Prior Authorization Approval Criteria

Effective Date: 07/01/2019

Prior authorization criteria is developed following evidence-based criteria including:

i. Safety, including concurrent drug utilization review (cDUR) when applicable
ii. Efficacy: the potential outcome of treatment under optimal circumstances
iii. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary
iv. Cost-Effectiveness: the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available
v. Relevant benefits of current formulary agents of similar use
vi. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

DENVER HEALTH MEDICAL PLAN INC.™

This document contains Prior Authorization Approval Criteria for the following medications:

1. Abilify Maintena (aripiprazole long-acting injectable)
2. Aimovig (erenumab)
3. Ampyra (dalfampridine)
4. Aubagio (teriflunomide)
5. Daytrana (methylphenidate extended release transdermal system)
6. Fanapt (iloperidone)
7. FreeStyle Libre 14-Day Reader and Sensor (continuous glucose monitoring system)
8. Gilenya (fingolimod)
9. Hepatitis C Virus (HCV) Non-Preferred Medications (Mavyret, Zepatier)
10. Hepatitis C Virus (HCV) Preferred Medications (Epclusa, Harvoni)
11. Invega (paliperidone)
12. Invega Sustenna (paliperidone palmitate)
13. Kapvay (clonidine extended release)
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15. Pristiq (desvenlafaxine)
16. Rozerem (ramelteon)
17. Saphris (asenapine)
18. Sensipar (cinalcalcet)
19. Silenor (doxepin)
20. Somatropin
21. Tecfidera (dimethyl fumarate)
22. Viibryd (vilazodone)
23. Zyprexa Relprevv (olanzapine pamoate extended release injection)

Prior Authorization Approval Criteria

Abilify Maintena

(aripiprazole long-acting injectable)

Generic name: aripiprazole long-acting injectable
Brand name: Abilify Maintena
Medication class: Antipsychotic

FDA-approved uses:

- Treatment of schizophrenia

Usual dose range:

- Schizophrenia – adults
  - 400mg monthly (may be reduced to 300 mg in patients with adverse reactions or who are known CYP2D6 poor metabolizers)

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation criteria

Bipolar I disorder/Schizophrenia:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Documented tolerance to oral aripiprazole
- Patient has a history of noncompliance and/or refuses to utilize oral medication and documentation that patient education and other efforts to improve adherence have been attempted
- Either one of the following:
  - Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of Risperdal Consta (Step Therapy required: trial of oral risperidone)

  OR
  - Documented stabilization on oral aripiprazole (trial of 4-6 weeks), evidenced by coverage by the plan or confirmed coverage by the previous plan (e.g. pharmacy has been filling through the previous plan)

Renewal criteria

- Must have documentation of adherence to therapy (>75% compliance)
- Documentation of effectiveness of therapy
- Documentation of continued need for long-acting injection (including a review of adherence with other oral medications)

Contraindications:

- Known hypersensitivity to aripiprazole.

Not approved if:

- Past history of neuroleptic malignant syndrome, seizures, or dementia-related psychosis
- Current history of orthostatic hypotension
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
    - Clozapine
    - Two other antipsychotics

Black box warning:

- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

Additional considerations:

- In conjunction with first dose, give 14 consecutive days of concurrent oral aripiprazole (10 mg to 20 mg) or current oral antipsychotic then discontinue
- Dosage adjustments are required for missed doses
- Dosage adjustments for patients who are CYP2D6 poor metabolizers and patients taking CYP2D6 inhibitors, CYP3A4 inhibitors, or CYP3A4 inducers for greater than 14 days
- Maximum dose is 400 mg monthly

Approval time frames:

- Initial – 6 months with a quantity limit of 1 vial/month
- Renewal – 1 year with a quantity limit of 1 vial/month

References:

- Abilify Maintena Prescribing Information (2019). Otsuka Pharmaceutical CO, Tokyo, Japan.
- Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord. 2018;20:97–170. https://doi.org/10.1111/bdi.12609
- American Psychiatric Association. Five things physicians and patients should question [guideline on the internet]. Available at: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association. Accessed on June 21, 2019.
- Kane JM, Sanchez R, Perry PP, Jin N, Johnson BR, Forbes RA et al. Aripiprazole intramuscular depot as maintenance treatment in patients with schizophrenia: a 52-week, multicenter, randomized, double-blind, placebo-controlled study. J Clin Psychiatry 2012; 73(5):617-624.
- PL Detail-Document, Comparison of Atypical Antipsychotics. Pharmacist's Letter/Prescriber's Letter 2015; 31(9): 310909.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Update 2012 on the long-term treatment of schizophrenia and management of antipsychotic-induced side effects. World J Biol Psychiatry 2013; 14: 2-44.
- Dixon L, Perkins D, Calmes C. American Psychiatric Association. Guideline Watch (September 2009): practice guideline for the treatment of patients with schizophrenia. Available at:

http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf. Accessed on June 21, 2019.

- American Psychiatric Association. Practice guideline for the treatment of patients with schizophrenia, second edition. Am J Psychiatry. 2004 Feb;161(2 Suppl):1-56.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: June 2013
Revision: June 2014, June 2015, June 2016, June 2017, June 2018, June 2019

Prior Authorization Approval Criteria

Aimovig (erenumab)

Generic name: erenumab injection
Brand name: Aimovig
Medication class: Calcitonin gene related peptide receptor (CGRP) antagonist

FDA-approved uses:

- Migraine prophylaxis

Usual dose range:

- Migraine prophylaxis
  - 70 mg – 140 mg subcutaneously once monthly

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Migraine prophylaxis

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Prescribed by or in consultation with a neurologist
- Confirmation of all of the following:
  - 15 or more headache days per month, of which 8 or more of these are migraine days
  - Chronic migraines for a duration of 3 or more months
- Failure to experience a substantial reduction in headache frequency after a trial of withdrawal from all analgesics for headache for a minimum of 4 weeks
- Failure to respond or intolerance to an adequate trial of **three** of the following:
  - An anti-epileptic drug (such as divalproex sodium or topiramate)
  - A beta-blocker (such as propranolol extended-release)
  - An antidepressant (such as venlafaxine or a TCA, such as amitriptyline)
  - Botox (PA Required)

Renewal Criteria

- Must have documentation of adherence to therapy (> 75% adherence)
- Documentation of effectiveness of therapy as evidenced by a 50% reduction in number of migraine days per month

Not approved if:

- Requesting more than 70 mg per month for new start; must have adequate trial of 70 mg per month before 140 mg dose will be considered

Additional considerations:

- Maximum dose of 140 mg once per month
- Avoid use if allergic to latex

Approval time frames:

- Initial – 6 months with MDL of 1 mL per 28 days
- Renewal – 1 year with MDL of up to 2 mL per 28 days

References:

- Aimovig Prescribing Information; Thousand Oaks, CA; Amgen, Inc.; 2018.
- Buse DC, Lipton RB, Hallström Y, et al. Migraine-related disability, impact, and health-related quality of life among patients with episodic migraine receiving preventive treatment with erenumab. Cephalalgia 2018
- Dodick DW, Ashina M, Brandes JL, et al. ARISE: A Phase 3 randomized trial of erenumab for episodic migraine. Cephalalgia 2018.
- Dodick DW, Silberstein SD, Bigal ME, et al. Effect of Fremanezumab Compared With Placebo for Prevention of Episodic Migraine: A Randomized Clinical Trial. JAMA 2018; 319(19):1999-2008.
- Edvinsson L, Haanes K, Warfvinge K, and Krause DN. CGRP as the target of new migraine therapies – successful translation from bench to clinic. Nat Rev Neurol 2018; 14(6):338-350.
- Goadsby PJ, Reuter U, Hallström Y, et al. A Controlled Trial of Erenumab for Episodic Migraine. N Engl J Med 2017; 377:2123-2132.
- MacGregor EA. Migraine in the Clinic. ACP Ann Intern Med 2013.
- Shamliyan TA, Choi J, Ramakrishnan R, et al. Preventive Pharmacologic Treatments for Episodic Migraine in Adults. J Gen Intern Med 2013; 28(9):1225-1237.
- Silberstein SD, Holland S, Freitag F, et al. Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults. Neurology 2012; 78:1337-1345.
- Sussman M, Benner J, Neumann P, and Menzin J. Cost-effectiveness analysis of erenumab for the preventive treatment of episodic and chronic migraine: Results from the US societal and payer perspectives. Cephalalgia 2018.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: December 2018
Revision:

Prior Authorization Approval Criteria

Ampyra (dalfampridine)

Generic name: dalfampridine
Brand name: Ampyra
Medication class: Potassium Channel blocker

FDA-approved uses:

- Improvement of walking ability in multiple sclerosis (MS) patients

Usual dose range:

- Improvement of walking ability in MS patients - adults 10 mg twice daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Improvement of walking ability in MS patients:

Adults

- FDA indicated diagnosis
- Prescribed by (or in consultation with) a neurologist
- 18 – 70 years of age
- Complete the 25 foot walk test in 8-45 seconds
  OR
- If 25 foot walk test is < 8 seconds, the Expanded Disability Status Scale (EDSS) must be between 4.5-6.5

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Improvement in 25 foot walk time of ≥ 20% after one month of therapy

Contraindications:

- History of seizure disorders
- Moderate to severe renal impairment (CrCL ≤ 50mL/min)
- Hypersensitivity to Ampyra or 4-aminopyridine

Not approved if:

- Patient has any contraindications
- Patient is wheelchair bound

Additional considerations:

- Discontinue Ampyra if patient experiences a seizure

Approval time frames:

- Initial – 3 months with MDL 2/day
- Renewal – 1 year with MDL 2/day

References:

- Ampyra ® [package insert], Ardsley, NY: Acorda; 2017.
- National Institute for Health and Care Excellence (2014) Multiple sclerosis in adults: management. Clinical Guideline CG186. London: National Institute for Health and Care Excellence.
- Goodman A.D., Brown T.R. Edwards K.R. et al. A Phase 3 Trial of Extended Release Oral Dalfampridine in Multiple Sclerosis. Ann Neurol 2010; 68:494-502.
- Goodman AD, Brown TR, Krupp LB, Schapiro RT, Schwid SR, Cohen R et al. Sustained-release oral fampridine in multiple sclerosis: a randomised, double-blind, controlled trial. Lancet 2009; 373(9665):732-738.
- Goodman AD, Brown TR, Cohen JA, Krupp LB, Schapiro R, Schwid SR et al. Dose comparison trial of sustained-release fampridine in multiple sclerosis. Neurology 2008; 71(15):1134-1141.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 11/11/14
Revision: November 2015, November 2016, November 2017, November 2018

Prior Authorization Approval Criteria

Aubagio (teriflunomide)

Generic name: teriflunomide
Brand name: Aubagio
Medication class: Pyrimidine synthesis inhibitor

FDA-approved uses:

- Relapsing forms of multiple sclerosis (MS)

Usual dose range:

- Relapsing forms of multiple sclerosis – adults 7-14 mg once daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Relapsing forms of multiple sclerosis:

Adults

- FDA indicated diagnosis
- Prescribed by (or in consultation with) a neurologist
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial (6 months) of Gilenya (fingolimod)- PA required

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Sever hepatic impairment
- Women who are pregnant or of childbearing potential not using reliable contraception
- Current treatment with leflunomide

Not approved if:

- Combined with Copaxone, Gilenya, Tecfidera, Tysabri, Rituxan or an interferon product
- Patient has any contraindications

Black box warning:

- Severe liver injury including fatal liver failure has been reported in patients treated with leflunomide. A similar risk would be expected for teriflunomide.
- Concomitant use of teriflunomide with other potentially hepatotoxic drugs may increase the risk of severe liver injury
- Teriflunomide may cause major birth defects if used during pregnancy. Pregnancy must be excluded before starting teriflunomide

Additional considerations:

- Female patients of child bearing age must use a reliable form of contraception

Approval time frames:

- Initial – 6 months with MDL 1/day
- Renewal – 1 year with MDL 1/day

References:

- Aubagio ® [package insert], Cambridge, MA: Genzyme Corp.; 2018.
- Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology 2018; 90:777.
- Confavreux C, O'connor P, Comi G, et al. Oral teriflunomide for patients with relapsing multiple sclerosis (TOWER): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet Neurol. 2014;13(3):247-56.
- National Institute for Health and Care Excellence (2014) Multiple sclerosis in adults: management. Clinical Guideline CG186. London: National Institute for Health and Care Excellence.
- O'connor P, Wolinsky JS, Confavreux C, et al. Randomized trial of oral teriflunomide for relapsing multiple sclerosis. N Engl J Med. 2011;365(14):1293-303.
- O'connor PW, Li D, Freedman MS, et al. A Phase II study of the safety and efficacy of teriflunomide in multiple sclerosis with relapses. Neurology. 2006;66(6):894-900.
- Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002; 58(2):169-78.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 11/11/14
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Prior Authorization Approval Criteria

Daytrana (methylphenidate extended release transdermal system)

Generic name: methylphenidate extended release transdermal system
Brand name: Daytrana
Medication class: CNS Stimulant

FDA-approved uses:

- Attention Deficit Hyperactivity Disorder (ADHD) in children (ages 6-12) and adolescents (ages 13-17)

Usual dose range:

- ADHD – children and adolescent 10 mg – 30 mg /9 hours

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

ADHD:

Children and Adolescents

- FDA indicated diagnosis
- Age 6 to 17 years of age
- Failure to respond (or intolerance) to each of the following
  - A formulary methylphenidate product
  - A formulary amphetamine product

OR

- Inability to take oral formulations

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence or >75% of the school year)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to methylphenidate
- Patients with marked anxiety, tension, or agitation
- Patients with a diagnosis of glaucoma
- Patient with a tic disorder or a family history or diagnosis of Tourette's syndrome
- Patients currently using or within 2 weeks of using an MAO inhibitor

Not approved if:

- Patient has a history of drug dependence or alcoholism
- Patient has a contraindication to treatment (see Contraindications)

Black box warning:

- Should be given cautiously to patients with a history of drug dependence or alcoholism. Chronic abusive use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior.

Additional considerations:

- Maximum daily dose is 30 mg/9 hours.
- The patch should be applied 2 hours before an effect is needed and should be removed 9 hours after application.
- Dose should be titrated to effect. Dose titration, final dosage and wear time should be individualized according to the needs and response of the patient.
- The recommended titration schedules are based on the following table from the package insert:

Upward Titration, if Response is Not Maximized				
	Week 1	Week 2	Week 3	Week 4
Patch Size	12.5 cm^2	18.75 cm^2	25 cm^2	37.5 cm^2
Nominal Delivered Dose (mg/9 hours)	10 mg	15 mg	20 mg	30 mg
Delivery Rate	1.1 mg/hr	1.6 mg/hr	2.2 mg/hr	3.3 mg/hr

Approval time frames:

- Initial – 1 year with MDL of 1 patch/day
- Renewal – 1 year with MDL of 1 patch/day

References:

1. Daytrana Prescribing Information. Noven Pharmaceuticals, Inc., Miami, FL: 2017.
2. American Academy of Pediatrics Subcommittee on ADHD, Steering Committee on Quality Improvement and Management. ADHD: clinical practice guidelines for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2011; 128:1007-1022.
3. Feldman HM, Reiff MI. Attention deficit-hyperactivity disorder in children and adolescents. N Engl J Med. 2014; 370:838-846.
4. Pelham WE, Burrows-MacLean L, Gnagy EM, Fabiano GA, Coles EK, Tresco KE et al: Transdermal methylphenidate, behavioral, and combined treatment for children with ADHD. Exp Clin Psychopharmacol. 2005; 13(2):111-126.
5. McGough JJ, Wigal SB, Abikoff H, Turnbow JM, Posner K, Moon E. A randomized, double-blind, placebo-controlled, laboratory classroom assessment of methylphenidate transdermal system in children with ADHD. J Atten Disord. 2006; 9(3):476-485.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 07/19/2013
Revision: July 2015, July 2016, July 2017, July 2018

Prior Authorization Approval Criteria

Fanapt (iloperidone)

Generic name: iloperidone
Brand name: Fanapt
Medication class: Antipsychotic

FDA-approved uses:

- Treatment of schizophrenia in adults

Usual dose range:

- Schizophrenia – adults
  - Starting dose 1 mg twice a day
  - Target dose 6-12 mg twice a day

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation criteria

Schizophrenia:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of three formulary antipsychotics agents

Renewal criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to iloperidone. Reactions have included urticaria and pruritus.

Not approved if:

- Patient has dementia-related psychosis
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
  - Clozapine
  - Two other antipsychotics

Black box warning:

- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

Additional considerations:

- Fanapt must be titrated slowly from a low starting dose to avoid orthostatic hypotension.
- Maximum daily dose is 24 mg/day
- Dose should be reduced in patients taking CYP2D6 or CYP3A4 inhibitors

Approval time frames:

- Initial – 6 months with MDL of 2/day
- Renewal – 1 year with MDL of 2/day

References:

- Fanapt Prescribing Information (2018). Novartis Pharmaceuticals Corporation East Hanover, NJ.
- American Psychiatric Association. Five things physicians and patients should question [guideline on the internet]. Available from: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association. Accessed on June 21, 2019.
- PL Detail-Document, Comparison of Atypical Antipsychotics. Pharmacist's Letter/Prescriber's Letter 2015; 31(9): 310909. June 2015.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 1: Update 2012 on the acute treatment of schizophrenia and the management of treatment resistance. World J Biol Psychiatry 2012; 13: 318-378.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Update 2012 on the long-term treatment of schizophrenia and management of antipsychotic-induced side effects. World J Biol Psychiatry 2013; 14: 2-44.
- Dixon L, Perkins D, Calmes C. American Psychiatric Association. Guideline Watch (September 2009): practice guideline for the treatment of patients with schizophrenia. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf. Accessed on June 21, 2019.
- Cutler AJ, Kalali AH, Weiden PJ, Hamilton J, Wolfgang CD. Four-week, double-blind, placebo- and ziprasidone-controlled trial of iloperidone in patients with acute exacerbations of schizophrenia. J Clin Psychopharmacol 2008; 28(2 Suppl 1):S20-S28.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: June 2013
Revision: June 2014, June 2015, June 2016, June 2017, June 2018, June 2019

Prior Authorization Approval Criteria
FreeStyle Libre 14-Day Reader and Sensor
(Continuous Glucose Monitoring System)

Generic name: continuous glucose monitoring system
Brand name: FreeStyle Libre 14-Day Reader and Sensor
Medication class: Diabetic testing supplies

FDA-approved uses:
- Type 1 Diabetes Mellitus
- Type 2 Diabetes Mellitus

Usual dose range:
- One sensor every 14 days

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Type 1 Diabetes Mellitus

Adults
- FDA indicated diagnosis
- 18 years of age or older

Type 2 Diabetes Mellitus

Adults
- FDA indicated diagnosis
- 18 years of age or older
- Confirmation of one of the following:
  - Insulin dependent requiring 3 or more insulin injections per day
  - Utilizes a continuous insulin infusion pump
- Confirmation of blood glucose testing needed 4 or more times per day

