12 years of age) or entecavir (for ≥2 years of age); AND
5. Member does **not** have any of the following;
   a) Acute autoimmune hepatitis;
   b) HIV;
   c) Hepatic decompensation.
6. **Dosage allowed:** Adults: 180 mcg (1.0 mL) once weekly by subcutaneous administration in the abdomen or thigh; pediatrics: BSA x 180 mcg/1.732 m^2 subcutaneously once weekly.

Note: Serial monitoring of HBV-DNA levels along with ALT level should be used in determining the need for a treatment.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

HEPATITIS C

For **initial** authorization:
1. Member is 5-17 years of age previously untreated with interferon alfa; AND
2. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist, a physician assistant or a nurse practitioner working with the above specialists.
3. **Dosage allowed:** Pediatrics: BSA x 180 mcg/1.732 m^2 subcutaneously once weekly.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MYELOPROLIFERATIVE NEOPLASMS (MYELOFIBROSIS (MF), POLYCYTHEMIA VERA (PV), AND ESSENTIAL THROMBOCYTHEMIA (ET))

For **initial** authorization:
1. Member has diagnosis of Myeloproliferative Neoplasms (or one of the following: myelofibrosis (MF), polycythemia vera (PV), or essential thrombocythemia (ET)); AND
2. Medication must be prescribed by oncologist or hematologist; AND
3. Member has tried and failed course of treatment with at least **two** of the following:
   a) Low-dose aspirin (81-100 mg);
   b) Phlebotomy (to maintain a hematocrit level of <45%) and/or hydroxyurea;
   c) Anagrelide.
4. **Dosage allowed:** 180 mcg (1.0 mL) once weekly by subcutaneous administration in the abdomen or thigh.

Note: Pegasys will be considered for younger members, pregnant members, or members who defer hydroxyurea.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Pegasys (peginterferon alfa-2a) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute hepatitis B
- Bechet's disease
- Chronic uveitis

DATE	ACTION/DESCRIPTION
03/21/2018	New policy for Pegasys created. Coverage for adults for Hepatitis C was removed since no longer recommended by AASLD guidelines and since other more effective treatments are currently available. NCCN recommendations of off-label use added. CHB criteria revised.
9/16/2021	Annual review, no changes

References:

1. Pegasys [package insert]. South San Francisco, CA: Genentech USA, Inc.; October, 2017.
2. Terrault NA, Bzowej NH, Chang KM, et al. "AASLD guidelines for treatment of chronic hepatitis B." *American Association for the Study of Liver Diseases*. Published: December 21, 2015. Accessed March 21, 2018.
3. Vannucchi AM. How I treat polycythemia vera. *Blood*, 124(22), 3212-3220. Accessed March 19, 2018. https://doi.org/10.1182/blood-2014-07-551929.
4. Quinta´s-Cardama A, Kantarjian H, Manshouri T, et al. "Pegylated Interferon Alfa-2a Yields High Rates of Hematologic and Molecular Response in Patients With Advanced Essential Thrombocythemia and Polycythemia." *VeraJ Clin Oncol*, 27:5418-5424. Published: November 10, 2009. Accessed: March 21, 2018. http://ascopubs.org/doi/pdfdirect/10.1200/JCO.2009.23.6075.
5. Mascarenhas JO, Prchal JT, Rambaldi A, et al. "Interim Analysis of the Myeloproliferative Disorders Research Consortium (MPD-RC) 112 Global Phase III Trial of Front Line Pegylated Interferon Alpha-2a Vs. Hydroxyurea in High Risk Polycythemia Vera and Essential Thrombocythemia." *Blood,* 128(22), 479. Accessed March 19, 2018. Retrieved from http://www.bloodjournal.org/content/128/22/479.
6. Mesa RA, Jamieson C, Bhatia R, et al. "NCCN Guidelines Insights: Myeloproliferative Neoplasms, Version 2.2018." *J Natl Compr Canc Netw* 2017;15:1193-1207. Published: 2017. Accessed: http://www.jnccn.org/content/15/10/1193.long.
7. HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. Published: September 21, 2017. Accessed: March 21, 2018.
8. Update on Prevention, Diagnosis, and Treatment of Chronic Hepatitis B: AASLD 2018 Hepatitis B Guidance. PRACTICE GUIDANCE | HEPATOLOGY, VOL. 67, NO. 4, 2018.

Effective date: 01/01/2022
Revised date: 03/21/2018

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Phosphodiesterase Type 5 Inhibitors (PDE-5 Inhibitors) for Pulmonary Arterial Hypertension: Adcirca/Alyq (tadalafil), Revatio (sildenafil)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Pulmonary Arterial Hypertension is a rare but serious condition characterized by elevated pulmonary arterial resistance. Adcirca, Alyq and Revatio are phosphodiesterase Type 5 Inhibitors approved for the treatment of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1. Revatio is indicated in adults with PAH to improve exercise ability and delay clinical worsening. Adcirca and Alyq are approved in adults with PAH to improve exercise capacity, measured by improvement in 6-minute walking distance.

Phosphodiesterase Type 5 Inhibitors (PDE-5 Inhibitors) will be considered for coverage when the following criteria are met:

Pulmonary Arterial Hypertension [WHO Group 1]

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization;
4. Member must have documentation PAP pressures are not adequately controlled, confirmed by **one** of the following:
   a) Patient had an acute response to vasodilator testing AND has tried a calcium channel blocker (CCB) for at least 3 months; OR
   b) Patient did not have a response to vasodilator testing; OR
   c) Patient cannot undergo vasodilator testing; OR
   d) Patient cannot take CCB therapy
5. **Dosage allowed/Quantity limit:**
   Adcirca/Alyq: 40 mg once daily
   Revatio: 20 mg 3 times daily (maximum dose of 80 mg 3 times daily)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

PDE-5 Inhibitors will be reauthorized when chart notes show at least one of the following:

1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least **one** of the following:
   a) Stabilization or improvement in functional class symptoms (see Appendix)
   b) Stabilization or improvement in 6MWD [6-minute walk distance]

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Phosphodiesterase Type 5 Inhibitors (PDE-5 Inhibitors) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/15/2011	Pulmonary Arterial Hypertension policy creation.
05/13/2014	Combined all PAH agents into one policy
07/09/2015	Revised guidelines for therapy aligning with CMS
08/18/2015	Revised guidelines to include diagnosis criteria
10/13/2021	Separated PAH agents by drug class; Updated guidelines; Added provider specialty

References:

1. Revatio [package insert]. New York, NY: Pfizer, Inc; February 2020
2. Adcirca [package insert]. Indianapolis, IN: Eli Lilly and Company; December 2019
3. Alyq [package insert]. New York, NY: Pfizer, Inc; February 2020
4. Coons, J.C., Pogue, K., Kolodziej, A.R. et al. Pulmonary Arterial Hypertension: a Pharmacotherapeutic Update. Curr Cardiol Rep. 2019; 21(141)
5. Klinger JR, Elliott CG et al. Therapy for Pulmonary Arterial Hypertension in Adults; Chest Journal. March 2019; 155(3): 565-586
6. Galie N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension: The Joint Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS): Endorsed by: Association for European Paediatric and Congenital Cardiology (AEPC), International Society for Heart and Lung Transplantation (ISHLT). European heart journal. 2016;37(1):67–119

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

World Health Organization Functional Assessment Classification	
Class I	Patients with PAH but without resulting limitation of physical activity. Ordinary physical activity does not cause undue dyspnea, fatigue, chest pain or near syncope.
Class II	Patients with PAH resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity increases dyspnea, fatigue, chest pain, or near syncope.
Class III	Patients with PAH resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity increases dyspnea, fatigue, chest pain, or near syncope.
Class IV	Patients with PAH unable to carry out any physical activity without symptoms. These patients may have signs of right-heart failure. Dyspnea and/or fatigue may even by present at rest. Discomfort is increased by any physical activity.

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Plegridy (peginterferon beta-1a)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 2 per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Plegridy (peginterferon beta-1a) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
2. Chart notes have been provided confirming diagnosis of Multiple Sclerosis based; AND
3. Documentation of trial and failure of or contraindication to Avonex, Copaxone/Glatopa, Extavia, or Rebif for at least 90 days submitted with chart notes.
4. **Dosage allowed:** Initial, 63 mcg subcutaneously on day 1, then 94 mcg on day 15, then 125 mcg on day 29; continue 125 mcg every 14 days thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member has documented biological response to treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Plegridy (peginterferon beta-1a) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/12/2017	New policy for Plegridy created. Not covered diagnosis added.
12/06/2017	Confirmation of diagnosis based on McDonald criteria is no longer required.
9/16/2021	Annual review, no changes

References:

1. Plegridy [package insert]. Cambridge, MA; Biogen Inc.: Revised July 2016.
2. Plegridy. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed April 7, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ponvory (ponesimod)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Ponvory was approved by the FDA in 2021 for the treatment of relapsing forms of multiple sclerosis (MS). It is the fourth, once-daily oral sphingosine-1-phosphate (S1P) receptor modulator, following Gilenya, Mayzent, and Zeposia. MS is a chronic autoimmune disease of the central nervous system. In the phase 3 OPTIMUM study, Ponvory was superior to teriflunomide at reducing the annualized relapse rate.

Ponvory (ponesimod) will be considered for coverage when the following criteria are met:

Multiple Sclerosis (MS)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of a relapsing form of MS (i.e., clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease); AND
4. Member has tried and failed or is unable to try at least 1 preferred sphingosine-1-phosphate (S1P) receptor modulator; AND
5. Medication will not be used concomitantly with any other disease modifying drugs for MS; AND
6. The following baseline assessments have been completed (or are scheduled):
   a) A complete blood count (CBC)
   b) An ophthalmic evaluation
   c) Liver function tests
   d) A cardiac evaluation by electrocardiogram (ECG); AND
7. Member has not experienced any of the following in the past 6 months: Myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure; AND
8. Member does not have Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome unless they have a functioning pacemaker.
9. **Dosage allowed/Quantity limit:** Following initial 14-day titration (see package insert), the maintenance dose is 20 mg orally once daily. (Limit 30 tablets per 30 days)

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as fewer relapses or no new or enlarged brain lesions on MRI.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Ponvory (ponesimod) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/18/2021	New policy for Ponvory created.
12/02/2021	Added safety/monitoring components to be consistent with the rest of the policies in this class.

References:

1. Ponvory [package insert]. Janssen Pharmaceuticals, Inc.; 2021. https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/PONVORY-pi.pdf
2. Kappos L, Fox RJ, Burcklen M, et al. Ponesimod Compared With Teriflunomide in Patients With Relapsing Multiple Sclerosis in the Active-Comparator Phase 3 OPTIMUM Study: A Randomized Clinical Trial. *JAMA Neurol*. 2021;78(5):558-567. doi:10.1001/jamaneurol.2021.0405
3. Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology [published correction appears in Neurology. 2019 Jan 8;92(2):112]. *Neurology*. 2018;90(17):777-788. doi:10.1212/WNL.0000000000005347
4. National Multiple Sclerosis Society. The Use of Disease-Modifying Therapies in Multiple Sclerosis: Principles and Current Evidence. A Consensus Paper by the Multiple Sclerosis Coalition; 2019. Available from: https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/DMT_Consensus_MS_Coalition.pdf. Accessed August 18, 2021.
5. Thompson AJ, Banwell BL, Barkhof F, et al. Diagnosis of multiple sclerosis: 2017 revisions of the McDonald criteria. *Lancet Neurol*. 2018;17(2):162-173. doi:10.1016/S1474-4422(17)30470-2

Effective date: 04/01/2022
Revised date: 12/02/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Praluent (alirocumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior authorization required (Non-preferred product) QUANTITY LIMIT – 2 injections per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Praluent (alirocumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HeFH))

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a lipid specialist or a cardiologist; AND
3. Member has a diagnosis of heterozygous familial hypercholesterolemia (FeFH) confirmed by **one** of the following:
   a) Dutch Lipid Network Criteria score of 9 or higher;
   b) Genetic testing confirmation;
   c) "Definite" Simon Broome Criteria (see Table 1 to determine eligibility, if not submitted with chart notes); AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days; AND
5. Member is unable to achieve LDL < 100 mg/dL[2] after a 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe; AND
6. Praluent will be used in combination with a statin and/or ezetimibe, unless contraindicated or intolerant; AND
7. Prescriber attests that the member will adhere to a diet regimen or diet modification.
8. **Dosage allowed**: 75 mg (1 injection of 75 mg/mL) every 2 weeks OR 300 mg (2 injections of 150 mg/mL) every 4 weeks OR 150 mg (1 injection of 150 mg/mL) every 2 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HoFH)

For **initial** authorization:

1. Member is 18 years old or older; AND

CareSource

2. Medication must be prescribed by or in consultation with a cardiologist or a lipid specialist; AND
3. Member has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by **one** of the following:
   a) Genetic testing confirmation of two mutant alleles in the LDLR, Apo-B, PCSK9, or LDLRAP1 gene locus; OR
   b) LDL-C > 500 mg/dL before any treatment or LDL-C > 300 mg/dL if treated with a lipid-lowering drug AND **one** of the following:
      i) Xanthoma before 10 years of age; OR
      ii) Evidence of heterozygous familial hypercholesterolemia (HeFH) (i.e., total cholesterol > 250 mg/dL) in both parents; AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days prior to therapy; AND
5. Member is unable to achieve LDL-C goal (see Note) after a 90-day trial with a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe; AND
6. Praluent will be used as an adjunct to other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis), unless contraindicated or intolerant; AND
7. Prescriber attests that the member will adhere to a diet regimen or diet modification.
8. **Dosage allowed**: 150 mg (1 injection of 150 mg/mL) subcutaneously once every 2 weeks.

NOTE: The LDL-C goals are <100 mg/dL for adults 18 years or older, < 135 mg/dL for children, and < 70 mg/dL for adults with clinical ASCVD.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PREVENTION OF CARDIOVASCULAR EVENTS

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a lipid specialist or a cardiologist; AND
3. Member has a history of clinical atherosclerotic cardiovascular disease (ASCVD) (e.g. angina, coronary or other arterial revascularization, MI, stroke, transient ischemic attack, peripheral arterial disease, etc.); AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days; AND
5. Member is unable to achieve LDL-C < 70 mg/dL[2] after a 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe; AND
6. Praluent will be used in combination with a statin and/or ezetimibe, unless contraindicated or intolerant; AND
7. Prescriber attests that the member will adhere to a diet regimen or diet modification.
8. **Dosage allowed**: 75 mg (1 injection of 75 mg/mL) every 2 weeks OR 300 mg (2 injections of 150 mg/mL) every 4 weeks OR 150 mg (1 injection of 150 mg/mL) every 2 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Praluent (alirocumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/09/2020	New policy for Praluent created. Retired old Biologic Cholesterol Agents policy.
04/27/2021	New indication Homozygous Familial Hypercholesterolemia (HoFH) added. Updated atorvastatin high-intensity requirement to reflect pediatric vs. adult dosing.

References:

1. Praluent [Package Insert]. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; April 2021.
2. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC Guideline on the Management of Blood Cholesterol. JACC. 2018;73(24)doi:10.1016/j.jacc.2018.11.002.
3. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. JACC. 2017;70(14):1785-1822.
4. Harada M, Arai H, Ishigaki Y, et al. Guidelines for diagnosis and treatment of familial hypercholesterolemia 2017. J Atheroscler Thromb. 2018 Aug 1; 25(8): 751–770.
5. McGowen, Dehkordi S, Moriarty P, et al. Diagnosis and treatment of heterozygous familial hypercholesterolemia. J Am Heart Assoc. 2019 Dec 17;8(24):e013225.
6. Kastelein JJ, Ginsberg, HN, Langslet G, et al. ODYSSEY FH I and FH II: 78 week resuls with alirocumab treatment in 735 patients with heterozygous familial hypercholesterolemia. Eur Heart J. 2015 Nov 14;36(43):2996-3003.
7. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Task Force on Expert Consensus Decision Pathways. *J Am Coll Cardiol*. 2017;70(14):1785-1822.
8. Pignone M. Management of elevated low density lipoprotein-cholesterol (LDL-C) in primary prevention of cardiovascular disease. In: Freeman MW, ed. *UpToDate*. Waltham, MA.; UpToDate; 2020. www.uptodate.com. Accessed July 09, 2020.
9. Blom DJ, Harada-Shiba M, Rubba P, et al. Efficacy and Safety of Alirocumab in Adults With Homozygous Familial Hypercholesterolemia: The ODYSSEY HoFH Trial. *J Am Coll Cardiol*. 2020;76(2):131-142.
10. Cuchel M, Bruckert E, Ginsberg HN, et al. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. Eur Heart J. 2014;35(32):2146-2157.

Effective date: 01/01/2022
Revised date: 04/27/2021

Table 1

Simon Broom Criteria

• Total cholesterol level > 290 mg/dL OR LDL-C > 190 mg/dL at baseline AND
• One of the following:
  ○ Physical finding of tendon xanthomas in 1st or 2nd degree relative;
  ○ Confirmation by gene or receptor testing (presence of LDL-R, ApoB, or PCSK9 mutation)

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Probuphine (buprenorphine subdermal implant)
BILLING CODE	J0570
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1 implant in each arm for 6 months each
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Probuphine (buprenorphine subdermal implant) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID DEPENDENCE

For **initial** authorization:

1. Member is 18 to 65 years of age; AND
2. Member has a documented diagnosis of opioid use disorder and/or other dependency in char notes; AND
3. Medication must be prescribed by a DATA 2000 waivered physician with an appropriate DEA number associated with an "X" prefix or SAMHSA certified; AND
4. Member must participate in a comprehensive rehabilitation program that includes psychosocial treatment (Documentation of treatment plan and taper strategy not required, but verification upon request must be provided); AND
5. Member must have achieved and sustained prolonged clinical stability on 8 mg/day or less of transmucosal buprenorphine equivalent for at least 3 months without any need for supplemental doses or adjustments. The dose should not have been tapered down to a lower dose for the sole purpose of transitioning to the subdermal implant; AND
6. A documented reason as to why oral therapy should not be continued; AND
7. All REMS Program criteria must be met (see www.probuphinerems.com).
8. **Dosage allowed:** 1 implant in one arm for 6 months, 1 implant in the opposite arm for a total of 12 months of therapy. Implants should not be used for additional treatment cycles after one insertion in each upper arm.

Note: Use of buprenorphine subdermal implant (Probuphine) is limited to a total duration of 12 months (1 implant in each arm for 6 months each).

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
Probuphine will not be reauthorized.

CareSource considers Probuphine (buprenorphine subdermal implant) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/03/2019	Policy for Probuphine modified into a new format.
03/11/2021	Annual review, no changes

References:

1. MedWatch: The FDA Safety Information and Adverse Event Reporting Program. Available at http://www.fda.gov/safety/medwatch/default.htm.
2. Probuphine [package insert]. Princeton, NJ: Braeburn Pharmaceuticals, Inc.; May 2016.
3. Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). US Dept of Health and Human Services. Results from the 2007 National Survey on Drug Use and Health: National Findings. (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.
4. Kakko J, Heilig M, Sarman I. Buprenorphine and methadone treatment of opiate dependence during pregnancy: Comparison of fetal growth and neonatal outcomes in two consecutive case series. Drug Alcohol Depend. 2008 Jul 1; 96(1-2):69-78.
5. Maremmani I and Gerra G. Buprenorphine-based regimens and methadone for the medical management of opioid dependence: selecting the appropriate drug for treatment. Am J Addict 2010;19: 668-568.
6. Nicholls L, Bragaw L, and Ruetsch C. Opioid dependence treatment and guidelines. J Manag Care Pharm. 2010 Feb;16(1 Suppl B):S14-21.
7. Jones HE, Martin PR, Heil SM, et al. Treatment of opioid dependent pregnant women: clinical and research issues. J Subst Abuse Treat 2008; 35(3): 245-259.
8. Orman JS, Keating GM. Buprenorphine/naloxone: a review of its use in the treatment of opioid dependence. Drugs. 2009; 69(5):577-607.
9. Drug Enforcement Administration Office of Diversion Control. DEA requirements for DATA waived physicians (DWPs). http://www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm.
10. Substance Abuse and Mental Health Services Administration. Buprenorphine Waiver Management. Updated 8/17/16. http://www.samhsa.gov/medication-assistedtreatment/buprenorphine-waiver-management.
11. Ohio. 5122-29-35. Licensure to conduct an opioid agonist program.
12. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
13. Ohio Administrative Code 4731-11.
14. Kampman K, Jarvis M. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. J Addict Med. 2015; 9: 1-10.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Procrit (epoetin alfa)
BILLING CODE	For Medical - J0885 (Non-ESRD) For Pharmacy - Must use valid NDC code
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office, Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— vary per diagnosis
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Procrit (epoetin alfa) is a **preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANEMIA

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Member has documented diagnosis of anemia due to **one** of the following:
   a) Myelodysplastic syndrome;
   b) Chronic Kidney Disease (GFR below 60 mL/min/1.73 m2);
   c) Concomitant Zidovudine treatment in member with HIV-infection;
   d) The effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy; AND
3. Member's individual iron status reveals **both** of the following:
   a) Transferrin saturation is at least 20%;
   b) Ferritin is at least 100 mcg/L; AND
4. Member is on supplemental iron therapy (unless serum ferritin level > 800 mcg/L); AND
5. Member's labs show hemoglobin ≤10 g/dL for adults (≤11 g/dL for children) within the last 14 days for initial therapy, OR ≤10.5 g/dL for adults (≤11.5 g/dL for children) currently receiving therapy.
6. **Dosage allowed:** Members with CKD - 50 to 100 Units/kg 3 times weekly (adults) as initial dose and 50 Units/kg 3 times weekly (pediatric patients). Individualize maintenance dose. Intravenous route recommended for members on hemodialysis. Members on Zidovudine due to HIV-infection -100 Units/kg 3 times weekly. Members with cancer - 40,000 Units weekly or 150 Units/kg 3 times weekly (adults); 600 Units/kg intravenously weekly (pediatric patients ≥5 years).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's hemoglobin increased, stayed the same and not decreased further (baseline labs and current labs required); AND
2. Red blood cells transfusions are not required or the number of the transfusions has decreased.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource

REDUCTION OF ALLOGENEIC RBC TRANSFUSIONS

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Medication is being used for reduction of allogeneic RBC transfusions in member undergoing elective, non-cardiac, nonvascular high-risk surgery at increased risk of or intolerant to transfusions; AND
3. Member's labs show hemoglobin ≤13 g/dL.
4. **Dosage allowed:** 300 Units/kg per day daily for 15 days or 600 Units/kg weekly.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Medication will not be reauthorized.

CareSource considers Procrit (epoetin alfa) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- In members with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy
- In members with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure
- In members with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion
- In members scheduled for surgery who are willing to donate autologous blood
- In members undergoing cardiac or vascular surgery
- As a substitute for RBC transfusions in patients who require immediate correction of anemia

DATE	ACTION/DESCRIPTION
10/04/2018	New policy for Procrit created. Hemoglobin requirement expanded. Endogenous serum erythropoietin level requirement removed.

References:

1. Procrit [package insert]. Thousand Oaks, CA: Amgen; September, 2017.
2. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology; Cancer- and Chemotherapy- Induced Anemia. V.2.2018. Available at https://www.nccn.org/professionals/physician_gls/pdf/anemia.pdf. Accessed January 30, 2018.
3. Wolters Kluwer. Facts & Comparisons. www.factsandcomparisons.com, 2011. (May 11, 2011).
4. Young. D. CMS Anemia Drugs Proposal: Bad for Amgen, Good for Patients, 17 May 2007.
5. New risk management program for erythropoiesis-stimulating agents. Aranesp, Procrit, and Epogen Article; Pharmacist's Letter; April 2010; Vol: 26 Hematology / Oncology.
6. Singh AK, Szczech L, Tang KL, et al. Correction of Anemia with Epoetin Alfa in Chronic Kidney Disease, N Engl j Med. 2006; 355:2085-98.
7. Mueller BU, Jacobsen RN, Jarosinski P, et al. Erythropoietin for zidovudine-associated anemia in children with HIV infection.
8. Pediatr AIDS and HIV Infect: Fetus to Adolesc. 1994;5:169-173.
9. Bohlius J, Wilson J, Seidenfeld J, et al., Recombinant Human Erythropoietins and Cancer Patients: Updated Meta-Analysis of 57 Studies Including 9353 Patients. J Natl Cancer Inst. 2006; 98:708-14.
10. Erythropoiesis-stimulating agents in oncology: a study-level meta-analysis of survival and other safety outcomes.

11. Glaspy J, Crawford J, Vansteenkiste J, Henry D, Rao S, Bowers P, Berlin JA, Tomita D, Bridges K, Ludwig H Br J Cancer. 2010;102(2):301. American Society of Clinical Oncology/American Society of Hematology clinical practice guideline update on the use of epoetin and darbepoetin in adult patients with cancer.
12. Rizzo JD, Brouwers M, Hurley P, Seidenfeld J, Arcasoy MO, Spivak JL, Bennett CL, Bohlius J, Evanchuk D, Goode MJ, Jakubowski AA, Regan DH, Somerfield MR, American Society of Clinical Oncology, American Society of Hematology; J Clin Oncol. 2010;28(33):4996. National Comprehensive Cancer Network (NCCN) guidelines www.nccn.org. Accessed September 3, 2015.
13. Aliment Pharmacol Ther. 2010 May;31(9):929-37. Epub 2010 Feb 18.Review article: optimizing SVR and management of the haematological side effects of peginterferon/ribavirin antiviral therapy for HCV - the role of epoetin, G-CSF and novel agents.
14. Definition and management of anemia in patients infected with hepatitis C virus. McHutchison JG, Manns MP, Longo DL Liver Int. 2006;26(4):389 MCG 20th edition, 2016.

Effective date: 10/19/2018
Revised date: 10/04/2018

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Prolia (denosumab)
BILLING CODE	J0897
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include alendronate, risedronate, ibandronate tablet, and zoledronic acid QUANTITY LIMIT— 60 mg every 6 months
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Prolia (denosumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOPOROSIS

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is being used to treat **one** the following:
   a) Osteoporosis in postmenopausal women;
   b) Osteoporosis in men;
   c) Glucocorticoid-induced osteoporosis in men and women who have been taking ≥ 7.5 mg of prednisone (or equivalent) daily and will remain on therapy for at least 6 months; AND
3. Member is at high-risk for fracture as evidenced by **one** of the following:[2,6]
   a) Bone mineral density (BMD) T-score –2.5 or below in the lumbar spine, femoral neck, proximal femur, 1/3 radius, or total hip;
   b) History of vertebral (spine) or hip fracture;
   c) T-score between –1 and –2.5 with a fragility fracture of proximal humerus, pelvis, or distal forearm;
   d) T-score between –1 and –2.5 with FRAX score of ≥ 20% for major osteoporotic fracture or ≥ 3% for hip fracture;
   e) Member is taking prednisone ≥30mg/day (or equivalent) and cumulative dose > 5g in the last year;
   f) Member is taking prednisone ≥ 7.5mg/day (or equivalent) for 6 months AND having greater than 10% BMD loss per year or a Z score < -3 at hip or spine; AND
4. Member has had an inadequate response to at least 12 months of an oral bisphosphonate (e.g., alendronate, risedronate) or an IV bisphosphonate (e.g., zoledronic acid (Reclast), ibandronate), unless not tolerated or contraindicated.
5. **Dosage allowed:** one subcutaneous injection (60 mg) every 6 months.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing stable or increase in bone mineral density, with no evidence of new fractures or vertebral fracture progression.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

BONE LOSS (for prostate cancer or breast cancer patients)

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication is intended to be used for **one** the following:
   a) Treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy (e.g., goserelin, leuprolide, bicalutamide) for non-metastatic prostate cancer;
   b) Treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy (e.g., anastrozole, letrozole) for breast cancer; AND
3. Member is at high risk for fracture, as defined by **one** of the following:[9,14]
   a) Has two of the following risk factors: Age > 65, T score < -1.5, smoking, BMI < 20, family history of hip fracture, personal history of fragility fracture > 50 years, oral glucocorticoid use > 6 months;
   b) T-score less than -2 in the femoral neck, total hip, or lumbar spine;
   c) Decrease in BMD ≥5% per year;
   d) FRAX score of ≥ 20% for major osteoporotic fracture or ≥ 3% for hip fracture; AND
4. Member has had an inadequate response to 12 months of an oral bisphosphonate (e.g., alendronate, risedronate) or an IV bisphosphonate (e.g., zoledronic acid (Reclast)), unless not tolerated or contraindicated.
5. **Dosage allowed:** one subcutaneous injection (60 mg) every 6 months.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member continues to be at high risk for fracture due to taking androgen deprivation therapy or aromatase inhibitor therapy; AND
2. Chart notes have been provided showing stable or increase in bone mineral density, with no evidence of new fractures or vertebral fracture progression.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Prolia (denosumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Bone metastases from solid tumors
- Giant Cell Tumor of Bone
- Multiple Myeloma
- Paget's disease

DATE	ACTION/DESCRIPTION
07/19/2019	New policy for Prolia created.
08/13/2020	For osteoporosis: added age requirement; removed Appendix of risk factors for fracture; added diagnostic criteria for GC-induced; removed exclusions (uncorrected hypocalcemia, dental disease, Xgeva within past 6 months); removed vitamin D &

	calcium requirement; removed reasons oral bisphosphonate cannot be used; changed trial to 12 months of oral or IV bisphosphonate; changed approval length to 12 months. For bone loss due to cancer drugs: added age requirement; redefined diagnostic requirements according to latest guidelines; removed exclusions (uncorrected hypocalcemia, dental disese, Xgeva within past 6 months); removed vitamin D & calcium requirement; trial specified to be 12 months or oral or IV bisphosphonate; changed approval length to 12 months.

References:

1. Prolia (denosumab) [prescribing information]. Thousand Oaks, CA: Amgen Inc; March 2020.
2. Camacho PM, Petak SM, Binkley N, et al. American Association of Clinical Endocrinologists and American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis – 2020. *Endocr Pract*. 2020 May;26(5):564-570.
3. Cosman, F., de Beur, S.J., LeBoff, M.S. et al. Clinician's Guide to Prevention and Treatment of Osteoporosis. Osteoporos Int 25, 2359–2381 (2014).
4. Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. *Arch Osteoporos*. 2017;12(1):43. doi:10.1007/s11657-017-0324-5.
5. Leder BZ. Optimizing Sequential and Combined Anabolic and Antiresorptive Osteoporosis Therapy. *JBMR Plus*. 2018;2(2):62-68. Published 2018 Feb 27.
6. Buckley L, Guyatt G, Fink HA, et al. 2017 American college of rheumatology guideline for the prevention and treatment of glucocorticoid-induced osteoporosis. *Arthritis Rheumatol*. 2017 Aug;69(8):1521-1537.
7. Rao SS, Budhwar N, Ashfaque A. Osteoporosis in men. *Am Fam Physician*. 2010 Sep 1;82(5):503-8.
8. Mohler JL, Lee RJ, Antonarakis ES, et al. Prostate cancer – NCCN Guidelines Version 4.2018. National Comprehensive Cancer Network. Updated August 15, 2018. Accessed February 27, 2019. https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf.
9. Cianferotti L, Bertoldo F, Carini M, et al. The prevention of fragility fractures in patients with non-metastatic prostate cancer: a position statement by the international osteoporosis foundation. *Oncotarget*. 2017;8(43):75646-75663. Published 2017 May 18.
10. Bienz M, Saad F. Androgen-deprivation therapy and bone loss in prostate cancer patients: a clinical review. *Bonekey Rep*. 2015;4:716. Published 2015 Jun 24.
11. Lee CE, Leslie WD, Czaykowski P, Gingerich J, Geirnaert M, Lau YK. A comprehensive bone-health management approach for men with prostate cancer receiving androgen deprivation therapy. *Curr Oncol*. 2011;18(4):e163-e172.
12. Gradishar WJ, Anderson BO, Abraham J, et al. Breast Cancer – NCCN Guidelines Version 4.2018. National Comprehensive Cancer Network. Updated February 8, 2019. Accessed February 27, 2019. https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf.
13. Taxel P, Faircloth E, Idrees S, Van Poznak C. Cancer Treatment-Induced Bone Loss in Women With Breast Cancer and Men With Prostate Cancer. *J Endocr Soc*. 2018;2(7):574-588. Published 2018 May 21.
14. Hadji P, Aapro MS, Body JJ, et al. Management of Aromatase Inhibitor-Associated Bone Loss (AIBL) in postmenopausal women with hormone sensitive breast cancer: Joint position statement of the IOF, CABS, ECTS, IEG, ESCEO IMS, and SIOG. *J Bone Oncol*. 2017;7:1-12. Published 2017 Mar 23.

Effective date: 10/1/2021
Revised date: 08/13/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Promacta (eltrombopag)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include immune globulins QUANTITY LIMIT — 30 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Promacta (eltrombopag) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

IMMUNE THROMBOCYTOPENIC PURPURA (ITP)

For **initial** authorization:

1. Member is 1 year of age or older; AND
2. Member has a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP); AND
3. Medication must be prescribed by or in consultation with a hematologist; AND
4. Member has ONE of the following conditions:
   a) Current platelet count is $<30x10^9$/L;
   b) $30x10^9$/L to $50x10^9$/L with one of the following:
      i) Symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma);
      ii) Have risk factors for bleeding (i.e., on anticoagulant, lifestyle that predisposes member to trauma, comorbidity such as peptic ulcer disease, undergoing medical procedure where blood loss is anticipated); AND
5. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with ONE of the following treatments:
   a) Corticosteroids (prednisone, prednisolone, methylprednisolone, and dexamethasone);
   b) Immunoglobulins;
   c) Splenectomy.
6. **Dosage allowed:** Administer 50 mg by mouth once daily for most patients 6 years and older; 25 mg by mouth once daily for 1 to 5 years of age. Max dose of 75 mg daily.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement in platelet count from baseline; AND
3. Member's platelet count is less than 200 x 10^9/L.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CHRONIC HEPATITIS C ASSOCIATED THROMBOCYTOPENIA

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a documented diagnosis of Thrombocytopenia associated with chronic Hepatitis C infection; AND
3. Medication must be prescribed by or in consultation with a hematologist or an infectious disease specialist; AND
4. Member has a platelet count of less than 75 x 10^9/L; AND
5. Member does not have any of the following:
   a) Decompensated liver disease (Child-Pugh score > 6, class B and C);
   b) History of ascites;
   c) Hepatic encephalopathy.
6. **Dosage allowed:** Initiate at a dose of 25 mg by mouth once daily, then adjust in 25 mg increment every week to achieve target platelet count. Max dose of 100 mg daily.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement in platelet count from baseline; AND
3. Member's platelet count is below 400 x 10^9/L; AND
4. Member is taking ribavirin or peginterferon concurrently as documented in chart notes and/or pharmacy claims.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 3 months.

SEVERE APLASTIC ANEMIA

For **initial** authorization:

1. Member is 17 years of age or older; AND
2. Member has a documented diagnosis of severe aplastic anemia defined as a marrow cellularity <25% plus at least 2 of the following criteria:
   a) Neutrophils or ANC < 0.5 x 10^9/L (500/mm^3);
   b) Platelets < 20 x 10^9/L (20,000/mm^3);
   c) Reticulocyte count < 20 x 10^9/L (20,000/mm^3); AND
3. Member has a baseline platelet count of less than or equal to 30 x 10^9/L; AND
4. Medication must be prescribed by or in consultation with a hematologist; AND
5. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with at least one course of immunosuppressive therapy (e.g., anti-thymocyte globulin (ATGAM), thymoglobulin, or cyclosporine).
6. **Dosage allowed:** Initiate at a dose of 50 mg by mouth once daily, then adjust in 50 mg increment every 2 weeks to achieve target platelet count ≥ 50 x 10^9/L. Max dose of 150 mg daily.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement in platelet count from baseline; AND
3. Member's platelet count is less than 400 x 10^9/L.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 3 months.

CareSource considers Promacta (eltrombopag) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- ITP with previous documented failure of Promacta
- Thrombocytopenia due to Myelodysplastic syndrome (MDS)

DATE	ACTION/DESCRIPTION
05/02/2018	New policy for Promacta created. Baseline liver enzymes levels requirement was removed. Four months of immunosuppressive therapy requirement for Severe Aplastic Anemia was removed. Platelets requirement threshold expanded.
11/17/2021	Annual review, no changes

References:

1. Promacta [Package Insert]. Research Triangle Park, NC: GlaxoSmithKline; October 2017.
2. Diagnosis and treatment of idiopathic thrombocytopenic purpura: recommendations of the American Society of Hematology. Ann Intern Med. 1997 Feb 15;126(4):319-26.
3. McHutchinson JG, Dusheiko G, Shiffman ML, et al. Eltrombopag for Thrombocytopenia in Patients with Cirrhosis Associated with Hepatitis C. N Engl J Med 2007; 357:2227-2236.
4. Killick SB, Bown N, Cavenagh J, et al. Guidelines for the diagnosis and management of adult aplastic anemia. Br J Haematol. 2016 Jan;172(2):187-207.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Pulmozyme (dornase alfa inhalation solution)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 75 per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Pulmozyme (dornase alfa inhalation solution) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 5 years of age or older; AND
2. Medication must be prescribed by a pulmonologist or an infectious disease specialist; AND
3. Member has a diagnosis of cystic fibrosis; AND
4. Member has forced vital capacity (FVC) predicted > 40% documented in chart note.
5. **Dosage allowed:** 2.5 mg daily using a recommended jet nebulizer/compressor system, or eRapid Nebulizer System. Some patients may benefit from twice daily administration.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.
2. Evidence of disease stability or disease improvement
   a) Note: Disease improvement is evidenced by chart notes with any of the following:
      i) Improved FEV1 and/or other lung function tests;
      ii) Improvement in sweat chloride;
      iii) Decrease in pulmonary exacerbations;
      iv) Decrease in pulmonary infections;
      v) Increase in weight-gain;
      vi) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Pulmozyme (dornase alfa inhalation solution) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Atelectasis

- Parapneumonic pleural effusions and empyemas (adults)

DATE	ACTION/DESCRIPTION
05/25/2017	New policy for Pulmozyme created. Not covered diagnosis added.
12/31/2020	Updated verbiage of approved nebulizers. Diagnosis of cystic fibrosis added to initial criteria.
11/17/2021	Annual review, no changes

References:

1. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. [cited 2016 Dec 19]. Available: https://www.guideline.gov.
2. Pulmozyme [package insert]. South San Francisco, CA: Genentech Inc; 2014.
3. Pulmozyme. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com.
4. Pulmozyme. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Qbrexza (glycopyrronium) cloth, 2.4%
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— carton of 30 pouches for 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Qbrexza (glycopyrronium) cloth, 2.4% is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PRIMARY AXILLARY HYPERHIDROSIS

For **initial** authorization:

1. Member must be 9 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has a diagnosis of severe axillary hyperhidrosis, including documentation in the chart notes of visible, excessive sweating of at least 6 months duration which significantly impairs daily activities; AND
4. Secondary causes of hyperhidrosis (e.g., hyperthyroidism) have been ruled out; AND
5. Member has tried and failed topical prescription-strength aluminum chloride (e.g. Xerac) for at least 60 days; AND
6. Member does not have a medical condition that may be exacerbated by anticholinergic effects (e.g. glaucoma, urinary retention, Sjogren's syndrome, myasthenia gravis).
7. **Dosage allowed:** Qbrexza cloth (one cloth per pouch) is used topically once daily to both axillae using a single cloth.

If member meets all the requirements listed above, the medication will be approved for 2 months.

For **reauthorization**:

1. Chart notes must document clinically significant decreased severity of sweating.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Qbrexza (glycopyrronium) cloth, 2.4% not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Hyperhidrosis of palms/hands, soles (feet), forehead and other regions

DATE	ACTION/DESCRIPTION
11/27/2018	New policy for Qbrexza created.
09/22/2020	Reordered the criteria, matched wording to Botox policy, removed sweat quantification measure, removed HDSS score, summarized the list of exclusions, removed the mental health issue piece, removed trial of Botox per IHS guideline, changed the reauth criteria, extended reauth duration per long term efficacy study, changed Drysol to Xerac and extended trial period to be 60 days, changed initial auth duration to 2 months instead of 1.
11/17/2021	Annual review, no changes

References:

1. Qbrexza [package insert]. Menlo Park, CA: Dermira, Inc. June, 2018.
2. ClinicalTrials.gov. Identifier: NCT02530281. Study of Glycopyrronium in Axillary Hyperhydrosis. Available at: https://clinicaltrials.gov/ct2/show/NCT02530281?term=NCT02530281&rank=1.
3. ClinicalTrials.gov. Identifier: NCT02530294. Study of Glycopyrronium in Subjects With Axillary Hyperhidrosis. Available at: https://clinicaltrials.gov/ct2/show/NCT02530294?term=NCT02530294&rank=1.
4. Doolittle, J., Walker, P., Mills, T. et al. Arch Dermatol Res (2016) 308: 743. https://doi.org/10.1007/s00403-016-1697-9 Hyperhidrosis: an update on prevalence and severity in the United States
5. Gelbard, Christina M. MD, et al. "Primary pediatric hyperhidrosis: a review of current treatment options". Pediatric Dermatology 25:6 (2008): 591-598.
6. Guidance for Industry: Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims. FDA, 2009.
7. Kowalski et. al., Validity and Reliability of the Hyperhidrosis Disease Severity Scale (HDSS). J Am Acad Dermatol. 50(3): P51, 2004. https://www.jaad.org/article/S0190-9622(03)03534-5/fulltext
8. A Comprehensive Approach to the Recognition, Diagnosis, and Severity-Based Treatment of Focal Hyperhidrosis: Recommendations of the Canadian Hyperhidrosis Advisory Committee, Dermatologic Surgery, August 2007, pages 908-923.
9. IPD Analytics. New Drug Approval. Qbrexza (glycopyrronium). Available at: http://www.ipdanalytics.com/.
10. Sammons JE, et al. Axillary hyperhidrosis: a focused review. J Dermatolog Treat. 2017 Nov;28(7):582-590.
11. Lee KY, et al. Turning the tide: a history and review of hyperhidrosis treatment. JRSM Open. 2014 Jan; 5(1):2042533313505511.
12. Primary Focal Axillary - International Hyperhidrosis Society: Official Site. Primary Focal Axillary - International Hyperhidrosis Society | Official Site. https://www.sweathelp.org/treatments-hcp/clinical-guidelines/primary-focal-hyperhidrosis/primary-focal-axillary.html. Published September 23, 2018. Accessed September 23, 2020.
13. Hornberger J, Grimes K, Naumann M, et al. Recognition, diagnosis, and treatment of primary focal hyperhidrosis. *J Am Acad Dermatol*. 2004;51(2):274-286. doi:10.1016/j.jaad.2003.12.029
14. Glaser DA, Hebert AA, Nast A, et al. Topical glycopyrronium tosylate for the treatment of primary axillary hyperhidrosis: Results from the ATMOS-1 and ATMOS-2 phase 3 randomized controlled trials. *J Am Acad Dermatol*. 2019;80(1):128-138.e2. doi:10.1016/j.jaad.2018.07.002
15. Glaser DA, Hebert AA, Nast A, et al. A 44-Week Open-Label Study Evaluating Safety and Efficacy of Topical Glycopyrronium Tosylate in Patients with Primary Axillary Hyperhidrosis. *Am J Clin Dermatol*. 2019;20(4):593-604. doi:10.1007/s40257-019-00446-6

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Radicava (edaravone injection)
BILLING CODE	J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— N/A
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Radicava (edaravone injection) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

For **initial** authorization:

1. Provider submitted detailed chart notes confirming member's Definite or Probable ALS based on El Escorial revised criteria; AND
2. Member can eat a meal, excrete, or move with oneself alone, and perform most functions of everyday life with little to no assistance (chart notes required); AND
3. Member does not have Parkinson's disease, schizophrenia, dementia, renal failure, or hypersensitivity to Radicava (edaravone); AND
4. Member's functionality retained most activities of daily living and defined as a total of 20 points or better on the ALS Functional Rating Scale – Revised (ALSFRS-R), and submitted with chart notes (i.e. scores for speech, salivation, swallowing, handwriting, walking, etc.).
5. **Dosage allowed:** 60 mg administered as an intravenous infusion over 60 minutes as follows: Initial treatment cycle: daily dosing for 14 days followed by a 14-day drug-free period; Subsequent treatment cycles: daily dosing for 10 days out of 14-day periods, followed by 14-day drug-free periods.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Radicava (edaravone injection) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/16/2017	New policy for Radicava created.
09/15/2017	Disease duration and percent-predicted forced vital capacity (%FVC) requirements were removed. ALSFRS-R score requirement was modified.

References:

1. Cedarbaum JM, Stambler N, Malta E, at el. The ALSFRS-R: a revised ALS functional rating scale that incorporates assessments of respiratory function. *Journal of the Neurological Sciences,* 169 (1999) 13 –21.
2. ALS Functional Rating Scale. Available at: http://www.outcomes-umassmed.org/als/alsscale.aspx. Accessed May 16, 2017.
3. The ALS Association. Criteria for the Diagnosis of ALS. El Escorial World Federation of Neurology. Available at: http://www.alsa.org/als-care/resources/publications-videos/factsheets/criteria-for-diagnosis.html. Accessed May 16, 2017.
4. Radicava [package insert]. Jersey City, NJ: MT Pharma America, Inc.; May, 2017.
5. ClinicalTrials.gov [Internet]. Identifier NCT01492686, Phase 3 Study of MCI-186 for Treatment of Amyotrophic Lateral Sclerosis; 2015 Jun 18 [cited 2017 May 16]; [about 4 screens]. Available from: https://clinicaltrials.gov/ct2/show/study/NCT01492686.

Effective date: 11/08/2017
Revised date: 09/15/2017

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Ravicti (glycerol phenylbuytyrate)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Buphenyl QUANTITY LIMIT— 11.2 mL/m^2/day
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ravicti (glycerol phenylbuytyrate) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

UREA CYCLE DISORDERS (UCDs)

For **initial** authorization:

1. Medication must be prescribed by, or in consultation with a metabolic or genetic specialist; AND
2. Member has documented history of hyperammonemia associated with diagnosis of a UCD as one of the following:
   a) Carbamoyl phosphate synthetase 1 deficiency (CPS1D);
   b) Orthinine transcarbamylase deficiency (OTCD);
   c) Argininosuccinate synthetase deficiency (ASSD/classic citrullinemia/type 1 citrullinemia);
   d) Argininosuccinate lyase deficiency (ASLD/argininosuccinic aciduria);
   e) Arginase deficiency (ARG1D/argininemia); AND
3. Member must currently be treated with, and adherent to dietary protein restriction, and when appropriate, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements) as documented in chart notes, or evident in pharmacy claims history (*Note:* Arginine supplementation should be used in all UCDs except ARG1D, citrulline supplementation should be used in OTCD and CPSID); AND
4. Dietary treatment has been insufficient to maintain plasma ammonia levels below the upper limit of normal (ULN), 35 µmol/L, despite treatment adherence; AND
5. Member tried and failed treatment with Buphenyl except one of the following:
   a) Not tolerated Buphenyl due to severe adverse effects;
   b) Has contraindication to Buphenyl (e.g., hypersensitivity, pregnancy, breastfeeding);
   c) Failed to maintain ammonia levels below ULN (35 µmol/L) despite optimized dosing (13 g/m^2/day, max: 20 g/day) and treatment adherence;
   d) Treatment was complicated by a clinical state where there is sodium retention and edema (e.g., congestive heart failure, severe renal insufficiency); AND
6. Member does **not** have ANY of the following:
   a) *N*-acetylglutamate synthase (NAGS) deficiency;
   b) Concomitant use of drugs known to increase ammonia levels (e.g., valproate, haloperidol, systemic corticosteroids); AND
7. Ravicti is NOT being used to treat acute hyperammonemia.
8. **Dosage allowed:** 4.5 to 11.2 mL/m^2/day (5 to 12.4 g/m^2/day).

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member meets all initial authorization requirements; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., normalized plasma ammonia levels).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ravicti (glycerol phenylbuytyrate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Byler disease (progressive familial intrahepatic cholestasis 1 (PFIC-1))
- Cirrhosis, hepatic encephalopathy
- Cystic fibrosis
- Medium-chain acyl-CoA dehydrogenase (MCAD) deficiency

DATE	ACTION/DESCRIPTION
05/20/2019	New policy for Ravicti created.
11/17/2021	Annual review, no changes

References:

1. Ravicti [package insert]. Lake Forest, IL: Horizon Therapeutics; 2018 Dec.
2. Buphenyl (sodium phenylbutyrate) [prescribing information]. Deerfield, IL: Horizon Pharma; June 2015.
3. ClinicalTrials.gov. Identifier: NCT00992459. Efficacy and Safety of HPN-100 for the Treatment of Adults With Urea Cycle Disorders. Available: clinicaltrials.gov/ct2/show/NCT00992459.
4. ClinicalTrials.gov. Identifier: NCT01347073. Study of the Safety, Pharmacokinetics and Efficacy of HPN-100, in Pediatric Subjects With Urea Cycle Disorders (UCDs). Available: clinicaltrials.gov/ct2/show/NCT01347073.
5. ClinicalTrials.gov. Identifier: NCT 00999167. A Study of Safety and Efficacy of HPN-100 in Subjects With Cirrhosis and Episodic Hepatic Encephalopathy (HALT-HE). Available: clinicaltrials.gov/ct2/show/NCT00999167.
6. ClinicalTrials.gov. Identifier: NCT01881984. Use of Ravicti™ in Patients With MCAD Deficiency With the 985A>G (K304E) Mutation. Available: clinicaltrials.gov/ct2/show/NCT01881984.
7. Häberle J, et al. Suggested Guidelines for the Diagnosis and Management of Urea Cycle Disorders. Orphanet Journal of Rare Diseases. 2012 Dec;7(1):32. Available: ncbi.nlm.nih.gov/pmc/articles/PMC3488504.
8. National Organization for Rare Diseases. rarediseases.org/physician-guide/urea-cycle-disorders.
9. NIH Rare Diseases Clinical Research Network: Urea Cycle Disorders Consortium. Urea Cycle Treatment Guidelines. Available: rarediseasesnetwork.org/cms/ucdc/healthcare-professionals/treatment-guidelines.
10. Ah Mew N, et al. Urea cycle disorders overview. In: Adam MP, et al., eds. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2019. 2003 Apr 29 [updated 2017 Jun 22].

