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NOTICE OF PUBLIC MEETING – DRUG USE REVIEW BOARD

AGENDA

Date of Posting: June 26, 2018

Date of Meeting: July 26, 2018 at 5:15 PM

Name of Organization: The State of Nevada, Department of Health and Human Services (DHHS), The Division of Health Care Financing and Policy (DHCFP), Drug Use Review Board (DUR)

Place of Meeting: Hyatt Place Reno-Tahoe Airport
1790 E. Plumb Lane
Reno, Nevada 89502
Phone: (775) 826-2500

Webinar Registration: https://optum.webex.com/optum/onstage/g.php?MTID=e489029e0f4a10412c98900b80fa9e4d5

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Event Number: 642 793 124

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For Audio Only: Phone: (763) 957-6300
Event: 642 793 124

AGENDA

1. Call to order and roll call

2. Public comment on any matter on the agenda

3. Administrative

   a. For Possible Action: Review and Approve Meeting Minutes from April 26, 2018.

   b. Status Update by the DHCFP.

4. Clinical presentations

   a. For Possible Action: Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for Hepatitis C Direct-Acting Antivirals.

      1. Public comment on proposed clinical prior authorization criteria.
      2. Presentation of utilization and clinical information.
      3. Discussion by Board and review of utilization data.
      4. Proposed adoption of updated prior authorization criteria.

   b. For Possible Action: Discussion and possible adoption of prior authorization criteria and/or quantity limits for antibiotics.

      1. Public comment on proposed clinical prior authorization criteria.
      2. Presentation of utilization and clinical information.
      3. Discussion by Board and review of utilization data.
      4. Proposed adoption of updated prior authorization criteria.

   c. For Possible Action: Discussion and possible adoption of prior authorization criteria and/or quantity limits for medications used in the treatment of hemophilia.

      1. Public comment on proposed clinical prior authorization criteria.
      2. Presentation of utilization and clinical information.
      3. Discussion by Board and review of utilization data.
      4. Proposed adoption of updated prior authorization criteria.

d. For Possible Action: Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for medications used in the treatment of irritable-bowel syndrome.

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.
3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

e. For Possible Action: Discussion and possible adoption of prior authorization criteria for tezacaftor/ivacxaftor (Symdeko®).

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.
3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

f. For Possible Action: Discussion and possible adoption of updated prior authorization criteria for ivacaftor (Kalydeco®).

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.
3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

g. For Possible Action: Discussion and possible adoption of updated prior authorization criteria for topical immunomodulators.

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.
3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

h. For Possible Action: Discussion and possible adoption of prior authorization criteria for compounded medications.

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.
3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

i. For Possible Action: Discussion and possible adoption of updated prior authorization criteria for neuromuscular blocking muscle relaxants (botulinium toxin).

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.

3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

j. For Possible Action: Discussion and possible adoption of prior authorization criteria for opioid containing cough preparations.

1. Public comment on proposed clinical prior authorization criteria.
2. Presentation of utilization and clinical information.
3. Discussion by Board and review of utilization data.
4. Proposed adoption of updated prior authorization criteria.

5. Public comment on any DUR Board requested report

6. DUR Board requested reports

a. Pharmacy lock-in program.

1. Discussion by the Board and review of utilization data.
2. For Possible Action: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

b. Opioid overdose deaths.

1. Discussion by the Board and review of utilization data.
2. For Possible Action: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

c. Opioid Utilization – Top prescriber and member, including more than four concurrent opioids.

1. Discussion by the Board and review of utilization data.
2. For Possible Action: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

d. Asthma and short-acting rescue inhaler utilization.

1. Discussion by the Board and review of utilization data.
2. For Possible Action: Requests for further evaluation or proposed clinical criteria to be presented at a later date.

7. Public comment on any Standard DUR report

8. Standard DUR reports

a. Review of Prescribing/Program Trends.

1. Top 10 Therapeutic Classes for Q3 2017, Q4 2017 and Q1 2018 (by payment and by claims).
2. Top 50 Drugs of Q3 2017, Q4 2017 and Q1 2018 (by payment and by claims).

b. Concurrent Drug Utilization Review (ProDUR).

1. Review of Q1 2018.
2. Review of top encounters by problem type.

c. Retrospective Drug Utilization Review (RetroDUR).

1. Status of previous quarter.
2. Status of current quarter.
3. Review and discussion of responses.

9. Closing discussion

a. Public comments on any subject.

b. Date and location of the next meeting.

1. Discussion of the time of the next meeting.

c. Adjournment.

PLEASE NOTE: Items may be taken out of order at the discretion of the chairperson. Items may be combined for consideration by the public body. Items may be pulled or removed from the agenda at any time. If an action item is not completed within the time frame that has been allotted, that action item will be continued at a future time designated and announced at this meeting by the chairperson. All public comment may be limited to five minutes.

Notice of this public workshop meeting and draft copies of the changes will be available on or after the date of this notice at the DHCFP Web site at http://dhcfp.nv.gov. The agenda posting of this meeting can be viewed at the follow locations: Carson City Central Office; Las Vegas District Office; Reno District Office; Elko District Office; Nevada State Library; Carson City Library; Churchill County Library; Las Vegas Library; Douglas County Library; Elko County Library; Esmeralda County Library; Lincoln County Library; Lyon County Library; Mineral County Library; Tonopah Public Library; Pershing County Library; Goldfield Public Library; Eureka Branch Library; Humboldt County Library; Lander County Library; Storey County Library; Washoe County Library; and White Pine County Library and may be reviewed during normal business hours.

If requested in writing, a copy of the meeting materials will be mailed to you. Requests and/or written comments may be sent to Colleen McLachlan at the Division of Health Care Financing

and Policy, 1100 E. William Street, Suite 101, Carson City, Nevada 89701, at least three days before the public hearing.

All persons that have requested in writing to receive the Public Hearings agenda have been duly notified by mail or e-mail.

Note: We are pleased to make accommodations for members of the public who have disabilities and wish to attend the meeting. If special arrangements are necessary, notify the Division of Health Care Financing and Policy as soon as possible and at least ten days in advance of the meeting, by e-mail at cmclachlan@dhcfp.nv.gov in writing, at 1100 East William Street, Suite 101, Carson City, Nevada 89701 or call Colleen McLachlan at (775) 684-3722.

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DRUG USE REVIEW BOARD

Meeting Minutes

Date of Meeting: **Thursday, April 26, 2018 at 5:15 PM**

Name of Organization: **The State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP), Drug Use Review Board (DUR).**

Place of Meeting: **Hyatt Place Reno-Tahoe Airport**
1790 E. Plumb Ln
Reno, NV 89502
Phone: (775) 826-2500

ATTENDEES

Board Members Present
Paul Oesterman, Pharm.D.
James Marx, MD
Michael Owens, MD
David England, Pharm.D
Yvette Kaunismaki, MD
Netochi Adeolokun, Pharm.D.

Board Member Absent
Marta Bunuel, MD
Jennifer Wheeler, Pharm.D.

DHCFP
Holly Long, Social Services Program Specialist
Linda Anderson, Senior Deputy Attorney General
Cody Phinney
Jack Zenteno

DXC
Beth Slamowitz, Pharm.D.

OptumRx
Carl Jeffery, Pharm.D.

Managed Care Organizations
Thomas Beranek – Silver Summit Health Plan
Ryan Bitton – Health Plan of Nevada
Jeannine Murray – Anthem

Public
Khanh Pham, NV Pharmacy Association
Laura Hill, Abbvie
Tom McCoy, ALS CAN
Ann Nelson, Vertex
James Kotusky, Gilead
Tracey Meeks, Vertex
Mark Schwartz, GSK
Laura Benthale, AMAG
Tom Horton, AMAG
Christy Lemons, Orexo
Patrick Moty, Horizon
Jennifer Zins, Nevada Partnership Access Treatment
Paige Barnes, Crowley and Farrato
Jenny Reese, Carrara NV/PhRMA
Lea Cartwright, NPA
Krystal Joy, Otsuka

Public Online
Stacey Frisk
Melisa McEwen, Otsuka
Betty Chan, Gilead

AGENDA

1. Call to Order and Roll Call

Chairman Paul Oesterman, Pharm.D, called the meeting to order on April 26, 2018, at 5:15 p.m. A quorum was established. Ground rules for the meeting was established.

2. Public Comment on Any Matter on the Agenda

Dr. Oesterman called for public comment.

Tom McCoy, ALS, CAN: I work for government relations for the American Cancer Society. ACS CAN working with that organization is a nonprofit, nonpartisan, advocacy of the American Cancer Society. They support Veteran's base policies, legislative solutions that designed to eliminating cancer (indiscernible). ACS CAN is concerned that the proposed Prior Authorization Policy being considered by the Drug Use Review Board is so blatantly based on price as opposed to the best treatment practices, political guidelines. We encourage the state to deduct a robust surveillance and engage in careful monitoring to this policy moving forward to ensure that enrolling and access of care is protected and that there are no unintended consequences either in near or short-term policy application. ACS CAN would be supportive with final decision on when to do prior authorizations if they are done within 24 hours.

Jim Marx: Speaking as a private citizen, I guess I would like to give an on-the-record summary of how we handle prior authorization situations when patients move from one managed care or fee for service organization to another and how do we implement that. Is there some process we need to implement or define?

Holly Long: Let me just be clear. So, you're asking what the process is when Medicaid recipient transfers from one MCO to another?

Jim Marx: Right, because what we see for time to time is that a patient has prior authorization grant under managed care organization. Two months later for some reason or another, they switch to another organization and go through the entire process exists, which sometimes can be several hours, so it's really a labor-intensive situation.

Holly Long: There is a Transition of Care Form that was established, and I'm not sure how exactly that was distributed as far as education to providers. Maybe one of the MCOs might have the information but I know that those Transition of Care Forms should be providing all of the information that would be consistent to be able to make that process as easy as possible. Are you familiar with those at all?

Jim Marx: Never heard of them.

Holly Long: Okay. Well I can definitely forward you a copy of one and we can get more information about how that whole process works to you. I know that it includes a lock-in program information; that's my side of it.

Jim Marx: Yeah, lock-in's a different issue.

Holly Long: But, it doesn't, actually I've seen the form and I know about it.

Jim Marx: Right, so I think that we need to do a better job informing all providers, not just me and Michael, so, I think that we really need to get that out there because I think that the inefficiencies that are imposed on the system really discourage good care.

Holly Long: Thank you. Yeah, I will definitely get more information to you and if you…

Jeannine Murray: Part 2 of with the 07/01/2017 contract was a change of the Transition of Care period and what that allows for is continuity of care of drugs. The way that I understand maybe have it implemented was that for any drug it's at least 30 days so if they had a P.A. on one and they came over, they should be able to at least get one fill but then if it is a maintenance drug, it's allowed for 60 days and if it's a behavioral health drug, and there was a list I believe that it classes, it's allowed for 90 days. So, there should be at least a minimum of a 30-day transition period before P.A. would be asked for. There's not a PA sharing process between anybody.

Jim Marx: That could be sort of opposing on some occasions, especially with different formularies so when you have situations where there's prior authorization on one formulary, it may not be yours or (indiscernible) formulary, but it does create a lot of problems and I think maybe what we should be looking for is maybe sort of a unified sort of formulary not necessarily preferred drugs but I think that at least having a common formulary might be something that you want to get addressed at some point.

3. Administrative

a. **For Possible Action:** Review and Approve Meeting Minutes from January 25, 2018.

There was a motion to accept the minutes as submitted and a motion seconding the approval. The minutes from January 25, 2018, were approved.

b. Status Update by DHCFP

Holly Long: These are a couple of things. Our hearings unit has updated language for consistency with the federal policy language specifying the circumstances under which a provider for requested expedited fair hearing for a recipient, that falls within Chapter 3100 of the Medicaid Services Manual. There are a couple of approvals that went through for the State Plan Amendment on February 22, 2018. Those include revisions for each of the alternative benefits plan. These include the prepaid ambulatory health plan delivery model. The service plan would provide authority for DHCFP to implement dental benefits administrator for DBA for managed care recipients. The DBA will serve urban Clark and Washoe County recipients for dental services. The DBA is intended to strengthen access to dental care providers for urban Nevada Medicaid recipients. Also, the ABP expanded coverages of the podiatry services by adding to allow for all Medicaid eligible recipients. The ABP also expanded coverage to include genital reconstruction procedures based on medical necessity for Medicaid recipients with the diagnosis of gender dysphoria and last, preventative enrollment services and chronic disease management now allow for coverage of medical nutrition therapy by registered dieticians for recipients with nutritionally-related chronic diseases. Also, I'm going to add that we have added the prescription drug take-back information with a link to DHCFP Pharmacy and Nevada Medicaid websites. The link is to the U.S. Department of Justice with resources listed that include information on the upcoming national prescription drug tack-back day

which is on April 28, this Sunday. Collection sites and other drug disposal information are listed and it also includes collection results from previous take-back days, and I have the website if anyone is interested. I also want to add that we are currently recruiting for the P&T or Pharmacy and Therapeutics Committee for a physician position if anybody would like to nominate a member for that, I'd be happy to share my contacts for those.

Paul Oesterman, Chair: Just one clarification. On the DEA take-back, it's Saturday.

Holly Long: Oh, I'm sorry, it's Saturday, thank you.

Paul Oesterman, Chair: This is something that I'm actually very passionate about. It's something that I actually started with the metro police in Las Vegas many years ago and it has now expanded nationally. I'm pleased to have all you people safely discard any unwanted or unused or expired medications; there are multiple drop-off sites throughout the country.

4. Clinical Presentations

a. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for hydroxyprogesterone caproate (Makena®)

Laura Benthale: I'm a senior medical science liaison with AMAG Pharmaceuticals and they are the makers of Makena. Makena is a progestin that is indicated for reduce the risk of preterm birth in women with a single-term pregnancy who have had a history of single-term pregnancy and preterm birth. The rate of preterm birth in Nevada in 2016 was 10.4%, increased from 9.9% in previous years. The March of Dimes has set a goal of 8.1% for all states by the year 2020. Makena is a sterile solution of hydroxyprogesterone caproate, or HPC, in castor oil for injection manufactured in both 1 ml single dose and 5 ml multidose vials. Additionally, a single-use prefilled disposable autoinjector was approved by the FDA as of February 14, 2018, via a supplemental new drug application referencing the safety and efficacy data of Makena intramuscular. As a result of this recent approval, Makena's prescribing information includes additional information regarding dosing, administration, pharmacogenetics, and adverse effects. Makena is administered either intramuscularly into the buttocks or by subcutaneous autoinjector into the fat of the upper arm once weekly by a healthcare provider beginning treatment between 16 weeks 0 days of gestation or 20 weeks 6 days gestation and continuing administration once weekly until 36 weeks 6 days gestation or delivery, whichever occurs first. Compared to control, Makena treatment reduced the portion of women delivering preterm at less than 37 weeks and similar reductions were found at earlier gestational ages, as well. The most common adverse reaction was injection site pain by the treatment groups. The Society for Maternal and Fetal Medicine clinical guidelines for use of progestogen in preterm birth prevention originally published in 2012 and reaffirmed in 2014 and 2017 recommended the use of hydroxyprogesterone caproate injection consistent with the Makena indication. Despite the ASMF guidelines, the utilization of this intervention has remained suboptimal as described in several published retrospective reviewed of HPC in various settings. Additionally, a 2016 publication by Stringer, et al. roughly identified barriers of potential solutions to prevent recurrent preterm birth. One recognized barrier included preauthorization processes that may influence provider willingness or ability to prescribe and offer HPC for the patient and potentially delay the initiation of this time sensitive therapy. Makena is the only FDA approved

pharmaceutical intervention to reduce the risk of recurrent preterm birth in certain women at risk. I would like to request the removal of prior authorization requirement for the Makena prescription provided on Medicaid.

Carl Jeffery: I have our proposed PA criteria or the removal of the PA criteria. Makena has come a long way from I think it was introduced in 2011. It has since progressed and Makena has proven itself effective. There used to be an option for some pharmacies to get this available compound in for a fraction of the cost but these are becoming harder and harder to come by to find any pharmacies that will make this in a sterile environment, and then there's supposed to be a generic coming out here shortly of this, too, so eventually that may be an option, as well. So, we just felt it was the right time to remove the criteria in here because we're really not seeing any PA denials for it and just to make sure that it's available to the people who need it.

Paul Oesterman, Chair: So we have a proposal to remove the current prior authorization restriction on the hydroxyprogesterone caproate.

Carl Jeffery: I don't know, it's kind of a new world for us, too, but now we have the MCOs here. I don't know if you guys want to opine about your agreement or disagreement to remove criteria modifying. Probably now is the time I would think to offer your opinion.
MCO representatives offer their approval of removing the criteria.

Paul Oesterman, Chair: I think it's fairly interesting having the 3 here for MCOs and the different formularies so hopefully Dr. Marx has said, we could consolidate a formulary and make life much easier for everybody; we'll see how that progresses. We need a motion to remove the existing prior authorization criteria for hydroxyprogesterone caproate. We have a motion and do we have a second; we have a motion and a second. Any further discussion on this topic?

