OptumRx

Prior Authorization Guideline

GL-16846 Anadrol-50 (oxymetholone)

Formulary OptumRx

Formulary Note

Approval Date 3/21/2013

Revision Date 5/23/2016

Technician Note :

P&T Approval Date: 12/5/2006; P&T Revision Date: 2/25/2016. **Effective 7/1/2016**

1 . Indications

Drug Name: Anadrol-50 (oxymetholone)

Indications

Anemia

Indicated for the treatment of anemias caused by deficient red cell production. Acquired aplastic anemia, congenital aplastic anemia, myelofibrosis and the hypoplastic anemias due to the administration of myelotoxic drugs often respond. Should not replace other supportive measures such as transfusion, correction of iron, folic acid, vitamin B(logbase12) or pyridoxine deficiency, antibacterial therapy and the appropriate use of corticosteroids. Note: anemias caused by deficient red cell production includes anemia due to chronic renal failure and pure red cell

asplasia.

2 . Criteria

Product Name: Anadrol-50

Approval Length	12 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of anemia caused by deficient red cell production

AND

2 History of failure or intolerance to multiple standard therapies for anemia, such as: erythropoiesis-stimulating agents, immunosuppressants, blood transfusions, etc. [A, B, 2-5]

AND

3 Treatment will not replace other supportive measures (e.g., transfusion, correction of iron, folic acid, vitamin B12 or pyridoxine deficiency, antibacterial therapy, corticosteroids)

Product Name: Anadrol-50

Approval Length	12 Month

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Improvement in anemia (e.g., increased hemoglobin, increased reticulocyte count, reduction/elimination for need of blood transfusions)

3 . Endnotes

A. Androgens were used in the treatment of aplastic anemia for many decades before the availability of immunosuppressants. There is some documented value of oxymetholone in small clinical trials for anemia, both parenteral and oral formulations, but should be reserved for patients unable to tolerate standard therapies due to their androgenic effects and safety profile. [2,3]
B. According to the National Kidney Foundation, use of androgen therapy as adjuvant therapy to erythropoiesis stimulating agents in anemic patients with chronic kidney disease is not recommended due to the serious safety concerns. Furthermore, the evidence for efficacy is of low quality. The Kidney Disease Improving Global Outcomes (KDIGO) guidelines recommend iron, erythropoiesis-stimulating agents, and red cell transfusions for management of anemia associated with chronic kidney disease (CKD); no mention is made of using anabolic steroids. [4.5]

4 . References

1. Anadrol-50 Prescribing Information. Alaven Pharmaceutical, June 2006.
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4. National Kidney Foundation. KDOQI clinical practice guidelines and clinical practice recommendations for anemia in chronic kidney disease. Am J Kidney Dis. 2006;47(Suppl 3):S1-S146.
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Prior Authorization Guideline

GL-17286 Antimalarial Agents

Formulary OptumRx

Formulary Note

Approval Date 3/21/2013

Revision Date 5/6/2016

Technician Note :

P&T Approval Date: 8/24/2001; P&T Revision Date: 2/25/2016 **Effective 7/1/2016**

1 . Indications

Drug Name: Coartem (artemether/lumefantrine) tablets

Indications

Malaria

Indicated for treatment of acute, uncomplicated malaria infections due to Plasmodium falciparum in patients of 5 kg bodyweight and above. Coartem tablets have been shown to be effective in geographical regions where resistance to chloroquine has been reported. Limitations of Use: 1) Is not approved for patients with severe or complicated P. falciparum malaria. 2) Is not approved for the prevention of malaria.

Drug Name: Qualaquin (quinine sulfate)

Indications

Malaria

Indicated only for treatment of uncomplicated Plasmodium falciparum malaria. Quinine sulfate has been shown to be effective in geographical regions where resistance to chloroquine has been documented. Oral capsules are not approved for patients with severe or complicated P. falciparum malaria. Oral capsules are not approved for prevention of malaria. Oral capsules are not approved for the treatment or prevention of nocturnal leg cramps.

2 . Criteria

Product Name: Brand Qualaquin, Generic quinine sulfate

Approval Length	7 days [3]
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of uncomplicated malaria [6]

AND

2 One of the following:

2.1 Both of the following:

2.1.1 Treatment in areas of chloroquine-sensitive malaria [A]*

AND

2.1.2 History of failure, contraindication or intolerance to one of the following: [4, 5, 6, 7]

- chloroquine
- hydroxychloroquine

OR

2.2 Treatment in areas of chloroquine-resistant malaria [B]*

AND

3 Not used for the treatment or prevention of nocturnal leg cramps [3]

Notes	*Call the Malaria Hotline (770-488-7788) for additional information if needed.

Product Name: Coartem

Approval Length	3 days [6,7]
Guideline Type	Non Formulary

Approval Criteria

1 Diagnosis of acute, uncomplicated malaria [6]

AND

2 One of the following:

2.1 Both of the following: **2.1.1** Treatment in areas of chloroquine-sensitive malaria [A]* **AND** **2.1.2** History of failure, contraindication or intolerance to one of the following: [5, 6, 7] • chloroquine • hydroxychloroquine **OR** **2.2** Treatment in areas of chloroquine-resistant malaria [4, B]*	
Notes	*Call the Malaria Hotline (770-488-7788) for additional information if needed.

3 . Endnotes

A. Areas of chloroquine-sensitive malaria include: Central America west of the panama canal; Haiti; the Dominican Republic; most of the Middle East. [5, 6, 7]
B. Areas of chloroquine-resistant malaria include: Southeast Asia, and all malarious regions except those specified as chloroquine-sensitive listed in Endnote A. [5, 6, 7]

4 . References

1. Coartem Prescribing Information. Novartis, August 2012 .
2. Malarone Tablets and Malarone Pediatric Tablets Prescribing Information. GlaxoSmithKline, September 2009.
3. Qualaquin Prescribing Information. Mutual Pharmaceutical Company, Inc., April 2011.
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http://wwwnc.cdc.gov/travel/yellowbook/2012/chapter-3-infectious-diseases-related-to-travel/malaria.htm Accessed September 24, 2012 .
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7. Center for Disease Control and Prevention. Treatment of Malaria (Guidelines for Clinicians) Updated April 2011. Available at: http://www.cdc.gov/malaria/resources/pdf/clinicalguidance.pdf Accessed September 24, 2012 .

Prior Authorization Guideline

GL-17219 Azole Antifungals

Formulary OptumRx

Formulary Note

Approval Date 8/20/2014

Revision Date 5/25/2016

Technician Note :

P&T Approval Date: 10/20/1998; P&T Revision Date: 2/25/2016; **Effective 7/1/2016**

1 . Indications

Drug Name: Sporanox (itraconazole) capsules

Indications

Blastomycosis

Indicated for the treatment of the following fungal infection in immunocompromised and non-immunocompromised patients: Blastomycosis, pulmonary and extrapulmonary

Histoplasmosis

Indicated for the treatment of the following fungal infection in immunocompromised and non-

immunocompromised patients: Histoplasmosis, including chronic cavitary pulmonary disease and disseminated, nonmeningeal histoplasmosis

Aspergillosis

Indicated for the treatment of the following fungal infection in immunocompromised and non-immunocompromised patients: Aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or refractory to amphotericin B therapy

Onychomycosis of the toenail

Indicated for the treatment of the following fungal infection in non-immunocompromised patients: Onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (Tinea unguium)

Onychomycosis of the fingernail

Indicated for the treatment of the following fungal infection in non-immunocompromised patients: Onychomycosis of the fingernail due to dermatophytes (Tinea unguium)

Drug Name: Sporanox Pulse Pak (itraconazole)

Indications

Onychomycosis of the fingernail

Indicated for the treatment of the following fungal infection in non-immunocompromised patients: Onychomycosis of the fingernail due to dermatophytes (Tinea unguium)

Drug Name: Sporanox (itraconazole) oral solution

Indications

Oropharyngeal and esophageal candidiasis

Indicated for the treatment of oropharyngeal and esophageal candidiasis.

Drug Name: Onmel (itraconazole)

Indications

Onychomycosis of the toenail
Indicated for the treatment of onychomycosis of the toenail due to Trichophyton rubrum or T. Mentagrophytes in non immunocompromised patients. Prior to initiating treatment, appropriate nail specimens for laboratory testing (KOH preparation, fungal culture, or nail biopsy) should be obtained to confirm the diagnosis of onychomycosis.

2 . Criteria

Product Name: Brand Sporanox capsules or generic itraconazole capsules

Diagnosis	Systemic fungal infections
Approval Length	6 months [16, 17, 18, B]
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis)

OR

2 Both of the following:

2.1 One of the following diagnoses:

- Tinea corporis (ring worm)
- Tinea cruris (jock itch)
- Tinea pedis (athlete's foot)

AND

2.2 The tinea infection is resistant to topical antifungal treatment

Product Name: Brand Sporanox capsules, generic itraconazole capsules, or Sporanox Pulse Pak

Diagnosis	Onychomycosis - Fingernails
Approval Length	1 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of fingernail onychomycosis as confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture
- Histology

AND

2 The patient's condition is causing debility or a disruption in their activities of daily living

AND

3 The patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine

Product Name: Brand Sporanox capsules or generic itraconazole capsules

Diagnosis	Onychomycosis - Toenails
Approval Length	3 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of toenail onychomycosis as confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture
- Histology

AND

2 The patient's condition is causing debility or a disruption in their activities of daily living

AND

3 The patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine

Product Name: Sporanox oral solution

Diagnosis	Candidiasis (esophageal or oropharyngeal)
Approval Length	1 month [G]
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of esophageal or oropharyngeal candidiasis that is refractory to treatment with fluconazole

Product Name: Onmel

Diagnosis	Onychomycosis - Toenails
Approval Length	3 months [25]
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of toenail onychomycosis as confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture
- Histology

AND

2 The patient's condition is causing debility or a disruption in their activities of daily living

AND

3 The patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine

3 . Endnotes

A. Fingernail infections are usually reevaluated 18 weeks or longer after completion of therapy. Toenail infections are usually reevaluated 6-9 months after completion of therapy. [10] Indeed, considering that toenails can take 12 to 18 months to grow out, many clinicians consider that 1 year is too short to assess clinical effectiveness. [11] Reports of long-term follow-up of treated patients have recently been presented, suggesting that positive mycology at 12 and 24 weeks after commencement of therapy are poor prognostic signs and may indicate a need for retreatment or for a change of drug. [13]
B. The optimal duration of therapy for aspergillosis has not been defined. Most clinicians treat infections (pulmonary) until resolution or stabilization of clinical and radiographic manifestations. The IDSA recommends a minimal treatment period of 6 – 12 weeks in immunocompetent patients for invasive conditions. [18]
C. Risk factors for invasive aspergillosis during AML therapy include the need for > 1 treatment course to achieve remission or chemotherapy for relapses or refractory AML. Risk factors for invasive aspergillosis in patients with GVHD include the need for prolonged high-dose steroid therapy (> 1 mg/kg/day of prednisone for 2-3 weeks) and the use of certain anti-GVHD therapies, such as infliximab and antithymocyte globulin. [18] The pivotal study of posaconazole defined prolonged (or anticipated prolonged) neutropenia as an absolute neutrophil count (ANC) of less than or equal to 500 cell/mm^3 for greater than or equal to 7 days. [24]
D. NCCN recommends secondary prophylaxis with an appropriate antifungal agent in patients with prior chronic disseminated candidiasis or with invasive filamentous fungal infection during subsequent cycles of chemotherapy or HSCT. In patients with invasive aspergillosis before HSCT, antifungal therapy for more than a month and resolution of radiologic abnormalities correlate with a lower likelihood of post-transplant recurrence of infection. Secondary prophylaxis with a mold-active agent is advised for the entire period of immunosuppression. Secondary prophylaxis is generally administered for the duration of immunosuppression. Per recommendation from an infectious disease specialist, posaconazole is used for secondary prophylaxis of prior fungal infections. [23, 30]
E. For fluconazole-refractory OPC, either itraconazole or posaconazole for up to 28 days is recommended. [19]
F. Ketoconazole tablets may cause severe hepatotoxicity and adrenal insufficiency. Therefore, ketoconazole tablets should be used only when other effective antifungal therapy is not available or tolerated and the potential benefits are considered to outweigh the potential risks. [15, 27]
G. Patients may be expected to relapse shortly after discontinuing therapy with Sporanox oral solution. Limited data on the safety of long-term use (> 6 months) of Sporanox Oral Solution are available at this time. [2]
H. The usual duration of therapy with ketoconazole tablets for systemic infection is 6 months. Treatment should be continued until active fungal infection has subsided. [15]
I. Duration of therapy with Noxafil tablets is based on recovery from neutropenia or immunosuppression. [22]
J. Isavuconazonium sulfate was noninferior to voriconazole for primary treatment in patients with proven, probable, or possible invasive fungal infection (Intent-to-treat population N=258; all-cause mortality rate through day 42, 18.6% vs 20.2%). Mean treatment duration was 47 days [31].
K. According to the IDSA guidelines for aspergillosis, duration of therapy for most conditions for aspergillosis has not been optimally defined. Most experts attempt to treat pulmonary infection until resolution or stabilization of all clinical and radiographic manifestations. Other factors include site of infection (e.g., osteomyelitis), level of

immunosuppression, and extent of disease. Reversal of immunosuppression, if feasible, is important for a favorable outcome for invasive aspergillosis." [18]