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Rebif (interferon beta-1a)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred product includes Avonex QUANTITY LIMIT— 12 per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Rebif (interferon beta-1a) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
2. Chart notes have been provided confirming diagnosis of Multiple Sclerosis.
3. **Dosage allowed:** 22 mcg or 44 mcg 3 times per week.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member has documented biological response to treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Rebif (interferon beta-1a) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Multiple Sclerosis - Clinically isolated syndrome (CIS)

DATE	ACTION/DESCRIPTION
06/07/2017	New policy for Rebif created. Not covered diagnosis added.
12/06/2017	Confirmation of diagnosis based on McDonald criteria is no longer required.
9/16/2021	Annual review, no changes

References:

1. Rebif [package insert]. Rockland, MA: EMD Serono Inc.; November, 2015.
2. Rebif. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 16, 2017.

3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Reblozyl (luspatercept-aamt)
BILLING CODE	J0896 (1 unit = 0.25 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-preferred product) QUANTITY LIMIT – see Dosage Allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Reblozyl (luspatercept-aamt) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

BETA THALASSEMIA

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a hematologist or oncologist; AND
3. Member has a confirmed diagnosis of beta thalassemia or Hemoglobin E/Beta-thalassemia; AND
4. Member requires regular red blood cell (RBC) transfusions, defined by **BOTH** of the following:
    a. Received a total of at least 6 units of RBC in the last 6 months ;
    b. No transfusion-free period for ≥ 35 days during the last 6 months; AND
5. Member does **NOT** have any of the following:
    a. Active Hepatitis B or C infection or positive human immunodeficiency virus (HIV);
    b. Major organ damage, including:
        i. Liver disease with ALT > 3x the upper limit of normal or evidence of cirrhosis;
        ii. Heart disease, heart failure as classified by the New York Heart Association (NYHA) classification 3 or higher, significant arrhythmia, or recent myocardial infarction within the last 6 months;
        iii. Lung disease, including significant pulmonary fibrosis or pulmonary hypertension;
        iv. Kidney disease.
6. **Dosage allowed**: 1mg/kg once every 3 weeks by subcutaneous injection. Dose can be increased to 1.25mg/kg if lack of response.

If member meets all the requirements listed above, the medication will be approved for 3 months (or up to 5 doses).

For **reauthorization**:

1. Member is in compliance with all other initial criteria; AND
2. Member has a reduction in RBC transfusion requirements of at least 2 units from baseline (prior to starting treatment); AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

MYELODYSPLASTIC SYNDROMES WITH RING SIDEROBLASTS

Any request for myelodysplastic syndromes must be submitted through NantHealth/Eviti portal.

CareSource considers Reblozyl (luspatercept-aamt) not medically necessary for the treatment of the following disease states based on lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acute severe anemia (in the setting that requires RBC transfusion)
- Alpha thalassemia
- Anemia not due to beta thalassemia
- Non-transfusion dependent beta thalassemia (intermediate beta thalassemia)
- Sickle beta thalassemia

DATE	ACTION/DESCRIPTION
05/04/2020	New policy for Reblozyl created.

References:

1. Reblozyl [Package Insert]. Summit, NJ: Celgene Corporation; November 2019.
2. Celgene. An Efficacy and Safety Study of Luspatercept (ACE-536) Versus Placebo in Adults Who Require Regular Red Blood Cell Transfusions Due to Beta Thalassemia (BELIEVE). NLM Identifier: NCT02604433.
3. Piga A, Perrotta S, Gamberini MR, et al. Luspatercept improves hemoglobin levels and blood transfusion requirements in a study of patients with beta thalassemia. Blood. 2019;133(12):1279-1289.
4. Muncie LH. Beta Thalassemia. *National Organization for Rare Disorders (NORD)*.

Effective date: 07/20/2020
Revised date: 05/04/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Relistor (methylnaltrexone)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include stool softeners, bulk forming laxatives, osmotic laxatives, stimulant laxatives, lubricant laxatives QUANTITY LIMIT— 90 tablets per 30 days, or 30 pre-filled syringes per 30 days (15 syringes or single-dose vials in cancer/advanced illness)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Relistor (methylnaltrexone) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID-INDUCED CONSTIPATION (OIC)

For **initial** authorization:

1. Member is 18 years old or older, with diagnosis of OIC; AND
2. One of the following:
   a) Member has been receiving opioids for non-cancer pain for longer than 4 weeks, and does **not** require frequent (e.g., weekly) opioid dosage escalation;
   b) Member has diagnosis of an advanced illness or active cancer; AND
3. Medication must be prescribed by or in consultation with a gastroenterologist, oncologist, palliative care or pain management specialist; AND
4. One of the following:
   a) Member is unable to swallow oral medications, and has a documented 4-day trial and failure of ALL of the following:
      i) Suppository of glycerin or bisacodyl;
      ii) Enema of sodium phosphate, glycerin, mineral oil, or docusate;
      iii) Enema of bisacodyl; OR
   b) Member is able to swallow oral medication, and has a documented 4-day trial and failure of ALL of the following:
      i) A bulk forming laxative (e.g., psyllium, methylcellulose);
      ii) An osmotic agent (e.g., polyethylene glycol, lactulose);
      iii) A stimulant laxative (e.g., bisacodyl, sennosides);
      iv) A stool softener (e.g., docusate);
      v) A lubricant laxative (e.g., mineral oil);
      vi) Amitiza (lubiprostone) (requires prior authorization);
      vii) Symproic (naldemedine) (requires prior authorization);
      viii) Movantik (naloxegol) (requires prior authorization); AND
5. Member does NOT have a known or suspected mechanical gastrointestinal obstruction.

6. **Dosage allowed:** For OIC in non-cancer pain: oral tablet 450 mg once daily in the morning or subcutaneous injection 12 mg once daily. For OIC in advanced illness or cancer: up to 12 mg every other day as needed subcutaneously.

Note: Relistor oral tablet is not indicated for OIC in advanced illness.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:
1. Member meets all initial authorization criteria; AND
2. Member has not experienced severe or persistent diarrhea during treatment; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of constipation.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Relistor (methylnaltrexone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/20/2019	New policy for Relistor created.
03/11/2021	Annual review, no changes

References:

1. ClinicalTrials.gov. Identifier NCT01186770. A study of oral methylnaltrexone (MNTX) for the treatment of opioid-induced constipation in subjects with chronic, non-malignant pain. Available: clinicaltrials.gov/ct2/show/NCT01186770.
2. ClinicalTrials.gov. Identifier NCT01004393. Methylnaltrexone for opioid-induced constipation in cancer patients. Available: clinicaltrials.gov/ct2/show/NCT01004393.
3. ClinicalTrials.gov. Identifier NCT00672477. Study evaluating subcutaneous methylnaltrexone for treatment of opioid-induced constipation in patients with advanced illness. Available: clinicaltrials.gov/ct2/show/NCT00672477.
4. Crockett SD, et al. American gastroenterological association institute guideline on the medical management of opioid-induced constipation. Gastroenterology. 2019 Jan 1;156(1):218-26.
5. Nee J, et al. Efficacy of treatments for opioid-Induced constipation: systematic review and meta-analysis. Clinical Gastroenterology and Hepatology. 2018 Oct 1;16(10):1569-84.
6. Relistor [prescribing information]. Bridgewater, NJ: Salix Pharmaceuticals Inc. 2018 Mar.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Remicade (infliximab)
BILLING CODE	J1745 (1 unit = 10 mg or 1 x 100 mg vial = 10 units)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz QUANTITY LIMIT—1200 mg (120 units per dose)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Remicade (infliximab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
8. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia and Cosentyx. Treatment failure requires at least for 12 weeks of therapy with each drug.
9. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 6 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by **one** of the following:
   a) Extensive small bowel disease involving more than 100 cm;
   b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
   c) Fistulizing disease.
6. **Dosage allowed:** 5mg/kg at 0, 2, and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq. Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:
1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Medication is being given in combination with methotrexate or with another non-biologic DMARD if unable to tolerate methotrexate; AND

6. Member has tried and failed treatment with at least **two** of the following: Actemra, Cimzia, Enbrel, Kevzara, Olumiant and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:
1. Member is 6 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a documented trial and inadequate response with **one** of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
5. **Dosage allowed:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Remicade (infliximab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Remicade created. Polices SRx-0041, SRx-0042, and SRx-0043 archived. For diagnosis of AS: trial of Humira and Enbrel requirement was added. For CD: Pediatric Crohn's Disease Activity Index (PCDAI) and Crohn's Disease Activity Index (CDAI) were requirements added; trial of Humira was added. For diagnosis of PP: immunosuppressive drug criterion was separated from phototherapies and topical agents' trials; Psoriasis Area and Severity Index (PASI) score requirement was added; trials of Humira and Enbrel were added. For PsA: trials of Humira and Enbrel were added. For RA: non-biologic DMARDS were listed and criterion was added to use drug in combination with methotrexate, or if intolerant to methotrexate, use another immunosuppressant; trials of Humira and Enbrel

	were added. For UC: requirement for moderate to severe UC was revised, Pediatric Ulcerative Colitis Activity Index (PUCAI) was added. Trial of Humira required for member ≥ 18 y.o. List of diagnoses considered not medically necessary was added.
02/26/2019	Humira removed from trial criteria. Actemra, Cimzia, Cosentyx, Enbrel, Kevzara, Olumiant, Otezla, Siliq and Xeljanz added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
11/22/2020	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. Updated maintenance dosing to 6 weeks. CD: Removed PCDAI and CDAI score requirements. Specified length of trials for conventional therapies, previously not specified. Those with severe disease can skip the drug trial. Changed initial approval to 6 months to observe efficacy. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. UC: Removed PUCAI and Mayo score requirements. Specified the length of trials for conventional therapies (previously not specified).

References:

1. Remicade [prescribing information]. Horsham, PA; Janssen Biotech, Inc.: May, 2020.
2. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
7. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
8. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
9. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
10. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
11. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
12. Lofberg R. Treatment of fistulas in Crohn's disease with infliximab. *Gut*. 1999;45(5):642-643.

13. Ricart E, Sandborn WJ. Infliximab for the treatment of fistulas in patients with Crohn's disease. *Gastroenterology*. 1999;117(5):1247-1248.
14. Sands BE, Anderson FH, Bernstein CN et al. A randomized controlled trial of infliximab maintenance therapy for fistulizing Crohn's disease (ACCENT II). *N Engl J Med*. 2004;350:876-885.
15. Mease PJ, et al. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blind, randomized, placebo-controlled trial. *Arthritis Rheum*. 2005; 52:3279.
16. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
17. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
18. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
19. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
20. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
21. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
22. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
23. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
24. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
25. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
26. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
27. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

Effective date: 10/1/2021
Revised date: 11/22/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Renflexis (infliximab-abda)
BILLING CODE	Q5104 (1 unit = 10 mg or 1 x 100 mg vial = 10 units)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Taltz, Enbrel, Humira, and Xeljanz 5 mg tablet QUANTITY LIMIT— 1200 mg (120 units per dose)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Renflexis (infliximab-abda) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
8. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Humira, or Taltz. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) that is indicated for AS, then the trial can be accepted.
9. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 6 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by **one** of the following:
   a) Extensive small bowel disease involving more than 100 cm;
   b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
   c) Fistulizing disease.
6. **Dosage allowed:** 5mg/kg at 0, 2, and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4-week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Humira, Enbrel, or Taltz. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) that is indicated for PsO, then the trial can be accepted.
8. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member has tried and failed treatment with at least **two** of the following: Humira, Enbrel, Taltz, or Xeljanz 5mg tablet. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) that is indicated for PsA, then the trial can be accepted.
7. **Dosage allowed:** 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:
1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND

Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Medication is being given in combination with methotrexate or with another non-biologic DMARD if unable to tolerate methotrexate; AND
6. Member has tried and failed treatment with at least **two** of the following: Humira, Enbrel, Taltz, or Xeljanz 5mg tablet. Treatment failure requires at least 12 weeks of therapy with each drug. Note: if member previously tried a non-preferred IL-17 inhibitor (e.g., Cosentyx) or TNF inhibitor (e.g., Cimzia) or JAK inhibitor (e.g., Kevzara) that is indicated for RA, then the trial can be accepted.
7. **Dosage allowed:** 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks thereafter. Prior to any dosages or dosing frequencies greater than listed, medical necessity documentation must be supplied to justify coverage.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:
1. Member is 6 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a documented trial and inadequate response with **one** of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
5. **Dosage allowed:** 5 mg/kg at 0, 2, and 6 weeks, followed by 5 mg/kg every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Renflexis (infliximab-abda) not medically necessary for the treatment of the following disease that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/03/2019	New policy for Renflexis created.
05/03/2021	Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. Updated list of preferred agents and drug trials for all diagnoses to match Ohio Department of Medicaid Unified Preferred Drug List. Added that if member previously

	tried a non-preferred option in the same drug class as preferred options, the trial is accepted. AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. CD: Removed PCDAI and CDAI score requirements. Specified length of trials for conventional therapies, previously not specified. Those with severe disease can skip the drug trial. Changed initial approval to 6 months to observe efficacy. PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. UC: Removed PUCAI and Mayo score requirements. Specified the length of trials for conventional therapies (previously not specified).

References:

1. Renflexis [prescribing information]. Station, NJ: Merck & Co., Inc.; June 2019.
2. Callhoff J, et al. Efficacy of TNFa blockers in patients with ankylosing spondylitis and non-radiographic axial spondyloarthritis: a meta-analysis. *Ann Rheum Dis*. 2015; 74:1241.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
6. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
7. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
8. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
9. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
10. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
11. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
12. Lofberg R. Treatment of fistulas in Crohn's disease with infliximab. *Gut*. 1999;45(5):642-643.
13. Ricart E, Sandborn WJ. Infliximab for the treatment of fistulas in patients with Crohn's disease. *Gastroenterology*. 1999;117(5):1247-1248.
14. Sands BE, Anderson FH, Bernstein CN et al. A randomized controlled trial of infliximab maintenance therapy for fistulizing Crohn's disease (ACCENT II). *N Engl J Med*. 2004;350:876-885.
15. Mease PJ, et al. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blind, randomized, placebo-controlled trial. *Arthritis Rheum*. 2005; 52:3279.
16. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
17. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
18. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.

19. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
20. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
21. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
22. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
23. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
24. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
25. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
26. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
27. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

Effective date: 10/1/2021
Revised date: 05/03/2021

CareSource Rx innovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Repatha (evolocumab)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Repatha, originally approved by the FDA in 2015, is an inhibitor of PCSK9 (proprotein convertase subtilisin/kexin type 9) for the treatment of familial hypercholesterolemia and to reduce the risk of cardiovascular events (heart attack, stroke) in cardiovascular disease patients. It is a subcutaneous injection self-administered every 2 weeks or once a month.
PCSK9 bind to LDL receptors in the liver to promote their degradation. Inhibiting PCSK9 from binding the LDL receptors increases the number of them available to clear LDL from the blood, which reduces LDL cholesterol levels.

Repatha (evolocumab) will be considered for coverage when the following criteria are met:

Homozygous Familial Hypercholesterolemia (HoFH)

For **initial** authorization:

1. Member is at least 10 years of age; AND
2. Medication must be prescribed by or in consultation with a lipid specialist or cardiologist; AND
3. Member has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by one of the following:
   a) Genetic testing confirmation of two mutant alleles in the LDLR, Apo-B, PCSK9, or LDLRAP1 gene locus; OR
   b) LDL-C > 500 mg/dL before any treatment or LDL-C > 300 mg/dL if treated with a lipid-lowering drug AND one of the following:
      i) Xanthoma before 10 years of age; OR
      ii) Evidence of heterozygous familial hypercholesterolemia (HeFH) (i.e., total cholesterol > 250 mg/dL) in both parents; AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days; AND
5. Member is unable to achieve LDL-C goal (see Note below) after a 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe; AND
6. Repatha will be used as an adjunct to other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis), unless contraindicated or intolerant; AND
7. Prescriber attests that the member will adhere to a diet regimen or a diet modification.
8. **Dosage allowed/Quantity limit:** 420 mg subQ once monthly.
   May increase to 420 mg every 2 weeks if clinically meaningful response not reached after 12 weeks, or if also on lipid apheresis.
   (Limit: 2 injections per 28 days)

NOTE: The LDL-C goals are <100 mg/dL for adults 18 years or older, < 135 mg/dL for children, and < 70 mg/dL for adults with clinical ASCVD.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Heterozygous Familial Hypercholesterolemia

For **initial** authorization:
1. Member must be 10 years of age or older; AND
2. Medication must be prescribed by or in consultation with a lipid specialist or a cardiologist; AND
3. Member has a diagnosis of heterozygous familial hypercholesterolemia (FeFH) confirmed by one of the following:
   a) Dutch Lipid Network Criteria score of 9 or higher;
   b) Genetic testing confirmation;
   c) "Definite" Simon Broome Criteria (see Table 1 to determine eligibility, if not submitted with chart notes); AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days; AND
5. Member is unable to achieve LDL < 100 mg/dL[3] after a 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe; AND
6. Repatha will be used in combination with a statin and/or ezetimibe, unless contraindicated or intolerant; AND
7. Prescriber attests that the member will adhere to a diet regimen or a diet modification.
8. **Dosage allowed/Quantity limit:** 140mg every 2 weeks OR 420mg every month. (Limit: 2 injections per 28 days)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Prevention of Cardiovascular Events

For **initial** authorization:
1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a lipid specialist or a cardiologist; AND
3. Member has a history of clinical atherosclerotic cardiovascular disease (ASCVD) (e.g. angina, acute coronary syndrome, coronary or other arterial revascularization, myocardial infarction (MI), stroke, transient ischemic attack, or peripheral arterial disease); AND
4. Chart notes must include documentation of baseline LDL-C level, taken within the past 90 days; AND
5. Member is unable to achieve LDL-C < 70 mg/dL3 after a 90-day trial of a high-intensity statin (i.e., rosuvastatin ≥ 20mg, atorvastatin ≥ 40mg for 18 years or older, ≥ 20mg for under 18 years old) together with ezetimibe. If intolerance occurs, a second attempt must be initiated with a moderate or low-intensity statin + ezetimibe; AND
6. Repatha will be used in combination with a statin and/or ezetimibe, unless contraindicated or intolerant; AND

7. Prescriber attests that the member will adhere to a diet regimen or a diet modification
8. **Dosage allowed/Quantity limit:** 140mg every 2 weeks OR 420mg every month. (Limit: 2 injections per 28 days)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes along with recent labs have been provided showing a meaningful reduction of LDL-C level from baseline OR LDL-C is at goal.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Repatha (evolocumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/09/2020	New policy for Repatha created. Retired old Biologic Cholesterol Agents policy.
04/27/2021	Updated genetic testing requirement under HoFH to ask for specific alleles (previously not specified). Updated atorvastatin high-intensity requirement to reflect pediatric vs. adult dosing for all diagnoses.
11/15/2021	Transferred to new template. Updated age for HoFH and HeFH and dosing for HoFH.

References:

1. Repatha [Package Insert]. Thousand Oaks, CA: Amgen Inc.; 2021.
2. Blom D, 2020. Homozygous Familial Hypercholesterolemia (HoFH). National Organization for Rare Disorder. NORD. April 2020.
3. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC Guideline on the Management of Blood Cholesterol. JACC. 2018;73(24)doi:10.1016/j.jacc.2018.11.002.
4. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. JACC. 2017;70(14):1785-1822.
5. Sabatine MS, Giugliano RP, Keech AC, et al. Evolocumab and clinical outcomes in patients with cardiovascular disease. N Engl J Med 2017; 376:1713-1722
6. Harada M, Arai H, Ishigaki Y, et al. Guidelines for diagnosis and treatment of familial hypercholesterolemia 2017. J Atheroscler Thromb. 2018 Aug 1; 25(8): 751–770.
7. McGowen, Dehkordi S, Moriarty P, et al. Diagnosis and treatment of heterozygous familial hypercholesterolemia. J Am Heart Assoc. 2019 Dec 17;8(24):e013225.
8. Cuchel M, Bruckert E, Ginsberg HN, et al. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. Eur Heart J. 2014;35(32):2146-2157.
9. American Diabetes Association. Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes-2020. Diabetes Care. 2020;43(Suppl 1):S111-S134.
10. Santos RD, Stein EA, Hovingh GK, et al. Long-term Evolocumab in patients with familial hypercholesterolemia. J Am Coll Cardiol. 2020;75(6):565-574.
11. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Task Force on Expert Consensus Decision Pathways. J Am Coll Cardiol. 2017;70(14):1785-1822.
12. Pignone M. Management of elevated low density lipoprotein-cholesterol (LDL-C) in primary prevention of cardiovascular disease. In: Freeman MW, ed. UpToDate. Waltham, MA.; UpToDate; 2020. www.uptodate.com. Accessed July 09, 2020.

Table 1

Simon Broom Criteria

• Total cholesterol level > 290 mg/dL OR LDL-C > 190 mg/dL at baseline AND
• One of the following:
  ○ Physical finding of tendon xanthomas in 1st or 2nd degree relative;
  ○ Confirmation by gene or receptor testing (presence of LDL-R, ApoB, or PCSK9 mutation)

Effective date: 04/01/2022
Revised date: 11/15/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Retacrit (epoetin alfa-epbx)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Aranesp QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Retacrit (epoetin alfa-epbx) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANEMIA

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Member has documented diagnosis of anemia due to **one** of the following:
   a) Myelodysplastic syndrome;
   b) Chronic Kidney Disease (GFR below 60 mL/min/1.73 m^2);
   c) Concomitant Zidovudine treatment in member with HIV-infection;
   d) The effects of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy; AND
3. Member's individual iron status reveals **both** of the following:
   a) Transferrin saturation is at least 20%;
   b) Ferritin is at least 100 mcg/L; AND
4. Member is on supplemental iron therapy; AND
5. Member's labs show hemoglobin ≤ 10 g/dL for adults (≤ 11 g/dL for children) within the last 14 days for initial therapy, OR ≤ 10.5 g/dL for adults (≤ 11.5 g/dL for children) currently receiving therapy.
6. **Dosage allowed:** Members with CKD - 50 to 100 Units/kg 3 times weekly (adults) as initial dose and 50 Units/kg 3 times weekly (pediatric patients). Individualize maintenance dose. Intravenous route recommended for members on hemodialysis. Members on Zidovudine due to HIV-infection -100 Units/kg 3 times weekly. Members with cancer - 40,000 Units weekly or 150 Units/kg 3 times weekly (adults); 600 Units/kg intravenously weekly (pediatric patients ≥ 5 years).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's hemoglobin increased, stayed the same and not decreased further (baseline labs and current labs required); AND
2. Red blood cells transfusions are not required or the number of the transfusions has decreased.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

REDUCTION OF ALLOGENEIC RBC TRANSFUSIONS

For **initial** authorization:

1. Medication must be prescribed by an oncologist, a nephrologist, an immunologist or infectious disease specialist; AND
2. Medication is being used for reduction of allogeneic RBC transfusions in member undergoing elective, non-cardiac, nonvascular high-risk surgery at increased risk of or intolerant to transfusions; AND
3. Member's labs show hemoglobin ≤ 13 g/dL.
4. **Dosage allowed:** 300 Units/kg per day daily for 15 days or 600 Units/kg weekly.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Medication will not be reauthorized.

CareSource considers Retacrit (epoetin alfa-epbx) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- In members with cancer receiving hormonal agents, biologic products, or radiotherapy, unless also receiving concomitant myelosuppressive chemotherapy
- In members with cancer receiving myelosuppressive chemotherapy when the anticipated outcome is cure
- In members with cancer receiving myelosuppressive chemotherapy in whom the anemia can be managed by transfusion
- In members scheduled for surgery who are willing to donate autologous blood
- In members undergoing cardiac or vascular surgery
- As a substitute for RBC transfusions in patients who require immediate correction of anemia

DATE	ACTION/DESCRIPTION
10/11/2019	New policy for Retacrit created.
11/17/2021	Annual review, no changes

References:

1. Retacrit [prescribing information]. New York, NY: Pfizer Inc.; January 2019.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Retisert (fluocinolone acetonide)
BILLING CODE	J7311
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient hospital
STATUS	Prior Authorization Required

Retisert is a 0.59 mg fluocinolone acetonide intravitreal implant indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye. It is released over a period of 30 months and has been shown to reduce the rate of recurrence and improve visual acuity.
Uveitis is an inflammation of the uvea (middle layer of the eye). It can be infectious or non-infectious. Non-infectious uveitis (NIU) is often associated with inflammatory conditions such as rheumatoid arthritis. If the anterior segment of the uvea is affected, it can be treated with topical glucocorticoids. If resistant or affecting the intermediate or posterior segments, more invasive or systemic treatment is needed.

Retisert (fluocinolone acetonide) will be considered for coverage when the following criteria are met:

Uveitis

For **initial** authorization:
1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a diagnosis of chronic (1 year or more) non-infectious uveitis affecting the posterior segment of the eye; AND
4. Member has tried and failed at least one of the following for at least 3 months:
   a) Systemic corticosteroid (e.g., prednisone)
   b) Non-biologic immunosuppressive (e.g., mycophenolate mofetil, methotrexate, cyclosporine, tacrolimus); AND
5. Member has had a failed trial of Ozurdex; AND
6. Member does not have any active infections of the eye.
7. **Dosage allowed/Quantity limit:** One implant (0.59 mg) per eye
   Limit: 2 implants (1 per eye) per 30 months

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must show improved or stabilized visual acuity following treatment and/or an improved vitreous haze score; AND
2. At least 30 months have elapsed since the prior treatment (of the same eye); AND
3. Member has recurrent symptoms.

If all the above requirements are met, the medication will be approved for an additional 3 months.

CareSource considers Retisert (fluocinolone acetonide) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/28/2021	New policy created for Retisert.

References:

1. Retisert [prescribing information]. Bausch & Lomb; 2021.
2. Brady CJ, Villanti AC, Law HA, et al. Corticosteroid implants for chronic non-infectious uveitis. *Cochrane Database Syst Rev*. 2016;2(2):CD010469. Published 2016 Feb 12. doi:10.1002/14651858.CD010469.pub2
3. Multicenter Uveitis Steroid Treatment (MUST) Trial Research Group, Kempen JH, Altaweel MM, et al. Benefits of Systemic Anti-inflammatory Therapy versus Fluocinolone Acetonide Intraocular Implant for Intermediate Uveitis, Posterior Uveitis, and Panuveitis: Fifty-four-Month Results of the Multicenter Uveitis Steroid Treatment (MUST) Trial and Follow-up Study. *Ophthalmology*. 2015;122(10):1967-1975. doi:10.1016/j.ophtha.2015.06.042
4. Writing Committee for the Multicenter Uveitis Steroid Treatment (MUST) Trial and Follow-up Study Research Group, Kempen JH, Altaweel MM, et al. Association Between Long-Lasting Intravitreous Fluocinolone Acetonide Implant vs Systemic Anti-inflammatory Therapy and Visual Acuity at 7 Years Among Patients With Intermediate, Posterior, or Panuveitis. *JAMA*. 2017;317(19):1993-2005. doi:10.1001/jama.2017.5103

Effective date: 04/01/2022
Revised date: 10/28/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Rezurock (belumosudil)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Rezurock is indicated for patients 12 years of age and older with chronic GVHD after the failure of at least 2 prior lines of systemic therapy. GVHD, a common complication following allogenic hematopoietic stem cell transplant (HSCT), occurs in about 50% of HSCT patients. Prednisone is the mainstay of initial therapy but at least half of patients require at least 2 lines of therapy. Clinical guidelines do not come to a consensus regarding optimal 2nd line therapy but describe a variety of options.
Rezurock is the first rho-associated, coiled-coil kinase 2 (ROCK2) inhibitor. The ROCK2 pathway modulates inflammatory response and fibrotic processes. ROCK2 inhibition is thought to both restore immune homeostasis and reduce fibrotic processes, which makes Rezurock unique from other pharmacologic treatment options. Approval was based on the phase 2 ROCKstar study.

Rezurock (belumosudil) will be considered for coverage when the following criteria are met:

Chronic Graft-Versus-Host Disease (cGVHD)

For **initial** authorization:
1. Member is at least 12 years of age; AND
2. Medication must be prescribed by or in consultation with a transplant or hematology/oncology specialist; AND
3. Member has a diagnosis of cGVHD with persistent manifestations; AND
4. Member has failed at least 2 prior lines of systemic therapy, i.e., systemic corticosteroid and another systemic treatment (calcineurin inhibitor, Jakafi, mycophenolate mofetil, sirolimus, methotrexate, Imbruvica); AND
5. If the member is on a chronic proton pump inhibitor (e.g., omeprazole), the member must attempt to discontinue it or switch to an alternate agent such as an H2 blocker (e.g., famotidine).
6. **Dosage allowed/Quantity limit:** 200 mg orally once daily. (QL: 30 tablets per 30 days).
   NOTE: Patients who must remain on a proton pump inhibitor will require 200 mg twice daily (and a QL override).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must show improvement of signs and symptoms of disease in at least 1 organ/site, without progression in any other organ/site.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Rezurock (belumosudil) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
09/29/2021	New policy created for Rezurock.

References:

1. Rezurock [prescribing information]. Kadmon Pharmaceuticals, LLC; 2021.
2. National Comprehensive Cancer Network. Hematopoietic Cell Transplantation (HCT): Pre-Transplant Recipient Evaluation and Management of Graft-Versus-Host Disease. (Version 5.2021). https://www.nccn.org/professionals/physician_gls/pdf/hct.pdf. Accessed October 4, 2021.
3. Jagasia M, Lazaryan A, Bachier CR, et al. ROCK2 Inhibition With Belumosudil (KD025) for the Treatment of Chronic Graft-Versus-Host Disease. *J Clin Oncol*. 2021;39(17):1888-1898. doi:10.1200/JCO.20.02754
4. Wolff D, Fatobene G, Rocha V, Kröger N, Flowers ME. Steroid-refractory chronic graft-versus-host disease: treatment options and patient management. *Bone Marrow Transplant*. 2021;56(9):2079-2087. doi:10.1038/s41409-021-01389-5
5. Penack O, Marchetti M, Ruutu T, et al. Prophylaxis and management of graft versus host disease after stem-cell transplantation for haematological malignancies: updated consensus recommendations of the European Society for Blood and Marrow Transplantation. *Lancet Haematol*. 2020;7(2):e157-e167. doi:10.1016/S2352-3026(19)30256-X

Effective date: 04/01/2022
Revised date: 09/29/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Rinvoq (upadacitinib)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 30 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Rinvoq (upadacitinib) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm^3), lymphopenia (ALC <500 cells/mm^3), or anemia (Hg < 8 g/dL); AND
5. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
6. **Dosage allowed:** 15 mg (1 tablet) once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Rinvoq (upadacitinib) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
09/26/2019	New policy for Rinvoq created.

11/19/2020	Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. Removed repeated TB test in reauth. Replaced the list of excluded diagnoses with the generic statement. Updated references.
11/17/2021	Annual review, no changes.

References:

1. Rinvoq [prescribing information]. North Chicago, IL: AbbVie Inc.; July 2020.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
3. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
4. ClinicalTrials.gov. Identifier: NCT02706873. A Study to Compare ABT-494 Monotherapy to Methotrexate Monotherapy in Subjects With Rheumatoid Arthritis (RA) Who Have Not Previously Taken Methotrexate (SELECT-EARLY). Available at: https://clinicaltrials.gov/ct2/show/NCT02706873?term=NCT02706873&rank=1.
5. ClinicalTrials.gov. Identifier: NCT02706951. A Study Comparing Upadacitinib (ABT-494) Monotherapy to Methotrexate (MTX) Monotherapy in Subjects With Rheumatoid Arthritis (RA) Who Have an Inadequate Response to MTX (SELECT-MONOTHERAPY). Available at: https://clinicaltrials.gov/ct2/show/NCT02706951?term=NCT02706951&rank=1.
6. ClinicalTrials.gov. Identifier: NCT02675426. A Study Comparing Upadacitinib (ABT-494) to Placebo in Subjects With Rheumatoid Arthritis on a Stable Dose of Conventional Synthetic Disease-Modifying Antirheumatic Drugs (csDMARDs) Who Have an Inadequate Response to csDMARDs Alone (SELECT-NEXT). Available at: https://clinicaltrials.gov/ct2/show/NCT02675426?term=NCT02675426&rank=1.
7. ClinicalTrials.gov. Identifier: NCT02629159. A Study Comparing ABT-494 to Placebo and to Adalimumab in Subjects With Rheumatoid Arthritis Who Are on a Stable Dose of Methotrexate and Who Have an Inadequate Response to Methotrexate (SELECT-COMPARE). Available at: https://clinicaltrials.gov/ct2/show/NCT02629159?term=NCT02629159&rank=1.
8. ClinicalTrials.gov. Identifier: NCT02706847. A Study to Compare Upadacitinib (ABT-494) to Placebo in Subjects With Rheumatoid Arthritis on Stable Dose of Conventional Synthetic Disease-Modifying Antirheumatic Drugs (csDMARDs) Who Have an Inadequate Response or Intolerance to Biologic DMARDs (SELECT-BEYOND). Available at: https://clinicaltrials.gov/ct2/show/NCT02706847?term=NCT02706847&rank=1.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Rituxan (rituximab)
BILLING CODE	J9312
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT—see "Dosage Allowed" sections
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Rituxan (rituximab) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

GRANULOMATOSIS WITH POLYANGIITIS (GPA) (WEGENER'S GRANULOMATOSIS) AND MICROSCOPIC POLYANGIITIS (MPA)

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Medication must be prescribed by or in consultation with a nephrologist or rheumatologist; AND
3. Member has a confirmed diagnosis of severe GPA or MPA, **or** non-severe disease (non-organ threatening, non-life-threatening) refractory to glucocorticoids in combination with methotrexate; AND
4. Rituxan will be initiated in combination with glucocorticoids; AND
5. Member has at least ONE of the following:
   a) Member's disease remains active or has progressed despite at least a 3 month trial of glucocorticoids in combination with cyclophosphamide;
   b) Further treatment with cyclophosphamide would exceed the maximum cumulative dose;
   c) Cyclophosphamide is contraindicated or not tolerated by the member.
6. **Dosage allowed:** Please refer to the Dosing and Administration section of the package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member tolerates infusions; AND
2. Chart notes demonstrate clinical improvement of disease signs and symptoms.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PEMPHIGUS VULGARIS (PV)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Must be prescribed by or in consultation with a dermatologist; AND
3. Member has a documented diagnosis of moderate to severe PV; AND
4. Rituxan will be initiated in combination with a corticosteroid taper (unless contraindicated); AND
5. Member has tried and failed or has contraindication to high dose corticosteroid (equivalent to 1.5mg/kg/day prednisone) and an adjuvant immunosuppressive agent such as azathioprine or mycophenolate mofetil.
6. **Dosage allowed:** Initial: Two 1000mg doses separated by 2 weeks; Maintenance: 500mg infusion at month 12 and every 6 months thereafter or based on clinical evaluation -- no sooner than 16 weeks following the previous infusion; Relapse: 1000mg infusion.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member tolerates infusions; AND
2. Chart notes demonstrate clinical improvement of signs and symptoms (e.g. healed lesions, fewer new lesions, etc.)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication is being prescribed by or in consultation with a rheumatologist; AND
3. Member has a documented diagnosis of moderately- to severely- active RA; AND
4. Rituxan is being used in combination with methotrexate, or another non-biologic DMARD if unable to tolerate methotrexate; AND
5. Member must have inadequate response or intolerance to one or more tumor necrosis factor (TNF) antagonists (e.g. adalimumab, etanercept, infliximab) for at least 3 months each. Note: TNF antagonists require prior authorization.
6. **Dosage allowed:** Two 1000mg doses separated by 2 weeks; subsequent courses repeated no sooner than every 16 weeks (every 24 weeks is typical).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member tolerates infusions; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, etc.)

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (aTTP)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a hematologist; AND
3. Member has a presumptive or confirmed diagnosis of aTTP including ALL of the following:
   a) Lab results showing thrombocytopenia (platelet count less than 150,000);
   b) Microangiopathic hemolytic anemia (MAHA) confirmed by presence of schistocytes on blood smear;

c) Documentation of a PLASMIC score between 5 and 7 (intermediate to high risk);[25]
d) Testing shows an ADAMTS13 activity level less than 10%, OR test has been ordered and results are pending.

4. Member's platelet count has not responded after at least 4 days of plasma exchange and glucocorticoid; AND
5. Rituxan is being used in addition to plasma exchange and glucocorticoid.
6. **Dosage allowed:** 375mg/m^2 once weekly for 4 doses (off label).[26]

If member meets all the requirements listed above, the medication will be approved for 30 days.

For **reauthorization**:
1. Member is experiencing a relapse of symptoms (thrombocytopenia and MAHA); AND
2. ADAMTS13 activity is less than 20% (lab report required).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 30 days.

NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

For **initial** authorization:
1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of NMOSD and is seropositive for aquaporin-4 (AQP4) IgG antibodies (documentation required).
4. **Dosage allowed:** 1g on day 1 and day 15, then 1g every 6 months[32] (off label)

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member tolerates infusions; AND
2. Chart notes must document disease stabilization, symptom improvement, and/or reduced frequency of relapses.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NON-HODGKIN'S LYMPHOMA (NHL)

These requests must be submitted through NantHealth/Eviti portal.

CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

These requests must be submitted through NantHealth/Eviti portal.

CareSource considers Rituxan (rituximab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
8/20/2013	Change in diagnosis
7/15/2014	Added diagnosis TTP and additional criteria to CD20+ CLL

7/15/2015	Added MCG 19th edition criteria
10/4/2016	Change in diagnoses to FDA approved uses, updated references with supporting guidelines and literature
6/9/2020	Transferred policy to new template, indicated Eviti carve-outs. Revised criteria for vasculitis diagnoses (GPA, MPA); previously listed as ANCA vasculitis – updated age, specified trial for non-severe, simplified the cyclophosphamide trial language. Revised criteria for Rheumatoid Arthritis – changed from trial of 2 TNF to 1 TNF. Added new diagnosis Pemphigus Vulgaris and its criteria
7/28/2020	Added criteria for aTTP.
10/13/2020	Added criteria for NMOSD. For RA, stated they must use another DMARD if they can't use MTX.

References:

1. Rituxan [package insert]. South San Francisco, CA: Genentech, Inc.; 2020.
2. Ntatsaki E, Carruthers D, Chakravarty K, et al. BSR and BHPR guideline for the management of adults with ANCA-associated vasculitis. Rheumatology April 2014: ket445
3. Stone JH, Merkel PA, Spiera R, et al. Rituximab versus cyclophosphamide for ANCAassociated vasculitis. N Engl J Med 2010; 363:221.
4. Jones RB, Tervaert JW, Hauser T, et al. Rituximab versus cyclophosphamide in ANCAassociated renal vasculitis. N Engl J Med 2010; 363:211.
5. Jones RB, Tervaert JW, Hauser T, et al. Rituximab versus cyclophosphamide in ANCAassociated renal vasculitis: 2-year results of a randomized trial. Ann Rheum Dis 2015; 74(6): 1178-1182.
6. Latimer NR, Carroll C, Wong R, et al. Rituximab in combination with corticosteroids for the treatment of anti-neutrophil cytoplasmic antibody-associated vasculitis: a NICE single technology appraisal. Pharmacoeconomics 2014; 32(12): 1171-1183.
7. Pagnoux C. Updates in ANCA-associated vasculitis. Eur J Rheumatol 2015
8. Singh JA, Saag KG, Bridges Jr. SL, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthitis. Arthritis Care & Research 2015: 1-25.
9. Leandro MJ. Rituximab: Principles of use and adverse effects in rheumatoid arthritis. *UpToDate*. https://www.uptodate.com/contents/rituximab-principles-of-use-and-adverse-effects-in-rheumatoid-arthritis?search=rheumatoid%20arthritis%20treatment&topicRef=7966&source=see_link. Updated April 3, 2020. Accessed June 9, 2020.
10. Finckh A, Ciurea A, Brulhart L, et al. Which subgroup of patients with rheumatoid arthritis benefits from switching to rituximab versus alternative anti-tumour necrosis factor (TNF) agents after previous failure of an anti-TNF agent? *Annals of the Rheumatic Diseases*. 2009;69(2):387-393. doi:10.1136/ard.2008.105064
11. Solau-Gervais E, Prudhomme C, Philippe P, et al. Efficacy of rituximab in the treatment of rheumatoid arthritis. Influence of serologic status, coprescription of methotrexate and prior TNF-alpha inhibitors exposure. *Joint Bone Spine*. 2012;79(3):281-284. doi:10.1016/j.jbspin.2011.05.002
12. Harrold LR, Reed GW, Magner R, et al. Comparative effectiveness and safety of rituximab versus subsequent anti–tumor necrosis factor therapy in patients with rheumatoid arthritis with prior exposure to anti–tumor necrosis factor therapies in the United States Corrona registry. *Arthritis Research & Therapy*. 2015;17(1). doi:10.1186/s13075-015-0776-1
13. Chatzidionysiou K, Lie E, Nasonov E, et al. Highest clinical effectiveness of rituximab in autoantibody-positive patients with rheumatoid arthritis and in those for whom no more than one previous TNF antagonist has failed: pooled data from 10 European registries. *Annals of the Rheumatic Diseases*. 2011;70(9):1575-1580. doi:10.1136/ard.2010.148759
14. Emery P, Gottenberg JE, Rubbert-Roth A, et al. Rituximab versus an alternative TNF inhibitor in patients with rheumatoid arthritis who failed to respond to a single previous TNF inhibitor: SWITCH-RA, a global, observational, comparative effectiveness study. *Annals of the Rheumatic Diseases*. 2014;74(6):979-984. doi:10.1136/annrheumdis-2013-203993
15. Hertl M, Eming R. Management of refractory pemphigus vulgaris and pemphigus foliaceus. *UpToDate*. https://www.uptodate.com/contents/management-of-refractory-pemphigus-vulgaris-and-pemphigus-foliaceus?search=pemphigus%20vulgaris&source=search_result&selectedTitle=3~40&usage_type=default&display_rank=3. Updated March 5, 2020. Accessed June 11, 2020.

16. Heelan K, Al-Mohammedi F, Smith MJ, et al. Durable Remission of Pemphigus With a Fixed-Dose Rituximab Protocol. *JAMA Dermatology*. 2014;150(7):703. doi:10.1001/jamadermatol.2013.6739
17. Murrell DF, Dick S, Ahmed A, et al. Consensus statement on definitions of disease, end points, and therapeutic response for pemphigus. *Journal of the American Academy of Dermatology*. 2008;58(6):1043-1046. doi:10.1016/j.jaad.2008.01.012
18. Agarwal A, Hall RP, Bañez LL, Cardones AR. Comparison of rituximab and conventional adjuvant therapy for pemphigus vulgaris: A retrospective analysis. *Plos One*. 2018;13(9). doi:10.1371/journal.pone.0198074
19. Merkel PA, Kaplan AA, Falk RJ. Granulomatosis with polyangiitis and microscopic polyangiitis: Initial immunosuppressive therapy. UpToDate. https://www.uptodate.com/contents/granulomatosis-with-polyangiitis-and-microscopic-polyangiitis-initial-immunosuppressive-therapy?search=Granulomatosis%20with%20polyangiitis%20and%20Microscopic%20Polyangiitis&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2. Updated January 23, 2019. Accessed June 11, 2020.
20. Mcgeoch L, Twilt M, Famorca L, et al. CanVasc Recommendations for the Management of Antineutrophil Cytoplasm Antibody-associated Vasculitides. *The Journal of Rheumatology*. 2015;43(1):97-120. doi:10.3899/jrheum.150376
21. Yates M, Watts R, Bajema I, et al. OP0053 Eular/ERA-EDTA Recommendations for The Management of Anca-Associated Vasculitis. *Annals of the Rheumatic Diseases*. 2016;75(Suppl 2). doi:10.1136/annrheumdis-2016-eular.1168
22. Terrier B, Pagnoux C, Perrodeau É, et al. Long-term efficacy of remission-maintenance regimens for ANCA-associated vasculitides. *Annals of the Rheumatic Diseases*. 2018;77(8):1150-1156. doi:10.1136/annrheumdis-2017-212768
23. George JN, Cuker A.Acquired TTP: Initial treatment. *UpToDate*. http://www.uptodate.com. Updated September 30, 2019. Accessed July 15, 2020.
24. ISTH Guideline for the Diagnosis and Management of Thrombotic Thrombocytopenic Purpura. https://cdn.ymaws.com/www.isth.org/resource/resmgr/guidance_and_guidelines/ttp_guideline/isth_ttp_guideline_september.pdf. Accessed 7/15/2020.
25. Coppo P, Cuker A, George JN. Thrombotic thrombocytopenic purpura: Toward targeted therapy and precision medicine. *Res Pract Thromb Haemost*. 2018;3(1):26-37. Published 2018 Nov 16. doi:10.1002/rth2.12160
26. Scully M, McDonald V, Cavenagh J, et al. A phase 2 study of the safety and efficacy of rituximab with plasma exchange in acute acquired thrombotic thrombocytopenic purpura. *Blood*. 2011;118(7):1746-1753. doi:10.1182/blood-2011-03-341131
27. Sayani FA, Abrams CS. How I treat refractory thrombotic thrombocytopenic purpura [published correction appears in Blood. 2017 Oct 5;130(14):1684]. *Blood*. 2015;125(25):3860-3867. doi:10.1182/blood-2014-11-551580
28. Lim W, Vesely SK, George JN. The role of rituximab in the management of patients with acquired thrombotic thrombocytopenic purpura. *Blood*. 2015;125(10):1526-1531. doi:10.1182/blood-2014-10-559211
29. Kessler RA, Mealy MA, Levy M. Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic. *Curr Treat Options Neurol*. 2016;18(1):2. doi:10.1007/s11940-015-0387-9
30. Weinshenker B. Neuromyelitis Optica Spectrum Disorder. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/neuromyelitis-optica/. Published August 25, 2020. Accessed October 2, 2020.
31. Mealy MA, Wingerchuk DM, Palace J, Greenberg BM, Levy M. Comparison of relapse and treatment failure rates among patients with neuromyelitis optica: multicenter study of treatment efficacy. *JAMA Neurol*. 2014;71(3):324-330. doi:10.1001/jamaneurol.2013.5699
32. Ciron J, Audoin B, Bourre B, et al. Recommendations for the use of Rituximab in neuromyelitis optica spectrum disorders. *Revue Neurologique*. 2018;174(4):255-264. doi:10.1016/j.neurol.2017.11.005
33. Damato V, Evoli A, Iorio R. Efficacy and Safety of Rituximab Therapy in Neuromyelitis Optica Spectrum Disorders: A Systematic Review and Meta-analysis. *JAMA Neurol*. 2016;73(11):1342-1348. doi:10.1001/jamaneurol.2016.1637
34. Tahara M, Oeda T, Okada K, et al. Safety and efficacy of rituximab in neuromyelitis optica spectrum disorders (RIN-1 study): a multicentre, randomised, double-blind, placebo-controlled trial. *The Lancet Neurology*. 2020;19(4):298-306. doi:10.1016/s1474-4422(20)30066-1

Effective date: 10/1/2021
Revised date: 10/13/2020

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ruconest (C1 esterase inhibitor (recombinant))
BILLING CODE	J0596
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior-Authorization Required (Non-Preferred Product) Alternative preferred products include Berinert and Firazyr QUANTITY LIMIT—8 vials per fill
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ruconest (C1 esterase inhibitor (recombinant)) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 13 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Medication is being prescribed for the treatment of acute HAE attacks; AND
5. Member has documented trial and failure of or contraindication to both Firazyr and Berinert (Chart notes required); AND
6. Medication is not being used in combination with another on-demand therapy (e.g. Berinert, Firazyr, Kalbitor); AND
7. Member does not have a history of allergy to rabbits or rabbit-derived products.
8. **Dosage allowed:** 50 IU per kg IV; not to exceed 4200 IU (2 vials) per dose. May repeat 1 time; no more than 2 doses within 24 hours.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improvement such as faster time to symptom relief or resolution of attack.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ruconest (C1 esterase inhibitor (recombinant)) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/28/2017	New policy for Ruconest created. Criteria for each type of HAE specified. Criteria of documentation of attacks, discontinuation of meds that can cause HAE, and restriction on combinations with other meds for acute attacks added.
01/20/2021	Updated references. Clarified the dosing. Removed statement about causative meds. Removed hematology as specialist. Simplified the diagnostic criteria. Removed log book requirement. Reworded the renewal criteria. Added rabbit allergy contraindication. Extended initial auth duration to 6 mo and renewal to 12 mo. Changed “rabbit-derived” to say “recombinant.” Adjusted quantity limit to allow for repeat doses as indicated. Removed exclusion of laryngeal attacks.