Jim Marx: Carl, I think years ago when this issue came up, I don't exactly know what the action was, but I think we were just allowing the compounded alternative; I don't recall the action of the state reviewed; there was something on the books that I think they wanted us to deal with, it may still be there.

Carl Jeffery: Okay, we'll take a look. I think everything is in there. Chapter 1200 is in here. I don't think it highlights anything that has anything of the compounded products. I know that was being used as an alternative sometime.
(indiscernible speaker)

Carl Jeffery: I don't think it's really being compounded much anymore.

Holly Long: I have the existing criteria in front of me but I don't see compound language in here.

Paul Oesterman, Chair: I've got it also and I don't see…

Carl Jeffery: Yeah, it's all in the binder or two.

Jim Marx: As I recall, the action is the same (indiscernible).

Paul Oesterman, Chair: I have a motion and a second. Any further discussion? Hearing none and seeing none and call for the question, all those in favor of the motion to remove a prior authorization restriction for hydroxyprogesterone caproate please indicate so by saying aye. All opposed say nay. The motion carries unanimously.

b. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for the monoclonal antibody agent class.

Paul Oesterman, Chair: Is there anybody in the audience who wishes to address the Board? Okay, hearing none and seeing none, we'll go ahead and talk about the brand-name Fasenra, benralizumab is the generic name. Carl, do you want to go ahead.

Carl Jeffery: Yeah and this one is a pretty simple one, too. We already have 3 drugs in this category that have similar criteria, all the similar indications for the eosinophilic asthma. Criteria is in there with the Optum logo on it. It kind of look's similar to what's in chapter 1200 already so we'll just incorporate those in there. But Fasenra is another effective product for reducing the effects of eosinophilic asthma and approved under the age of 12. There was one change. Holly did a really nice job of all the comparisons of what the different plans have for the proposed criteria. The recent change with the blood eosinophilic level, so I just wanted to make sure it is 150 and not the 300; I think some of them are 300 but there is some data that should be done at 150.

Paul Oesterman, Chair: Are any of these 3 different agents preferred through P&T?

Carl Jeffery: These have not been discussed at P&T. We tried but we didn't have a quorum last time so they will be discussed at the June P&T meeting.

Paul Oesterman, Chair: From our managed care organizations, any input?

Ryan Bitton: I think the criteria proposed is compared with all 4 of the criteria which is about the same, at 150. We don't prefer one from the medical benefit.

Holly Long: Was there any reason for the initial authorization, looking over Summit and it looks like in HPN, and an initial authorization for 6 months compared to the 12 months that's proposed.

Ryan Bitton: I think it is just to be consistent, there is no clinical rationale.

Paul Oesterman, Chair: So we have the proposed criteria for some coverage consistent with the addition of the Fasenra products. We have all 3 products requiring prior authorization, 12-month initial authorization. Do we have a motion to approve the addition of the Fasenra products? We have a motion. Do we have a second? I have a motion and I have a second. Is there any additional discussion? Hearing none and seeing none, we will call for the question. All those in favor please indicate so by saying aye for the addition of the third products into this class. All those opposed say nay. Motion carries.

c. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for GnRH Analogs

Paul Oesterman, Chair: Is there anybody in the audience who wishes to address the Board? Hearing none and seeing none, we will go ahead and start our discussions on the GnRH Analogs.

Carl Jeffery: So if you remember, maybe 2 years ago we had this discussion about covering the hormone therapies for gender transitions. This is kind of in that same line where we're covering Lupron. I think what it is being used for most frequently is to delay puberty for youth that are questioning and so it's kind of the gender identity disorder. We've had a lot of requests for it and we just don't know what to do with them because we don't have any established guidelines and there's not an FDA-approved indication but it is approved in the common compendia and it's something that is frequently used so we put some criteria together and took a stab at what I think is appropriate in the binder. Basically it's to delay the onset of puberty until maybe the youth has some time to get some counseling and find out which road they want to go down.

Jim Marx: Carl, number 2, who needs to demonstrate knowledge, prescribers, pharmacists, the patient?

Carl Jeffery: That would be the prescriber. So this will be just added because we already have some criteria for the Lupron and the GnRH Analogs in Chapter 1200, this would be in addition to what is already listed, the other criteria would not change.

Holly Long: I believe it is correct that each of the managed care organizations have this diagnosis listed. Is that right?

Ryan Bitton: Yes

Jeannine Murray: We have it as a "Not", so we would have to flip it to allow.

Ryan Bitton: Carl, there is no age limit or hormone limit in the proposed criteria.

Carl Jeffery: I did think about that, but my thought was to leave it up to the prescriber as to what is appropriate as every child is different when they start puberty. It would be hard to document that in a role like that.

Beth Slamowitz: There's no way to verify lab values, so if anything, we're asking for certain values, they would just be in an attestation from the prescribers and yes we did allow within these limits, but nothing we could verify.

Paul Oesterman, Chair: The only product that we're looking at right now for this gender dysphoria is the Goserelin?

Carl Jeffery: I think there's some utilization for the Zoladex but I don't think it's being used for this indication. I don't see Zoladex as really or any other ones out there, and I don't see

anything here; it's mostly for the prostate cancer. I did break the utilization down. I was interested in seeing it. The utilization starts on page 129 of the counts and which ones are being used and then the age of the recipient. So on page 130, it's kind of a confusing graph, let me see if I can pull it up for a second. So here we have just the fee for service Medicaid utilization on the next page. Over here, the numbers on the left are the identifier of the prescriber so we only have 7 different prescribers that actually use this for youth. Up at the top is the age of the recipient so we've got any ages from anywhere from 7 up to 17 and one 30 year old which I'm guessing it's probably for Oncology or some other indication. But, the specialty is here so you can see that most of these are coming out of the Endocrinology department, the nurse practitioners, pediatrics, and then a couple unknown but it's mostly where we're seeing these come out of anyway.

Jim Marx: Are any of the nurse practitioners practicing under endocrinology department or pediatrics department?

Carl Jeffery: They didn't show up as being under that site, I don't know. Our specialty database is kind of questionable most of the time so we have to kind of take it with a grain of salt.

Jim Marx: There's a little bit of concern, I guess. The nurse practitioner has almost the majority of the patients under the age 12.

Carl Jeffery: And they may be endocrinologists or it's hard to say; I'm not sure what kind of practice they're in. Anthem is also broken down by age, down to age 10, but again we've got the identifier is the 3, 4, 5 over here and then the age of the recipient from the prescribing. I don't know if those are the, you have to break down the specialties, for that.

Jim Marx: I guess I'd like to see a little bit better breakdown of what those nurse practitioners with regard to practicing maybe totally appropriate and maybe just they work with an endocrinologist. Is there any way of drilling down into that database? Sounds like a whole lot of …

Carl Jeffery: Usually there are just two providers and usually what I end up doing is just getting their names and find out where they practice.

Jim Marx: Yeah, that, I can't imagine it would take a long time, but I think it is relevant.

Beth Slamowitz: There are two nurse practitioners?

Carl Jeffery: Right.

Paul Oesterman, Chair: Would you be willing to approve the criteria and have it brought back next month or next time with a look at the nurse practitioner information?

Carl Jeffery: Could we also say we do look up the nurse practitioners and find out there is endocrinology, then you're okay and…And then we can leave it?

Paul Oesterman, Chair: Part of the issue is that it's an off-label. So, are we going to end up with 2 sets of criteria or with 1 being the off-label indication and then the other?

Carl Jeffery: Well, we just we'll put in there. I mean, it is supported in common compendia, so we got it allowed. So it'll be included in the chapter 1200 under a separate header for coverage.

Paul Oesterman, Chair: As Dr. Owens pointed out, the existing criteria says the medication is prescribed by or in consultation with the pediatric endocrinologist. How many pediatric endocrinologists to we have in the state?

Carl Jeffery: At least one. I'm aware there's one in Reno; I'm sure there's a couple more.

Paul Oesterman, Chair: Okay, so we have the criteria for coverage for Lupron products for gender identity disorders. Do we have a motion to approve this with the understanding that the nurse practitioners will then examine and brought to the committee next time unless it's determined that they are working in association with pediatric endocrinology? We have a motion and second. Any further discussion? Hearing none, I'll call for the question. All those in favor please indicate so by saying aye. Motion carries.

d. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria and/or quantity limits for Hepatitis C Direct-Acting Antiviral agents.

Paul Oesterman, Chair: Our next possible action in the clinical realm is the discussion and possible adoption of updated prior authorization criteria and/or quantity limits for Hepatitis C Direct-Acting Antiviral drugs, and I believe this is left over from last meeting that we were trying to simplify the criteria. Do we have anybody in the audience who wishes to address the Board, either on the phone or in person? Hearing none….

Betty Chan: Hi, yes, this is Betty Chan from Gilead Sciences. I just wanted to get some clarification on the simplification of that the criteria. From reading the binder, it looks like that first page or what you're showing on the screen, can it be more of the simplification, basically those criteria have to be met, and then what the choices between which agent to choose. There is no preference for the fee for service population. I just want to get some clarification and some confirmation.

Carl Jeffery: Whatever decision is made here tonight is independent of what has been the preferred choice, so we would still have our preferred medications in the category and I believe the MCOs would as well.

Betty Chan: Okay, so the simplification is really kind of what you have on the screen is what you're, what is that?

Carl Jeffery: That's the proposed clinical guidelines for these. If they were to get a nonpreferred at least for fee for service, I believe it is similar for the MCOs, but if they wanted to get a nonpreferred product, they would have to either try a preferred product first or have some good reason why they couldn't use the preferred product before they get nonpreferred, and that's the decision from our P&T committee.

Jim Marx: What's the, how do we designate an HIV specialist? Is there some sort of recognized board or?

Carl Jeffery: It's pretty much all of these specialties that are self-proclaimed.

Jim Marx: Self-proclaimed.

Carl Jeffery: Yeah, anybody can hang a shingle; most of the time they've got some kind of training, but we don't ask for board certification. A lot of these are board certified specialists but we don't ask for any of that so they can proclaim themselves to be that way.

Jeannine Murray: Can I ask a question? On simplification and I don't know, it's sometimes what I hear, so I'm certainly not an expert in the area, but is there thought to be given around how when the diagnosis was first made and how long they've had it, because isn't it true that some people with hepatitis C will just revert and cure on their own? I mean, is there a thought around that maybe they have had the virus for 6 months, I mean, I'm just wondering if there's some type of timeline like that that might need to be considered before treatment, or else I'm afraid you would treat people that maybe would have just cured on their own.

Carl Jeffery: Yeah, I think you've got a point and I don't remember all the exact numbers. Betty can probably run them off the top of her head, but I know there's a population that is infected with hepatitis C, only a small percentage, whatever it is, breaks down, carries the virus, and you're right, some of them resolve on their own.

Betty Chan: About 15% spontaneously get through the virus on their own and acute infection within the first 6 months so the criteria is consistent for someone that has had it maybe 6 months versus a person who has had it chronically.

Carl Jeffery: Right it would be chronic hepatitis C I think would be the word.

Jeannine Murray: You should add that to the diagnosis of chronic and then define chronic.

Carl Jeffery: Yeah, that would be a good way to do it.

Paul Oesterman, Chair: So I'm hearing that we want to modify bullet point number 1 to the diagnosis of chronic hepatitis C and now let's determine what defines chronic.

Jim Marx: Are we specifying that they meet or exceed that 6-month interval, are we going to allow that 6-month interval, could have an SVR in that period of time spontaneously.

Carl Jeffery: Yeah, I'm not sure how the diagnosis is stated with the chronic hepatitis C.

Paul Oesterman, Chair: Betty do you have any input on that?

Betty Chan: From the criteria, I have from other plans. I would recommend to say the diagnosis of chronic hepatitis C, acute infections actually resolve usually were up to 2 to 3 to 6 months so I think anything over 6 months is appropriate, but I do know that in literature, it does say that most of the acute infections that do respond or resolve spontaneously happen within 3 to 6 months. After 6 months, I think would be fair.

Carl Jeffery: So say a sustained viral load of greater than 6 months from…

Betty Chan: However, though, I do caution against when you get your first viral load and you know that's chronic or when they got their infection, that is kind of tricky, so a person may not know when they got infected.

Carl Jeffery: I think when I initially put this criteria together, I put that responsibility on the prescriber, too, so it's up to them to identify and I think this is what the simplified criteria really embodies is that we are going to really put this back on the prescriber to make sure that the appropriate patients are getting the treatment.

Beth Slamowitz: You could still state Chronic but just not have to describe it.

Ryan Bitton: I think by just putting the chronic in there is kind of in lines with this department and having prior authorization to cross our company. You don't say six months, three months, say just call it chronic and for most part, the provider is not treating acute hepatitis with this stuff. We don't see an issue with that.

Paul Oesterman, Chair: Okay so we have the proposed initial authorization for 24 weeks with all of this criteria with 5 points being that point number 1 would be a diagnosis of chronic hepatitis C, point 2 the genotype has been confirmed, point 3 the liver disease has been assessed, point 4 the prescriber certifies the shortest duration of treatment will be used based on the indication of the requested drug, and bullet point 5 is prescribed by or in consultation with one of the following specialists. I think this criteria is quite simpler than what we had previously and it's nice for us to be able to once in a while make life a little bit easier and simpler for people.

Ryan Bitton: I'll give my 2 cents. I speak for HPN, but conversations with Jeannine and Tom probably similar. I think we agree with simplification and I think that it's scary to get a look at a prior authorization document that is 20-25 pages, but I think that what that document did was give instructions for use, and 12 weeks, 8 weeks, and 24 weeks, this is how you use Vosevi, this is how you use Harvoni, and I think the simplified criteria embodies all the restrictions that we've kind of had in place but now it's 24 week. But some of these agents should be used for 8 weeks or 12 weeks. Some them aren't indicated for all genotypes, and so the concern I have is that we simplified it and maybe it's a better way to take so many pages down to 4 but rather taking 20 pages down to half page, I'm cautious and it's a real concern. If we're paying for 24 weeks of 15 to 30,000 a month therapies that aren't supported by the IDSA guidelines that oversee hepatitis treatment, I think all of our guidelines with prior authorizations were built off, to document it, and those guidelines continue to change and thus our protocols continue to be updated. We have aligned with the CMS's mandates around hepatitis-C, and so I know it's good to simplify but it might be losing a little bit of the guidance and steer us to the appropriate duration of treatment and oversimplify.

Beth Slamowitz: Could we possibly for the window but up to 24 weeks based on FDA and patient guidance?

Jeannine Murray: Or even could we ensure a chart that would list the drugs and the length of time because you're right, it does appear 12 to 16 weeks, they're all the different, that we give the guidance on the specific drugs what genotype, I just feel like you could have a chart where you have the drugs, the genotypes that are approved for…

Carl Jeffery: And those are all listed in the indications, so I think we could have under the approval criteria that it will be approved for the duration of therapy of which genotype and so they would leave it up to the call center to define to get together that inform and they would go down and say yeah, we're judging on type 1, you know, all the way down there and say, yes according to the FDA indications, it's for 12 weeks.

Beth Slamowitz: I think the idea of a chart is good for clarification but I think the reason for the simplification was so that with each new product that comes out, there wasn't a need for an additional update, an additional criteria added, to simplify it so that a little bit of the responsibility on the provider to prescribe appropriately but that it was still within the FDA guidelines of the class of drugs so like Carl said, whether you put the approval length up to 24 weeks or if you put as indicated for prescribing medication, however, you want to define that or word that so it locks it into a specific drug but with the chart maybe just kind of constantly updating.

Jeannine Murray: How is that going to work for denial language if we don't have a specific policy?

Ryan Bitton: If it's clearly stated that it's based on the duration, based on FDA approval for the specific product combination and as on IDSA guidelines, treatment for hepatitis C on exam, that covers what it's appropriate, but what is happening is reviewing pharmacists, or people that are not experts in hepatitis C, they'll need guidance and so what's going to happen is we'll have to simplify criteria but then in order to guide people who are reviewing to make sure they are doing what is appropriate, they'll be another piece of information, and I'm sure Optum Rx will have cases similar.

Jeannine Murray: Well won't it take longer to approve it?

Ryan Bitton: Well, we're also looking for similar alternatives, so they…

Beth Slamowitz: Don't they still have to do that, though, I mean I guess this is going to need your process, so I mean if they call in for Harvoni and the individual whether it be a technician or pharmacist on the other end of the phone that takes the request for the prior authorization, do they not have a protocol that they have to follow where they look up the drug and it has the requirements and exactly what needs to be improved for this diagnosis or whatever.