L. According to the IDSA guidelines for the treatment of aspergillosis, both Amphtericin B and itraconazole are listed as second line treatment options for the treatment of invasive disease. [18]

4 . References

1. Sporanox Capsules Prescribing Information. Janssen Pharmaceutica N.V., June 2014.
2. Sporanox Oral Solution Prescribing Information. Ortho Biotech Products L.P., June 2014.
3. Vfend Prescribing Information. Pfizer Inc., February 2014.
4. Diflucan Prescribing Information. Roerig Inc., November 2011
5. Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines 2010. MMWR 2010; 59:. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm.
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8. Pappas P, Rex J, Sobel J, et al. Guidelines for treatment of candidiasis. Clin Infect Dis. 2004;38:161-189.
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11. Sigurgeirsson B, Olafsson JH, Steinsson JP, et al. Long-term effectiveness of treatment with terbinafine vs. itraconazole in onychomycosis: a 5-year blinded prospective follow-up study. Arch Dermatol. 2002;138:353-7.
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18. Walsh TJ, Anaissie EJ, Denning DW, Herbrecht R, Kontoyiannis DP, Marr KA, et al. Treatment of aspergillosis: clinical practice guidelines of the Infectious Diseases Society of America. Clin Infect Dis. 2008;46:327-360.
19. Pappas PG, Kauffman CA, Andes D, Benjamin DK, Calandra TF, Edwards JE, et al. Clinical practice guidelines: guidelines for the management of candidiasis – 2009 update by the Infectious Diseases Society of America. Clin Infect Dis. 2009;48-503-535.
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23. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Prevention and Treatment of Cancer-Related Infections. V.1.2015. Available at: http://www.nccn.org/professionals/physician_gls/pdf/infections.pdf. Accessed April 07, 2015.
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Prior Authorization Guideline

GL-16848 Belbuca-Butrans (buprenorphine)

Formulary OptumRx

Formulary Note

Approval Date 2/15/2016

Revision Date 5/23/2016

Technician Note :

P&T Approval Date: 5/20/2007; P&T Revision Date: 2/25/2016. **Effective 7/1/2016**

1 . Indications

Drug Name: Belbuca (buprenorphine) film, Butrans (buprenorphine) transdermal patch

Indications

Chronic pain

Indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Limitations of use: Because of the risks of addiction, abuse and misuse with opioids, even at recommended doses, and because of the greater risk of overdose and death with extended-release opioid formulations, reserve Butrans/Belbuca for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or

would be otherwise inadequate to provide sufficient management of pain. Butrans/Belbuca is not indicated as an as-needed (prn) analgesic.

2 . Criteria

Product Name: Belbuca, Butrans

Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

1.1 Patient is under hospice care

OR

1.2 All of the following:

1.2.1 Diagnosis of severe pain

AND

1.2.2 Patient requires continuous, around-the-clock opioid analgesic for an extended period of time (at least 2 weeks)

AND

1.2.3 One of the following:

1.2.3.1 History of failure or intolerance to at least two generic extended-release opioid products and/or opioid combination products:

- Oxymorphone ER
- Morphine ER
- Fentanyl
- Methadone
- Tramadol ER
- Opioid Combinations

OR

1.2.3.2 Patient has documented swallowing difficulties

3 . Background

Benefit/Coverage/Program Information

Quantity Limit

These products are subject to an OptumRx standard quantity limit. The quantity limit may vary form the standard limit based upon plan-specific benefit design. Please refer to your benefit materials.

4 . References

1. Butrans Prescribing Information. Purdue Pharma L.P., June 2014.
2. Belbuca Prescribing Information. Endo Pharmaceuticals, December 2015.

Prior Authorization Guideline

GL-31641 Cannabinoids

Formulary OptumRx

Formulary Note

Approval Date 9/29/2016

Revision Date 9/29/2016

Technician Note :

P&T Approval Date: 10/3/2006; P&T Revision Date: 9/28/2016. **Effective 10/15/2016**

1 . Indications

Drug Name: Cesamet (nabilone)

Indications

Chemotherapy-induced nausea and vomiting Indicated for the treatment of the nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. This restriction is required because a substantial proportion of any group of patients treated with Cesamet can be expected to experience disturbing psychotomimetic reactions not observed with other antiemetic agents. Because of its potential to alter the mental state, Cesamet is intended for use under circumstances that permit close supervision of the patient by a responsible individual particularly

during initial use of Cesamet and during dose adjustments. Cesamet contains nabilone, which is controlled in Schedule II of the Controlled Substances Act. Schedule II substances have a high potential for abuse. Prescriptions for Cesamet should be limited to the amount necessary for a single cycle of chemotherapy (ie, a few days). Cesamet capsules are not intended to be used on as needed basis or as a first antiemetic product prescribed for a patient. As with all controlled drugs, prescribers should monitor patients receiving nabilone for signs of excessive use, abuse and misuse. Patients who may be at increased risk for substance abuse include those with a personal or family history of substance abuse (including drug or alcohol abuse) or mental illness.

Drug Name: Marinol (dronabinol) capsule, Syndros (dronabinol) oral solution

Indications

Chemotherapy-induced nausea and vomiting Indicated for the treatment of nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments.

Anorexia in patients with AIDS Indicated for the treatment of anorexia associated with weight loss in patients with AIDS.

2 . Criteria

Product Name: Cesamet or Brand Marinol

Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	6 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Patient is receiving cancer chemotherapy

AND

2 History of failure, contraindication, or intolerance to formulary generic dronabinol capsules*

AND

3 History of failure, contraindication, or intolerance to a 5HT-3 receptor antagonist [eg, Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] [2]

AND

4 History of failure, contraindication, or intolerance to one of the following: [2, A]

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Notes	*This product may require prior authorization.

Product Name: Syndros

Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	6 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Patient is receiving cancer chemotherapy

AND

2 One of the following:

2.1 History of failure or intolerance to formulary generic dronabinol capsules*

OR

2.2 Patient is unable to swallow capsules

AND

3 History of failure, contraindication, or intolerance to a 5HT-3 receptor antagonist [eg, Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] [2]

AND

4 History of failure, contraindication, or intolerance to one of the following: [2, A]

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Notes	*This product may require prior authorization.

Product Name: Generic dronabinol

Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	6 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Patient is receiving cancer chemotherapy

AND

2 History of failure, contraindication, or intolerance to a 5HT-3 receptor antagonist [eg, Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)] [2]

AND

3 History of failure, contraindication, or intolerance to one of the following: [2, A]

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Product Name: Brand Marinol

Diagnosis	Anorexia in Patients with AIDS

Approval Length	3 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of anorexia with weight loss in patients with AIDS

AND

2 Patient is on antiretroviral therapy [8,11]

AND

3 One of the following [4,5,11]:

3.1 Patient is 65 years of age or greater

OR

3.2 Both of the following:

- Patient is less than 65 years of age
- History of failure, contraindication, or intolerance to Megace (megestrol)

AND

4 History of failure or intolerance to formulary generic dronabinol capsules*

Notes	*This product may require prior authorization.

Product Name: Syndros

Diagnosis	Anorexia in Patients with AIDS
Approval Length	3 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of anorexia with weight loss in patients with AIDS

AND

2 Patient is on antiretroviral therapy [8,11]

AND

3 One of the following [4,5,11]:

3.1 Patient is 65 years of age or greater

OR

3.2 Both of the following:

- Patient is less than 65 years of age
- History of failure, contraindication, or intolerance to Megace (megestrol)

AND

4 One of the following:

4.1 History of failure or intolerance to formulary generic dronabinol capsules*

OR

4.2 Patient is unable to swallow capsules

Notes	*This product may require prior authorization.

Product Name: Generic dronabinol

Diagnosis	Anorexia in Patients with AIDS
Approval Length	3 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of anorexia with weight loss in patients with AIDS

AND

2 Patient is on antiretroviral therapy [8,11]

AND

3 One of the following [4,5,11]:

3.1 Patient is 65 years of age or greater

OR

3.2 Both of the following:

- Patient is less than 65 years of age
- History of failure, contraindication, or intolerance to Megace (megestrol)

3 . Endnotes

A. Per NCCN, cannabinoids are agents that can be used for breakthrough treatment. Other agents used for breakthrough treatment include: phenothiazines (prochlorperazine, promethazine), prokinetic agents (metoclopramide), antipsychotic agents (haloperidol, olanzapine), corticosteroids (dexamethasone), benzodiazepines (lorazepam), antispasmodics (scopolamine) and 5-HT3 receptor antagonists (dolasetron, granisetron, ondansetron). [2]

4 . References

1. Cesamet Prescribing Information. Meda Pharmaceuticals Inc, September 2013.
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Prior Authorization Guideline

GL-16844 Horizant (gabapentin enacarbil)

Formulary OptumRx

Formulary Note

Approval Date 4/12/2016

Revision Date 4/12/2016

Technician Note :

P&T Approval Date: 2/25/2016 **Effective 7/1/2016**

1 . Indications

Drug Name: Horizant (gabapentin enacarbil)

Indications

Restless Legs Syndrome (RLS)

Indicated for the treatment of moderate-to-severe primary restless legs syndrome (RLS) in adults. Horizant is not recommended for patients who are required to sleep during the daytime and remain awake at night.

Postherpetic Neuralgia (PHN)

Indicated for the management of postherpetic neuralgia (PHN) in adults.

2 . Criteria

Product Name: Horizant

Diagnosis	Restless Legs Syndrome (RLS)
Approval Length	6 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of moderate-to-severe primary restless legs syndrome (RLS)

AND

2 History of failure, contraindication, or intolerance to one of the following [A]:

- ropinirole
- pramipexole

Product Name: Horizant

Diagnosis	Restless Legs Syndrome (RLS)
Approval Length	12 Month
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 Patient has experienced an improvement in RLS disease symptoms (e.g., decrease in symptom onset or severity, improved sleep, or decrease in symptom intensity)

Product Name: Horizant

Diagnosis	Postherpetic Neuralgia (PHN)
Approval Length	6 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of postherpetic neuralgia (PHN)

AND

2 One of the following [B]:

2.1 History of trial with inadequate response to a dose of at least 1800 mg of generic gabapentin

OR

2.2 History of intolerance to generic gabapentin

Product Name: Horizant

Diagnosis	Postherpetic Neuralgia (PHN)
Approval Length	12 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Patient has experienced an improvement in PHN disease symptoms (e.g., decrease in pain severity)

3 . Background

Benefit/Coverage/Program Information

Quantity Limit

This product is subject to an OptumRx standard quantity limit. The quantity limit may vary from the standard limit based upon plan-specific benefit design. Please refer to your benefit materials.

4 . Endnotes

A. Dopamine agonists (such as ropinirole, pramipexole) are the most extensively studied and used therapies for the treatment for daily RLS symptoms. Clinicians can treat patients with levodopa with a dopa decarboxylase inhibitor, opioids, or Horizant (gabapentin enacarbil). Cabergoline can be used if other recommended agents have provided an inadequate response, due to the risk of potential side effects including heart valve damage. Other pharmacologic options include gabapentin, Lyrica (pregabalin), carbamazepine, or clonidine. [2]
B. While Horizant (gabapentin enacarbil) may improve patient convenience (twice daily rather than three times daily dosing), generic gabapentin is a more well-established, cost-effective therapy for PHN. The use of Horizant (gabapentin enacarbil) should be reserved for patients who have experienced treatment failure or intolerance to generic gabapentin. [3-5]
C. The established quantity limit is based on the recommended dosing. Doses greater than 1,200 mg daily have not been demonstrated to have additional benefit. Higher doses have resulted in an increase in adverse reactions. [1]

5 . References

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4. Dubinsky RM, Kabbani H, El-Chammi Z, et al. Practice parameter: treatment of postherpetic neuralgia: an evidence-based report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2004; 63(6):959-965.
5. Johnson RW and Rice ASC. Postherpetic neuralgia. N Engl J Med. 2014;371:15236-1533.

Prior Authorization Guideline

GL-32286 Opioid Dependence

Formulary OptumRx

Formulary Note

Approval Date 11/17/2016

Revision Date 11/17/2016

Technician Note :

P&T Approval Date: 2/25/2016; P&T Revision Date: 10/26/2016.