References:

1. Ruconest [package insert]. Warren NJ: Pharming Healthcare, Inc; 2020.
2. Frank MM, Zuraw B, Banerji A, et al. Management of children with hereditary angioedema due to C1 inhibitor deficiency. Pediatrics. 2016 Nov;138(5). pii: e20160575.
3. Riedl MA, Bernstein JA, Li H, et al. Recombinant human C1-esterase inhibitor relieves symptoms of hereditary angioedema attacks: phase 3, randomized, placebo-controlled trial. *Ann Allergy Asthma Immunol*. 2014;112(2):163-169.e1. doi:10.1016/j.anai.2013.12.004
4. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046
5. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384

Effective date: 10/1/2021
Revised date: 01/20/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Rukobia (fostemsavir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT --- 60 tablets/30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Rukobia (Fostemsavir) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with the following disease states and meet their individual criteria as stated.

MULTIDRUG-RESISTANT HIV-1 INFECTION

For **initial** authorization:

1. Member must be at least 18 years of age or older; AND
2. The medication must be prescribed by or in consultation with an HIV specialist; AND
3. Member must have documented resistance to at least one antiretroviral from three drug classes or have failed at least 3 drug classes for HIV treatment due to intolerance or contraindication; AND
4. Member has 2 or fewer fully active anti-retroviral agents available to add to Rukobia (fostemsavir); AND
5. Member is failing current regimen as evidenced by HIV RNA count > 200 copies/mL; AND
6. Member is NOT using Rukobia (fostemsavir) as monotherapy. Provider must include documentation of entire anti-retroviral regimen.
7. **Dosage allowed:** 600mg twice daily.

If member meets all the requirements listed above, the medication will be approved for 6 months

For **reauthorization**:

1. Rukobia (fostemsavir) is not being used as monotherapy; AND
2. Chart notes have been provided that show the member has demonstrated improvement as evidenced by one of the following:
   a) HIV RNA load < 200 copies/mL; OR
   b) Decrease in HIV RNA load from initial authorization; AND
3. Member is adherent to antiretroviral regimen as prescribed proven through claim history, chart notes, or prescriber/member attestation.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Rukobia (fostemsavir) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/30/2020	New policy for Rukobia (fostemsavir) created.
11/19/2021	Annual review, no changes

References:

1. Department of Health and Human Services. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Available at https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/AdultandAdolescentGL.pdf. Accessed October 10, 2020.
2. Rukobia [package insert]. Research Triangle Park, NC; GlaxoSmithKline. July 2020.
3. Kozal M, Aberg J, Pialoux G, et al. Fostemsavir in adults with multidrug-resistant infection. N Engl J Med. 2020 Mar 26;382(13):1232-1243. doi: 10.1056/NEJMoa1902493.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Ruzurgi (amifampridine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product: pyridostigmine QUANTITY LIMIT— 300 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ruzurgi (amifampridine) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS)

For **initial** authorization:

1. Member is 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or oncologist; AND
3. Member has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS) confirmed by documentation of at least one of the following:
   a) Repetitive nerve stimulation (RNS) testing showing reproducible post-exercise increase in compound muscle action potential (CMAP) amplitude of at least 60 percent compared with pre-exercise baseline value or a similar increment on high-frequency repetitive nerve stimulation without exercise; or
   b) Positive anti-P/Q type voltage-gated calcium channel antibody test; AND
4. Member has progressive proximal muscle weakness; AND
5. Member does not have a history of seizures.
6. **Dosage allowed:**
   Weight less than 45 kg: Initial, 7.5 mg to 15 mg/day in 2-3 divided doses; may increase daily in 2.5 mg to 5 mg increments, divided in up to 5 doses per day; max 15 mg per dose and 50 mg per day.
   Weight 45 kg or more: Initial, 15 mg to 30 mg/day in 2-3 divided doses; may increase daily in 5 mg to 10 mg increments, divided in up to 5 doses per day; max 30 mg per dose and 100 mg per day.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes must document improved muscle strength.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ruzurgi (amifampridine) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Myasthenia gravis (MG)

DATE	ACTION/DESCRIPTION
11/13/2019	New policy for Ruzurgi created.
04/28/2021	Updated references. Added oncology as specialist. Changed diagnostic criteria from “and” to “or.” Removed baseline ECG. Added muscle weakness (symptomatic). Abbreviated dosing information. Removed restrictions except for seizure. Revised renewal criteria. Corrected quantity limit.

References:

1. Ruzurgi (amifampridine) [prescribing information]. Princeton, NJ: Jacobus Pharmaceutical Company, Inc; April 2020.
2. ClinicalTrials.gov. Identifier: NCT: 01511978. Effectiveness of 3,4-Diaminopyridine in Lambert-Eaton Myasthenic Syndrome (DAPPER). Available: https://clinicaltrials.gov/ct2/show/NCT01511978?term=NCT%3A+01511978&draw=1&rank=1.
3. Kesner VG, et al. Lambert-Eaton myasthenic syndrome. Neurologic clinics. 2018;36(2):379-394.
4. Oh SJ, et al. Amifampridine phosphate (Firdapse®) is effective and safe in a phase 3 clinical trial in LEMS. Muscle & nerve. 2016;53(5):717-725.
5. Titulaer MJ, Lang B, Verschuuren JJ. Lambert-Eaton myasthenic syndrome: from clinical characteristics to therapeutic strategies. *Lancet Neurol*. 2011;10(12):1098-1107. doi:10.1016/S1474-4422(11)70245-9
6. Schoser B, Eymard B, Datt J, Mantegazza R. Lambert-Eaton myasthenic syndrome (LEMS): a rare autoimmune presynaptic disorder often associated with cancer [published correction appears in J Neurol. 2017 Jul 10;:]. *J Neurol*. 2017;264(9):1854-1863. doi:10.1007/s00415-017-8541-9

Effective date: 01/01/2022
Revised date: 04/28/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Ryplazim (plasminogen, human-tvmh)
BILLING CODE	J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Ryplazim (plasminogen, human-tvmh) is plasma-derived human plasminogen indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia). It was approved by the FDA on June 4, 2021 and is the first approved treatment for plasminogen deficiency type 1.

Individuals with this disease lack a protein called plasminogen, which is responsible for the ability of the body to break down fibrin clots. Plasminogen deficiency leads to an accumulation of fibrin, causing the development of growths (lesions) that can impair normal tissue and organ function and may lead to blindness when these lesions affect the eyes. Ligneous conjunctivitis (LC) appears to be the most common clinical manifestation and is characterized by inflamed, woody growths on the conjunctival membranes that, if left untreated, can result in visual impairment or blindness.

Treatment with Ryplazim temporarily increases plasminogen levels in blood. The effectiveness and safety of Ryplazim (plasminogen) is primarily based on one single-arm, open-label (unblinded) clinical trial enrolling 15 adult and pediatric patients with plasminogen deficiency type 1. All patients received Ryplazim administered every two to four days for 48 weeks. The effectiveness of Ryplazim was demonstrated by at least 50% improvement of their lesions in all 11 patients who had lesions at baseline, and absence of recurrent or new lesions in any of the 15 patients through the 48 weeks of treatment.

Ryplazim (plasminogen, human-tvmh) will be considered for coverage when the following criteria are met:

Hypoplasminogenemia

For **initial** authorization:

1. Member must be at least 11 months old;
2. Medication must be prescribed by a hematologist or medical geneticist;
3. Member has a documented history of disease-related lesions and symptoms consistent with a diagnosis of hypoplasminogenemia; AND
4. Documentation of baseline plasminogen activity level ≤ 45%.
5. **Dosage allowed/Quantity limit:** 6.6 mg/kg body weight given intravenously every 2 to 4 days

If all the above requirements are met, the medication will be approved for 12 weeks.

For **reauthorization**:

Ryplazim will be reauthorized when chart notes show at least one of the following:

a) Absence of recurrent or new lesions
b) Decrease in the lesion number and/or size
c) Increase in trough plasminogen activity level by at least 10% from baseline

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Ryplazim (plasminogen, human-tvmh) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/06/2021	Ryplazim policy creation

References:

1. Ryplazim [package insert]. Laval, Quebec, CA; Prometric Bioproduction, Inc.; June 2021
2. Shapiro, Amy D. et al. 'Plasminogen replacement therapy for the treatment of children and adults with congenital plasminogen deficiency' Blood. 2018 Mar 22;131(12):1301-1310
3. Shapiro AD, et al. An international registry of patients with plasminogen deficiency (HISTORY). Haematologica. 2020;105(3):554-561

Effective date: 04/01/2022
Creation date: 10/06/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Saphnelo (anifrolumab-fnia)
BILLING CODE	J3490/J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Saphnelo is a first in class type 1 interferon (IFN-1) inhibitor, and the first drug to target IFN-1 for the treatment of Systemic Lupus Erythematosus (SLE). Saphnelo is indicated for adults with moderate to severe SLE, in combination with standard therapy. SLE is the most common type of lupus. It is a chronic autoimmune disease with periods of flares and remissions that causes inflammation and damage throughout the body. Up to 60-80% of adult SLE patients have increased type 1 IFN signaling, which is associated with higher disease activity/severity. Pooled clinical trial data for Saphnelo demonstrates improved overall disease activity.

Saphnelo (anifrolumab-fnia) will be considered for coverage when the following criteria are met:

Systemic Lupus Erythematosus (SLE)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a rheumatologist; AND
3. Chart notes document at least one of the following:
   a) Positive anti-nuclear antibody (ANA) titer ≥1:80
   b) Elevated (above normal) anti-double-stranded DNA (anti-dsDNA)
   c) Elevated (above normal) anti-Smith (anti-Sm) antibody; AND
4. Member has documented moderate to severe SLE or SELENA-SLEDAI score of 6 or greater; AND
5. Member has tried and failed all the following (unless contraindicated):
   a) Hydroxychloroquine (or chloroquine), and
   b) Corticosteroid, and
   c) A non-steroid immunosuppressant (i.e., methotrexate, azathioprine, mycophenolate mofetil) for at least 12 weeks; AND
6. At least one of the above standard therapies will be continued with Saphnelo; AND
7. Saphnelo will not be used with other biologic therapies; AND
8. Member does not have severe active lupus nephritis or severe active central nervous system lupus.
9. **Dosage allowed/Quantity limit:** 300 mg IV infusion every 4 weeks (1 vial per 28 days)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improved disease activity such as reduced number of flares, reduced severity of skin disease, or ability to taper glucocorticoid use.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Saphnelo (anifrolumab-fnia) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
09/15/2021	New policy for Saphnelo created.

References:

1. Saphnelo. [prescribing information]. AstraZeneca; 2021.
2. Furie R, Khamashta M, Merrill JT, et al. Anifrolumab, an Anti-Interferon-α Receptor Monoclonal Antibody, in Moderate-to-Severe Systemic Lupus Erythematosus. *Arthritis Rheumatol*. 2017;69(2):376-386. doi:10.1002/art.39962
3. Morand EF, Furie R, Tanaka Y, et al. Trial of Anifrolumab in Active Systemic Lupus Erythematosus. *N Engl J Med*. 2020;382(3):211-221. doi:10.1056/NEJMoa1912196
4. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus. *Ann Rheum Dis*. 2019;78(6):736-745. doi:10.1136/annrheumdis-2019-215089
5. Gordon C, Amissah-Arthur MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults: Executive Summary. *Rheumatology (Oxford)*. 2018;57(1):14-18. doi:10.1093/rheumatology/kex291
6. Fanouriakis A, Tziolos N, Bertsias G, Boumpas DT. Update on the diagnosis and management of systemic lupus erythematosus. Ann Rheum Dis. 2021;80(1):14-25. doi:10.1136/annrheumdis-2020-218272
7. Kleinmann JF, Tubach F, Le Guern V, et al. International and multidisciplinary expert recommendations for the use of biologics in systemic lupus erythematosus. Autoimmun Rev. 2017;16(6):650-657. doi:10.1016/j.autrev.2017.04.011

Effective date: 04/01/2022
Revised date: 09/15/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	NPlate (romiplostim)
BILLING CODE	J2796
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Hospital, Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include immune globulins and Promacta QUANTITY LIMIT— 10 mcg/kg (actual body weight)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

NPlate (romiplostim) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

IMMUNE THROMBOCYTOPENIC PURPURA (ITP)

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP); AND
3. Medication must be prescribed by or in consultation with a hematologist; AND
4. Member has ONE of the following conditions:
   a) Current platelet count is $<30x10^9$/L;
   b) $30x10^9$/L to $50x10^9$/L with one of the following:
      i) Symptomatic bleeding (e.g., significant mucous membrane bleeding, gastrointestinal bleeding or trauma);
      ii) Have risk factors for bleeding (i.e., on anticoagulant, lifestyle that predisposes member to trauma, comorbidity such as peptic ulcer disease, undergoing medical procedure where blood loss is anticipated); AND
5. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with ONE of the following treatments:
   a) Corticosteroids (prednisone, prednisolone, methylprednisolone, and dexamethasone);
   b) Immunoglobulins;
   c) Splenectomy.
6. **Dosage allowed:** Administer 1mcg/kg subcutaneously once weekly, then adjust the weekly dose by increments of 1 mcg/kg until the patient achieves a platelet count ≥ 50 x 10^9/L. Max dose 10 mcg/kg.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement in platelet count from baseline; AND
3. Member's platelet count is less than 400 x 109/L.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers NPlate (romiplostim) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Any cause of thrombocytopenia other than chronic ITP
- Chronic Hepatitis C (CHC) Thrombocytopenia
- ITP with previous documented failure of Nplate
- Severe aplastic anemia
- Thrombocytopenia due to Myelodysplastic syndrome (MDS)

DATE	ACTION/DESCRIPTION
10/04/2018	New policy for NPlate created. Platelets requirement threshold expanded.

References:

1. Nplate [Package Insert]. Thousand Oaks, CA: Amgen, Inc.; October, 2017.
2. Diagnosis and treatment of idiopathic thrombocytopenic purpura: recommendations of the American Society of Hematology. Ann Intern Med. 1997 Feb 15;126(4):319-26.
3. Cooper N, Terrinoni I, Newland A. The efficacy and safety of romiplostim in adult patients with chronic immune thrombocytopenia. Ther Adv Hematol. 2012 Oct; 3(5): 291–298.
4. Bussel JB, Cheng G, Saleh MN, et al. Eltrombopag for the treatment of chronic idiopathic thrombocytopenic purpura. N Engl J Med. 2007; 357:2237.
5. Kuter DJ, et al. Romiplostim or standard of care in patients with immune thrombocytopenia. N Engl J Med. 2010 Nov 11;363(20):1889-99.
6. Kuter DJ, et al. Efficacy of romiplostim in patients with chronic immune thrombocytopenic purpura: a double-blind randomised controlled trial. Lancet. 2008 Feb 2;371(9610):395-403.
7. Kuter DJ, et al. Long-term treatment with romiplostim in patients with chronic immune thrombocytopenia: safety and efficacy. Br J Haematol. 2013 May;161(3):411-23.
8. Neunert C, et al. The American Society of Hematology 2011 evidence-based practice guideline for immune thrombocytopenia. Blood. 2011 Apr 21;117(16):4190-207.

Effective date: 10/19/2018
Revised date: 10/04/2018

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Short-Acting Somatropin Injections for Growth Hormone Deficiency - Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Zomacton
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Somatropin is a recombinant human growth hormone with initial FDA approval in 1987. There are currently seven brands of short-acting Somatropin used daily as replacement therapy for growth failure and growth hormone deficiency. Somatropin binds to a dimeric GH receptor in the cell membrane of target cells resulting in intracellular signal transduction and a host of pharmacodynamic effects. They are: Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen and Zomacton.

Short-Acting Somatropin Injections will be considered for coverage when the following criteria are met:

Adult Growth Hormone Deficiency (GHD) – Adult or Childhood Onset

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by an endocrinologist; AND
3. Member must have a diagnosis of GHD confirmed by **one** of the following:
   a) Two pre-treatment stimulation tests with a peak serum growth hormone concentration < 5 µg/mL (must include lab results with reference ranges), unless Macrilen (prior authorization required) was used, in which case a GH level must be < 2.8 ng/ml; OR
   b) One pre-treatment stimulation test with a peak serum growth hormone concentration < 5 µg/mL (must include lab results with reference ranges) AND one of the following:
      i) Documentation of structural abnormalities of the growth hormone axis (see appendix)
      ii) Documentation of childhood-onset GHD due to congenital abnormalities of the growth hormone axis (see appendix)
      iii) Documentation of at least two other pituitary growth hormone deficiencies (see appendix)
4. Member must have a 90-day trial of Omnitrope 5.8 mg vial which was documented as ineffective, or contraindicated.
5. **Dosage allowed/Quantity limit:**

Drug	Dosage/Quantity Limit
Genotropin/Omnitrope	Weight based dosing: 0.04-0.08 mg/kg/week. Non-weight based dosing: starting dose 0.2 mg/day (0.15-0.30 mg/day) and increased every 1-2 months in increments of 0.1-0.2 mg/day, doses vary considerably.
Humatrope	Weight based dosing: 0.006 mg/kg/day - 0.0125 mg/kg/day. Non-weight based dosing: starting dose 0.2 mg/day (0.15-0.30 mg/day) and increased every 1-2 months in increments of 0.1-0.2 mg/day, doses vary considerably.
Norditropin	Weight based dosing: 0.004-0.016 mg/kg/day. Non-weight based dosing: starting dose 0.2 mg/day (0.15-0.30 mg/day) and increased every 1-2 months in increments of 0.1-0.2 mg/day, doses vary considerably

Nutropin/Nutropin AQ	Weight based dosing: 0.006-0.025 mg/kg/day if ≤ 35 years or 0.0125 mg/kg/day > 35 years. Non-weight based dosing: starting dose 0.2 mg/day (0.15-0.30 mg/day) and increased every 1-2 months in increments of 0.1-0.2 mg/day, doses vary considerably.
Saizen	Weight based dosing: 0.005 mg/kg/day initially; can be increased as tolerated to not more than 0.01 mg/kg/day after 4 weeks. Non-weight based dosing: starting dose 0.2 mg/day (0.15- 0.30 mg/day) and increased every 1-2 months in increments of 0.1-0.2 mg/day, doses vary considerably.
Zomacton	Weight based dosing: 0.006 mg/kg/day - 0.0125 mg/kg/day. Non-weight based dosing: starting dose 0.2 mg/day (0.15-0.30 mg/day) and increased every 1-2 months in increments of 0.1-0.2 mg/day, doses vary considerably.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Short-acting Somatropin Injections will be reauthorized when chart notes show all of the following:
1. Member must be in compliance with all of the initial criteria; AND
2. Member's current IGF-1 level not elevated for age/gender (does not apply to members w/ structural abnormality of hypothalamus/pituitary and at least pituitary hormone deficiencies or childhood onset GHD and congenital abnormality of hypothalamus/pituitary).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Noonan Syndrome – Norditropin Only

For **initial** authorization:
1. Member must have a diagnosis of Noonan Syndrome confirmed by genetic analyses (must include documentation); AND
2. Member is 17 years of age or younger; AND
3. Medication must be prescribed by an endocrinologist; AND
4. Member's pre-treatment height is > 2 SD below the mean and 1 year height velocity is > 1 SD below the mean for age (must include growth charts and documentation); AND
5. If member is age 12 or older, the member's epiphyses are open, confirmed by radiograph of the wrist and hand (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age.
6. **Dosage allowed/Quantity limit:** 0.46 mg/kg/week.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Norditropin will be reauthorized when chart notes show all of the following:
1. Member must be in compliance with all of the initial criteria; AND
2. If member is age 12 or older, the member's epiphyses are open, confirmed by radiograph of the wrist and hand (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age; AND
3. Member has a growth rate > 2.5 cm/year unless there is a documented reason for lack of efficacy (on treatment < 1 year, off treatment for a reason for a period of time, nearing final adult height, late stages of puberty).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Pediatric Growth Failure due to Chronic Kidney Disease – Nutropin Only

For **initial** authorization:
1. Member is age 17 years or younger; AND
2. Member must have a diagnosis of growth failure due to chronic kidney disease (i.e., irreversible renal insufficiency with CrCl < 75 mL/min per 1.73 m2 or dialysis dependent awaiting renal transplant (must include documentation)); AND

3. Medication must be prescribed by an endocrinologist or nephrologist; AND
4. Member's pre-treatment height is > 2 SD below the mean and 1 year height velocity is > 1 SD below the mean for age (must include growth charts and documentation); AND
5. If member is age 12 or older, the member's epiphyses are open, confirmed by radiograph of the wrist and hand (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age.
6. **Dosage allowed/Quantity limit:** 0.35 mg/kg/week.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Nutropin will be reauthorized when chart notes show at least one of the following:
1. Member must be in compliance with all of the initial criteria; AND
2. If member is age 12 or older, the member's epiphyses are open, confirmed by radiograph of the wrist and hand (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age; AND
3. Member has a growth rate > 2.5 cm/year unless there is a documented reason for lack of efficacy (on treatment < 1 year, off treatment for a reason for a period of time, nearing final adult height, late stages of puberty).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Pediatric Growth Hormone Deficiency

For **initial** authorization:
7. Member is one year of age or older and weighs at least 11.5kg;
8. Medication must be prescribed by an endocrinologist; AND
9. Member must have a diagnosis of GHD confirmed by **one** of the following:
   a) Two pre-treatment stimulation tests with a peak serum growth hormone concentration < 10 ng/mL (must include lab results with reference ranges); OR
   b) One pre-treatment treatment stimulation test with a peak serum growth hormone concentration < 10 ng/mL (must include lab results with reference ranges) AND one of the following:
      i) Documentation of structural abnormalities of the growth hormone axis (see appendix)
      ii) Documentation of congenital abnormalities of the growth hormone axis (see appendix)
      iii) Documentation of at least two other pituitary growth hormone deficiencies (see appendix)
10. Member must have a pretreatment height (must include growth charts) of > 2 SD below the mean for age and gender; AND
11. Member must have a documented 90-day trial and failure of Omnitrope 5.8 mg vial; AND
12. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included).
13. **Dosage allowed/Quantity limit:**

Drug	Dosage/Quantity Limit
Genotropin/Omnitrope	0.16-0.24 mg/kg/week
Humatrope	0.18-0.30 mg/kg/week
Norditropin	0.17-0.24 mg/kg/week
Nutropin/Nutropin AQ	Pediatric: up to 0.3 mg/kg/week Pubertal patient: up to 0.7 mg/kg/week
Saizen	0.18 mg/kg/week
Zomacton	0.18-0.30 mg/kg/week

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Short-acting Somatropin Injections will be reauthorized when chart notes show at least one of the following:

4. Member has a growth rate of at least 2 cm/year;
5. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Prader-Willi Syndrome

For **initial** authorization:

1. Member is 17 years of age or younger; AND
2. Medication must be prescribed by an endocrinologist; AND
3. Member must have a diagnosis of Prader-Willi Syndrome confirmed by genetic analyses (must include documentation); AND
4. Member's pre-treatment height is > 2 SD below the mean and 1 year height velocity is > 1 SD below the mean for age (must include growth charts and documentation); AND
5. Member must have a documented 90-day trial and failure of Omnitrope 5.8 mg vial;
6. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age
7. **Dosage allowed/Quantity limit:**

Drug	Dosage/Quantity Limit
Genotropin/Omnitrope	0.24 mg/kg/week
Norditropin	0.24 mg/kg/week

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Short-acting Somatropin Injections will be reauthorized when chart notes show at least one of the following:

1. Member must be in compliance with all of the initial criteria; AND
2. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age; AND
3. Member has a growth rate > 2.5 cm/year unless there is a documented reason for lack of efficacy (on treatment < 1 year, off treatment for a reason for a period of time, nearing final adult height, late stages of puberty).

If all the above requirements are met, the medication will be approved for an additional 12 months.

SHOX Deficiency

For **initial** authorization:

1. Member must have a diagnosis of SHOX gene deficiency confirmed by genetic analyses (must include documentation); AND
2. Medication must be prescribed by an endocrinologist; AND
3. Member's pre-treatment height is > 2 SD below the mean and 1 year height velocity is > 1 SD below the mean for age (must include growth charts and documentation); AND
4. If member is age 12 or older, the member's epiphyses are open, confirmed by radiograph of the wrist and hand (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age.
5. **Dosage allowed/Quantity limit:** 0.35 mg/kg/week.

Drug	Dosage/Quantity Limit
Humatrope	0.35 mg/kg/week

Zomacton	0.35 mg/kg/week

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Humatrope and Zomacton will be reauthorized when chart notes show at least one of the following:
1. Member must be in compliance with all of the initial criteria; AND
2. If member is age 12 or older, the member's epiphyses are open, confirmed by radiograph of the wrist and hand (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age; AND
3. Member has a growth rate > 2.5 cm/year unless there is a documented reason for lack of efficacy (on treatment < 1 year, off treatment for a reason for a period of time, nearing final adult height, late stages of puberty).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Small for Gestational Age

For **initial** authorization:
1. Member is 2 years of age or older prior to initiating treatment; AND
2. Medication must be prescribed by an endocrinologist; AND
3. Member must have a diagnosis of small for gestational age (SGA) and failed to catch up growth by 2 years of age; AND
4. Member's birth weight and/or length are > 2 SD below the mean for gestational age (must include growth charts and documentation); AND
5. Member's height remains > 2 SD below population for age and gender (must include growth charts and documentation); AND
6. Member must have a documented 90-day trial and failure of Omnitrope 5.8 mg vial;
7. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age.
8. **Dosage allowed/Quantity limit:**

Drug	Dosage/Quantity Limit
Genotropin/Omnitrope	Up to 0.48 mg/kg/week
Humatrope	Up to 0.47 mg/kg/week
Norditropin	Up to 0.47 mg/kg/week
Zomacton	Up to 0.47 mg/kg/week

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Short-acting Somatropin Injections will be reauthorized when chart notes show at least one of the following:
1. Member must be in compliance with all of the initial criteria; AND
2. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age; AND
3. Member has a growth rate > 2.5 cm/year unless there is a documented reason for lack of efficacy (on treatment < 1 year, off treatment for a reason for a period of time, nearing final adult height, late stages of puberty).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Turner Syndrome

For **initial** authorization:

1. Member is female age 2 to 17 years; AND
2. Medication must be prescribed by an endocrinologist; AND
3. Member must have a diagnosis of Turner Syndrome confirmed by genetic analyses (must include documentation); AND
4. Member's pre-treatment height is > 2 SD below the mean and 1 year height velocity is > 1 SD below the mean for age (must include growth charts and documentation); AND
5. Member must have a documented 90-day trial and failure of Omnitrope 5.8 mg vial
6. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age.
7. **Dosage allowed/Quantity limit:**

Drug	Dosage/Quantity Limit
Genotropin/Omnitrope	0.33 mg/kg/week
Humatrope	Up to 0.375 mg/kg/week
Norditropin	Up to 0.47 mg/kg/week
Nutropin/Nutropin AQ	Up to 0.375 mg/kg/week
Zomacton	Up to 0.375 mg/kg/week

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

Short-acting Somatropin Injections will be reauthorized when chart notes show at least one of the following:

1. Member must be in compliance with all of the initial criteria; AND
2. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included). Comparison of bone age to chronological age should be documented as abnormal by > 2 SD below the mean for chronological age; AND
3. Member has a growth rate > 2.5 cm/year unless there is a documented reason for lack of efficacy (on treatment < 1 year, off treatment for a reason for a period of time, nearing final adult height, late stages of puberty).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Short-acting Somatropin Injections not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/17/2021	New policy for Short-Acting Somatropin Injections created; combined short-acting somatropin into a single policy and updated the adult and pediatric GHD sections per current literature

Appendix:

1) Acquired structural abnormalities
    - CNS tumor or neoplasm (craniopharyngioma, glioma, pituitary adenoma, etc.)
    - Cysts (Rathke cleft cyst or arachnoid cleft cyst)
    - Surgery
    - Radiation
    - Chemotherapy
    - CNS infection
    - CNS infarction (e.g., Sheehan's syndrome)
    - Inflammatory lesions (e.g., autoimmune hypohysitis)
    - Infiltrative lesions (e.g., sarcoidosis, histiocytosis)
    - Head trauma or traumatic brain injury
    - Aneurysmal subarachnoid hemorrhage
    - Panhypopituitarism or multiple pituitary hormone deficiency

2) Congenital abnormalities
    - Known genetic mutations in growth-hormone releasing hormone (GHRH) receptor, GH gene, GH receptor or pituitary transcription factors
    - Optic nerve hypoplasia/septo-optic dysplasia
    - Empty sella syndrome
    - Ectopic posterior pituitary
    - Pituitary aplasia/hypoplasia
    - Pituitary stalk defect
    - Anencephaly or prosencephaly
    - Vascular malformations

3) Pituitary hormones, other than growth hormone (GH)
    - Adrenocorticotropic hormone (ACTH)
    - Antidiuretic hormone (ADH)
    - Follicle stimulating hormone (FSH)
    - Luteinizing hormone (LH)
    - Oxytocin
    - Prolactin
    - Thyroid stimulating hormone (TSH)

References:

1. Genotropin [prescribing information]. New York, NY: Pfizer, Inc.; April 2019.
2. Omnitrope (somatropin) package insert. Princeton, NY: Sandoz, Inc.; June 2019.
3. Humatrope [prescribing information]. Indianapolis, IN: Eli Lilly; December 2016.
4. Nutropin AQ [prescribing information]. South San Fransico, CA: Genetech, Inc.; December 2016.
5. Saizen [prescribing information]. Rockland, MD: EMD Serono, Inc.; May 2018.
6. Zomacton [prescribing information]. Parsippany, NJ: Ferring Pharmaceuticals; July 2018.
7. Norditropin [prescribing information]. Plainsboro, NJ: Novo Nordisk; February 2018.
8. Cook DM, Yuen KCJ, Biller BMK, et al. American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for Growth Hormone Use in Growth Hormone-Deficient Adults and Transition Patients – 2009 update. Endocr Pract. 2009; 15(2): 1-29.
9. Gharib H, Cook DM, Saenger PH, et al. American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for Growth Hormone Use Adults and Children – 2003 update. Endocr Pract. 2003; 9(1): 64-76.
10. American Association of Clinical Endocrinologists. American Association of Clinical Endocrinologists Position Statement Growth Hormone Usage in Short Children. December 2003.
11. Molitch ME, Clemmons Dr, Malozowski S, et al. Evaluation and treatment of adult growth hormone deficiency: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2011; 96: 1587-1609.
12. National Institute for Clinical Excellence: Guidance on the use of human growth hormone (somatropin) for the treatment of growth failure in children. May 2010.
13. National Institute for Clinical Excellence: Human growth hormone (somatropin) in adults with growth hormone deficiency. August 2003.
14. Wilson TA, Rose SR, Cohen P, et al. Update of guidelines for the use of growth hormone in children: The Lawson Wilkins Endocrinology Society Drug and Therapeutics Committee. J Pediatr. 2003; 143: 415-421.
15. Deal CL, Tony M, Hoybye C, et al. Growth Hormone Research Society workshop summary: consensus guidelines for recombinant human growth hormone therapy in Prader-Willi syndrome. J Clin Endocrinol Metab. 2013; 98: 1072-1087.
16. Blum WF, Crowe BJ, Quigley CA, et al. Growth hormone in effective in treatment of short stature associated with short stature homeobox-containing gene deficiency: two-year results of a randomized, controlled, multicenter trial. J Clin Endocinol Metab. 2007; 92: 219-228.
17. Blum WF, Ross JL, Zimmermann Ag, et al. Growth hormone treatment to final height produces similar height gains in patients with SHOX deficiency and Tuner syndrome: results of a multicenter trial. J Clin Endocrinol Metab. 2013; 98 (8): 1383-1392.
18. Kirk J, Betts P, Butler G, et al. Short stature in Noonan syndrome: response to growth hormone therapy. Arch Dis Child. 2001; 84(5): 440-443.
19. Raynal P. Growth hormone and noonan syndrome: update in dysfunctional signaling aspects and in therapy for short stature.
20. Mahan JD, Warady BA. Assessment and treatment of short stature in pediatric patients with chronic kidney disease: a consensus statement. Pediatr Nephrol. 2006; 21(7): 917-930.
21. Romano AA, Allanson JE, Dahlgren J, et al. Noonan syndrome: clinical features, diagnosis, and management guidelines. Pediatrics 2010;126(4): 746-759
22. Clayton PE, Cianfarani S, Czernichow P, et al. Management of the Child Born Small for Gestational Age Through to Adulthood: A Consensus Statement of the International Societies of Pediatric Endocrinology and the Growth Hormone Research Society, J Clin Endrocrinol Metab. 2007; 92(3): 804-810.
23. Baxter L, Bryant J, Cave CB, Milne R. Recombinant growth hormone for children and adolescents with Turner syndrome.
24. Nemecheck PM, Polsky B, Gottlieb MS. Treatment Guidelines for HIV-associated wasting. May Clinc Proc. 2000; 27: 386-394.
25. Goldstone AP, Holland AJ, Hauffa BP, et al. Recommendations for the diagnosis and management of Prader-Willi Syndrome. J Clin Endocrinol Metab. 2008; 93: 4183-4197.
26. Blum WF, Crowe BJ, Quigley CA, et al. Growth hormone in effective in treatment of short stature associated with short stature homeobox-containing gene deficiency: two-year results of a randomized, controlled, multicenter trial. J Clin Endocinol Metab. 2007; 92: 219-228.
27. Blum WF, Ross JL, Zimmermann Ag, et al. Growth hormone treatment to final height produces similar height gains in patients with SHOX deficiency and Tuner syndrome: results of a multicenter trial. J Clin Endocrinol Metab. 2013; 98 (8): 1383-1392.
28. Kirk J, Betts P, Butler G, et al. Short stature in Noonan syndrome: response to growth hormone therapy. Arch Dis Child. 2001; 84(5): 440-443.

29. Raynal P. Growth hormone and noonan syndrome: update in dysfunctional signaling aspects and in therapy for short stature.
30. Mahan JD, Warady BA. Assessment and treatment of short stature in pediatric patients with chronic kidney disease: a consensus statement. Pediatr Nephrol. 2006; 21(7): 917-930.
31. Romano AA, Allanson JE, Dahlgren J, et al. Noonan syndrome: clinical features, diagnosis, and management guidelines. Pediatrics 2010;126(4): 746-759.
32. Clayton PE, Cianfarani S, Czernichow P, et al. Management of the Child Born Small for Gestational Age Through to Adulthood: A Consensus Statement of the International Societies of Pediatric Endocrinology and the Growth Hormone Research Society, J Clin Endrocrinol Metab. 2007; 92(3): 804-810.
33. Baxter L, Bryant J, Cave CB, Milne R. Recombinant growth hormone for children and adolescents with Turner syndrome.

Effective date: 04/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Simponi Aria (golimumab)
BILLING CODE	J1602 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Actemra, Enbrel, Cimzia, Cosentyx, Kevzara, Olumiant, Otezla and Xeljanz QUANTITY LIMIT— see Dosage allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Simponi Aria (golimumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Member has a documented diagnosis of active ankylosing spondylitis (AS); AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Current imaging results show an inflammation of one or both of the sacroiliac joints (sacroiliitis); AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response; AND
8. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia and Cosentyx. Treatment failure requires at least 12 weeks of therapy with each drug.
9. **Dosage allowed:** 2 mg/kg intravenous infusion at weeks 0 and 4, and every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (pJIA)

For **initial** authorization:

1. Member must be 2 years of age or older; AND
2. Member has a confirmed diagnosis of active pJIA; AND

3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Medication must be prescribed by or in consultation with a rheumatologist; AND
5. Member has had an adequate trial and failure of a non-biologic DMARD (e.g., methotrexate, leflunomide, etc.) for 8 weeks, unless not tolerated or contraindicated; AND
6. Member must have tried and failed treatment with **both** Enbrel and Actemra. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** 80 mg/m^2 (body surface area) intravenous infusion at week 0 and 4, and every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:
1. Member must be 2 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life).
6. For adult 18 years or older only: Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla, and Xeljanz. Treatment failure requires at least 12 weeks of therapy with each drug.
7. **Dosage allowed:** Adults: 2 mg/kg intravenous infusion at weeks 0 and 4, and every 8 weeks thereafter. Pediatrics: 80 mg/m^2 (BSA) intravenous infusion at weeks 0 and 4, and every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Medication is being given in combination with methotrexate or with another non-biologic DMARD if member is unable to tolerate methotrexate; AND
6. Member must have tried and failed treatment with at least **two** of the following: Actemra, Cimzia, Enbrel, Kevzara, Olumiant and Xeljanz. Treatment failure requires at least for 12 weeks of therapy with each drug.
7. **Dosage allowed:** 2 mg/kg intravenous infusion at weeks 0 and 4, and every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Simponi Aria (golimumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Simponi Aria created. Policy SRx-0042 archived. List of diagnoses considered not medically necessary was added.
11/13/2017	New indications of AS and PsA added.
02/26/2019	Dosing information corrected. Humira was removed from criteria; Actemra, Cimzia, Cosentyx, Kevzara, Olumiant, Otezla and Xeljanz added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. References added. Symptoms of back pain for AS extended till before age of 50. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
10/12/2020	New diagnosis of pJIA added. Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. For AS: Removed list of symptoms of spondyloarthritis because imaging result should be sufficient. Removed peripheral arthritis requirement – not relevant for this diagnosis. For PsA: Age requirement expanded to 2 years or older. Updated dosing and biologic trials reflective of age label change. Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). For RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors.

References:

1. Simponi Aria [prescribing information]. Horsham, PA; Janssen Biotech, Inc.: September, 2020.
2. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
3. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
4. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
5. Deodhar A, Reveille JD, Harrison DD, et al. Safety and Efficacy of Golimumab Administered Intravenously in Adults with Ankylosing Spondylitis: Results through Week 28 of the GO-ALIVE Study [published correction appears in J Rheumatol. 2018 Feb;45(2):291]. *J Rheumatol*. 2018;45(3):341-348.
6. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guidelines for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care Res* (Hoboken). 2019 Jun;71(6):717-734.
7. ClinicalTrials.gov. Identifier: NCT02277444. A Study to Evaluate the Pharmacokinetics, Efficacy and Safety of Intravenous Golimumab in Pediatric Participants With Active Polyarticular Course Juvenile Idiopathic Arthritis Despite Methotrexate Therapy (GO-VIVA). Available at: https://clinicaltrials.gov/ct2/show/NCT02277444.
8. Kavanaugh A, et al. Golimumab in psoriatic arthritis: one-year clinical efficacy, radiographic, and safety results from a phase III, randomized, placebo-controlled trial. *Arthritis Rheum*. 2012 Aug;64(8):2504-17.
9. Michelon MA, et al. Role of golimumab, a TNF-alpha inhibitor, in the treatment of the psoriatic arthritis. *Clin Cosmet Investig Dermatol*. 2010;3:79-84.
10. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
11. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
12. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
13. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
14. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.
15. Smolen JS. Insights into the efficacy of golimumab plus methotrexate in patients with active rheumatoid arthritis who discontinued prior anti-tumour necrosis factor therapy: post-hoc analyses from the GO-AFTER study. *Ann Rheum Dis*. 2014 Oct;73(10):1811-8.
16. Li Z, et al. Efficacy and safety results from a Phase 3, randomized, placebo-controlled trial of subcutaneous golimumab in Chinese patients with active rheumatoid arthritis despite methotrexate therapy. *Int J Rheum Dis*. 2016 Nov;19(11):1143-1156.

Effective date: TBD
Revised date: 10/12/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Skyrizi (risankizumab-rzaa)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Cimzia, Cosentyx, Enbrel, Otezla and Siliq QUANTITY LIMIT— 2 syringes every 12 weeks after loading doses
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Skyrizi (risankizumab-rzaa) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Member must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq. Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:** 150 mg (two 75 mg injections) administered by subcutaneous injection at week 0, week 4, and every 12 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Skyrizi (risankizumab-rzaa) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/28/2019	New policy for Skyrizi created.
11/18/2020	Removed rheumatologist from prescriber requirement. Removed PsO 6 months or longer. Changed BSA to 3% or sensitive areas. Removed PASI score. Removed repeat TB for reauth. Updated references.

References:

1. Skyrizi [prescribing information]. North Chicago, IL: AbbVie Inc.; March 2020.
2. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
3. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
4. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
5. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
6. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
7. ClinicalTrials.gov. Identifier: NCT02684370. BI 655066 (Risankizumab) Compared to Placebo and Active Comparator (Ustekinumab) in Patients With Moderate to Severe Chronic Plaque Psoriasis. Available at: https://clinicaltrials.gov/ct2/show/NCT02684370?term=ULTIMMA-1&rank=1.
8. ClinicalTrials.gov. Identifier: NCT02684357. BI 655066 Versus Placebo & Active Comparator (Ustekinumab) in Patients With Moderate to Severe Chronic Plaque Psoriasis. Available at: https://clinicaltrials.gov/ct2/show/NCT02684357?term=ULTIMMA-2&rank=1.

Effective date: 04/01/2021
Revised date: 11/18/2020

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Skytrofa (lonapegsomatropin)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Skytrofa (lonapegsomatropin) was approved by the FDA on August 25, 2021 is sustained-release growth hormone product. It is indicated for patients one year of age or older who weigh at least 11.5 kg and have growth failure due to inadequate secretion of endogenous growth hormone. It is administered as a once-weekly subcutaneous injection. In the pivotal head-to-head clinical trial, once weekly Skytrofa was compared to daily Genotropin. Skytrofa demonstrated higher annualized height velocity at week 52 compared to Genotropin. Patients in the Skytrofa group experienced an annualized height velocity of 11.2 cm/year versus the Genotropin group who experienced annualized height velocity growth of 10.3 cm/year.

Skytrofa (lonapegsomatropin) will be considered for coverage when the following criteria are met:

Pediatric Growth Hormone Deficiency

For **initial** authorization:

1. Member is one year of age or older and weighs at least 11.5kg;
2. Medication must be prescribed by an endocrinologist; AND
3. Member must have a diagnosis of GHD confirmed by **one** of the following:
   a) Two pre-treatment stimulation tests with a peak serum growth hormone concentration < 10 ng/mL (must include lab results with reference ranges); OR
   b) One pre-treatment treatment stimulation test with a peak serum growth hormone concentration < 10 ng/mL (must include lab results with reference ranges) AND one of the following:
      i) Documentation of structural abnormalities of the growth hormone axis (see appendix)
      ii) Documentation of congenital abnormalities of the growth hormone axis (see appendix)
      iii) Documentation of at least two other pituitary growth hormone deficiencies (see appendix)
4. Member must have a pretreatment height (must include growth charts) of > 2 SD below the mean for age and gender; AND
5. Member must have a documented 90-day trial and failure of Omnitrope 5.8 mg vial; AND
6. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included).
7. **Dosage allowed/Quantity limit:** 0.24mg/kg given subcutaneously once weekly

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Skytrofa will be reauthorized when chart notes show at least one of the following:

1. Member has a growth rate of at least 2 cm/year;
2. If member is age 12 or older, radiographic evidence the member's epiphyses are open (x-ray results must be included).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Skytrofa (lonapegsomatropin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/13/2021	Skytrofa policy creation

References:

1. Skytrofa [package insert]. Laval, Quebec, CA; Prometric Bioproduction, Inc.; June 2021.
2. Boguszewski MC. Growth hormone deficiency and replacement in children. *Rev Endocr Metab Disord*. 2021 Mar; 22: 101–108.
3. Pediatric Endocrine Society (PES) Guidelines for growth Hormone and insulin-like growth factor-1 treatment in children and adolescents; *Horm Res Paediatr*. 2016;86(6):361-397
4. Rogol AD, Hayden GF. Etiologies and early diagnosis of short stature and growth failure in children and adolescents. *J Pediatr*. 2014 May;164(5 Suppl):S1-14.e6
5. National Institute for Clinical Excellence: Guidance on the use of human growth hormone (somatropin) for the treatment of growth failure in children. May 2010
6. Wilson TA, Rose SR, Cohen P, et al. Update of guidelines for the use of growth hormone in children: The Lawson Wilkins Endocrinology Society Drug and Therapeutics Committee. *J Pediatr*. 2003; 143: 415-421

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

1) Acquired structural abnormalities
    - CNS tumor or neoplasm (craniopharyngioma, glioma, pituitary adenoma, etc.)
    - Cysts (Rathke cleft cyst or arachnoid cleft cyst)
    - Surgery
    - Radiation
    - Chemotherapy
    - CNS infection
    - CNS infarction (e.g., Sheehan's syndrome)
    - Inflammatory lesions (e.g., autoimmune hypohysitis)
    - Infiltrative lesions (e.g., sarcoidosis, histiocytosis)
    - Head trauma or traumatic brain injury
    - Aneurysmal subarachnoid hemorrhage
    - Panhypopituitarism or multiple pituitary hormone deficiency

2) Congenital abnormalities
    - Known genetic mutations in growth-hormone releasing hormone (GHRH) receptor, GH gene, GH receptor or pituitary transcription factors
    - Optic nerve hypoplasia/septo-optic dysplasia
    - Empty sella syndrome
    - Ectopic posterior pituitary
    - Pituitary aplasia/hypoplasia
    - Pituitary stalk defect
    - Anencephaly or prosencephaly
    - Vascular malformations

3) Pituitary hormones, other than growth hormone (GH)
    - Adrenocorticotropic hormone (ACTH)
    - Antidiuretic hormone (ADH)
    - Follicle stimulating hormone (FSH)
    - Luteinizing hormone (LH)
    - Oxytocin
    - Prolactin
    - Thyroid stimulating hormone (TSH)

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Sogroya (somapacitan-beco)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Sogroya (somapacitan-beco) was approved by the FDA on August 28, 2020 for adults with growth hormone deficiency. It is administered once weekly by injection under the skin. Growth hormone deficiency involves inadequate secretion of growth hormone from the pituitary gland.

Efficacy of Sogroya was established in a 34-week randomized, double-blind, placebo-controlled trial. At the end of the treatment period, patients in the weekly Sogroya group experienced a decrease in truncal fat by 1.06%, patients taking placebo experienced truncal fat increase by 0.47%, and patients in the daily somatropin group experienced truncal fat decrease by 2.23%.

Sogroya (somapacitan-beco) will be considered for coverage when the following criteria are met:

Adult Growth Hormone Deficiency

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by an endocrinologist; AND
3. Member must have a diagnosis of GHD confirmed by **one** of the following:
   a) Two pre-treatment stimulation tests with a peak serum growth hormone concentration < 5 µg/mL (must include lab results with reference ranges), unless Macrilen (prior authorization required) was used, in which case a GH level must be < 2.8 ng/ml; OR
   b) One pre-treatment stimulation test with a peak serum growth hormone concentration < 5 µg/mL (must include lab results with reference ranges) AND one of the following:
      i) Documentation of structural abnormalities of the growth hormone axis (see appendix)
      ii) Documentation of childhood-onset GHD due to congenital abnormalities of the growth hormone axis (see appendix)
      iii) Documentation of at least two other pituitary growth hormone deficiencies (see appendix)
4. Member must have a 90-day trial of Omnitrope 5.8 mg vial which was documented as ineffective, or contraindicated.
5. **Dosage allowed/Quantity limit:** Initial dose of 1.5mg once weekly given subcutaneously, not to exceed 8 mg once weekly

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

Sogroya will be reauthorized when chart notes show all of the following:

1. Member must be in compliance with all of the initial criteria; AND
2. Member's current IGF-1 level not elevated for age/gender (does not apply to members w/ structural abnormality of hypothalamus/pituitary and at least pituitary hormone deficiencies or childhood onset GHD and congenital abnormality of hypothalamus/pituitary).