Renewal Criteria
- Must have documentation of adherence to therapy (> 75% adherence)

Additional considerations:
- Maximum of 2 sensors per 28 days
- FreeStyle Precision Neo test strips are compatible with this system will be considered by formulary exception/prior authorization request

- Short-term/intermittent use of this system may be considered as an exception to the above criteria when appropriate medical rationale is provided with the prior authorization request

Approval time frames:

- Initial – 1 year with quantity limit of 2 sensors per 28 days
- Renewal – 1 year with quantity limit of 2 sensors per 28 days

References:

- FreeStyle Libre 14 day User's Manual. Alameda, CA; Abbott Diabetes Care; 2018.
- Bolinder, Jan, et al. Novel glucose-sensing technology and hypoglycaemia in type 1 diabetes: a multicentre, non-masked, randomised controlled trial. The Lancet 388.10057 (2016): 2254-2263.
- Haak, Thomas, et al. Flash glucose-sensing technology as a replacement for blood glucose monitoring for the management of insulin- treated type 2 diabetes: a multicenter, open- label randomized controlled trial. Diabetes Therapy 8.1 (2017): 55-73

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: December 2018
Revision: February 2019

Prior Authorization Approval Criteria

Gilenya (fingolimod)

Generic name: fingolimod
Brand name: Gilenya
Medication class: Spinogosine 1-phosphate receptor modulator

FDA-approved uses:

- Relapsing forms of multiple sclerosis (MS)

Usual dose range:

- Relapsing forms of multiple sclerosis – child ≤ 40kg 0.25 mg daily
- Relapsing forms of multiple sclerosis – child > 40kg 0.5 mg once daily
- Relapsing forms of multiple sclerosis – adults 0.5 mg once daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Relapsing forms of multiple sclerosis:

Adults

- FDA indicated diagnosis
- Prescribed by (or in consultation with) a neurologist
- 10 years of age or older

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Patients who in the last 6 months experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure
- History or presence of Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless patient has a functioning pacemaker
- Baseline QTc interval ≥500 msec; Baseline QTc interval ≥450 msec in males and >470 msec in females should not be dosed in a 6 hour observation and should be referred back to neurologist to arrange 24 hour continuous monitoring
- Treatment with Class Ia or Class III anti-arrhythmic drugs

Not approved if:

- Combined with Copaxone, Aubagio, Tecfidera, Tysabri, Rituxan or an interferon product
- Patient has any contraindications

Additional considerations:

- Patient must be observed for 6 hours after the initial dose and all other doses where the patient has not received the medication for two weeks or more.
- Use with caution in individuals with cardiovascular disease

Approval time frames:

- Initial – 6 months with MDL 1/day
- Renewal – 1 year with MDL 1/day

References:

- Gilenya ® [package insert], East Hanover, NJ: Novartis.; 2018.
- Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology 2018; 90:777.
- Calabresi PA, Radue EW, Goodin D, et al. Safety and efficacy of fingolimod in patients with relapsing-remitting multiple sclerosis (FREEDOMS II): a double-blind, randomised, placebo-controlled, phase 3 trial. Lancet Neurol. 2014;13(6):545-56.
- National Institute for Health and Care Excellence (2014) Multiple sclerosis in adults: management. Clinical Guideline CG186. London: National Institute for Health and Care Excellence.
- Cohen JA, Barkhof F, Comi G, et al. Oral fingolimod or intramuscular interferon for relapsing multiple sclerosis. N Engl J Med. 2010;362(5):402-15.
- Kappos L, Radue EW, O'connor P, et al. A placebo-controlled trial of oral fingolimod in relapsing multiple sclerosis. N Engl J Med. 2010;362(5):387-401.
- Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002; 58(2):169-78.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 11/11/14
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Prior Authorization Approval Criteria

Mavyret, Zepatier

(Hepatitis C Virus Non-Preferred Medications)

Non-Preferred Formulary agents: Mavyret, Zepatier

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria (PLEASE CHECK BOX or write N/A to confirm that point has been addressed)

- □ If requesting completion of therapy, then go to "Renewal Criteria" section below
- □ If new request, must have a contraindication to preferred formulary alternatives (Epclusa, Harvoni) documented on the PA request form or listed here:

  _____
- □ Hepatitis C virus (HCV) infection with a confirmed genotype (GT) obtained within the last year:
  - □ GT1 □ GT2 □ GT3 □ GT4 □ GT5 □ GT6
- □ 18 years of age or older
- □ Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist or HIV specialist
- □ Confirmation that prescriber and patient understand that patients who terminated previous HCV treatment with a direct-acting antiviral (DAA) medication due to nonmedical reasons will not be considered for retreatment
- □ Confirmation that the patient does not have a limited life expectancy (less than 12 months) due to non-liver related comorbid conditions
- □ Confirmation that patient is willing to adhere to treatment requirements
- Confirmation of one of the following:
  - □ No alcohol or drug use
  - □ If alcohol or drug use, then documentation that patient is receiving or enrolled in counseling or substance abuse treatment program for at least a month prior to initiating treatment
- Confirmation of one of the following:
  - □ No cirrhosis
  - □ Compensated cirrhosis
- Confirmation of one of the following:
  - □ Treatment-naïve
    - □ If no cirrhosis
      - □ Mavyret for 8 weeks is preferred for all genotypes
    - □ If compensated cirrhosis
      - □ GT1a
        - o If NS5A RAS present, then Mavyret for 12 weeks is preferred
        - o If NS5A RAS absent, then Zepatier for 12 weeks is preferred
      - □ GT1b

- Zepatier for 12 weeks is preferred
- GT2
  - Mavyret for 12 weeks is preferred
- GT3
  - Mavyret for 12 weeks is preferred
- GT4
  - Zepatier for 12 weeks is preferred
- GT5
  - Mavyret for 12 weeks is preferred
- GT6
  - Mavyret for 12 weeks is preferred

- Treatment-experienced
  - If previously failed PEG-IFN/ribavirin and/or Sovaldi and confirmation of one of the following
    - No cirrhosis
      - For GT1, GT2, GT4, GT5 or GT6: Mavyret for 8 weeks is preferred
      - For GT3: Mavyret for 16 weeks is preferred
    - Compensated cirrhosis
      - For GT1, GT2, GT4, GT5 or GT6: Mavyret for 12 weeks is preferred
      - For GT3: Mavyret for 16 weeks is preferred
  - If previously failed Harvoni or Daklinza/PEG-IFN/ribavirin
    - For GT1: Mavyret for 16 weeks is preferred
  - If previously failed Olysio/Sovaldi or Olysio/PEG-IFN/ribavirin or Victrelis/PEG-IFN/ribavirin or Incivek/PEG-IFN/ribavirin
    - For GT1: Mavyret for 12 weeks is preferred

Renewal Criteria

- Must have documentation of adherence to therapy confirmed by patient receiving refills within one week of completing previous fill
- Documentation of HCV RNA level after 4 weeks on treatment
  - If undetectable, then the remainder of the treatment course will be approved
  - If detectable (>25 copies), then HCV RNA will be reassessed in 2 weeks
    - If HCV RNA has increased > 1 log from nadir, then therapy will be discontinued

Contraindications:

- Severe hepatic impairment (Child-Pugh C)
- Concomitant use with atazanavir or rifampin

Not approved if:

- Less than 12 months since the last attempt of HCV treatment
- Evidence of medication non-adherence to treatment of concurrent medical diseases (e.g. poorly controlled DM, severe HTN, heart failure, significant CAD, COPD, thyroid disease)
- Concurrent psychiatric illness without strong primary care physician and psychiatric support
- Known hypersensitivity to drugs used to treat HCV

Additional considerations:

- May not be required when there are confirmed major drug-drug interactions that prevent its use and changing current medications is not appropriate
- Treatment-experienced patients with previous failure of a DAA (i.e. Daklinza, Epclusa, Harvoni, Mavyret, Olysio, Sovaldi, Technivie, Viekira Pak, Viekira XR, Vosevi, Zepatier) that do not meet the initiation criteria above will only be considered on a case-by-case basis and must be in accordance with the AASLD/IDSA HCV guidelines
- Treatment of patients with decompensated cirrhosis will be considered on a case-by-case basis and must be in accordance with the AASLD/IDSA HCV guidelines
- Mavyret maximum daily limit (MDL) is 3 tablets per day
- Zepatier MDL is 1 tablet per day

Approval time frames:

- Initial approval
    - 8 weeks with MDL: 3/day for Mavryet; 1/day for Zepatier

- Renewal (only required for treatment courses longer than 8 weeks)
    - 4 additional weeks with MDL: 3/day for Mavryet; 1/day for Zepatier
    - Total course of up to 12 weeks

References:

- Mavyret Prescribing Information. AbbVie Inc.., North Chicago, IL: 2017.
- Zepatier Prescribing Information. Merck & Co., Inc., Whitehouse Station, NJ: 2018.
- Guidance from the American Association for the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA) Recommendations for Testing, Managing, and Treating hepatitis C. Available online at http://www.hcvguidelines.org/full-report-view Accessed April 16, 2018.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: September 2017
Revision: May 2018

DENVER HEALTH MEDICAL PLAN INC.