1 . Indications

Drug Name: Bunavail (buprenorphine/naloxone) buccal film, generic buprenorphine/naloxone sublingual tablets **Indications** **Opioid dependence (maintenance treatment)** Indicated for the maintenance treatment of opioid dependence and should be used as part of a complete treatment plan to include counseling and psychosocial support.
Drug Name: Suboxone (buprenorphine/naloxone) sublingual film, Zubsolv

(buprenorphine/naloxone) sublingual tablets **Indications** **Opioid dependence (induction and maintenance treatment)** Indicated for treatment of opioid dependence and should be used as part of a complete treatment plan to include counseling and psychosocial support.
Drug Name: Generic buprenorphine sublingual tablets **Indications** **Opioid dependence** Indicated for the treatment of opioid dependence and are preferred for induction. Buprenorphine HCl Sublingual Tablets should be used as part of a complete treatment plan to include counseling and psychosocial support.

2 . Criteria

Product Name: Bunavail buccal film, generic buprenorphine/naloxone sublingual tablets, Suboxone sublingual film, or Zubsolv sublingual tablets

Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of opioid dependence

AND

2 Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and provides registration number [A]

AND

3 Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) [B]

AND

4 Patient is not receiving any other opioids, written by the same or a different prescriber within the past 7 days, as verified by claims history

AND

5 Patient is not pregnant

Product Name: Bunavail buccal film, generic buprenorphine/naloxone sublingual tablets, Suboxone sublingual film, or Zubsolv sublingual tablets

Approval Length	9 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of opioid dependence

AND

2 Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and provides registration number [A]

AND

3 Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) [B]

AND

4 One of the following:

4.1 Patient is not receiving any other opioids, written by the same or a different prescriber since starting therapy, as verified by claims history

OR

4.2 Both of the following:

4.2.1 Patient has received other opioids, written by the same or a different prescriber since starting therapy

AND

4.2.2 Prescriber is aware and acknowledges that opioid history was necessary as part of good medical practices in the care of the patient.

AND

5 Patient is not pregnant

AND

6 Random urine drug screens are being used by the prescriber to evaluate and assess the patientâ€™s progress (e.g., relapse, progress/accomplishment of treatment goals) [C]

Product Name: buprenorphine

Diagnosis	Opioid Dependence, non-pregnant patient
Approval Length	1 Month [D]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of opioid dependence

AND

2 Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and provides registration number [A]

AND

3 Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) [B]

AND

4 Patient is not receiving any other opioids, written by the same or a different prescriber within the past 7 days, as verified by claims history

AND

5 Patient is not pregnant*

Notes	*Continued coverage of buprenorphine should be reserved for pregnant females. Non-pregnant (male or non-pregnant female) members should be transitioned from Subutex to Suboxone, Bunavail, or Zubsolv for long term opioid dependence management as soon as possible. [7]

Product Name: buprenorphine

Diagnosis	Opioid Dependence, pregnant patient
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of opioid dependence

AND

2 Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and provides registration number [A]

AND

3 Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) [B]

AND

4 Patient is not receiving any other opioids, written by the same or a different prescriber within the past 7 days, as verified by claims history

AND

5 Patient is pregnant [D]

Product Name: buprenorphine

Diagnosis	Opioid Dependence, all patients
Approval Length	9 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria	

1 Diagnosis of opioid dependence

AND

2 Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and provides registration number [A]

AND

3 Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) [B]

AND

4 One of the following:

4.1 Patient is not receiving any other opioids, written by the same or a different prescriber since starting therapy, as verified by claims history

OR

4.2 Both of the following:

4.2.1 Patient has received other opioids, written by the same or a different prescriber since starting therapy

AND

4.2.2 Prescriber is aware and acknowledges that opioid history was necessary as part of

good medical practices in the care of the patient. **AND** **5** Patient is pregnant* [D] **AND** **6** Random urine drug screens are being used by the prescriber to evaluate and assess the patientâ€™s progress (e.g., relapse, progress/accomplishment of treatment goals) [C]	
Notes	*Continued coverage of buprenorphine should be reserved for pregnant females. Non-pregnant (male or non-pregnant female) members should be transitioned from Subutex to Suboxone, Bunavail, or Zubsolv for long term opioid dependence management as soon as possible.

3 . Endnotes

A. The Drug Addiction Treatment Act (DATA) of 2000 requires qualifying physicians to receive a waiver to prescribe Schedule III-IV drugs such as buprenorphine or the combination of it to treat opioid dependence patients in their offices. In order to obtain the waiver to prescribe Subutex/Suboxone/Zubsolv, the physician must be certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and must have a valid and current state medical license, DEA registration and meet criteria indicating adequate training for addiction management.
B. In the treatment of opioid dependence, buprenorphine should be part of a comprehensive treatment program that includes self-help groups, counseling, ongoing

care, vocational training with initial and ongoing drug screening to assess recent drug used. [5,6]

C. Patients should be seen at least once a week initially and adjusted based on progress. Random urine drug screens should be done at least monthly to assess patientâ€™s progress and relapse. [6,7]
D. Pregnant mothers who are inducted with buprenorphrine monotherapy should be maintained on buprenorphrine due to the risk of naloxone precipitating withdrawal in both the mother and the fetus. [5,6] According to SAMHSA consensus panel, male and non-pregnant female members should be transitioned from Subutex to Suboxone, Bunavail or Zubsolv for long term opioid dependence management as soon as possible. [7]

4 . References

1. Buprenorphine HCl - Naloxone HCl Sublingual Tablets Prescribing Information. Amneal Pharmaceuticals of New York, LLC., September 2015.
2. Buprenorphine HCl Sublingual Tablets Prescribing Information. Roxane Laboratories, Inc., January 2015.
3. Zubsolv Prescribing Information. Orexo US, Inc., August 2015.
4. Bunavail Prescribing Information. BioDelivery Sciences International, Inc., June 2014.
5. World Health Organization (WHO). Guidelines for the identification and management of substance use and substance use disorders in pregnancy. Geneva (Switzerland): World Health Organization (WHO); 2014. 204 p.
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7. McNicholas, L (chair). Clinical guidelines for the use of buprenorphine in the treatment of opioid dependence. SAMHSA: Center for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. 2004.

Prior Authorization Guideline

GL-31347 Oral Fentanyl Products

Formulary OptumRx

Formulary Note

Approval Date 8/10/2016

Revision Date 8/10/2016

Technician Note :

P&T Approval Date: 11/16/2001; P&T Revision Date: 7/27/2016 **Effective 9/1/2016**

1 . Indications

Drug Name: Abstral (fentanyl)

Indications

Breakthrough pain Indicated for the management of breakthrough pain in cancer patients 18 years of age and older who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, or at least 25 mcg of transdermal fentanyl/hour, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or at least 25 mg oral oxymorphone daily, or an equianalgesic dose of another opioid medication daily for a week or longer. Patients must remain on around-the-clock

opioids when taking Abstral. Abstral is contraindicated for patients who are not already tolerant to opioids because life-threatening respiratory depression and death could result at any dose in patients not on a chronic regimen of opioids. For this reason, Abstral is contraindicated in the management of acute or postoperative pain, including headache/migraine, dental pain, or use in the emergency room. Abstral is intended to be prescribed only by healthcare professionals who are knowledgeable of, and skilled in, the use of Schedule II opioids to treat cancer pain. Limitations of Use: As a part of the TIRF REMS Access program, Abstral may be dispensed only to outpatients enrolled in the program. For inpatient administration of Abstral (e.g., hospitals, hospices, and long-term care facilities that prescribe for inpatient use), patient and prescriber enrollment is not required.

Drug Name: Actiq (fentanyl citrate) oral transmucosal lozenge

Indications

Breakthrough pain Indicated for the management of breakthrough pain in cancer patients 16 years of age and older who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily, or an equianalgesic dose of another opioid daily for a week or longer. Patients must remain on around-the-clock opioids when taking Actiq. This product must not be used in opioid non-tolerant patients because life-threatening respiratory depression and death could occur at any dose in patients not on a chronic regimen of opioids. For this reason, Actiq is contraindicated in the management of acute or postoperative pain. Actiq is intended to be used only in the care of opioid-tolerant cancer patients and only by oncologists and pain specialists who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain. Limitations of Use: As a part of the TIRF REMS Access program, Actiq Q may be dispensed only to outpatients enrolled in the program. For inpatient administration of Actiq (e.g., hospitals, hospices, and long-term care facilities that prescribe for inpatient use), patient and prescriber enrollment is not required.

Drug Name: Fentora (fentanyl buccal tablet)

Indications

Breakthrough pain Indicated for the management of breakthrough pain in cancer patients 18 years of age and older who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, at least 25 mcg/hr of transdermal fentanyl, at least 30 mg of oral oxycodone daily, at least

8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily, or an equianalgesic dose of another opioid daily for a week or longer. Patients must remain on around-the-clock opioids while taking Fentora. This product must not be used in opioid non-tolerant patients because life-threatening hypoventilation and death could occur at any dose in patients not on a chronic regimen of opioids. For this reason, Fentora is contraindicated in the management of acute or postoperative pain. Fentora is intended to be used only in the care of opioid tolerant cancer patients and only by healthcare professionals who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain. Limitations of Use: As a part of the TIRF REMS Access program, Fentora may be dispensed only to outpatients enrolled in the program. For inpatient administration of Fentora (e.g., hospitals, hospices, and long-term care facilities that prescribe for inpatient use), patient and prescriber enrollment is not required.

Drug Name: Lazanda (fentanyl) nasal spray

Indications

Breakthrough pain Indicated for the management of breakthrough pain in cancer patients 18 years of age and older who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer. Patients must remain on around-the-clock opioids when taking Lazanda. Lazanda is contraindicated for patients who are not already tolerant to opioids because life-threatening respiratory depression and death could occur in patients not taking chronic opioids. For this reason, Lazanda is contraindicated in the management of acute or postoperative pain, including headache/migraine, or dental pain. Lazanda is intended to be prescribed only by healthcare professionals who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain. Limitations of Use: As a part of the TIRF REMS Access program, Lazanda may be dispensed only to outpatients enrolled in the program.For inpatient administration of Lazanda (e.g., hospitals, hospices, and long-term care facilities that prescribefor inpatient use), patient enrollment is not required.

Drug Name: Subsys (fentanyl sublingual spray)

Indications

Breakthrough pain Indicated for the management of breakthrough pain in adult cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid daily for a week or longer.

Patients must remain on around-the-clock opioids when taking Subsys . This product must not be used in opioid non-tolerant patients because life-threatening respiratory depression and death could occur at any dose in patients not on a chronic regimen of opioids. For this reason, Subsys is contraindicated in the management of acute or postoperative pain. Subsys is intended to be used only in the care of cancer patients and only by oncologists and pain specialists who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain. Limitations of Use As part of the Transmucosal Immediate-Release Fentanyl (TIRF) REMS ACCESS Program, Subsys may be dispensed only to outpatients enrolled in the program. For inpatient administration (e.g., hospitals, hospices, and long-term care facilities that prescribe for inpatient use) of Subsys, patient enrollment is not required.

2 . Criteria

Product Name: Abstral*, Brand Actiq, Fentora*, Lazanda*, or Subsys

Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 For the management of breakthrough cancer pain [A]

and

2 Patient must have at least a one week history of one of the following medications to demonstrate tolerance to opioids: [3, 5, B]

- Morphine sulfate at doses of greater than or equal to 60 mg/day
- Fentanyl transdermal patch at doses greater than or equal to 25 Âµg/hr
- Oxycodone at a dose of greater than or equal to 30 mg/day
- Oral hydromorphone at a dose of greater than or equal to 8 mg/day
- Oral oxymorphone at a dose of greater than or equal to 25 mg/day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or

equal to 20 mg/day)

and

3 History of failure or intolerance to generic fentanyl lozenge

and

4 The patient is currently taking a long-acting opioid around the clock for cancer pain

and

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

- Pain specialist
- Oncologist
- Hematologist
- Hospice care specialist
- Palliative care specialist

Notes	*Product may be excluded depending on the plan

Product Name: Generic fentanyl lozenge

Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 For the management of breakthrough cancer pain [A]

and

2 Patient must have at least a one week history of one of the following medications to demonstrate tolerance to opioids: [3, 5, B]

- Morphine sulfate at doses of greater than or equal to 60 mg/day
- Fentanyl transdermal patch at doses greater than or equal to 25 Âµg/hr
- Oxycodone at a dose of greater than or equal to 30 mg/day
- Oral hydromorphone at a dose of greater than or equal to 8 mg/day
- Oral oxymorphone at a dose of greater than or equal to 25 mg/day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day)

and

3 The patient is currently taking a long-acting opioid around the clock for cancer pain

and

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

- Pain specialist
- Oncologist
- Hematologist
- Hospice care specialist
- Palliative care specialist

Product Name: Abstral*, Brand Actiq, Fentora*, Generic fentanyl lozenge, Lazanda*, or Subsys

Approval Length	12 Month
Guideline Type	Quantity Limit

Approval Criteria

1 For the management of breakthrough cancer pain

and

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

- Pain specialist
- Oncologist
- Hematologist
- Hospice care specialist
- Palliative care specialist

and

3 The prescriber maintains and provides chart documentation of the patientâ€™s evaluation, including all of the following:

- An appropriate patient medical history and physical examination
- A description of the nature and intensity of the pain
- Documentation of appropriate dose escalation
- Documentation of ongoing, periodic review of the course of opioid therapy
- An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- Verification that the risks and benefits of the use of the controlled substance have been discussed with the patient, significant other(s), and/or guardian

Notes	*Product may be excluded depending on the plan.