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Sogroya (somapacitan-beco) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/13/2021	Sogroya policy creation

References:

1. Sogroya [package insert]. Plainsboro, NJ: Novo Nordisk, Inc; August 2020
2. Yuen KCJ, Biller BMK, Radovick S, et al. American Association of Clinical Endocrinologists and American College of Endocrinology guidelines for management of growth hormone deficiency in adults and patients transitioning from pediatric to adult care. Endocr Pract. 2019; 25:1191-1232
3. Johannsson G, Gordon MB, et al. Once-weekly Somapacitan is Effective and Well Tolerated in Adults with GH Deficiency: A Randomized Phase 3 Trial. *J Clin Endocrinol Metab*. 2020 Apr 1;105 (4): 1358-1376
4. Molitch ME, Clemmons DR, Malozowski S, et al. Evaluation and treatment of adult growth hormone deficiency: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2011; 96:1587-1609
5. American Association of Clinical Endocrinologists. Medical guidelines for clinical practice for growth hormone use in growth hormone-deficient adults and transition patients 2009 update. *Endocr Pract*. 2009;15(2):1-28

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

1) Acquired structural abnormalities
    - CNS tumor or neoplasm (craniopharyngioma, glioma, pituitary adenoma, etc.)
    - Cysts (Rathke cleft cyst or arachnoid cleft cyst)
    - Surgery
    - Radiation
    - Chemotherapy
    - CNS infection
    - CNS infarction (e.g., Sheehan's syndrome)
    - Inflammatory lesions (e.g., autoimmune hypohysitis)
    - Infiltrative lesions (e.g., sarcoidosis, histiocytosis)
    - Head trauma or traumatic brain injury
    - Aneurysmal subarachnoid hemorrhage
    - Panhypopituitarism

2) Congenital abnormalities
    - Known genetic mutations in growth-hormone releasing hormone (GHRH) receptor, GH gene, GH receptor or pituitary transcription factors
    - Optic nerve hypoplasia/septo-optic dysplasia
    - Empty sella syndrome
    - Ectopic posterior pituitary
    - Pituitary aplasia/hypoplasia
    - Pituitary stalk defect
    - Anencephaly or prosencephaly
    - Other mid-line defects
      Vascular malformations

3) Pituitary hormones, other than growth hormone (GH)
    - Adrenocorticotropic hormone (ACTH)
    - Antidiuretic hormone (ADH)
    - Follicle stimulating hormone (FSH)
    - Luteinizing hormone (LH)
    - Oxytocin
    - Prolactin
    - Thyroid stimulating hormone (TSH)

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Soliris (eculizumab)
BILLING CODE	J1300
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (non-preferred product) QUANTITY LIMIT— see **Dosage allowed**
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Soliris (eculizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a hematologist or nephrologist; AND
2. Member has a diagnosis of aHUS supported by ALL of the following:
   a) Thrombocytopenia (platelet count < 150 x 10^9/L),
   b) Evidence of hemolysis i.e. elevated lactate dehydrogenase (LDH), low haptoglobin count, or presence of fragmented red blood cells or schistocytes on blood smear,
   c) Evidence of renal impairment (e.g. raised SCr or low eGFR); AND
3. Shiga toxin-producing E. coli related HUS (STEC-HUS) has been ruled out; AND
4. ADAMTS13 activity level is > 5% (to rule out TTP); AND
5. Member has tried and failed or is unable to try Ultomiris; AND
6. Member has received meningococcal vaccine.
7. **Dosage allowed:**
   Pediatrics: See weight-based dosing in package insert.
   Adults: 900mg weekly x 4 weeks, then 1200mg 1 week later, then 1200mg every 2 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must demonstrate hematologic normalization as evidenced by increased platelet count or LDH maintained below upper limit of normal; AND
2. Improved or preserved kidney function.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

GENERALIZED MYASTHENIA GRAVIS (gMG)

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of severe, refractory gMG with documentation of positive serologic test for anti-AChR antibodies[25]; AND
4. Member has tried and failed one of the following (unless contraindicated or intolerable):
    i) Corticosteroid and at least 2 other immunosuppressive therapies[24] (e.g. azathioprine [first line], cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) over 1 year or more[15] (total); OR
    ii) At least 1 immunosuppressive therapy and has required plasmapheresis or plasma exchange or intravenous immunoglobulin (IVIG) at least every 3 months over the past year[15]; AND
5. Member has received meningococcal vaccine.
6. **Dosage allowed:** 900 mg IV weekly for the first 4 weeks, followed by 1200 mg for the fifth dose 1 week later, then 1200 mg every 2 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must demonstrate improvement in activities of daily living, muscle strength, and/or health-related quality of life; fewer exacerbations or hospitalizations, or reduced use of rescue medication.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of NMOSD and is seropositive for aquaporin-4 (AQP4) IgG antibodies (documentation required); AND
4. Member had had 1 or more relapses within the past year; AND
5. Member has tried and failed at least one of the following for 6 months or longer: azathioprine, mycophenolate, rituximab[19,20,21] (requires prior auth); AND
6. Member has tried and failed Enspryng (requires prior auth) for at least 6 months or has contraindication; AND
7. Member has received meningococcal vaccine.
8. **Dosage allowed:** 900 mg IV weekly for the first 4 weeks, followed by 1200 mg for the fifth dose 1 week later, then 1200 mg every 2 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document disease stabilization, symptom improvement, and/or reduced frequency of relapses.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is prescribed by or in consultation with a hematologist; AND
3. Member has a diagnosis of PNH as confirmed by flow cytometry; AND
4. Member has a lactate dehydrogenase (LDH) level >1.5x upper limit of normal (ULN); AND
5. Member has tried and failed or is unable to try Ultomiris; AND
6. Member has received meningococcal vaccine.
7. **Dosage allowed:** 600mg weekly x 4 weeks, then 900mg 1 week later, then 900mg every 2 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Clinical evidence of positive response to therapy such as increased hemoglobin level, decreased need for transfusions, normalized LDH levels, improved fatigue.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Soliris (eculizumab) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/14/2017	New policy for Soliris created.
10/26/2019	New diagnosis of Neuromyelitis optica spectrum disorder (NMOSD) added.
10/15/2020	Revised criteria for NMOSD to align with other products. Only require at least 1 relapse in past year. Added trial of a standard therapy. Added trial of Enspryng. Re-worded the criteria for meningitis vaccine. Removed the part about stable immunosuppressive therapy (just assessed for study purpose). Removed restrictions on prior Rituxan, mitoxantrone, IVIG (only applicable to the study design). Changed initial auth duration to 6 months. Edited the renewal criteria to be more appropriate. Also corrected the dose information error. Changed to non-preferred drug status.
02/08/2021	gMG: Updated references. Added specialist requirement. Removed MG-ADL score. Amended prerequisite drugs to more closely match guidelines and literature. Removed clinical trial exclusion criteria. Reduced initial auth duration to 6 months. Revised renewal criteria.
06/02/2021	aHUS: Updated references. Added specialist requirement. Revised diagnostic parameters. Removed list of restrictions from clinical trials. Stated Ultomiris as preferred. Amended dosing information. Revised renewal criteria. PNH: Updated references. Added age limit. Removed nephrology as specialist. Removed transfusion and organ damage requirements. Preference for Ultomiris. Amended dosing information. Reduced initial auth duration from 12 months to 6 months. Revised renewal criteria.

References:

1. Soliris (eculizumab) [prescribing information]. Boston, MA: Alexion Pharmaceuticals Inc; 2020.
2. Hillmen P, Young NS, Schubert J, et. al. The complement inhibitor eculizumab in paroxysmal nocturnal hemoglobinuria. N Eng J Med. 2006;355:1233-1243. Doi: 10.1056/NEJMMoa061648.

3. Brodsky RA, Young NS, Antonioli E, et. al. Multicenter phase 3 study of the complement inhibitor eculizumab for the treatment of patients with paroxysmal nocturnal hemoglobulinemia. Blood. 2008;111:1840-1847. Doi: 10.1182/blood-2007-06-094136.
4. Sahin F, Akay OM, Ayer M, et. al. Pesg PNH diagnosis, follow-up, and treatment guidelines. *Am J Blood Res.* 2016;6(2):19-27. Available at www.ajblood.us/files/ajbr0031541.pdf. Accessed July 17, 2017.
5. Parker C, Omine M, Richards S, et. al. Diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Blood.* 2005;106(12):3699-3709. Doi: 10.1182/blood-2005-04-1717.
6. Parker CJ. Update on the diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Hematology Am Soc Hematol Educ Program*. 2016;2016(1):208-216. doi:10.1182/asheducation-2016.1.208
7. Brodsky RA. Advances in the diagnosis and therapy of paroxysmal nocturnal hemoglobinuria. *Blood Rev*. 2008;22(2):65-74. doi:10.1016/j.blre.2007.10.002
8. Devos T, Meers S, Boeckx N, et al. Diagnosis and management of PNH: Review and recommendations from a Belgian expert panel. *Eur J Haematol*. 2018;101(6):737-749. doi:10.1111/ejh.13166
9. Patriquin CJ, Kiss T, Caplan S, et al. How we treat paroxysmal nocturnal hemoglobinuria: A consensus statement of the Canadian PNH Network and review of the national registry. *Eur J Haematol*. 2019;102(1):36-52. doi:10.1111/ejh.13176
10. Schubert, Jörg, and Jan Menne. "Eculizumab for the treatment of hemolytic paroxysmal nocturnal hemoglobinuria, atypical hemolytic uremic syndrome and refractory myasthenia gravis." Expert Opinion on Orphan Drugs 5.4 (2017): 375-379.
11. Legendre CM, Licht C, Muus P, et. al. Terminal complement inhibitor eculizumab in atypical hemolytic-uremic syndrome. N Eng J Med. 2013;368:2169-2181. Doi: 10.1056/NEJMMoa1208981.
12. Kaplan BS, Ruebner RL, Spinale JM, Copelovitch L. Current treatment of atypical hemolytic uremic syndrome. *Intractable Rare Dis Res.* 2014;3(2):34-35. Doi: 10.5582/irdr.2014.01001.
13. Sawai T, Nangaku M, Ashida A, et al. Diagnostic criteria for atypical hemolytic uremic syndrome proposed by the Joint Committee of the Japanese Society of Nephrology and the Japan Pediatric Society. *Pediatr Int*. 2014;56(1):1-5. doi:10.1111/ped.12274
14. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. *Pediatr Nephrol*. 2016;31(1):15-39. doi:10.1007/s00467-015-3076-8
15. Pugh D, O'Sullivan ED, Duthie FA, Masson P, Kavanagh D. Interventions for atypical haemolytic uraemic syndrome. *Cochrane Database Syst Rev*. 2021;3(3):CD012862. Published 2021 Mar 23. doi:10.1002/14651858.CD012862.pub2
16. ClinicalTrials.gov web site. U.S. National Library of Medicine. Identifier NCT00098280. Eculizumab to Treat Paroxysmal Nocturnal Hemoglobinuria. March 4, 2008. Available at: https://clinicaltrials.gov/ct2/show/NCT00098280?term=eculizumab&recrs=adef&cond=PAROXYSMAL+NOCTURNAL+HEMOGLOBINURIA&draw=1&rank=9.
17. ClinicalTrials.gov Identifier: NCT01892345. A Randomized Controlled Trial of Eculizumab in AQP4 Antibody-positive Participants With NMO (PREVENT Study). Available to: https://clinicaltrials.gov/ct2/show/NCT01892345?term=NCT01892345&draw=1&rank=1.
18. Howard Jr, James F., et al. "Safety and efficacy of eculizumab in anti-acetylcholine receptor antibody-positive refractory generalised myasthenia gravis (REGAIN): a phase 3, randomised, double-blind, placebo-controlled, multicentre study." The Lancet Neurology 16.12 (2017): 976-986.
19. Dhillon, Sohita. "Eculizumab: A Review in Generalized Myasthenia Gravis." Drugs 78.3 (2018): 367-376.
20. Kessler RA, Mealy MA, Levy M. Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic. *Curr Treat Options Neurol*. 2016;18(1):2. doi:10.1007/s11940-015-0387-9
21. Weinshenker B. Neuromyelitis Optica Spectrum Disorder. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/neuromyelitis-optica/. Published August 25, 2020. Accessed October 2, 2020.
22. Mealy MA, Wingerchuk DM, Palace J, Greenberg BM, Levy M. Comparison of relapse and treatment failure rates among patients with neuromyelitis optica: multicenter study of treatment efficacy. *JAMA Neurol*. 2014;71(3):324-330. doi:10.1001/jamaneurol.2013.5699
23. Pittock SJ, Berthele A, Fujihara K, et al. Eculizumab in Aquaporin-4-Positive Neuromyelitis Optica Spectrum Disorder. *N Engl J Med*. 2019;381(7):614-625. doi:10.1056/NEJMoa1900866
24. Pardo S, Giovannoni G, Hawkes C, Lechner-Scott J, Waubant E, Levy M. Editorial on: Eculizumab in aquaporin-4-positive neuromyelitis optica spectrum disorder. *Mult Scler Relat Disord*. 2019;33:A1-A2. doi:10.1016/j.msard.2019.07.001
25. Frampton JE. Eculizumab: A Review in Neuromyelitis Optica Spectrum Disorder [published correction appears in Drugs. 2020 Apr 21;:] [published correction appears in Drugs. 2020 Apr 22;:]. *Drugs*. 2020;80(7):719-727. doi:10.1007/s40265-020-01297-w

26. Sanders DB, Wolfe GI, Benatar M, et al. International consensus guidance for management of myasthenia gravis: Executive summary. *Neurology*. 2016;87(4):419-425. doi:10.1212/WNL.0000000000002790
27. Narayanaswami P, Sanders DB, Wolfe G, et al. International Consensus Guidance for Management of Myasthenia Gravis: 2020 Update. *Neurology*. 2021;96(3):114-122. doi:10.1212/WNL.0000000000011124

Effective date: 01/01/2022
Revised date: 06/02/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Soluble Guanylate Cyclase (sGC) Stimulator for Pulmonary Arterial Hypertension: Adempas (riociguat)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Pulmonary Arterial Hypertension is a rare but serious condition characterized by elevated pulmonary arterial resistance. Adempas is a soluble guanylate cyclase stimulator is FDA approved for adults with Persistent or recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) WHO Group 4 after surgical treatment or inoperable CTEPH to improve exercise capacity and WHO functional class. It is also approved for adults with Pulmonary Arterial Hypertension (PAH) WHO Group 1 to improve exercise capacity, improve WHO functional class and to delay clinical worsening.

Adempas (riociguat) will be considered for coverage when the following criteria are met:

Pulmonary Arterial Hypertension [WHO Group 1]

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH) confirmed by right heart catheterization;
4. Member must have documentation pulmonary arterial pressures are not adequately controlled, confirmed by **one** of the following:
   a) Patient had an acute response to vasodilator testing AND has tried a calcium channel blocker (CCB) for at least 3 months; OR
   b) Patient did not have a response to vasodilator testing; OR
   c) Patient cannot undergo vasodilator testing; OR
   d) Patient cannot take CCB therapy;
5. **Dosage allowed/Quantity limit:** Starting dose 1 mg three times per day. Increase dosage by 0.5 mg at intervals of no sooner than 2-weeks as tolerated to a maximum of 2.5 mg three times a day

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
Endothelin Receptor Antagonists will be reauthorized when chart notes show at least one of the following:

1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in functional class symptoms
   b) Stabilization or improvement in 6MWD [6-minute walk distance]
   c) Improvements in PVR and NT-proBNP

If all the above requirements are met, the medication will be approved for an additional 12 months.

Chronic Thromboembolic Pulmonary Hypertension [WHO Group 4]

For **initial** authorization:

1. Member is at least eighteen years of age or older;
2. Medication must be prescribed by or in consultation with a cardiologist or pulmonologist; AND
3. Member must have a diagnosis of World Health Organization (WHO) Group 4 Chronic Thromboembolic Pulmonary Hypertension (CTEPH) confirmed by right heart catheterization; AND
4. Member has at least **one** of the following:
   a) WHO functional class II, III or IV symptoms (see appendix) AND the member has persistent or recurrent CTEPH after surgery (endartectomy - PEA) OR
   b) WHO functional class II, III or IV symptoms and the patient is not a candidate for surgery AND the member has previous trial and failure with anticoagulation for at least 90 days; AND
5. **Dosage allowed/Quantity limit:** Starting dose 1 mg three times per day. Increase dosage by 0.5 mg at intervals of no sooner than 2-weeks as tolerated to a maximum of 2.5 mg three times a day

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

Endothelin Receptor Antagonists will be reauthorized when chart notes show at least one of the following:

1. Member has documentation of improvement in signs and symptoms of disease as evidenced by at least one of the following:
   a) Stabilization or improvement in functional class symptoms
   b) Stabilization or improvement in 6MWD [6-minute walk distance]
   c) Improvement in PVR and/or NT-proBNP levels

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Adempas (riociguat) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
06/15/2011	Pulmonary Arterial Hypertension policy creation.
05/13/2014	Combined all PAH agents into one policy
07/09/2015	Revised guidelines for therapy aligning with CMS
08/18/2015	Revised guidelines to include diagnosis criteria
10/13/2021	Separated PAH agents by drug class; Updated guidelines; Added provider specialty; Included new FDA approval for CTEPH WHO Group 4

References:

1. Adempas [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc; September 2021
2. Coons, J.C., Pogue, K., Kolodziej, A.R. et al. Pulmonary Arterial Hypertension: a Pharmacotherapeutic Update. Curr Cardiol Rep. 2019; 21(141)
3. Klinger JR, Elliott CG et al. Therapy for Pulmonary Arterial Hypertension in Adults; Chest Journal. March 2019; 155(3): 565-586
4. Galie N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension: The Joint Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS): Endorsed by: Association for European Paediatric and Congenital Cardiology (AEPC), International Society for Heart and Lung Transplantation (ISHLT). European heart journal. 2016;37(1):67–119
5. Benza RL, Ghofrani HA, Grünig E, Hoeper MM, Jansa P, Jing ZC, Kim NH, Langleben D, Simonneau G, Wang C, Busse D, Meier C, Ghio S. Effect of riociguat on right ventricular function in patients with pulmonary arterial hypertension and chronic thromboembolic pulmonary hypertension. J Heart Lung Transplant. 2021 Oct;40(10):1172-1180.

Effective date: 04/01/2022
Creation date: 10/13/2021

Appendix:

World Health Organization Functional Assessment Classification	
Class I	Patients with PAH but without resulting limitation of physical activity. Ordinary physical activity does not cause undue dyspnea, fatigue, chest pain or near syncope.
Class II	Patients with PAH resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity increases dyspnea, fatigue, chest pain, or near syncope.
Class III	Patients with PAH resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity increases dyspnea, fatigue, chest pain, or near syncope.
Class IV	Patients with PAH unable to carry out any physical activity without symptoms. These patients may have signs of right-heart failure. Dyspnea and/or fatigue may even by present at rest. Discomfort is increased by any physical activity.

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Injectable somatostatin analogs (First generation): Sandostatin (octreotide), Sandostatin LAR (octreotide), Somatuline depot (lanreotide)
BILLING CODE	J2354/ J2353/ J1930/ NDC
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT— See "dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Somatuline depot (lanreotide) and Sandostatin LAR (octreotide) are **non-preferred** products and will only be considered for coverage under the **medical** benefit; Sandostatin (octreotide) is a **preferred** product and will only be considered for coverage under the **medical** benefit

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACROMEGALY

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an endocrinologist; AND
3. Member has diagnosis of uncontrolled acromegaly confirmed by insulin-like growth factor (IGF-1) elevation above normal level (lab report required); AND
4. Member had an inadequate response to surgery or radiation, or member is ineligible for these treatments (documentation required); AND
5. If IGF-1 elevation is 1.5x upper limit of normal or less, member must have a trial of, or contraindication or intolerance to cabergoline.[3]
6. **Dosage allowed:**
   Octreotide: Initial 50mcg subQ/IV 3 times daily, titrate as indicated, usual maintenance dose 100mcg 3 times daily, max 500mcg 3 times daily. NOTE: Doses in excess of 300mcg per day seldom confer additional benefit.
   Sandostatin LAR: Start at 20mg IM every 4 weeks for 3 months, then adjust according to GH and IGF-1 per package insert, no more than 40mg every 4 weeks.
   Somatuline depot: Start at 90mg subQ every 4 weeks for 3 months, then adjust according to GH and IGF-1 per package insert, no more than 120mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes/lab report must show normalized or improved (decreased) IGF-1.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NOTE to Reviewer: A short-acting product may be used concurrently with a long-acting product.

CARCINOID SYNDROME

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with an oncologist or gastroenterologist; AND
3. Member has a neuroendocrine tumor, including carcinoid tumor or vasoactive intestinal peptide tumor (VIPoma); AND
4. Member is experiencing flushing and/or diarrhea symptoms associated with carcinoid syndrome (or VIPoma syndrome), not attributed to another cause.
5. **Dosage allowed:**
   Octreotide: 100mcg-750mcg per day subQ/IV in divided doses.
   Sandostatin LAR: 10mg to 30mg IM every 4 weeks.
   Somatuline depot: 120mg subQ every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. For short-acting products (octreotide): Chart notes must document symptomatic improvement of flushing and/or diarrhea episodes.
2. For long-acting products (Sandostatin LAR, Somatuline Depot): Chart notes must document reduced frequency of short-acting somatostatin analog rescue therapy for symptom control.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

NOTE to Reviewer: A short-acting product may be used concurrently with a long-acting product.

GASTROENTEROPANCREATIC NEUROENDOCRINE TUMORS (GEP-NETs)

Any request for **cancer** must be submitted through NantHealth/Eviti portal.

CareSource considers Sandostatin (octreotide) Sandostatin LAR (octreotide), Somatuline depot (lanreotide) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/03/2020	New policy for injectable somatostatin analogs created.

References:

1. Somatuline Depot (lanreotide acetate) [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc; 2019.
2. Katznelson L, Laws ER, Melmed S, et al. Acromegaly: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*. 2014;99(11):3933-3951. doi:10.1210/jc.2014-2700
3. Melmed S, Bronstein MD, Chanson P, et al. A Consensus Statement on acromegaly therapeutic outcomes. *Nature Reviews Endocrinology*. 2018;14(9):552-561. doi:10.1038/s41574-018-0058-5
4. Zahr R, Fleseriu M. Updates in Diagnosis and Treatment of Acromegaly. *Eur Endocrinol*. 2018;14(2):57-61. doi:10.17925/EE.2018.14.2.57
5. Fleseriu M, Biller BMK, Freda PU, et al. A Pituitary Society update to acromegaly management guidelines. *Pituitary*. October 2020. doi:10.1007/s11102-020-01091-7
6. Vinik AI, Wolin EM, Liyanage N, Gomez-Panzani E, Fisher GA; ELECT Study Group *. EVALUATION OF LANREOTIDE DEPOT/AUTOGEL EFFICACY AND SAFETY AS A CARCINOID SYNDROME TREATMENT (ELECT): A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL. Endocr Pract. 2016 Sep;22(9):1068-80. doi: 10.4158/EP151172.OR. Epub 2016 May 23. PMID: 27214300.

7. Pavel M, Öberg K, Falconi M, Krenning EP, Sundin A, Perren A, Berruti A; ESMO Guidelines Committee. Electronic address: clinicalguidelines@esmo.org. Gastroenteropancreatic neuroendocrine neoplasms: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol. 2020 Jul;31(7):844-860. doi: 10.1016/j.annonc.2020.03.304. Epub 2020 Apr 6. PMID: 32272208.
8. Strosberg JR, Halfdanarson TR, Bellizzi AM, Chan JA, Dillon JS, Heaney AP, Kunz PL, O'Dorisio TM, Salem R, Segelov E, Howe JR, Pommier RF, Brendtro K, Bashir MA, Singh S, Soulen MC, Tang L, Zacks JS, Yao JC, Bergsland EK. The North American Neuroendocrine Tumor Society Consensus Guidelines for Surveillance and Medical Management of Midgut Neuroendocrine Tumors. Pancreas. 2017 Jul;46(6):707-714. doi: 10.1097/MPA.0000000000000850. PMID: 28609356; PMCID: PMC5642985.
9. Cook R, Hendifar AE. Evidence-Based Policy in Practice: Management of Carcinoid Syndrome Diarrhea. P T. 2019;44(7):424-427.
10. National Comprehensive Cancer Network. Neuroendocrine and Adrenal Tumors. (Version 2.2020). https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed November 3, 2020.
11. Pandit S, Annamaraju P, Bhusal K. Carcinoid Syndrome. [Updated 2020 Jun 25]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448096/

Effective date: 10/1/2021
Revised date: 11/03/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Spinraza (nusinersen)
BILLING CODE	J2326 (1 unit = 0.1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 12 mg or 5 mL per administration
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Spinraza (nusinersen) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SPINAL MUSCULAR ATROPHY (SMA)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a neurologist with expertise in the treatment of SMA; AND
2. Member has documented diagnosis of SMA type I, II or III confirmed by BOTH of the following diagnostic test results (both a and b):
   a) The mutation or deletion of genes in chromosome 5q resulting in **one** of the following:
      i) homozygous gene deletion OR mutation (e.g., homozygous deletion of exon 7 at locus 5q13);
      ii) compound heterozygous mutation (e.g., deletion of SMN1 exon 7(allele 1) and mutation of SMN1 (allele 2));
   b) Genetic testing confirming 2 or 3 copies of SMN2; AND
3. Member has documented laboratory tests at baseline and prior to each dose of Spinraza as listed below:
   a) Platelet count; AND
   b) Prothrombin time; activated partial thromboplastin time; AND
   c) Quantitative spot urine protein testing; AND
4. Member has documentation of baseline of at least **one** of the following exams (based on patient age and motor ability):
   a) Hammersmith Infant Neurological Exam (HINE) (infant to early childhood);
   b) Hammersmith Functional Motor Scale Expanded (HFMSE);
   c) Upper Limb Module (ULM) Test (Non ambulatory);
   d) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND); AND
5. Member's gestational age is 37 to 42 weeks for singleton births or 34 to 42 weeks for twins; AND
6. Member's documented oxygen saturation is ≥ 92% (awake or asleep) without any supplemental oxygen or respiratory support; AND
7. Member does not have shunt or central nervous system (CNS) catheter; AND
8. Member has no history of bacterial meningitis or viral encephalitis; AND
9. Medication must not be concomitantly used with Zolgensma (discontinuation of Spinraza prior to Zolgensma therapy is required and Spinraza will not be reauthorized after Zolgensma infusion).
10. **Dosage allowed:** Initiate Spinraza treatment with 4 loading doses (12 mg (5 mL) per administration). The first three loading doses should be administered at 14-day intervals, the 4th loading dose should

be administered 30 days after the 3rd dose. A maintenance dose should be administered once every 4 months thereafter.

If member meets all the requirements listed above, the medication will be approved 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member has documentation of positive clinical improvement from pretreatment baseline status in spinal muscular atrophy-associated symptoms or maintenance (not worsening) of the disease state (e.g., decreased decline in motor function, increased ability to kick, increased in the motor milestones of head control, rolling, sitting, crawling, standing, or walking, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Spinraza (nusinersen) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/05/2017	New policy for Spinraza created.
06/11/2019	Concomitant used of Spinraza with Zolgensma will not be authorized. Spinraza must be discontinued before Zolgensma infusion. Spinraza will not be reauthorized after Zolgensma infusion.

References:

1. Spinraza [package insert]. Cambridge, MA; Biogen Inc.; December, 2016.
2. Markowitz JA, Singh P, Darras BT. Spinal Muscular Atrophy: A Clinical and Research Update. Pediatric Neurology 46 (2012) 1-12.
3. Ionis Pharmaceuticals, Inc. A Study to Assess the Efficacy and Safety of IONIS-SMN Rx in Infants With Spinal Muscular Atrophy. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000 Available from: https://clinicaltrials.gov/show/NCT02193074. NLM Identifier: NCT02193074.
4. Ionis Pharmaceuticals, Inc. A Study to Assess the Efficacy and Safety of IONIS-SMN Rx in Patients With Later-onset Spinal Muscular Atrophy. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). 2000. Available from: https://clinicaltrials.gov/show/NCT02292537. NLM Identifier: NCT02292537.
5. Finkel RS, Chiriboga CA, Vajsar J, et al. Treatment of infantile-onset spinal muscular atrophy with nusinersen: a phase 2, open-label, dose-escalation study. Lancet. 2017 Dec 17;388(10063):3017-3026.

Effective date: 09/26/2019
Revised date: 06/11/2019

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Spravato (esketamine)
BILLING CODE	Must use valid NDC or HCPCS code
BENEFIT TYPE	Pharmacy or Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT – 8 kits per month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Spravato (esketamine) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with the following disease state and meet the individual criteria as stated.

MAJOR DEPRESSIVE DISORDER WITH SUICIDAL IDEATION

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a diagnosis of major depressive disorder (MDD) with documentation of acute suicidal ideation or behavior requiring immediate intervention; AND
3. Medication is being prescribed by a psychiatrist in a Spravato REMS certified center; AND
4. Medication must be used in conjunction with an oral antidepressant (e.g., citalopram, duloxetine, venlafaxine, bupropion, trazodone).
5. **Dosage allowed:** 84 mg (1 kit) twice per week for 4 weeks (8 kits total).

Note: If member also has concomitant treatment resistant depression (TRD), must meet criteria for TRD in order to qualify for longer approval duration.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:

Continuation of Spravato beyond 4 weeks has not been established for the same episode. If this is a new suicidal ideation episode, must follow initial criteria.

TREATMENT RESISTANT DEPRESSION

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a diagnosis of treatment resistant major depressive disorder; AND
3. Medication is being prescribed by a psychiatrist in a Spravato REMS certified center; AND
4. Medication will be used in conjunction with an oral antidepressant; AND
5. Member has tried and failed at least TWO of the following oral antidepressants from different drug classes at optimized doses for at least 8 weeks, at least one of which must be an SSRI or SNRI:
   a) Selective Serotonin Reuptake Inhibitor (e.g. citalopram, fluoxetine);
   b) Selective Norepinephrine Reuptake Inhibitor (e.g. duloxetine, venlafaxine);
   c) Tricyclic Antidepressant (e.g. nortriptyline);

d) Monoamine Oxidase Inhibitor (e.g. tranylcypromine);
e) Bupropion;
f) Mirtazapine; AND

6. Documentation of the member's baseline depression status using an appropriate rating scale [e.g., Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI), Quick Inventory of Depressive Symptomatology (QIDS), Montgomery-Åsberg Depression Rating Scale (MADRS), Hamilton Rating Scale for Depression (HAM-D)].
7. **Dosage allowed:**

Induction Phase	**Weeks 1 to 4:** Administer twice per week	Day 1 starting dose: 56 mg Subsequent doses: 56 mg or 84 mg
Maintenance Phase	**Weeks 5 to 8**: Administer once weekly	56 mg or 84 mg
	Week 9 and after: Administer every 2 weeks or once weekly*	56 mg or 84 mg

If member meets all the requirements listed above, the medication will be approved for 2 months.

For **reauthorization**:

1. Member must be compliant with concomitant use of an oral antidepressant; AND
2. Documented improvement of depressive symptoms as measured by an appropriate rating scale (e.g. PHQ-9, BDI, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Spravato (esketamine) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/23/2019	New policy for Spravato created.
11/06/2020	New diagnosis of MDD with suicidal ideation added. For TRD: added that medication must be prescribed by psychiatrist in a REMS certified center in accordance with package insert.
01/11/2021	TRD: Changed "depression" to "major depressive disorder." Clarified the dosing. Added dose requirement to step drugs and that one must be an SSRI or SNRI (first line). Removed trazodone. Revised list of severity scales. Reworded renewal criteria.

References:

1. Spravato [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; July, 2020.
2. Daly EJ, Singh JB, Fedgchin M, et al. Efficacy and Safety of Intranasal Esketamine Adjunctive to Oral Antidepressant Therapy in Treatment-Resistant Depression: A Randomized Clinical Trial. *JAMA Psychiatry*. 2018;75(2):139-148.
3. Daly EJ, Trivedi MH, Janik A, et al. Efficacy of Esketamine Nasal Spray Plus Oral Antidepressant Treatment for Relapse Prevention in Patients With Treatment-Resistant Depression: A Randomized Clinical Trial. *JAMA Psychiatry*. 2019;76(9):893-903.

4. Gelenberg A., Freeman M., Markowitz J., et. al. Practice guideline for the treatment of patients with major depressive disorder. *Am J Psychiatry*. May 2010. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf.
5. Weber AN, Michail M, Thompson A, Fiedorowicz JG. Psychiatric Emergencies: Assessing and Managing Suicidal Ideation. *Med Clin North Am*. 2017;101(3):553-571.
6. American Psychiatric Association. Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. 2003. https://psychiatryonline-org.cedarville.ohionet.org/guidelines (Accessed on November 06, 2020).
7. Hirschfeld RM, Russell JM. Assessment and treatment of suicidal patients. N Engl J Med. 1997;337(13):910-915.
8. ClinicalTrials.gov. A Study to Evaluate the Efficacy and Safety of Intranasal Esketamine in Addition to Comprehensive Standard of Care for the Rapid Reduction of the Symptoms of Major Depressive Disorder, Including Suicidal Ideation, in Adult Participants Assessed to be at Imminent Risk for Suicide (Aspire II). Identifier: NCT03097133. Available at: https://clinicaltrials.gov/ct2/show/NCT03097133.
9. ClinicalTrials.gov. A Study to Evaluate the Efficacy and Safety of Intranasal Esketamine in Addition to Comprehensive Standard of Care for the Rapid Reduction of the Symptoms of Major Depressive Disorder, Including Suicidal Ideation, in Adult Participants Assessed to be at Imminent Risk for Suicide (Aspire I). Identifier: NCT03039192. Available at: https://clinicaltrials.gov/ct2/show/NCT03039192.
10. Mithawala PK, Davis DM. Managing treatment-resistant depression. *US Pharm*. 2020;45(5):15-19.
11. Gaynes BN, Asher G, Gartlehner G, et al. *Definition of Treatment-Resistant Depression in the Medicare Population*. Rockville (MD): Agency for Healthcare Research and Quality (US); February 9, 2018.
12. Fekadu A, Donocik JG, Cleare AJ. Standardisation framework for the Maudsley staging method for treatment resistance in depression. *BMC Psychiatry*. 2018;18(1):100. Published 2018 Apr 11. doi:10.1186/s12888-018-1679-x
13. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. *Am J Psychiatry*. 2006;163(11):1905-1917. doi:10.1176/ajp.2006.163.11.1905

Effective date: 07/01/2021
Revised date: 01/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Stelara (ustekinumab)
BILLING CODE	J3357 (1 unit = 1 mg) Must have valid NDC for self-administered product
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Enbrel, Cimzia, Cosentyx, Xeljanz, Otezla and Siliq QUANTITY LIMIT— 90 units per 56 days (after loading dose)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Stelara (ustekinumab) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member is 18 years of age or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate. Note: Trial is not required if member is switching from another biologic agent; OR
5. Member has severe disease that requires immediate use of a biologic agent, as indicated by one of the following:
   a) Extensive small bowel disease involving more than 100 cm;
   b) History of bowel or colon resection and is at high risk for CD recurrence (e.g., smoker, <30 years old, 2 or more resections, penetrating/fistulizing disease, etc.);
   c) Fistulizing disease; AND
6. Member has tried and failed at least 12 weeks of an anti-TNF agent (e.g., Cimzia, Humira), unless not tolerated or contraindicated.
7. **Dosage allowed:**
   a) Induction (medical benefit): a one-time IV infusion based on weight. Up to 55 kg = 260 mg (2 vials); greater than 55 kg to 85 kg = 390 mg (3 vials); greater than 85 kg = 520 mg (4 vials);
   b) Maintenance (pharmacy or medical benefit): subcutaneous injection of 90 mg dose 8 weeks after induction and every 8 weeks thereafter.

Note to reviewer: A one-time induction dose is approved on the medical benefit. Maintenance therapy is approved on either pharmacy OR medical benefit. Please inactivate any duplicate prior authorization.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq (if member is < 18 years of age, only Enbrel trial is needed). Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:**
   a) Adults: 100 kg or less: 45 mg subcutaneously at 0 and 4 weeks, and then every 12 weeks thereafter; more than 100 kg: 90 mg subcutaneously at 0 and 4 weeks, and then every 12 weeks thereafter;
   b) Pediatrics (6 to 17): subcutaneous dose by weight at week 0, week 4, and every 12 weeks thereafter. Less than 60 kg: 0.75 mg/kg; 60 kg to 100 kg: 45 mg; more than 100 kg: 90 mg.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or a dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member has tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla and Xeljanz. Treatment failure requires at least for 12 weeks of therapy with each drug.
7. **Dosage allowed:** 45 mg subcutaneously at 0 and 4 weeks, and then every 12 weeks thereafter. If member has co-existent moderate-to-severe PsO, use the dosing regimen for adult PsO.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:

1. Member is 18 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member have had a documented trial and inadequate response with **one** of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.).
5. **Dosage allowed:**
   a) Induction (medical benefit): a one-time IV infusion based on weight. 55 kg or less = 260 mg (2 vials); greater than 55 kg to 85 kg = 390 mg (3 vials); greater than 85 kg = 520 mg (4 vials);
   b) Maintenance (pharmacy or medical benefit): subcutaneous injection of 90 mg dose 8 weeks after induction and every 8 weeks thereafter.

Note to reviewer: A one-time induction dose is approved on the medical benefit. Maintenance therapy is approved on either pharmacy OR medical benefit. Please inactivate any duplicate prior authorization.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Stelara (ustekinumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	Policy for Stelara created. Policies SRx-0042 and SRx-0043 archived. New diagnosis of Crohn's disease was added. For diagnosis of PsO: immunosuppressive criterion was separated from phototherapies and topical agents trials; TNF inhibitors Humira and Enbrel were listed as required trials; Psoriasis Area and Severity Index (PASI) score requirement was added. For diagnosis of PsA: TNF inhibitors Humira and Enbrel were listed as required trials. List of diagnoses considered not medically necessary was added.
11/13/2017	Age requirement for diagnosis of PsO updated.
02/26/2019	Humira was removed from criteria; Cimzia, Cosentyx, Otezla, Siliq and Xeljanz added to trial agents list. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
10/31/2019	New indication of Ulcerative Colitis added.
11/23/2020	Removed repeat TB for reauth for all diagnoses. For CD: specified length of trials for conventional therapies, previously not specified. For severe disease, removed esophageal/gastroduodenal disease, specified that history of colonic resection must also be high risk for recurrence. Updated dosage section and added note for internal PA review. For PsO: Age requirement expanded to include 6 years or older. Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. For PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). For UC: removed Mayo score requirement; removed TNF as a trial option; specified the length of trials for conventional therapies (previously not specified). Updated dosage section and added note for internal PA review.
11/17/2021	Annual review, no changes

References:

1. Stelara [package insert]. Horsham, PA: Janssen Biotech Inc; July, 2020.
2. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
3. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
4. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
5. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.
6. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines,

methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
7. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
8. Feagan BG, Sandborn WJ, Gasink C, et al. Ustekinumab as Induction and Maintenance Therapy for Crohn's Disease. N Engl J Med 2016; 375:1946-1960.
9. Sandborn WJ, Feagan BG, Fedorak RN, et al. A randomized trial of Ustekinumab, a human interleukin-12/23 monoclonal antibody, in patients with moderate-to-severe Crohn's disease. *Gastroenterology*. 2008 Oct;135(4):1130-41. Epub 2008 Jul 17.
10. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
11. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
12. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
13. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
14. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201.
15. Leonardi CL, Kimball AB, Yeilding N, et al. Efficacy and safety of ustekinumab, a human interleukin-12/23 monoclonal antibody, in patients with psoriasis: 76-week results from a randomized, double-blind, placebo-controlled trial (PHOENIX-1). *Lancet* 2008;371:1665–74.
16. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
17. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
18. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
19. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of Psoriatic Arthritis. *Arthritis Rheumatol*. 2019 Jan;71(1):5-32.
20. McInnes IB, Kavanaugh A, Gottleib AB, et al. Efficacy and safety of ustekinumab in patients with active psoriatic arthritis: 1 year results of the phase 3, multicentre, double-blind, placebo-controlled PSUMMIT 1 trial. *Lancet*. 2013 Aug 31;382(9894):780-9. doi: 10.1016/S0140-6736(13)60594-2. Epub 2013 Jun 13.
21. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
22. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Strensiq (asfotase alfa)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— up to 9 mg/kg per week
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Strensiq (asfotase alfa) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HYPOPHOSPHATASIA (HPP)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with an endocrinologist or other specialist in metabolic bone disease; AND
2. Member has a diagnosis of hypophosphatasia (HPP) with perinatal/infantile- or juvenile-onset (**before** 18 years of age) with ALL of the following documented:
   a) Serum alkaline phosphatase (ALP) below age-adjusted normal range;
   b) Plasma pyridoxal 5'-phosphate (PLP) elevation;
   c) Radiographic evidence of skeletal abnormality.
3. **Dosage allowed:**
   Perinatal/Infantile-Onset HPP: 2 mg/kg administered subQ three times per week, or 1 mg/kg administered six times per week. The dose may be increased to 3 mg/kg three times per week for insufficient efficacy (e.g., no improvement in respiratory status, growth, or radiographic findings).
   Juvenile-Onset HPP: 2 mg/kg administered subQ three times per week, or 1 mg/kg administered six times per week.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document improvement in clinical signs and symptoms of hypophosphatasia, such as respiratory status, growth, or radiographic (skeletal healing) findings.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Strensiq (asfotase alfa) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Pseudohypophosphatasia

DATE	ACTION/DESCRIPTION
09/13/2018	New policy for Strensiq created.
04/23/2021	Updated references. Emphasized disease onset must be before age 18 years. Amended diagnostic criteria to be more simplified: Removed pain, growth components; Removed genetic testing requirement; Added PLP measure. Specified renewal criteria.

References:

1. Strensiq [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc.; June 2020.
2. Mornet E, Nunes ME. Hypophophatasia. 2007 Nov 20 [Updated 2016 Feb 4]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2018. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1150/.
3. Whyte MP, Greenberg CR, Salman NJ, et al. Enzyme-Replacement Therapy in Life-Threatening Hypophosphatasia. N Engl J Med 2012; 366:904-913. Available at: http://www.nejm.org/doi/full/10.1056/NEJMoa1106173.
4. Rush ET. Childhood hypophosphatasia: to treat or not to treat. Orphanet J Rare Dis. 2018 Jul 16;13 (1):116.
5. Whyte MP, Madson KL, Phillips D, et al. Asfotase alfa therapy for children with hypophosphatasia. *JCI Insight*. 2016;1(9):e85971. Published 2016 Jun 16. doi:10.1172/jci.insight.85971
6. Whyte MP. Hypophosphatasia - aetiology, nosology, pathogenesis, diagnosis and treatment. *Nat Rev Endocrinol*. 2016;12(4):233-246. doi:10.1038/nrendo.2016.14
7. Kishnani PS, Rockman-Greenberg C, Rauch F, et al. Five-year efficacy and safety of asfotase alfa therapy for adults and adolescents with hypophosphatasia. *Bone*. 2019;121:149-162. doi:10.1016/j.bone.2018.12.011
8. Shapiro JR, Lewiecki EM. Hypophosphatasia in Adults: Clinical Assessment and Treatment Considerations. *J Bone Miner Res*. 2017;32(10):1977-1980. doi:10.1002/jbmr.3226

Effective date: 01/01/2022
Revised date: 04/23/2021

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Sublocade (buprenorphine extended-release) injection, for subcutaneous use
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include transmucosal buprenorphine-containing products and Vivitrol QUANTITY LIMIT— up to 300 mg monthly
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Sublocade (buprenorphine extended-release) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID DEPENDENCE

For **initial** authorization:

1. Member must have had at least 7 days treatment with transmucosal buprenorphine-containing product (equivalent of 8 to 24 mg of buprenorphine daily) within the last 21 days; AND
2. Medication must be prescribed and administered by addiction specialist (i.e., DATA 2000 certified) solely for the treatment of opioid dependence.
3. **Dosage allowed:** Initially, two monthly doses of 300 mg after treatment has been inducted and adjusted with 8 to 24 mg of a transmucosal buprenorphine-containing product for a minimum of 7 days, followed by 100 mg monthly for maintenance. Increasing the maintenance dose to 300 mg monthly may be considered with submission of detailed chart notes documenting lack of satisfactory clinical response to Sublocade 100 mg, recent clinical opioid withdrawal scale and specific clinical reasons outlined by provider.

If member meets all the requirements listed above, the medication will be approved for lifetime.

CareSource considers Sublocade (buprenorphine extended-release) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/23/2018	New policy for Sublocade created.
03/11/2021	Annual review, no changes

References:

1. Sublocade [package insert]. North Chesterfield, VA: Indivior, Inc; March 2018.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Suboxone (buprenorphine and naloxone) sublingual film, for sublingual or buccal use
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include generic buprenorphine/naloxone sublingual tablets QUANTITY LIMIT— 30-day supply at a time only
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Strength	Quantity Limit
2 mg – 0.5 mg	1 film per day
4 mg – 1 mg	1 film per day
8 mg – 2 mg	2 films per day
12 mg – 3 mg	2 films per day

Suboxone (buprenorphine and naloxone) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID DEPENDENCE

For **initial** authorization:

1. All of the following:
   a) The individual has failed an adequate trial of the preferred generic buprenorphine/naloxone sublingual tablets within the previous 120 days (*Note:* Adequate trial is defined as at least 28 days of treatment); AND
   b) One of the following:
      i) The member experienced therapeutic failure with the preferred generic buprenorphine/naloxone sublingual tablets (*Note:* Brand and non-preferred buprenorphine agents will not be approved for members who report lesser efficacy as compared to the preferred generic buprenorphine sublingual tablets unless it would be clinically inappropriate to address efficacy with dose adjustment); OR
      ii) Generic sublingual tablets caused adverse outcome; AND
   c) The prescriber has provided a copy and confirmation of a MedWatch form submission to the FDA documenting the therapeutic failure or adverse outcome experienced by the member (*Note*: The MedWatch form is available at https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf)

OR

2. Both of the following:
   a) The individual has a hypersensitivity reaction to an inactive ingredient in the preferred generic buprenorphine sublingual tablets; AND
   b) The hypersensitivity reaction(s) is clearly documented in the member's medical record.

3. **Dosage allowed:** The maintenance dose of Suboxone is generally in the range of 4 mg/1 mg buprenorphine/naloxone to 24 mg/6 mg buprenorphine/naloxone per day. The recommended target dosage during maintenance is 16 mg/4 mg buprenorphine/naloxone/day as a single daily dose. Dosages higher than 24 mg/6 mg daily have not been demonstrated to provide a clinical advantage.

Additional Notes:

- GI upset or irritation is not generally considered an allergy or failed treatment. Members should be referred to their physician or pharmacist for advice on dose adjustment, and/or other options to reduce GI upset/irritation.
- Common documented side effects attributed to the drug (i.e., headache, nausea, blurred vision, fatigue, muscle aches) are not considered an allergy and would be expected to occur at the same level in both the generic and brand agent.
- Drug hypersensitivity symptoms may include skin rash, hives, itching, fever, swelling, shortness of breath, wheezing, runny nose, itchy and/or watery eyes, and in severe cases, anaphylaxis.

If member meets all the requirements listed above, the medication will be approved for lifetime.

CareSource considers Suboxone (buprenorphine and naloxone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/03/2019	New policy for Suboxone created.
03/11/2021	Annual review, no changes

References:

1. MedWatch: The FDA Safety Information and Adverse Event Reporting Program. Available at http://www.fda.gov/safety/medwatch/default.htm.
2. Suboxone [package insert]. Richmond, VA: Indivior Inc.; February, 2017.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Subutex (buprenorphine)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) with some exceptions QUANTITY LIMIT— up to 16 mg/day
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Subutex (buprenorphine) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID DEPENDENCE

For **initial** authorization:

1. Medication will **not** be authorized if one of the following criteria met:
   a) Member is 15 years of age or younger; OR
   b) Members who are 16 to 44 years old and not pregnant receiving short acting buprenorphine without naloxone for longer than 9 months; OR
   c) Dosages requested are greater than 16 mg/day; OR
   d) Member has claims for concurrent use of opioids (including Medication Assisted Treatments) and benzodiazepines; OR
   e) Members who are male or female 45 years of age or older receiving short acting buprenorphine without naloxone.
      **Exception:* if member requests buprenorphine without naloxone than must meets all of the following criteria with Prior Authorization request:
      i) Member has documented trial of buprenorphine/naloxone combination product supported by claims history (at least one claim in the last 120 days); AND
      ii) Member has documented allergic hypersensitivity reaction to buprenorphine/naloxone combination product, supported by chart notes; OR
      iii) Member has documented clinically significant adverse drug reaction in response to buprenorphine/naloxone combination product, and the prescriber has provided a copy and confirmation of a MedWatch form submission to the FDA.

If member meets all the requirements listed above and:

- ***Member is pregnant, the medication will be approved for 12 months, OR***
- ***Member is male or non-pregnant, the medication will be approved for lifetime.***

CareSource considers Subutex (buprenorphine) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/03/2019	New policy for Subutex created.
03/11/2021	Annual review, no changes

References:

1. MedWatch: The FDA Safety Information and Adverse Event Reporting Program. Available at http://www.fda.gov/safety/medwatch/default.htm.
2. Subutex [prescribing information]. Richmond, VA: Indivior Inc; September 2017.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Supartz FX (sodium hyaluronate)
BILLING CODE	J7321
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) Alternative preferred products include Durolane, Gelsyn-3 QUANTITY LIMIT— 5 injections (5 units)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Supartz FX (sodium hyaluronate) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions; AND
7. Member is not allergic to avian proteins, feathers, and egg products.
8. **Dosage allowed:** Inject 20 mg (2 mL) once weekly for up to 5 weeks (total of 5 injections).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Supartz FX (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of

CareSource

robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy - Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/17/2017	New policy for Supartz FX created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed.

References:

1. Supartz [package insert]. Bioventus LLC: Durham NJ; April, 2015.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015)
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22
10. Christensen R, Bartels EM, Astrup A, Bliddal H. Effect of weight reduction in obese patients diagnosed with knee osteoarthritis: a systematic review and meta-analysis. Ann Rheum Dis. 2007: 66(4):433-9.
11. Ueno, Y. et al. Investigation on result of use after launch of ARTZ and ARTZ Dispo: Evaluation on the efficacy, safety and utility in the medication for osteoarthritis of the knee and periarthritis of the shoulder. Japanese Pharmacology & Therapeutics 23(8):2151-2170, 1995.
12. Day, R. et al. A double blind, randomized, multicenter, parallel group study of the effectiveness and tolerance of intraarticular hyaluronan in osteoarthritis of the knee. J Rheumatol 31:755-782, 2004.
13. Karlsson, J. et al. Comparison of two hyaluronan drugs and placebo in patients with knee osteoarthritis. A controlled, randomized, double blind, parallel-design multicentre study. Rheumatology (Oxford). 2002 Nov; 41(11):1240-8.
14. Bannuru R, Sullivan M, McAlindon T, Brodie C. Safety of Repeated Injections of Sodium Hyaluronate (SUPARTZ) for Knee Osteoarthritis: A Systematic Review and Meta-Analysis. Cartilage [serial online]. October 1, 2016;7(4):322-332. Available from: Scopus®, Ipswich, MA. Accessed April 10, 2017.
15. Supartz FX. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
16. Supartz FX. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
17. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
18. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

CareSource

Effective date: 05/17/2017
Revised date: 05/17/2017

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Supprelin LA (histrelin acetate)
BILLING CODE	J9226 (1 unit = 1 implant)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Lupron PED QUANTITY LIMIT— 1 implant every 12 months
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Supprelin LA (histrelin acetate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CENTRAL PRECOCIOUS PUBERTY (CPP)

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Member has early onset of pubertal symptoms before age of 8 for female or 9 for male; AND
3. Member has confirmed diagnosis of central precocious puberty, as evidenced by **both** of the following:
   a) Pubertal response to a gonadotropin releasing hormone (GnRH) stimulation test OR pubertal levels of basal luteinizing hormones (LH) and estradiol or testosterone hormones;
   b) Bone age is advanced by at least one year greater than chronological age; AND
4. Medication must be prescribed by or in consultation with an endocrinologist; AND
5. Member's baseline LH level, sex steroid level (estradiol or testosterone), and height are submitted with chart notes.
6. **Dosage allowed:** 1 implant (50 mg) every 12 months.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. If member is 11 years or older for females or 12 years or older for males, prescriber must provide a clinical reason for continuing medication beyond the recommended age for resuming puberty; AND
2. Chart notes have been provided showing efficacy of response (e.g., slowed growth rate, slowed bone age advancement, LH and sex steroid hormone levels have been suppressed or reduced from baseline).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Supprelin LA (histrelin acetate) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
07/22/2020	New policy for Supprelin LA created.