Prior Authorization Approval Criteria

Epclusa, Harvoni

(Hepatitis C Virus Preferred Medications)

Preferred Formulary agents: Epclusa, Harvoni

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria (PLEASE CHECK BOX or write N/A to confirm that point has been addressed)

- □ If requesting completion of therapy, then go to "Renewal Criteria" section below
- □ 18 years of age or older (12 years of age or older for Harvoni)
- □ Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist or HIV specialist
- □ Confirmation that prescriber and patient understand that patients who terminated previous HCV treatment with a direct-acting antiviral (DAA) medication due to nonmedical reasons will not be considered for retreatment
- □ Confirmation that patient is willing to adhere to treatment requirements
- □ Confirmation that the patient does not have a limited life expectancy (less than 12 months) due to non-liver related comorbid conditions
- Confirmation of one of the following:
  - □ No alcohol or drug use
  - □ If alcohol or drug use, then documentation that patient is receiving or enrolled in counseling or substance abuse treatment program for at least a month prior to initiating treatment
- Confirmation of one of the following:
  - □ No cirrhosis
  - □ Compensated cirrhosis
- Confirmation of one of the following:
  - □ Treatment-naïve
  - □ Treatment-experienced
- Confirmation of Hepatitis C virus (HCV) infection with a genotype obtained within the last year by selecting one of the following and completing additional criteria:
  - □ **Genotype 1 (a or b)**
    - □ If **all** of the following are confirmed, then Harvoni for 8 weeks is preferred
      - □ HCV RNA level < 6 million copies
      - □ Treatment-naïve
      - □ No evidence of cirrhosis
      - □ HIV negative
      - □ Not Black or African American
        - □ If any of the above are not confirmed, then Epclusa for 12 weeks is preferred
  - □ **Genotype 2**
    - □ Epclusa for 12 weeks is preferred

- **Genotype 3**
  - Treatment-naïve
    - Without cirrhosis
      - Epclusa for 12 weeks is preferred
    - With compensated cirrhosis, then RAS testing for Y93 is required
      - If RAS absent, then Epclusa for 12 weeks is preferred
      - If RAS present, then Epclusa plus ribavirin for 12 weeks is preferred
  - Treatment-experienced
    - Without cirrhosis, then RAS testing for Y93H is required
      - If RAS absent, then Epclusa for 12 weeks is preferred
      - If RAS present, then Epclusa plus ribavirin for 12 weeks is preferred
    - With compensated cirrhosis
      - Epclusa plus ribavirin for 12 weeks is preferred

- **Genotype 4, 5 or 6**
  - Epclusa for 12 weeks is preferred

Renewal Criteria

- Must have documentation of adherence to therapy confirmed by patient receiving refills within one week of completing previous fill
- Documentation of HCV RNA level after 4 weeks on treatment
  - If undetectable, then the remainder of the treatment course will be approved
  - If detectable (>25 copies), then HCV RNA will be reassessed in 2 weeks
    - If HCV RNA has increased > 1 log from nadir, then therapy will be discontinued

Contraindications:

- Ribavirin is contraindicated in pregnancy and men whose female partners are pregnant

Not approved if:

- Less than 12 months since the last attempt of HCV treatment
- Evidence of medication non-adherence to treatment of concurrent medical diseases (e.g. poorly controlled DM, severe HTN, heart failure, significant CAD, COPD, thyroid disease)
- Concurrent psychiatric illness without strong primary care physician and psychiatric support
- Known hypersensitivity to drugs used to treat HCV

Additional considerations:

- Preferred HCV medications may not be required when there are confirmed major drug-drug interactions that prevent their use and changing current medications is not appropriate
- Some preferred HCV medication regimens may require concomitant ribavirin
    - If contraindication to ribavirin is documented, then the preferred HCV medication regimen will not be required for use and other appropriate treatment regimens will be considered
- Treatment-experienced patients with previous failure of a DAA (i.e. Daklinza, Epclusa, Harvoni, Mavyret, Olysio, Sovaldi, Technivie, Viekira Pak, Viekira XR, Vosevi, Zepatier) that do not meet the initiation criteria above will only be considered on a case-by-case basis and must be in accordance with the AASLD/IDSA HCV guidelines
- Treatment of patients with decompensated cirrhosis will be considered on a case-by-case basis and must be in accordance with the AASLD/IDSA HCV guidelines
- Maximum daily limit (MDL) is 1 tablet per day

Approval time frames:

- Initial approval
    - 8 weeks with MDL of 1/day

- Renewal (only required for treatment courses longer than 8 weeks)
    - 4 additional weeks with MDL of 1/day
    - Total course of up to 12 weeks

References:

- Epclusa Prescribing Information. Gilead Sciences, Foster City, CA: 2017.
- Harvoni Prescribing Information. Gilead Sciences, Foster City, CA: 2017.
- Guidance from the American Association for the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA) Recommendations for Testing, Managing, and Treating hepatitis C. Available online at http://www.hcvguidelines.org/full-report-view Accessed April 16, 2018.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: October 2016
Revision: July 2017, September 2017, May 2018

Prior Authorization Approval Criteria

Invega (paliperidone)

Generic name: paliperidone
Brand name: Invega
Medication class: Antipsychotic

FDA-approved uses:

- Treatment of schizophrenia in adults and adolescents
- Treatment of schizoaffective disorder in adults as monotherapy and as an adjunct to mood stabilizers and/or antidepressants

Usual dose range:

- Schizophrenia/Schizoaffective disorder – adults 3-12 mg/day
- Schizophrenia – adolescents
  - Weight < 51kg 3-6 mg/day
  - Weight ≥ 51kg 3-12 mg/day

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation criteria

Schizophrenia/Schizoaffective disorder:

Adolescents and Adults

- FDA indicated diagnosis
- 12 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of each of the following:
  - Risperidone
  - One additional formulary antipsychotic agent

Renewal criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to paliperidone, risperidone, or to any components in the formulation.

Not approved if:

- Past history of dementia-related psychosis
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
  - Clozapine
  - Two other antipsychotics

Black box warning:

- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

Additional considerations:

- At least 6 days should elapse between dosage increases
- The dose should be increased no more than 3 mg at a time
- Consideration may be given to individuals with hepatic impairment
- Maximum daily dose
    - Adults and adolescents (≥ 51kg) – 12 mg/day
    - Adolescents < 51kg – 6 mg/day
    - Mild renal impairment (CrCl 50-80mL/min) – 6 mg/day
    - Severe renal impairment (CrCl 10-50 mL/min) – 3 mg/day

Approval time frames:

- Initial – 6 months with MDL of 1/day
- Renewal – 1 year with MDL of 1/day
- Special approval notes – for 12 mg/day doses use 6 mg tablet with MDL of 2/day

References:

- Invega Prescribing Information (2019). Janssen Pharmaceuticals, Inc. Titusville, NJ.
- American Psychiatric Association. Five things physicians and patients should question [guideline on the internet]. Available from: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association/. Accessed on June 21, 2019.
- PL Detail-Document, Comparison of Atypical Antipsychotics. Pharmacist's Letter/Prescriber's Letter 2015; 31(9): 310909. June 2015.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 1: Update 2012 on the acute treatment of schizophrenia and the management of treatment resistance. World J Biol Psychiatry 2012; 13: 318-378.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Update 2012 on the long-term treatment of schizophrenia and management of antipsychotic-induced side effects. World J Biol Psychiatry 2013; 14: 2-44.
- Dixon L, Perkins D, Calmes C. American Psychiatric Association. Guideline Watch (September 2009): practice guideline for the treatment of patients with schizophrenia. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf. Accessed on June 21, 2019.
- Kane J, Canas F, Kramer M, Gassmann-Mayer C, Lim P, Eerdekens M. Treatment of schizophrenia with paliperidone extended-release tablets: A 6-week placebo-controlled trial. SchIzophr Res 2007; 90:147-161.
- Davidson M, Emsley R, Kramer M, Ford L, Pan G, Lim P et al. Efficacy, safety and early response of paliperidone extended release tablets (paliperidone ER): Results of a 6-week randomized, placebo-controlled study. Schizophrenia Res 2007; 93:117-130.
- Marder SR, Kramer M, Ford L, Eerdekens E, Lim P, Eerdekens M et al. Efficacy and safety of paliperidone extended-release tablets: Results of a 6-week, randomized, placebo controlled study. Biol Psychiatry 2007; 62:1363-1370.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: June 2013
Revision: June 2014, June 2015, June 2016, June 2017, June 2018, June 2019

Prior Authorization Approval Criteria

Invega Sustenna (paliperidone palmitate)

Generic name: paliperidone palmitate
Brand name: Invega Sustenna
Medication class: Antipsychotic

FDA-approved uses:

- Treatment of schizophrenia
- Treatment of schizoaffective disorder as monotherapy and as adjunct to mood stabilizers or antidepressants

Usual dose range:

- Initial loading dose
  - Schizophrenia: 234 mg on day 1, 156 mg on day 8
  - Schizoaffective disorder: 234 mg on day 1, 156 mg on day 8
- Maintenance
  - Schizophrenia: 39-234 mg every month
  - Schizoaffective disorder: 78-234 mg every month

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation criteria

Schizophrenia/Schizoaffective disorder:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Documented tolerance to oral paliperidone or risperidone
- Patient has a history of noncompliance and/or refuses to utilize oral medication and documentation that patient education and other efforts to improve adherence have been attempted
- Either one of the following:
  - Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of Risperdal Consta (Step Therapy required: trial of oral risperidone)

  OR
  - Documented stabilization on oral paliperidone (trial of 4-6 weeks), evidenced by previous prior authorization approval by the plan or confirmed coverage by the previous plan (e.g. pharmacy has been filling through the previous plan)

Renewal criteria

- Must have documentation of adherence to therapy (>75% compliance)
- Documentation of effectiveness of therapy
- Documentation of continued need for long-acting injection (including a review of adherence with other oral medications)

Contraindications:

- Known hypersensitivity to paliperidone, risperidone, or to any components in the formulation

Not approved if:

- Past history of dementia-related psychosis
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
    - Clozapine
    - Two other antipsychotics