3 . Background

Benefit/Coverage/Program Information

Quantity Limit

These products are subject to an OptumRx standard quantity limit. The quantity limit may vary from the standard limit based upon plan-specific benefit design. Please refer to your benefit materials.

4 . Endnotes

A. Abstral, Actiq, Fentora, Lazanda, and Subsys are intended to be used only in the care of cancer patients and only by oncologists and pain specialists who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain [1, 2, 8-10]
B. Abstral, Actiq, Fentora, Lazanda, and Subsys are only intended for patients who are opioid tolerant. Patients considered opioid tolerant are those who are taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer. [1, 2, 8-10]

5 . References

1. Actiq Prescribing Information. Cephalon, December 2011.
2. Fentora Prescribing Information. Cephalon, February 2013.
3. American Academy of Pain Medicine. The use of opioids for the treatment of chronic pain (2013). http://www.painmed.org/files/use-of-opioids-for-the-treatment-of-chronic-pain.pdf. Accessed February 24, 2015.
4. American Geriatrics Society. Pharmacological management of persistent pain in older persons (2009). Available at: http://www.americangeriatrics.org/files/documents/2009_Guideline.pdf. Accessed February 24, 2015.
5. American Pain Society. Principles of analgesic use in the treatment of acute pain and cancer pain (6th ed.) (2010). Glenview, IL: American Pain Society.
6. National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology: Adult Cancer Pain, version 2.2015. Available at: http://www.nccn.org. Accessed June 2, 2015.

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8. Abstral Prescribing Information. Galena Biopharma Inc., November 2014.
9. Lazanda Prescribing Information. Depomed, Inc., March, 2016.
10. Subsys Prescribing Information. INSYS Therapeutics, Inc., December 2014.

Prior Authorization Guideline

GL-30194 Oxandrin (oxandrolone)

Formulary OptumRx

Formulary Note

Approval Date 7/1/2016

Revision Date 7/1/2016

Technician Note :

P&T Approval: 9/30/2002; P&T Revision Date: 2/25/2016. **Effective 7/1/2016**

1 . Indications

Drug Name: Oxandrin (oxandrolone)

Indications

Promote weight gain Indicated for adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who without definite pathophysiologic reasons fail to gain or to maintain normal weight, to offset the protein catabolism associated with prolonged administration of corticosteroids, and for the relief of the bone pain frequently accompanying osteoporosis.

Off Label Uses

Promote weight gain in HIV-related wasting syndrome Has been effective in promoting weight gain in patients with HIV-related wasting syndrome.

2 . Criteria

Product Name: Brand Oxandrin, Generic oxandrolone

Diagnosis	Weight gain
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Oxandrin will be used adjunct therapy to promote weight gain

and

2 Diagnosis of one of the following:

- Extensive surgery
- Chronic infections
- Severe trauma
- Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons

and

3 History of failure, contraindication, or intolerance to nutritional supplements

and

4 A nutritional consult was performed

Product Name: Brand Oxandrin, Generic oxandrolone

Diagnosis	Weight gain
Approval Length	3 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Patient has experienced an improvement in weight gain or increase in lean body mass.

Product Name: Brand Oxandrin, Generic oxandrolone

Diagnosis	Bone pain
Approval Length	1 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of bone pain associated with osteoporosis

Product Name: Brand Oxandrin, Generic oxandrolone

Diagnosis	Protein catabolism
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Oxandrin will be used to counterbalance protein catabolism associated with chronic corticosteroid administration

Product Name: Brand Oxandrin, Generic oxandrolone

Diagnosis	Protein catabolism
Approval Length	3 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Patient has experienced an improvement in weight gain or increase in lean body mass.

3 . References

1. Oxandrin Prescribing Information. Savient Pharmaceuticals, Inc., 2007.

Prior Authorization Guideline

GL-31012 Provigil (modafinil), Nuvigil (armodafinil)

Formulary OptumRx

Formulary Note

Approval Date 8/8/2016

Revision Date 8/8/2016

Technician Note :

P&T Approval Date: 5/21/1999; P&T Revision Date: 7/27/2016 **Effective 8/15/2016**

1 . Indications

Drug Name: Provigil (modafinil)

Indications

Narcolepsy Indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy.

Obstructive sleep apnea/hypopnea syndrome (OSAHS) Indicated to improve wakefulness in adult patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS). Are indicated as an adjunct to standard treatment(s) for the underlying obstruction. If continuous positive airway pressure (CPAP) is the treatment of choice for a

patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating Provigil or Nuvigil. If Provigil or Nuvigil is used adjunctively with CPAP, the encouragement of and periodic assessment of CPAP compliance is necessary.

Shift work sleep disorder Indicated to improve wakefulness in adult patients with excessive sleepiness associated with shift work sleep disorder. For all indications, careful attention to the diagnosis and treatment of the underlying sleep disorder(s) is of utmost importance. Prescribers should be aware that some patients may have more than one sleep disorder contributing to their excessive sleepiness. The effectiveness of modafinil or Nuvigil in long-term use (greater than 9 weeks in Narcolepsy clinical trials and 12 weeks in OSAHS and SWSD clinical trials for modafinil or greater than 12 weeks for Nuvigil) has not been systematically evaluated in placebo-controlled trials. The physician who elects to prescribe Provigil or Nuvigil for an extended time in patients with Narcolepsy, OSAHS, or SWSD should periodically reevaluate long-term usefulness for the individual patient.

Off Label Uses

Idiopathic Hypersomnia Shown to reduce excessive sleepiness in patients with idiopathic hypersomnia. [8, 13]

Fatigue due to multiple sclerosis (MS) In a double-blind, placebo-controlled study, treatment with modafinil significantly improved fatigue symptoms compared with placebo in patients with multiple sclerosis (MS) [13, 19]

Adjunctive therapy for the treatment of major depressive disorder (MDD) or bipolar disorder In a meta-analysis of 4 MDD RCTs and 2 bipolar depression RCTs, adjunctive treatment with modafinil improved overall depression scores, remission rates, and fatigue symptoms. [13, 21]

Drug Name: Nuvigil (armodafinil)

Indications

Narcolepsy Indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy.

Obstructive sleep apnea/hypopnea syndrome (OSAHS) Indicated to improve wakefulness in adult patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS). Are indicated as an adjunct to standard treatment(s) for the underlying obstruction. If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating Provigil or Nuvigil. If Provigil or Nuvigil is used adjunctively with CPAP, the encouragement of and periodic assessment of CPAP compliance is necessary.

Shift work sleep disorder Indicated to improve wakefulness in adult patients with excessive sleepiness associated with shift work sleep disorder. For all indications, careful attention to the diagnosis and treatment of the underlying sleep disorder(s) is of utmost importance. Prescribers should be aware that some patients may have more than one sleep disorder contributing to their excessive sleepiness. The effectiveness of modafinil or Nuvigil in long-term use (greater than 9 weeks in Narcolepsy clinical trials and 12 weeks in OSAHS and SWSD clinical trials for modafinil or greater than 12 weeks for Nuvigil) has not been systematically evaluated in placebo-controlled trials. The physician who elects to prescribe Provigil or Nuvigil for an extended time in patients with Narcolepsy, OSAHS, or SWSD should periodically reevaluate long-term usefulness for the individual patient.

2 . Criteria

Product Name: Generic armodafinil, Generic modafinil, Brand Nuvigil, or Brand Provigil

Diagnosis	Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS)
Approval Length	3 Months [B]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of obstructive sleep apnea/hypopnea syndrome defined by one of the following: [2, 11]

1.1 15 or more obstructive respiratory events (apneas, hypopneas, or respiratory effort related arousals [RERA]) per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) [11, 18, E]

OR

1.2 Both of the following: [11, 18, E]

1.2.1 5 or more obstructive respiratory events (apneas, hypopneas, or respiratory effort related arousals [RERA]) per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

and

1.2.2 One of the following symptoms:

- Unintentional sleep episodes during wakefulness
- Daytime sleepiness
- Unrefreshing sleep
- Fatigue
- Insomnia
- Waking up breath holding, gasping, or choking
- Loud snoring
- Breathing interruptions during sleep

and

2 Both of the following:

2.1 Standard treatments for the underlying obstruction (e.g., continuous positive airway pressure [CPAP], bi-level positive airway pressure [BPAP], etc.) have been used for 3 months or longer [13]

and

2.2 Patient is fully compliant with standard treatment(s) for the underlying obstruction.

Product Name: Generic armodafinil, Generic modafinil, Brand Nuvigil, or Brand Provigil

Diagnosis	Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS)
Approval Length	12 Month
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 Patient continues to be fully compliant on concurrent standard treatment(s) for the underlying obstruction (e.g., CPAP, BPAP, etc.)

and

2 Patient is experiencing relief of symptomatic hypersomnolence with Provigil or Nuvigil use

Product Name: Generic armodafinil, Generic modafinil, Brand Nuvigil, or Brand Provigil

Diagnosis	Shift Work Sleep Disorder (SWSD)
Approval Length	3 Months [7, 16, B]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Chart documented diagnosis of Shift Work Sleep Disorder confirmed by one of the following: [2, 7, 11, 16]

1.1 Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase

OR

1.2 Sleep study demonstrating loss of a normal sleep wake pattern (i.e., disturbed chronobiologic rhythmicity)

and

2 Sleep disturbance causes clinically significant distress or significant impairment in occupational functioning [8]

and

3 No other medical or mental disorder (e.g., depression) accounts for the symptoms [2, 7, 11]

and

4 Symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., jet lag syndrome) [2, 11]

Product Name: Generic armodafinil, Generic modafinil, Brand Nuvigil, or Brand Provigil

Diagnosis	Shift Work Sleep Disorder (SWSD)
Approval Length	3 Months [B]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Patient is experiencing relief with use of Provigil or Nuvigil of excessive sleepiness or insomnia associated with a work period (usually night work) that occurs during the habitual sleep phase [2]

and

2 One of the following:

2.1 Sleep disturbance continues to cause clinically significant distress or significant impairment in occupational functioning [8]

OR

2.2 Patient still requires treatment for Shift Work Sleep Disorder

Product Name: Generic modafinil, Brand Provigil

Diagnosis	Fatigue due to MS (off-label) [13, 19. H]
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of multiple sclerosis (MS)

and

2 Patient is experiencing fatigue

and

3 Used in combination with standard educational therapies (e.g., psychoeducation, behavioral programs, scheduled naps, additional non-pharmacological therapies, etc) [H]

Product Name: Generic modafinil, Brand Provigil

Diagnosis	Fatigue due to MS (off-label) [13, 19, H]
Approval Length	6 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Patient is experiencing relief of fatigue with Provigil therapy

and

2 Used in combination with standard educational therapies (e.g., psychoeducation, behavioral programs, scheduled naps, additional non-pharmacological therapies, etc) [H]

Product Name: Generic armodafinil 50 mg, Generic modafinil 100 mg, Brand Nuvigil 50 mg, or Brand Provigil 100 mg

Guideline Type	Quantity Limit

Quantity Limit Table

DrugName	Strength	Limit
Generic armodafinil, Brand Nuvigil	50 mg	2 tablet per day
Generic modafinil, Brand Provigil	100 mg	1 tablet per day

Approval Criteria

1 One of the following:

1.1 Quantity limit override requests must involve an FDA-approved indication.

OR

1.2 Quantity limit override requests involving off-label indications must meet off-label guideline requirements.

and

2 One of the following:

2.1 For titration purposes (one time authorization)

OR

2.2 Requested strength/dose is commercially unavailable

OR

2.3 Patient is on a dose alternating schedule

Notes	Authorization will be issued for the length of therapy based on indication, except for titration purposes (initial authorization: 3 months (all indications), reauthorization: SWSD: 3 months; MS fatigue: 6 months; all others: 12 months). Not to exceed maximum FDA-approved dose.

Product Name: Generic modafinil 200 mg, Brand Provigil 200 mg

Guideline Type	Quantity Limit

Quantity Limit Table

DrugName	Strength	Limit
Generic modafinil, Brand Provigil	200 mg	1 tablet per day

Approval Criteria

1 One of the following:

1.1 Quantity limit override requests must involve an FDA-approved indication.

OR

1.2 Quantity limit override requests involving off-label indications must meet off-label guideline requirements.

and

2 History of inadequate response to Provigil 200 mg/day

and

3 One of the following:**

3.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

3.2 Higher dose or quantity is supported by one of following compendia:

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX System

Notes	Authorization will be issued for the length of therapy based on indication, except for titration purposes (initial authorization: 3 months (all indications), reauthorization: SWSD: 3 months; MS fatigue: 6 months; all others: 12 months). Not to exceed maximum FDA-approved dose. **NOTE: Published biomedical literature may be used as evidence to support safety and additional efficacy at higher than maximum doses for the diagnosis provided.