References:

1. Supprelin LA [package insert]. Malvern, PA: Endo Pharmaceuticals, Inc.; November, 2019.
2. ClinicalTrials.gov. Histrelin subcutaneous implant in children with central precocious puberty. Identifier: NCT00779103. Available at: https://clinicaltrials.gov/ct2/show/NCT00779103.
3. Chen M, Eugster EA. Central Precocious Puberty: Update on Diagnosis and Treatment. *Paediatr Drugs*. 2015;17(4):273-281.
4. Carel JC, Eugster EA, Rogol A, et al; ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123(4).
5. Creo AL, Schwenk WF. Bone age: a handy tool for pediatric providers. *Pediatrics*. Dec 2017, 140 (6) e20171486.
6. Klein KO. Precocious puberty: who has it? Who should be treated?. *J Clin Endocrinol Metab*. 1999;84(2):411-414.

Effective date: 10/1/2021
Revised date: 07/22/2020

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Susvimo (ranibizumab)
BILLING CODE	J3590
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient hospital
STATUS	Prior Authorization Required

Susvimo, an intravitreal ocular implant, was approved by the FDA in 2021. It is indicated for the treatment of patients with Neovascular (wet) Age-related Macular Degeneration (AMD) who have previously responded to at least two intravitreal injections of a Vascular Endothelial Growth Factor (VEGF) inhibitor medication. VEGF inhibitors suppress endothelial cell proliferation, neovascularization, and vascular permeability.
Susvimo was previously referred to as Lucentis Port Delivery System (PDS) since it is essentially a longer lasting version of Lucentis, releasing ranibizumab over a 6-month period rather than needing to be administered monthly. After 6 months, the port can be re-filled. Lucentis is approved for other indications aside from just wet AMD.
Susvimo has a black box warning for endophthalmitis, an infection inside the eye which is a medical emergency. Approval was based on the phase 3 Archway trial which demonstrated equivalent visual acuity results between Susvimo and Lucentis.

Susvimo (ranibizumab) will be considered for coverage when the following criteria are met:

Neovascular (wet) Age-related Macular Degeneration (AMD)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a diagnosis of wet AMD; AND
4. Member has previously responded to at least 2 intravitreal injections of a VEGF inhibitor; bevacizumab is the preferred product (others require prior authorization); AND
5. Member does NOT have any ocular or periocular infections or active intraocular inflammation.
6. **Dosage allowed/Quantity limit:** 2 mg via surgical administration every 6 months. (1 single dose vial per eye per 6 months)

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must include documentation of improved or stabilized visual acuity.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Susvimo (ranibizumab) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/09/2021	New policy for Susvimo created.

References:

1. SUSVIMO [package insert]. South San Francisco, CA: Genentech, Inc; 2021.
2. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P1-P65. doi:10.1016/j.ophtha.2019.09.024
3. Solomon SD, Lindsley K, Vedula SS, Krzystolik MG, Hawkins BS. Anti-vascular endothelial growth factor for neovascular age-related macular degeneration. *Cochrane Database Syst Rev*. 2019;3(3):CD005139. Published 2019 Mar 4. doi:10.1002/14651858.CD005139.pub4
4. A Phase III Study to Evaluate the Port Delivery System With Ranibizumab Compared With Monthly Ranibizumab Injections in Participants With Wet Age-Related Macular Degeneration (Archway). ClinicalTrials.gov Identifier: NCT03677934. Updated October 28, 2021. Accessed November 10, 2021. https://clinicaltrials.gov/ct2/show/NCT03677934

Effective date: 04/01/2022
Revised date: 11/09/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Symdeko (tezacaftor/ivacaftor)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 56 tablets per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Symdeko (tezacaftor/ivacaftor) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Member has a diagnosis of cystic fibrosis; AND
3. Medication must be prescribed by a pulmonologist or an infectious disease specialist; AND
4. Member has had genetic testing documented in chart notes with two copies (homozygous) of the F508del mutation (F508del/F508del) in their CFTR gene; OR
5. Member has at least one of the following mutations in the CFTR gene: 546insCTA, E92K, G576A, L346P, R117G, S589N 711+3A→G, E116K, G576A;R668C, L967S, R117H, S737F 2789+5G→A, E193K, G622D, L997F, R117L, S912L, 3272-26A→G, E403D, G970D, L1324P, R117P, S945L, 3849+10kbC→T, E588V, G1069R, L1335P, R170H, S977F, A120T, E822K, G1244E, L1480P, R258G, S1159F, A234D, E831X, G1249R, M152V, R334L, S1159P, A349V, F191V, G1349D, M265R, R334Q, S1251N, A455E, F311del, H939R, M952I, R347H, S1255P, A554E, F311L, H1054D, M952T, R347L, T338I, A1006E, F508C, H1375P, P5L, R347P, T1036N, A1067T, F508C;S1251N, I148T, P67L, R352Q, T1053I, D110E, F508del, I175V, P205S, R352W, V201M, D110H, F575Y, I336K, Q98R, R553Q, V232D, D192G, F1016S, I601F, Q237E, R668C, V562I, D443Y, F1052V, I618T, Q237H, R751L, V754M, D443Y;G576A;R668C, F1074L, I807M, Q359R, R792G, V1153E, D579G, F1099L, I980K, Q1291R, R933G, V1240G, D614G, G126D, I1027T, R31L, R1066H, V1293G, D836Y, G178E, I1139V, R74Q, R1070Q, W1282R, D924N, G178R, I1269N, R74W, R1070W, Y109N, D979V, G194R, I1366N, R74W;D1270N, R1162L ,Y161S, D1152H, G194V, K1060T, R74W;V201M, R1283M, Y1014C, D1270N, G314E, L15P, R74W;V201M;D1270N, R1283S, Y1032C, E56K, G551D, L206W, R75Q, S549N, E60K, G551S, L320V, R117C, S549R.
6. **Dosage allowed:** One tablet (containing tezacaftor 100 mg/ivacaftor 150 mg) in the morning and one tablet (containing ivacaftor 150 mg) in the evening, approximately 12 hours apart.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member's adherence to medication is confirmed by claims history; AND
3. Chart notes submitted with any of the following:
   a) Improved FEV1 and/or other lung function tests;
   b) Improvement in sweat chloride;
   c) Decrease in pulmonary exacerbations;
   d) Decrease in pulmonary infections;
   e) Increase in weight-gain;
   f) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Symdeko (tezacaftor/ivacaftor) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
02/27/2018	New policy for Symdeko created.
12/31/2020	Age changed to 6 years old and older (previously only approved for patients 12 years and older). Added approved mutations based on new FDA approvals. Diagnosis of cystic fibrosis added to initial criteria. Changed status to Preferred. Removed requiring trials of Orkambi and Kalydeco. Reauthorization criteria updated to ask for evidence of disease improvement.
11/17/2021	Annual review, no changes

References:

1. Symdeko [package insert]. Boston, MA: Vertex Pharmaceuticals Incorporated; December, 2020.
2. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. Available: https://www.guideline.gov.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Synagis (palivizumab)
BILLING CODE	CPT Code 90378 (1 unit = 50 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 200 mg per month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Synagis (palivizumab) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated. CareSource is currently reviewing Synagis requests on a case-by-case basis outside of the typical RSV season window due to the increased interseasonal Respiratory Syncytial Virus (RSV) activity.

PREVENTION OF RESPIRATORY TRACT DISEASE CAUSED BY RESPIRATORY SYNCYTIAL VIRUS (RSV)

For **initial** authorization:

1. Medication will be administered during the RSV season (*November 1st through March 31st*) AND initiation of injections should be timed with the onset of laboratory confirmed cases of RSV activity in the community, no earlier than November 1, 2021; AND
2. Member is < 12 months old at the beginning of the RSV season AND meets **one** of the following criteria (chart notes must be provided to support evidence):
   a) Member was born < 29 weeks, 0 days' gestation;
   b) Member has Chronic Lung Disease (CLD) of prematurity (defined as gestational age < 32 weeks, 0 days and a requirement for > 21% oxygen for at least the first 28 days after birth);
   c) Member has hemodynamically significant Congenital Heart Disease (CHD) with **one** or more of the following:
      i) Acyanotic heart disease (e.g., atrial septal defect (ASD), ventricular septal defect (VSD), etc.), AND member is receiving medication to control congestive heart failure (CHF) AND will require cardiac surgical procedures;
      ii) Moderate to severe pulmonary hypertension;
      iii) Cyanotic heart disease and referred by a pediatric cardiologist (e.g., coarctation of aorta, Ebstein's anomaly, hypoplastic left heart syndrome, Tetralogy of Fallot (TOF), total anomalous pulmonary venous connection (TAPVC), etc.);
   d) Member has pulmonary abnormalities or neuromuscular disorder that impairs the ability to clear secretions from the upper airways;
   e) Member is profoundly immunocompromised during the RSV season (e.g., concurrent chemotherapy, stem cell transplantation, organ transplantation, etc.);
   f) Member undergoes cardiac transplantation during the RSV season;
   g) Member has Cystic Fibrosis with clinical evidence of CLD and/or nutritional compromise in the first year of life; OR
3. Member is 12 – 24 months old at the beginning of the RSV season AND meets **one** of the following criteria (chart notes must be provided to support evidence):
   a) Member was born < 32 weeks, 0 days' gestation **and** has CLD of prematurity that required at least 28 days of oxygen after birth and who continues to require supplemental oxygen, chronic systemic

corticosteroid therapy, or diuretic therapy during the 6 month period before the start of the second RSV season;
   b) Member is profoundly immunocompromised during the RSV season (e.g., concurrent chemotherapy, stem cell transplantation, organ transplantation, etc.);
   c) Member undergoes cardiac transplantation during the RSV season;
   d) Member has Cystic Fibrosis with **one** of the following:
      i) Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life, or abnormalities on chest radiography or chest computed tomography that persist when stable);
      ii) Weight for length less than the 10th percentile on a pediatric growth chart.
4. **Dosage allowed:** 15 mg/kg once monthly for a total of 5 doses or until the end of the RSV season.

If member meets all the requirements listed above, the medication will be approved for 5 months or until the end of the RSV season (March 31, 2022), whichever comes first.

CareSource considers Synagis (palivizumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Prophylaxis of Health Care-Associated RSV Disease
- RSV prophylaxis for children with Down syndrome
- RSV prophylaxis for children who were previously infected with RSV in the current season
- RSV prophylaxis for infants and children with hemodynamically insignificant heart disease (e.g. Secundum atrial septal defect, small ventricular septal defect, pulmonary stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with mild cardiomyopathy who are not receiving medical therapy for the condition
- Children with CHD in the second year of life
- Treatment of RSV Disease

DATE	ACTION/DESCRIPTION
09/01/2017	New policy for Synagis created. Criteria divided by age groups. Cystic Fibrosis coverage was added. Cardiac transplantation category was added.
08/07/2018	RSV season time limits updated for 2018-2019.
09/04/2019	RSV season time limits updated for 2019-2020.
08/24/2020	RSV season time limits updated for 2020-2021. Changed “request must be made during RSV season” to “Medication will be administered during RSV season”. Removed previous cardiac or cardiopulmonary procedure under CHD because of inconsistency with guidelines. Added pediatric cardiologist referral to cyanotic heart defect. Removed bronchodilator as an option under 3a.
8/25/2021	RSV season time limits updated for 2021-2022

References:

1. Palivizumab (Synagis) [prescribing information]. Gathersburg, MD: MedImmune, LLC; May 2017.
2. American Academy of Pediatrics Committee on Infectious Diseases; American Academy of Pediatrics Bronchiolitis Guidelines Committee. RSV Policy Statement —Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics.* 2014;134(2):415–420.

3. American Academy of Pediatrics Committee on Infectious Diseases; American Academy of Pediatrics Bronchiolitis Guidelines Committee. Updated guidance for palivizumab prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection. *Pediatrics*. 2014;134(2):e620-e638. doi:10.1542/peds.2014-1666.
4. Feltes T, Cabalka A, Meissner H, et al. Palivizumab prophylaxis reduces hospitalization due to respiratory syncytial virus in young children with hemodynamically significant congenital heart disease. *J Pediatr.* 2003 Oct;143(4):532-40.
5. Weinrauch LA. Cyanotic heart disease: MedlinePlus. Verimed Healthcare Network: October 2015. https://medlineplus.gov/ency/article/001104.htm.
6. Anderson EJ, Krilov LR, DeVincenzo JP, et al. SENTINEL1: An Observational Study of Respiratory Syncytial Virus Hospitalizations among U.S. Infants Born at 29 to 35 Weeks' Gestational Age Not Receiving Immunoprophylaxis. Thieme Medical Publishers, Inc. May 27, 2016.
7. Kong AM, Krilov LR, Fergie J, et al. The 2014–2015 National Impact of the 2014 American Academy of Pediatrics Guidance for Respiratory Syncytial Virus Immunoprophylaxis on Preterm Infants Born in the United States. Thieme Medical Publishers, Inc. July 26, 2017.
8. Goldstain M, Krilov LR, Fergie J, et al. Respiratory Syncytial Virus Hospitalizations among U.S. Preterm Infants Compared with Term Infants Before and After the 2014 American Academy of Pediatrics Guidance on Immunoprophylaxis: 2012–2016. Thieme Medical Publishers, Inc. April 26, 2018.
9. MARP ID SENTINEL1 ID Week 2016 poster ML-3016-US-0098.
10. 2018 PAS Poster Goldstein et al. RSVHs Before and Two Seasons After 2014 AAP Guidance on RSVIP.
11. Rajah B, Sanchez PJ, Garcia-Maurino C, et al. Impact of the Updated Guidance for Palivizumab Prophylaxis against Respiratory Syncytial Virus Infection: A Single Center Experience. *J Pediatr* 2016. November 15, 2016.
12. Use of palivizumab in children with congenital heart disease. *Paediatr Child Health*. 2003;8(10):631-636. doi:10.1093/pch/8.10.631.

Effective date: 09/16/2021
Revised date: 08/25/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Synvisc-One (sodium hyaluronate)
BILLING CODE	J7325
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Durolane, Supartz FX, Gelsyn-3 QUANTITY LIMIT— 1 injection (48 unit)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Synvisc-One (sodium hyaluronate) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OSTEOARTHRITIS OF THE KNEE

For **initial** authorization:

1. Member must be 40 years old or older; AND
2. Member must have a diagnosis of osteoarthritis confirmed by radiological evidence (e.g. Kellgren-Lawrence Scale score of grade 2 or greater); AND
3. Medication must be prescribed by an orthopedic surgeon, interventional pain physicians, rheumatologists, physiatrists (PM&R) and all sports medicine subspecialties; AND
4. Member tried and failed an intra-articular corticosteroid injection(s) in which efficacy was < 4 weeks duration; AND
5. Documentation that member tried and failed ALL of the following:
   a) Weight loss attempts or attempts at lifestyle modifications to promote weight loss (only for members with BMI ≥ 30); AND
   b) Sufficient trial (e.g. 2 to 3 months) of non-pharmacologic therapies (bracing/orthotics, physical/occupational therapy); AND
   c) At least 3 simple analgesic therapies (acetaminophen, NSAIDs, oral or topical salicylates); AND
6. Member is not using medication for hip or shoulder related conditions, AND
7. Member is not allergic to avian proteins, feathers, and egg products; AND
8. Member has tried and failed to respond to treatment with Supartz FX or Durolane or Gelsyn-3 (documented in chart notes and confirmed by claims history).
9. **Dosage allowed:** Inject 48 mg (6 mL) once.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must have documented significant pain relief that was achieved with the initial course of treatment; AND
2. Initial course of treatment has been completed for 6 months or longer; AND
3. Member meets all of the criteria for the initial approval.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Synvisc-One (sodium hyaluronate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Refractory interstitial cystitis
- Arthropathy – Disorder of shoulder
- Intravitreal tamponade
- Keratoconjunctivitis sicca
- Subacromial impingement, Syndrome of the shoulder

DATE	ACTION/DESCRIPTION
05/23/2017	New policy for Synvisc-One created. Minimum age and BMI requirements changed. Limits of additional courses of treatment changed. Trial of Supartz FX or Gel-One added.
08/04/2017	Trial of Gelsyn-3 added as additional option to the other preferred products.
05/15/2018	Trial of another preferred product Durolane was added. Non-preferred product Gel-One was removed from trial requirements.
03/11/2021	Annual review, no change

References:

1. Synvisc-One [package insert]. Ridgefield, NJ: Genzyme, Inc.; January, 2010.
2. American Academy of Orthopaedic Surgeons. Treatment of Osteoarthritis of the Knee. Evidence-based guideline 2nd Edition. May 2013. Available at: http://www.aaos.org/research/guidelines/TreatmentofOsteoarthritisoftheKneeGuideline.pdf (December 31, 2015).
3. American College of Rheumatology, Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee: 2012 update. Arthritis Care & Research 2012; 64(4):465-474. Agency for Healthcare Research and Quality (AHRQ). Three Treatments for Osteoarthritis of the Knee: Evidence Shows Lack of Benefit. Clinician's Guide. March, 2011.
4. Goldberg VM, Buckwater MD. Hyaluronans in the treatment of osteoarthritis of the knee: evidence for disease modifying activity. Osteoarthritis and Cartilage March 2005;13(3):216-224.
5. Majeed M. Relationship between serum hyaluronic acid level and disease activity in early rheumatoid arthritis. Ann Rheum Dis September 2004; 63(9): 1166-8.
6. Tascioglu F, Oner C. Efficacy of intra-articular sodium hyaluronate in the treatment of knee osteoarthritis. Clini Rheumatol. 2003;22:112-117.
7. Lo, G H, et al. JAMA. 2003;290:3115-3121. Intra-articular Hyaluronic Acid in Treatment of Knee Osteoarthritis: A Meta- analysis. Retrieved 3/17/2011 from http://jama.ama-assn.org/cgi/reprint/290/23/3115.
8. Bellamy N, Campbell J, Robinson V, Gee T, Bourne R, Wells G. Viscosupplementation for the treatment of osteoarthritis of the knee. Cochrane Database Syst Rev. 2006;(2):CD005321.
9. Divine JG; Zazulak BT; Hewett TE. Viscosupplementation for knee osteoarthritis: a systematic review. Clin Orthop Relat Res. 2007; 455:113-22.
10. Synvisc-One. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed May 17, 2017.
11. Synvisc-One. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed May 17, 2017.
12. McGrath AF, McGrath AM, Jessop ZM, et al. A comparison of intra-articular hyaluronic acid competitors in the treatment of mild to moderate knee osteoarthritis. J Arthritis. 2013; 2(1):108. doi:10.4172/2167-7921.1000108.
13. Leighton R, Åkermark C, Therrien R, et. al. NASHA hyaluronic acid vs methylprednisolone for knee osteoarthritis: a prospective, multi-centre, randomized, non-inferiority trial. Osteoarthritis Cartilage. 2014; 22(1):17-25.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Takhzyro (lanadelumab-flyo)
BILLING CODE	J0593
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product: Haegarda QUANTITY LIMIT— 2 vials (300 mg/2 ml per vial) per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Takhzyro (lanadelumab-flyo) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEREDITARY ANGIOEDEMA (HAE)

For **initial** authorization:

1. Member must be 12 years of age or older; AND
2. Medication must be prescribed by or in consultation with an allergist or immunologist; AND
3. Member has a diagnosis of HAE type I or type II confirmed by both of the following:
   a) Low C4 level;
   b) Low (<50% of normal) C1 inhibitor antigenic and/or functional level; AND
4. Chart notes must document the member's baseline frequency of HAE attacks; AND
5. Member is inadequately controlled with on-demand treatment alone; AND
6. Takhzyro is being prescribed for ongoing prophylaxis and will not be used to treat acute attacks; AND
7. Member has a trial and failure of or contraindication to Haegarda.
8. **Dosage allowed:** 300 mg subQ every 2 weeks. A dosing interval of 300 mg every 4 weeks is also effective and may be considered if the patient is well-controlled (e.g., attack free) for more than 6 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must be provided that show a reduced rate of HAE attacks since starting treatment.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Takhzyro (lanadelumab-flyo) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Acquired angioedema (AAE)

- Treatment of acute HAE attacks

DATE	ACTION/DESCRIPTION
08/06/2019	New policy Takhzyro created.
01/13/2021	Updated criteria to align with the other HAE prophylactic drug revisions. Updated references. Greatly simplified the diagnostic confirmation criteria. Removed minimum required number of attacks, per guidelines; will just ask for baseline measure. Removed the statement about causative medications. Added that they must try on-demand treatment first. Rewrote the renewal criteria and removed log book requirement. Extended initial auth duration to 6 mo and renewal to 12 mo. Corrected the J code for billing.

References:

1. Takhzyro [package insert]. Lexington, MA: Dyax Corp.; November, 2018.
2. ClinicalTrials.gov Identifier: NCT02586805. Efficacy and Safety Study of DX-2930 to Prevent Acute Angioedema Attacks in Patients With Type I and Type II HAE. Available at: https://clinicaltrials.gov/ct2/show/NCT02586805?term=NCT02586805&rank=1.
3. ClinicalTrials.gov Identifier: NCT02741596. Long-term Safety and Efficacy Study of DX-2930 (SHP643) to Prevent Acute Angioedema Attacks in Patients With Type I and Type II HAE. Available at: https://www.clinicaltrials.gov/ct2/show/NCT02741596?term=NCT02741596&rank=1.
4. Lumry W. Management and Prevention of Hereditary Angioedema Attacks. Am J Manag Care. 2013;19:S111-S118.
5. Busse PJ, Christiansen SC, Riedl MA, et al. US HAEA Medical Advisory Board 2020 Guidelines for the Management of Hereditary Angioedema [published online ahead of print, 2020 Sep 6]. *J Allergy Clin Immunol Pract*. 2020;S2213-2198(20)30878-3. doi:10.1016/j.jaip.2020.08.046.
6. Maurer M, Magerl M, Ansotegui I, et al. The international WAO/EAACI guideline for the management of hereditary angioedema-The 2017 revision and update. *Allergy*. 2018;73(8):1575-1596. doi:10.1111/all.13384.
7. Banerji A, Riedl MA, Bernstein JA, et al. Effect of Lanadelumab Compared With Placebo on Prevention of Hereditary Angioedema Attacks: A Randomized Clinical Trial [published correction appears in JAMA. 2019 Apr 23;321(16):1636]. *JAMA*. 2018;320(20):2108-2121. doi:10.1001/jama.2018.16773.

Effective date: 10/1/2021
Revised date: 01/13/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Taltz (ixekizumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Enbrel, Cimzia, Cosentyx, Otezla, Siliq and Xeljanz QUANTITY LIMIT— 1 injection per 28 days (after loading doses)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Taltz (ixekizumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ANKYLOSING SPONDYLITIS (AS) or NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (nr-axSpA)

Note: Diagnosis of axial spondyloarthritis (axSpA) is also accepted. SpA comprises of 2 subtypes – ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA).

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Member has a documented diagnosis of active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA); AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Medication must be prescribed by or in consultation with a rheumatologist; AND
5. Member has had back pain for 3 months or more that began before the age of 50; AND
6. Member shows at least one of the following signs or symptoms of Spondyloarthritis:
   a) Elevated serum C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR);
   b) Positive HLA-B27 test;
   c) Sacroiliitis; AND
7. Member has tried and failed to respond to treatment with at least **two** NSAIDs taken at the maximum recommended dosages. Treatment failure requires at least 4 weeks of therapy with each NSAID without an adequate response.
8. Member has tried and failed treatment with **two** of the following drugs, for 12 weeks per trial: Enbrel, Cimzia, or Cosentyx. (Note: will also accept any non-formulary trial of the same drug class).
9. **Dosage allowed:** AS: 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks; nr-axSpA: 80 mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:
1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq (Only applicable to members who is greater than or equal to 18 years old; if member is < 18 years of age - must try Enbrel only). Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:**
   a) Adults: 160 mg (two 80 mg injections) at week 0, followed by 80 mg at week 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks.
   b) Pediatrics:
      i) Weight > 50 kg: 160 mg (two 80 mg injections) at week 0, followed by 80 mg every 4 weeks.
      ii) Weight 25-50 kg: 80 mg at week 0, followed by 40 mg every 4 weeks.
      iii) Weight < 25 kg: 40 mg at week 0, followed by 20 mg every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing the member has shown improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member has tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla and Xeljanz. Treatment failure requires at least for 12 weeks of therapy with each drug.
7. **Dosage allowed:** 160 mg (two 80 mg injections) at Week 0, followed by 80 mg every 4 weeks. For PsA patients with coexistent moderate-to-severe PsO, use the dosing regimen for adult PsO.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Taltz (ixekizumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/19/2017	New policy for Taltz created.
02/05/2018	New indication for Psoriatic Arthritis added.
02/26/2019	Humira was removed from criteria; Cimzia, Cosentyx, Otezla, Siliq and Xeljanz added to trial agents list. Initial authorization length increased to 12 months for PsO. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Requirements on axial disease type removed from PsA. Reauthorization criteria on documented member's PASI score improvement incorporated into general chart noted documentation requirements. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
04/29/2020	Age requirement for diagnosis of PsO updated.
09/22/2020	Added new indications: Ankylosing Spondylitis and Non-radiographic Axial Spondyloarthritis. For PsO: Removed rheumatologist from prescriber. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. For PsA: Added requirement of diagnosis of PsA. Changed the trial section to be 4 weeks of an NSAID AND 3 months of a DMARD unless other circumstances apply (e.g., concomitant axial disease, severe PsA, etc.). Removed repeat TB test for reauth for all diagnoses.
11/17/2021	Annual review, no changes

References:

1. Taltz [package insert]. Indianapolis, IN; Eli Lilly and Company: May, 2020.
2. Menter A, Korman NJ, Elmets CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6. Guidelines of care for the treatment of psoriasis and psoriatic arthritis: Case-based presentations and evidence-based conclusions. Journal of the American Academy of Dermatology, Volume 65, Issue 1, 137 – 174.
3. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. *Arthritis Rheumatol*. 2019 Oct;71(10):1599-1613. doi: 10.1002/art.41042. Epub 2019 Aug 22.
4. Akgul O, Ozgocmen S. Classification criteria for spondyloarthropathies. *World J Orthop*. 2011;2(12):107-115. doi:10.5312/wjo.v2.i12.07.
5. ClinicalTrials.gov. A Study of Ixekizumab (LY2439821) in Participants With Nonradiographic Axial Spondyloarthritis (COAST-X). Identifier: NCT02757352. Available at: https://clinicaltrials.gov/ct2/show/NCT02757352.
6. ClinicalTrials.gov. A Study of Ixekizumab (LY2439821) in bDMARD-Naive Participants With Radiographic Axial Spondyloarthritis (COAST-V). Identifier: NCT02696785. Available at: https://clinicaltrials.gov/ct2/show/NCT02696785.
7. Yu DT, Tubergen AV. Treatment of axial spondyloarthritis (ankylosing spondylitis and nonradiographic axial spondyloarthritis) in adults. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc.
8. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. J Am Acad Dermatol. 2020;S0190-9622(20)32288-X. doi:10.1016/j.jaad.2020.07.087
9. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. J Am Acad Dermatol. 2020;82(6):1445-1486. doi:10.1016/j.jaad.2020.02.044
10. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019;80(4):1029-1072. doi:10.1016/j.jaad.2018.11.057
11. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. J Am Acad Dermatol. 2019;81(3):775-804. doi:10.1016/j.jaad.2019.04.042
12. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. J Am Acad Dermatol 2020;82:161-201.
13. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
14. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
15. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. Arthritis Rheumatol. 2016 May;68(5):1060-71.
16. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of Psoriatic Arthritis. Arthritis Rheumatol. 2019 Jan;71(1):5-32.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Tavalisse (fostamatinib disodium hexahydrate)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes eltrombopag QUANTITY LIMIT— 60 tabs per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tavalisse (fostamatinib disodium hexahydrate) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHRONIC IMMUNE THROMBOCYTOPENIA (ITP)

For **initial** authorization:

1. Member is 18 years of age or older with diagnosis of chronic ITP for at least 3 months; AND
2. Medication must be prescribed by or in consultation with a hematologist; AND
3. Member had an inadequate response, intolerance, or contraindication to documented prior therapy with ONE of the following treatments:
   a) Corticosteroids (prednisone, prednisolone, methylprednisolone, and dexamethasone);
   b) Immunoglobulins;
   c) Splenectomy; AND
4. Member has tried and failed treatment with eltrombopag or romiplostim (Nplate); AND
5. Member's platelet count is < 35,000/µL or there is documentation that the member has experienced significant bleeding at a higher platelet count; AND
6. Member does not have ANY of the following:
   a) Clinical diagnosis of autoimmune hemolytic anemia;
   b) Uncontrolled or poorly controlled hypertension;
   c) History of coagulopathy including prothrombotic conditions.
7. **Dosage allowed:** Initiate Tavalisse at 100 mg orally twice daily with or without food. After 4 weeks, increase to 150 mg twice daily, if needed, to achieve platelet counts of at least 50 x 10^9/L as necessary to reduce the risk of bleeding.

Note: Discontinue Tavalisse after 12 weeks of treatment if the platelet count does not increase to a level sufficient to avoid clinically important bleeding.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member's platelet count of at least 50 x 10^9/L was achieved and documented in chart notes; AND
2. Monthly CBCs (including platelet counts), monthly liver function tests (e.g., ALT, AST, and bilirubin), and monthly blood pressure measurements submitted with chart notes; AND

3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Tavalisse (fostamatinib disodium hexahydrate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Thrombocytopenia due to Myelodysplastic syndrome (MDS)

DATE	ACTION/DESCRIPTION
08/31/2018	New policy for Tavalisse created.
11/17/2021	Annual review, no changes

References:

1. Tavalisse [package insert]. South San Francisco, CA: Rigel Pharmaceuticals, Inc., April, 2018.
2. ClinicalTrials.gov. Identifier: NCT02076399. A Efficacy and Safety Study of R935788 in the Treatment of Persistent/Chronic Immune Thrombocytopenic Purpura (ITP) (FIT). Available at: https://clinicaltrials.gov/ct2/show/NCT02076399?term=NCT02076399&rank=1.
3. ClinicalTrials.gov. Identifier: NCT NCT02076412. A Efficacy and Safety Study of Fostamatinib in the Treatment of Persistent/Chronic Immune Thrombocytopenic Purpura (ITP) (FIT). Available at: https://clinicaltrials.gov/ct2/show/NCT02076412?term=02076412&rank=1.
4. ClinicalTrials.gov. Identifier: NCT 02077192. Open Label Study of R788 in the Treatment of Persistent/Chronic Immune Thrombocytopenic Purpura (ITP). Available at: https://clinicaltrials.gov/ct2/show/NCT02077192?term=NCT+02077192&rank=1.
5. Diagnosis and treatment of idiopathic thrombocytopenic purpura: recommendations of the American Society of Hematology. Ann Intern Med. 1997 Feb 15;126(4):319-26.
6. George JN, et al. Immune thrombocytopenia (ITP) in adults: Initial treatment and prognosis. In: UpToDate. Waltham, MA: UpToDate; 2018.
7. George JN, et al. Immune thrombocytopenia (ITP) in adults: Second-line and subsequent therapies. In: UpToDate. Waltham, MA: UpToDate; 2018.
8. NCCN Guidelines. Myelodysplastic Syndromes. V.1.2019.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Tecartus (Brexucabtagene Autoleucel)
BILLING CODE	Q2043
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Inpatient/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Quantity Limit – 1 infusion per lifetime
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tecartus (Brexucabtagene Autoleucel) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

MANTLE CELL LYMPHOMA (MCL)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Healthcare facility/provider has enrolled in the Yescarta and Tecartus REMS program; AND
3. Member has a diagnosis of relapsed or refractory MCL, defined as disease progression after last regimen or failure to achieve a partial response or complete response to the last regimen; AND
4. Member has had prior treatment with ALL of the following:
   a) Anthracycline or bendamustine-containing chemotherapy,
   b) Anti-CD20 monoclonal antibody (Rituximab),
   c) Bruton tyrosine kinase inhibitor (BTKi) (i.e. ibrutinib, acalabrutinib, or zanubrutinib); AND
5. Member has an Eastern cooperative oncology group (ECOG) performance status of 0 or 1; AND
6. Member does NOT have ANY of the following:
   a) Active or uncontrolled infection,
   b) Central nervous system (CNS) lymphoma,
   c) History of allogeneic stem cell transplantation,
   d) Prior chimeric antigen receptor (CAR) therapy or other genetically modified T-cell therapy; AND
7. Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).
8. **Dosage allowed:** 2 x 10^6 chimeric antigen receptor (CAR)-positive viable T cells/kg IV; MAX 2 x 10^8 CAR-positive viable T cells.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Tecartus will not be reauthorized for continued therapy.

CareSource considers Tecartus (Brexucabtagene Autoleucel) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/18/2020	New policy for Tecartus created.
04/22/2021	Updated billing code.

References:

1. Tecartus [package insert]. Santa Monica, CA: Kite Pharma, Inc; 2021.
2. Wang M, Munoz J, Goy A, et al. KTE-X19 CAR T-Cell Therapy in Relapsed or Refractory Mantle-Cell Lymphoma. *N Engl J Med*. 2020;382(14):1331-1342. doi:10.1056/NEJMoa1914347
3. National Comprehensive Cancer Network. B-Cell Lymphomas (Version 3.2021). https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed April 22, 2021.
4. Mckay P, Leach M, Jackson B, Robinson S, Rule S. Guideline for the management of mantle cell lymphoma. *British Journal of Haematology*. 2018;182(1):46-62. doi:10.1111/bjh.15283
5. Dreyling M, Campo E, Hermine O, et al. Newly diagnosed and relapsed mantle cell lymphoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Annals of Oncology*. 2017;28:iv62-iv71. doi:10.1093/annonc/mdx223
6. IPD analytics. Accessed August 7, 2020

Effective date: 10/1/2021
Revised date: 04/22/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Tecfidera (dimethyl fumarate)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 60 per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tecfidera (dimethyl fumarate) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis.
4. **Dosage allowed:** 120 mg orally twice daily for 7 days; then 240 mg orally twice daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Tecfidera (dimethyl fumarate) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis

DATE	ACTION/DESCRIPTION
06/07/2017	New policy for Tecfidera created. Not covered diagnosis added.
12/06/2017	Age coverage expanded. Confirmation of diagnosis based on McDonald criteria is no longer required.
09/16/2021	Annual review, no changes

References:

1. Tecfidera [package insert]. Cambridge, MA; Biogen, Inc. January, 2017.

2. Tecfidera. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 16, 2017.
3. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
4. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Tegsedi (inotersen)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 4 prefilled syringes per month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tegsedi (inotersen) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

POLYNEUROPATHY OF HEREDITARY TRANSTHYRETIN-MEDIATED (hATTR) AMYLOIDOSIS

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of amyloidosis (e.g., hematologist, geneticist, etc.); AND
3. Member has diagnosis of hATTR Amyloidosis with polyneuropathy confirmed by chart notes; AND
4. Member has documented transthyretin (TTR) gene mutation as confirmed through genetic testing (documentation required); AND
5. Member must have documentation of familial amyloid polyneuropathy (FAP) stage 1 (unimpaired ambulation; mostly mild sensory, motor, and autonomic neuropathy in the lower limbs) or stage 2 (assistance with ambulation required; mostly moderate impairment progression to the lower limbs, upper limbs, and trunk); AND
6. Member does **not** have ANY of the following:
   a) Prior liver transplant;
   b) Known Primary or Leptomeningeal Amyloidosis;
   c) Platelet count < 100 x 10^9/L; AND
7. Member is **not** using Tegsedi concomitantly with Onpattro, Vyndaqel, or Vyndamax.
8. **Dosage allowed:** 284 mg SQ injection once weekly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member continues to have FAP stage 1 or stage 2; AND
2. Chart notes have been provided that show the member has positive response to Tegsedi (e.g., quality of life and motor function improved, disease progression slowed down, serum TTR levels reduced); AND
3. Member did not have acute glomerulonephritis caused by Tegsedi; AND
4. Member's platelet count is no less than 100 x 10^9/L; AND
5. Member is not using Tegsedi concomitantly with Onpattro, Vyndaqel or Vyndamax.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Tegsedi (inotersen) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/07/2019	New policy for Tegsedi created.
07/06/2020	Removed “office” from site of service allowed. Expanded prescriber to include physicians who specialize in treating amyloidosis. Simplified diagnostic requirement of hATTR to just any method of confirmation by chart notes. Separated genetic testing and FAP staging into their own mandatory requirements. Removed the following exclusions: type 1 or type 2 DM, sensorimotor or autonomic neuropathy, Acute Coronary Syndrome or major surgery, HF Class III, anticipated survival less than 2 years.

References:

1. Tegsedi [prescribing information]. Carlsbad, CA: Ionis Pharmaceuticals, Inc.; October, 2018.
2. ClinicalTrials.gov Identifier: NCT01737398. Efficacy and Safety of Inotersen in Familial Amyloid Polyneuropathy. Available at: https://www.clinicaltrials.gov/ct2/show/NCT01737398?term=NCT+01737398&rank=1.
3. Ando Y, Coelho T, Berk JL, et al. Guideline of transthyretin-related hereditary amyloidosis for clinicians. Orphanet J Rare Dis. 2013;8:31.
4. National Institutes of Health (NIH). Transthyretin amyloidosis. Available at: https://ghr.nlm.nih.gov/condition/transthyretin-amyloidosis.
5. Amyloid transthyretin (ATTR) Amyloidosis: Signs, symptoms, and diagnostic workup. 2018 Akcea Therapeutics, Inc. Available at: https://www.hattrguide.com/wp-content/uploads/2018/04/Diagnostic-Card.pdf
6. BioNews Services, LLC. Stages of familial amyloid polyneuropathy. Available at: https://fapnewstoday.com/stages-of-familial-amyloid-polyneuropathy/
7. Ruberg FL, Grogan M, Hanna M, et al. Transthyretin amyloid cardiomyopathy. J Am Coll Cardiol. 2019 Jun, 73 (22) 2872-2891.

Effective date: 10/1/2021
Revised date: 07/06/2020

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Tepezza (teprotumumab-trbw)
BILLING CODE	J3241
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital/Infusion Site
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "Dosage allowed" below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tepezza (teprotumumab-trbw) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

THYROID EYE DISEASE

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a confirmed diagnosis of Graves' disease; AND
4. Member has active moderate to severe thyroid eye disease (TED) with a Clinical Activity Score (CAS) of 4 or greater documented in chart notes;
5. Chart notes must be submitted showing that the member is euthyroid or mildly hypo- or hyper-thyroid (defined as having free thyroxine (FT4) and free triiodothyronine (FT3) levels less than 50% above or below the reference normal limits) prior to starting therapy; AND
6. Member has tried and failed a 12-week course of a high-dose systemic corticosteroid (e.g. methylprednisolone) or has a significant intolerance or contraindication to corticosteroids.
7. **Dosage allowed:** 10mg/kg initial dose intravenously followed by seven 20mg/kg infusions every 3 weeks.

If member meets all the requirements listed above, the medication will be approved for 24 weeks.

For **reauthorization**:

Retreatment will not be authorized due to a lack of robust literature available to support the use of Tepezza beyond 24 weeks.

CareSource considers Tepezza (teprotumumab-trbw) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/22/2020	New policy for Tepezza created.
11/17/2021	Annual review, no changes

References:

1. Tepezza Prescribing Information. Lake Forest, IL: Horizon Therapeutics USA, Inc.; January 2020. Available at: https://www.hzndocs.com/TEPEZZA-Prescribing-Information.pdf. Accessed April 22, 2020.

2. NCT03298867 in ClinicalTrials.gov. NIH U.S. National Library of Medicine. Accessed April 22, 2020.
3. NCT03461211 in ClinicalTrials.gov. NIH U.S. National Library of Medicine. Accessed April 22, 2020.
4. Douglas S. Ross, Henry B. Burch, David S. Cooper, M. Carol Greenlee, Peter Laurberg, Ana Luiza Maia, Scott A. Rivkees, Mary Samuels, Julie Ann Sosa, Marius N. Stan, and Martin A. Walter.Thyroid.Oct 2016.1343-1421.http://doi.org/10.1089/thy.2016.0229
5. Bartalena L, Baldeschi L, Boboridis K, Eckstein A, Kahaly G, J, Marcocci C, Perros P, Salvi M, Wiersinga W, M: The 2016 European Thyroid Association/European Group on Graves' Orbitopathy Guidelines for the Management of Graves' Orbitopathy. Eur Thyroid J 2016;5:9-26. doi: 10.1159/000443828.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Tobi (tobramycin inhalation solution), Tobi Podhaler
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required QUANTITY LIMIT—280 mL per 56 days (solution) 228 capsules per 56 days (podhaler)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tobi (brand name) and Tobi Podhaler are **non-preferred** products and generic tobramycin inhaled solution is a **preferred** product. These will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Member has a diagnosis of cystic fibrosis and has a positive culture for Pseudomonas aeruginosa documented in chart notes; AND
3. Member is not colonized with Burkholderia cepacia; AND
4. Medication is prescribed by a pulmonologist or an infectious disease specialist; AND
5. Member has documented forced expiratory volume in 1 second (FEV1) > 25% or < 75% predicted; AND
6. For Tobi Podhaler or brand name Tobi inhalation solution, member must have trial and failure of generic tobramycin inhalation solution with ineffectiveness, intolerance or contraindication documented in chart notes.
7. **Dosage allowed:** 300 mg every 12 hours for the solution or 112 mg (4 x 28 mg capsules) every 12 hours for podhaler; administer in repeated cycles of 28 days on drug followed by 28 days off drug

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.
2. Evidence of disease stability or disease improvement
   a) Note: Disease improvement is evidenced by chart notes with any of the following:
      i) Improved FEV1 and/or other lung function tests;
      ii) Improvement in sweat chloride;
      iii) Decrease in pulmonary exacerbations;
      iv) Decrease in pulmonary infections;
      v) Increase in weight-gain;
      vi) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Tobi, Tobi podhaler, and generic tobramycin inhaled solution not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/25/2017	New policy for Tobi created. Not covered diagnosis added.
12/30/2020	Reauthorization criteria updated to simplified statement. Diagnosis of cystic fibrosis added to initial criteria. Kitabis removed as preferred option. Exclusion criteria updated. Generic tobramycin and Tobi podhaler added to policy.
11/17/2021	Annual review, no changes

References:

1. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. [cited 2016 Dec 19]. Available: https://www.guideline.gov.
2. Tobi [package insert]. East Hanover, New Jersey: Novartis Pharmaceuticals Corporation; 2015.
3. Tobi. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Tremfya (guselkumab)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Cimzia, Cosentyx, Enbrel, Otezla, Xeljanz and Siliq QUANTITY LIMIT— 1 syringe every 8 weeks after loading doses
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tremfya (guselkumab) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PLAQUE PSORIASIS (PsO)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a dermatologist; AND
3. Member has clinical documentation of moderate to severe plaque psoriasis characterized by 3% or more of body surface area (BSA) or disease affecting sensitive areas (e.g., hands, feet, face, genitals, etc.); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has tried and failed to respond to treatment with at least **one** of the following:
   a) At least 12 weeks of photochemotherapy (i.e., psoralen plus ultraviolet A therapy);
   b) At least 12 weeks of phototherapy (i.e., UVB light therapy, Excimer laser treatments);
   c) At least a 4 week trial with topical antipsoriatic agents (i.e., anthralin, calcipotriene, coal tar, corticosteroids, tazarotene, tacrolimus, pimecrolimus); AND
6. Member has tried and failed, or unable to tolerate a systemic non-biologic DMARD (i.e., cyclosporine, methotrexate, acitretin) for at least 12 weeks; AND
7. Member has tried and failed treatment with at least **two** of the following: Cimzia, Cosentyx, Enbrel, Otezla and Siliq. Treatment failure requires at least 12 weeks of therapy with each drug.
8. **Dosage allowed:** 100 mg administered by subcutaneous injection at Week 0, Week 4 and every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., documented member's BSA improvement, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member must have tried and failed treatment with at least **two** of the following: Enbrel, Cimzia, Cosentyx, Otezla, and Xeljanz (all require prior authorization). Treatment failure requires at least for 12 weeks of therapy with each drug.
7. **Dosage allowed:** 100 mg administered by subcutaneous injection at Week 0, Week 4 and every 8 weeks thereafter.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Tremfya (guselkumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/19/2017	New policy for Tremfya created.
02/26/2019	Humira was removed from criteria; Cimzia, Cosentyx, Otezla and Siliq added to trial agents list. Initial authorization length increased to 12 months. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. Reauthorization criteria on documented member's PASI score improvement incorporated into general chart noted documentation requirements.
09/23/2020	New indication Psoriatic Arthritis added. For PsO: Removed rheumatologist from prescriber. Removed PsO for 6 months or longer. Changed BSA to 3% or sensitive area involvement. Removed PASI score requirement. Removed repeated TB test for reauth.
11/17/2021	Annual review, no changes

References:

1. Tremfya [package insert]. Horsham, PA: Janssen Biotech, Inc.; July, 2020.

2. Elmets CA, Korman NJ, Prater EF, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis with topical therapy and alternative medicine modalities for psoriasis severity measures [published online ahead of print, 2020 Jul 30]. *J Am Acad Dermatol*. 2020;S0190-9622(20)32288-X.
3. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
4. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
5. Elmets CA, Lim HW, Stoff B, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management and treatment of psoriasis with phototherapy [published correction appears in J Am Acad Dermatol. 2020 Mar;82(3):780]. *J Am Acad Dermatol*. 2019;81(3):775-804.
6. Menter A, Cordoro KM, Davis DM, et al. Joint AAD-NPF Guidelines of care for the management and treatment of psoriasis in pediatric patients. *J Am Acad Dermatol* 2020;82:161-201
7. ClinicalTrials.gov. A Study Evaluating the Efficacy and Safety of Guselkumab Administered Subcutaneously in Participants With Active Psoriatic Arthritis Including Those Previously Treated With Biologic Anti -Tumor Necrosis Factor (TNF) Alpha Agent(s) (Discover-1). Identifier: NCT03162796. Available at: https://clinicaltrials.gov/ct2/show/NCT03162796.
8. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of Psoriatic Arthritis. *Arthritis Rheumatol*. 2019 Jan;71(1):5-32.
9. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
10. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
11. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Trikafta (elexacaftor, tezacaftor and ivacaftor tablets; ivacaftor tablets)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 84-count tablet carton for 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Trikafta (elexacaftor, tezacaftor and ivacaftor tablets; ivacaftor tablets) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CYSTIC FIBROSIS

For **initial** authorization:

1. Member is 6 years old or older; AND
2. Medication must be prescribed by pulmonologist or an infectious disease specialist; AND
3. Member has a diagnosis of cystic fibrosis; AND
4. Member has had genetic testing documented in chart notes with at least one F508del mutation in the CFTR gene: OR
5. Member has at least one of the following mutations in the CFTR gene: 3141del9, E822K, G1069R, L967S, R117L, S912L, 546insCTA, F191V, G1244E, L997F, R117P, S945L, A46D, F311del, G1249R, L1077P, R170H, S977F, A120T, F311L, G1349D, L1324P, R258G, S1159F, A234D, F508C, H139R, L1335P, R334L, S1159P, A349V, F508C;S1251N, H199Y, L1480P, R334Q, S1251N, A455E, F508del, H939R, M152V, R347H, S1255P, A554E, F575Y, H1054D, M265R, R347L, T338I, A1006E, F1016S, H1085P, M952I, R347P, T1036N, A1067T, F1052V, H1085R, M952T, R352Q, T1053I, D110E, F1074L, H1375P, M1101K, R352W, V201M, D110H, F1099L, I148T, P5L, R553Q, V232D, D192G, G27R, I175V, P67L, R668C, V456A, D443Y, G85E, I336K, P205S, R751L, V456F, D443Y;G576A;R668C, G126D, I502T, P574H, R792G, V562I, D579G, G178E, I601F, Q98R, R933G, V754M, D614G, G178R, I618T, Q237E, R1066H, V1153E, D836Y, G194R, I807M, Q237H, R1070Q, V1240G, D924N, G194V, I980K, Q359R, R1070W, V1293G, D979V, G314E, I1027T, Q1291R, R1162L, W361R, D1152H, G463V, I1139V, R31L, R1283M, W1098C, D1270N, G480C, I1269N, R74Q, R1283S, W1282R, E56K, G551D, I1366N, R74W, S13F, Y109N, E60K, G551S, K1060T, R74W;D1270N, S341P, Y161D, E92K, G576A, L15P, R74W;V201M, S364P, Y161S, E116K, G576A;R668C, L165S, R74W;V201M;D1270N, S492F, Y563N, E193K, G622D, L206W, R75Q, S549N, Y1014C, E403D, G628R, L320V, R117C, S549R, Y1032C, E474K, G970D, L346P, R117G, S589N, E588V, G1061R, L453S, R117H, S737F.
6. **Dosage allowed:** Morning dose: two elexacaftor 100 mg, tezacaftor 50 mg and ivacaftor 75 mg tablets. Evening dose: one ivacaftor 150 mg tablet. Morning and evening dose should be taken approximately 12 hours apart

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member's adherence to medication is confirmed by claims history; AND
3. Chart notes submitted with any of the following:
   a) Improved FEV1 and/or other lung function tests;
   b) Improvement in sweat chloride;
   c) Decrease in pulmonary exacerbations;
   d) Decrease in pulmonary infections;
   e) Increase in weight-gain;
   f) Decrease in hospitalizations.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Trikafta (elexacaftor, tezacaftor and ivacaftor tablets; ivacaftor tablets) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/12/2019	New policy for Trikafta created.
12/31/2020	New approved FDA mutations included. Diagnosis of cystic fibrosis added to initial criteria.
08/09/2021	Changed lower age limit to 6 years.