Black box warning:

- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo

Additional considerations:

- To reduce the risk of hypersensitivity and first dose adverse effects patients should have a documented exposed to oral risperidone or paliperidone prior to initiation of paliperidone palmitate.
- Patients should not receive supplemental oral doses of antipsychotics after the first dose of IM paliperidone palmitate.
- Dose adjustments:
    - Moderate to severe renal impairment (CrCl < 50mL/min) – not recommended
    - Mild renal impairment (CrCl 50-80mL/min)
        - Initial loading dose – 156 mg on day 1 and 117 mg on day 7 then 78 mg monthly
- Maximum daily dose is 234 mg monthly

Approval time frames:

- Initial – 6 months with a quantity limit of 1 syringe/month
- Renewal – 1 year with a quantity limit of 1 syringe/month

References:

- Invega Sustenna Prescribing Information (2019). Janssen Pharmaceuticals, Inc. Titusville, NJ.
- American Psychiatric Association. Five things physicians and patients should question [guideline on the internet]. Available from: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association/. Accessed on June 21, 2019.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 1: Update 2012 on the acute treatment of schizophrenia and the management of treatment resistance. World J Biol Psychiatry 2012; 13: 318-378.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Update 2012 on the long-term treatment of schizophrenia and management of antipsychotic-induced side effects. World J Biol Psychiatry 2013; 14: 2-44.
- Dixon L, Perkins D, Calmes C. American Psychiatric Association. Guideline Watch (September 2009): practice guideline for the treatment of patients with schizophrenia. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf. Accessed on June 21, 2019.

- Kramer M, Litman R, Hough D, Lane R, Lim P, Lin Y et al. Paliperidone palmitate, a potential long-acting treatment for patients with schizophrenia. Int J Neuropsychopharmacol 2010; 13(5):635-647.
- Pandina GJ, Lindenmayer J-P, Lull J, Lim P, Gopal S, Herben V et al. A randomized, placebo-controlled study to assess the efficacy and safety of 3 doses of paliperidone palmitate in adults with acutely exacerbated schizophrenia. J Clin Psychopharmacol 2010; 30(3): 235-244.
- Hough D, Lindenmayer J-P, Gopal S, Melkote R, Lim P, Herben V et al. Safety and tolerability of deltoid and gluteal injections of paliperidone palmitate in schizophrenia. Prog Neuropsychopharmacol Biol Psych 2009; 33(6):1022-1031.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: June 2013
Revision: June 2014, June 2015, June 2016, June 2017, June 2018, June 2019

Prior Authorization Approval Criteria

Kapvay (clonidine extended-release)

Generic name: clonidine extended release
Brand name: Kapvay
Medication class: antiadrenergic agent, centrally acting

FDA-approved uses:

- Attention Deficit Hyperactivity Disorder (ADHD) as monotherapy and as adjunctive therapy to stimulant medications in children and adolescents

Usual dose range:

- ADHD – children and adolescents ages 6 to 17
  0.1 mg – 0.4 mg/daily (taken twice daily, divided equally or split with the higher dose given at bedtime)

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

ADHD:

Children and adolescents

- FDA indicated diagnosis
- Age 6 to 17 years of age
- Failure to respond (or intolerance) to both of the following:
  - Guanfacine extended-release
  - Atomoxetine

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence or >75% of the school year)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to clonidine

Not approved if:

- Patient has a known hypersensitivity to clonidine

Additional considerations:

- Dose should be initiated with one 0.1 mg tablet at bedtime, and the daily dosage should be adjusted in increments of 0.1 mg/day at weekly intervals until the desired response is

achieved. Doses should be taken twice daily, with either an equal or higher split dosage given at bedtime.

Total Daily Dose	Morning Dose	Bedtime Dose
0.1 mg/day		0.1 mg
0.2 mg/day	0.1 mg	0.1 mg
0.3 mg/day	0.1 mg	0.2 mg
0.4 mg/day	0.2 mg	0.2 mg

- Tablet should not be crushed, chewed, or broken before swallowing
- When discontinuing, the dosage should be tapered in decrements of no more than 0.1 mg every 3 to 7 days to avoid rebound hypertension
- Heart rate and blood pressure should be determined prior to initiation of therapy, following dosage increases, and periodically during therapy
- Maximum daily dose is 0.4 mg/day

Approval time frames:

- Initial – 1 year with MDL of 1-4/day (based on dose)
- Renewal – 1 year with MDL of 1-4/day (based on dose)

References:

1. Kapvay Prescribing Information. Shionogi Inc. Florham Park, NJ: 2018.
2. Feldman HM, Reiff MI. Attention deficit-hyperactivity disorder in children and adolescents. N Engl J Med. 2014; 370:838-846.
3. American Academy of Pediatrics Subcommittee on ADHD, Steering Committee on Quality Improvement and Management. ADHD: clinical practice guidelines for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2011; 128:1007-1022.
4. Kollins SH, Jain R, Brams M, Segal S, Findling RL, Wigal SB et al. Clonidine extended-release tablets as add-on therapy to psychostimulants in children and adolescents with ADHD. Pediatrics. 2011; 127(6):e1406-e1413.
5. Jain R, Segal S, Kollins SH, Khayrallah M. Clonidine extended-release tablets for pediatric patients with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry. 2011; 50(2):171-179.
6. Palumbo DR, Sallee FR, Pelham WE, Bukstein OG, Daviss WB, McDermott MP. Clonidine for attention-deficit/hyperactivity disorder: I. Efficacy and tolerability outcomes. J Am Acad Child Adolesc Psychiatry. 2008; 47(2):180-188.
7. Hazell PL, Stuart JE: A randomized controlled trial of clonidine added to psychostimulant medication for hyperactive and aggressive children. J Am Acad Child Adolesc Psychiatry 2003; 42(8):886-894.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 07/19/2013
Revision: July 2015, July 2016, July 2017, July 2018

DENVER HEALTH MEDICAL PLAN INC.

Prior Authorization Approval Criteria
Latuda (lurasidone)

Generic name: lurasidone
Brand name: Latuda
Medication class: Antipsychotic

FDA-approved uses:

- Schizophrenia
- Depressive episodes associated with Bipolar I Disorder (bipolar depression), as monotherapy and as adjunctive therapy with lithium or valproate

Usual dose range:

- Schizophrenia – adolescents and adults 40-160 mg/day
- Bipolar Depression – adults 20-120 mg/day

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation criteria

Schizophrenia:

Adolescents and adults

- FDA indicated diagnosis
- 13 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of three formulary antipsychotic agents

Bipolar Depression:

Adolescents and adults

- FDA indicated diagnosis
- 10 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of two of the following:
  - Lithium*
  - Lamotrigine
  - Quetiapine immediate release*

*If patient has a BMI>35 or BMI>30 with multiple risk factors (HTN/DM/etc) then quetiapine and lithium are not required

Renewal criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to Latuda or any components in the formulation
- Co-administration with a strong CYP3A4 inhibitor or inducer

Not approved if:

- Patient has dementia-related psychosis
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
  - Clozapine
  - Two other antipsychotics

Black box warning:

- Children, adolescents, and young adults taking antidepressants for major depressive disorder and other psychiatric disorders are at increased risk of suicidal thinking and behavior.
- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo

Additional considerations:

- Maximum daily dose is 160 mg/day; should be taken with food (at least 350 calories)
- Moderate (CrCl 30 - 50 mL/min) and severe (CrCl < 30 mL/min) renal impairment, the starting dose is 20 mg/day and maximum dose is 80 mg/day
- Moderate (Child Pugh score 7 to 9) hepatic impairment, the starting dose is 20 mg/day and the maximum dose is 80 mg/day
- Severe (Child Pugh score 10 to 15) hepatic impairment, the starting dose is 20 mg/day and the maximum dose is 40 mg/day
- FDA Pregnancy Category B (per approved label of 7/2013)

Approval time frames:

- Initial – 6 months with MDL of 1/day
- Renewal – 1 year with MDL of 1/day

References:

- Latuda Prescribing Information. Sunovion Pharmaceuticals Inc., Marlborough, MA: 2018.
- Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord. 2018;20:97–170. https://doi.org/10.1111/bdi.12609
- American Psychiatric Association. Five things physicians and patients should question [guideline on the internet]. Available from: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association/ Accessed June 21, 2019.
- PL Detail-Document, Comparison of Atypical Antipsychotics. Pharmacist's Letter/Prescriber's Letter 2015; 31(9): 310909. June 2015.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 1: Update 2012 on the acute treatment of schizophrenia and the management of treatment resistance. World J Biol Psychiatry 2012; 13: 318-378.
- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 2: Update 2012

on the long-term treatment of schizophrenia and management of antipsychotic-induced side effects. World J Biol Psychiatry 2013; 14: 2-44.