Product Name: Generic armodafinil 150 mg, Brand Nuvigil 150 mg, Generic armodafinil 200 mg, Brand Nuvigil 200 mg, Generic armodafinil 250 mg, or Brand Nuvigil 250 mg

Guideline Type	Quantity Limit

Quantity Limit Table

DrugName	Strength	Limit
Generic armodafinil, Brand Nuvigil	150 mg	1 tablet per day
Generic armodafinil, Brand Nuvigil	250 mg	1 tablet per day
Generic armodafinil, Brand Nuvigil	200 mg	1 tablet per day

Approval Criteria

1 One of the following:

1.1 Quantity limit override requests must involve an FDA-approved indication.

OR

1.2 Quantity limit override requests involving off-label indications must meet off-label guideline requirements.

and

2 One of the following**

2.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

2.2 Higher dose or quantity is supported by one of following compendia

- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX System

Notes	Authorization will be issued for the length of therapy based on indication, except for titration purposes (initial authorization: 3 months (all indications), reauthorization: SWSD: 3 months; all others: 12 months). Not to exceed maximum FDA-approved dose. NOTE: Published biomedical literature may be used as evidence to support safety and additional efficacy at higher than maximum doses for the diagnosis provided.

Product Name: Generic armodafinil, Generic modafinil, Brand Nuvigil, or Brand Provigil

Diagnosis	Narcolepsy
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) [2-4,12, A, C, D]

Product Name: Generic armodafinil, Generic modafinil, Brand Nuvigil, or Brand Provigil

Diagnosis	Narcolepsy
Approval Length	12 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Documentation of positive clinical response to Provigil or Nuvigil therapy

Product Name: Generic modafinil, Brand Provigil

Diagnosis	Idiopathic Hypersomnia (off-label)[13]
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of idiopathic hypersomnia as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) [8, 11, 13, F, G]

Product Name: Generic modafinil, Brand Provigil

Diagnosis	Idiopathic Hypersomnia (off-label)[13]
Approval Length	12 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Documentation of positive clinical response to Provigil therapy

Product Name: Generic modafinil, Brand Provigil

Diagnosis	Adjunctive therapy for the treatment of major depressive disorder or bipolar depression (off-label)[13, 21]
Approval Length	3 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Treatment-resistant depression, defined as both of the following:

1.1 Diagnosis of one of the following:

- Major depressive disorder (MDD)
- Bipolar depression

and

1.2 History of failure, contraindication, or intolerance to at least two antidepressants from different classes (e.g., SSRIs, SNRIs, bupropion)

and

2 Used as adjunctive therapy

Product Name: Generic modafinil, Brand Provigil

Diagnosis	Adjunctive therapy for the treatment of major depressive disorder or bipolar depression (off-label)[13, 21]
Approval Length	12 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Documentation of positive clinical response to Provigil therapy

and

2 Used as adjunctive therapy

3 . Definitions

Definition	Description
Apnea-Hypopnea Index (AHI) [1, 10]	The total number of episodes of apnea and hypopnea divided by the number of hours of sleep.
Cataplexy [1, 10]	A sudden loss of muscle tone that leads to feelings of weakness and a loss of voluntary muscle control.
CPAP (continuous positive	A treatment in which a pump forces air into the nasal

airway pressure) [1, 10]	passages at pressures high enough to overcome obstructions in the airway and stimulate normal breathing. The airway pressure delivered into the upper airway is continuous during both inspiration and expiration.
Epworth Sleepiness Scale [1, 10]	A scale used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy.
Maintenance of Wakefulness Test (MWT) [1, 10]	A daytime procedure that measures the ability to remain awake during sleep-inducing circumstances.
Multiple sleep latency test (MSLT) [1, 10]	An objective daytime polysomnographic assessment of the patientâ€™s ability to fall asleep in an unstimulating environment.
Narcolepsy [1, 10]	A neurological condition in which people experience excessive daytime sleepiness, cataplexy, sleep paralysis, hallucinations and intermittent, uncontrollable sleep attacks during the daytime.
Non-Rapid Eye Movement (NREM) sleep [1, 10]	One of the two basic states of sleep; consists of Stages 1, 2 (light sleep) and 3,4 (deep sleep).
Obstructive sleep apnea (OSA) [1, 10]	The most common kind of sleep apnea. It is caused by a blockage of the upper airway.
Polysomnography [1, 10]	A test that records sleep architecture (i.e. the amount of NREM and REM sleep, number of arousals) and a variety of body functions during sleep, including breathing patterns, heart rhythms and limb movements.
Rapid Eye Movement (REM) sleep [1, 10]	One of the two basic states of sleep. REM sleep, also known as "dream sleep," is characterized by rapid eye movements, and more irregular breathing and heart rate compared to NREM sleep.
Shift work sleep disorder [1, 10]	Symptoms of insomnia or excessive sleepiness that occur as transient phenomena in relation to work schedules.

4 . Endnotes

A. The American Academy of Sleep Medicine guidelines list modafinil as a â€œstandardâ€ patient strategy that reflects a high degree of clinical certainty. [5]
B. The effectiveness of modafinil (greater than 9 weeks for narcolepsy and 12 weeks for obstructive sleep apnea or SWSD) and the effectiveness of armodafinil in long-term use (greater than 12 weeks) have not been systematically evaluated in placebo-controlled trials. Product labeling advises that the use of modafinil and armodafinil for longer than 12 weeks should be periodically reevaluated. [1, 12]
C. The current international classification of Sleep Disorder (ICSD) diagnostic criteria for narcolepsy with cataplexy include: [11] 1. Excessive sleepiness is present almost daily for at least 3 month 2. Definite history of cataplexy 3. Where possible, the diagnosis should be confirmed by nocturnal polysomnography (PSG) documenting sufficient sleep (minimum 6 hours) followed by mean sleep latency test (MSLT) documenting mean sleep latency of less than or equal to 8 minutes with greater than or equal to 2 sleep onset REM periods (SOREMPs); alternative confirmation with cerebrospinal fluid (CSF) hypocretin-1 level less than or equal to 110 pg/ml or one third of mean normal values. 4. Hypersomnia is not better explained by other sleep, medical, neurological, or psychiatric disorders
D. The current international classification of Sleep Disorder (ICSD) diagnostic criteria for narcolepsy without cataplexy include: [11] 1. Excessive sleepiness is present almost daily for at least 3 month 2. Typical cataplexy not present, although atypical or doubtful cataplexy-like events may be reported 3. The diagnosis must be confirmed by nocturnal PSG documenting sufficient sleep (minimum 6 hours) followed by MSLT documenting mean sleep latency of less than or equal to 8 minutes and greater than or equal to 2 SOREMPs 4. Hypersomnia is not better explained by other sleep, medical, neurological, or psychiatric disorders
E. The current International Classification of Sleep Disorders, 2nd Edition (ICSD-2) diagnostic criteria for obstructive sleep apnea-hypopnea syndrome (OSAHS) are listed below. Diagnostic criteria require: 1+2+3, or if greater than or equal to 15 scoreable events/hour, then 2+3. [11] 1. At least one of the following: a. Complains by patient of unintended sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia b. Patient wakes with breath holding, gasping, or choking c. Bed partner reports loud snoring, breathing interruptions, or both during the patient's sleep 2. Polysomnography recording showing greater than or equal to 5 scoreable respiratory events/hour (apneas, hypopneas, respiratory effort-related arousals) with respiratory effort during each 3. Disorder is not explained by another current sleep disorder, medical or neurological disorder, medication use, or substance use disorder
F. The current International Classification of Sleep Disorders, 2nd Edition (ICSD-2) diagnostic criteria for idiopathic hypersomnia with long sleep time include: [11] 1. Excessive sleepiness is present almost daily for at least 3 months 2. Nocturnal sleep time prolonged (greater than or equal to 10 hours), as documented by history, sleep log, or actigraphy; waking is usually laborious 3. Nocturnal polysomnography excludes other causes of sleepiness 4. Nocturnal polysomnography shows short sleep latency and major sleep period greater than or equal to 10 hours in duration 5. If MSLT is performed following overnight polysomnography, mean sleep latency is <8 min with less than two SOREMPS; mean sleep latency in idiopathic hypersomnia with long sleep time averages 6.2 +/- 3.0 min 6. Hypersomnia is not better explained by other sleep, medical, neurological, or psychiatric disorders

G. The current International Classification of Sleep Disorders, 2nd Edition (ICSD-2) diagnostic criteria for idiopathic hypersomnia without long sleep time include: [11] 1. Excessive sleepiness is present almost daily for at least 3 months 2. Nocturnal sleep time is normal (>6 and < 10 hours), as documented by history, sleep log, or actigraphy; waking is usually laborious 3. Nocturnal polysomnography excludes other causes of sleepiness 4. MSLT performed following overnight polysomnography documents mean sleep latency <8 min with less than two SOREMPS. Mean sleep latency in idiopathic hypersomnia averages 6.2 +/- 3.0 min 5. Hypersomnia is not better explained by other sleep, medical, neurological, or psychiatric disorders
H. Despite lack of good clinical evidence or statement/guideline from a professional society, use of modafinil for fatigue is considered the standard practice in MS patients [20].

5 . References

1. Provigil Prescribing Information. Cephalon, Inc., January 2013.
2. Kushida CA, Littner MR, Morgenthaler T, et al. Practice parameters for the indications for polysomnography and related procedures: an update for 2005. Sleep. 2005;28(4):499-521.
3. US Modafinil in Narcolepsy Multicenter Study Group. Randomized trial of modafinil as a treatment for the excessive daytime somnolence of narcolepsy. Neurology. 2000;54(5):1166-75.
4. US Modafinil in Narcolepsy Multicenter Study Group. Randomized trial of modafinil for the treatment of pathological somnolence in narcolepsy. Ann Neurol. 1998;43(1):99-97.
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20. Per clinical consultation with multiple sclerosis specialist. April 24, 2013.
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Prior Authorization Guideline

GL-17126 Regranex (becaplermin)

Formulary OptumRx

Formulary Note

Approval Date 3/21/2013

Revision Date 5/3/2016

Technician Note :

P&T Approval Date: 7/16/2009; P&T Revision Date: 2/25/2016 **Effective 7/1/2016**

1 . Indications

Drug Name: Regranex Gel (becaplermin)

Indications

Diabetic Neuropathic Ulcers

Indicated for the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply, when used as an adjunct to, and not a substitute for, good ulcer care practices including initial sharp debridement, pressure relief and infection control. Limitations of Use: The efficacy of Regranex Gel has not been established for the treatment of pressure ulcers and venous stasis ulcers and has not been evaluated for the treatment of diabetic neuropathic ulcers that do not extend through the

dermis into subcutaneous tissue (Stage I or II, IAET staging classification) or ischemic diabetic ulcers. The effects of becaplermin on exposed joints, tendons, ligaments, and bone have not been established in humans. Regranex is a non-sterile, low bioburden preserved product. Therefore, it should not be used in wounds that close by primary intention.

2 . Criteria

Product Name: Regranex

Approval Length	5 Months [1,2,A]
Guideline Type	Prior Authorization

Approval Criteria

1 Patient has a lower extremity diabetic neuropathic ulcer [1]

AND

2 Treatment will be given in combination with ulcer wound care (e.g., debridement, infection control, and/or pressure relief) [1]

3 . Endnotes

A. Fifty percent of patients will achieve complete healing within 20 weeks with Regranex. Reassessment is required for further therapy. [1] According to the prescribing label, if the ulcer does not decrease in size by approximately 30% after 10 weeks of treatment or complete healing has not occurred in 20 weeks, continued treatment with Regranex should be reassessed. [1]
B. Postmarketing studies have demonstrated an increased risk of mortality secondary to malignancy observed in patients treated with greater than or equal to 3 tubes of Regranex gel [1]

4 . References

1. Regranex Prescribing Information. Ortho-McNeil Pharmaceutical, Inc., October 2011.
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Prior Authorization Guideline

GL-31983 Restasis (cyclosporine 0.05%)

Formulary OptumRx

Formulary Note

Approval Date 10/31/2016

Revision Date 10/31/2016

Technician Note :

P&T Approval Date: 10/26/2016. **Effective 11/15/2016**

1 . Indications

Drug Name: Restasis (cyclosporine 0.05%) ophthalmic emulsion

Indications

Keratoconjunctivitis sicca Indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.