Ryan Bitton: It's a 25-page policy and guide to them, these are the 5 questions to ask that appropriate use. So, we have been on a path of having 2 documents and tried to transparent and all the followed criteria that we have out there so there's only been (indiscernible). I just think that; president is the wrong word so I think simplification is compressive and we need to understand the process. This has 25 pages. I mean, you can go to page 8 where it talks about how to use Vosevi and there was a guidance on what other criteria listed for Vosevi. This is a lot of repetition because we're repeating these 5 or 6 things 10 times for each drug and it looks scary, and I could understand but I think, there wasn't anything hidden in the MCO and I didn't get those long policies; that it goes against what we've got up here. There's a nuance here how the process works and how to support people who are actually in the clinic to assist us when they get the phone call with the fax of the electronic prior authorization.

Beth Slamowitz: So you're saying you'd have to take that 25-page policy and that would chop it up into multiple worksheets from this checklist and say, okay for this drug, all we get from that criteria, all these things were met.

Jeannine Murray: That would have to be appropriate that we could still use that criteria in that way. I think taking it down, making it simple; I agree with everything that Ryan said. I just feel like for us, I know the policy is there so that if a denial should occur and you have to have a policy to fall back on and if the policy is just those 5 bullets and we don't have any direction on drugs, I think it would be difficult to say, well but our policy on Zepatier is this because we're not talking about a Zepatier policy here and I think it's just going to have to be an understanding then that are you saying that the MCOs cannot have our own drug?

Paul Oesterman, Chair: What if the criteria from the approval like something to the effect of up to 24 weeks based upon the specific agent's indication per manufacturer?

Beth Slamowitz: Well, the number four actually states that it the prescriber certifies the shortest duration of treatment so it kind of already sets that precedent that the prescriber should use the shortest duration based on the drug that's being requested.

Netochi Adeolokun: What about the situations where patients have decompensated cirrhosis and they have to use like ribavirin plus whatever. Would a different prior authorization be required for those agents?

Carl Jeffery: We don't have P.A. restrictions for ribavirin, so they could be able to get whatever the primary antiviral is plus the ribavirin.

Jeannine Murray: Using it like retreatment and stuff, isn't that a different policy? It makes me think about other things that we're not talking about.

Carl Jeffery: Specifically it doesn't address retreatment management or kind of co-infections or anything.

Paul Oesterman, Chair: Dave, you've been pretty quiet. What are your thoughts? Well at this point, we have in front of us the proposed criteria for the change of number 1 to include the word chronic or the diagnosis of chronic hepatitis C. Do we have a motion to approve this criteria? In the absence of approving this criteria we would retain the existing criteria.

Jim Marx: I would suggest since the MCO has some issues with this, let's get your heads together and come up with something that you think is sort of succinct, cohesive, usable, and put this on the bench until the next meeting and see if you guys can come up with something that maybe suits you better and works better, that you feel more comfortable with, so again, I think the issue is really we want to be consistent and we don't want to have any sort of strife and enmity between the MCO and fee for service and all that and I think if we can control something more mutually acceptable then I see there is a lot of reluctance on your part.

Beth Slamowitz: I think the other thing you keep in mind, too, is to kind of discuss the other is there is a lag time before this actually becomes policy, before it actually goes on the books so there is some time for internal processes and align and get in place because we

have the same issues that we have to address. I don't know if that's helpful or not but just throw that out there that if there are some concerns for it, not necessarily with the policy but more with internal processes, how to execute the policy, that it's not going into something that is going to have to start tomorrow.

Holly Long: If we push it out it will have been the second time that we have pushed it to another meeting.

Ryan Bitton: And, I think my problem was, I appreciate your sentiment and I think the historic policies, I think you were pretty much in alignment from the consistency of how we approve drugs, and I think there's implication if I remember the meeting last time correctly what that time before, trying to simplify it, so the documents were long but the criteria is repeated for every drug to be sure we would have the appropriate guidelines. So, not that anyone is going to be guided by clinical rationale criteria on a website, they already know, but that's just how we do things, so there hasn't been any enmity with fee for service criteria or on our end. This is one arena, but for the most part, the criteria is pretty well consolidated, but it just looks different because it's all divided down on papers, but it was long.

Carl Jeffery: And I think our issue that we didn't have any criteria for the Mavyret or Vosevi and that's what was going on there. We don't have any specific criteria for those medications.

Ryan Bitton: I think there's always going to be new drugs, and I think that if we simplify the processes to update criteria, I get worried because there is always going to be drugs and simplify things with the new drug of the criteria. I get the concept.

Holly Long: Bringing in a little bit from what's going on in other states. Other states are looking at simplifying their criteria, as well, and in reaching out to other Medicaid states. They're all kind of like, well what are you doing, do we want to do the same thing but nobody can really organize their thoughts as to whether that's the way to do that. A lot of the states are still looking at fibrosis scores and they make their decisions off of that. I think looking at other states, Nevada's really doesn't look that bad. It's a lot more condensed than the other states that I looked at. And, there was a State of Medicaid Access Report Card that came out within the last year (in 2017) and the state of Nevada received an A- on the hepatitis C prior authorization criteria and compared to the other states, we're doing really well. So, I don't know where that would put us by simplifying it, They like it because we increased the access, but there is the safety aspect they take into consideration too.

Ryan Bitton: They are all long, trying to make things very comprehensive and criteria from a safety perspective and from a cost perspective too.

Paul Oesterman, Chair: At this point, we have the proposed revised criteria down to at least 5 points in front of us. I have not heard a motion to approve it so at this point, the existing criteria will remain in place until such time as our MCOs can get together and present to us their version of a revised criteria.

Paul Oesterman, Chair: So this agenda item will be deferred to the next meeting.

Holly Long: I would like to add to it, we're going to still work on the simplified criteria and make a decision around whether we're going to choose a different simplified criteria than what we have that we also consider adding the PA criteria for Mavyret and Vosevi that we never addressed initially.

Paul Oesterman, Chair: We cannot do that at this meeting because it was…

Holly Long: No, no, I meant next time. Sorry, yeah.

Paul Oesterman, Chair: We'll put that on the agenda for next time.

Carl Jeffery: Going back to the old days where we had hep-C on every agenda.

e. **For Possible Action:** Discussion and possible adoption of updated prior authorization criteria for High Dollar Claims.

Paul Oesterman, Chair: Just as a reminder for our guests online, on the phone, or in the audience, one of the purviews of this committee is not to focus on specific drug costs. We can look at, and this was discussed with the approval of our Deputy Attorney General on the phone the other day, the over-arching high-dollar claims not specific drugs, per se. With that being said, do we have anybody in the audience who wishes to address, please step forward, state your name, for your 5 minutes of fame.

Khanh Pham: On behalf of the Nevada Pharmacy Association, my name is Khanh Pham. I am a practicing pharmacist. Also, a CDE. I see patients with diabetes and hepatitis, too, and my concern is the high-dollar claims. How do you define that? Because all that's left with hep-C is expensive. One out of three baby boomers have it, too. How do you put the price on a patient's life? I commend you for taking such good care of patient you debate. How would you come up with the right criteria to save lives? I appreciate that. Also, the patients that I see, that would be really active to care and I see a lot of things you don't see, I see them every day. I also work in endocrinologist center. I see a lot of things you don't. I ask, I urge you to remove the criteria for high dollar and please remove it.

Paul Oesterman, Chair: For clarification for the audience. Right now there are a couple of different dollar figures and these are for single claims that would require prior authorization. It is not to say that these drugs should not be available, but they would require prior authorization and Anthem has a 5000 dollar limit, HPN has a 10,000 dollar limit, Optum is 10,000, and Silver Summit doesn't have any…

Carl Jeffery: But, that's what's proposed for Optum. We don't have a current limit now but I think Anthem is the only one that does currently, right?

Jeannine Murray: We have a limit, and I was going to say to address her question, there are drugs that are excluded from the high-dollar limit like the obvious hep-c and certain specialty drugs because they just are always above that. The cost limits that we had in place, and one that comes to mind for me, is Vivitrol. It's in place because sometimes what happens is the pharmacist will put in 4, as in 4 ml instead of 1 vile, and so that's where the high cost limit comes from is more maybe the data entry issue, so I just wanted to put that out there because I see that with Vivitrol. I guess I don't really look at everything else; but

I do see that one. Yes, we have a limit. We also have a limit on compounds to a different dollar amount.

Ryan Bitton: You have other groups that more than operational like preventing fraud or miscoding because it's been approved by the FDA, we allow coverage and trying to go through the prior authorization perspective. It's above 10,000 and for some reasons we don't already have the prior authorization, all hepatitis C drugs would have prior authorization, would these be non-formulary to protect. It could be Vivitrol, or miscoded then it would be approved if it goes above that 10,000 dollar amount. So we don't see a lot of these types of requests because we already have a 10,000 dollar limit in there because most claims are not 10,000 dollars. Vivitrol doesn't cost 10,000 on a regular month.

Jeannine Murray: No, it shouldn't cost 5000.

Carl Jeffery: So, and maybe we should go back and cover some history for the public and the new members of the board. So at the last meeting, we had a discussion about specifically the orphan drugs. There's a lot of new drugs for orphan indications coming out. These are extremely rare diseases that we may not even have anybody in Nevada that has these, but we want to get our hands around them not to have open access to these to make sure that these appropriate patients get them. So in lieu of bringing every new medication that comes to market with an orphan disease indication to have criteria placed on this, this was kind of our thought is that well we can just add this and we'll have an FDA-approved indication related to all of them. Some of the more complex therapies will certainly like that. We've had a lot of muscular dystrophy drugs. We've talked about those. They're very complex medications and have some very specific guidelines. We will still bring those to the board for specific guidelines but this is to capture those, like the Luxturnas of the world that we may not ever see a claim for it but we want to be prepared and make sure that the correct person is getting the correct medications.

Holly Long: We didn't want to pick on orphan drugs and we didn't want to miss the FDA fast track that we're having now.

Paul Oesterman, Chair: I think we also need to remember as you brought up today, that this is a CMS mandate, that these products have to be either FDA approved or the existing literature and peer reviews indicating the possible safety and efficacy for these products.

Holly Long: And, there are a lot of other states that are doing the same thing and a lot of other states have a much lower flag as low as 2000 dollars where it starts flagging.

Carl Jeffery: And, that's where we did break it down so we did look at those numbers so starting at the utilization numbers. There's 214 the breakdown of the products. Page 218 is a summary and that gives a breakdown of starting about 1000 dollars in 500-dollar increments of about how many claims per month we're seeing of those medications. So, why we picked 10,000 was it would seem to capture, just a number; it's a good starting point I think is our point there and we'll assess how that goes, and then our process would be that any of these would require prior authorization at the point where they would deny at the point sale, they would have to call in for a prior authorization, meet the guidelines where it's an FDA-approved indication or it's in a common compendia that's used, and appropriate indications. And, it'll be approved for a year so they wouldn't have to do this

every single claim; it would be just making sure that we're not using something way off label that some providers maybe makes a mistake or maybe doesn't understand the indication. We just want to make sure that everybody's doing their due diligence and I think this is a good safeguard in place.

Jim Marx: Do we have any access to their utilization as obviously we get a lot more power with these analysis if we had more numbers and raise the n, I don't know if it's any more proficient to get the MCO utilization and that will give us more impact on how these policies will be really effective.

Carl Jeffery: There is some utilization, and starting on page 221, there's some utilization there for the Health Plan of Nevada.

Jim Marx: Okay so we've got HPN in it.

Ryan Bitton: The request for utilization, it was kind of broad because Carl was trying and Holly were trying to determine the dollar amount? And, so it's broad so we just chose our specialty list and brought it to the specialty program. Most of the utilization seen from our submission is much less than 10,000 dollars, but I think that we can just look at that amount. You have a similar report that has to do with properly diagnosing.

Carl Jeffery: And, I think I did get some from Anthem but it was just in a format that wasn't conducive to putting in a binder.

Jeannine Murray: We could maybe, if this is what you're asking, not so much to look at a list of drugs but would it be appropriate maybe to look at what drugs hit that kind of reject, is that possible? I'm trying to think like how it rejects in the system to see if it's possible but maybe that would be something to look at.

Carl Jeffery: It was easy for us because we don't require prior authorization yet on any of this so we just basically report any single claim that's over 10,000 dollars. And certainly we can exclude some medications, certainly some classes that maybe not included here like hemophilia medications. I don't know if they want to exclude the antineoplastics. And, I think the question then, too, becomes if you want to apply this to only pharmacy point of sale claims or for apply this rule to physicians administering drug claims. There's really not very many physician-administered drug claims at this level. A few of them are going to be this antineoplastic.

Holly Long: I do want to comment, too, that DHCFP in general, we were really happy to see that Optum came up with more options rather than just this is the limit and FDA approval. Even if it's not FDA approved there's some other options, especially with the specialty drugs that work with drugs to be able to get that access to the patient. The one thing that we did want to see is the exception list to be able to add that to the list to see those that would be excluded in the criteria.

Paul Oesterman, Chair: We don't have the exception list at this point.

Holly Long: Jeannine do you have your exceptions to this?

Jeannine Murray: I don't. I don't know that I would have given it to you.

Holly Long: Oh, okay.

Jeannine Murray: I just know that, like I know hep-C is one of those drug classes that is an exception. I know a lot of our specialty drugs are exceptions because for the most part, they're all over on that.

Carl Jeffery: Yeah, and I think I had that on criteria, too. Let me pull it up real quick. I know the criteria that any, it's hard to see in here, but if there's any product that already has the PA criteria established, that would take precedence over this criteria.

Paul Oesterman, Chair: We had a couple of people state that they are concerned about access to these products and I feel that access is not being prevented, it's just that the prior authorization criteria will be in place.

Carl Jeffery: It assures that the state is in compliance with CMS regulations saying that they, because CMS has gone back to states in scenarios and saying you're not using this per label, we're going to take our money back because we get federal match, so it does happen.

Paul Oesterman, Chair: We've got the proposed criteria here for single point of sales claim that exceeds 10,000 dollars would require prior authorization. If other prior authorization criteria exists, it would supersede this criteria. Prior authorization for these point of sale claims over 10,000 dollars would be good for 12 months and the medications would have to have an FDA approved medication or peer reviewed articles, two of them that support the use of the off-label use.

(indiscernible speakers)

Carl Jeffery: I did recently; it's not included in your binder, so Beth was asking me about PAD claims, as well. I ran a report a couple days ago looking up PAD claims that exceed 10,000 dollars and there's really not that many so most of them aren't going to exceed that. We're going to address that at a future meeting with the PAD claims that we want to.

Paul Oesterman, Chair: So, at this point, I'll ask, do we have a motion to approve this criteria for single point of sale claims that exceed 10,000 dollars? We have a motion, do we have a second? Okay, we have a second. Any additional discussions?

Yvette Kaunismaki: Did we talk about exceptions to the criteria?

Paul Oesterman, Chair: Most of those that would have an exception would already have a prior authorization so they wouldn't even fall under this.

Carl Jeffery: The only one that wouldn't, and maybe I would ask the board to consider, is the hemophilia drugs. Those, of course, frequently exceed that. The antineoplastic is up for debate but for me, I would think I would stick with having that criteria in there, as well.

Paul Oesterman, Chair: Okay, so we have a motion and a second.

Jim Marx: Is there any provision for like an override process for immediate dosing and an urgent PA process to handle it. Is there some means that would provide for an override?

Carl Jeffery: We have an emergency override for 96 hours while the PA is being processed.

Jim Marx: And that would apply to this category?

Carl Jeffery: Yeah, and then we turn around all PA's within 24 hours and that is CMS mandate. Our average is about 6 or 8 hours.

Paul Oesterman, Chair: The hemophilia drugs do not require prior authorization.

Carl Jeffery: They don't currently.

Paul Oesterman, Chair: So, we have a second and a motion to approve this. Can we get a modification amendment to exclude hemophilia drugs? Is any motion and second to agree to that?

Netochi Adeolokun: Yes.

Paul Oesterman, Chair: Okay, so we have an amendment to the motion to approve the single point of sale claims that exceed 10,000 dollars where other prior authorization criteria, if they exist, would replace this criteria and hemophilia drugs would be excluded from this. Any further discussion.

Beth Slamowitz: Can I add a caveat to that?

David England: Go ahead.

Beth Slamowitz: Sorry, it's a quick one. But, just like Jeannine and Ryan were talking about as far as what I would call fat finger mistakes with data entry, we see that a lot usually with drugs as far as quantities because they are such large units and quantities a lot of the times, so just a consideration, I know you don't necessarily exclude it, but this will definitely catch that if they were included; a lot of those fat finger mistakes that Carl and I actually do manually every month so I guess (indiscernible).

Paul Oesterman, Chair: My gut feeling is that the expenditure is totally excluded in the pharmacies that make those fat finger mistakes, they have a price for their failure to type in the right number.

Carl Jeffery: I think, you know, hemophilia has been something, getting off the side topic, it's something that I've kind of wanted to address at some point anyway so maybe we'll come up with something next visit and maybe we can address some of that.

Beth Slamowitz: Some of the data that Carl researched and we looked at and coming up with this policy, again, the majority of the expenditure is from the hemophilia patients and so that maybe something that needs to be addressed at some point.