- Dixon L, Perkins D, Calmes C. American Psychiatric Association. Guideline Watch (September 2009): practice guideline for the treatment of patients with schizophrenia. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf. Accessed on June 21, 2019.
- Meltzer HY, Cucchiaro J, Silva R, Ogasa M, Phillips D, Xu J et al. Lurasidone in the treatment of schizophrenia: a randomized, double-blind, placebo- and olanzapine-controlled study. Am J Psychiatry 2011; 168(9): 957-967.
- Grunze H, Vieta E, Goodwin GM, Bowden C, Licht RW, Möller H-J et al. The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders: Update 2010 on the treatment of acute bipolar depression. World J Biol Psychiatry 2010; 11: 81-109.
- Loebel A, Cucchiaro J, Silva R, Krager H, Hsu J, Sarma K et al. Lurasidone monotherapy in the treatment of bipolar I depression: a randomized, double-blind, placebo-controlled study. Am J Psychiatry 2014; 171(2): 160-168.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: June 2013
Revision: June 2014, June 2015, June 2016, June 2017, June 2018, June 2019

Prior Authorization Approval Criteria

Pristiq (desvenlafaxine)

Generic name: desvenlafaxine
Brand name: Pristiq
Medication class: Antidepressant

FDA-approved uses:

- Major Depressive Disorder (MDD)

Usual dose range:

- Major Depressive Disorder – adults 50 mg once daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Major Depressive Disorder:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of each of the following:
  - Venlafaxine
  - An additional formulary antidepressant agent (bupropion, mirtazapine, a tricyclic antidepressant, an SSRI, or another SNRI)

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Hypersensitivity to Pristiq or venlafaxine
- Concomitant use in patients taking MAOIs

Not approved if:

- Patient is currently using MAOIs
- Patient currently taking another SSRI/SNRI with no plan to discontinue therapy

Black box warning:

- Children, adolescents, and young adults taking antidepressants for major depressive disorder and other psychiatric disorders are at increased risk of suicidal thinking and behavior.

Additional considerations:

- A gradual reduction in dose rather than abrupt cessation is recommended whenever possible
- Prescribe with care in patients with a history of seizure
- Patients should have regular blood pressure monitoring, since increases in blood pressure were observed in clinical studies
- Hyponatremia may occur as a result of treatment, discontinue therapy in patients with symptomatic hyponatremia
- Maximum daily dose – 50 mg/day

Approval time frames:

- Initial – 1 year with MDL of 1/day
- Renewal – 1 year with MDL of 1/day

References:

- Pristiq Prescribing Information. Pfizer Inc, New York, NY: 2018.
- American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder (3rd edition). Am J Psychiatr. 2010; 157(Suppl 4):1-45.
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Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 07/10/2013
Revision: 07/10/2014, July 2015, July 2016, July 2017, July 2018

Prior Authorization Approval Criteria

Rozerem (ramelteon)

Generic name: ramelteon
Brand name: Rozerem
Medication class: Nonbenzodiazepine hypnotic

FDA-approved uses:

- Insomnia

Usual dose range:

- Insomnia - adult — 8 mg at bedtime

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Insomnia:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial of each of the following:
  - Melatonin [Over-the-counter (OTC)]
  - Trazodone or diphenhydramine (OTC)
  - Either of the following:
    - Zolpidem or zolpidem extended-release or eszopiclone
      -OR-
    - Diagnosis of drug abuse or dependence

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to ramelteon
- Concomitant use of fluvoxamine

Not approved if:

- Patient is currently taking other medications that can cause wakefulness (e.g. stimulants)
- Patient is currently taking fluvoxamine

Additional considerations:

- Do NOT take with meals
- Maximum daily dose is 8mg/day

Approval time frames:

- Initial – 1 year with MDL of 1/day
- Renewal – 1 year with MDL of 1/day

References:

- Rozerem Prescribing Information. Takeda Pharmaceuticals America, Inc., Deerfield, IL: 2018.
- Sateia MJ, Buysse DJ, Krystal AD, Neubauer DN, Heald JL. Clinical practice guideline for the pharmacologic treatment of chronic insomnia in adults: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2017;13(2):307–349.
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Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 07/10/2013
Revision: 07/10/2014, July 2015, July 2016, July 2017, July 2018

Prior Authorization Approval Criteria
Saphris (asenapine)

Generic name: Saphris
Brand name: asenapine
Medication class: antipsychotic

FDA-approved uses:
- Treatment of schizophrenia
- Acute treatment of manic or mixed episodes associated with bipolar I disorder as monotherapy or adjunctive treatment to lithium or valproate

Usual dose range:
- Schizophrenia – adults 5-10 mg twice a day sublingually
- Bipolar Mania – adults 5-10 mg twice a day sublingually
- Bipolar Mania – pediatric patients (10-17 years) 2.5-10 mg twice a day sublingually

Criteria for use: (bullet points are all inclusive unless otherwise noted)
Initiation criteria

Schizophrenia:

Adults
- FDA indicated diagnosis
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of three formulary antipsychotics agents

OR
- Patient requires orally disintegrating formulation
- Failure to respond (or intolerance) to an adequate trial (at least 30 days) of each of the following:
  - Risperidone ODT
  - Olanzapine ODT

Bipolar I Disorder:

Pediatrics and Adults
- FDA indicated diagnosis
- 10 years of age or older
- Failure to respond (or intolerance) to an adequate trial (at least 30 days with adequate blood levels) of each of the following:
  - Lithium OR valproic acid
  - Two formulary antipsychotic agents

OR
- Patient requires orally disintegrating formulation
- Failure to respond (or intolerance) to an adequate trial (at least 30 days) of each of the following:
  - Risperidone ODT
  - Olanzapine ODT

Renewal criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to asenapine, or to any components in the formulation.

Not approved if:

- Past history of dementia-related psychosis
- Patient has severe hepatic impairment
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
  - Clozapine
  - Two other antipsychotics

Black box warning:

- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

Additional considerations:

- Maximum daily dose is 10 mg twice a day

Approval time frames:

- Initial – 6 month(s) with MDL of 2/day
- Renewal – 1 year(s) with MDL of 2/day
- Special approval notes – for renewals of patients requiring orally disintegrating formulation verify that they still need ODT formulation

References:

- Saphris Prescribing Information (2017). Merck & Co. Inc., Whitehouse Station, NJ.
- Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord. 2018;20:97–170. https://doi.org/10.1111/bdi.12609
- American Psychiatric Association. Five things physicians and patients should question [guideline on the internet]. Available from: http://www.choosingwisely.org/doctor-patient-lists/american-psychiatric-association/ Accessed on June 21, 2019.
- PL Detail-Document, Comparison of Atypical Antipsychotics. Pharmacist's Letter/Prescriber's Letter 2015; 31(9): 310909. June 2015.
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- Hasan A, Falkai P, Wobrock T, Lieberman J, Glenthøj B, Gattaz W et al. World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Schizophrenia, Part 1: Update 2012 on the acute treatment of schizophrenia and the management of treatment resistance. World J Biol Psychiatry 2012; 13: 318-378.
- Dixon L, Perkins D, Calmes C. American Psychiatric Association. Guideline Watch (September 2009): practice guideline for the treatment of patients with schizophrenia. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf. Accessed on June 21, 2019.
- Potkin SG, Cohen M, Panagides J. Efficacy and tolerability of asenapine in acute schizophrenia: a placebo- and risperidone-controlled trial. J Clin Psychiatry 2007; 68:1492-1500.

- Kane JM, Cohen M, Zhao J, Alphs L, Panagides J. Efficacy and safety of asenapine in a placebo- and haloperidol-controlled trial in patients with acute exacerbation of schizophrenia. J Clin Psychopharmacol 2010; 30:106-115.
- Grunze H, Vieta E, Goodwin GM, Bowden C, Licht RW, Möller H-J et al. The World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for the Biological Treatment of Bipolar Disorders: Update 2009 on the treatment of acute mania. World J Biol Psychiatry 2009; 10: 85-116.
- McIntyre RS, Cohen M, Zhao J, Alphs L, Macek TA, Panagides J. Asenapine in the treatment of acute mania in bipolar I disorder: a randomized, double-blind, placebo-controlled trial. J Affect Disord 2010; 122(1-2): 27-38.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
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Prior Authorization Approval Criteria

Sensipar (cinalcalcet)

Generic name: cinalcalcet
Brand name: Sensipar
Medication class: Calcimimetic

FDA-approved uses:

- Primary hyperparathyroidism / Parathyroid Carcinoma
- Secondary hyperparathyroidism

Usual dose range:

- Primary hyperparathyroidism/Parathyroid carcinoma:
  - Up to 90 mg four times daily
- Secondary hyperparathyroidism:
  - Up to 180 mg once daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Primary hyperparathyroidism/Parathyroid carcinoma:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Prescribed by endocrinologist or oncologist
- Hypercalcemia associated with parathyroid carcinoma confirmed by a serum calcium level ≥ 8.4 mg/dL
- Confirmation that patient is not a candidate for parathyroidectomy

Secondary hyperparathyroidism:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Prescribed by endocrinologist or nephrologist
- Patient is on dialysis
- Documentation of iPTH > 300 pg/mL and serum calcium ≥ 8.4 mg/dL

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy
  - Serum calcium levels have decrease from baseline or remained stable since previous request
  - iPTH has decreased from baseline or remained stable since previous request

Contraindications:

- Hypersensitivity to any ingredients
- Patients with hypocalcemia

Not approved if:

- Any of the above contraindications are present

Additional considerations:

- Lowers seizure threshold
- Maximum total daily dose is 360 mg/day

Approval time frames:

- Initial – 6 months with MDL of 4/day
- Renewal – 1 year with MDL of 4/day

References:

- Sensipar Prescribing Information. Amgen Inc. Thousand Oaks, CA: 2019.
- Kidney Disease: Improving Global Outcomes (KDIGO) CKD-MBD Work Group. KDIGO 2017 clinical practice guideline update for the diagnosis, evaluation, prevention, and treatment of Chronic Kidney Disease-Mineral and Bone Disorder (CKD-MBD). Kidney Int Suppl 2017;7:1-59.
- National Kidney Foundation. K/DOQI clinical practice guidelines for bone metabolism and disease in chronic kidney disease. Am J Kidney Dis 2003; 42:S1.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
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Revision: June 2015, June 2016, June 2017, June 2018, June 2019

Prior Authorization Approval Criteria

Silenor (doxepin)