References:

1. Trikafta [prescribing information]. Boston, MA: Vertex Pharmaceuticals Inc; December, 2020.
2. National Guideline Clearinghouse (NGC). Guideline summary: Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. In: National Guideline Clearinghouse (NGC) [Web site]. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2013 Apr 01. Available: https://www.atsjournals.org/doi/full/10.1164/rccm.201207-1160OE.

Effective date: 01/01/2022
Revised date: 08/09/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Triptodur (triptorelin)
BILLING CODE	J3316
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Lupron QUANTITY LIMIT— 22.5 mg every 24 weeks
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Triptodur (triptorelin) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CENTRAL PRECOCIOUS PUBERTY (CPP)

For **initial** authorization:

1. Member is 2 years old or older; AND
2. Member has early onset of pubertal symptoms before the age of 8 for female or 9 for male; AND
3. Member has confirmed diagnosis of central precocious puberty, as evidenced by **both** of the following:
   a) Pubertal response to a gonadotropin releasing hormone (GnRH) stimulation test OR pubertal levels of basal luteinizing hormones (LH) and estradiol or testosterone hormones;
   b) Bone age is advanced by at least one year greater than chronological age; AND
4. Medication must be prescribed by or in consultation with an endocrinologist; AND
5. Member's baseline LH level, sex steroid level (estradiol or testosterone), and height are submitted with chart notes.
6. **Dosage allowed:** 22.5mg intramuscularly once every 24 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. If member is 11 years or older for females or 12 years or older for males, prescriber must provide a clinical reason for continuing medication beyond the recommended age for resuming puberty; AND
2. Chart notes have been provided showing efficacy of response (e.g., slowed growth rate, slowed bone age advancement, LH and sex steroid hormone levels have been suppressed or reduced to prepubertal levels).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Triptodur (triptorelin) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/11/2019	New policy for Triptodur created.

07/28/2020	Diagnostic requirements (#3) updated to require both conditions: advanced bone age and GnRH stimulation test or pubertal hormone levels; removed ruled out diagnoses; removed list of secondary puberty signs and symptoms (redundancy); removed baseline weight; specified baseline LH hormones; Added requirement for discontinuation of treatment in reauth; added prescriber requirement.

References:

1. Triptodur [package insert]. Atlanta, GA: Arbor Pharmaceuticals, LLC; October 2018.
2. ClinicalTrials.gov Identifier: NCT00564850. Efficacy and Safety Study of Pamoate of Triptorelin in Children With Precocious Puberty (DECAPUB). Available at: https://clinicaltrials.gov/ct2/show/NCT00564850.
3. Eksioglu AS, et al. Value of pelvic sonography in the diagnosis of various forms of precocious puberty in girls. J Clin Ultrasound. 2013 Feb;41(2):84-93.
4. Sathasivam A, et al. Pelvic ultrasonography in the evaluation of central precocious puberty: comparison with leuprolide stimulation test. J Pediatr. 2011 Sep;159(3):490-5.
5. U.S. National Library of Medicine. National Institutes of Health Department of Health & Human Services. Central precocious puberty. Available at: https://ghr.nlm.nih.gov/condition/central-precocious-puberty.
6. John S. Fuqua, Treatment and Outcomes of Precocious Puberty: An Update, The Journal of Clinical Endocrinology & Metabolism, Volume 98, Issue 6, 1 June 2013, Pages 2198–2207, https://doi.org/10.1210/jc.2013-1024.
7. Tanner JM. Puberty and the Tanner Stages. Child Growth Foundation. Available at: https://childgrowthfoundation.org/wp-content/uploads/2018/05/Puberty-and-the-Tanner-Stages.pdf.
8. Chen M, Eugster EA. Central Precocious Puberty: Update on Diagnosis and Treatment. *Paediatr Drugs*. 2015;17(4):273-281.
9. Carel JC, Eugster EA, Rogol A, et al; ESPE-LWPES GnRH Analogs Consensus Conference Group. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2009;123(4).
10. Creo AL, Schwenk WF. Bone age: a handy tool for pediatric providers. *Pediatrics*. Dec 2017, 140 (6) e20171486.
11. Klein KO. Precocious puberty: who has it? Who should be treated?. *J Clin Endocrinol Metab*. 1999;84(2):411-414.

Effective date: 10/1/2021
Revised date: 07/28/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Trogarzo (ibalizumab-uiyk)
BILLING CODE	J1746
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT – for loading dose 10 vials and for maintenance dose 8 vials/month
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Trogarzo (ibalizumab-uiyk) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with the following disease states and meet their individual criteria as stated.

MULTIDRUG-RESISTANT HIV-1 INFECTION

For **initial** authorization:

1. Member must be at least 18 years of age or older; AND
2. The medication must be prescribed by or in consultation with an HIV specialist; AND
3. Member must have documented resistance to at least one antiretroviral from the three drug classes or have failed at least 3 drug classes for HIV treatment due to intolerance or contraindication; AND
4. Member is failing current regimen as evidenced by HIV RNA count > 200 copies/mL; AND
5. Member has at least 1 anti-retroviral agent available to add to Trogarzo (ibalizumab-uiyk); AND
6. Member is NOT using Trogarzo (ibalizumab-uiyk) as monotherapy. Provider must include documentation of entire anti-retroviral regimen; AND
7. Member/prescriber attestation to be adherent to treatment regimen and appointments for maintenance doses.
8. **Dosage allowed:** 2000mg IV for loading dose followed by 800mg IV infusion every 2 weeks for maintenance dose.

If member meets all the requirements listed above, the medication will be approved for 6 months

For **reauthorization**:

1. Trogarzo (ibalizumab-uiyk) is not being used as monotherapy; AND
2. Chart notes have been provided that show the member has demonstrated improvement as evidenced by one of the following:
   a) HIV RNA load < 200 copies/mL; OR
   b) Decrease in HIV RNA load from initial authorization; AND
3. Member is adherent to antiretroviral regimen as prescribed proven through chart notes, or prescriber/member attestation.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Trogarzo (ibalizumab-uiyk) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/03/2020	New policy for Trogarzo (ibalizumab-uiyk) created.

References:

1. Department of Health and Human Services. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Available at https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/AdultandAdolescentGL.pdf. Accessed October 10, 2020.
2. Emu B, Fessel J, Schrader S, et al. Phase 3 Study for Ibalizumab for Multidrug-Resistant HIV-1. N Engl J Med. 2018 Aug 16;379(7):645-654.
3. Trogarzo [package insert]. Montréal, Québec Canada; Theratechnologies. April 2020.

Effective date: 10/1/2021
Revised date: 11/03/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Tysabri (natalizumab)
BILLING CODE	J2323 (1 unit = 1 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital (Must obtain through Specialty Pharmacy, physician/facility "Buy & Bill" is not covered)
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product for Crohn's Disease includes Cimzia QUANTITY LIMIT— 300 units/mg per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Tysabri (natalizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CROHN'S DISEASE (CD)

For **initial** authorization:

1. Member must be at least 18 years or older with moderately to severely active CD; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has had a documented trial and inadequate response, or intolerance to at least **one** of the following conventional therapies: a 4-week trial of a corticosteroid OR a 12-week trial of 6-mercaptopurine, azathioprine, or methotrexate. Note: Trial is not required if member is switching from another biologic agent; AND
4. Member has tried and failed a trial of an anti TNF-drug (e.g., Cimzia, Humira, Remicade) unless not tolerated or contraindicated. Note: trial of a biologic is not required if member has multiple sclerosis and CD; AND
5. Documentation has been provided showing that member has tested negative for anti-John Cunningham virus (JVC) antibody; AND
6. Medication is not being used in combination with immunosuppressants or TNF-alpha inhibitors.
7. **Dosage allowed:** 300 mg intravenous infusion once every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement in signs and symptoms of CD (defined as mucosal healing, fewer flare-ups of symptoms, improved quality of life, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RELAPSING-REMITTING MULTIPLE SCLEROSIS (RRMS), SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS (SPMS)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Member has documentation in chart notes that member was tested for John Cunningham virus (JCV) with ELISA prior to initiating treatment; AND
4. Member has documented trial and failure or contraindication to at least **two** preferred multiple sclerosis agents (two injectable drugs OR two oral drugs OR one injectable and one oral drug). Treatment failure requires at least 3 months of therapy without an adequate response.
5. **Dosage allowed:** 300 mg intravenous infusion over one hour every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Tysabri (natalizumab) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Clinically Isolated Syndrome (CIS) in Multiple Sclerosis
- Primary Progressive Multiple Sclerosis

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Tysabri created. Policy SRx-0041 archived. For diagnosis of CD: trial of Humira required. For RRMS and SPMS diagnoses trial of two formulary agents required. List of diagnoses considered not medically necessary was added.
12/06/2017	Age coverage expanded.
02/26/2019	Humira trial removed from criteria for CD.
11/23/2020	For CD: Changed the trial to only ask for 1 conventional therapy rather than 2. Also added a trial of an anti-TNF in accordance with package insert and guidelines. Changed initial auth to 3 months to observe benefit (must discontinue if no benefit after 3 months).
09/16/2021	Annual review, no changes

References:

1. Tysabri [package insert]. Cambridge, MA; Biogen, Inc.: June, 2020.
2. Sulz MC, Burri E, Michetti P, et al. Treatment Algorithms for Crohn's Disease. *Digestion*. 2020;101 Suppl 1:43-57.
3. Lichtenstein GR, Loftus EV, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. ACG Clinical Guideline: Management of Crohn's Disease in Adults. *Am J Gastroenterol*. 2018;113(4):481-517.
4. Torres J, Bonovas S, Doherty G, et al. ECCO Guidelines on Therapeutics in Crohn's Disease: Medical Treatment. *J Crohns Colitis*. 2020;14(1):4-22.
5. Pimentel AM, Rocha R, Santana GO. Crohn's disease of esophagus, stomach and duodenum. *World J Gastrointest Pharmacol Ther*. 2019;10(2):35-49.

6. Terdiman JP, Gruss CB, Heidelbaugh JJ, Sultan S, Falck-Ytter YT; AGA Institute Clinical Practice and Quality Management Committee. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF-α biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013;145(6):1459-1463.
7. Regueiro M, Velayos F, Greer JB, et al. American Gastroenterological Association Institute Technical Review on the Management of Crohn's Disease After Surgical Resection. *Gastroenterology*. 2017;152(1):277-295.e3.
8. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Udenyca (pegfilgrastim-cbqv)
BILLING CODE	Q5111 (1 unit = 6 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 2 units per 28 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Udenyca (pegfilgrastim-cbqv) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:

1. Member has a non-myeloid malignancy; AND
2. Medication will not be administered less than 14 days before OR less than 24 hours after chemotherapy; AND
3. Chart notes with length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the day of the cycle on which the Udenyca will be administered, are submitted with prior authorization request; AND
4. Member has a documented history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy and is receiving myelosuppressive chemotherapy; OR
5. Member is receiving myelosuppressive anti-cancer drugs associated with a high risk (> 20%, see Appendix for description) for incidence of febrile neutropenia; OR
6. Member is receiving myelosuppressive anti-cancer drugs associated with at intermediate risk (10-20%, see Appendix for description) for incidence of febrile neutropenia including **one** of the following:
   a) Previous chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Bone marrow involvement with tumor;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (bilirubin > 2.0);
   f) Renal dysfunction (creatinine clearance < 50);
   g) Age > 65 years receiving full chemotherapy dose intensity.
7. **Dosage allowed:** Up to 6 mg per chemotherapy cycle, beginning at least 24 hours after completion of chemotherapy.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Udenyca (pegfilgrastim-cbqv) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplant

DATE	ACTION/DESCRIPTION
10/11/2019	New policy for Udenyca created.
03/11/2021	Annual review, no changes

References:
1. Udenyca [prescribing information]. Redwood City, CA: Coherus BioSciences, Inc.; September 2019.
2. NCCN Guidelines for Hematopoietic Growth Factors, Version 1.2020, Pages MGF-1 through MGF-D.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (> 20%).

This list is not comprehensive. There are other regimens that have a high risk for the development of febrile neutropenia. See NCCN guidelines for treatment by cancer site for details.

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	Dose-dense MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
Bone Cancer	VAI (vincristine, doxorubicin or dactinomycin, ifosfamide)
	VDC-IE (vincristine, doxorubicin or dactinomycin, and cyclophosphamide alternating with ifosfamide and etoposide)
	VIDE (vincristine, ifosfamide. doxorubicin or dactinomycin, etoposide)
Breast Cancer	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel)
	TAC (docetaxel, doxorubicin, cyclophosphamide)
	TC (docetaxel, cyclophosphamide)
	TCH (docetaxel, carboplatin, trastuzumab)
Head and Neck Squamous Cell Carcinoma	TPF (docetaxel, cisplatin, 5-fluorouracil)
Hodgkin Lymphoma	Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine)
	Escalated BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin)
	ICE (ifosfamide, carboplatin, etoposide)
	Dose-dense CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone)
	MINE (mesna, ifosfamide, mitoxantrone, etoposide)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine)
	HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone)
Melanoma	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Multiple Myeloma	DT-PACE (dexamethasone/thalidomide/ cisplatin/doxorubicin/cyclophosphamide/etoposide) ± bortezomib (VTD-PACE)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha)
Ovarian Cancer	Topotecan
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)

	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	Topotecan
Testicular cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% - 20%)

Cancer Histology	**Regimen**
Occult primary - Adenocarcinoma	Gemcitabine/docetaxel
Bone Cancer	Cisplatin/doxorubicin
	VDC (vincristine, doxorubicin or dactinomycin, cyclophosphamide)
Breast cancer	Docetaxel
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (taxane portion only)
	Paclitaxel every 21 days
Cervical Cancer	Cisplatin/topotecan
	Paclitaxel/cisplatin
	Topotecan
	Irinotecan
Colorectal	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Non-Hodgkin's lymphomas	GDP (gemcitabine, dexamethasone, cisplatin/carboplatin)
	CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) including regimens with pegylated liposomal doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel
	Cisplatin/vinorelbine
	Cisplatin/docetaxel
	Cisplatin/etoposide
	Carboplatin/paclitaxel
	Docetaxel
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX

Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
	BEP (bleomycin, etoposide, cisplatin)
Uterine Sarcoma	Docetaxel

National Comprehensive Cancer Network (NCCN): Hematopoietic Growth Factors, 2019.

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Ultomiris (ravulizumab-cwvz)
BILLING CODE	J1303
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— see **Dosage allowed**
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Ultomiris (ravulizumab-cwvz) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a hematologist or nephrologist; AND
2. Member has a diagnosis of aHUS supported by ALL of the following:
   a) Thrombocytopenia (platelet count < 150 x 10^9/L),
   b) Evidence of hemolysis i.e. elevated lactate dehydrogenase (LDH), low haptoglobin count, or presence of fragmented red blood cells or schistocytes on blood smear,
   c) Evidence of renal impairment (e.g. raised SCr or low eGFR); AND
3. Shiga toxin-producing E. coli related HUS (STEC-HUS) has been ruled out; AND
4. ADAMTS13 activity level is > 5% (to rule out TTP); AND
5. Member has received meningococcal vaccine.
6. **Dosage allowed:** Administered by IV infusion; loading dose followed by maintenance doses starting 2 weeks later, based on body weight, per prescribing information. See appendix at end of policy.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must demonstrate hematologic normalization as evidenced by increased platelet count or LDH maintained below upper limit of normal; AND
2. Improved or preserved kidney function.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

For **initial** authorization:

1. Medication is prescribed by or in consultation with a hematologist; AND
2. Member has a diagnosis of PNH as confirmed by flow cytometry; AND
3. Member has a lactate dehydrogenase (LDH) level >1.5x upper limit of normal (ULN); AND
4. Member has received meningococcal vaccine.
5. **Dosage allowed:** Administered by IV infusion; loading dose followed by maintenance doses starting 2 weeks later, based on body weight, per prescribing information. See appendix at end of policy.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Clinical evidence of positive response to therapy such as increased hemoglobin level, decreased need for transfusions, normalized LDH levels, improved fatigue.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Ultomiris (ravulizumab-cwvz) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/07/2019	New policy for Ultomiris created.
10/26/2019	New diagnosis of aHUS added.
06/03/2021	aHUS: Updated references. Added specialist requirement. Revised diagnostic parameters. Summarized excluded causes. Removed list of restrictions from clinical trials. Revised renewal criteria. PNH: Updated references. Removed nephrology as specialist. Removed transfusion and organ damage requirements. Updated dosing information. Reduced initial approval duration from 12 months to 6 months. Revised renewal criteria.

References:

1. Ultomiris [package insert]. Boston, MA: Alexion Pharmaceuticals, Inc., June 2021.
2. Kaplan BS, Ruebner RL, Spinale JM, Copelovitch L. Current treatment of atypical hemolytic uremic syndrome. Intractable Rare Dis Res. 2014;3(2):34-35. Doi: 10.5582/irdr.2014.01001.
3. Tanaka K, Adams B, Aris AM, et al. The long-acting C5 inhibitor, ravulizumab, is efficacious and safe in pediatric patients with atypical hemolytic uremic syndrome previously treated with eculizumab [published correction appears in Pediatr Nephrol. 2020 Dec 9;:]. *Pediatr Nephrol*. 2021;36(4):889-898. doi:10.1007/s00467-020-04774-2
4. Sawai T, Nangaku M, Ashida A, et al. Diagnostic criteria for atypical hemolytic uremic syndrome proposed by the Joint Committee of the Japanese Society of Nephrology and the Japan Pediatric Society. *Pediatr Int*. 2014;56(1):1-5. doi:10.1111/ped.12274
5. Loirat C, Fakhouri F, Ariceta G, et al. An international consensus approach to the management of atypical hemolytic uremic syndrome in children. *Pediatr Nephrol*. 2016;31(1):15-39. doi:10.1007/s00467-015-3076-8
6. Pugh D, O'Sullivan ED, Duthie FA, Masson P, Kavanagh D. Interventions for atypical haemolytic uraemic syndrome. *Cochrane Database Syst Rev*. 2021;3(3):CD012862. Published 2021 Mar 23. doi:10.1002/14651858.CD012862.pub2
7. Parker CJ. Update on the diagnosis and management of paroxysmal nocturnal hemoglobinuria. *Hematology Am Soc Hematol Educ Program*. 2016;2016(1):208-216. doi:10.1182/asheducation-2016.1.208
8. Patriquin CJ, Kiss T, Caplan S, et al. How we treat paroxysmal nocturnal hemoglobinuria: A consensus statement of the Canadian PNH Network and review of the national registry. *Eur J Haematol*. 2019;102(1):36-52. doi:10.1111/ejh.13176

9. Devos T, Meers S, Boeckx N, et al. Diagnosis and management of PNH: Review and recommendations from a Belgian expert panel. *Eur J Haematol*. 2018;101(6):737-749. doi:10.1111/ejh.13166
10. Lee JW, Sicre de Fontbrune F, Wong Lee Lee L, et al. Ravulizumab (ALXN1210) vs eculizumab in adult patients with PNH naive to complement inhibitors: the 301 study. *Blood*. 2019;133(6):530-539. doi:10.1182/blood-2018-09-876136
11. Kulasekararaj AG, Hill A, Rottinghaus ST, et al. Ravulizumab (ALXN1210) vs eculizumab in C5-inhibitor-experienced adult patients with PNH: the 302 study. *Blood*. 2019;133(6):540-549. doi:10.1182/blood-2018-09-876805

APPENDIX:

Table 1: ULTOMIRIS Weight-Based Dosing Regimen - PNH and aHUS

Body Weight Range (kg)	Loading Dose (mg)	Maintenance Dose (mg) and Dosing Interval	
5 to less than 10	600	300	Every 4 weeks
10 to less than 20	600	600	
20 to less than 30	900	2,100	Every 8 weeks
30 to less than 40	1,200	2,700	
40 to less than 60	2,400	3,000	
60 to less than 100	2,700	3,300	
100 or greater	3,000	3,600	

Effective date: 01/01/2022
Revised date: 06/03/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Uplizna (inebilizumab-cdon)
BILLING CODE	J1823
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT—1 vial every 6 months (maintenance)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Uplizna (inebilizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a diagnosis of NMOSD and is seropositive for aquaporin-4 (AQP4) IgG antibodies (documentation required); AND
4. Member has had 1 or more relapses within the past year; AND
5. Member has tried and failed at least one of the following for 6 months or longer: azathioprine, mycophenolate, rituximab[2,4,5] (requires prior auth); AND
6. Member has tested negative for hepatitis B and tuberculosis within the past year; AND
7. **Dosage allowed:** 300mg IV infusion on days 1 and 15 followed by 300mg IV infusion every 6 months.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must document disease stabilization, symptom improvement, and/or reduced frequency of relapses.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Uplizna (inebilizumab) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/02/2020	New policy for Uplizna created.

References:

1. Uplizna (inebilizumab-cdon) [package insert]. Gaithersburg, MD: Viela Bio Inc.; 2020.

2. Kessler RA, Mealy MA, Levy M. Treatment of Neuromyelitis Optica Spectrum Disorder: Acute, Preventive, and Symptomatic. *Curr Treat Options Neurol*. 2016;18(1):2. doi:10.1007/s11940-015-0387-9
3. Cree BAC, Bennett JL, Kim HJ, et al. Inebilizumab for the treatment of neuromyelitis optica spectrum disorder (N-MOmentum): a double-blind, randomised placebo-controlled phase 2/3 trial. *Lancet*. 2019;394(10206):1352-1363. doi:10.1016/S0140-6736(19)31817-3
4. Weinshenker B. Neuromyelitis Optica Spectrum Disorder. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/neuromyelitis-optica/. Published August 25, 2020. Accessed October 2, 2020.
5. Mealy MA, Wingerchuk DM, Palace J, Greenberg BM, Levy M. Comparison of relapse and treatment failure rates among patients with neuromyelitis optica: multicenter study of treatment efficacy. *JAMA Neurol*. 2014;71(3):324-330. doi:10.1001/jamaneurol.2013.5699
6. IPD Analytics. Accessed October 2, 2020.

Effective date: 10/1/2021
Revised date: 10/02/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Varubi (rolapitant)
BILLING CODE	For medical: J8670 For Rx: must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Office/Outpatient/Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include ondansetron and promethazine QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Varubi (rolapitant) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

PREVENTION OF NAUSEA AND VOMITING

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is being used in combination with a serotonin (5-HT3) receptor antagonist **and** dexamethasone in all members receiving highly or moderately emetogenic chemotherapy regimens including carboplatin (AUC ≥ 4)-containing regimens; AND
3. Member has tried and failed to respond to treatment with at least **two** preferred formulary agents for highly or moderately emetogenic chemotherapy (Chart notes or pharmacy claims required).
4. **Dosage allowed:** The recommended dosage for tablet form is 180 mg as a single dose. The recommended dosage for injectable emulsion is 166.5 mg administered as an intravenous infusion over 30 minutes. Medication must be administered prior to the initiation of each chemotherapy cycle, but at **no less than 2 week intervals**.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Varubi (rolapitant) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
01/08/2018	New policy for Varubi created.
11/19/2021	Annual review, no changes

References:

1. Varubi [package insert]. Waltham, MA; Tesaro, Inc: October, 2017.
2. Berger MJ, Ettinger DS, Aston J, et al. NCCN Guidelines® Insights. Antiemesis, Version 2.2017. Featured Updates to the NCCN Guidelines. Natl Compr Canc Netw 2017;15(7):883–893. doi:10.6004/jnccn.2017.0117.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Version 2.2017 – March 28, 2017. https://www.nccn.org/professionals/physician_gls/PDF/antiemesis.pdf.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Vigabatrin (generic for Sabril), Vigadrone
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage Allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Vigabatrin (generic for Sabril) and Vigadrone are **non-preferred** products and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

INFANTILE SPASMS (West syndrome, X-linked infantile spasms syndrome)

For **initial** authorization:

1. Member is 1 month to 2 years of age; AND
2. Medication must be prescribed by a pediatric neurologist or an epileptologist; AND
3. Member has documented diagnosis of infantile spasms; AND
4. Medication must be used as monotherapy; AND
5. Member has documentation of vision assessment at baseline (test result required or plan to have vision assessment no later than 4 weeks after starting treatment).
6. **Dosage allowed:** Initiate therapy at 50 mg/kg/day given in 2 divided doses; subsequent doses can be titrated every 3 days per package insert, up to a maximum of 150 mg/kg/day given in 2 divided doses.

If member meets all the requirements listed above, the medication will be approved for 4 weeks.

For **reauthorization**:

1. Member is 2 years of age or younger; AND
2. Chart notes demonstrate clinical benefits from the initial use of medication (e.g., reduction of spasms), which outweigh the risks of vision loss.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

REFRACTORY COMPLEX PARTIAL SEIZURES

For **initial** authorization:

1. Member is 2 years of age or older; AND
2. Medication must be prescribed by a pediatric neurologist or an epileptologist; AND
3. Member has a documented diagnosis of refractory complex partial seizures (also known as focal seizures); AND
4. Medication must be used as adjunctive therapy with other antiepileptic drugs (e.g., carbamazepine, levetiracetam, lamotrigine, etc.); AND
5. Member has documentation of trial and failure with two other antiepileptic drugs; AND

6. Member has documentation of vision assessment at baseline (test result required or plan to have vision assessment no later than 4 weeks after starting treatment).
7. **Dosage allowed:**
   a) Pediatric (2 to 16 years of age): administered in two divided doses, titrated to maintenance dose.
      i) 10 kg to 15 kg: total daily starting dose 350 mg/day; maintenance dose 1050 mg/day;
      ii) > 15 kg to 20 kg: total daily starting dose 450 mg/day; maintenance dose 1300 mg/day;
      iii) > 20 kg to 25 kg: total daily starting dose 500 mg/day; maintenance dose 1500 mg/day;
      iv) > 25 kg to 60 kg: total daily starting dose 500 mg/day; maintenance dose 2000 mg/day.
   b) Pediatric weighing more than 60 kg and adults: initial dose 1000 mg/day (500 mg twice daily), titrated up to 3000 mg/day (1500 mg twice daily).

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Chart notes demonstrate clinical benefits from the initial use of medication (e.g., reduced seizure frequency or severity), which outweigh the risks of vision loss.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers vigabatrin (generic for Sabril) and Vigadrone not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/08/2018	New policy for Sabril created. Policy placed in the new format.
01/29/2021	Changed title name to vigabatrin (generic for Sabril), added Vigadrone. Infantile Spasms: specified vision testing requirement at baseline to be either before or no more than 4 weeks after treatment started; removed documentation of vision testing during maintenance; reduced initial auth to 4 weeks and reauth to 6 months; added member's age must be younger than 2 in reauth; specified clinical benefit requirements for reauth. Complex Partial Seizure: age expanded to 2 years old (previously 10); specified vision testing requirement at baseline to be either before or no more than 4 weeks after treatment started; removed documentation of vision testing during maintenance; updated dosing; reduced initial auth to 3 months and reauth to 6 months; specified clinical benefit requirements for reauth.
11/19/2021	Annual review, no changes

References:

1. Sabril [package insert]. Deerfield, IL: Lundbeck Inc.; January 2020.
2. AAN/CNS evidence-based guideline update on medical treatment of infantile spasms. *Neurology* 2012: 78 (24): 1974 – 80. doi: 10.1212/WNL.0b013e318259e2cf.
3. Wilmshurst JM, Gaillard WD, Vinayan KP, et al. Summary of recommendations for the management of infantile seizures: Task Force Report for the ILAE Commission of Pediatrics. *Epilepsia*. 2015;56(8):1185-1197. doi:10.1111/epi.13057.
4. Nelson GR. Management of infantile spasms. *Transl Pediatr*. 2015;4(4):260-270. doi:10.3978/j.issn.2224-4336.2015.09.01.
5. Management and prognosis of infantile spasms. Daniel G Glaze. UpToDate [online database]. Available from: http://www.uptodate.com
6. Go CY, Mackay MT, Weiss SK, et al. Evidence-based guideline update: Medical treatment of infantile spasms. Report of the Guideline Development Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society. *Neurology*. 2012; 78(24): 1974 – 1980.
7. Hancock EC, Osborne JP, Edwards SW. Treatment of infantile spasms. *Cochrane Database Syst Rev*. 2013.

8. Dean C, Mosier M, Penry K. Dose-response study of vigabatrin as add-on therapy in patients with uncontrolled complex partial seizures. *Epilepsia*. 1999;40(1):74-82.
9. Waterhouse EJ, Mims KN, Gowda SN. Treatment of refractory complex partial seizures: role of vigabatrin. *Neuropsychiatr Dis Treat*. 2009;5:505-515.
10. Treiman DM. Management of refractory complex partial seizures: current state of the art. *Neuropsychiatr Dis Treat*. 2010;6:297-308. Published 2010 Jun 24.
11. Nielsen JC, Tolbert D, Patel M, et al. Vigabatrin pediatric dosing information for refractory complex partial seizures: results from a population dose-response analysis. *Epilepsia*. 2014;55(12):e134-e138.
12. Krauss GL, Sperling MR. Treating patients with medically resistant epilepsy [published correction appears in Neurol Clin Pract. 2012 Mar;2(1):4]. *Neurol Clin Pract*. 2011;1(1):14-23.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Viltepso (viltolarsen)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Viltepso (viltolarsen) is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. This is the second FDA-approved treatment for patients with this specific type of mutation, following the approval of Vyondys (golodirsen). Similar to the other exon-skipping agents, Viltepso has been shown to increase dystrophin production in skeletal muscle. However, the increased levels of dystrophin may or may not result in an improvement of functional outcomes. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Viltepso (viltolarsen) will be considered for coverage when the following criteria are met:

DUCHENNE MUSCULAR DYSTROPHY (DMD)

For **initial** authorization:

1. Member has a diagnosis of DMD with confirmed mutation of DMD gene that is amenable to exon 53 skipping (genetic testing results required); AND
2. Medication is being prescribed by or in consultation with a DMD specialist (i.e., neurologist); AND
3. Member is currently stable on corticosteroid for at least 6 months prior to starting therapy with Viltepso, unless not tolerated or contraindicated; AND
4. Chart notes have been provided to show that the member is able to walk independently without assistive devices.
5. **Dosage allowed/Quantity limit:** 80 mg/kg IV weekly.

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show stability or slowed rate of decline of the member's motor function compared to baseline; AND
2. Chart notes confirm that member remains able to walk independently without assistive devices.

If all the above requirements are met, the medication will be approved for an additional 6 months.

CareSource considers Viltepso (viltolarsen) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
01/06/2021	New policy for Viltepso created.

04/06/2021	Increased duration of steroid trial to 6 months.

References:

1. Viltepso [package insert]. Paramus, NJ; NS Pharma, Inc. August 2020.
2. Clemens PR, Rao VK, Connolly AM, et al. Safety, Tolerability, and Efficacy of Viltolarsen in Boys With Duchenne Muscular Dystrophy Amenable to Exon 53 Skipping: A Phase 2 Randomized Clinical Trial [published correction appears in doi: 10.1001/jamaneurol.2020.2025]. *JAMA Neurol*. 2020;77(8):982-991.
3. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management [published correction appears in Lancet Neurol. 2018 Apr 4;:]. *Lancet Neurol*. 2018;17(3):251-267.
4. Gloss D, Moxley RT 3rd, Ashwal S, Oskoui M. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(5):465-472.

Effective date: 10/1/2021
Revised date: 04/06/2021

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Vimizim (elosulfase alfa)
BILLING CODE	J1322
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Home/Office/Outpatient
STATUS	Prior Authorization Required

Vimizim is an enzyme replacement therapy that was approved by the FDA in 2014 for the treatment of Mucopolysaccharidosis type IVA, also known as MPS IVA or Morquio A syndrome. MPS IVA is a rare, genetic lysosomal storage disease. Pathogenic mutations of the GALNS gene cause the enzyme N-acetylgalactosamine-6-sulfatase (GALNS) to be deficient or absent. Normally this lysosomal enzyme breaks down glycosaminoglycans (GAGs) (previously known as mucopolysaccharides) but when it is reduced in MPS IVA, the GAG substrates keratan sulfate (KS) and chondroitin-6-sulfate (C6S) accumulate throughout the body to cause cellular, tissue, and organ dysfunction, notably skeletal deformities. Vimizim provides an exogenous source of N-acetylgalactosamine-6-sulfatase.

Vimizim (elosulfase alfa) will be considered for coverage when the following criteria are met:

Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome)

For **initial** authorization:

1. Medication must be prescribed by or in consultation with a geneticist, metabolic specialist, or pediatrician experienced with managing mucopolysaccharidoses; AND
2. Member has a diagnosis of MPS IVA confirmed by at least one of the following:
   a) Low GALNS enzyme activity AND normal activity of a second sulfatase (to exclude Multiple Sulfatase Deficiency), and/or
   b) Molecular genetic testing identifies pathogenic GALNS gene mutations; AND
3. Documentation of baseline urinary KS (uKS) level.
4. **Dosage allowed/Quantity limit:** 2 mg/kg IV infusion once weekly

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show improvement or stabilized signs and symptoms of disease such as improved endurance (e.g., 6-minute walk test) and/or reduced uKS levels.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Vimizim (elosulfase alfa) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/20/2021	New policy for Vimizim created.

References:

1. Vimizim [package insert]. Novato, CA: BioMarin Pharmaceutical, Inc; 2019.
2. Akyol MU, Alden TD, Amartino H, et al. Recommendations for the management of MPS IVA: systematic evidence- and consensus-based guidance. Orphanet J Rare Dis. 2019;14(1):137. Published 2019 Jun 13. doi:10.1186/s13023-019-1074-9
3. Regier DS, Oetgen M, Tanpaiboon P. Mucopolysaccharidosis Type IVA. 2013 Jul 11 [Updated 2021 Jun 17]. In: Adam MP, Ardinger HH, Pagon RA, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2021. Available from: https://www.ncbi.nlm.nih.gov/books/NBK148668/
4. Wood TC, Harvey K, Beck M, et al. Diagnosing mucopolysaccharidosis IVA. *J Inherit Metab Dis*. 2013;36(2):293-307. doi:10.1007/s10545-013-9587-1
5. Jones SA, Bialer M, Parini R, et al. Safety and clinical activity of elosulfase alfa in pediatric patients with Morquio A syndrome (mucopolysaccharidosis IVA) less than 5 y. *Pediatr Res*. 2015;78(6):717-722. doi:10.1038/pr.2015.169
6. Cleary M, Davison J, Gould R, et al. Impact of long-term elosulfase alfa treatment on clinical and patient-reported outcomes in patients with mucopolysaccharidosis type IVA: results from a Managed Access Agreement in England. *Orphanet J Rare Dis*. 2021;16(1):38. Published 2021 Jan 21. doi:10.1186/s13023-021-01675-x
7. Hendriksz CJ, Burton B, Fleming TR, et al. Efficacy and safety of enzyme replacement therapy with BMN 110 (elosulfase alfa) for Morquio A syndrome (mucopolysaccharidosis IVA): a phase 3 randomised placebo-controlled study. *J Inherit Metab Dis*. 2014;37(6):979-990. doi:10.1007/s10545-014-9715-6

Effective date: 01/01/2022
Revised date: 07/20/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Visudyne (verteporfin)
BILLING CODE	J3396
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
STATUS	Prior Authorization Required

Visudyne is a light activated drug used in photodynamic therapy to treat certain cases of choroidal neovascularization (CNV). A course of therapy is a 2-step process. First Visudyne is administered. Second, Visudyne is activated with light from a nonthermal diode laser. Photoactivation of Visudyne is controlled by the light dose delivered. Patients must avoid exposure of skin or eyes to direct sunlight or bright indoor light for 5 days following the procedure.
CNV is the creation of new blood vessels in the choroid layer of the eye and can lead to vision loss. Age-related macular degeneration is the most common cause of CNV.

Visudyne (verteporfin) will be considered for coverage when the following criteria are met:

Choroidal Neovascularization (CNV)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a documented diagnosis of predominantly classic subfoveal choroidal neovascularization (CNV) due to one of the following:
   a) "Wet" age-related macular degeneration (AMD)
   b) Pathologic myopia
   c) Presumed ocular histoplasmosis; AND
4. Trial and failure of bevacizumab; AND
5. Member does NOT have predominantly occult subfoveal CNV.
6. **Dosage allowed/Quantity limit:** 6 mg/m^2 body surface area IV

If all the above requirements are met, the medication will be approved for 3 months (1 dose per eye).

For **reauthorization**:
1. Chart notes must document positive clinical response (e.g., slowed progression of vision loss) following photodynamic treatment; AND
2. Choroidal neovascular leakage has recurred as detected on fluorescein angiography (FA) or optical coherence tomography (OCT).

If all the above requirements are met, the medication will be approved for an additional 3 months (1 dose per eye).

CareSource considers Visudyne (verteporfin) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
10/19/2021	New policy created for Visudyne.

References:

1. Visudyne [prescribing information]. Bausch & Lomb; 2021.
2. Soubrane G, Bressler NM. Treatment of subfoveal choroidal neovascularisation in age related macular degeneration: focus on clinical application of verteporfin photodynamic therapy. *Br J Ophthalmol*. 2001;85(4):483-495. doi:10.1136/bjo.85.4.483
3. Fenton C, Perry CM. Verteporfin: a review of its use in the management of subfoveal choroidal neovascularisation. *Drugs Aging*. 2006;23(5):421-445. doi:10.2165/00002512-200623050-00006
4. Wormald R, Evans J, Smeeth L, Henshaw K. Photodynamic therapy for neovascular age-related macular degeneration. *Cochrane Database Syst Rev*. 2007;(3):CD002030. Published 2007 Jul 18. doi:10.1002/14651858.CD002030.pub3
5. Flaxel CJ, Adelman RA, Bailey ST, et al. Age-Related Macular Degeneration Preferred Practice Pattern® [published correction appears in Ophthalmology. 2020 Sep;127(9):1279]. *Ophthalmology*. 2020;127(1):P1-P65. doi:10.1016/j.ophtha.2019.09.024
6. Zhu Y, Zhang T, Xu G, Peng L. Anti-vascular endothelial growth factor for choroidal neovascularisation in people with pathological myopia. *Cochrane Database Syst Rev*. 2016;12(12):CD011160. Published 2016 Dec 15. doi:10.1002/14651858.CD011160.pub2

Effective date: 04/01/2022
Revised date: 10/19/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Mavyret and Sofosbuvir/velpatasvir (generic for Epclusa) QUANTITY LIMIT— 28 for a 28 day supply
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Vosevi (sofosbuvir/velpatasvir/voxilaprevir) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEPATITIS C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A)

For **initial** authorization:

1. Member is treatment-experienced, without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
2. Member must be 18 years of age or older; AND
3. Member has genotype 1, 2, 3, 4, 5, or 6 (laboratory documentation required) and have previously been treated with an HCV regimen containing an NS5A inhibitor; OR
4. Member has genotype 1a or 3 (laboratory documentation required) and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor; AND
5. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
6. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
7. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
8. Member has evidence of liver fibrosis stage 3 or 4 confirmed by liver biopsy, or elastography only (lab chart notes required) unless one of the following (fibrosis stage F0-4 covered):
   a) Hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation);
   b) Post liver transplantation;
   c) Extrahepatic disease (i.e., kidney disease: proteinuria, nephrotic syndrome or membranoproliferative glomerulonephritis; cryoglobulinemia with end- organ manifestations (e.g., vasculitis));
   d) HIV or HBV coinfection.
9. **Dosage allowed:** One tablet once daily for 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 12 weeks.

For **reauthorization**:
1. Vosevi will not be reauthorized.

CareSource considers Vosevi (sofosbuvir/velpatasvir/voxilaprevir) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
12/17/2018	New policy for Vosevi created. Criteria written based Ohio Department of Medicaid requirements.
05/01/2019	Sofosbuvir/velpatasvir (generic for Epclusa) trial added.
03/11/2021	Annual review, no changes

References:

1. Vosevi [package Insert]. Foster City, CA: Gilead Sciences, Inc.; November, 2017.
2. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
3. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Vumerity (diroximel fumarate)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 30-day Starter dose bottle (bottle of 106 capsules), 30-day Maintenance dose bottle (bottle of 120 capsules)
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Vumerity (diroximel fumarate) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

RELAPSING-REMITTING MULTIPLE SCLEROSIS, CLINICALLY ISOLATED SYNDROME, ACTIVE SECONDARY PROGRESSIVE DISEASE

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by, or in consultation with, or under the guidance of a neurologist; AND
3. Chart notes have been provided confirming diagnosis of Multiple Sclerosis;
4. Baseline of complete blood cell count (CBC), including lymphocyte count, serum aminotransferase, alkaline phosphatase, and total bilirubin levels must be submitted with chart notes.
5. **Dosage allowed:** Starting dose: 231 mg twice a day, orally, for 7 days. Maintenance dose after 7 days: 462 mg (administered as two 231 mg capsules) twice a day, orally.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. A complete blood cell count (CBC), including lymphocyte count, serum aminotransferase, alkaline phosphatase, and total bilirubin levels must be submitted with chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Vumerity (diroximel fumarate) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
11/12/2019	New policy for Vumerity created.
09/16/2021	Annual review, no changes

References:

1. Vumerity [prescribing information]. Cambridge, MA; Biogen, Inc; October 2019.
2. Goodin DS, Frohman EM, Garmany GP Jr, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002 Jan;58(2):169-78.
3. Polman CH, Reingold SC, Banwell B, et al. Diagnostic criteria for multiple sclerosis: 2010 Revisions to the McDonald criteria. Annals of Neurology. 2011;69(2):292-302. doi:10.1002/ana.22366.
4. Naismith, Robert T., et al. "Diroximel fumarate (DRF) in patients with relapsing–remitting multiple sclerosis: Interim safety and efficacy results from the phase 3 EVOLVE-MS-1 study." Multiple Sclerosis Journal (2019): 1352458519881761.
5. Arnold, Douglas L., et al. "Diroximel Fumarate (DRF) in Patients With Relapsing-Remitting Multiple Sclerosis: Interim Efficacy and Safety Results From the Phase 3 EVOLVE-MS-1 Study (P3. 2-060)." (2019): P3-2.
6. Palte, Michael J., et al. "Improving the gastrointestinal tolerability of fumaric acid esters: Early findings on gastrointestinal events with diroximel fumarate in patients with relapsing-remitting multiple sclerosis from the phase 3, open-label EVOLVE-MS-1 Study." Advances in therapy (2019): 1-12.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Vyepti (eptinezumab-jjmr)
BILLING CODE	J3032
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 300mg (3 vials) per 90 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Vyepti (eptinezumab-jjmr) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHRONIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by a neurologist or a headache specialist; AND
3. Medication is being prescribed for the prevention of chronic migraine, defined as **both** of the following and must be documented in chart notes:
   a) ≥ 15 headache days per month for at least 3 months;
   b) ≥ 8 migraine days per month for at least 3 months; AND
4. Member has tried and failed 2 quarterly injections (6 months) of onabotulinumtoxinA (Botox); OR
5. Member has tried and failed or unable to tolerate **two** prophylactic medications from the following groups for 2 months per trial:
   a) Beta-blockers (e.g., metoprolol, timolol, or propranolol);
   b) Calcium channel blockers (e.g., verapamil);
   c) Antidepressants (e.g., amitriptyline or venlafaxine);
   d) Anticonvulsant medications (e.g., topiramate or valproic acid); AND
6. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month);
7. If the dosage requested is 300mg, member must have a 3-month trial and failure for each of **two** of the following drugs: Aimovig (erenumab), Emgality (galcanezumab), or Ajovy (fremanezumab) AND a 3-month trial of the 100mg Vyepti dose; AND
8. Member does not have ANY of the following:
   a) Member was older than 50 years of age when first diagnosed with migraines;
   b) Active medication-overuse headache, cluster headache, or hemiplegic migraine;
   c) Concurrent use with botulinum toxin injection or any other prophylactic CGRP products (e.g., Ajovy, Aimovig, Emgality).
9. **Dosage allowed:** 100mg administered intravenously every 3 months. A dose of 300mg may also be used. No evidence is established for any other dosages.

Note: Vyepti is considered experimental and investigational as combination therapy with Botox, Aimovig, Ajovy, or Emgality because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member is in compliance with all other initial criteria; AND
2. If the request is for a dosage increase to 300mg, member must have a 3-month trial and failure for each of **two** of the following drugs: Aimovig (erenumab), Emgality (galcanezumab), or Ajovy (fremanezumab), unless not tolerated or contraindicated; AND
3. Chart notes have been provided showing improvement in migraine frequency and severity (e.g., reduced migraine days, reduced use of medications for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

EPISODIC MIGRAINE HEADACHE PROPHYLAXIS

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by a neurologist or a headache specialist; AND
3. Medication is being prescribed for prevention of episodic migraine, defined as **both** of the following and must be documented in chart notes:
    a. ≤ 14 headache days per month for at least 3 months;
    b. 4 or more migraine days per month for at least 3 months that cause significant impairment to quality of life (i.e. requiring bed rest, missed school/work); AND
4. Member has tried and failed or unable to tolerate **three** prophylactic medications from the following groups for 2 months per trial:
    a. Beta-blockers (e.g., metoprolol, timolol, or propranolol);
    b. Calcium channel blockers (e.g., verapamil);
    c. Antidepressants (e.g., amitriptyline or venlafaxine);
    d. Anticonvulsant medications (e.g., topiramate or valproic acid); AND
5. Member has tried and failed or unable to tolerate **two** of the following abortive therapeutic options: ergotamine, triptans, combination analgesics, or simple analgesics (at least one trial must be a triptan drug) for 2 months per trial (for at least 8 days per month);
6. If the dosage requested is 300mg, member must have a 3-month trial and failure for each of **two** of the following drugs: Aimovig (erenumab), Emgality (galcanezumab), or Ajovy (fremanezumab) AND a 3-month trial of the 100mg Vyepti dose; AND
7. Member does not have ANY of the following:
    a. Member was older than 50 years of age when first diagnosed with migraines;
    b. Active medication-overuse headache, cluster headache, or hemiplegic migraine;
    c. Concurrent use with botulinum toxin injection or any other prophylactic CGRP products (e.g., Ajovy, Aimovig, Emgality).
8. **Dosage allowed:** 100mg administered intravenously every 3 months. A dose of 300mg may also be used. No evidence is established for any other dosages.

Note: Vyepti is considered experimental and investigational as combination therapy with Botox, Aimovig, Ajovy, or Emgality because the safety and effectiveness of these combinations has not been established.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member is in compliance with all other initial criteria; AND
2. If the request is for a dosage increase to 300mg, member must have a 3-month trial and failure for each of **two** of the following drugs: Aimovig (erenumab), Emgality (galcanezumab), or Ajovy (fremanezumab), unless not tolerated or contraindicated; AND
3. Chart notes have been provided showing improvement in migraine frequency and severity (e.g., reduced migraine days, reduced use of medications for acute migraines attacks).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Vyepti (eptinezumab-jjmr) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/22/2020	New policy for Vyepti created.

References:

1. VYEPTI [package insert]. Deerfield, IL: Lundbeck Seattle BioPharmaceuticals, Inc.
2. Ashina M, Saper J, Cady R, Schaeffler B, Biondi D, Hirman J, Pederson S, Allan B, Smith J. Eptinezumab in episodic migraine: the randomized, double-blind, placebo-controlled PROMISE-1 study. *Cephalalgia*. 2020 Mar; 40(3):241-254.
3. Buse D, Manack A, Serrano D, et al. Headache impact of chronic and episodic migraine: results from the American Migraine Prevalence and Prevention study. Headache. 2012;52(1):3-17. doi:10.1111/j.1526-4610.2011.02046.x
4. Lipton RB, Goadsby PJ, Smith J, Schaeffler BA, Biondi DM, Hirman J, Pederson S, Allan B, Cady R. Efficacy and safety of eptinezumab in patients with chronic migraine. PROMISE-2. *Neurology*. 2020 Mar 31; 94(13):e31364-e1377.
5. Silberstein SD, Holland S, Freitag F, et al. Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults. Neurology Apr 2012, 78 (17) 1337-1345.
6. Headache Classification Committee of the International Headache Society (IHS) The International Classification of Headache Disorders. *Cephalalgia*. 2018 Jan;38(1):1-211.
7. Aimovig [package insert]. Thousand Oaks, CA: Amgen Inc.; May 2018.
8. Ajovy [package insert]. North Wales, PA: Teva Pharmaceuticals USA, Inc; January 2019.
9. Emgality [package insert]. Indianapolis, IN: Eli Lilly and Company; September, 2018.
10. The American Headache Society Position Statement on Integrating New Migraine Treatments into Clinical Practice. Headache: The Journal of Head and Face Pain. 2019;59: 1-18.