Paul Oesterman, Chair: Right now at this point we have the motion that includes the exclusion of hemophilia patients so I'll call for the question. All those in favor of the proposal with the single point of sales claims exceeding 10,000 dollars requiring prior authorization, if prior authorization criteria already exists for the product, we can supersede this criteria and hemophilia products currently excluded. All those in favor please indicate

so by saying aye. All opposed say nay. The motion carries. And, we'll add to the agenda for next time's discussion on hemophilia products.

5. Public Comment on any DUR Board Requested Report

Paul Oesterman, Chair: At this point, I'll ask if there's any public comment on any additional topics and issues that need discussed? Hearing none and seeing none, we'll go ahead and continue on with the Drug Utilization Review Board Requested Reports.

6. DUR Board Requested Reports

a. Acetaminophen Utilization

Carl Jeffery: So this was quite a challenging report to put together as I needed to have some paper. The MCO was running copies for it. So, it's starting on page 228. On the fee for service side, we only have 2 patients exceeding 4 grams per day, so the member ID is 19 or 181. I've got the details on the following pages so I took those 2 patients and broke down what exactly they're getting. So page 231, you can see member 19, they just get a lot of Tylenol with codeine and butalbital/codeine with caffeine with codeine every 5 days and that's a lot. There's 30 tablets of each every 5 days on those.

Jim Marx: It seems like, I guess I haven't seen it recently, we occasionally see a lot of typos with the (indiscernible).

Carl Jeffery: I am, too. What I think our…

Jim Marx: I wonder if some of these amounts (indiscernible).

Carl Jeffery: Well, and we don't know…

Jim Marx: And a lot of it's over-the-counter, too.

Carl Jeffery: Right, and that's what I was going to say. If they're using it over-the-counter, we won't know that they're taking it with their regular acetaminophen prescription products. But this one, I would like to find that prescriber and the pharmacist and slap their hand. I don't know what pharmacist would let this go out the door. You see the breakdown. It includes the other members, too. How I did it was I had to break it down by month and the fills they received per month, so there could be a few false positives in there where somebody filled 30 tablets, they were getting a high dose for 3 days at the beginning of the month and high dose for 3 days at the end of the month and it's going to show up on these, so there's going to be some false positives. It's just hard to track down the number of patients with the acetaminophen dose totals. But overall, I think our limit is working pretty good so I don't see any problems with these. We do have the other ones on page 235 is the report we have received from Silver Summit including the utilizations of acetaminophen per day. Theirs is all very midline or how you want to give anymore details on that report. And, then there's 2 pages that were passed out earlier.

Jeannine Murray: Quick shout out and thanks to Holly for telling me that I had just calculated the Tylenol amount in the liquid. I sent over something that 7 people were getting like 75 and 50 grams of Tylenol a day.

Paul Oesterman, Chair: Well, it's good to see that the minimal got over the 4 gram per day.

Carl Jeffery: I think it's something that's provider education is working, as well, I think it's something that every pharmacist will accept but at least 2 pharmacists that I can see in this report that are acutely aware of the acetaminophen dosing as that is pretty easily identifiable.

Jim Marx: I guess I have to shine new light on it. I still feel like the 4 grams is excessive.

Carl Jeffery: Well, our limit is 2.8 grams, so our system, we're not able to set up limits across products.

Jeannine Murray: I was going to ask you that question. So, is it accumulative or is it 2.8 grams per fill.

Carl Jeffery: Ours is set up per product, per fill.

Jeannine Murray: Per fill, okay.

Carl Jeffery: I wish we could set it up so it would cross products.

Jeannine Murray: Well, I was talking to them and they said, oh I think they'd have to go to an accumulator and I don't think you can do that so I wanted to ask.

Holly Long: Seeing how there's only 2 providers that stick out like this, is this one of those situations where you might feel the right to reach out to them like you have in the past and send them a letter, you know, we're recommending this because we see this utilization or, because there's only 2 of them not do anything.

Jim Marx: I think they should have the pharmacy board do that.

Holly Long: Pharmacy board?

Jim Marx: They have to pay more attention to the pharmacy.

Paul Oesterman, Chair: There's 2 members, do we know if they're getting all of these at the same pharmacy or?

Carl Jeffery: I've got the data. I don't have it included in here, so we can look at that.

Paul Oesterman, Chair: I definitely agree that there should be some kind of follow-up on these 2 members. Any other discussion on our acetaminophen utilization?

b. Opioid utilization – Members under age 18 years

Carl Jeffery: So, it's kind of a similar report that we looked at last time. We looked at more MCO data on these. You can see that the product on page 241, it's actually broken down by age for the fee for service here, so you can see what the different ages are, which products are more popular for the different ages. I think you probably want this as an action item at the next meeting to add some limitations on this and I think you eluded to the cough syrups, as well. So, we'll come back at the next meeting with some proposed criteria for all the opioid children and include the opioid cough syrups.

Paul Oesterman, Chair: The current recommendation is all opiate-containing cough syrups not be prescribed for patients under the age of 18. We'll be bringing criteria to that effect for the next meeting.

Jim Marx: I'm a little concerned about the methadone and spiking in the 0 to 5.

Carl Jeffery: I bet those are detox babies.

Jim Marx: Oh, detox babies.

Carl Jeffery: I'm concerned about them too, but they shouldn't be getting it. It's too bad they are even in there but.

Holly Long: Looking at national numbers, too, the age group that is having the most trouble nationwide is 12 to 17. They have high utilization across the board.

Carl Jeffery: You've got kids in high school sports that hurt themselves and go in for a knee operation or something and then get that or dental.

Jim Marx: If you have this narrowed down to a diagnosis, that would be nice.

Carl Jeffery: Yeah, diagnosis is a really difficult thing to get.

Paul Oesterman, Chair: I've heard this before.

Carl Jeffery: Yeah, we tried, I think we got a report for the diagnosis of diabetes in there, terrific report it's just 200 pages long. And in this one, you've got all the MCOs. I don't know if the MCOs want to speak to any of their data.

Ryan Bitton: We are in the process of doing a cough syrup criteria as well. We'll come back to that.

Carl Jeffery: No, the 4 or more is to cross out all. Yeah, 243, it's in our next item there.

Paul Oesterman, Chair: It says 4 or more opioids in what time?

Carl Jeffery: Concomitantly, so usually it ended up being per month.

Jim Marx: Do you consider a dosage form of other opioids or others, oxycodone 15 or oxycodone 5, would that be 2 opioids versus 1?

Carl Jeffery: That's why I included the strength on there so you can see like encrypted ID #1 here, they've got several different strengths of morphine sulfate.

Jim Marx: But see, that wouldn't really be; I'd be concerned if he really was getting 4 of the oxycodone and methadone, morphine, and say fentanyl or something like that.

Carl Jeffery: The way my query was built, it was a whole dose members in there and look for the 2 different opioids, but that's why I included the specifics on their use across.

Paul Oesterman, Chair: Encrypted ID #6, this data is for 1-year period, but you have 393 days of hydromorphone tablets. Are of any of these, you probably don't have the data either, but are any of these patients our lock-in patients? We haven't talked lock-in for a while.

Carl Jeffery: Good question. I don't know. I could take the IDs and cross reference the IDs. With that one that got 393 days, it's possible they filled it April 2st and then March 31st they got another one, so it actually would be 13 months of a medication.

Paul Oesterman, Chair: I would recommend you take a look at these 62 patients and look to see about possible lock in or just if we could get diagnosis information.

Carl Jeffery: Well this is four within a year so there's a potential they switched products.

Ryan Bitton: The report that HPN ran a report for Q4. We identified 8 members, the population is going to be different but back, there's not a lot of patients, that was a year, over 3 months, and it was for the unique what we call GPIs dosage, dosage forms and strengths. That's what we did. So, we're not seeing a lot in ours, 280,000 members.

Jeannine Murray: In Amerigroup population really quick looking at what our report was and it looked like 24 people for the year that we had for 8 months.

Paul Oesterman, Chair: I think one of the really exciting things for me is on page 251 and I know I'm getting ahead, but it looks like our usage is steadily declining. Unlike Facebook, our member counts seems to be dropping, too.

Paul Oesterman, Chair: Those patients are declined and finding street drugs and overdosing, that's why they're (indiscernible).

Carl Jeffery: Those are the numbers that are effective. Those are the numbers I've seen, too. I think there's some unintended consequences of the opioid crackdown. The opioid deaths associated with the fentanyl in particular on the street.

Jim Marx: We have doctors telling us; they're not prescribing fentanyl any more.

Carl Jeffery: It's not the same thing.

c. Opioid Utilization – Top prescriber and member, including more than four concurrent opioids

Paul Oesterman, Chair: We have the opioid utilization, top prescriber and member, top 10 prescribers. Refresh my memory because I know it was a nurse practitioner that was

in Carson, in Las Vegas. That we reached out to and their supervising physician wrote back.

Holly Long: I think we read that letter last time.

Carl Jeffery: That reports on 250 you're looking for. We looked at the period before so I think we wanted to re-review that. So, the encrypted IDs on the prescribers so you can see our nurse practitioner in Vegas, he's still there, number 1. Has decreased member counts and decreased claim counts so it is something to be said for that.

Jim Marx: How would a physician in Greenfield, Wisconsin be number 3, on page 256.

Carl Jeffery: Some of the…

Jim Marx: That is a little suspicious.

Carl Jeffery: Some of those I think are and you can probably speak to them, but I know in our database, sometimes we get addressed of their billing office and so this could be their billing office.

Jeannine Murray: I would have to go in and look specifically.

Jim Marx: I think somehow we should capture their practice address. I think that's a real problem.

Jeannine Murray: I think it's what's tied to their NPI is the problem.

Jim Marx: No, the NPI is the practice location so it wouldn't be reflected in their billing address.

Jeannine Murray: Sometimes the addresses that they have listed on there, but I mean I can look at that.

Jim Marx: It's a mailing address, so.

Jeannine Murray: It's the same thing when we talk about like specialty and whatever their first specialty is, that's listed on their NPI but I can look at the Wisconsin person for sure, and you guys were talking about the nurse practitioner in Vegas and made me wonder if that's the number 1.

Carl Jeffery: So, I did a comparison across the different plans here so on page 263, I couldn't use yours because you didn't send me NPIs so they were already encrypted IDs. I couldn't include yours because I didn't know them but the other ones, so you have fee for service, Silver Summit, Health Plan of Nevada. So our number one prescriber that we would see is prescriber X. He doesn't show up in any of the other plans, or at least in my data. I could share that data. I just didn't want to publicly announce this. We don't want to call the providers out to publicly shame them, or maybe we do. The red highlighted ones are the ones that show up in multiple plans.

Jim Marx: Which pages?

Carl Jeffery: 263. I guess yours doesn't have color in here so.

Paul Oesterman, Chair: They're shaded.

Carl Jeffery: Yeah.

Paul Oesterman, Chair: While we're looking at this, I mentioned lock-in patients and it might be nice to be able to take a look at lock-in patients and see if there is some that we can unlock at this point now to balance out the workload.

Carl Jeffery: We've talked about how to unlock patients before. You know, once they're locked in, there's really no maintenance associated with them. I mean, we don't really do anything.

Holly Long: Actually I think some of the MCOs do move them out after a period of time and I've talked to them about not doing that because it is a burden if you only lock them in for a year and then you have to reevaluate it and go through the process again and realistically once the person is locked in, what would that be like to unlock them and then have to put them back in lock-in, which it sounded like it was more realistic. I can't remember who it was, was it you, Ryan?

Ryan Bitton: Yeah, we have criteria, but we're not going to lock in someone who's no longer meeting the criteria for the lock-in program.

Holly Long: So do you reevaluate it after, over time?

Ryan Bitton: Yes, I can't remember the specifics but it's a year lock in and then I can't remember if it's 18 months and then every month thereafter. There are a few people who have been in for a long period of time. If they don't meet criteria, then we pull them out. It's really not a lot of effort on our part. We put them on and off, there is a letter sent. Most people don't fall off. I think when you put them in a lock-in, we've stated that is the kind of policy.

Jeannine Murray: We reevaluate, as well, at 12 months but we don't remove a lock until they've been evaluated. For the lock statement, they get reevaluated.

Ryan Bitton: Yeah, we don't take it off until they don't meet criteria any more.

Jim Marx: The real problem we see where the rubber meets the road and with lock-in is that we've seen supply issues and a lot of the pharmacies don't understand lock-in and our programs are for alternative pharmacies where there is a supply issue, and a lot of them are not really well informed so I think that is something you guys can do a better job on, informing those pharmacists how to handle those rare situations but there is still a very problematic education scope, very belligerent when that happens.

Ryan Bitton: I know they escalate; people hear about those and you're right, though, there's confusion with that, saying look, you can't get it with that pharmacy then still with the process that will allow you to work around that.

Carl Jeffery: So on page 262, we also looked at the source. We had a great report coming out of the HHS system. Again, there's a ton of data that was kind of hard to distill down into something that I could present here, so I will continue to work with support and see if there's some other good information to share with you, but I thought

it was interesting to find that opioid overdose services on page 262, I've got it up on the screen, too, it shows…

Jim Marx: How do you define that? What's the filter for that?

Carl Jeffery: It's actually a diagnosis of.. So, these are people who have gone to the ER or had been admitted to the hospital with an overdose.

Jim Marx: So, this is a mode of admission.

Carl Jeffery: This is the place of service where they're admitted to so I do see the… The most predominant place is the hospital emergency room where we had 200…

Jim Marx: There are some people admitted to an ambulance?

Carl Jeffery: Ambulance has the service where they transported somebody with the opioid overdose

Holly Long: I think when I asked for it, I asked for primary or secondary or tertiary diagnoses are going to fall into this to be evaluated for.

Carl Jeffery: And what Holly asked me to do, I didn't get a chance to do it, she wanted me to look at the dates service and find out how the services they think they're declining, so again, I didn't get a chance to put that in the other…

Holly Long: Paul you had asked for deaths due to overdose, which I ran into a little bit of any obstacle using toxicology reports and when those are available so the report that I would have would be very, very limited and I was trying to compare it before the quantity limit criteria implementations and after, so I believe in talking to the team that develops that report, if we do it at the next meeting that that will give me a good 6 months before and 6 months after that we can look at, so we chose to go this route instead but yeah, would be nice to be able to see like Carl was saying, if there's some differences between before and after implementation.

Paul Oesterman, Chair: We'll try on that for next meeting.

Jim Marx: It's interesting how many more ambulance situations there are with MCOs in the fee for service.

Carl Jeffery: Well, keep in mind that that's just the population. We have about a third or even a quarter of the population, they've got 75% of it.

Jim Marx: Yes, so you're looking at all count.

d. Diabetic patients with hospital admissions

Paul Oesterman, Chair: We have our top 10 drugs and reports. It doesn't look like there's any significant changes in quarter to quarter.

Carl Jeffery: I've got one little quick chart on 264. This is what I eluded to earlier. This was the diabetes 200-page report. So yeah, 264 was how many patients with diabetes-related diagnosis with going to the emergency room. So, this one was really hard to distill down so there's a lot of data on here. So you can see in 2017 versus 2018, the primary diagnosis about 2700 in 2017, 2300 patients in 2018.

Jim Marx: Weren't we looking at lapses in compliance, too, because I remember we talked about that at some point.

Carl Jeffery: Well, I think what I remember we looked at was if they were monitoring and doing some blood monitoring on insulin, but it would be interesting to see compliance, too. The medication possession ratio has kind of fallen out of favor but I think there are some new measures that they can use talking about how compliant patients are.

Jim Marx: There's probably not a lot of money in the overall scheme of things.

Carl Jeffery: Now, and it's hard to say, secondary diagnoses aren't very accurate because they go to the hospital for a sprained ankle and they also have diabetes so it gets coded in there.

7. Public Comment on any Standard DUR Report

Paul Oesterman, Chair: Anybody in the audience have anything they wish to add at this point?

8. Standard DUR Reports

Paul Oesterman, Chair: These are the DUR Reports. For our new members of the Board, these are reports that we get each meeting and we are using this as a guide for specific topics that we want, additional information on for the next meeting. So, if you see anything in your area of expertise which you'd like us to drill down on, Carl would be more than happy to do it.

Carl Jeffery: It is interesting to see the decreased amount, so look at the top 10 group, sorted by paid amount. The antivirals were number 2 in second quarter 2017 before and now moved down the list and number three, a pretty significant amount. So, I think that's the trend and I think it would be good to continue looking at those antivirals and we'll be talking about hep-C at the next meeting again but it's interesting to see how that decline goes. With antivirals, it just occurred to me, too, it is also probably including HIV.

Jim Marx: Is that a liposomal lidocaine or something?

Carl Jeffery: Which page is it?

Jim Marx: On 269 at the bottom.

Paul Oesterman, Chair: Topical patches?

Jim Marx: But those are generic

Carl Jeffery: There's still crazy expenditures.

Paul Oesterman, Chair: We have taken those off our formulary and are using the menthol/lidocaine patches.

Carl Jeffery: Are you using more than just topical use or anything?