Generic name: doxepin
Brand name: Silenor
Medication class: tricyclic antidepressant

FDA-approved uses:

- Insomnia

Usual dose range:

- Insomnia - adult 3 mg - 6 mg at bedtime

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Insomnia:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial of each of the following:
  - Doxepin capsule or oral concentrate
  - Trazodone
  - Either of the following:
    - Zolpidem or zolpidem extended-release or eszopiclone
      -OR-
    - Diagnosis of drug abuse or dependence

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Known hypersensitivity to doxepin or other dibenzoxepines
- Concomitant use in patients taking MAOIs
- Use in patients with uncontrolled narrow-angle glaucoma
- Severe urinary retention

Not approved if:

- Patient is currently taking other medications that can cause wakefulness (e.g. stimulants)
- Patient is currently using MAOIs
- Patient has a diagnosis of narrow-angled glaucoma
- Patient has a diagnosis of severe sleep apnea
- Patient has severe urinary retention

Additional considerations:

- Start dosing at 3 mg/day for patients who are elderly, have severe hepatic impairment, or history of urinary retention
- Do NOT take with meals
- Maximum daily dose is 6 mg/day

Approval time frames:

- Initial – 1 year with MDL of 1/day
- Renewal – 1 year with MDL of 1/day

References:

- Silenor Prescribing Information. Somaxon Pharmaceuticals, Inc., San Diego, CA: 2018.
- Sateia MJ, Buysse DJ, Krystal AD, Neubauer DN, Heald JL. Clinical practice guideline for the pharmacologic treatment of chronic insomnia in adults: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med. 2017;13(2):307–349.
- Wilson SJ, Nutt DJ, Alford C, Argyropoulos SV, Baldwin DS, Bateson AN et al. British Association for Psychopharmacology consensus statement on evidence-based treatment of insomnia, parasomnias and circadian rhythm disorders. J Psychopharmacol. 2010;24(11):1577-1601.
- Scharf M, Rogowski R, Hull S, Cohn M, Mayleben D, Feldman N et al. Efficacy and safety of doxepin 1 mg, 3 mg, and 6 mg in elderly patients with primary insomnia: a randomized, double-blind, placebo-controlled crossover study. J Clin Psychiatry. 2008;69(10):1557-1564.
- Roth T , Rogowski R , Hull S , Schwartz H, Koshorek G, Corser B et al. Efficacy and safety of doxepin 1 mg, 3 mg, and 6 mg in adults with primary insomnia. Sleep. 2007;30(11):1555-1561.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 07/10/2013
Revision: 07/10/2014, July 2015, July 2016, July 2017, July 2018

Prior Authorization Approval Criteria

Somatropin

Generic name: somatropin
Brand name: Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Zomacton
Medication class: Pituitary Hormone/ Growth Hormone Modifier

FDA-approved uses:

- Growth hormone deficiency
- Noonan's syndrome
- Prader-Willi syndrome
- Renal function impairment with growth failure
- Short stature disorder, Idiopathic
- Short stature disorder - Turner syndrome
- Short-stature homeobox-containing gene (SHOX) deficiency
- Small for gestational age baby, with no catch-up growth by age 2 to 4 years

Usual dose range:

Adult Dosing

- **Growth hormone deficiency**: weight-based dosing schedule: initial, not more than 0.04 mg/kg/week SUBQ given as a daily divided dose; increase at 4 to 8 week intervals
- **Growth hormone deficiency**: alternative dosing schedule: initial, 0.2 mg/day (range, 0.15 to 0.3 mg/day) SUBQ; increase by 0.1 to 0.2 mg/day every 1 to 2 months according to patient response

Pediatric Dosing

- **Growth hormone deficiency:** 0.15 to 0.3 mg/kg/week SUBQ, divided into equal daily doses given 6 or 7 days/week
- **Noonan's syndrome:** up to 0.462 mg/kg/week SUBQ, divided into equal daily doses
- **Prader-Willi syndrome:** 0.24 mg/kg/week SUBQ, divided into equal daily doses given 6 to 7 days/week
- **Renal function impairment with growth failure:** up to 0.35 mg/kg/week SUBQ, divided into equal daily doses; may continue up to time of renal transplantation
- **Short stature disorder, Idiopathic:** up to 0.47 mg/kg/week SUBQ, divided into equal daily doses given 6 or 7 days/week
- **Short stature disorder - Turner syndrome:** up to 0.47 mg/kg/week SUBQ, divided into equal daily doses given 6 or 7 days/week
- **Short-stature homeobox-containing gene (SHOX) deficiency:** 0.35 mg/kg/week SUBQ, divided into equal daily doses given 6 to 7 days/week
- **Small for gestational age baby, with no catch-up growth by age 2 to 4 years:** up to 0.48 mg/kg/week SUBQ, divided into equal daily doses given 6 or 7 days/week

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Growth hormone deficiency

[*Important consideration: Acquired growth hormone deficiency with confirmation of known etiology (e.g. brain tumor, pituitary/hypothalamus tumor, radiation therapy, etc.) may not require the following criteria to be met*]

Adult

- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Confirmed panhypopituitarism (deficiencies of TSH, ACTH, and gonadotropins), pituitary or hypothalamic disease by documentation of one of the following:
  - Subnormal serum IGF-1 concentration based on age and sex

-OR-

  - Subnormal serum growth hormone response to potent stimuli
    - Preferred: Insulin tolerance test (ITT) (Peak GH≤5.0 µg/L)
    - GHRH + arginine (ARG) or the glucagon test
      - Peak GH ≤ 11.0 µg/L in patients with BMI < 25 kg/m2
      - Peak GH ≤ 8.0 µg/L in patients with BMI> 25 and < 30 kg/m2
      - Peak GH ≤ 4.0 µg/L in patients with BMI ≥ 30 kg/m2

Pediatric

- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Signs of growth deficiency by confirmation of ≤10th percentile per pediatric growth chart
- Documentation of the following:
  - Failure of two standard growth hormone stimulation tests (with arginine, clonidine, glucagon, insulin, levodopa, or propranolol)
    - Failure defined as a peak measured GH level of less than 10 ng/ml after stimulation

-OR-

  - Documentation of both of the following:
    - Decrease in one of the following lab values:
      - Insulin-like growth factor-1 (IGF-I)
      - Insulin-like growth factor binding protein-3 (IGFBP-3)
      - Bone age
    - Failure of one standard growth hormone stimulation test

Noonan's syndrome

Pediatric

- FDA indicated diagnosis

- Prescribed by an endocrinologist
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender

Prader-Willi syndrome

Pediatric

- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender

Renal function impairment with growth failure

Pediatric

- FDA indicated diagnosis
- Prescribed by (or under the care of) a nephrologist
- Confirmation that patient is pre-transplant
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender

Short stature disorder, Idiopathic

Pediatric

- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender
- Predicted height is <63 inches for male
- Predicted height is <59 inches for female
- Documentation of epiphyses not closed (X-ray)

Short stature disorder - Turner syndrome

Pediatric

- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender

Short-stature homeobox-containing gene (SHOX) deficiency:

Pediatric

- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Confirmed by genetic testing
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender

Small for gestational age baby, with no catch-up growth by age 2 to 4 years

Pediatric
- FDA indicated diagnosis
- Prescribed by an endocrinologist
- Height before initiation of therapy must be greater than 2 standard deviations below normal mean for age and gender

Renewal Criteria

Adult (only for the diagnosis of growth hormone deficiency)
- Improvement of IGF-1 levels to determine dose, waist/hip ratios, thyroid function tests, lipids, body weight
  - Therapy should be discontinued when:
    - Patient has reached satisfactory adult height
    - When the patient ceases to respond
  - Adults may require life-long therapy as determined by a GH ≤ 3 ng/ml after a year of therapy

Pediatric (for all FDA-approved indications)
- Height determination, documentation that epiphyseal is not closed, improved growth velocity
  - Therapy should be discontinued when:
    - When epiphyses have fused
    - When the patient ceases to respond
  - Growth of 5 cm/year or more is expected, if growth rate does not exceed 2.5 cm in a 6-month period, dose adjustments should be considered for an additional 6 months; if there is still no satisfactory response, discontinuation of therapy should be considered

Contraindications:
- Acute critical illness
- Children with Prader-Willi syndrome who are severely obese or have severe respiratory impairment, there have been reports of sudden death
  - Use may be appropriate if severe respiratory impairment is being treated
- Active proliferative or severe non-proliferative diabetic retinopathy
- Children with closed epiphyses (X-ray)
- Known hypersensitivity to somatropin or m-cresol
- Pregnancy/Breast feeding

Not approved if:
- Any of the contraindications listed above are present

Additional considerations:
- If patient meets the above "Initiation Criteria" for somatropin therapy for any diagnosis, the plan will only approve a preferred product. Other products may be considered if the patient has tried and failed, has intolerance, or has documented medical rationale to support why they are unable to use the plan-preferred product

- For pediatric growth hormone deficiency: once a maintenance dose has been reached, monitoring should be done every 6-12 months on IGF-1; thyroid lab values only need to be monitored for the first 6-12 months of therapy to ensure they remain within normal limits
- Bone age may be advanced in cases of concomitant precocious puberty, thus it would not be expected to be low as stated in the above initiation criteria for pediatric growth hormone deficiency
- Caution when using in the presence of active malignancy

Approval time frames:

- Initial – 6 months; MDL is weight-based per request
- Renewal – 6 months; MDL is weight-based per request

References:.