Effective date: 07/20/2020
Revised date: 05/22/2020

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Vyndaqel (tafamidis meglumine) and Vyndamax (tafamidis)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Vyndaqel(tafamidis meglumine) and Vyndamax(tafamidis) are **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CARDIOMYOPATHY OF WILD TYPE OR HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (ATTR-CM)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a cardiologist or a physician who specializes in the treatment of amyloidosis (e.g., hematologist, geneticist, etc.); AND
3. Member has diagnosis of ATTR-CM confirmed by ALL of the following:
   a) The demonstration of amyloid deposits via tissue biopsy or via cardiac pyrophosphate imaging;
   b) Genetic testing confirming TTR gene mutation for hereditary ATTR-CM or immunohistochemical analysis, scintigraphy, or mass spectrometry confirming presence of transthyretin precursor proteins for wild type ATTR-CM;
   c) Documentation of MRI or ECG results confirming cardiac involvement or medical history of Heart Failure (HF) with at least 1 prior hospitalization for HF or clinical evidence of HF (without hospitalization) manifested by signs or symptoms of volume overload or elevated intracardiac pressures (e.g., elevated jugular venous pressure, shortness of breath or signs of pulmonary congestion on x-ray or auscultation, peripheral edema) that required/requires treatment with a diuretic for improvement; AND
4. Documented baseline of 6-minute walk test; AND
5. Member does **not** have ANY of the following:
   a) A New York Heart Association (NYHA) classification of IV;
   b) Presence of primary (light chain) amyloidosis;
   c) Prior liver or heart transplantation or implanted cardiac mechanical assist device; AND
6. Member is not receiving Vyndagel and/or Vyndamax with Tegsedi or Onpattro.
7. **Dosage allowed**: Vyndaqel 80 mg orally once daily, or Vyndamax 61 mg orally once daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease (e.g., distance walked on 6-minute walk improved, reduced the decline in functional capacity and quality of life, cardiovascular-related hospitalizations decreased); AND
3. Member is not receiving Vyndagel and/or Vyndamax with Tegsedi or Onpattro.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Vyndaqel (tafamidis meglumine) and Vyndamax (tafamidis) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Primary amyloidosis

DATE	ACTION/DESCRIPTION
08/08/2019	New policy for Vyndaqel (tafamidis meglumine) and Vyndamax (tafamidis) created.
07/21/2020	Expanded prescriber to include physicians who specialize in treating amyloidosis.
06/10/2021	Annual review, no changes

References:

1. Vyndaqel and Vydamax [package insert]. New York, NY: Pfizer Labs.; May 2019.
2. ClinicalTrials.gov Identifier: NCT01994889. Safety and Efficacy of Tafamidis in Patients With Transthyretin Cardiomyopathy (ATTR-ACT). Available at: https://www.clinicaltrials.gov/ct2/show/NCT01994889?term=NCT01994889&rank=1.
3. Maurer MS, Schwartz JH, Gundapaneni B, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med. 2018 Sep 13; 379(11):1007-1016.
4. Shintani Y, et al. Monitoring treatment response to tafamidis by serial native T1 and extracellular volume in transthyretin amyloid cardiomyopathy. ESC Heart Fail. 2019;6(1):232–236.
5. Maurer MS, et al. Tafamidis in Transthyretin Amyloid Cardiomyopathy.Effects on Transthyretin Stabilization and Clinical Outcomes. Heart Failure. 2015;8:519–526.
6. Bokhari S, et al. (99m)Tc-pyrophosphate scintigraphy for differentiating light-chain cardiac amyloidosis from the transthyretin-related familial and senile cardiac amyloidoses. Circ Cardiovasc Imaging. 2013;6(2):195–201.
7. Brown EE, et al. Genetic testing improves identification of transthyretin amyloid (ATTR) subtype in cardiac amyloidosis. Amyloid. 2017 Jun;24(2):92-95.

Effective date: 01/01/2022
Revised date: 06/10/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Vyondys 53 (golodirsen)
BILLING CODE	J1429 (1 unit = 10 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Office/Home
COVERAGE REQUIREMENTS	Prior authorization required (Non-Preferred Product) QUANTITY LIMIT – see dosage allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Vyondys 53 (golodirsen) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

DUCHENNE MUSCULAR DYSTROPHY (DMD)

For **initial** authorization:

1. Member has a diagnosis of DMD with confirmed mutation of DMD gene that is amenable to exon 53 skipping (genetic testing results required); AND
2. Medication is being prescribed by or in consultation with a DMD specialist (i.e., neurologist); AND
3. Member is currently stable on corticosteroid for at least 6 months prior to starting therapy, unless not tolerated or contraindicated; AND
4. Member has had a 90-day trial and failure of, or contraindication to Viltepso; AND
5. Chart notes have been provided to show that the member is able to walk independently without assistive devices.
6. **Dosage allowed**: 30 mg per kg of body weight once weekly.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show stability or slowed rate of decline of the member's motor function compared to baseline; AND
2. Chart notes confirm that member remains able to walk independently without assistive devices.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Vyondys 53 (golodirsen) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
1/21/2020	New policy for Vyondys 53 created.
06/17/2020	Length of corticosteroid trial specified to be at least 3 months. Age requirement removed.
01/14/2021	Added prescriber requirement. Simplified ambulatory requirement. Added requirement of stability or slowed rate of decline of motor function in reauth section. Added a trial of Viltepso.

CareSource

04/06/2021	Increased duration of steroid trial to 6 months.

References:

1. Vyondys 53 [Package Insert]. Cambridge, MA: Sarepta Therapeutics, Inc.; August 2020.
2. Sarepta Therapeutics, Inc. Phase I/II Study of SRP-4053 in DMD Patients. NLM Identifier: NCT02310906.
3. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management [published correction appears in Lancet Neurol. 2018 Apr 4;:]. *Lancet Neurol*. 2018;17(3):251-267.
4. Gloss D, Moxley RT 3rd, Ashwal S, Oskoui M. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(5):465-472.
5. Frank DE, Schnell FJ, Akana C, et al. Increased dystrophin production with golodirsen in patients with Duchenne muscular dystrophy. *Neurology*. 2020;94(21):e2270-e2282. doi:10.1212/WNL.0000000000009233

Effective date: 10/1/2021
Revised date: 04/06/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Wakix (pitolisant)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 60 tablets per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Wakix (pitolisant) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

NARCOLEPSY WITH EXCESSIVE DAYTIME SLEEPINESS (EDS)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or sleep specialist; AND
3. Member has a diagnosis of narcolepsy confirmed by sleep studies: polysomnogram and MSLT (multiple sleep latency test); AND
4. Member has symptoms of excessive sleepiness not attributed to other factors such as insufficient sleep, irregular sleep schedule, co-existent sleep disorder, medications or other substances; AND
5. Member's current score on the Epworth sleepiness scale (ESS) is documented in chart notes; AND
6. Member has tried and failed or did not tolerate the following, at max tolerated dose, for at least 30 days each: modafinil or armodafinil, AND Sunosi; AND
7. Member does not have ANY of the following:
   a) Severe hepatic impairment;
   b) End stage renal disease;
   c) QT interval prolongation or cardiac arrythmia.
8. **Dosage allowed:** Up to 2 tablets per day; max daily dose of 35.6mg (Two 17.8mg tablets once daily).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show the member has an improved score on the Epworth sleepiness scale, and/or chart notes have been provided that show the member has improved signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

NARCOLEPSY WITH CATAPLEXY

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or sleep specialist; AND
3. Member must have a diagnosis of narcolepsy with cataplexy confirmed by sleep studies: polysomnogram and MSLT (multiple sleep latency test); AND
4. Member's current score on the Epworth Sleepiness Scale and baseline number of cataplexy attacks must be documented; AND
5. Member must have, unless specifically contraindicated, a compliant trial and failure of at least **one** of the following cataplexy treatments for no less than 30 days each: a tricyclic antidepressant (such as clomipramine), selective serotonin reuptake inhibitor (such as fluoxetine), or serotonin-norepinephrine reuptake inhibitor (such as venlafaxine); AND
6. Member does not have ANY of the following:
   a) Severe hepatic impairment;
   b) End stage renal disease;
   c) QT interval prolongation or cardiac arrythmia.
7. **Dosage allowed:** Up to 2 tablets per day; max daily dose of 35.6mg (Two 17.8mg tablets once daily).

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes must show decreased frequency and/or severity of cataplexy attacks.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Wakix (pitolisant) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
5/21/2020	New policy for Wakix created.
11/12/2020	Added criteria for label update with cataplexy.
02/01/2021	For cataplexy, changed from trial and failure of 2 antidepressants to 1.

References:

1. Wakix [package insert]. Plymouth Meeting, PA: Harmony Biosciences, LLC; 2020.
2. Wakix. Micromedex Solutions. Greenwood Village, CO: Truven Health Analytics. http://micromedex.com/. Updated April 15, 2020. Accessed May 13, 2020.
3. Dauvilliers Y, Bassetti C, Lammers GJ, et al: Pitolisant versus placebo or modafinil in patients with narcolepsy: a double-blind, randomised trial. *Lancet Neurol* 2013; 12(11):1068-1075.
4. Dauvilliers Y, Arnulf I, Szakacs Z, Leu-Semenescu S, Lecomte I, Scart-Gres C, Lecomte JM, Schwartz JC; HARMONY III study group. Long-term use of pitolisant to treat patients with narcolepsy: Harmony III Study. *Sleep*. 2019 Oct 21;42(11). pii: zsz174. doi: 10.1093/sleep/zsz174
5. IPD analytics. Accessed May 13, 2020.
6. Lehert P, Falissard B. Multiple treatment comparison in narcolepsy: a network meta-analysis. *Sleep*. 2018;41(12). doi:10.1093/sleep/zsy185
7. Morgenthaler TI, Kapur VK, Brown TM, et al. Practice Parameters for the Treatment of Narcolepsy and other Hypersomnias of Central Origin. *Sleep*. 2007;30(12):1705-1711. doi:10.1093/sleep/30.12.1705
8. Scammell TE. Narcolepsy. *N Engl J Med*. 2015;373(27):2654-2662. doi:10.1056/NEJMra1500587
9. Szakacs Z, Dauvilliers Y, Mikhaylov V, et al. Safety and efficacy of pitolisant on cataplexy in patients with narcolepsy: a randomised, double-blind, placebo-controlled trial. *Lancet Neurol*. 2017;16(3):200-207. doi:10.1016/S1474-4422(16)30333-7

Effective date: 01/01/2022
Revised date: 02/01/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Xeljanz/Xeljanz XR (tofacitinib)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Xeljanz/Xeljanz XR (tofacitinib) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (pcJIA) – XELJANZ immediate-release only

For **initial** authorization:

1. Member must be 2 years of age or older;
2. Member has a confirmed diagnosis of active pcJIA; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Medication must be prescribed by or in consultation with a rheumatologist; AND
5. Member has had an adequate trial and failure of a non-biologic DMARD (e.g., methotrexate, leflunomide, etc.) for 8 weeks, unless not tolerated or contraindicated; AND
6. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm^3), lymphopenia (ALC <500 cells/mm^3), or anemia (Hg < 9 g/dL).
7. **Dosage allowed:**
   a) 10 kg to 19 kg: 3.2 mg (3.2 mL oral solution) twice daily;
   b) 20 kg to 39 kg: 4 mg (4 mL oral solution) twice daily;
   c) 40 kg or higher: 5 mg (one 5 mg tablet or 5 mL oral solution) twice daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource

PSORIATIC ARTHRITIS (PsA)

For **initial** authorization:

1. Member must be 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a rheumatologist or dermatologist; AND
3. Member has a documented diagnosis of active psoriatic arthritis (PsA); AND
4. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
5. Member has met a 4-week trial of an NSAID taken at maximally tolerated doses AND a 3-month trial of a non-biologic DMARD agent (e.g., methotrexate, sulfasalazine, cyclosporine, etc.) unless **one** of the following situations is met:
   a) Non-biologic DMARD is not required for:
      i) Concomitant axial disease (i.e., involving sacroiliac joint and spine) or enthesitis; OR
   b) NSAID and non-biologic DMARD are not required for:
      i) Severe PsA (defined as having at least one of the following: erosive disease, active PsA at many sites including dactylitis or enthesitis, elevated levels of ESR or CRP, joint deformities, or major impairment in quality of life); AND
6. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm^3), lymphopenia (ALC <500 cells/mm^3), or anemia (Hg < 9 g/dL).
7. **Dosage allowed:** Xeljanz is 5 mg twice daily; Xeljanz XR is 11 mg once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

RHEUMATOID ARTHRITIS (RA)

For **initial** authorization:

1. Member must be 18 years of age or older with moderately to severely active RA; AND
2. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
3. Medication must be prescribed by or in consultation with a rheumatologist; AND
4. Member must have a trial and failure of, or intolerance to methotrexate and **one** other non-biologic DMARD (i.e., hydroxychloroquine, sulfasalazine, and leflunomide) for 3 months per trial, either together or separately; AND
   Note: only one non-biologic DMARD is required if member has a poor prognostic factor such as high swollen joint count, presence of early joint erosions, presence of autoantibodies (RF and/or ACPA).
5. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm^3), lymphopenia (ALC <500 cells/mm^3), or anemia (Hg < 9 g/dL).
6. **Dosage allowed:** Xeljanz is 5 mg twice daily; Xeljanz XR is 11 mg once daily.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes demonstrate improvement of RA signs and symptoms (e.g. fewer number of painful and swollen joints, achievement of remission, slowed progression of joint damage, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

ULCERATIVE COLITIS (UC)

For **initial** authorization:

1. Member is 18 years of age or older with moderately to severely active UC; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Must have a documented negative TB test (i.e., tuberculosis skin test (PPD), interferon-gamma release assay (IGRA)) within 12 months prior to starting therapy; AND
4. Member must have a documented history of inadequate response or intolerance to a tumor necrosis factor (TNF) blocker (e.g., Remicade, Humira, Simponi); AND
5. Member does not have any laboratory abnormalities indicating neutropenia (ANC <1000 cells/mm^3), lymphopenia (ALC <500 cells/mm^3), or anemia (Hg < 9 g/dL).
6. **Dosage allowed:**
   a) Xeljanz:
      i) Induction: 10 mg twice daily for at least 8 weeks or up to 16 weeks. Discontinue after 16 weeks if adequate therapeutic response is not achieved.
      ii) Maintenance: 5 mg twice daily.
   b) Xeljanz XR:
      i) Induction: 22 mg once daily for at least 8 weeks or up to 16 weeks. Discontinue after 16 weeks if adequate therapeutic response is not achieved.
      ii) Maintenance: 11 mg once daily.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided showing improvement in signs and symptoms of UC (defined as clinical remission, decrease in rectal bleeding, decreased corticosteroid use, etc.).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Xeljanz/Xeljanz XR (tofacitinib) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/10/2017	New policy for Xeljanz/Xeljanz XR created. Policy SRx-0042 archived. For diagnosis of RA: trial of Humira and Enbrel required. List of diagnoses considered not medically necessary was added.
02/05/2018	New indication of Psoriatic Arthritis (PsA) was added.
09/14/2018	New indication of Ulcerative Colitis was added. Requirements on axial disease type removed from PsA.
02/26/2019	Humira and Enbrel removed from trials requirement. Initial authorization length increased to 12 months for UC. TB test allowed to be done within 12 months prior to initiation of therapy; chest x-ray option removed. References updated. Other drugs options allowed for PsA if there is an intolerance or contraindication to methotrexate.
08/06/2019	For diagnosis of UC, treatment options of immunomodulators, corticosteroids and salicylates were removed.
10/06/2020	New diagnosis polyarticular course juvenile idiopathic arthritis (pcJIA) added. Replaced list of excluded diagnoses with the generic statement. Updated references. For all diagnoses: Removed repeat TB in reauth for all diagnoses. Added member does not have neutropenia, anemia, or lymphopenia.

	For PsA: Added requirement of diagnosis of PsA. Allowed coverage of axial disease with trial of NSAID. Changed length of trials to be 4 weeks of NSAID and 3 months of non-biologic DMARD. For RA: Changed the trials to require methotrexate as one of the non-biologic DMARD trials; only one trial is needed if member has poor prognostic factors. For UC: removed Mayo score in diagnosis. Removed requirement that exclude Crohn's disease symptoms.

References:

1. Xeljanz [package insert]. New York, NY: Pfizer; October, 2020.
2. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guidelines for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Care Res* (Hoboken). 2019 Jun;71(6):717-734.
3. ClinicalTrials.gov. Identifier: NCT02592434. Efficacy study of Tofacitinib in pediatric JIA population. Available at: https://clinicaltrials.gov/ct2/show/NCT02592434.
4. Mistry RR, Patro P, Agarwal V, Misra DP. Enthesitis-related arthritis: current perspectives. *Open Access Rheumatol*. 2019;11:19-31. Published 2019 Jan 25
5. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the treatment of Psoriatic Arthritis. *Arthritis Rheumatol*. 2019 Jan;71(1):5-32.
6. Gladman DD, Ritchlin C. Clinical manifestations and diagnosis of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
7. Gladman DD, Ritchlin C. Treatment of psoriatic arthritis. In: Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Accessed September 23, 2020.
8. Coates LC, Kavanaugh A, Mease PJ, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis 2015 Treatment Recommendations for Psoriatic Arthritis. *Arthritis Rheumatol*. 2016 May;68(5):1060-71.
9. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413.
10. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.
11. ClinicalTrials.gov. Identifier: NCT01458951. A Study To Evaluate Both The Efficacy and Safety Profile of CP-690,550 In Patients With Moderately to Severely Active Ulcerative Colitis (OCTAVE). Available at: https://clinicaltrials.gov/ct2/show/NCT01458951?term=xeljanz&draw=2&rank=55.
12. Pascart T et al. Comparative efficacy of tocilizumab, abatacept and rituximab after non-TNF inhibitor failure: results from a multicentre study. I*nt J Rheum Dis*. 2016 Nov;19(11):1093-1102.
13. Fleischmann R, Kremer J, Cush J, et al. Placebo-controlled trial of tofacitinib monotherapy in rheumatoid arthritis. *N Engl J Med*. 2012b;367(6):495-507.
14. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Rheumatol*. 2016;68(1):1-26.
15. Smolen JS, Landewé RBM, Bijlsma JWJ, et al. EULAR recommendations for the management of rheumatoid arthritis with synthetic and biological disease-modifying antirheumatic drugs: 2019 update. *Ann Rheum Dis*. 2020;79(6):685-699.

Effective date: 01/01/2022
Revised date: 10/06/2020

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Xeomin (incobotulinumtoxinA)
BILLING CODE	J0588
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
STATUS	Prior Authorization Required

Xeomin is a neurotoxin produced from Clostridium botulinum serotype A. Xeomin works through the inhibition of acetylcholine release from peripheral nerve endings, causing neuromuscular blockage and muscle paralysis. It is the only botulinum toxin that does not require refrigeration before reconstitution.
Blepharospasm is the abnormal contraction of eyelids. Xeomin was approved as a first-line treatment for Blepharospasm by the FDA in 2019. In a Phase 3, randomized, double-blind, placebo-controlled, multi-center trial, Xeomin demonstrated a statistically significant improvement in baseline Jankovic Rating Scale (JRS) Severity subscores.
Cervical dystonia (also known as spasmodic torticollis) involves the involuntary contractions of the neck that cause abnormal movements and postures of the neck and head. Xeomin is indicated for the treatment of adults with cervical dystonia in both botulinum toxin-naïve and previously treated patients.
Chronic sialorrhea, or excessive drooling, is a common symptom for patients with Parkinson's Disease or other neurological or cognitive impairments. Xeomin is the first neuromodulator approved to treat pediatric patients with chronic sialorrhea.
Xeomin was approved as treatment for upper limb spasticity by the FDA in 2020. The approval was based on the results of a randomized, multi-center, placebo-controlled trial showing improvement in muscle tone (Ashworth Scale Score) and a 7-point Investigator's Global Impression of Change Scale. Xeomin is also the first neuromodulator approved to treat pediatric upper limb spasticity.

Xeomin (incobotulinumtoxinA) will be considered for coverage when the following criteria are met:

BLEPHAROSPASM

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or ophthalmologist; AND
3. Member has a diagnosis of blepharospasm, characterized by spasms inducing narrowing or closure of the eyelids.
4. **Dosage allowed:** Not to exceed 50 units per eye (100 units per treatment session) every 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. lessening of involuntary contraction).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or other specialist experienced with treating cervical dystonia; AND
3. Member has a documented diagnosis of moderate to severe cervical dystonia as evidenced by involuntary contractions of neck muscles, leading to abnormal movements or postures; AND
4. Symptoms affect quality of life and daily functions.
5. **Dosage allowed:** Up to 120 units every 12 weeks, divided among affected muscles.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. severity of abnormal head position, neck pain).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CHRONIC SIALORRHEA

For **initial** authorization:

1. Member is 2 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has diagnosis of chronic sialorrhea impacting quality of life for at least 3 months; AND
4. Member has tried and failed or has a contraindication to at least one anticholinergic drug (e.g. scopolamine, benztropine, glycopyrrolate, amitriptyline).
5. **Dosage allowed:** May repeat no sooner than every 16 weeks;

Adult:

Gland(s)	Units Per Side	Total
Parotid gland(s)	30 Units	60 Units
Submandibular gland(s)	20 Units	40 Units
Both Glands	50 Units	**100 Units**

Pediatric:

Body weight	Parotid gland, each side		Submandibular gland, each side		Total dose, both glands, both sides
	Dose per gland	Volume per injection	Dose per gland	Volume per injection	
12 kg or more to less than 15 kg	6 Units	0.24 mL	4 Units	0.16 mL	20 Units
15 kg or more to less than 19 kg	9 Units	0.36 mL	6 Units	0.24 mL	30 Units
19 kg or more to less than 23 kg	12 Units	0.48 mL	8 Units	0.32 mL	40 Units
23 kg or more to less than 27 kg	15 Units	0.6 mL	10 Unts	0.4 mL	50 Units
27 kg or more to less than 30 kg	18 Units	0.72 mL	12 Units	0.48 mL	60 Units
30 kg or more	22.5 Units	0.9 mL	15 Units	0.6 mL	75 Units

If member meets all the requirements listed above, the medication will be approved for 16 weeks.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SPASTICITY (upper limb only)

For **initial** authorization:
1. Member is 2 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or other specialist experienced with treating spasticity (e.g., PM&R); AND
3. Member has a documented diagnosis of UPPER limb spasticity that affects daily functioning and quality of life; AND
4. Spasticity is secondary to a neurologic condition such as stroke, or brain or spinal cord injury; AND
5. Member has tried or is unable to try a conservative treatment approach such as physical therapy or oral medication (e.g. baclofen, tizanidine).
6. **Dosage allowed:** (adult and pediatric) Maximum of 400 units per treatment session, every 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. decrease in severity of increased muscle tone).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Xeomin (incobotulinumtoxinA) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/06/2018	New policy for Xeomin created. Age requirement removed for diagnoses of Cervical Dystonia and Upper Limb Spasticity. Criterion “no infection at proposed injection site” removed from Cervical Dystonia diagnosis; pain and abnormal head position requirements clarified and medications trial added. For Upper Limb Spasticity Ashworth scale requirement removed, post-stroke requirement and chart notes requirement of abnormal muscle tone documentation added.
04/05/2019	New indication of Chronic Sialorrhea added. Dose allowance increased for diagnosis of Cervical Dystonia. Trial of Botox removed form diagnosis of Blepharospasm.
06/09/2020	Edited criteria for Chronic Sialorrhea to more closely align with Myobloc – simplified exclusion criteria and added trial of anticholinergics. Changed qty limit at top of document.
08/24/2020	Blepharospasm: Extend re-auth duration to 12 mo, added specialist, re-phrased dose, revised diagnostic phrasing. Added reference. Cervical dystonia: Added age limit and specialist requirement. Re-worded the diagnosis requirement. Removed trial of oral medication. Removed exclusions. Corrected the dose. Extended re-auth duration. Updated references. Spasticity: Added age and specialist. Added trial of conventional treatment. Extended initial auth duration. Corrected the dose. Added references. Label recently expanded to include pediatrics.

12/31/2020	Updated the age limit and dosing for chronic sialorrhea to include pediatric patients, per recent label change. Added a couple references. Changed from try 2 anticholinergics to try 1 anticholinergic.
08/10/2021	Transferred to new template. Allowing additional specialists for cervical dystonia and spasticity indications.

References:

1. Xeomin [package insert]. Raleigh, NC: Merz Pharmaceuticals, LLC; 2020.
2. Simpson DM, et al. Practice guideline update summary: botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2016 May 10;86(19):1818-26.
3. Teasell R, et al. Evidence to practice: botulinum toxin in the treatment of spasticity post stroke. Top Stroke Rehabil. 2012 Mar-Apr;19(2):115-21.
4. Chen R, et al. Botulinum toxin for Post-stroke Limb Spasticity. Ischemic Stroke Therapeutics. 2016; 203-207.
5. Cameron MH, et al. Botulinum toxin for symptomatic therapy in multiple sclerosis. Curr Neurol Neurosci Rep. 2014 Aug;14(8):463.
6. Bavikatte G, Sit PL, Hassoon A. Management of Drooling of Saliva. *BJMP*. 2012;5(1):a507. [https://www.bjmp.org/content/management-drooling-saliva]
7. Pellegrini A, Lunetta C, et. al. Sialorrhea: How to manage a frequent complication of motor neuron disease. *EMJ Neurol*. 2015;3[1]:107-113. [https://emj.emg-health.com/wp-content/uploads/sites/2/2018/02/Sialorrhoea-How-to-Manage-a-Frequent-Complication-of-Motor-Neuron-Disease.pdf]
8. Jost WH, Friedman A, Michel O, et al. Long-term incobotulinumtoxinA treatment for chronic sialorrhea: Efficacy and safety over 64 weeks. *Parkinsonism & Related Disorders*. 2020;70:23-30. doi:10.1016/j.parkreldis.2019.11.024
9. Cervical Dystonia. NORD (National Organization for Rare Disorders). https://rarediseases.org/rare-diseases/cervical-dystonia/. Published July 19, 2019. Accessed July 17, 2020.
10. Simpson DM, Hallett M, Ashman EJ, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache. *Neurology*. 2016;86(19):1818-1826. doi:10.1212/wnl.0000000000002560
11. Dressler D, Altenmueller E, Bhidayasiri R, et al. Strategies for treatment of dystonia. *Journal of Neural Transmission*. 2015;123(3):251-258. doi:10.1007/s00702-015-1453-x
12. Defazio G, Hallett M, Jinnah HA, Berardelli A. Development and validation of a clinical guideline for diagnosing blepharospasm. *Neurology*. 2013;81(3):236-240. doi:10.1212/WNL.0b013e31829bfdf6
13. Lindsay C, Kouzouna A, Simcox C, Pandyan AD. Pharmacological interventions other than botulinum toxin for spasticity after stroke. Cochrane Database of Systematic Reviews 2016, Issue 10. Art. No.: CD010362. DOI: 10.1002/14651858.CD010362.pub2.
14. FDA approves first pediatric indication for xeomin® (incobotulinumtoxina) for the treatment of upper limb spasticity, excluding spasticity caused by cerebral palsy | Merz USA. Merz USA. Published August 19, 2020. Accessed August 24, 2020. https://www.merzusa.com/news/fda-approves-first-pediatric-indication-for-xeomin/.
15. Seppi K, Chaudhuri KR, Coelho M, et al. Update on treatments for nonmotor symptoms of Parkinson's disease—an evidence-based medicine review. *Movement Disorders*. 2019;34(2):180-198. doi:10.1002/mds.27602
16. Glader L. Sialorrhea in Cerebral Palsy. AACPDM. https://www.aacpdm.org/publications/care-pathways/sialorrhea. Published June 4, 2018. Accessed January 4, 2021.

Effective date: 01/01/2022
Revised date: 08/10/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Xgeva (denosumab)
BILLING CODE	J0897
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "Dosage allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Xgeva (denosumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

MULTIPLE MYELOMA AND BONE METASTASIS FROM SOLID TUMORS

Any request for multiple myeloma and bone metastasis from solid tumors must be submitted through NantHealth/Eviti portal.

GIANT CELL TUMOR OF BONE

For **initial** authorization:

1. Member is 12 years of age or older; AND
2. Member has a confirmed diagnosis of giant cell tumor of bone that is either recurrent (tumor came back after surgery), cannot be removed by surgery, or where surgery is likely to result in severe morbidity (i.e., loss of limbs or joint removal).
3. **Dosage allowed:** one subcutaneous injection (120 mg) every 4 weeks with additional 120 mg doses on day 8 and 15 of the first month of therapy.

If member meets all the requirements listed above, the medication will be approved for 12 months.

For **reauthorization**:

1. Chart notes have been provided showing that the tumor is stable or decreased in size from baseline.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

HYPERCALCEMIA OF MALIGNANCY

Any request for hypercalcemia of malignancy must be submitted through NantHealth/Eviti portal.

CareSource considers Xgeva (denosumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/13/2020	New policy for Xgeva created.

References:

1. Xgeva [prescribing information]. Thousand Oaks, CA: Amgen Inc.; June, 2020.
2. National Comprehensive Cancer Network. Multiple myeloma (Version 4.2020). https://www.nccn.org/professionals/physician_gls/pdf/myeloma.pdf. Accessed August 14, 2020.
3. Anderson K, Ismaila N, Flynn PJ, et al. Role of Bone-Modifying Agents in Multiple Myeloma: American Society of Clinical Oncology Clinical Practice Guideline Update. *J Clin Oncol*. 2018 Mar 10;36(8):812-818.
4. Van der Heijden L, Dijkstra PD, van de Sande MA, et al. The clinical approach toward giant cell tumor of bone. *Oncologist*. 2014;19(5):550-561.
5. Sternlicht H, Glezerman IG. Hypercalcemia of malignancy and new treatment options. *Ther Clin Risk Manag*. 2015;11:1779-1788. Published 2015 Dec 4.

Effective date: 10/1/2021
Revised date: 08/13/2020

CareSource Rx Innovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Xipere (triamcinolone)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
STATUS	Prior Authorization Required

Xipere, approved by the FDA in 2021, is an injectable suspension formulation of triamcinolone acetonide, indicated for the treatment of macular edema associated with uveitis. It is injected into the suprachoroidal space to deliver the medication to the choroid and retina at the back of the eye. Xipere is currently the only FDA approved medication administered by this particular route and the first specifically for macular edema associated with uveitis. It was approved based on results of the phase 3 PEACHTREE trial. Xipere will compete with the intravitreal injectable, Triesence, and with the intravitreal implants, i.e., Retisert, Ozurdex, and Yutiq.
Uveitis is an inflammation of the uvea (middle layer of the eye). It can be infectious or non-infectious. Non-infectious uveitis (NIU) is often associated with inflammatory conditions such as rheumatoid arthritis. Approximately one-third of uveitis patients develop uveitic macular edema, a build-up of fluid in the macula, the area of the retina responsible for central vision.
Suprachoroidal administration is a more targeted technique which has shown to lessen the risk of the ocular adverse effects of intravitreal corticosteroids and systemic adverse effects of oral corticosteroids.

Xipere (triamcinolone) will be considered for coverage when the following criteria are met:

Uveitic Macular Edema

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a diagnosis of non-infectious uveitis (pan, anterior, intermediate, or posterior); AND
4. Member has a diagnosis of macular edema associated with uveitis; AND
5. Documentation of best corrected visual acuity (BCVA) at baseline; AND
6. Member does not have any active or suspected ocular or periocular infections.
7. **Dosage allowed/Quantity limit:** 4 mg (0.1mL) via suprachoroidal injection every 6 months (per eye)

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must show improved or stabilized visual acuity following treatment and/or reduction from baseline in central subfield thickness (CST); AND
2. At least 6 months have elapsed between treatments.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Xipere (triamcinolone) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/10/2021	New policy for Xipere created.

References:

1. Xipere [prescribing information]. Clearside Biomedical, Inc; 2021.
2. Yeh S, Khurana RN, Shah M, et al. Efficacy and Safety of Suprachoroidal CLS-TA for Macular Edema Secondary to Noninfectious Uveitis: Phase 3 Randomized Trial. *Ophthalmology*. 2020;127(7):948-955. doi:10.1016/j.ophtha.2020.01.006
3. Price KW, Albini TA, Yeh S. Suprachoroidal Injection of Triamcinolone- Review of a Novel Treatment for Macular Edema Caused by Noninfectious Uveitis. *US Ophthalmic Rev*. 2020;13(2):76-79. doi:10.17925/usor.2020.13.2.76
4. Khurana RN, Merrill P, Yeh S, et al. Extension study of the safety and efficacy of CLS-TA for treatment of macular oedema associated with non-infectious uveitis (MAGNOLIA) [published online ahead of print, 2021 Mar 12]. *Br J Ophthalmol*. 2021;bjophthalmol-2020-317560. doi:10.1136/bjophthalmol-2020-317560
5. Singer MA, Merrill P, Yeh S, Hall C, Kapik B, Ciulla TA. Suprachoroidal CLS-TA versus Rescue Therapies for the Treatment of Uveitic Macular Edema: A Post Hoc Analysis of PEACHTREE [published online ahead of print, 2021 Nov 6]. *Clin Exp Ophthalmol*. 2021;10.1111/ceo.14024. doi:10.1111/ceo.14024
6. Merrill PT, Henry CR, Nguyen QD, Reddy A, Kapik B, Ciulla TA. Suprachoroidal CLS-TA with and without Systemic Corticosteroid and/or Steroid-Sparing Therapy: A Post-Hoc Analysis of the Phase 3 PEACHTREE Clinical Trial [published online ahead of print, 2021 Aug 18]. *Ocul Immunol Inflamm*. 2021;1-8. doi:10.1080/09273948.2021.1954199

Effective date: 04/01/2022
Revised date: 11/10/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Xolair (omalizumab)
BILLING CODE	J2357 (1 unit = 5 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— see dosage allowed
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Xolair (omalizumab) is a **preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with allergist, immunologist, or otorhinolaryngologist (ENT); AND
3. Member has a diagnosis of bilateral CRSwNP for more than 12 weeks; AND
4. Chart notes must show documentation of bilateral nasal polyps by direct examination, endoscopy, or sinus CT scan; AND
5. Member has symptoms of chronic rhinosinusitis after at least a 4-week trial with an intranasal corticosteroid (e.g., mometasone, fluticasone) in combination with nasal saline irrigation AND **one** of the following:
   a) Prior sinonasal surgery;
   b) Systemic corticosteroids (unless not tolerated or contraindicated); AND
6. Medication is used as an add-on maintenance treatment in combination with intranasal corticosteroid, unless not tolerated or contraindicated; AND
7. The member's weight (kg) and baseline serum IgE level (IU/mL) is documented in chart notes; AND
8. Member does **not** have allergic fungal rhinosinusitis (AFRS).
9. **Dosage allowed:** 75 mg to 600 mg subQ every 2 or 4 weeks based on serum total IgE level (IU/mL) measure before the start of treatment and by body weight (kg). See the dose determination chart in package insert.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Medication is to be used as add-on maintenance therapy in combination with intranasal corticosteroids, unless not tolerated or contraindicated; AND
3. Chart notes have been provided showing improvement of signs and symptoms such as reduced post-nasal drip, reduced nasal polyp size, and/or reduced nasal congestion symptoms.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CHRONIC IDIOPATHIC URTICARIA (CIU)

For **initial** authorization:

10. Member must be 12 years of age or older; AND
11. Medication must be prescribed by or under the recommendation of a dermatologist, allergist, or immunologist; AND
12. Member has a diagnosis of Chronic Idiopathic Urticaria that has been continuously or intermittently present for at least 6 weeks; AND
13. Member has trialed and failed at least **one** of the following for no less than 14 days:
    a) A second generation H1 antihistamine (i.e. loratadine, cetirizine, fexofenadine) at 2-4 times the FDA-approved dosage;
    b) Two second generation H1 antihistamines in combination;
    c) A second generation H1 antihistamine plus a leukotriene receptor antagonist (i.e. montelukast, zafirlukast);
    d) A second generation H1 antihistamine plus a first generation H1 antihistamine (i.e. diphenhydramine, hydroxyzine, chlorpheniramine);
    e) A second generation H1 antihistamine plus an H2 antagonist (i.e. famotidine, cimetidine, ranitidine).
14. **Dosage allowed:** 150 or 300 mg by subcutaneous injection every 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 16 weeks.

For **reauthorization**:

4. Member must be in compliance with all other initial criteria; AND
5. Chart notes have been provided to support a positive clinical response (i.e. reduction in itch severity and/or hive count).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

MODERATE TO SEVERE PERSISTENT ASTHMA

For **initial** authorization:

1. Member must be 6 years of age or older; AND
2. Medication must be prescribed by on in consultation with a pulmonologist, immunologist or allergist; AND
3. Member has allergy testing performed, as indicated by:
    a) Positive skin testing for perennial aeroallergen; AND/OR
    b) Reactivity to at least one aeroallergen documented by elevated serum IgE level; AND
4. Member has a weight documented and a baseline plasma immunoglobulin E (IgE) level of 30 IU/mL or higher; AND
5. Member has at least two documented severe asthma exacerbations requiring oral corticosteroids (OCS), or at least one requiring hospitalization, within last year; AND
6. Member's asthma has been inadequately controlled after 3 months of conventional treatment of medium to high doses of inhaled corticosteroids (ICS) and long acting beta 2-agonists (LABA); AND
7. Medication is being used as add-on maintenance treatment to conventional therapies for asthma (i.e. ICS, LABA, etc.); AND
8. Medication is not used in conjunction with any other biologic therapy for asthma.
9. **Dosage allowed:** 75 to 375 mg by subcutaneous injection every 2 or 4 weeks.

If member meets all the requirements listed above, the medication will be approved for 16 weeks.

For **reauthorization**:

1. Medication is not being used as monotherapy for asthma; AND
2. Member must be in compliance with all other initial criteria; AND
3. Chart notes have been provided that show the member has demonstrated improvement during 16 weeks of medication therapy:
   a) Decreased frequency of emergency department visit or hospitalizations due to asthma exacerbations; OR
   b) Improved functional ability (i.e. decreased effect of asthma on ability to exercise, function in school or at work, or quality of sleep); OR
   c) Decreased utilization of rescue medications or oral corticosteroids.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Xolair (omalizumab) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/18/2017	New policy for Xolair created. For CIU urticaria activity score, trial of oral corticosteroids and trial length added.
01/12/2021	Persistent Asthma: added documented weight; added exacerbation requirement (two requiring OCS or one requiring hospitalization within the last year); FEV1 removed; ICS + LTRA removed; added not to be used with other asthma biologics. CIU: added immunologist; documented urticaria activity and itch severity scores removed; trial of oral corticosteroids removed; added trial option of a 2nd generation H1antihistamine 2-4x FDA approved dosage; added examples of trial drugs for reference. New indication Nasal Polyps added.

References:

1. Xolair [package insert]. South San Francisco, CA: GenetechUSA, Inc; December, 2020.
2. Buhl R. Omalizumab (Xolair) improves quality of life in adult patients with allergic asthma: A review. Respir Med. 2003;97(2):123-129.
3. Finn A, Gross G, van Bavel J, et al. Omalizumab improves asthma-related quality of life in patients with severe allergic asthma. J Allergy Clin Immunol. 2003;111(2):278-284.
4. Bang LM, Plosker GL. Omalizumab: A review of its use in the management of allergic asthma. Treat Respir Med. 2004;3(3):183-199.
5. Difficult-To-Treat & Severe Asthma in Adolescent and Adult Patients: Diagnosis and Management. Global Initiative For Asthma (GINA); Apr. 2019. Available at: https://ginasthma.org/wp-content/uploads/2018/11/GINA-SA-FINAL-wms.pdf.
6. 2020 Focused Updates To The Asthma Management Guidelines. National Institute of Health; Dec 2020. Available at: https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates.
7. Bernstein JA, Lang DM, Khan DA, et al. The diagnosis and management of acute and chronic urticaria: 2014 update. *J Allergy Clin Immunol*. 2014;133(5):1270-1277. doi:10.1016/j.jaci.2014.02.036
8. Zuberbier T, Aberer W, Asero R, et al. The EAACI/GA²LEN/EDF/WAO guideline for the definition, classification, diagnosis and management of urticaria. *Allergy.* 2018; 73(7): 1355-1566. doi.org/10.1111/all.13397.
9. Gevaert P, Omachi TA, Corren J, et al. Efficacy and safety of omalizumab in nasal polyposis: 2 randomized phase 3 trials. *J Allergy Clin Immunol*. 2020;146(3):595-605.
10. Stevens WW, Schleimer RP, Kern RC. Chronic Rhinosinusitis with Nasal Polyps. *J Allergy Clin Immunol Pract*. 2016;4(4):565-572. doi:10.1016/j.jaip.2016.04.012.
11. Peters AT, Spector S, Hsu J, et al. Diagnosis and management of rhinosinusitis: a practice parameter update. *Ann Allergy Asthma Immunol*. 2014;113(4):347-85. DOI: 10.1016/j.anai.2014.07.025.
12. Sedaghat AR. Chronic rhinosinusitis. *Am Fam Physician*. 2017;96(8):500.506.
13. Laidlaw TM, Buchheit KM. Biologics in chronic rhinosinusitis with nasal polyposis. *Ann Allergy Asthma Immunol*. 2020;124(4):326-332. doi:10.1016/j.anai.2019.12.001.

14. Orlandi RR, Kingdom TT, Hwang PH, et al. International consensus statement of allergy and rhinology: rhinosinusitis. *Int Forum Allergy Rhinol*. 2016 Feb;6 Suppl 1:S22-209. doi: 10.1002/alr.21695.
15. Fokkens WJ, Lund V, Bachert C, et al. EUFOREA consensus on biologics for CRSwNP with or without asthma. *Allergy*. 2019 Dec;74(12):2312-2319. doi: 10.1111/all.13875.

Effective date: 10/1/2021
Revised date: 01/12/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Xyrem (sodium oxybate) and Xywav (calcium, magnesium, potassium, and sodium oxybates)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Xywav is a central nervous system depressant indicated for the treatment of cataplexy or excessive daytime sleepiness in patients 7 years of age and older with narcolepsy as well as idiopathic hypersomnia for adults. Narcolepsy is a chronic neurologic disorder involving dysregulation of the sleep/wake cycle. It is estimated about 50 per 100,000 people in the U.S. have narcolepsy. Idiopathic hypersomnia (IH) is a chronic neurological disorder that results in daytime sleepiness, frequently accompanied by long nocturnal or daytime sleep, unrefreshing sleep, difficulty in awakening, cognitive dysfunction, and autonomic symptoms. A less common condition than narcolepsy, there are approximately 20 to 50 cases per million of idiopathic hypersomnia. The exact mechanism of action of Xywav is unknown, but it's hypothesized the therapeutic effects work through the $GABA_B$ actions during sleep at noradrenergic and dopaminergic neurons, as well as at thalamocortical neurons.

Xyrem (sodium oxybate) and Xywav (calcium, magnesium, potassium, and sodium oxybates) will be considered for coverage when the following criteria are met:

Idiopathic Hypersomnia – Xywav only

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or sleep specialist; AND
3. Member must have a diagnosis of idiopathic hypersomnia with the presence of at least **one** of the following:
   a) MSLT (multiple sleep latency test) showing a mean sleep latency of ≤ 8 minutes;
   b) Total 24-hour sleep time is ≥660 minutes (usually 12 to 14 hours) on 24-hour polysomnography or by wrist actigraphy in association with a sleep log;
4. Documentation of a MSLT showing fewer than two sleep-onset rapid eye movement periods (SOREMPs), or no SOREMPs if the REM sleep latency before polysomnogram is 15 minutes or less;
5. Documentation of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months; AND
6. Baseline Epworth score has been submitted in chart notes;
7. Member does NOT have documentation of cataplexy; AND
8. Member has a previous trial of modafinil for at least 60 days which was ineffective, not tolerated, or contraindicated; AND
9. Member has documentation of at least 7 hours of sleep per night; AND
10. Member has a previous trial of a stimulant medication (i.e., methylphenidate or dextroamphetamine) for at least 60 days which was ineffective, not tolerated, or contraindicated.
11. **Dosage allowed/Quantity limit:** Administer as a once or twice nightly regimen.
    a) Once nightly dosing: Initiate dosage at 3 g or less per night orally, as one dose. Titrate to effect in increments of up to 1.5g per night per week, up to 6g total nightly dose.
    b) Twice nightly dosing: Initiate dosage at 4.5g or less per night orally, divided into two doses. Titrate to effect in increments of up to 1.5g per night per week, up to 9g total nightly dose.

QL: 540 mL/30 days

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
Xywav will be reauthorized when chart notes show ALL of the following:
1. Chart notes must show the member has an improved score on the Epworth Sleepiness Scale and/or improved signs and symptoms of daytime sleepiness; AND
2. Member must continue to abstain from alcohol and any sedative hypnotic agents; AND
3. Member tolerates therapy and does not experience unmanageable or severe adverse effects; AND
4. Chart notes must not reveal any evidence of abuse, misuse, or diversion.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Narcolepsy with Excessive Daytime Sleepiness (EDS)

For **initial** authorization:
1. Member is 7 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or sleep specialist; AND
3. Member has a diagnosis of narcolepsy with EDS confirmed by sleep studies: polysomnogram and MSLT (multiple sleep latency test); AND
4. Member's current score on the Epworth Sleepiness Scale (ESS) is documented in chart notes; AND
5. a) Age 18 years or older: Member has had a compliant trial and failure for at least 30 days for each of the following at maximally tolerated doses: modafinil OR armodafinil, AND Sunosi; AND at least 60 days of Wakix, unless not tolerated or contraindicated; OR
   b) Less than 18 years of age: Member has had a compliant trial and failure of modafinil for at least 30 days (trial of a stimulant medication such as methylphenidate is also acceptable); AND
6. Member is not using any alcohol or sedative hypnotic agents (such as zolpidem).
7. **Dosage allowed/Quantity limit:** 9g per day (4.5g per dose).
   QL: 540 mL/30 days

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must show the member has an improved score on the Epworth Sleepiness Scale and/or improved signs and symptoms of daytime sleepiness; AND
2. Member must continue to abstain from alcohol and any sedative hypnotic agents; AND
3. Member tolerates therapy and does not experience unmanageable or severe adverse effects; AND
4. Chart notes must not reveal any evidence or concerns of abuse, misuse, or diversion.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Narcolepsy with Cataplexy

For **initial** authorization:
1. Member is 7 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist or sleep specialist; AND
3. Member must have a diagnosis of narcolepsy with cataplexy confirmed by sleep studies: polysomnogram and MSLT (multiple sleep latency test); AND
4. Member's current score on the Epworth Sleepiness Scale and baseline frequency of cataplexy attacks (e.g. weekly rate) must be documented; AND
5. Member must have, unless specifically contraindicated, a compliant trial and failure of at least one of the following cataplexy treatments for no less than 30 days: A tricyclic antidepressant (such as clomipramine), selective serotonin reuptake inhibitor (such as fluoxetine), or serotonin-norepinephrine reuptake inhibitor (such as venlafaxine); AND
6. Members 18 years of age and older must have a trial and failure of Wakix for at least 60 days; AND

7. Member is not using any alcohol or sedative hypnotic agents (such as zolpidem).
8. **Dosage allowed/Quantity limit:** 9g per day (4.5g per dose).
   QL: 540 mL/30 days

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes must show decreased frequency and/or severity of cataplexy attacks; AND
2. Member must continue to abstain from alcohol and any sedative hypnotic agents; AND
3. Member tolerates therapy and does not experience unmanageable or severe adverse effects; AND
4. Chart notes must not reveal any evidence of abuse, misuse, or diversion.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Xyrem (sodium oxybate) and Xywav (calcium, magnesium, potassium, and sodium oxybates) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
05/26/2020	New policy for Xyrem created.
01/28/2021	Xywav added to policy. For cataplexy section: reduced trial of antidepressants from 2 to 1; added step through Wakix for adults.
11/15/2021	Transferred to new template. Added new section for idiopathic hypersomnia. Narcolepsy with EDS: For peds, emphasized modafinil as step therapy rather than a stimulant per the newest AASM guideline update; retained stimulant as an option.