Paul Oesterman, Chair: Same topical.

Carl Jeffery: I see that sometimes they prescribe for arthritis and we argue about it's not effective for arthritis.

Jim Marx: I've had patients responding pretty effectively actually who started it, so I could testify. We're pretty positive about the patches.

Netochi Adeolokun: Also, on page 269, right above pregabalin the glucose blood, is that like testing supplies or…

Carl Jeffery: Right, those are testing supplies. I'm going to have to look at the lidocaine ones. There shouldn't be that many, I mean claims, we have prior authorization code so I'm wondering how those are.

Paul Oesterman, Chair: Especially with the shortage of lidocaine there has been.

Carl Jeffery: Oh really?

Jim Marx: Yeah, we can't get it .

Carl Jeffery: It's all going to the Medicaid population.

Paul Oesterman, Chair: Have you redone the last report for activity.

Carl Jeffery: I did.

Paul Oesterman, Chair: It looks different.

Carl Jeffery: I did, so this is my first stab at it, so I did just a raw output of DUR things. I could format it however I want so. I put it together here as just kind of a first stab at it to see what you guys like to see? Let me know if there's something more or less you don't want to see on there. But, I know we talked about like the different severity levels. That wasn't showing on the previous report; how many claims. So, this actually shows the number of claims that were originally denied that were then later paid versus the ones who were initially paid and I would like to think that they go the message and then reverse it.

Jim Marx: Morphine and gabapentin; it's like everybody on board is getting that.

Paul Oesterman, Chair: I'm still a little confused on the total count, original paid versus original rejected and then rejected to paid.

Carl Jeffery: Right, so page 275, you go across the columns. So we've got some have total alert count, that's the total number of alerts whether it be, sometimes the pharmacy can see the message, sometimes it's denies with a message, so this is going to include all of those. So, the final paid count, so those are how many you've actually got paid until they ask for an override or it's an alert and they pass it and then it would be sort of the final reverse and for whatever reason, it created an alert and then the pharmacy reversed it. We don't know if it's because of the DUR, it could be just because it sat on the shelf or even the case member came to get it. So, the final rejected, so that's how many rejected and they could never get an override code in there just to get it approved and then sum of the original paid claim accounts, essentially it's how many messages they received or eventually got them paid on there. And, then on the paid to reverse counts, it's how many paid and then they either saw the methods and then reversed them and then rejected the paid so it rejected initially and then paid, and then rejected or rejected the entry into the override. There's a some overlap between these columns and…

Paul Oesterman, Chair: So are there any particular topics that you would like to have data presented at the next meeting that would be of interest? We have a new psychiatrist on our board. Is there anything in the psychotropic realm, because I know pediatric psych has been addressed fairly extensively in the past. Is there anything else?

Yvette Kaunismaki: Not at this time, I do notice there is a lot of utilization.

Carl Jeffery: It's something we struggled with. I don't know if you're involved with some of the policy making from about 3 ago years now. It's been kind of a while since we've updated that, but we had a lot of input from that.
Paul Oesterman, Chair: That's an understatement.

Carl Jeffery: From the psychiatrists in the community about half the policy that we eventually ended up with, you know the one medication from each class is allowed to four different classes than anything more then requires prior authorization. I don't know if you…

Yvette Kaunismaki: I wasn't around for that.

Carl Jeffery: Yeah, and if you ever speak to the colleagues that are maybe wanting a refresh, we can open that can of worms again.

Holly Long: I have a couple of topics I would like to propose for the agenda next time. Along with the high cost criteria and the research that I did for that and Jeannine is familiar with this, we saw that a lot of other states are doing criteria around compounds and so I also talked to Carl about putting it on the agenda for the next time, proposing some criteria around compounds. A lot of states have proposed a dollar amount and a lot of them said 500 dollars and they are working their way down because of the abuse that they see. So, I would like to bring some information around that next time. I was surprised. I wouldn't really think of it. I would like to see access open for things like that where it's difficult for recipients to be able to

get a drug that they need and they have to mix things to make that work for them, but unfortunately there is a lot of abuse around it. Once we started researching it, it was very easy to find a lot of information around it. The second topic for that I would like to bring to the agenda is Botox. When we were looking for something else, unfortunately we came across over-utilization and problems around Botox. We need to look at specifically what the diagnoses are getting for that and then also like to talk about that next time.

Paul Oesterman, Chair: Does it require a prior auth?

Holly Long: No, does it? .

Carl Jeffery: I thought we had some criteria for the Botox.

Holly Long: I believe it's in policy that it's not supposed to be prescribed for cosmetic reasons but I don't know exactly what the edit is so…

Carl Jeffery: I don't think we have any criteria on it now. I know we discussed this in the past and we've decided to not put any criteria on it.

Jim Marx: How would Botox be a pharmacy benefit? Usually Botox is given as a buy and bill type situation.

Carl Jeffery: We still see a lot of claims that the pharmacy fills for it which gets into the doctor's office.

Holly Long: Most of what I saw so far, and I just started diving into this, was around migraines and incontinence is used. There is criteria around it in another chapter so part of what I would do is look at what they had in the chapter that exists around Medicaid and try to outline with pharmacy so that it can be consistent across the board.
Paul Oesterman, Chair: We have cough syrups…

Holly Long: And, under 18.

Carl Jeffery: I have all our notes.

Paul Oesterman, Chair: With that being said, anybody have any last-minute public comment? Hearing none, we are scheduled for our next meeting when?

Carl Jeffery: July 26.

Paul Oesterman, Chair: July 26, same time, same place.

Carl Jeffery: Yeah.

Ryan Bitton: I would just like to say thank you to everybody for having us at the table. I felt it was collaborative and I really appreciated the graciousness of it.

Paul Oesterman, Chair: We appreciate your input. It's a good marriage.

Ryan Bitton: Yes.

a. Adjournment.

Paul Oesterman, Chair: With that being said, we will adjourn the meeting. I thank everybody, especially those in the audience who chose to be here.

Meeting adjourned at 7:30 PM

Prior Authorization Guideline

Guideline Name Daklinza (daclatasvir)

1 . Indications

Drug Name: Daklinza (daclatasvir) **<u>Indications</u>** **Chronic Hepatitis C (CHC)** Indicated for use with sofosbuvir, with or without ribavirin, for the treatment of patients with chronic hepatitis C virus (HCV) genotype 1 or genotype 3 infection. Limitations of Use: Sustained virologic response (SVR12) rates are reduced in HCV genotype 3-infected patients with cirrhosis receiving Daklinza in combination with sofosbuvir for 12 weeks.

2 . Criteria

Product Name: Daklinza

Diagnosis	Chronic Hepatitis C - Genotype 1
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Used in combination with Sovaldi (sofosbuvir)

AND

3 One of the following:

3.1 Patient is without decompensated cirrhosis and is not a liver transplant recipient

OR

3.2 Both of the following:

3.2.1 Patient has decompensated cirrhosis and/or is a liver transplant recipient

AND

3.2.2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient has not failed a prior HCV NS5A-containing regimen (e.g., Daklinza)

Product Name: Daklinza

Diagnosis	Chronic Hepatitis C - Genotype 3
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 3

AND

2 Used in combination with Sovaldi (sofosbuvir)

AND

3 One of the following:

3.1 Patient is without cirrhosis and is not a liver transplant recipient

OR

3.2 Both of the following:

3.2.1 Patient has cirrhosis (compensated or decompensated) and/or is a liver transplant recipient

AND

3.2.2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient has not failed a prior HCV NS5A-containing regimen (e.g., Daklinza)

Guideline Name Epclusa (sofosbuvir/velpatasvir)

1 . Indications

Drug Name: Epclusa (sofosbuvir and velpatasvir)

Indications

Hepatitis C Indicated for the treatment of adult patients with chronic hepatitis C virus (HCV) genotype 1, 2, 3, 4, 5 or 6 infection without cirrhosis or without compensated cirrhosis, and with decompensated cirrhosis for use in combination with ribavirin.

2 . Criteria

Product Name: Epclusa

Diagnosis	Chronic Hepatitis C (without decompensation) - Genotype 1, 2, 3, 4, 5, or 6
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5, or 6

AND

2 Patient is not receiving Epclusa (sofosbuvir/velpatasvir) in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

3 Both of the following:

- Patient does not have decompensated liver disease
- Epclusa is used alone

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist

Product Name: Epclusa

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6 - Patients with Decompensated Liver Disease - Epclusa plus ribavirin
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5, or 6

AND

2 Patient is not receiving Epclusa (sofosbuvir/velpatasvir) in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

3 Both of the following:

- Patient has decompensated liver disease
- Epclusa is used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist

Product Name: Epclusa

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6 - Patients with Decompensated Liver Disease - Ribavirin Intolerance/Ineligible OR Prior Sofosbuvir or NS5A-based Treatment Failure
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5, or 6

AND

2 Patient is not receiving Epclusa (sofosbuvir/velpatasvir) in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

3 Patient has decompensated liver disease

AND

4 One of the following:

4.1 Patient is ribavirin intolerant or ineligible

OR

4.2 Both of the following:

4.2.1 Prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based treatment

AND

4.2.2 Epclusa is used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist

Guideline Name Harvoni (ledipasvir/sofosbuvir)

1 . Indications

Drug Name: Harvoni

Indications

Chronic Hepatitis C Indicated for the treatment of adult and pediatric patients 12 years of age and older or weighing at least 35 kg with chronic hepatitis C virus (HCV) genotype 1, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis. Indicated in combination with ribavirin for adults with genotype 1 HCV infection with decompensated cirrhosis, or for adults with genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or with compensated cirrhosis.

2 . Criteria

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1 - Treatment Naive without Cirrhosis - Pre-Treatment HCV RNA less than 6 Million IU/mL
Approval Length	8 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Patient is without cirrhosis

AND

3 Patient is treatment-naive

AND

4 Submission of medical records documenting pre-treatment HCV RNA less than 6 million IU/mL

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1 - Treatment Naive without Cirrhosis - Pre-Treatment HCV RNA greater than or equal to 6 Million IU/mL
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Patient is without cirrhosis

AND

3 Patient is treatment-naive

AND

4 Submission of medical records documenting pre-treatment HCV RNA greater than or equal to 6 million IU/mL

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1 - Treatment Naive with Compensated Cirrhosis
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has cirrhosis

AND

3 Patient is treatment-naive

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1 - Treatment Experienced without Cirrhosis
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Patient is without cirrhosis

AND

3 One of the following:

3.1 Patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor (e.g., Incivek [telaprevir],

Olysio [simeprevir], Victrelis [boceprevir]) plus peginterferon plus ribavirin

OR

3.2 Both of the following:

3.2.1 Patient has experienced treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) (except in combination with Olysio [simeprevir])

AND

3.2.2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1 - Ribavirin Eligible - Treatment Experienced with Compensated Cirrhosis
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has cirrhosis

AND

3 Patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor (e.g., Incivek [telaprevir], Olysio [simeprevir], Victrelis [boceprevir]) plus peginterferon plus ribavirin

AND

4 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

AND

7 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1 - Ribavirin Ineligible - Treatment Experienced with Compensated Cirrhosis
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has cirrhosis

AND

3 Patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor (e.g., Incivek [telaprevir], Olysio [simeprevir], Victrelis [boceprevir]) plus peginterferon plus ribavirin

AND

4 Patient is ribavirin ineligible

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

AND

7 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1, 4, 5, or 6 – Decompensated Cirrhosis OR Post-Liver Transplant
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C virus (HCV) genotype 1, 4, 5, or 6

AND

2 One of the following:

2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has decompensated cirrhosis (e.g., Child-Pugh Class B or C)

OR

2.2 Both of the following:

2.2.1 Patient is a liver transplant recipient

AND

2.2.2 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

3 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 1, 4, 5, or 6 – Decompensated Cirrhosis; Ribavirin Ineligible OR Prior Failure of a Sovaldi- or NS5A-based Regimen
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C virus (HCV) genotype 1, 4, 5, or 6

AND

2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has decompensated cirrhosis (e.g., Child-Pugh Class B or C)

AND

3 One of the following:

3.1 Patient is ribavirin ineligible

OR

3.2 Both of the following:

3.2.1 Patient has experienced treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) or an NS5A inhibitor (e.g., Daklinza [daclatasvir])

AND

3.2.2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 4; Treatment-Naïve or Treatment-Experienced (peginterferon plus ribavirin)
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 4

AND

2 One of the following:

2.1 Patient is treatment-naive

OR

2.2 One of the following:

2.2.1 Patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin and is without cirrhosis

OR

2.2.2 Both of the following:

2.2.2.1 Patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin and has compensated cirrhosis (Child-Pugh Class A)

AND

2.2.2.2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Product Name: Harvoni

Diagnosis	Chronic Hepatitis C - Genotype 5 or 6; Treatment-Naïve or Treatment-Experienced (peginterferon plus ribavirin)
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 5 or 6

AND

2 One of the following:

2.1 Patient is treatment-naive

OR

2.2 Patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])

Guideline Name Mavyret (glecaprevir/pibrentasvir)

1 . Indications

Drug Name: Mavyret (glecaprevir/pibrentasvir)

Indications

Chronic Hepatitis C (CHC) Indicated for the treatment of adult patients with chronic hepatitis C virus (HCV) genotype 1, 2, 3, 4, 5 or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A). Indicated for the treatment of adult patients with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor (PI), but not both.

2 . Criteria

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6; Treatment-Naïve; without Cirrhosis
Approval Length	8 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6

AND

2 Patient is treatment-naive

AND

3 Patient is without cirrhosis

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6; Treatment-Naïve; with Compensated Cirrhosis
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6

AND

2 Patient is treatment-naive

AND

3 Patient has compensated cirrhosis (Child-Pugh Class A)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 1; Treatment-Experienced (Prior failure to an NS3/4A Protease Inhibitor); without Decompensated Cirrhosis
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Patient has experienced failure with a previous treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]

AND

3 Patient has had no previous treatment experience with a treatment regimen that included an NS5A inhibitor (e.g., Daklinza [daclatasvir])

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 1; Treatment-Experienced (Prior failure to an NS5A Inhibitor); without Decompensated Cirrhosis
Approval Length	16 Week

Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Patient has experienced failure with a previous treatment regimen that included an NS5A inhibitor (e.g., Daklinza [daclatasvir])

AND

3 Patient has had no previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 3; Treatment-Experienced (Interferon- or Sovaldi-based Regimen); without Decompensated Cirrhosis
Approval Length	16 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 3

AND

2 Patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)

AND

3 Patient has had no previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 4, 5, or 6; Treatment-Experienced (Interferon- or Sovaldi-based Regimen); without Cirrhosis
Approval Length	8 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1, 2, 4, 5, or 6

AND

2 Patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)

AND

3 Patient has had no previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])

AND

4 Patient is without cirrhosis

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Mavyret (glecaprevir/pibrentasvir)

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 4, 5, or 6; Treatment-Experienced (Interferon- or Sovaldi-based Regimen); with Compensated Cirrhosis
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1, 2, 4, 5, or 6

AND

2 Patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)

AND

3 Patient has had no previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])

AND

4 Patient has compensated cirrhosis (e.g., Child-Pugh Class A)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Guideline Name Olysio (simeprevir)

1 . Indications

Drug Name: Olysio (simeprevir)

Indications

Chronic Hepatitis C Indicated for the treatment of chronic hepatitis C virus (HCV) genotype 1 or 4 infection as a component of a combination antiviral treatment regimen. Limitations of use: - Efficacy of Olysio in combination with peginterferon alfa (Peg-IFN-alfa) and ribavirin (RBV) is substantially reduced in patients infected with HCV genotype 1a with an NS3 Q80K polymorphism at baseline compared to patients infected with hepatitis C virus (HCV) genotype 1a without the Q80K polymorphism. - Olysio is not recommended in patients who have previously failed therapy with a treatment regimen that included Olysio or other HCV protease inhibitors.

2 . Criteria

Product Name: Olysio (simeprevir)

Diagnosis	Chronic Hepatitis C - Genotype 1 or 4 – Olysio + Alfa Interferons + Ribavirin Treatment Regimen
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following:

1.1 Both of the following:

- Diagnosis of chronic hepatitis C genotype 1a infection
- Patient does not have the NS3 Q80K polymorphism

OR

1.2 Diagnosis of chronic hepatitis C genotype 1b infection

OR

1.3 Diagnosis of chronic hepatitis C genotype 4 infection

AND

2 Patient has not experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]

AND

3 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

4 Used in combination with peginterferon alfa and ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

Product Name: Olysio (simeprevir)

Diagnosis	Chronic Hepatitis C - Genotype 1 - without Cirrhosis – Olysio + Sovaldi Treatment Regimen
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Patient is without cirrhosis

AND

3 Used in combination with Sovaldi (sofosbuvir)

AND

4 Patient has not experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

Product Name: Olysio (simeprevir)

Diagnosis	Chronic Hepatitis C - Genotype 1 - with Cirrhosis – Olysio + Sovaldi Treatment Regimen
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has cirrhosis

AND

3 Used in combination with Sovaldi (sofosbuvir)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

6 Patient has not experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]

Guideline Name Sovaldi (sofosbuvir)

1 . Indications

Drug Name: Sovaldi (sofosbuvir)

Indications

Chronic Hepatitis C (CHC) Indicated for the treatment of genotype 1, 2, 3 or 4 chronic hepatitis C virus (HCV) infection as a component of a combination antiviral treatment regimen Indicated for use in combination with ribavirin for the treatment of pediatric patients 12 years of age and older or weighing at least 35 kg without cirrhosis or with compensated cirrhosis with genotype 2 or 3 HCV infection.