2 . Criteria

Product Name: Restasis

Approval Length	12 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

1.1 Diagnosis of moderate to severe keratoconjunctivitis sicca (dry eye)

OR

1.2 Diagnosis of Sjogren syndrome with suppressed tear production due to ocular inflammation

AND

2 Patient has suppressed tear production due to ocular inflammation as determined by at least one of the following diagnostic tests: [A, 2]

- Schirmer test (aqueous tear production and clearance)
- Tear break-up time
- Ocular surface dye staining
- Tear film osmolarity
- Fluorescein clearance test/ tear function test

AND

3 Failure or intolerance to at least one over-the-counter ocular lubricant used at an optimal dose and frequency for at least two weeks (e.g., artificial tears, lubricating gels/ointments, etc.) [B, 2]

AND

4 One of the following:

4.1 Patient will not be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, NSAIDS)

OR

4.2 Topical ophthalmic anti-inflammatory drugs will only be used concurrently for a short period (up to 8 weeks) while transitioning to monotherapy with Restasis

Product Name: Restasis

Approval Length	12 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Documentation of positive clinical response to Restasis therapy (e.g., increased tear production or improvement in dry eye symptoms)

AND

2 Patient will not be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, NSAIDS)

3 . Endnotes

A. Standard diagnostic tests include the schirmer test (aqueous tear production and clearance), tear break-up time, ocular surface dye staining, tear film osmolarity and fluorescein clearance test/ tear function test. However, no single test is adequate to establish a diagnosis of dry eye; the diagnosis should be based on multiple factors. [2]
B. As disease severity increases, aqueous enhancement of the eye using topical agents is appropriate (i.e., emulsions, gels, and ointments can be used). Anti-inflammatory therapies (topical cyclosporine and corticosteroids), systemic omega-3 fatty acid supplements, punctual plugs and spectacle side shields/moisture chambers may also be considered in addition to aqueous enhancement therapies in patients who need additional symptom management. [2]

4 . References

1. Restasis Prescribing Information. Allergan Inc., June 2013.
2. American Academy of Ophthalmology. Preferred Practice Patterns - Dry Eye Syndrome. October 2013. Available at: http://one.aao.org/preferred-practice-pattern/dry-eye-syndrome-ppp--2013. Accessed March 3, 2014.

Prior Authorization Guideline

GL-17097 Rilutek (riluzole)

Formulary OptumRx

Formulary Note

Approval Date 3/21/2013

Revision Date 4/29/2016

Technician Note :

P&T Approval Date: 8/2/2005; P&T Revision Date: 2/25/2016. **Effective 7/1/2016**

1 . Indications

Drug Name: Rilutek (riluzole)

Indications

Amyotrophic Lateral Sclerosis (ALS)

Indicated for the treatment of patients with amyotrophic lateral sclerosis (ALS). Rilutek extends survival and/or time to tracheostomy.

2 . Criteria

Product Name: Rilutek

Approval Length	60 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of amyotrophic lateral sclerosis (ALS)

3 . References

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Prior Authorization Guideline

GL-17408 Statin Combination Products

Formulary OptumRx

Formulary Note

Approval Date 3/21/2013

Revision Date 5/24/2016

Technician Note :

P&T Approval Date: 7/13/2007; P&T Revision Date: 2/25/2016 **Effective 7/1/2016**

1 . Indications

Drug Name: Vytorin (ezetimibe/simvastatin)

Indications

Primary Hyperlipidemia

Indicated for the reduction of elevated total cholesterol (total-C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), triglycerides (TG), and non-high density lipoprotein cholesterol (non-HDL-C), and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary (heterozygous familial and non-familial) hyperlipidemia or mixed dyslipidemia. Limitations of use: No incremental benefit of Vytorin on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin has been established. Vytorin

has not been studied in Fredrickson type I, III, IV, and V dyslipidemias.

Homozygous Familial Hypercholesterolemia (HoFH)

Indicated for the reduction of elevated total-C and LDL-C in patients with homozygous familial hypercholesterolemia, as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) of if such treatments are unavailable. Limitations of use: No incremental benefit of Vytorin on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin has been established. Vytorin has not been studied in Fredrickson type I, III, IV, and V dyslipidemias.

2 . Criteria

Product Name: Vytorin 10/80 mg*

Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

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

OR

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

AND

2 Patient has been taking Vytorin 10/80 mg per day chronically (12 months or more)

AND **3** Patient has no evidence of myopathy (e.g., muscle pain, muscle tenderness, muscle weakness) on Vytorin 10/80 mg per day [2] **AND** **4** For continuation of therapy with Vytorin 10/80 mg per day [2]	
Notes	*Product may be excluded depending on the plan.

3 . References

1. Vytorin Prescribing Information. Merck & Co., Inc., March 2015.
2. FDA Drug Safety Communication: New restrictions, contraindications, and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury. United States Food and Drug Administration website. http://www.fda.gov/Drugs/DrugSafety/ucm256581.htm. Accessed July 19, 2011.

Prior Authorization Guideline

GL-30141 Statins

Formulary OptumRx

Formulary Note

Approval Date 6/24/2016

Revision Date 6/24/2016

Technician Note :

P&T Approval Date: 8/17/2010; P&T Revision Date: 6/22/2016 **Effective 7/1/2016**

1 . Indications

Drug Name: Altoprev (lovastatin extended-release)

Indications

Prevention of coronary heart disease Indicated in patients without symptomatic coronary heart disease (CHD), but at high risk, is indicated to reduce the risk of myocardial infarction, unstable angina, and coronary revascularization procedures. Indicated to slow the progression of coronary atherosclerosis in patients with coronary heart disease as part of a treatment strategy to lower Total-C and LDL-C to target levels.

Hyperlipidemia Indicated as an adjunct to diet for the reduction of elevated Total-C, LDL-C,

Apo B, and TG, and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and non-familial) and mixed dyslipidemia (Fredrickson types IIa and IIb).

Drug Name: Lescol (fluvastatin), Lescol XL (fluvastatin extended-release)

Indications

Hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia Indicated as an adjunct to diet to reduce elevated total cholesterol (Total-C), low-density lipoprotein cholesterol (LDL-C), triglyceride (TG) and apolipoprotein B (Apo B) levels, and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary hypercholesterolemia and mixed dyslipidemia (Fredrickson Type IIa and IIb). Indicated as an adjunct to diet to reduce Total-C, LDL-C, and Apo B levels in adolescent boys and adolescent girls who are at least one year post-menarche, 10-16 years of age, with heterozygous familial hypercholesterolemia and the following findings are present: (1) LDL-C remains greater than or equal to 190 mg/dL or (2) LDL-C remains greater than or equal to 160 mg/dL and there is a positive family history of premature cardiovascular disease or two or more other cardiovascular disease risk factors are present.

Secondary prevention of cardiovascular disease Indicated in patients with clinically evident CHD to reduce the risk of undergoing coronary revascularization procedures and to slow the progression of coronary atherosclerosis.

Drug Name: Lipitor (atorvastatin)

Indications

Prevention of cardiovascular disease Indicated in adult patients without clinically evident coronary heart disease, but with multiple risk factors for coronary heart disease such as age, smoking, hypertension, low HDL-C, or a family history of early coronary heart disease, to reduce the risk of myocardial infarction, stroke, and revascularization procedures and angina. Indicated in patients with type 2 diabetes, and without clinically evident coronary heart disease, but with multiple risk factors for coronary heart disease such as retinopathy, albuminuria, smoking, or hypertension, to reduce the risk of myocardial infarction and stroke. Indicated in patients with clinically evident coronary heart disease to reduce the risk of non-fatal myocardial infarction, fatal and non-fatal stroke, revascularization procedures, hospitalization for CHF, and angina.

Hyperlipidemia Indicated as an adjunct to diet to reduce elevated total-C, LDL-C, apo B, and TG levels and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemia (Fredrickson Types IIa and IIb); as an adjunct to diet for the treatment of patients with elevated serum TG levels (Fredrickson Type IV); for the treatment of patients with primary dysbetalipoproteinemia (Fredrickson Type III) who do not

respond adequately to diet; to reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable; as an adjunct to diet to reduce total-C, LDL-C, and apo B levels in boys and postmenarchal girls, 10 to 17 years of age, with heterozygous familial hypercholesterolemia if after an adequate trial of diet therapy the following findings are present: (1) LDL-C remains greater than or equal to 190 mg/dL or (2) LDL-C remains greater than or equal to 160 mg/dL and there is a positive family history of premature cardiovascular disease or two or more other CVD risk factors are present in the pediatric patient.

Drug Name: Livalo (pitavastatin)

Indications

Primary hyperlipidemia and mixed dyslipidemia Indicated as an adjunctive therapy to diet to reduce elevated total cholesterol (TC), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), triglycerides (TG), and to increase HDL-C in adult patients with primary hyperlipidemia or mixed dyslipidemia.

Drug Name: Mevacor (lovastatin)

Indications

Primary prevention of coronary heart disease Indicated in individuals without symptomatic cardiovascular disease, average to moderately elevated total C and LDL C, and below average HDL C, to reduce the risk of myocardial infarction, unstable angina, and coronary revascularization procedures.

Coronary heart disease Indicated to slow the progression of coronary atherosclerosis in patients with coronary heart disease as part of a treatment strategy to lower total C and LDL C to target levels.

Hypercholesterolemia Therapy with lipid-altering agents should be a component of multiple risk factor intervention in those individuals at significantly increased risk for atherosclerotic vascular disease due to hypercholesterolemia. Indicated as an adjunct to diet for the reduction of elevated total C and LDL C levels in patients with primary hypercholesterolemia (Types IIa and IIb), when the response to diet restricted in saturated fat and cholesterol and to other nonpharmacological measures alone has been inadequate.

Adolescent patients with heterozygous familial hypercholesterolemia (heFH) Indicated as an adjunct to diet to reduce total C, LDL C and apolipoprotein B levels in adolescent boys and girls who are at least one year post-menarche, 10-17 years of age, with heFH if after an adequate trial of diet therapy the following findings are present (1) LDL-C remains greater than

189 mg/dL or (2) LDL-C remains greater than 160 mg/dL and there is a positive family history of premature cardiovascular disease or two or more other CVD risk factors are present in the adolescent patient.

Drug Name: Pravachol (pravastatin)

Indications

Prevention of cardiovascular disease Indicated in hypercholesterolemic patients without clinically evident coronary heart disease (CHD) to reduce the risk of myocardial infarction (MI), myocardial revascularization procedures, and cardiovascular mortality with no increase in death from non-cardiovascular causes. Indicated in patients with clinically evident CHD to reduce the risk of total mortality by reducing coronary death, MI, myocardial revascularization procedures, stroke and stroke/transient ischemic attack (TIA), and to slow the progression of coronary atherosclerosis.

Hyperlipidemia Indicated as an adjunct to diet to reduce elevated total cholesterol (Total-C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (ApoB), and triglyceride (TG) levels and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary hypercholesterolemia and mixed dyslipidemia (Fredrickson Types IIa and IIb); as an adjunct to diet for the treatment of patients with elevated serum TG levels (Fredrickson Type IV); for the treatment of patients with primary dysbetalipoproteinemia (Fredrickson Type III) who do not respond adequately to diet; as an adjunct to diet and lifestyle modification for treatment of heterozygous familial hypercholesterolemia (HeFH) in children and adolescent patients ages 8 years and older if after an adequate trial of diet the following findings are present: (1) LDL-C remains greater than or equal to 190 mg/dL or (2) LDL-C remains greater than or equal to 160 mg/dL and there is a positive family history of premature cardiovascular disease (CVD) or two or more other CVD risk factors are present in the patient.

Drug Name: Zocor (simvastatin)

Indications

Reductions in risk of CHD mortality and cardiovascular events Indicated in patients at high risk of coronary events because of existing coronary heart disease, diabetes, peripheral vessel disease, history of stroke or other cerebrovascular disease to reduce the risk of total mortality by reducing CHD deaths, non-fatal myocardial infarction and stroke, and coronary and non-coronary revascularization procedures.

Hyperlipidemia Indicated to reduce elevated total cholesterol (total-C), low-density lipoprotein cholesterol (LDL-C), apolipoprotein B (Apo B), and triglycerides (TG), and to increase high-density lipoprotein cholesterol (HDL-C) in patients with primary hyperlipidemia (Fredrickson type

IIa, heterozygous familial and nonfamilial) or mixed dyslipidemia (Fredrickson type IIb); to reduce elevated TG in patients with hypertriglyceridemia (Fredrickson type IV hyperlipidemia); to reduce elevated TG and VLDL-C in patients with primary dysbetalipoproteinemia (Fredrickson type III hyperlipidemia); and to reduce total-C and LDL-C in patients with homozygous familial hypercholesterolemia (HoFH) as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable.

Adolescent patients with heterozygous familial hypercholesterolemia (HeFH) Indicated as an adjunct to diet to reduce total-C, LDL-C, and Apo B levels in adolescent boys and girls who are at least one year post-menarche, 10-17 years of age, with HeFH, if after an adequate trial of diet therapy the following findings are present: (1) LDL cholesterol remains greater than or equal to 190 mg/dL; or (2) LDL cholesterol remains greater than or equal to 160 mg/dL and there is a positive family history of premature cardiovascular disease (CVD) or two or more other CVD risk factors are present in the adolescent patient.