References:

1. Xywav [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; 2021.
2. American Academy of Sleep Medicine. International Classification of Sleep Disorders, 3rd ed. 2014.
3. Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med.
4. Lecendreux M, Bruni O, Franco P, et al. Clinical experience suggests that modafinil is an effective and safe treatment for paediatric narcolepsy. Journal of Sleep Research. 2012;21(4):481-483.
5. Lehert P, Falissard B. Multiple treatment comparison in narcolepsy: a network meta-analysis. Sleep. 2018;41(12). doi:10.1093/sleep/zsy185
6. Morgenthaler TI, Kapur VK, Brown TM, et al. Practice Parameters for the Treatment of Narcolepsy and other Hypersomnias of Central Origin. Sleep. 2007;30(12):1705-1711.
7. Bogan RK, Thorpy MJ, Dauvilliers Y, et al. Efficacy and safety of calcium, magnesium, potassium, and sodium oxybates (lower-sodium oxybate [LXB]; JZP-258) in a placebo-controlled, double-blind, randomized withdrawal study in adults with narcolepsy with cataplexy [published online ahead of print, 2020 Oct 14]. Sleep. 2020
8. Barateau, L., & Dauvilliers, Y. (2019). Recent advances in treatment for narcolepsy. Therapeutic advances in neurological disorders.
9. Thorpy MJ, Bogan RK. Update on the pharmacologic management of narcolepsy: mechanisms of action and clinical implications. Sleep Med. 2020;68:97-109.
10. Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2021;17(9):1881-1893. doi:10.5664/jcsm.9328
11. Maski K, Trotti LM, Kotagal S, et al. Treatment of central disorders of hypersomnolence: an American Academy of Sleep Medicine systematic review, meta-analysis, and GRADE assessment. *J Clin Sleep Med*. 2021;17(9):1895-1945. doi:10.5664/jcsm.9326

Effective date: 04/01/2022
Revised date: 11/15/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Yescarta (axicabtagene ciloleucel)
BILLING CODE	Q2041
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient/Inpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Yescarta (axicabtagene ciloleucel) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

LARGE B-CELL LYMPHOMA

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a diagnosis of relapsed or refractory large B-cell lymphoma including **one** of the following:
   a) Diffuse large B-cell lymphoma (DLBCL) not otherwise specified;
   b) Primary mediastinal large B-cell lymphoma;
   c) High grade B-cell lymphoma;
   d) DLBCL arising from follicular lymphoma; AND
3. Member's disease is refractory or relapsed, defined as **one** or more of the following:
   a) No response, partial response, disease progression, or relapse after two or more lines of chemotherapy, including both anti-CD20 monoclonal antibody (e.g., rituximab) unless tumor is CD20-negative and anthracycline;
   b) Relapsed after autologous hematopoietic stem cell transplantation (HSCT); AND
4. Member has an Eastern cooperative oncology group (ECOG) performance status of 0 or 1; AND
5. Member does **not** have ANY of the following:
   a) Prior allogeneic HSCT;
   b) History or presence of primary central nervous system (CNS) lymphoma;
   c) Prior CAR-T therapy (e.g., Kymriah); AND
6. Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) prior to collection of cells (negative results must be submitted); AND
7. Healthcare facility/provider has enrolled in the Yescarta and Tecartus REMS program.
8. **Dosage allowed:** 2×10^6 CAR-positive viable T cells per kg body weight, with a maximum of 2×10^8 CAR-positive viable T cells.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Yescarta will not be reauthorized for continued therapy.

FOLLICULAR LYMPHOMA

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has a diagnosis of relapsed or refractory follicular lymphoma; AND
3. Member has measurable disease after 2 or more lines of systemic therapy, including the combination of an anti-CD20 monoclonal antibody and an alkylating agent; AND
4. Member has an Eastern cooperative oncology group (ECOG) performance status of 0 or 1; AND
5. Member does **not** have ANY of the following:
   a) Prior allogeneic HSCT;
   b) History or presence of primary central nervous system (CNS) lymphoma;
   c) Prior CAR-T therapy; AND
6. Member has been screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) prior to collection of cells (negative results must be submitted); AND
7. Healthcare facility/provider has enrolled in the Yescarta and Tecartus REMS program.
8. **Dosage allowed:** 2×10^6 CAR-positive viable T cells per kg body weight, with a maximum of 2×10^8 CAR-positive viable T cells.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Yescarta will not be reauthorized for continued therapy.

CareSource considers Yescarta (axicabtagene ciloleucel) not medically necessary for the treatment of diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/24/2017	New policy for Yescarta created.
08/27/2018	Criteria expanded for member's disease history requirement.
08/04/2020	Defined age 18 or older for adults. Specified trial requirement for 2 or more lines of chemo or relapsed after autologous stem cell transplant. Removed pre-treatment regimens because they are already addressed in REMS. Required screening results for active infections. Removed hypersensitivity to aminoglycoside requirement, CNS disorders, and other forms of malignancy from exclusion list. Added prior CAR-T treatment, life expectancy to exclusion list. Updated the name of REMS program.
05/19/2021	Added criteria for new indication of follicular lymphoma. Large B-Cell Lymphoma: Removed life expectancy restriction. Added ECOG score. Added "partial response" to 3a per NCCN slide BCEL-7.

References:

1. Yescarta [package insert]. Santa Monica, CA; Kite Pharma, Inc., April 2021.
2. ClinicalTrials.gov. Identifier NCT02348216. Safety and Efficacy of KTE-C19 in Adults With Refractory Aggressive Non-Hodgkin Lymphoma (ZUMA-1). Available at https://clinicaltrials.gov/ct2/show/NCT02348216.
3. National Comprehensive Cancer Network. B-Cell Lymphomas (Version 4.2021). https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed May 19, 2021.
4. Neelapu SS, et al. Axicabtagene ciloleucel CAR T-cell therapy in refractory large B-cell lymphoma. N Engl J Med. 2017;377(26):2531-2544.
5. A Phase 2 Multicenter Study of Axicabtagene Ciloleucel in Subjects With Relapsed/Refractory Indolent Non-Hodgkin Lymphoma (ZUMA-5). ClinicalTrials.gov identifier: NCT03105336. Updated May 17, 2021. Accessed May 19, 2021. https://clinicaltrials.gov/ct2/show/NCT03105336.

Effective date: 10/1/2021

CareSource

Revised date: 05/19/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Yutiq (fluocinolone acetonide)
BILLING CODE	J7314
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
STATUS	Prior Authorization Required

Yutiq is a 0.18 mg fluocinolone acetonide intravitreal implant that was approved by the FDA in 2018. It is indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye and lasts 36 months.
Uveitis is an inflammation of the uvea (middle layer of the eye). It can be infectious or non-infectious. Non-infectious uveitis (NIU) is often associated with inflammatory conditions such as rheumatoid arthritis. If the anterior segment of the uvea is affected, it can be treated with topical glucocorticoids. If resistant or affecting the intermediate or posterior segments, more invasive or systemic treatment is needed.

Yutiq (fluocinolone acetonide) will be considered for coverage when the following criteria are met:

Uveitis

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with an ophthalmologist; AND
3. Member has a diagnosis of chronic (1 year or more) non-infectious uveitis affecting the posterior segment of the eye; AND
4. Member has tried and failed at least one of the following for at least 3 months:
   a) Systemic corticosteroid (e.g., prednisone)
   b) Non-biologic immunosuppressive (e.g., mycophenolate mofetil, methotrexate, cyclosporine, tacrolimus); AND
5. Member does not have any active or suspected infections in or around the eye.
6. **Dosage allowed/Quantity limit:** One implant (0.18 mg) per eye
   Limit: 2 implants (1 per eye) per 36 months

If all the above requirements are met, the medication will be approved for 3 months.

For **reauthorization**:
1. Chart notes must show improved or stabilized visual acuity following treatment and/or an improved vitreous haze score; AND
2. At least 36 months have elapsed since the prior treatment (of the same eye); AND
3. Member has recurrent symptoms.

If all the above requirements are met, the medication will be approved for an additional 3 months.

CareSource considers Yutiq (fluocinolone acetonide) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
11/02/2021	New policy created for Yutiq.

References:

1. Yutiq [prescribing information]. EyePoint Pharmaceuticals US, Inc.; 2021.
2. Jaffe GJ, Pavesio CE; Study Investigators. Effect of a Fluocinolone Acetonide Insert on Recurrence Rates in Noninfectious Intermediate, Posterior, or Panuveitis: Three-Year Results. *Ophthalmology*. 2020;127(10):1395-1404. doi:10.1016/j.ophtha.2020.04.001
3. Steeples LR, Pockar S, Jones NP, Leal I. Evaluating the Safety, Efficacy and Patient Acceptability of Intravitreal Fluocinolone Acetonide (0.2mcg/Day) Implant in the Treatment of Non-Infectious Uveitis Affecting the Posterior Segment. *Clin Ophthalmol*. 2021;15:1433-1442. Published 2021 Apr 7. doi:10.2147/OPTH.S216912
4. Conrady CD, Yeh S. A Review of Ocular Drug Delivery Platforms and Drugs for Infectious and Noninfectious Uveitis: The Past, Present, and Future. *Pharmaceutics*. 2021;13(8):1224. Published 2021 Aug 8. doi:10.3390/pharmaceutics13081224

Effective date: 04/01/2022
Revised date: 11/02/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Zarxio (filgrastim-sndz)
BILLING CODE	For medical - Q5101 For Rx - must use valid NDC
BENEFIT TYPE	Medical or Pharmacy
SITE OF SERVICE ALLOWED	Home/Office/Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— N/A
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zarxio (filgrastim-sndz) is a **preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

ACUTE MYELOID LEUKEMIA

For **initial** authorization:

1. Member has diagnosis of AML documented in chart notes; AND
2. Medication is being used to reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy treatment; AND
3. Medication is being administered 24 hours after the last dose of chemotherapy until neutrophil recovery (ANC ≥ 1000/mm^3 for 3 consecutive days or ≥ 10,000/mm^3 for 1 day) or for a maximum of 35 days; AND
4. Chart notes with the length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the days of the cycle on which Zarxio will be administered are submitted with the prior authorization request.
5. **Dosage allowed:** 5 mcg/kg/day subcutaneous injection, short intravenous infusion (15 to 30 minutes), or continuous intravenous infusion.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Zarxio therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS BONE MARROW TRANSPLANT (BMT)

For **initial** authorization:

1. Member has diagnosis of non-myeloid malignancy and is undergoing myeloablative chemotherapy followed by autologous BMT; AND
2. Medication is being used to reduce duration of neutropenia following autologous BMT.
3. **Dosage allowed:** 10 mcg/kg/day beginning at least 24 hours after cytotoxic chemotherapy and 24 hours after bone marrow infusion.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Zarxio therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

AUTOLOGOUS PERIPHERAL BLOOD PROGENITOR CELL (PBPC) MOBILIZATION

For **initial** authorization:

1. Medication is being used to mobilize autologous peripheral blood progenitor cells for collection by leukapheresis; AND
2. Medication is being administered for at least 4 days before first leukapheresis and continued until the last leukapheresis (until a sustainable ANC (≥ 1000/mm^3) is reached).
3. **Dosage allowed:** 10 mcg/kg/day subcutaneous injection.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For **reauthorization**:

1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Zarxio therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

PREVENTION OF FEBRILE NEUTROPENIA

For **initial** authorization:

1. Member has a non-myeloid malignancy; AND
2. Medication will not be administered within 24 hours before or after chemotherapy; AND
3. Chart notes with the length of chemotherapy cycle, the days of the cycle on which chemotherapy will be administered, and the days of the cycle on which Zarxio will be administered are submitted with the prior authorization request; AND
4. Member is receiving myelosuppressive chemotherapy and has a history of febrile neutropenia (defined as an ANC < 1000/mm^3 and temperature > 38.2°C) following a previous course of chemotherapy; OR
5. Member is receiving a myelosuppressive chemotherapy regimen that is associated with a high risk (>20%) of febrile neutropenia; OR
6. Member is receiving a myelosuppressive chemotherapy regimen that is associated with an intermediate risk (10-20%) of febrile neutropenia AND has at least **one** of the following risk factors:
   a) Prior chemotherapy or radiation therapy;
   b) Persistent neutropenia;
   c) Tumor involving the bone marrow;
   d) Recent surgery and/or open wounds;
   e) Liver dysfunction (i.e. documented bilirubin >2.0);
   f) Renal dysfunction (i.e. documented creatinine clearance <50 mL/min);
   g) Age >65 years receiving full intensity dose of chemotherapy.
7. **Dosage allowed:** 5 mcg/kg per day.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Zarxio therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SEVERE CHRONIC NEUTROPENIA

For **initial** authorization:
1. Member has a history of SCN (i.e. congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia) with chart notes confirming **both** of the following:
   a) Absolute neutrophil count (ANC) < 500/mm^3 on three occasions during a 6 month period (or for cyclic neutropenia 5 consecutive days of ANC < 500/mm^3 per cycle); AND
   b) Member must have experienced a clinically significant infection during the previous 12 months.
2. **Dosage allowed:** Idiopathic neutropenia: 5 mcg/kg per day as a single dose; Cyclic neutropenia: 5 mcg/kg per day as a single dose; Congenital neutropenia: 6 mcg/kg per day in 2 divided doses.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all initial criteria; AND
2. Chart notes have been provided that show the member is stable or has shown improvement on Zarxio therapy.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Zarxio (filgrastim-sndz) not medically necessary for the treatment of the following disease states based on a lack of robust clinical controlled trials showing superior efficacy compared to currently available treatments:

- Agranulocytosis
- AIDS - Neutropenia
- Aplastic anemia
- Febrile neutropenia
- Febrile neutropenia, In myeloid malignancies following bone marrow transplant; Prophylaxis
- Hematopoietic Syndrome of Acute Radiation Syndrome
- Infectious disease; Prophylaxis
- Leukemia
- Myelodysplastic syndrome
- Neutropenia - Pre-eclampsia

DATE	ACTION/DESCRIPTION
10/19/2017	New policy for Zarxio created. Age limits and degree of hematotoxicity was removed; radiation exposure level requirement was decreased. Criteria coverage for Prevention of Febrile Neutropenia was expanded. Chemotherapy regimens with high and intermediate risk of febrile neutropenia were added to the policy's appendix. List of not covered diagnoses was added.

References:

1. Zarxio (filgrastim-sndz) [prescribing information]. Princeton, NJ: Sandoz Inc; March 2016.
2. Schmitz N, Linch DC. Randomised trial of filgrastim-mobilized peripheral blood progenitor cell transplantation versus autologous bone-marrow transplantation in lymphoma patients. *Lancet*. 1996;347(8998): 353-358. Doi: 10.1016/S0140-6736(96)90536-X.
3. Blackwell K, Semiglazov V, Krasnozhon D, et al. Comparison of EP2006, a filgrastim biosimilar, to the reference: a phase III, randomized, double-blind clinical study in the prevention of severe neutropenia in patients with breast cancer receiving myelosuppressive chemotherapy. *Ann Oncol.* 2015;26:1948-1953. Doi: 10.1093/annonc/mdv281.
4. Dale DC, Bonilla MA, Davis MW, et al. A randomized controlled phase III trial of recombinant human granulocyte colony-stimulating factor (filgrastim) for treatment of severe chronic neutropenia. 1993;81(10):2496-2502.
5. Crawford J, Becker PS, Armitage JO, et al. Myeloid growth factors. NCCN Clinical Practice Guidelines in Oncology. Available from www.nccn.org. Published April 28, 2017. Accessed July 27, 2017.
6. Harada K, Yamada Y, Konishi T, et al. Comparison of transplant outcomes and economic costs between biosimilar and originator filgrastim in allogeneic hematopoietic stem cell transplantation. *Int J Hematol*. 2016;104:709-719. Doi: 10.1007/s/12185-016-2085-0.
7. Radiation Emergency Medical Management. Myeloid cytokines for acute exposure to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). U.S. Department of Health and Human Services. Available from https://www.remm.nlm.gov/cytokines.htm. Updated February 22, 2017. Accessed July 27, 2017.
8. Filgrastim-sndz. Micromedex Solutions. Truven Health Analytics, Inc. Ann Arbor, MI. Available at: http://www.micromedexsolutions.com. Accessed March 15, 2017.

Effective date: 11/08/2017
Revised date: 10/19/2017

CareSource

Appendix

Chemotherapy Regimens with a High Risk for Febrile Neutropenia (>20%)

Cancer Type	Regimen
Acute Lymphoblastic Leukemia (ALL)	ALL induction regimens (see NCCN guidelines)
Bladder Cancer	MVAC (methotrexate, vinblastine, doxorubicin, cisplatin) (neoadjuvant, adjuvant, metastatic)
Breast Cancer	Docetaxel + trastuzumab (metastatic or relapsed)
	Dose-dense AC followed by T (doxorubicin, cyclophosphamide, paclitaxel) (adjuvant)
	TAC (docetaxel, doxorubicin, cyclophosphamide) (adjuvant)
Esophageal and Gastric Cancers	Docetaxel/cisplatin/fluorouracil
Hodgkin Lymphoma	BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone)
Kidney Cancer	Doxorubicin/gemcitabine
Non-Hodgkin's Lymphoma	ICE (ifosfamide, carboplatin, etoposide) (diffuse large B-cell lymphoma [DLBCL], peripheral T-cell lymphomas [PTCL], 2nd line)
	RICE (rituximab, ifosfamide, carboplatin, etoposide)
	CHOP-14 (cyclophosphamide, doxorubicin, vincristine, prednisone) + rituximab
	MINE (mesna, ifosfamide, novantrone, etoposide) (DLBCL, 2nd line, refractory)
	DHAP (dexamethasone, cisplatin, cytarabine)
	ESHAP (etoposide, methylprednisolone, cisplatin, cytarabine (Ara-C)) (DLBCL, PTCL, 2nd line, recurrent)
	HyperCVAD + rituximab (cyclophosphamide, vincristine, doxorubicin, dexamethasone + rituximab)
Melanoma	Dacarbazine-based combination (dacarbazine, cisplatin, vinblastine) (advanced, metastatic, or recurrent)
	Dacarbazine-based combination with IL-2, interferon alpha (dacarbazine, cisplatin, vinblastine, IL-2, interferon alpha) (advanced, metastatic, or recurrent)
Ovarian Cancer	Topotecan
	Paclitaxel
	Docetaxel
Soft Tissue Sarcoma	MAID (mesna, doxorubicin, ifosfammide, dacarbazine)
	Doxorubicin
	Ifosfamide/doxorubicin
Small Cell Lung Cancer	topotecan
Testicular cancer	VelP (vinblastine, ifosfamide, cisplatin)
	VIP (etoposide, ifosfamide, cisplatin)
	BEP (bleomycin, etoposide, cisplatin)

	TIP (paclitaxel, ifosfamide, cisplatin)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

Chemotherapy Regimens with an Intermediate Risk of Febrile Neutropenia (10% to 19%)

Cancer Histology	**Regimen**
Occult primary - adenocarcinoma	Gemcitabine/docetaxel
Breast cancer	Docetaxel every 21 days
	CMF classic (cyclophosphamide, methotrexate, fluorouracil) (adjuvant)
	AC (doxorubicin, cyclophosphamide) + sequential docetaxel (adjuvant) (taxane portion only)
	AC + sequential docetaxel + trastuzumab (adjuvant)
	FEC (fluorouracil, epirubicin, cyclophosphamide) + sequential docetaxel
	TC (docetaxel, cyclophosphamide)
Cervical Cancer	Cisplatin/topotecan (recurrent or metastatic)
	Paclitaxel/cisplatin
	Topotecan (recurrent or metastatic)
	Irinotecan (recurrent or metastatic)
Colorectal	FOLFOX (fluorouracil, leucovorin, oxaliplatin)
Esophageal and Gastric Cancers	Irinotecan/cisplatin
	Epirubicin/cisplatin/5-fluorouracil
	Epirubicin/cisplatin/capecitabine
Multiple myeloma	DT-PACE (dexamethasone/thalidomide/cisplatin/doxorubicin/cyclophoaphamide/etoposide)
	DT-PACE + bortezomib (VTD-PACE)
Non-Hodgkin's lymphomas	EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) (AIDS-related NHL, Burkitt lymphoma, recurrent, otherr NHL subtypes)
	EPOCH-IT chemotherapy (AIDS-related NHL, DLBCL, recurrent)
	GDP (gemcitabine, dexamethasone, cisplatin) (DLBCL, PTCL, 2nd line)
	GDP (gemcitabine, dexamethasone, cisplatin) + rituximab (DLBCL, 2nd line, Burkitt lymphoma, other NHL subtypes)
	FMR (fludarabine, mitoxantrone, rituximab)
	CHOP + rituximab (cyclophosphamide, doxorubicin, vincristine, prednisone, rituximab) including regimens with pegylated liposomal doxorubicin or mitoxantrone substituted for doxorubicin
Non-Small Cell Lung Cancer	Cisplatin/paclitaxel (advanced/metastatic)
	Cisplatin/vinorelbine (adjuvant, advanced/metastatic)
	Cisplatin/docetaxel (adjuvant, advanced/metastatic)
	Cisplatin/etoposide (adjuvant, advanced/metastatic)

	Carboplatin/paclitaxel (adjuvant, advanced/metastatic)
	Docetaxel (advanced/metastatic)
Ovarian Cancer	Carboplatin/docetaxel
Pancreatic Cancer	FOLFIRINOX
Prostate Cancer	Cabazitaxel
Small Cell Lung Cancer	Etoposide/carboplatin
Testicular Cancer	Etoposide/cisplatin
Uterine Sarcoma	Docetaxel (advanced or metastatic)

National Comprehensive Cancer Network (NCCN): Myeloid Growth Factors, 2016.

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Zavesca (miglustat)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Preferred Product) QUANTITY LIMIT— 90 caps per 30 days
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zavesca (miglustat) is a **preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

GAUCHER DISEASE

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Member has mild or moderate type 1 Gaucher disease (Glucocerebrosidase deficiency confirmed in chart notes); AND
3. Member is unable to receive enzyme replacement therapy (chart notes confirming that enzyme replacement therapy is not a therapeutic option required) AND member did **not** take enzyme replacement therapy in the preceding 6 months; AND
4. Baseline of liver volume, spleen volume, hemoglobin concentration, and platelet count submitted with chart notes.
5. **Dosage allowed:** Recommended dosage is 100 mg administered orally three times a day at regular intervals.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease; AND
3. Reduction of liver volume and spleen volume is documented in chart notes.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 6 months.

CareSource considers Zavesca (miglustat) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
06/29/2017	New policy for Zavesca created.
11/17/2021	Annual review, no changes

References:

1. Zavesca [package insert]. South San Francisco, CA; Actelion Pharmaceuticals US, Inc: February, 2016.

Effective date: 01/01/2022
Revised date: 11/17/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Zepatier (grazoprevir/elbasvir)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include Mavyret and Sofosbuvir/velpatasvir (generic for Epclusa) QUANTITY LIMIT— 28 for a 28 day supply
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zepatier (grazoprevir/elbasvir) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

HEPATITIS C (without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A))

For **initial** authorization:

1. Member is treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Turcotte-Pugh Class A); AND
2. Member must be 18 years of age or older; AND
3. Member has genotype 1 or 4 (laboratory documentation required); AND
4. Member has been tested for NS5A resistance-associated polymorphisms if Genotype is 1a; AND
5. Medication must be prescribed by a board certified hepatologist, gastroenterologist, infectious disease specialist or a nurse practitioner working with the above specialists; AND
6. Member's documented viral load taken within 6 months of beginning therapy and submitted with chart notes; AND
7. Member has documented current monthly negative urine drug and alcohol screens for 3 consecutive months (laboratory documentation required); AND
8. Member does **not** have moderate to severe hepatic impairment (Child-Turcotte-Pugh B and C); AND
9. Member has tried and failed course of treatment with Sofosbuvir/velpatasvir (generic for Epclusa) and with Mavyret (Dates and HCV RNA values must be documented in chart notes).
10. **Dosage allowed:** One tablet once daily for 12 weeks OR one tablet once daily with ribavirin for 16 weeks if member has NS5A resistance-associated polymorphisms.

Note: Member's life expectancy must be no less than one year due to non-liver related comorbidities.

If member meets all the requirements listed above, the medication will be approved for 12-16 weeks, see Appendix below.

For **reauthorization**:

1. Zepatier will not be reauthorized for continued therapy.

CareSource considers Zepatier (grazoprevir/elbasvir) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/09/2017	New policy for Zepatier created. Alternative products were indicated. Hep B test requirement was added. Drug and alcohol screens for 3 consecutive months required for all regardless of abuse history. Evidence of liver fibrosis exceptions was expanded. Reauthorization requirement of 2 consecutive values of HCV RNA ≥25 IU per mL during the post-treatment period and documented reason of treatment failure were added.
06/08/2017	Fibrosis stage 2 and above covered.
11/22/2017	Medication status changed to non-preferred. Substance abuse program information is no longer required. Trial of preferred agent is required. Reauthorization criteria were removed. Criterion on absence of moderate to severe liver impairment was added.
12/07/2017	Criterion of “life expectancy not less than one year due to non-liver related comorbidities” removed from criteria and added in a form of the note. Hepatitis B testing is no longer required.
12/21/2017	Fibrosis score requirement was removed.
05/01/2019	Sofosbuvir/velpatasvir (generic for Epclusa) added to trials.
11/19/2021	Annual review, no changes

References:

1. Zepatier [package insert]. Merck Sharp & Dohme Corp: Whitehouse Station, NJ; February, 2017.
2. Hepatitis C Information | Division of Viral Hepatitis | CDC. (2015, May 31). Retrieved from https://www.cdc.gov/hepatitis/hcv/index.htm.
3. American Association for the Study of Liver Diseases and the Infectious Diseases Society of America (AASLD) and Infectious Diseases Society of America (IDSA). HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; 2017. Available at: https://www.hcvguidelines.org/.
4. Afdhal, N. (2012). Fibroscan (Transient Elastography) for the Measurement of Liver Fibrosis. Gastroenterology & Hepatology, 8(9), 605-607.

Effective date: 01/01/2022
Revised date: 11/19/2021

Appendix. Treatment Duration

Genotype and Population	Treatment	Duration
Genotype 1a: Treatment-naïve or PegIFN/RBV experienced[1] without baseline NS5A polymorphisms[2]	Zepatier	12 weeks
Genotype 1a: Treatment-naïve or PegIFN/RBV experienced[1] with baseline NS5A polymorphisms[2]	Zepatier + ribavirin	16 weeks
Genotype 1b: Treatment-naïve or PegIFN/RBV experienced[1]	Zepatier	12 weeks
Genotype 1a or 1b: PegIFN/RBV/PI-experienced[3]	Zepatier + ribavirin	12 weeks
Genotype 4: Treatment-naïve	Zepatier	12 weeks
Genotype 4: PegIFN/RBV-experienced[1]	Zepatier + ribavirin	16 weeks

[1]Peginterferon alfa + ribavirin.
[2]Polymorphisms at amino acid positions 28, 30, 31, or 93.
[3]Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor.

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Zeposia (ozanimod)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Zeposia was approved by the FDA in 2020 for the treatment of relapsing forms of multiple sclerosis (MS). MS is a chronic autoimmune disease of the central nervous system that disrupts communication in the brain and between the brain and body. Zeposia is a once-daily oral sphingosine-1-phosphate (S1P) receptor modulator with high affinity for S1P receptors 1 and 5. Unlike its in-class competitor products, first-dose monitoring is not required for Zeposia. However, a baseline ECG is still recommended, as well as other initial evaluations. Efficacy between products appears to be similar.
In 2021, Zeposia was approved for the treatment of ulcerative colitis (UC), becoming the first S1P receptor modulator approved for this indication. As an oral drug, it sets itself apart as most other UC drugs are injectable. Approval was based on the pivotal phase 3 trial, True North.

Zeposia (ozanimod) will be considered for coverage when the following criteria are met:

Multiple Sclerosis (MS)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of a relapsing form of MS (i.e., clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease); AND
4. The following baseline assessments have been completed (or are scheduled):
   a) A complete blood count (CBC)
   b) An ophthalmic evaluation
   c) Baseline liver function tests
   d) A cardiac evaluation by electrocardiogram (ECG)
5. Member has not experienced any of the following in the past 6 months: Myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure; AND
6. Member does not have Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker; AND
7. Member does not have severe untreated sleep apnea; AND
8. Zeposia will not be used concomitantly with any other disease modifying drugs for MS.
9. **Dosage allowed/Quantity limit:** After titration, the recommended dose is 0.92 mg once daily. (30 capsules per 30 days).

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. Chart notes have been provided showing an improvement in signs and symptoms of disease (e.g., fewer relapses, slowed disability progression, reduced number or volume of brain lesions).

If all the above requirements are met, the medication will be approved for an additional 12 months.

Ulcerative Colitis (UC)

For **initial** authorization:
1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with a gastroenterologist; AND
3. Member has a documented diagnosis of moderately to severely active UC; AND
4. Member must have a documented trial and inadequate response with at least one of the following:
   a) 3 months of 6-mercaptopurine or azathioprine;
   b) 30 days of Corticosteroid (e.g., budesonide, prednisone, methylprednisolone, etc.);
   c) 3 months of 5-aminosalicylate (e.g., Asacol HD, Lialda, Pentasa, Delzicol, mesalamine, etc.); AND
5. Trial and failure of a preferred biologic drug indicated for UC; AND
6. The following baseline assessments have been completed (or are scheduled):
   a) A complete blood count (CBC)
   b) An ophthalmic evaluation
   c) Baseline liver function tests
   d) A cardiac evaluation by electrocardiogram (ECG)
7. Member has not experienced any of the following in the past 6 months: Myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure; AND
8. Member does not have Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless they have a functioning pacemaker; AND
9. Zeposia is not being prescribed in combination with biologic therapy for UC.
10. **Dosage allowed/Quantity limit:** After titration, the recommended dose is 0.92 mg once daily. (30 capsules per 30 days).

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:
1. Chart notes have been provided showing an improvement in signs and symptoms of disease such as clinical remission, reduced rectal bleeding, decreased stool frequency, or endoscopic-histologic mucosal healing.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Zeposia (ozanimod) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
08/07/2020	New policy for Zeposia created.
10/13/2021	Transferred to new template. Added new indication section for UC. MS section: Updated references. General changes to language and safety monitoring for consistency with related drugs. Removed baseline relapse and lesion count.

References:

1. Zeposia [package insert]. Summit, NJ; Celgene Corporation, May 2021.
2. Rae-Grant A, Day GS, Marrie RA, et al. Comprehensive systematic review summary: Disease-modifying therapies for adults with multiple sclerosis. *Neurology 2018*;90:789-800.
3. Cohen JA, Comi G, Arnold DL, et al. Efficacy and safety of ozanimod in multiple sclerosis: Dose-blinded extension of a randomized phase II study. *Multiple Sclerosis Journal 2019*;25(9):1255-1262. doi: 10.1177/1352458518789884.
4. Cohen JA, Comi G, Selmaj KW, et al. Safety and efficacy of ozanimod versus interferon beta-1a in relapsing multiple sclerosis (RADIANCE): a multicenter, randomized, 24-month, phase 3 trial. Lancet Neurol 2019, doi: 10.1016/S1474-4422(19)30238-8.
5. Kurtzke JF. Rating neurologic impairment in multiple sclerosis: an expanded disability status scale (EDSS). *Neurology*. 1983 Nov;33(11):1444-52.
6. Finkelsztejn A. Multiple sclerosis: overview of disease-modifying agents. *Perspect Medicin Chem*. 2014;6:65-72. Published 2014 Oct 5.
7. Swallow E, Patterson-Lomba O, Yin L, et al. Comparative safety and efficacy of ozanimod versus fingolimod for relapsing multiple sclerosis. *J Comp Eff Res*. 2020;9(4):275-285.
8. National Multiple Sclerosis Society. The Use of Disease-Modifying Therapies in Multiple Sclerosis: Principles and Current Evidence. A Consensus Paper by the Multiple Sclerosis Coalition; 2019. Available from: https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/DMT_Consensus_MS_Coalition.pdf. Accessed August 18, 2021.
9. Roy R, Alotaibi AA, Freedman MS. Sphingosine 1-Phosphate Receptor Modulators for Multiple Sclerosis. *CNS Drugs*. 2021;35(4):385-402. doi:10.1007/s40263-021-00798-w
10. Comi G, Kappos L, Selmaj KW, et al. Safety and efficacy of ozanimod versus interferon beta-1a in relapsing multiple sclerosis (SUNBEAM): a multicentre, randomised, minimum 12-month, phase 3 trial. *Lancet Neurol*. 2019;18(11):1009-1020. doi:10.1016/S1474-4422(19)30239-X
11. Sandborn WJ, Feagan BG, D'Haens G, et al. Ozanimod as Induction and Maintenance Therapy for Ulcerative Colitis. *N Engl J Med*. 2021;385(14):1280-1291. doi:10.1056/NEJMoa2033617
12. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. ACG Clinical Guideline: Ulcerative Colitis in Adults. *Am J Gastroenterol*. 2019;114(3):384-413
13. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA Clinical Practice Guidelines on the Management of Moderate to Severe Ulcerative Colitis. *Gastroenterology*. 2020;158(5):1450-1461.
14. Trigo-Vicente C, Gimeno-Ballester V, García-López S, López-Del Val A. Systematic review and network meta-analysis of treatment for moderate-to-severe ulcerative colitis. *Int J Clin Pharm*. 2018;40(6):1411-1419. doi:10.1007/s11096-018-0743-4

Effective date: 04/01/2022
Revised date: 10/13/2021

CareSource Rxinnovations

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Zokinvy (lonafarnib)
BILLING CODE	Must use valid NDC
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
STATUS	Prior Authorization Required

Zokinvy is an oral farnesyltransferase inhibitor initially approved by the FDA in 2020. It is used for the treatment of certain mutations in processing-deficient Progeroid Laminopathies and to reduce the risk of mortality in Hutchinson-Gilford Progeria Syndrome. These are rare and fatal diseases of premature aging. Cardiovascular complications are the primary cause of mortality. Zokinvy is the first FDA approved disease-modifying treatment for these patients. Farnesyltransferase inhibition prevents farnesylation and subsequent accumulation of aberrant progerin and progerin-like proteins in the inner nuclear membrane.

Zokinvy (lonafarnib) will be considered for coverage when the following criteria are met:

Hutchinson-Gilford Progeria Syndrome

For **initial** authorization:

1. Member is at least 12 months of age; AND
2. Member has a body surface area (BSA) of 0.39 m^2 or greater; AND
3. Medication must be prescribed by or in consultation with a pediatrician, geneticist, cardiologist, or metabolic specialist; AND
4. Member has a diagnosis of Hutchinson-Gilford Progeria Syndrome confirmed by a known causative variant mutation in the LMNA gene (documentation required); AND
5. Member is NOT taking any of the following contraindicated drugs/drug classes:
   a) Strong or moderate CYP3A4 inhibitors or inducers;
   b) Midazolam;
   c) Lovastatin, simvastatin, or atorvastatin.
6. **Dosage allowed/Quantity limit:** Start at 115 mg/m^2 twice daily. After 4 months, increase to 150 mg/m^2 twice daily. Round all total doses to nearest 25 mg increment.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:

1. Member is tolerating therapy and is taking an appropriate dose.

If all the above requirements are met, the medication will be approved for an additional 12 months.

Processing-deficient Progeroid Laminopathies

For **initial** authorization:

1. Member is at least 12 months of age; AND
2. Member has a body surface area (BSA) of 0.39 m^2 or greater; AND
3. Medication must be prescribed by or in consultation with a pediatrician, geneticist, cardiologist, or metabolic specialist; AND

4. Member has a diagnosis of processing-deficient progeroid laminopathies confirmed by a known causative variant mutation in the LMNA gene (documentation required) with either:
   a) Heterozygous *LMNA* mutation with progerin-like protein accumulation, or
   b) Homozygous or compound heterozygous *ZMPSTE24* mutations
5. Member is NOT taking any of the following contraindicated drugs/drug classes:
   a) Strong or moderate CYP3A4 inhibitors or inducers;
   b) Midazolam;
   c) Lovastatin, simvastatin, or atorvastatin.
6. **Dosage allowed/Quantity limit:** Start at 115 mg/m^2 twice daily. After 4 months, increase to 150 mg/m^2 twice daily. Round all total doses to nearest 25 mg increment.

If all the above requirements are met, the medication will be approved for 12 months.

For **reauthorization**:
1. Member is tolerating therapy and is taking an appropriate dose.

If all the above requirements are met, the medication will be approved for an additional 12 months.

CareSource considers Zokinvy (lonafarnib) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.

DATE	ACTION/DESCRIPTION
07/01/2021	New policy for Zokinvy created.

References:

1. Zokinvy (lonafarnib) [package insert]. Palo Alto, CA; Eiger BioPharmaceuticals, Inc. Revised 11/2020
2. Gordon LB, Kleinman ME, Miller DT, et al. Clinical trial of a farnesyltransferase inhibitor in children with Hutchinson-Gilford progeria syndrome. *Proc Natl Acad Sci U S A*. 2012;109(41):16666-16671. doi:10.1073/pnas.1202529109

Effective date: 01/01/2022
Revised date: 07/01/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Zoladex (goserelin acetate)
BILLING CODE	Must use a valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home/Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "Dosage allowed" below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zoladex (goserelin acetate) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

CANCER

Any request for **breast cancer** or **prostate cancer** must be submitted through NantHealth/Eviti portal.

DYSFUNCTIONAL UTERINE BLEEDING

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a gynecologist; AND
3. Member will be undergoing endometrial ablation for dysfunctional uterine bleeding; AND
4. Member is **not** pregnant or breastfeeding.
5. **Dosage allowed:** Up to 2 implants (3.6 mg per implant) are allowed per ablation procedure.

If member meets all the requirements listed above, the medication will be approved for 28 days.

For **reauthorization**:

Retreatment is not allowed due to this is a one-time use prior to endometrial ablation.

ENDOMETRIOSIS

For **initial** authorization:

1. Member is premenopausal and 18 years of age or older; AND
2. Member is having painful symptoms (e.g., pelvic pain, dysmenorrhea, etc.) associated with endometriosis (documentation required); AND
3. Medication must be prescribed by or in consultation with a gynecologist; AND
4. Member has tried and failed to control symptoms after trials with **both** of the following, unless not tolerated or contraindicated:
   a) 30 days of an NSAID;
   b) 3 months of a hormonal contraceptive; AND
5. Member is **not** pregnant or planning to become pregnant while taking medication.
6. **Dosage allowed:** 1 implant (3.6 mg) subcutaneously every 28 days.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
Retreatment will not be authorized due to a lack of clinical data available to support the use of Zoladex beyond 6 months.

CareSource considers Zoladex (goserelin acetate) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
10/26/2020	New policy for Zoladex created.
11/19/2021	Annual review, no changes

References:

1. Zoladex [package insert]. Lake Forest, IL: TerSera Therapeutics LLC; February, 2019.
2. Donnez J, Vilos G, Gannon MJ, et al. Goserelin acetate (Zoladex) plus endometrial ablation for dysfunctional uterine bleeding: a 3-year follow-up evaluation. *Fertil Steril*. 2001;75(3):620-622.
3. Schrager S, Falleroni J, Edgoose J. Evaluation and treatment of endometriosis. *Am Fam Physician*. 2013 Jan 15;87(2):107-13.
4. DiVasta AD, Feldman HA, Sadler Gallagher J, et al. Hormonal Add-Back Therapy for Females Treated With Gonadotropin-Releasing Hormone Agonist for Endometriosis: A Randomized Controlled Trial. *Obstet Gynecol*. 2015;126(3):617-627.
5. Armstrong C. ACOG updates guideline on diagnosis and treatment of endometriosis. *Am Fam Physician*. 2011 Jan 1;83(1):84-85.

Effective date: 01/01/2022
Revised date: 11/19/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Zolgensma (onasemnogene abeparvovec-xioi)
BILLING CODE	J3399
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient Hospital
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1.1×10^{14} vector genomes per kilogram (vg/kg) of body weight
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zolgensma (onasemnogene abeparvovec-xioi) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

SPINAL MUSCULAR ATROPHY (SMA)

For **initial** authorization:

1. Member is less than 12 months old at the time of infusion and has documented onset of symptoms before 6 months of age; AND
2. Member has documented diagnosis of SMA type I confirmed by ALL of the following diagnostic test results (both a and b):
   a) The mutation or deletion of genes in chromosome 5q resulting in one of the following:
      i) homozygous gene deletion OR mutation (e.g., homozygous deletion of exon 7 at locus 5q13);
      ii) compound heterozygous mutation (e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2));
   b) Genetic testing confirming 2 copies of SMN2; AND
3. Medication must be prescribed by or in consultation with a neurologist; AND
4. Member does **not** have advanced SMA (e.g., complete paralysis of limbs, permanent ventilator dependence); AND
5. Medication must **not** be concomitantly used with Spinraza (discontinuation of Spinraza prior to Zolgensma therapy is required); AND
6. On day one prior to Zolgensma infusion member will receive systemic corticosteroids equivalent to oral prednisolone at 1 mg/kg of body weight per day (for a total of 30 days); AND
7. Member has documented ALL of the following:
   a) Liver function tests (clinical exam, AST, ALT, total bilirubin, prothrombin time);
   b) Platelet counts and troponin-I;
   c) Baseline testing for the presence of anti-AAV9 antibodies (titer must be ≤ 1:50); AND
8. Member has documentation of baseline of at least one of the following exams (based on patient age and motor ability):
   a) Hammersmith Infant Neurological Exam (HINE) (infant to early childhood);
   b) Hammersmith Functional Motor Scale Expanded (HFMSE);
   c) Upper Limb Module (ULM) Test (Non ambulatory);

d) Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND); AND
9. Member's gestational age is ≥ 35 weeks; AND
10. Member must be up-to-date on childhood vaccinations and prophylaxis against respiratory syncytial virus; AND
11. Member has **not** have any of the following:
    a) Signs of aspiration;
    b) Active viral infection;
    c) Concomitant use of drugs for treatment of myopathy or neuropathy, agents used to treat diabetes mellitus, or ongoing immunosuppressive therapy or immunosuppressive therapy within 3 months (e.g., corticosteroids, cyclosporine, tacrolimus, methotrexate, cyclophosphamide, intravenous immunoglobulin, rituximab);
    d) Tracheostomy (i.e., invasive ventilatory support) or required of non-invasive ventilatory support while awake over the 7 days;
    e) Upper or lower respiratory infection requiring medical attention, medical intervention, or increase in supportive care of any manner within 4 weeks prior to request.
12. **Dosage allowed:** 1.1×10^{14} vector genomes (vg) per kg of body weight.

Note: Use of Zolgensma in premature neonates before reaching full term gestational age is not recommended because concomitant treatment with corticosteroids may adversely affect neurological development.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:
1. Zolgensma will not be reauthorized for continuous use.

CareSource considers Zolgensma (onasemnogene abeparvovec-xioi) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
05/31/2019	New policy for Zolgensma (onasemnogene abeparvovec-xioi) created.
06/29/2020	J Code updated.
09/16/2021	Annual review, no changes

References:

1. Zolgensma [prescribing information]. Bannockburn, IL: AveXis, Inc; 2019.
2. AveXis, Inc. Gene Transfer Clinical Trial for Spinal Muscular Atrophy Type 1. In: ClinicalTrials.gov [Internet]. Bethesda (MD): National Library of Medicine (US). Available from: https://clinicaltrials.gov/ct2/show/NCT02122952?term=ZOLGENSMA&rank=8. Identifier: NCT02122952.
3. Mendell JR, Al-Zaidy S, Shell R, et al. Single-Dose Gene-Replacement Therapy for Spinal Muscular Atrophy. N Engl J Med 2017;377:1713-22.
4. Kolb SJ, Coffey CS, Yankey JW, et al. Natural history of infantile-onset spinal muscular atrophy. Ann Neurol. 2017;82(6):883 891.
5. Govoni A, Gagliardi D, Comi GP, Corti S. Time is motor neuron: therapeutic window and its correlation with pathogenic mechanisms in spinal muscular atrophy. Mol Neurobiol. 2018;55(8):6307 6318.
6. Stifani N. Motor neurons and the generation of spinal motor neuron diversity. Front Cell Neurosci. 2014;8:293.
7. Prior TW. Perspectives and diagnostic considerations in spinal muscular atrophy. Genet Med. 2010;12(3):145 152.
8. Farrar MA, et al. Emerging therapies and challenges in spinal muscular atrophy. Ann Neurol 2017;81(3):355–368.
9. De Sanctis R, et al. Developmental milestones in type I spinal muscular atrophy. Neuromusc Disord 2016;26(11):754–759.
10. Lowes LP, et al. Impact of age and motor function in a phase 1/2A study of infants with SMA Type 1 receiving single-dose gene replacement therapy. Pediatric Neurology (2019).

11. Waldrop MA, et al. Current Treatment Options in Neurology—SMA Therapeutics. Curr Treatment Options Beurology. 2019;21(6):25.

Effective date: 01/01/2022
Revised date: 09/16/2021

CareSource

PHARMACY POLICY STATEMENT
Marketplace

DRUG NAME	Zubsolv (buprenorphine and naloxone) sublingual tablets for sublingual administration
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred products include generic buprenorphine/naloxone sublingual tablets QUANTITY LIMIT— 30-day supply at a time only
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Strength	Quantity Limit
0.7 mg - 0.18 mg	1 tab per day
2.9 mg - 0.7 mg	1 tab per day
11.4 mg - 2.9 mg	1 tab per day
1.4 mg - 0.36 mg	1 tab per day
5.7 mg - 1.4 mg	1 tab per day
8.6 mg - 2.1 mg	2 tabs per day

Zubsolv (buprenorphine and naloxone) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

OPIOID DEPENDENCE

For **initial** authorization:

1. All of the following:
   a) The individual has failed an adequate trial of the preferred generic buprenorphine/naloxone sublingual tablets within the previous 120 days (*Note:* Adequate trial is defined as at least 28 days of treatment); AND
   b) One of the following:
      i) The member experienced therapeutic failure with the preferred generic buprenorphine/naloxone sublingual tablets (*Note:* Brand and non-preferred buprenorphine agents will not be approved for members who report lesser efficacy as compared to the preferred generic buprenorphine sublingual tablets unless it would be clinically inappropriate to address efficacy with dose adjustment); OR
      ii) Generic sublingual tablets caused adverse outcome; AND
   c) The prescriber has provided a copy and confirmation of a MedWatch form submission to the FDA documenting the therapeutic failure or adverse outcome experienced by the member (*Note*: The MedWatch form is available at https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf)

OR

2. Both of the following:
   a) The individual has a hypersensitivity reaction to an inactive ingredient in the preferred generic buprenorphine sublingual tablets; AND

b) The hypersensitivity reaction(s) is clearly documented in the member's medical record.

3. **Dosage allowed:** The maintenance dose of Zubsolv sublingual tablet is generally in the range of 2.9 mg/0.71 mg buprenorphine/naloxone to 17.2 mg/4.2 mg buprenorphine/naloxone per day. The recommended target dose is 11.4 mg/2.9 mg as a single daily dose. Dosages higher than 17.2 mg/4.2 mg buprenorphine/naloxone have not been demonstrated to provide any clinical advantage.

Additional Notes:

- GI upset or irritation is not generally considered an allergy or failed treatment. Members should be referred to their physician or pharmacist for advice on dose adjustment, and/or other options to reduce GI upset/irritation.
- Common documented side effects attributed to the drug (i.e. headache, nausea, blurred vision, fatigue, muscle aches) are not considered an allergy and would be expected to occur at the same level in both the generic and brand agent.
- Drug hypersensitivity symptoms may include skin rash, hives, itching, fever, swelling, shortness of breath, wheezing, runny nose, itchy and/or watery eyes, and in severe cases, anaphylaxis.

If member meets all the requirements listed above, the medication will be approved for lifetime.

CareSource considers Zubsolv (buprenorphine and naloxone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
04/03/2019	New policy for Zubsolv created.
03/11/2021	Annual review, no changes

References:

1. MedWatch: The FDA Safety Information and Adverse Event Reporting Program. Available at http://www.fda.gov/safety/medwatch/default.htm.
2. Zubsolv [package insert]. Morristown, NJ: Orexo US, Inc.; September, 2017.

Effective date: 01/01/2022
Revised date: 03/11/2021

CareSource

PHARMACY POLICY STATEMENT **Marketplace**	
DRUG NAME	Zulresso (brexanolone)
BILLING CODE	J3490
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	TBD
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see **Dosage allowed** below
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Zulresso (brexanolone) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

POSTPARTUM DEPRESSION (PPD)

For **initial** authorization:

1. Member is 18 years old or older and ≤ 6 months postpartum; AND
2. Member has diagnosis of PPD and has documented onset of symptoms in the third trimester or within 4 weeks of delivery; AND
3. Member must have ceased lactating before drug administration, or if still lactating or actively breastfeeding, agreed to temporarily cease giving breastmilk to their infant(s); AND
4. Medication must be prescribed by or in consultation with psychiatrist, ob/gyn provider; AND
5. Member has documented total baseline score of Hamilton Rating Scale for Depression ≥ 20; AND
6. Member does **not** have ANY of the following:
   a) Active psychosis,
   b) Attempted suicide associated with index case of postpartum depression,
   c) Medical history of bipolar disorders, schizophrenia, and/or schizoaffective disorder.
7. **Dosage allowed:** Infusion over a total of 60 hours (2.5 days) as follows:
   0 to 4 hours: Initiate with a dosage of 30 mcg/kg/hour,
   4 to 24 hours: Increase dosage to 60 mcg/kg/hour,
   24 to 52 hours: Increase dosage to 90 mcg/kg/hour (a reduction in dosage to 60 mcg/kg/hour may be considered during this time period for patients who do not tolerate 90 mcg/kg/hour),
   52 to 56 hours: Decrease dosage to 60 mcg/kg/hour,
   56 to 60 hours: Decrease dosage to 30 mcg/kg/hour.

If member meets all the requirements listed above, the medication will be approved for 1 month.

For **reauthorization**:

1. Zulresso will not be authorized for continues administration (it is a single time injection).

CareSource considers Zulresso (brexanolone) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/12/2019	New policy for Zulresso created.
09/16/2021	Annual review, no changes

References:

1. Zulresso [prescribing information]. Cambridge, MA: Sage Therapeutics, Inc.; June 2019.
2. ClinicalTrials.gov Identifier: NCT02942004. A Study to Evaluate Efficacy and Safety of SAGE-547 in Participants With Severe Postpartum Depression (547-PPD-202B). Available at: https://clinicaltrials.gov/ct2/show/NCT02942004?term=NCT02942004&rank=1.
3. ClinicalTrials.gov Identifier: NCT02942017. A Study to Evaluate Safety and Efficacy of SAGE-547 in Participants With Moderate Postpartum Depression (547-PPD-202C). Available at: https://clinicaltrials.gov/ct2/show/NCT02942017?term=NCT02942017&rank=1.
4. Hamilton M. A rating scale for depression. Journal of Neurology, Neurosurgery and Psychiatry, 1960; 23:56-62. Available at: https://www.outcometracker.org/library/HAM-D.pdf.

Effective date: 01/01/2022
Revised date: 09/16/2021