2 . Criteria

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C (without decompensation) - Genotype 1 or 4 - Sovaldi Plus Peginterferon Plus Ribavirin
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 1 or 4

2 Used in combination with peginterferon alfa and ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist

- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

5 Patient has not experienced failure with a previous treatment regimen that includes Sovaldi

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C (without decompensation) - Genotype 3 - Sovaldi Plus Ribavirin
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

1.1 All of the following:

1.1.1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 3 infection

AND

1.1.2 Patient is 18 years of age or older

OR

1.2 Both of the following:

1.2.1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C virus (HCV) genotype 3

AND

1.2.2 One of the following:

1.2.2.1 Patient is 12 to 17 years of age

OR

1.2.2.2 Both of the following:

- Patient weighs at least 35 kg
- Patient is less than 12 years of age

AND

2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

5 Patient has not experienced failure with a previous treatment regimen that includes Sovaldi

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C (without decompensation) - Genotype 2 - Sovaldi Plus Ribavirin
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 One of the following:

1.1 All of the following:

1.1.1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 2 infection

AND

1.1.2 Patient is 18 years of age or older

OR

1.2 Both of the following:

1.2.1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 2 infection

AND

1.2.2 One of the following:

1.2.2.1 Patient is 12 to 17 years of age

OR

1.2.2.2 Both of the following:

- Patient weights at least 35 kg
- Patient is less than 12 years of age

AND

2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

5 Patient has not experienced failure with a previous treatment regimen that includes Sovaldi

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C (without decompensation) - Genotype 1 - without Cirrhosis - Sovaldi plus Olysio Therapy
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Used in combination with Olysio (simeprevir)

AND

3 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

4 Patient is without cirrhosis

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

7 Patient has not experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C (without decompensation) - Genotype 1 - with Cirrhosis - Sovaldi plus Olysio Therapy
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Used in combination with Olysio (simeprevir)

AND

3 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

4 Patient has cirrhosis

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

7 Patient has not experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C - Genotype 1 - Sovaldi plus Daklinza Therapy
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Used in combination with Daklinza (daclatasvir)

AND

3 One of the following:

3.1 Patient is without decompensated cirrhosis and is not a liver transplant recipient

OR

3.2 Both of the following:

3.2.1 Patient has decompensated cirrhosis and/or is a liver transplant recipient

AND

3.2.2 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient has not failed a prior HCV NS5A-containing regimen (e.g., Daklinza)

Product Name: Sovaldi

Diagnosis	Chronic Hepatitis C - Genotype 3 - Sovaldi plus Daklinza Therapy
Approval Length	12 Week

Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes or laboratory values) documenting diagnosis of chronic hepatitis C genotype 3

AND

2 Used in combination with Daklinza (daclatasvir)

AND

3 One of the following:

3.1 Patient is without cirrhosis and is not a liver transplant recipient

OR

3.2 Both of the following:

3.2.1 Patient has cirrhosis (compensated or decompensated) and/or is a liver transplant recipient

AND

3.2.2 Used in combination with ribavirin

AND

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

- Hepatologist

- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient has not failed a prior HCV NS5A-containing regimen (e.g., Daklinza)

Guideline Name Technivie (ombitasvir, paritaprevir and ritonavir)

1 . Indications

Drug Name: Technivie (ombitasvir, paritaprevir and ritonavir)

Indications

Chronic Hepatitis C (CHC) Indicated in combination with ribavirin for the treatment of patients with genotype 4 chronic hepatitis C virus infection without cirrhosis or with compensated cirrhosis.

2 . Criteria

Product Name: Technivie

Diagnosis	Chronic Hepatitis C - Genotype 4
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 4

AND

2 One of the following:

2.1 Patient is without cirrhosis

OR

2.2 Patient has compensated cirrhosis

AND

3 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Technivie in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

6 Patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh B or C)

Guideline Name Viekira (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)

1 . Indications

Drug Name: Viekira Pak, Viekira XR (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)

Indications

Chronic Hepatitis C Indicated for the treatment of adult patients with chronic hepatitis C virus (HCV): a) genotype 1b without cirrhosis or with compensated cirrhosis, and b) genotype 1a without cirrhosis or with compensated cirrhosis for use in combination with ribavirin.

2 . Criteria

Product Name: Viekira Pak, Viekira XR

Diagnosis	Chronic Hepatitis C - Genotype 1a or Mixed Genotype 1 Infection – without Cirrhosis AND without Liver Transplant
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1a or mixed genotype 1 infection

AND

2 Patient is without cirrhosis

AND

3 Used in combination with ribavirin

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient has not experienced failure with a previous treatment regimen that includes a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (Daklinza [daclatasvir])

AND

7 Patient is not receiving Viekira in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]

Product Name: Viekira Pak, Viekira XR

Diagnosis	Chronic Hepatitis C - Genotype 1a or Mixed Genotype 1 Infection – with Cirrhosis AND without Liver Transplant
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1a or mixed genotype 1 infection

AND

2 Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has cirrhosis

AND

3 Used in combination with ribavirin

AND

4 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the Academy of HIV Medicine

AND

6 Patient has not experienced failure with a previous treatment regimen that includes a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (Daklinza [daclatasvir])

AND

7 Patient is not receiving Viekira in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]

Product Name: Viekira Pak, Viekira XR

Diagnosis	Chronic Hepatitis C - Genotype 1b - without Liver Transplant
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1b

AND

2 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist Certified through the Academy of HIV Medicine

AND

4 Patient has not experienced failure with a previous treatment regimen that includes a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (Daklinza [daclatasvir])

AND

5 Patient is not receiving Viekira in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]

Product Name: Viekira Pak, Viekira XR

Diagnosis	Chronic hepatitis C - Genotype 1 (Regardless of Subgenotype) – Liver Transplant Recipient
Approval Length	24 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1

AND

2 Documentation that the patient is a liver transplant recipient

AND

3 Submission of medical records (e.g., chart notes or laboratory values) documenting normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)

AND

4 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient has not experienced failure with a previous treatment regimen that includes a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (Daklinza [daclatasvir])

AND

7 Patient is not receiving Viekira in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]

Guideline Name Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

1 . Indications

Drug Name: Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

Indications

Chronic Hepatitis C (CHC) Indicated for the treatment of adult patients with chronic hepatitis C virus (HCV) infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have: • Genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor. • Genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor. (Additional benefit of Vosevi over Epclusa [sofosbuvir/velpatasvir] was not shown in adults with genotype 1b, 2, 4, 5, or 6 infection previously treated with sofosbuvir without an NS5A inhibitor.)

2 . Criteria

Product Name: Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

Diagnosis	Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6; without Decompensated Cirrhosis; Prior Relapser to NS5A-Based Regimen
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6

AND

2 Patient is a previous relapser to an NS5A-based regimen (e.g., Daklinza [daclatasvir]; Epclusa [sofosbuvir/velpatasvir]; Harvoni [ledipasvir/sofosbuvir]; Mavyret [glecaprevir/pibrentasvir]; Technivie [ombitasvir/paritaprevir/ritonavir]; Viekira [ombitasvir/paritaprevir/ritonavir & dasabuvir]; Zepatier [elbasvir/grazoprevir])

AND

3 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

Diagnosis	Chronic Hepatitis C - Genotype 1a; without Decompensated Cirrhosis; Prior Relapser to Sofosbuvir-Based Regimen without an NS5A Inhibitor
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1a

AND

2 Patient is a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor

AND

3 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name: Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

Diagnosis	Chronic Hepatitis C - Genotype 3; without Decompensated Cirrhosis; Prior Relapser to Sofosbuvir-Based Regimen without an NS5A Inhibitor
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 3

AND

2 Patient is a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor

AND

3 Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Guideline Name Zepatier (elbasvir/grazoprevir)

1 . Indications

Drug Name: Zepatier (elbasvir/grazoprevir)

Indications

Chronic Hepatitis C Indicated with or without ribavirin for the treatment of chronic hepatitis C virus (HCV) genotypes 1 or 4 infection in adults.

2 . Criteria

Product Name: Zepatier

Diagnosis	Chronic Hepatitis C - Genotype 1a: treatment-naïve or PegIFN/RBV-experienced or PegIFN/RBV/protease inhibitor-experienced WITHOUT baseline NS5A polymorphisms*
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1a

AND

2 One of the following:

2.1 Patient is treatment-naive

OR

2.2 Patient has prior failure to peginterferon alfa plus ribavirin treatment

OR

2.3 Both of the following:

- Patient has prior failure to treatment with peginterferon alfa plus ribavirin plus a HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)
- Used in combination with ribavirin

AND

3 Both of the following: [1, A]

3.1 Patient has been tested for the presence of NS5A resistance-associated polymorphisms

AND

3.2 Patient is without baseline NS5A resistance-associated polymorphisms (i.e., polymorphisms at amino acid positions 28, 30, 31, or 93)

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

6 Patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C)

Notes	**NS5A resistance-associated polymorphisms at amino acid positions 28, 30, 31, or 93.

Product Name: Zepatier

Diagnosis	Chronic Hepatitis C - Genotype 1a: treatment-naïve or PegIFN/RBV-experienced or PegIFN/RBV/protease inhibitor-experienced WITH baseline NS5A polymorphisms*
Approval Length	16 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1a

AND

2 One of the following:

- Patient is treatment-naive
- Patient has prior failure to peginterferon alfa plus ribavirin treatment
- Patient has prior failure to treatment with peginterferon alfa plus ribavirin plus a HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)

AND

3 Both of the following: [1, A]

3.1 Patient has been tested for the presence of NS5A resistance-associated polymorphisms

AND

3.2 Patient has baseline NS5A resistance-associated polymorphisms (i.e., polymorphisms at amino acid positions 28, 30, 31, or 93)

AND

4 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

6 Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

7 Patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C)

Notes	*NS5A resistance-associated polymorphisms at amino acid positions 28, 30, 31, or 93.

Product Name: Zepatier

Diagnosis	Chronic Hepatitis C - Genotype 1b: treatment-naïve or PegIFN/RBV-experienced or PegIFN/RBV/protease inhibitor-experienced
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1b

AND

2 One of the following:

2.1 Patient is treatment-naive

OR

2.2 Patient has prior failure to peginterferon alfa plus ribavirin treatment

OR

2.3 Both of the following:

- Patient has prior failure to treatment with peginterferon alfa plus ribavirin plus a HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)
- Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist

- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

5 Patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C)

Product Name: Zepatier

Diagnosis	Chronic Hepatitis C - Genotype 4: Treatment-naive
Approval Length	12 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of genotype 4

AND

2 Patient is treatment-naive

AND

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

- Hepatologist
- Gastroenterologist

- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

4 Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

5 Patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C)

Product Name: Zepatier

Diagnosis	Chronic Hepatitis C - Genotype 4: PegIFN/RBV-experienced
Approval Length	16 Week
Guideline Type	Prior Authorization

Approval Criteria

1 Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of genotype 4

AND

2 Patient has prior failure to peginterferon alfa plus ribavirin treatment

AND

3 Used in combination with ribavirin

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist
- HIV specialist certified through the American Academy of HIV Medicine

AND

5 Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]

AND

6 Patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C)

Mavyret
(glecaprevir/pibrentasvir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Cirrhosis status, or Transplant status.

*****IN, SC, WA Medicaid – Hepatitis C benefits are carved out***
******Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York; For all other markets, please see market specific criteria.***

Medication	Quantity Limit
Mavyret (glecaprevir/pibrentasvir)	3 tablets per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected)	Associated Treatment Regimens	Total Approval Duration for Mavyret (glecaprevir/pibrentasvir)
Genotypes 1, 2, 3, 4, 5, or 6 (treatment-naïve, without cirrhosis)	Mavyret	8 weeks
Genotypes 1, 2, 3, 4, 5, or 6 (treatment-naïve, with compensated cirrhosis)	Mavyret	12 weeks
Genotype 1 (treatment-experienced with an NS5A[2a] inhibitor and without prior treatment with an NS3/4A[2c] protease inhibitor, with compensated cirrhosis or without cirrhosis)	Mavyret	16 weeks
Genotype 1 (treatment-experienced with an NS3/4A[2c] protease inhibitor or sofosbuvir and without prior treatment with an NS5A[2a] inhibitor, with compensated cirrhosis or without cirrhosis)	Mavyret	12 weeks
Genotype 2 (treatment-experienced with sofosbuvir + ribavirin, with compensated cirrhosis or without cirrhosis)	Mavyret	12 weeks
Genotype 3 (dual P/R[2b] treatment-experienced with compensated cirrhosis or without cirrhosis)	Mavyret	16 weeks
Genotypes 1, 2, 4, 5, or 6 (dual P/R[2b] treatment-experienced without cirrhosis)	Mavyret	8 weeks
Genotypes 1, 2, 4, 5, and 6 (dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Mavyret	12 weeks

Genotypes 1, 2, 3, 4, 5, or 6 (treatment-naïve or treatment-experienced, post-liver allograft transplant recipient, with compensated cirrhosis or without cirrhosis)	Mavyret	12 weeks
Genotypes 1, 2, 3, 4, 5, or 6 (treatment-naïve or treatment-experienced, post-kidney transplant recipient, with compensated cirrhosis or without cirrhosis)	Mavyret	12 weeks

APPROVAL CRITERIA

Requests for Mavyret (glecaprevir/pibrentasvir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has compensated[1] liver disease (with or without cirrhosis);

AND

VI. Individual is using in **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):
   A. As monotherapy for **one** of the following:
      1. Individual is treatment-naïve, with compensated[1] cirrhosis or without cirrhosis, and Genotypes 1, 2, 3, 4, 5, or 6;

      OR

      2. Individual is treatment-experienced with a prior HCV NS5A[2a] inhibitor regimen without prior HCV treatment with an NS3/4A[2c] protease inhibitor with compensated[1] cirrhosis or without cirrhosis, and Genotype 1;

      OR

      3. Individual is treatment-experienced with a prior HCV NS3/4A[2c] protease inhibitor regimen without prior HCV treatment with an NS5A[2a] inhibitor, with compensated[1] cirrhosis or without cirrhosis, and Genotype 1;

      OR

      4. Individual is dual P/R[2b] treatment-experienced without prior HCV treatment with an HCV NS3/4A[2c] protease inhibitor, sofosbuvir-based regimen or NS5A[2a] inhibitor, with compensated[1] cirrhosis or without cirrhosis, and Genotypes 1, 2, 3, 4, 5, or 6;

OR

5. Individual is treatment-experienced with a sofosbuvir-containing regimen without an NS5A[2b] inhibitor, with compensated[1] cirrhosis or without cirrhosis, and Genotypes 1 or 2;

OR

6. Individual is a post-liver allograft transplant recipient with or without compensated[1] cirrhosis, and Genotypes 1, 2, 3, 4, 5, or 6 (AASLD/IDSA 2017);

OR

7. Individual is a post-kidney transplant recipient, with or without compensated[1] cirrhosis, and Genotypes 1, 2, 3, 4, 5, or 6 (AASLD/IDSA 2017).

Mavyret (glecaprevir/pibrentasvir) may **not** be approved for the following:

I. Individual has decompensated[1] cirrhosis; **OR**
II. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to ritonavir-containing antiretroviral regimens, efavirenz, etravirine, darunavir/cobicistat, atazanavir, carbamazepine, St John's wort, ethinyl estradiol-containing medications, atorvastatin, lovastatin, simvastatin, and rifampin; **OR**
III. Individual is using in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such as dasabuvir) or nucleotide NS5B polymerase inhibitor (such as sofosbuvir); **OR**
IV. Individual is using in combination with a regimen containing another NS5A[2a] inhibitor; **OR**
V. Individual is using in combination with a regimen containing another NS3/4A[2c] protease inhibitor; **OR**
VI. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of elbasvir/grazoprevir, ombitasvir/paritaprevir/ritonavir and dasabuvir, ombitasvir/paritaprevir/ritonavir, or sofosbuvir/velpatasvir/voxilaprevir.

Notes:

1. **Compensated Liver Disease:**
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
   a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
   b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
   c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
   d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
   e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should

be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

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PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist’s Letter/Prescriber’s Letter. April 2016.

Vosevi
(sofosbuvir/velpatasvir/voxilaprevir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Cirrhosis status or Polymorphism status.