- Genotropin Prescribing Information. Pharmacia & Upjohn Company. New York, NY: 2016.
- Humatrope Prescribing Information. Eli Lilly and Company. Indianapolis, IN: 2017.
- Norditropin Prescribing Information. Novo Nordisk. Princeton, NJ: 2018.
- Nutropin Prescribing Information. Genentech, Inc. South San Francisco, CA: 2018.
- Omnitrope Prescribing Information. Sandoz Inc. Princeton, NJ: 2016.
- Zomacton Prescribing Information. Ferring Pharmaceuticals Inc. Parsippany, NJ: 2018.
- Grimberg A, DiVall SA, Polychronakos C, et al. Guidelines for Growth Hormone and Insulin-Like Growth Factor-I Treatment in Children and Adolescents: Growth Hormone Deficiency, Idiopathic Short Stature, and Primary Insulin-Like Growth Factor-I Deficiency. Horm Res Paediatr 2016; 86:361.
- American Association of Clinical Endocrinologists. Medical Guidelines for clinical practice for growth hormone use in growth hormone-deficient adults and transition patients-2009 Update. *Endocr Pract*. 2009;15(Suppl 2).
- American Association of Clinical Endocrinologists. Medical Guidelines for clinical practice for growth hormone use in adults and children-2003 Update. *Endocr Pract*. 2003;9(1).
- Deal CL, Tony M, Hoybye C, et al. Growth hormone research society workshop summary: consensus guidelines for recombinant human growth hormone therapy in prader-willi syndrome. *J Clin Endocrinol Metab*. 2013 Jun;98(6):E1072-87.
- Hardin DS. Treatment of short stature and growth hormone deficiency in children with somatropin (rDNA origin). *Biologics*. 2008 December; 2(4): 655–661
- Rogol AD, Geffner M, Hoppin AG. Diagnostic approach to short stature. In: UpToDate, Rose, BD (Ed), UpToDate, Waltham, MA, 2005.
- Yuksel B, Ozbek MN, Mungan NO, et al. Serum IGF-1 and IGFBP-3 levels in healthy children between 0 and 6 years of age. *J Clin Res Ped Endo.* 2011;3(2):84-88.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
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DENVER HEALTH MEDICAL PLAN INC.

Prior Authorization Approval Criteria

Tecfidera (dimethyl fumerate)

Generic name: dimethyl fumerate
Brand name: Tecfidera
Medication class: immunomodulator

FDA-approved uses:

- Relapsing forms of multiple sclerosis (MS)

Usual dose range:

- Relapsing forms of multiple sclerosis – adults 240 mg twice daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Relapsing forms of multiple sclerosis:

Adults

- FDA indicated diagnosis
- Prescribed by (or in consultation with) a neurologist
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial (6 months) of Gilenya (fingolimod)- PA required

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- None

Not approved if:

- Combined with Copaxone, Aubagio, Gilenya, Tysabri, Rituxan or an interferon product

Additional considerations:

- Tecfidera has not been studied in patients with low lymphocyte counts
- Recommended titration schedule is 120 mg twice daily for 7 days, then 240 mg twice daily
  - Slower titration or premedication with nonenteric-coated aspirin (up to 325 mg 30 minutes prior to dose) may reduce the incidence of flushing

Approval time frames:

- Initial – 6 months with MDL 2/day
- Renewal – 1 year with MDL 2/day

References:

- Tecfidera ® [package insert], Cambridge, MA: Biogen Idec Inc.; 2018.
- Rae-Grant A, Day GS, Marrie RA, et al. Practice guideline recommendations summary: Disease-modifying therapies for adults with multiple sclerosis: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology. Neurology 2018; 90:777.
- National Institute for Health and Care Excellence (2014) Multiple sclerosis in adults: management. Clinical Guideline CG186. London: National Institute for Health and Care Excellence.
- Havrdova E, Hutchinson M, Kurukulasuriya NC, et al. Oral BG-12 (dimethyl fumarate) for relapsing-remitting multiple sclerosis: a review of DEFINE and CONFIRM. Evaluation of: Gold R, Kappos L, Arnold D, et al. Placebo-controlled phase 3 study of oral BG-12 for relapsing multiple sclerosis. N Engl J Med 2012;367:1098-107; and Fox RJ, Miller DH, Phillips JT, et al. Placebo-controlled phase 3 study of oral BG-12 or glatiramer in multiple sclerosis. N Engl J Med 2012;367:1087-97. Expert Opin Pharmacother. 2013;14(15):2145-56.
- Gold R, Kappos L, Arnold DL, et al. Placebo-controlled phase 3 study of oral BG-12 for relapsing multiple sclerosis. N Engl J Med. 2012;367(12):1098-107.
- Fox RJ, Miller DH, Phillips JT, et al. Placebo-controlled phase 3 study of oral BG-12 or glatiramer in multiple sclerosis. N Engl J Med. 2012;367(12):1087-97.
- Goodin DS, Frohman EM, Garmany GP, et al. Disease modifying therapies in multiple sclerosis: report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology and the MS Council for Clinical Practice Guidelines. Neurology. 2002;58(2):169-78.

Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
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Prior Authorization Approval Criteria

Viibryd (vilazodone)

Generic name: vilazodone
Brand name: Viibryd
Medication class: Antidepressant

FDA-approved uses:

- Major Depressive Disorder (MDD)

Usual dose range:

- Major Depressive Disorder – adults 20-40 mg once daily

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation Criteria

Major Depressive Disorder:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of each of the following:
  - Separate monotherapy trials of two different formulary Selective Serotonin Reuptake Inhibitors (SSRIs)
  - An additional formulary antidepressant agent (bupropion, mirtazapine, a tricyclic antidepressant, a Serotonin Norepinenphrine Reuptake Inhibitor [SNRI], or a third SSRI)

Renewal Criteria

- Must have documentation of adherence to therapy (>75% adherence)
- Documentation of effectiveness of therapy

Contraindications:

- Concomitant use in patients taking MAOIs

Not approved if:

- Patient is currently using MAOIs
- Patient currently taking another SSRI/SNRI with no plan to discontinue therapy

Black box warning:

- Children, adolescents, and young adults taking antidepressants for major depressive disorder and other psychiatric disorders are at increased risk of suicidal thinking and behavior.

Additional considerations:

- A gradual reduction in dose rather than abrupt cessation is recommended whenever possible
- Hyponatremia can occur in association with the syndrome of inappropriate antidiuretic hormone secretion (SIADH)
- Prescribe with care in patients with a history of seizure
- Maximum daily dose – 40 mg/day
- Take with food

Approval time frames:

- Initial – 1 year with MDL of 1/day
- Renewal – 1 year with MDL of 1/day

References:

- Viibryd Prescribing Information. Forest Pharmaceuticals, St. Louise, MO: 2018.
- American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder (3rd edition). Am J Psychiatr. 2010; 157(Suppl 4):1-45.
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Formal Review as per Rx-DOP-3.0 Criteria Development and Maintenance Procedures:
Initial: 07/10/2013
Revision: 07/10/2014, July 2015, July 2016, July 2017, July 2018

Prior Authorization Approval Criteria

Zyprexa Relprevv

(olanzapine pamoate extended release injection)

Generic name: olanzapine pamoate extended release injection
Brand name: Zyprexa Relprevv
Medication class: Antipsychotic

FDA-approved uses:

- Treatment of schizophrenia

Usual dose range:

- Schizophrenia – adult
  - Dose is based on correspondence to oral olanzapine dose
  - Initial dose — 210 mg or 300 mg every 2 weeks or 405 mg every 4 weeks
  - Maintenance — 150 mg, 210 mg or 300 mg every 2 weeks or 300 mg or 405 mg every 4 weeks

Criteria for use: (bullet points are all inclusive unless otherwise noted)

Initiation criteria

Schizophrenia:

Adults

- FDA indicated diagnosis
- 18 years of age or older
- Documented tolerance to oral olanzapine
- Patient has a history of noncompliance and/or refuses to utilize oral medication and documentation that patient education and other efforts to improve adherence have been attempted
- Either one of the following:
  - Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of Risperdal Consta (Step Therapy required: trial of oral risperidone)

  OR
  - Documented stabilization on oral olanzapine (trial of 4-6 weeks)

Renewal criteria

- Must have documentation of adherence to therapy (>75% compliance)
- Documentation of effectiveness of therapy
- Documentation of continued need for long-acting injection (including a review of adherence with other oral medications)

Contraindications:

- Known hypersensitivity to olanzapine or to any components in the formulation

Not approved if:

- Past history of dementia-related psychosis
- Combining with another antipsychotic unless patient has tried maximum tolerated doses of all of the following as monotherapy:
    - Clozapine
    - Two other antipsychotics

Black box warning:

- Patients are at risk for severe sedation (including coma) and/or delirium after each injection and must be observed for at least 3 hours in a registered facility with ready access to emergency response services.
- Because of this risk, Zyprexa Relprevv is available only through a restricted distribution program called Zyprexa Relprevv Patient Care Program and requires prescriber, healthcare facility, patient, and pharmacy enrollment
- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo

Additional considerations:

- Medication can only be administered in a registered healthcare facility with ready access to emergency response services, and the patient will be monitored for at least 3 hours after injection for delirium/sedation syndrome prior to release
- Establish tolerability with oral olanzapine prior to initiating treatment
- Plasma concentrations remain in the therapeutic effective range and oral supplementation is generally not necessary
- Maximum dose is 405mg every 4 weeks or 300mg every 2 weeks

Approval time frames:

- Initial
    - 6 months with the following quantity limits:
        - 2 vials/month for 150 mg, 210 mg, or 300 mg injection
        - 1 vial/month for 405 mg injection

- Renewal
    - 1 year with the following quantity limits:
        - 2 vials/month for 150 mg, 210 mg, or 300 mg injection
        - 1 vial/month for 405 mg injection

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