2 . Criteria

Product Name: Altoprev*, Brand Lescol*, Brand Lescol XL, Brand Lipitor*, Livalo*, Brand Mevacor*, Brand Pravachol*, or Brand Zocor* (5 mg, 10 mg, 20 mg, 40 mg)

Guideline Type	Step Therapy
Approval Criteria **1** History of both of the following: • Tier 1 statin (atorvastatin, fluvastatin, fluvastatin ER, lovastatin, pravastatin, rosuvastatin, simvastatin) • Tier 2 statin (Crestor, Vytorin)	
Notes	*Product may be excluded depending on the plan.

Product Name: Generic simvastatin 80 mg

Approval Length	12 Month

Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

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

OR

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

and

2 Patient has been taking Zocor (simvastatin) 80 mg per day chronically (12 months or more)

and

3 Patient has no evidence of myopathy (e.g., muscle pain, muscle tenderness, muscle weakness) on Zocor (simvastatin) 80 mg per day [2]

and

4 For continuation of therapy with Zocor (simvastatin) 80 mg per day [2]

Product Name: Brand Zocor 80 mg*

Approval Length	12 Month

Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

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

OR

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

and

2 History of failure, contraindication, or intolerance to both of the following:

- Tier 1 statin (atorvastatin, fluvastatin, fluvastatin ER, lovastatin, pravastatin, simvastatin)
- Tier 2 statin (Crestor, Vytorin)

and

3 Patient has been taking Zocor (simvastatin) 80 mg per day chronically (12 months or more)

and

4 Patient has no evidence of myopathy (e.g., muscle pain, muscle tenderness, muscle weakness) on Zocor (simvastatin) 80 mg per day [2]

and **5** For continuation of therapy with Zocor (simvastatin) 80 mg per day [2]	
Notes	*Product may be excluded depending on the plan.

3 . References

1. Zocor Prescribing Information. Merck & Co., Inc., March 2015.
2. FDA Drug Safety Communication: New restrictions, contraindications, and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury. United States Food and Drug Administration website. http://www.fda.gov/Drugs/DrugSafety/ucm256581.htm. Accessed March 7, 2014.
3. Altoprev Prescribing Information. Shionogi, Inc., April 2014.
4. Lescol/Lescol XL Prescribing Information. Novartis Pharmaceuticals, October 2012.
5. Lipitor Prescribing Information. Pfizer Ireland Pharmaceuticals, November 2015.
6. Livalo Prescribing Information. Kowa Pharmaceuticals, November 2012.
7. Mevacor Prescribing Information. Merck & Co., Inc., February 2014.
8. Pravachol Prescribing Information. Bristol-Myers Squibb Co., August 2013.

Prior Authorization Guideline

GL-15713 Symlin (pramlintide acetate injection)

Formulary OptumRx

Formulary Note

Approval Date 3/31/2014

Revision Date 3/26/2016

Technician Note :

P&T Approval Date: 6/7/2005; P&T Revision Date: 2/25/2016 **Effective 7/1/2016**

1 . Indications

Drug Name: Symlin (pramlintide acetate)

Indications

Type 1 Diabetes Mellitus

Indicated for type 1 diabetes, as an adjunct treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy.

Type 2 Diabetes Mellitus

Indicated for type 2 diabetes, as an adjunct treatment in patients who use mealtime insulin

therapy and who have failed to achieve desired glucose control despite optimal insulin therapy, with or without a concurrent sulfonylurea agent and/or metformin.

2 . Criteria

Product Name: Symlin

Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following diagnoses:

- Type 1 diabetes
- Type 2 diabetes

AND

2 Age greater than or equal to 18 years [A]

AND

3 Concurrent use of insulin therapy

AND

4 Not used in patients with gastroparesis	
Notes	Symlin is contraindicated in patients with hypoglycemia unawareness and known diagnosis of gastroparesis.

3 . Endnotes

A. Symlin has not been evaluated in the pediatric population. Safety and effectiveness of Symlin in pediatric patients have not been established. [1]

4 . References

1. Symlin Prescribing Information. Amylin Pharmaceuticals, Inc., February 2015.
2. AACE Comprehensive Diabetes Management Algorithm, Endocr Pract. 2013;19 (No. 2)
3. Inzucchi SE, Bergenstal RM, Buse JB, et al. Management of hyperglycemia in type 2 diabetes: a patient centered approach. Diabetes Care. 2012, 19 April 2012 [Epub ahead of print]
4. American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2013; 36 (suppl 1): S11-S66.

Prior Authorization Guideline

GL-17241 Topical Antifungals

Formulary OptumRx

Formulary Note

Approval Date 6/1/2016

Revision Date 6/1/2016

Technician Note :

P&T Approval Date: 2/25/2016. **Effective 7/1/2016**

1 . Indications

Drug Name: Jublia (efinaconazole) topical solution **<u>Indications</u>** **Onychomycosis of the toenails** Indicated for the topical treatment of onychomycosis of the toenail(s) due to Trichophyton rubrum and Trichophyton mentagrophytes.
Drug Name: Kerydin (tavaborole) topical solution

Indications

Onychomycosis of the toenails

Indicated for the treatment of onychomycosis of the toenails due to Trichophyton rubrum or Trichophyton mentagrophytes.

Drug Name: Ciclopirox Kit / Ciclodan Solution Kit / CNL8 Nail Kit (ciclopirox)

Indications

Onychomycosis

Indicated as topical treatment in immunocompetent patients with mild to moderate onychomycosis of fingernails and toenails without lunula involvement, due to Trichophyton rubrum. The comprehensive management program includes removal of the unattached, infected nails as frequently as monthly, by a health care professional who has special competence in the diagnosis and treatment of nail disorders, including minor nail procedures.

2 . Criteria

Product Name: Jublia

Approval Length	48 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of onychomycosis of the toenails

AND

2 The patient does not have dermatophytomas or lunula (matrix) involvement

AND

3 Diagnosis of toenail onychomycosis has been confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture
- Histology

AND

4 The patient has mild to moderate disease defined by the presence of all of the following:

- Involvement of at least 1 great toenail
- The target great toenail (TGT) includes at least a 3 mm section of clear nail (measured from the proximal nail fold) and less than or equal to a 3 mm distal toenail plate thickness
- 20% to 50% clinical involvement of the target toenail

AND

5 The patient's condition is causing debility or a disruption in their activities of daily living

AND

6 History of failure, contraindication, or intolerance to oral terbinafine

Product Name: Kerydin

Approval Length	48 Week

Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of onychomycosis of the toenails

AND

2 The patient does not have dermatophytomas or lunula (matrix) involvement

AND

3 Diagnosis of toenail onychomycosis has been confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture
- Histology

AND

4 The patient has mild to moderate disease defined by the presence of all of the following:

- Involvement of at least 1 great toenail
- The target great toenail (TGT) includes at least a 3 mm section of clear nail (measured from the proximal nail fold) and less than or equal to a 3 mm distal toenail plate thickness
- 20% to 60% clinical involvement of the target toenail

AND

5 The patient's condition is causing debility or a disruption in their activities of daily living

AND

6 History of failure, contraindication or intolerance to oral terbinafine

Product Name: Ciclopirox Kit, Ciclodan Solution Kit, CNL8 Nail Kit

Diagnosis	Toenail onychomycosis
Approval Length	48 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of onychomycosis of the toenails

AND

2 The patient does not have dermatophytomas or lunula (matrix) involvement

AND

3 Diagnosis of toenail onychomycosis has been confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture

- Histology

AND

4 The patient has mild to moderate disease defined by the presence of all of the following:

- Involvement of at least 1 great toenail
- The target great toenail (TGT) includes at least a 3 mm section of clear nail (measured from the proximal nail fold) and less than or equal to a 3 mm distal toenail plate thickness
- 20% to 65% clinical involvement of the target toenail

AND

5 The patient's condition is causing debility or a disruption in their activities of daily living

AND

6 History of failure, contraindication, or intolerance to oral terbinafine

Product Name: Ciclopirox Kit, Ciclodan Solution Kit, CNL8 Nail Kit

Diagnosis	Fingernail onychomycosis
Approval Length	48 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of onychomycosis of the fingernails

AND

2 The patient does not have dermatophytomas or lunula (matrix) involvement

AND

3 Diagnosis of fingernail onychomycosis has been confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Culture
- Histology

AND

4 The patient's condition is causing debility or a disruption in their activities of daily living

AND

5 History of failure, contraindication, or intolerance to oral terbinafine

3 . Endnotes

A. Fingernail infections are usually reevaluated 18 weeks or longer after completion of therapy. Toenail infections are usually reevaluated 6-9 months after completion of therapy. [4] Indeed, considering that toenails can take 12 to 18 months to grow out, many clinicians consider that 1 year is too short to assess clinical effectiveness. [5] Reports of long-term follow-up of treated patients have recently been presented, suggesting that positive mycology at 12 and 24 weeks after commencement of therapy are poor prognostic signs and may indicate a need for retreatment or for a change of drug. [6]

4 . References

1. Jublia prescribing information. Valeant Pharmaceuticals North America LLC, Bridgewater, NJ. June 2014.
2. Kerydin prescribing information. Anacor Pharmaceuticals, Inc. East Meadow Circle Palo Alto, CA. July 2014.
3. Ciclodan prescribing information. Medimetriks Pharmaceuticals, Inc. March 2011.
4. McEvoy GK. AHFS Drug Information 2005. Bethesda, MD: American Society of Health-System Pharmacists, Inc; 2005.
5. Sigurgeirsson B, Olafsson JH, Steinsson JP, et al. Long-term effectiveness of treatment with terbinafine vs. itraconazole in onychomycosis: a 5-year blinded prospective follow-up study. Arch Dermatol. 2002;138:353-7.
6. Roberts DT, Taylor WD, Boyle J. Guidelines for treatment of onychomycosis. Br J Dermatol. 2003;148:402-410.

Prior Authorization Guideline

GL-31310 Topical Retinoid Agents

Formulary OptumRx

Formulary Note

Approval Date 8/8/2016

Revision Date 8/8/2016

Technician Note :

P&T Approval Date: 12/16/2005; P&T Revision Date: 2/25/2016 P&T **Effective 7/1/2016**

1 . Indications

Drug Name: Tazorac cream and gel (0.05% and 0.1%) **Indications** **Plaque psoriasis** Indicated for the topical treatment of patients with plaque psoriasis.
Drug Name: Tretinoin **Off Label Uses**

Wound healing (mild) [20] Tretinoin 0.05% cream has been shown to decrease would healing time in patients receiving electroepilation. Enhanced healing of epidermal wounds in patients undergoing dermabrasion when pretreated with tretinoin 0.05% cream has been reported. DRUGDEX Recommendation: Adult, Class IIb, Evidence favors efficacy.

Actinic keratosis [12]

Alopecia areata [20]

Hyperkeratosis [20]

Keloid scar [20]

Systematized epidermal nevus [20]

Drug Name: Atralin (tretinoin), Avita (tretinoin) cream and gel, Fabior (tazarotene) foam, Retin-A (tretinoin) cream and gel, Retin-A Micro (tretinoin) gel, Tazorac (tazarotene) cream and gel 0.1%, Tretin X (tretinoin) cream and gel

Indications

Acne vulgaris Indicated for the treatment of acne vulgaris.

Drug Name: Differin (adapalene) cream/lotion/gel, Epiduo (adapalene/benzoyl peroxide) gel, Veltin (tetrinoin/clindamycin) gel, Ziana (tretinoin/clindamycin) gel

Indications

Acne vulgaris Indicated for the treatment of acne vulgaris.