***** IN, SC, WA Medicaid – Hepatitis C benefits are Carved Out***
******Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid only; For all other markets, please refer to market specific criteria.***

Medication	Quantity Limit
Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	1 tablet per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected)	Associated Treatment Regimens	Total Approval Duration for Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
Genotype 1 (NS5A[2a] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Vosevi	12 weeks
Genotype 1a (previous sofosbuvir-containing regimen without an NS5A[2a], with compensated cirrhosis or without cirrhosis)	Vosevi	12 weeks
Genotype 3 (DAA[2e] treatment-experienced, without cirrhosis)	Vosevi	12 weeks
Genotype 3 (non-NS5A[2a] treatment-experienced, with compensated cirrhosis)	Vosevi	12 weeks
Genotype 3 (NS5A[2a] treatment-experienced, with compensated cirrhosis)	Vosevi + RBV	12 weeks
Genotype 3 (dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Vosevi	12 weeks
Genotype 3 (treatment naïve with compensated cirrhosis or dual P/R[2b] treatment-experienced without cirrhosis, with Y93H polymorphism)	Vosevi	12 weeks
Genotypes 4, 5, or 6 (DAA[2e] treatment experienced with compensated cirrhosis or without cirrhosis)	Vosevi	12 weeks

APPROVAL CRITERIA

Requests for Vosevi (sofosbuvir/velpatasvir/voxilaprevir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has compensated[1] liver disease (with or without cirrhosis);

AND

VI. Individual is using in **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):
A. As monotherapy for **one** of the following:
1. Individual is NS5A[2a] treatment-experienced with compensated[1] cirrhosis or without cirrhosis, and Genotype 1;

OR

2. Individual is treatment experienced with a sofosbuvir-containing regimen without an NS5A[2b] inhibitor, with compensated[1] cirrhosis or without cirrhosis, and Genotype 1a; **AND**
3. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with Vosevi; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Vosevi; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens; **OR**
    d. Individual failed to achieve a sustained viral response (SVR) or relapsed after achieving a SVR during a prior successfully completed Hepatitis C regimen containing an NS5A[2a] inhibitor;

OR

4. Individual is direct acting antiviral (DAA)[2e] treatment-experienced without cirrhosis, and Genotype 3;

OR

5. Individual is non-NS5A[2a] treatment-experienced with compensated[1] cirrhosis, and Genotype 3;

OR

6. Individual is dual P/R[2b] treatment-experienced, with compensated[1] cirrhosis, and Genotype 3;

OR

7. Individual is treatment-naïve, with compensated[1] cirrhosis or dual P/R[2b] treatment-experienced without cirrhosis, polymorphism present at the Y93H amino acid position, and Genotype 3;

OR

8. Individual is DAA[2e] treatment-experienced with compensated[1] cirrhosis or without cirrhosis, and Genotype 4, 5 or 6;

OR

B. In combination with ribavirin for the following:

1. Individual is NS5A[2a] treatment-experienced, with compensated[1] cirrhosis and Genotype 3.

Vosevi (sofosbuvir/velpatasvir/voxilaprevir) may **not** be approved for the following:

I. Individual has severe or end-stage CKD[3]or requires dialysis; **OR**
II. Individual has decompensated[1] cirrhosis; **OR**
III. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: amiodarone, atazanavir- or lopinavir containing regimens, tipranavir/ritonavir, efavirenz, etravirine, nevirapine, rosuvastatin, and pitavastatin, cyclosporine, poly glycoprotein (P-gp) inducers and moderate or strong cytochrome (CYP) 3A4 inducers (such as but not limited to, phenytoin, St. John's Wort, phenobarbital, rifampin, rifabutin, rifapentine, carbamazepine, oxcarbazepine), or Breast Cancer Resistance Protein (BCRP) substrates (such as but not limited to, methotrexate, mitoxantrone, imatinib, irinotecan, lapatinib, sulfasalazine, topotecan); **OR**
IV. Individual is using in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such as dasabuvir) or another nucleotide NS5B polymerase inhibitor; **OR**
V. Individual is using in combination with a regimen containing another NS5A[2a] inhibitor; **OR**
VI. Individual is using in combination with a regimen containing another NS3/4A[2c] protease inhibitor.

Notes:

1. **Compensated Liver Disease:**
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.
   Moderate to Severe (Decompensated) Liver Disease:

The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
    a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
    b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
    c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
    d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
    e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should

be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria.
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

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DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed on: January 25, 2018.

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U.S. Department of Health and Human Services AIDSinfo treatment guidelines. Concomitant use of selected antiretroviral drugs and hepatitis C virus direct-acting antiviral drugs for treatment of HCV in adults with HIV. Available at https://aidsinfo.nih.gov/guidelines/htmltables/1/5536. Accessed on: December 27, 2017.

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PL Detail-Document, Cytochrome P450 Drug Interactions. Pharmacist's Letter/Prescriber's Letter. May 2016.

PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Epclusa (sofosbuvir/velpatasvir)

Overrides	Approval Duration
Quantity Limit Prior Authorization	Based on Genotype, Treatment status, Cirrhosis status, Polymorphism status, or Ribavirin Eligibility status

*****IN, SC, WA Medicaid - Hepatitis C benefits are carved out***
******Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid; For all other markets, please see specific criteria.***

Medication	Quantity Limit
Epclusa (sofosbuvir/velpatasvir) 400 mg/100 mg	1 tablet per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration of Epclusa
Genotypes 1, 2, 4, 5, or 6 (treatment- naïve, dual P/R[2b] treatment-experienced, or triple[2d] treatment-experienced with compensated cirrhosis or without cirrhosis)	Epclusa	12 weeks
Genotype 1b (previous sofosbuvir containing regimen without an NS5A[2a], with compensated cirrhosis or without cirrhosis)	Epclusa	12 weeks
Genotype 2 (sofosbuvir plus ribavirin treatment-experienced, with compensated cirrhosis or without cirrhosis)	Epclusa	12 weeks
Genotype 3 (treatment-naïve, with compensated cirrhosis or without cirrhosis, no Y93H polymorphism)	Epclusa	12 weeks
Genotype 3 (dual P/R[2b] treatment-experienced, without cirrhosis, no Y93H polymorphism)	Epclusa	12 weeks
Genotype 3 (dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Epclusa + RBV	12 weeks
Genotypes 1, 2, 3, 4, 5 or 6 (treatment-naïve or treatment-experienced without sofosbuvir or NS5A[2a], with decompensated cirrhosis)	Epclusa + RBV	12 weeks

Genotypes 1, 2, 3, 4, 5 or 6 (treatment-naïve or treatment-experienced without sofosbuvir or NS5A[2a], with decompensated cirrhosis, ineligible for ribavirin)	Epclusa	24 weeks
Genotypes 1, 2, 3, 4, 5 or 6 (treatment-experienced with sofosbuvir or NS5A[2a], with decompensated cirrhosis)	Epclusa + RBV	24 weeks
Genotypes 2 or 3 (post-liver allograft transplant recipient, with compensated or decompensated cirrhosis)	Epclusa + RBV	12 weeks

APPROVAL CRITERIA

Requests for Epclusa (sofosbuvir/velpatasvir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a], which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has compensated[1] liver disease (with or without cirrhosis) or decompensated[1] liver disease;

AND

VI. Individual is using in **one** of the following antiviral treatment regimens (AASLD/IDSA 2017) :
    A. As monotherapy for **one** of the following:
        1. Individual is treatment-naïve or dual P/R[2b] treatment- experienced, or triple[2d] treatment-experienced with compensated[1] cirrhosis or without cirrhosis, and Genotypes 1, 2, 4, 5, or 6; **AND**

           For Genotype 1, 2, 5, 6:
        2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
            a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
            b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Epclusa; **OR**
            c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimens;

OR

3. Individual is treatment experienced with a sofosbuvir-containing regimen without an NS5A[2b] inhibitor with compensated[1] cirrhosis or without cirrhosis, and Genotype 1b;
   OR
4. Individual is sofosbuvir plus ribavirin treatment-experienced with compensated[1] cirrhosis or without cirrhosis, and Genotype 2
   OR
5. Individual is treatment-naïve with compensated[1] cirrhosis or without cirrhosis, no Y93H polymorphism, and Genotype 3; **AND**
6. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
   a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
   b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Epclusa; **OR**
   c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimens;

OR

7. Individual is dual P/R[2b] treatment-experienced without cirrhosis, no polymorphism present at Y93H amino acid position, and Genotype 3;

OR

8. Individual is treatment-naïve, dual P/R[2b] treatment-experienced, or triple treatment-experienced with decompensated[1] cirrhosis, ribavirin ineligible, and Genotypes 1, 2, 3, 4, 5 or 6;

OR

B. In combination with ribavirin for one of the following:
   1. Individual is dual P/R[2b] treatment-experienced, with compensated[1] cirrhosis, and Genotype 3; **OR**
   2. Individual is treatment-naïve, dual P/R[2b] treatment- experienced, or triple[2d] treatment-experienced with decompensated[1] cirrhosis, and Genotypes 1, 2, 3, 4, 5 or 6; **OR**
   3. Individual is sofosbuvir or NS5A2a treatment-experienced with decompensated[1] cirrhosis, and Genotypes 1, 2, 3, 4, 5, or 6; **OR**
   4. Individual is a post-liver allograft transplant recipient, with decompensated[1] cirrhosis, and Genotypes 2 or 3;

   OR

   5. Individual is a post-liver allograft transplant recipient, with compensated[1] cirrhosis, and Genotypes 2 or 3; **AND**
   6. Individual has had a prior trial (medication samples/coupons/discount

cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**

a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Epclusa; **OR**
c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimens.

Epclusa (sofosbuvir/velpatasvir) may **not** be approved for the following:

I. Individual has severe or end stage CKD[3] or requires dialysis; **OR**
II. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St John's Wort, tipranavir/ritonavir, topotecan, efavirenz, etravirine, nevirapine, or lumacaftor; **OR**
III. Individual is using in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such as dasabuvir) or another nucleotide NS5B polymerase inhibitor; **OR**
IV. Individual is using in combination with another regimen containing a NS5A[2a] inhibitor; **OR**
V. Individual is using in combination with a regimen containing a NS3/4A[2c] protease inhibitor; **OR**
VI. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of sofosbuvir/velpatasvir/voxilaprevir.

Notes:

[a]Per label, Epclusa (sofosbuvir/velpatasvir) may be used in individuals who are co-infected with HIV-1. The AASLD/IDSA treatment guidance recommends that concurrent use with tenofovir disoproxil fumarate (TDF) should be avoided with an eGFR below 60 mL/min.

1. **Compensated Liver Disease**:
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication)	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
    a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
    b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
    c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
    d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
    e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
Severe CKD (Stage 4): eGFR 15-29 mL/min
End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic

failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria.
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

Centers for Disease Control and Prevention. Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. *MMWR*. 2013; 62(18):362-365. Available from: https://www.cdc.gov/mmwr/pdf/wk/mm6218.pdf. Accessed on: December 27, 2017.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed on: January 25, 2018.

European Association for the Study of the Liver. EASL Recommendations on Treatment of Hepatitis C 2016. *J Hepatol*. 2017; 66(1):153-194. Available from: http://www.journal-of-hepatology.eu/article/S0168-8278(16)30489-5/pdf. Accessed on: December 27, 2017.

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DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2018; Updated periodically.

PL Detail-Document, Cytochrome P450 Drug Interactions. Pharmacist's Letter/Prescriber's Letter. May 2016.

PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Harvoni (sofosbuvir/ledipasvir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Baseline HCV RNA status, Cirrhosis status, Transplant status, or Ribavirin Eligibility status

*****IN, SC, WA Medicaid – Hepatitis C benefits are carved out***
******Criteria is applicable to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid only; For all other markets, please see market specific criteria.***

Medication	Quantity Limit
Harvoni (sofosbuvir/ledipasvir	1 tablet per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration of Harvoni
Genotype 1 (treatment-naïve, baseline HCV RNA level of less than 6 million IU/mL, without cirrhosis)	Harvoni	8 or 12 [Δ] weeks
Genotype 1 (treatment-naïve, baseline HCV RNA level of greater than or equal to 6 million IU/mL, without cirrhosis)	Harvoni	12 weeks
Genotype 1 (treatment-naïve, with compensated cirrhosis)	Harvoni	12 weeks
Genotype 1 (dual P/R[2b] or triple[2d] treatment-experienced, without cirrhosis)	Harvoni	12 weeks
Genotype 1 (dual P/R[2b] or triple[2d] treatment-experienced with compensated cirrhosis)	Harvoni + RBV	12 weeks
Genotype 1 [treatment-experienced with sofosbuvir (non-simeprevir-containing) regimen, without cirrhosis]	Harvoni + RBV	12 weeks
Genotype 4 (treatment-naïve, with compensated cirrhosis or without cirrhosis)	Harvoni	12 weeks
Genotype 4 (dual P/R[2b] without cirrhosis)	Harvoni	12 weeks
Genotype 4 (dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Harvoni + RBV	12 weeks
Genotype 1,4, 5 or 6 (treatment-naïve or treatment-experienced, post-liver allograft transplant, with compensated or decompensated cirrhosis or without cirrhosis)	Harvoni + RBV	12 weeks

Genotypes 1 or 4 (treatment-naïve or treatment-experienced, post-kidney transplant recipient, with compensated cirrhosis or without cirrhosis)	Harvoni	12 weeks
Genotype 1, 4, 5 or 6 (treatment naïve, or treatment-experienced, without sofosbuvir or NS5A[2a] with decompensated cirrhosis)	Harvoni + RBV	12 weeks
Genotype 1, 4, 5 or 6 (treatment-naïve or treatment-experienced without sofosbuvir or NS5A2a, ribavirin ineligible, with decompensated cirrhosis)	Harvoni	24 weeks
Genotype 1, 4, 5 or 6 (treatment-experienced with sofosbuvir-containing regimen, with decompensated cirrhosis)	Harvoni + RBV	24 weeks
Genotype 5 or 6 (treatment-naïve, or dual P/R[2b] treatment-experienced with compensated cirrhosis or without cirrhosis)	Harvoni	12 weeks
Adolescent[†], Genotype 1 (treatment-naïve, with compensated cirrhosis or without cirrhosis)	Harvoni	12 weeks
Adolescent[†], Genotype 1 (dual P/R[2b] treatment-experienced, without cirrhosis)	Harvoni	12 weeks
Adolescent[†], Genotype 1 (dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Harvoni	24 weeks
Adolescent[†], Genotypes 4, 5, or 6 (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Harvoni	12 weeks

[Δ]The September 2017 AASLD/IDSA treatment guidance recommends a 12 week course of therapy for certain subpopulations, such as individuals co-infected with HCV/HIV and African American individuals.
[†] The September 2017 AASLD/IDSA treatment guidance defines treatment-eligible adolescents as 12-17 years old or weighing at least 35 kg.