2 . Criteria

Product Name: Brand Avita, Generic Adapalene, Generic Tretinoin, or Generic Tretinoin Microsphere

Diagnosis	Acne vulgaris

Approval Length	12 Month
Guideline Type	Prior Authorization
Approval Criteria **1** Diagnosis of acne vulgaris	
Notes	Treatment for cosmetic purposes (ie, wrinkles, senile lentigo, solar elastosis, dyschromia, melasma or chloasma, hyperpigmentation of skin, facial mottling) is a benefit exclusion. [A]

Product Name: Brand Atralin, Brand Differin, Epiduo, Epiduo Forte, Fabior, Brand Retin-A, Brand Retin-A Micro, Tazorac 0.1 %, Tretin X, Veltin, or Ziana

Diagnosis	Acne vulgaris
Approval Length	12 Month
Guideline Type	Prior Authorization
Approval Criteria **1** Diagnosis of acne vulgaris **and** **2** History of failure, contraindication, or intolerance to three formulary retinoid products (eg, Atralin gel, Avita cream or gel, Tretinoin cream or gel)	
Notes	Treatment for cosmetic purposes (ie, wrinkles, senile lentigo, solar elastosis, dyschromia, melasma or chloasma, hyperpigmentation of skin, facial mottling) is a benefit exclusion. [A]

Product Name: Tazorac

Diagnosis	Psoriasis
Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of psoriasis

and

2 One of the following:

2.1 History of failure, contraindication, or intolerance to two medium to high potency formulary or non-formulary corticosteroid topical treatments (eg, see table: Relative Potency of Selected Topical Corticosteroid Products in Background section) [5]

OR

2.2 Prescribed by a dermatologist

Notes	Treatment for cosmetic purposes (ie, wrinkles, senile lentigo, solar elastosis, dyschromia, melasma or chloasma, hyperpigmentation of skin, facial mottling) is a benefit exclusion. [A]

Product Name: Brand Avita, Generic Tretinoin, or Generic Tretinoin Microsphere

Diagnosis	Other Medical Uses (Off-Label)
Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following diagnoses: [A, 12, 20]

- Actinic keratosis
- Alopecia areata
- Hyperkeratosis
- Keloid scar
- Systematized epidermal nevus
- Wound healing (mild)

Notes	Treatment for cosmetic purposes (ie, wrinkles, senile lentigo, solar elastosis, dyschromia, melasma or chloasma, hyperpigmentation of skin, facial mottling) is a benefit exclusion. [A]

Product Name: Brand Atralin, Brand Retin-A, Brand Retin-A Micro, or Tretin X

Diagnosis	Other Medical Uses (Off-Label)
Approval Length	12 Month
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following diagnoses: [A, 12, 20]

- Actinic keratosis
- Alopecia areata
- Hyperkeratosis
- Keloid Scar
- Systematized epidermal nevus
- Wound healing (mild)

and

2 History of failure, contraindication, or intolerance to three formulary tretinoin products (eg, Avita cream or gel, Tretinoin cream or gel)

Notes	Treatment for cosmetic purposes (ie, wrinkles, senile lentigo, solar elastosis, dyschromia, melasma or chloasma, hyperpigmentation of skin, facial mottling) is a benefit exclusion. [A]

3 . Background

Clinical Practice Guidelines

Facts and Comparisons: Relative Potency of Selected Topical Corticosteroid Products [5]

Medium potency	High potency
Betamethasone dipropionate	Amcinonide
Betamethasone valerate	Augmented betamethasone dipropionate
Clocortolone pivalate	Betamethasone dipropionate
Desoximetasone	Betamethasone valerate
Fluocinolone acetonide	Desoximetasone
Flurandrenolide	Diflorasone diacetate
Fluticasone propionate	Fluocinolone acetonide
Hydrocortisone butyrate	Fluocinonide
Hydrocortisone valerate	Halcinonide
Mometasone furoate	Triamcinolone acetonide
Triamcinolone acetonide	

The use of topical retinoids for the following conditions was clarified as either medical or cosmetic (plan exclusions) [18]

Uses	Medical vs. Cosmetic
Actinic keratosis	Medical
Alopecia areata	Medical
Chloasma	Cosmetic
Fine wrinkles on face	Cosmetic
Hyperkeratosis	Medical
Hyperpigmentation of skin, Facial mottling	Cosmetic
Keloid scar	Medical
Roughness of skin, Facial tactile roughness	Cosmetic
Systematized epidermal nevus	Medical
Ultraviolet-induced change in normal skin	Cosmetic
Wound healing (mild)	Medical

4 . Endnotes

A. The use of topical retinoids for the following conditions was clarified as either medical or cosmetic (plan exclusions) [18] Please refer to Background section for table with details.

5 . References

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Prior Authorization Guideline

GL-17402 Xifaxan (rifaximin)

Formulary OptumRx

Formulary Note

Approval Date 7/15/2015

Revision Date 6/2/2016

Technician Note :

P&T Approval Date: 12/6/2004; P&T Revision Date: 2/25/2016. **Effective 7/1/2016**

1 . Indications

Drug Name: Xifaxan (rifaximin)

Indications

Travelers' Diarrhea

200mg is indicated for the treatment of travelers' diarrhea (TD) caused by noninvasive strains of Escherichia coli in adults and pediatric patients 12 years of age and older. Limitations of use: Should not be used in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than Escherichia coli.

Prophylaxis of Hepatic Encephalopathy Recurrence

550 mg is indicated for reduction in risk of overt hepatic encephalopathy (HE) recurrence in patients greater than or equal to 18 years of age. In the trials of Xifaxan for HE, 91% of patients were using lactulose concomitantly. Differences in the treatment effect of those patients not using lactulose concomitantly could not be assessed. Has not been studied in patients with MELD (Model for End-Stage Liver Disease) score greater than 25, and only 8.6% of patients in the controlled trial had MELD scores over 19. There is increased systemic exposure in patients with more severe hepatic dysfunction.

Irritable Bowel Syndrome with Diarrhea

550 mg is indicated for the treatment of irritable bowel syndrome with diarrhea in adults.

Off Label Uses

Small Bowel Bacterial Overgrowth (SBBO)

Has been used for the treatment of small intestinal bacterial overgrowth. [12,13]

2 . Criteria

Product Name: Xifaxan 200 mg tablets

Diagnosis	Travelers' Diarrhea
Approval Length	1 time only
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of travelers' diarrhea

AND

2 One of the following:

2.1 History of failure to one of the following: [4, 5, E, F]

- Cipro (ciprofloxacin)
- Levaquin (levofloxacin)
- Ofloxacin
- Zithromax (azithromycin)

OR

2.2 Resistance, contraindication, or intolerance to all of the following antibiotics:

- Cipro (ciprofloxacin)
- Levaquin (levofloxacin)
- Ofloxacin
- Zithromax (azithromycin)

Product Name: Xifaxan 200 mg tablets [13, 15]

Diagnosis	Small Bowel Bacterial Overgrowth (SBBO) (off-label)
Approval Length	3 Months [D]
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of Small Bowel Bacterial Overgrowth (SBBO)

AND

2 One of the following:

2.1 History of failure to two of the following antibiotics:

- Neomycin
- Augmentin (amoxicillin/clavulanic acid)
- Cipro (ciprofloxacin)
- Bactrim (trimethoprim-sulfamethoxazole)
- Vibramycin (doxycycline) or Minocin (minocycline) or tetracycline
- Flagyl (metronidazole)

OR

2.2 Resistance, contraindication, or intolerance to all of the following antibiotics:

- Neomycin
- Augmentin (amoxicillin/clavulanic acid)
- Cipro (ciprofloxacin)
- Bactrim (trimethoprim-sulfamethoxazole)
- Vibramycin (doxycycline) or Minocin (minocycline) or tetracycline
- Flagyl (metronidazole)

Product Name: Xifaxan 200 mg tablets [13, 15]

Diagnosis	Small Bowel Bacterial Overgrowth (off-label)
Approval Length	3 Months [D]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Documentation of positive clinical response to Xifaxan therapy (e.g., resolution of symptoms or relapse with Xifaxan discontinuation)

Product Name: Xifaxan 550 mg tablets

Diagnosis	Irritable Bowel Syndrome with Diarrhea

Approval Length	2 Weeks
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) [G]

AND

2 History of failure, contraindication, or intolerance to one of the following:

- Antispasmodic agent (e.g., dicyclomine, hyoscyamine)
- Tricyclic antidepressant (amitriptyline)
- Antidiarrheal agent (e.g., loperamide)

Product Name: Xifaxan 550 mg tablets

Diagnosis	Irritable Bowel Syndrome with Diarrhea
Approval Length	2 Weeks
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 Patient experiences IBS-D symptom recurrence [H, I]

AND

2 Patient has not already received 3 treatment courses of Xifaxan for IBS-D in their lifetime [J]

Notes	Not to exceed the FDA-recommended dosage of up to 2 retreatment courses.

Product Name: Xifaxan 550 mg tablets

Diagnosis	Prophylaxis of Hepatic Encephalopathy Recurrence
Approval Length	6 Months [B]
Guideline Type	Prior Authorization

Approval Criteria

1 Used for prophylaxis of hepatic encephalopathy (HE) recurrence

AND

2 History of failure, contraindication, or intolerance to lactulose

3 . Endnotes

A. Antibiotic treatment should be avoided in diarrhea caused by enterohemorrhagic E. coli. [9]
B. Long-term use (greater than or equal to 6 months) of rifaximin in patients with hepatic encephalopathy was associated with lower hospitalization frequency and duration, lower hospital charges, better clinical status, and fewer adverse events when compared to treatment with lactulose. [11]
C. The main goals in the treatment of SBBO are 1) treatment of underlying small intestinal abnormality, when possible; 2) concentration on long-term antibiotic therapy when surgical management is not feasible; 3) adjunctive treatment of dysmotility, such as a prokinetic agent; and 4) nutritional support, particularly in patients with weight loss or vitamin deficiency. [12]
D. In most patients, a single course of treatment (10 days) markedly improves symptoms, and patients may remain free of symptoms for months. In others, symptoms recur quickly, and acceptable results can only be obtained with cyclic treatment (1 of every 4 weeks). In still others, continuous treatment may be needed for 1 to 2 months. If the antimicrobial agent is effective, a resolution or marked diminution of symptoms will be notable within several days of initiating therapy. Diarrhea and steatorrhea will decrease, and cobalamin malabsorption will be corrected. [12]
E. According to the Centers for Disease Control and Prevention's Yellow Book, fluoroquinolones including, but not limited to, ciprofloxacin and levofloxacin, are considered first line agents in the treatment of Traveler's Diarrhea (TD). Azithromycin is also considered a first line agent for treatment of TD and is especially efficacious in the pediatric population. The overall usefulness of Rifaximin for empiric self-treatment remains to be determined as Rifaximin has only been shown to be efficacious in patients with noninvasive strains of E. coli. [14]
F. Levofloxacin, ofloxacin and ciprofloxacin have all been shown to be highly effective in the treatment and prevention of Travelers' Diarrhea and should be considered first-line therapy options for this indication. [16]
G. In the TARGET I, II and III pivotal trials, Irritable Bowel Syndrome was diagnosed using the ROME II diagnostic criteria. According to the ROME-II criteria, an IBS-D diagnosis requires at least 12 consecutive weeks in the previous 12 months of abdominal discomfort or pain that has two out of the three following features: relieved with defecation; and/or onset associated with a change in frequency of stool; and/or onset associated with a change in appearance of stool [17, 19].
H. In the TARGET III pivotal trial, a total of 636 responders (59%) required retreatment. The median time to recurrence for patients who experienced initial response was 10 weeks (range from 6 to 24 weeks) [19]
I. According to the ROME-III criteria, recurrent signs and symptoms of IBS-D include the following: a return of abdominal pain or mushy/watery stool consistency for at least 3 weeks during a 4-week follow-up period. [20]
J. The recommended dose of Xifaxan for IBS-D is one 550 mg tablet taken orally three times a day for 14 days. Patients who experience a recurrence of symptoms can be retreated up to two times with the same dosage regimen. [1]

4 . References

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Prior Authorization Guideline

GL-31711 Xiidra (lifitegrast)

Formulary OptumRx

Formulary Note

Approval Date 8/30/2016

Revision Date 8/30/2016

Technician Note :

P&T Approval Date: 8/18/2016. **Effective 9/15/2016**

1 . Indications

Drug Name: Xiidra (lifitegrast)

Indications

Dry eye disease Indicated for the treatment of the signs and symptoms of dry eye disease (DED)

2 . Criteria

Product Name: Xiidra*

Diagnosis	Dry eye disease
Approval Length	12 Month
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 Diagnosis of dry eye disease

AND

2 Patient has suppressed tear production due to ocular inflammation as determined by at least one of the following diagnostic tests: [A, 2]

- Schirmer test (aqueous tear production and clearance)
- Tear break-up time
- Ocular surface dye staining
- Tear film osmolarity
- Fluorescein clearance test/ tear function test

AND

3 History of failure, contraindication, or intolerance to at least one over-the-counter ocular lubricant used at an optimal dose and frequency for at least two weeks (e.g., artificial tears, lubricating gels/ointments, etc.) [B, 2]

Notes	*Prior Authorization may not apply depending on the plan.

Product Name: Xiidra*

Approval Length	12 Month
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** Documentation of positive clinical response to Xiidra therapy (e.g., increased tear production or improvement in dry eye symptoms)	
Notes	*Prior Authorization may not apply depending on the plan.

3 . Endnotes

A. Standard diagnostic tests include the schirmer test (aqueous tear production and clearance), tear break-up time, ocular surface dye staining, tear film osmolarity and fluorescein clearance test/ tear function test. However, no single test is adequate to establish a diagnosis of dry eye; the diagnosis should be based on multiple factors. [2]
B. As disease severity increases, aqueous enhancement of the eye using topical agents is appropriate (i.e., emulsions, gels, and ointments can be used). Anti-inflammatory therapies (topical cyclosporine and corticosteroids), systemic omega-3 fatty acid supplements, punctual plugs and spectacle side shields/moisture chambers may also be considered in addition to aqueous enhancement therapies in patients who need additional symptom management. [2]

4 . References

1. Xiidra Prescribing Information. Shire US Inc, June 2016.
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