APPROVAL CRITERIA

Requests for Harvoni (ledipasvir/sofosbuvir) may be approved if the following criteria are met:

I. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a], which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**;
II. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
III. If an 8 week treatment duration is requested, a copy of the baseline quantitative hepatitis C virus (HCV) RNA test result is provided to document baseline level of viremia; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**

V. Individual has compensated[1] liver disease (with or without cirrhosis) or decompensated[1] liver disease;

AND

VI. Individual is using in **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):

A. Individual is 18 years of age or older; **AND**

B. As monotherapy for **one** of the following:

1. Individual is treatment-naïve with compensated[1] cirrhosis or without cirrhosis and Genotype 1;
   OR
2. Individual is dual P/R[2b] or triple[2d] treatment-experienced without cirrhosis and Genotype1;

AND

3. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
   a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
   b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Harvoni;
      OR
   c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

4. Individual is treatment-naïve, compensated[1] cirrhosis or without cirrhosis and Genotype 4;
   OR
5. Individual is dual P/R[2b] treatment-experienced without cirrhosis and Genotype 4;

AND

6. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to either Epclusa OR Mavyret; **OR**
   a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
   b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Epclusa OR Mavyret which is not also in Harvoni; **OR**
   c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

7. Individual is treatment-naïve, or dual P/R[2b] treatment-experienced with compensated[1] cirrhosis or without cirrhosis and with Genotypes 5 or 6;

AND

8. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Harvoni; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

9. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, ribavirin ineligible, with decompensated[1] cirrhosis and Genotypes 1, 5 or 6;

OR

10. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, ribavirin ineligible, with decompensated[1] cirrhosis and Genotype 4;

AND

11. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response Epclusa; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Epclusa which is not also in Harvoni; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

12. Individual is a post-kidney transplant recipient, with compensated[1] cirrhosis or without cirrhosis, and Genotypes 1 or 4;

AND

13. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Harvoni; **OR**
    c. Individual is concurrently using an agent that cannot be substituted

with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

14. Individual is 12 to 17 years of age (or less than 12 years of age and at least 35 kg) with compensated[1] cirrhosis or without cirrhosis, Genotypes 1, 4, 5, or 6, and using as monotherapy;

OR

C. Individual is 18 years of age or older;

AND

D. In combination with ribavirin for **one** of the following:

1. Individual is P/R[2b] treatment-experienced with compensated[1] cirrhosis, and Genotype 1;
   OR
2. Individual is triple[2d] treatment-experienced with compensated[1] cirrhosis, and Genotype 1;
   OR
3. Individual is sofosbuvir (non simeprevir-containing) treatment-experienced without cirrhosis and Genotype 1 (AASLD/IDSA 2017);

AND

4. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
   a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
   b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Harvoni; **OR**
   c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

5. Individual is dual P/R[2b] treatment-experienced, with compensated[1] cirrhosis, and Genotype 4; **AND**
6. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to either Epclusa OR Mavyret; **OR**
   a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
   b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Epclusa OR Mavyret which is not also in Harvoni; **OR**
   c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

7. Individual is treatment-naïve, or treatment-experienced with decompensated[1] cirrhosis and Genotype 1, 5 or 6;

OR

8. Individual is treatment-naïve, or treatment-experienced with decompensated[1] cirrhosis and Genotype 4; **AND**
9. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Epclusa; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Epclusa which is not also in Harvoni; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

10. Individual is a post-liver allograft transplant recipient, with compensated[1] cirrhosis, and Genotypes 1, 4, 5 or 6;

OR

11. Individual is a post-liver allograft transplant recipient, without cirrhosis and Genotypes 1, 4, 5 or 6; **AND**
12. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Harvoni; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

13. Individual is a post-liver allograft transplant recipient, decompensated[1] cirrhosis, and Genotypes 1, 4, 5 or 6.

Harvoni (ledipasvir/sofosbuvir) may not be approved for the following:

I. Individual has severe or end-stage CKD[3] or requires dialysis; **OR**
II. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, , elvitegravir/cobicistat/emtricitabine/tenofovir DF,

tipranavir/ritonavir, rosuvastatin or p-gp inducers (such as but not limited to rifabutin, rifampin, rifapentine, St John's Wort); **OR**

III. Individual is using in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such as dasabuvir) or another nucleotide NS5B polymerase inhibitor (such as sofosbuvir); **OR**

IV. Individual is using in combination with a regimen containing another NS5A[2a]; **OR**

V. Individual is using in combination with a regimen containing NS3/4A[2c] protease inhibitor; **OR**

VI. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS5A[2a] inhibitor.

Notes:

a. Per label, Harvoni (ledipasvir/sofosbuvir) may be used in individuals who are co-infected with HIV-1. The AASLD/IDSA treatment guidance recommends that concurrent use with tenofovir disoproxil fumarate (TDF) should be avoided with an eGFR below 60 mL/min.

1. **Compensated Liver Disease**:
   According to the American Association for the Study of Liver Diseases (AASLD 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2016)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication)	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2009, 2016)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)

Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
    a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
    b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
    c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
    d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
    e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	**Metavir**
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria.
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

Centers for Disease Control and Prevention. Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. *MMWR*. 2013; 62(18):362-365. Available from: https://www.cdc.gov/mmwr/pdf/wk/mm6218.pdf. Accessed on: December 27, 2017.

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PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Zepatier (elbasvir/grazoprevir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Cirrhosis status, NS5A Resistant-associated Polymorphism status, or Prior Virologic Response status

***** IN, SC, WA Medicaid – Hepatitis C benefits are carved out***
*****Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid; For all other markets, please see market specific criteria.***

Medications	Quantity Limit
Zepatier (elbasvir/grazoprevir)	1 tablet per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimen	Total Approval Duration of Zepatier
Genotype 1b (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Zepatier	12 weeks
Genotype 1b (triple[2d] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Zepatier + RBV	12 weeks
Genotype 1a (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis, or without cirrhosis without baseline NS5A resistant-associated polymorphism)	Zepatier	12 weeks
Genotype 1a (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis, with baseline NS5A resistant-associated polymorphism)	Zepatier + RBV	16 weeks
Genotype 1a (triple[2d] treatment-experienced, with compensated cirrhosis or without cirrhosis, without baseline NS5A resistant-associated polymorphism)	Zepatier + RBV	12 weeks

Genotype 1a (triple[2d] treatment-experienced, with compensated cirrhosis or without cirrhosis, with baseline NS5A resistant-associated polymorphism)	Zepatier + RBV	16 weeks
Genotype 3 (dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Zepatier + Sovaldi	12 weeks
Genotype 4 (treatment-naïve, with compensated cirrhosis or without cirrhosis)	Zepatier	12 weeks
Genotype 4 (dual P/R[2b] treatment-experienced with virologic relapse, with compensated cirrhosis or without cirrhosis)	Zepatier	12 weeks
Genotype 4 (dual P/R[2b] treatment-experienced with on- treatment virologic failure[†], with compensated cirrhosis or without cirrhosis)	Zepatier + RBV	16 weeks

[†]The September 2017 AASLD/IDSA treatment guidance defines on-treatment virologic failure as experiencing failure to suppress or breakthrough during treatment.

APPROVAL CRITERIA

Requests for Zepatier (elbasvir/grazoprevir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a], which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has compensated[1] liver disease (with or without cirrhosis); **AND**
VI. If Genotype 1a subtype is present, a copy of the baseline NS5A resistant-associated polymorphism test result is provided;

AND

VII. Individual is using in **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):
    A. As monotherapy for **one** of the following:
        1. Individual is treatment-naïve or dual P/R[2b] treatment-experienced, with compensated[1] cirrhosis or without cirrhosis, and Genotype 1b or Genotype 1a

without a baseline NS5A resistant-associated polymorphism at amino acid positions M28, Q30, L31, and/or Y93; **AND**

2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with Zepatier; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Zepatier; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

3. Individual is treatment-naïve, with compensated[1] cirrhosis or without cirrhosis, and Genotype 4; **OR**
4. Individual is a dual P/R[2b] treatment-experienced virologic relapser, with compensated[1] cirrhosis or without cirrhosis, and Genotype 4;

AND

5. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Epclusa OR Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with Zepatier; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Epclusa OR Mavyret which is not also in Zepatier; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

B. In combination with ribavirin for **one** of the following:
    1. Individual is treatment-naïve, dual P/R[2b], or triple[2d] treatment-experienced, with compensated[1] cirrhosis or without cirrhosis, and Genotype 1a with a baseline NS5A resistant-associated polymorphism at amino acid positions M28, Q30, L31, and/or Y93; **OR**
    2. Individual is triple[2d]treatment-experienced, with compensated[1] cirrhosis or without cirrhosis, and Genotype 1b or 1a without a baseline NS5A resistant-associated polymorphism at amino acid positions M28, Q30, L31, and/or Y93;

    AND

    3. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**

a. Individual is currently on and completing a course of therapy with Zepatier; **OR**
b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Zepatier; **OR**
c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

4. Individual is a dual P/R[2b]treatment-experienced with prior on-treatment virologic failure, with compensated[1] cirrhosis or without cirrhosis, and Genotype 4; **AND**
5. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Epclusa OR Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with Zepatier; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Epclusa OR Mavyret which is not also in Zepatier; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

C. In combination with sofosbuvir for dual P/R[2b] treatment-experienced individuals, with compensated cirrhosis[1], and Genotype 3.

Zepatier (elbasvir/grazoprevir) may not be approved for the following:

I. Individual has decompensated[1] cirrhosis; **OR**
II. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: strong cytochrome (CYP) 3A4 inducers (such as but not limited to, efavirenz, phenytoin, phenobarbital, carbamazepine, St John's Wort, rifampin, rifabutin, rifapentine), organic anion transporting peptide (OATP) 1B1/1B3 inhibitors (such as but not limited to, atazanavir, darunavir, lopinavir, saquinavir, tipranavir, cyclosporine, eltrombopag, gemfibrozil, ritonavir-containing regimens), cobicistat-containing regimens, nevirapine, nafcillin, etravirine, modafinil, bosentan, oral ketoconazole; **OR**
III. Individual is using in combination with a regiment containing another NS3/4A[2c] protease inhibitor; **OR**
IV. Individual is using in combination with a regimen containing another NS5A[2a] inhibitor; **OR**
V. Individual is using in combination with a regimen containing a NS5B polymerase inhibitor other than sofosbuvir (such as dasabuvir); **OR**

VI. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS5B polymerase inhibitor (such as dasabuvir or sofosbuvir) or an NS5A[2a] inhibitor.

Notes:

[a]Per label, Zepatier (grazoprevir/elbasvir) may be used in individuals who are co-infected with human immunodeficiency virus-1 (HIV-1).

1. **Compensated Liver Disease**:
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication)	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
    a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
    b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
    c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
    d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
    e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria

New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

Centers for Disease Control and Prevention. Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. *MMWR*. 2013; 62(18):362-365. Available from: https://www.cdc.gov/mmwr/pdf/wk/mm6218.pdf. Accessed on: December 27, 2017.

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PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Daklinza (daclatasvir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Cirrhosis status, Transplant status, or Ribavirin Eligibility

*****IN, SC, WA Medicaid - Hepatitis C benefits are carved out***
*****Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid; For all other markets, please see market specific criteria.***

Medication	Quantity Limit
Daklinza (daclatasvir)	1 tablet per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration for Daklinza
Genotype 1 (treatment-naïve or dual P/R[2b] treatment-experienced, without cirrhosis)	Daklinza + Sovaldi	12 weeks
Genotype 2 (treatment-naïve or dual P/R[2b] treatment-experienced, without cirrhosis	Daklinza + Sovaldi	12 weeks
Genotype 2 (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Daklinza + Sovaldi	16 or 24 weeks
Genotype 3 (treatment-naïve or -dual P/R[2b] treatment-experienced, without cirrhosis)	Daklinza + Sovaldi	12 weeks
Genotype 3 (treatment-naïve, with compensated cirrhosis)	Daklinza + Sovaldi ± RBV	24 weeks
Genotypes 1, 2, 3, 4, 5 or 6 (treatment-naïve or -experienced, post-liver allograft transplant, with compensated cirrhosis or without cirrhosis)	Daklinza + Sovaldi + RBV	12 weeks
Genotypes 2 or 3 (treatment-naïve or -experienced, post-liver allograft transplant, with decompensated cirrhosis)	Daklinza + Sovaldi + RBV	12 weeks
Genotypes 1, 2, 3, or 4 (treatment-naïve or -experienced without sofosbuvir or NS5A[2a] with decompensated cirrhosis)	Daklinza + Sovaldi + RBV	12 weeks

Genotypes 1, 2, 3, or 4 (treatment-naïve or -experienced without sofosbuvir or NS5A[2a], ribavirin ineligible, with decompensated cirrhosis)	Daklinza + Sovaldi	24 weeks
Genotypes 2, 3, 5 or 6 (treatment-naïve or -experienced, post-kidney transplant, with compensated cirrhosis or without cirrhosis)	Daklinza + Sovaldi + RBV	12 weeks

APPROVAL CRITERIA

Requests for Daklinza (daclatasvir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has compensated[1] liver disease (with or without cirrhosis) or decompensated[1] liver disease;

AND

VI. Individual is using with **one** of the following antiviral treatment regimens (AASLD/IDSA 2017) :
    A. Individual is using in combination with Sovaldi (sofosbuvir) for **one** of the following:
        1. Individual is treatment-naïve or dual P/R[2b] treatment-experienced without cirrhosis, Genotype 1; **AND**
        2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
            a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
            b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Daklinza or Sovaldi; **OR**
            c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

        OR
        3. Individual is treatment-naïve or dual P/R[2b] treatment-experienced with compensated[1] cirrhosis or without cirrhosis, and Genotype 2;
        OR
        4. Individual is treatment-naïve, without cirrhosis and Genotype 3;
        AND
        5. Individual has had a prior trial and inadequate response to Mavyret; **OR**

a. Individual is currently on and completing a course of therapy with requested regimen; **OR**
b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Daklinza or Sovaldi; **OR**
c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen; **OR**
d. Individual is a post-allograft transplant recipient;

OR

6. Individual is dual P/R[2b] treatment-experienced, without cirrhosis and Genotype 3;

OR

7. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, ribavirin ineligible, with decompensated[1] cirrhosis and Genotypes 1, 2, or 3

OR

8. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, ribavirin ineligible, with decompensated[1] cirrhosis and Genotype 4; **AND**
9. Individual has had a prior trial and inadequate response to Epclusa; **OR**
    a. Individual is currently on and completing a course of therapy with requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Epclusa which is not also in Daklinza or Sovaldi; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen;

OR

B. In combination with Sovaldi (sofosbuvir) with or without ribavirin for the following:
    1. Individual is treatment-naïve, with compensated[1] cirrhosis, and Genotype 3; **AND**
    2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
        a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
        b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Daklinza or Sovaldi; **OR**
        c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

C. In combination with Sovaldi (sofosbuvir) and ribavirin for **one** of the following:
    10. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, with decompensated[1] cirrhosis, Genotypes 1, 2, or 3 ;

OR

11. Individual is treatment-naïve, or dual treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, with decompensated[1] cirrhosis, Genotype 4; **AND**
12. Individual has had a prior trial and inadequate response to Epclusa; **OR**

a. Individual is currently on and completing a course of therapy with requested regimen; **OR**
b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Epclusa which is not also in Daklinza or Sovaldi; **OR**
c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen;

OR

13. Individual is a post-liver allograft transplant recipient with compensated[1] cirrhosis and Genotypes 1, 4, 5 or 6;

OR

14. Individual is a post-liver allograft transplant recipient without cirrhosis and Genotypes 1, 4, 5 or 6; **AND**
15. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Daklinza or Sovaldi; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

16. Individual is a post-liver allograft transplant recipient without cirrhosis, and Genotypes 2 or 3; **AND**
17. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**

a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Daklinza or Sovaldi; **OR**
c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

18. Individual is a post-liver allograft transplant recipient with compensated[1] cirrhosis, and Genotypes 2 or 3; **OR**
19. Individual is a post-liver allograft transplant recipient with decompensated[1] cirrhosis, and Genotypes 2 or 3;

OR

20. Individual is a post-kidney transplant recipient, with compensated[1] cirrhosis or without cirrhosis, and Genotypes 2, 3, 5, or 6; **AND**

21. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Daklinza or Sovaldi; **OR**
c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens.

Daklinza (daclatasvir) may **not** be approved for the following:

I. Individual is using with sofosbuvir and has severe or end-stage CKD[3] or requires dialysis; **OR**
II. Individual is using sofosbuvir and a known NS5A polymorphism is present; **OR**
III. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: amiodarone (when used in combination with sofosbuvir) or strong cytochrome (CYP) 3A inducers (such as but not limited to, carbamazepine, phenytoin, rifampin, or St John's Wort); **OR**
IV. Individual is using with sofosbuvir and requesting in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such dasabuvir) or another nucleotide NS5B polymerase inhibitor (such as sofosbuvir); **OR**
V. Individual is using with sofosbuvir and requesting in combination with a regimen containing another NS5A[2a]; **OR**
VI. Individual is using with sofosbuvir and requesting in combination with a regimen containing a NS3/4A[2c] protease inhibitor; **OR**
VII. Individual is requesting the regimen for re-treatment in combination with sofosbuvir and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of an NS5A[2a] inhibitor.

Notes:

[a]Per label, use in combination with Sovaldi (sofosbuvir) for individuals co-infected with HIV-1 is included with dosing to follow same recommendations as mono-infected individuals. The Daklinza label provides dose adjustment recommendations when concomitantly used with select HIV antiviral agents.

1. **Compensated Liver Disease**: According to the American Association for the Study of Liver Diseases (AASLD/IDSA 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive

definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

Moderate to Severe (Decompensated) Liver Disease:
The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication)	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
   a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
   b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
   c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
   d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
   e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min
4. Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria.
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

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DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed on: January 25, 2018.

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U.S. Food & Drug Administration. Drugs@FDA: FDA Approved Drug Products (Package inserts). Available from: http://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Accessed on: January 25, 2018.

U.S. Department of Health and Human Services AIDSinfo treatment guidelines. Concomitant use of selected antiretroviral drugs and hepatitis C virus direct-acting antiviral drugs for treatment of HCV in adults with HIV. Available at https://aidsinfo.nih.gov/guidelines/htmltables/1/5536. Accessed on: December 27, 2017.

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PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016

Ombitasvir+paritaprevir+ritonavir + dasabuvir Agents

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, or Cirrhosis status

IN, SC, WA Medicaid – Hepatitis C benefits are Carved Out
****Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid only; For all other markets, please refer to market specific criteria.***

Medication	Quantity Limit
Viekira Pak (ombitasvir + paritaprevir + ritonavir + dasabuvir)	4 tablets per day
Viekira XR (ombitasvir + paritaprevir + ritonavir + dasabuvir)	3 tablets per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration of ombitasvir + paritaprevir + ritonavir + dasabuvir agents (Viekira Pak, Viekira XR)
Genotype 1b (treatment naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Viekira Pak Viekira XR	12 weeks
Genotype 1a, unknown Genotype 1 subtype, or mixed Genotype 1 subtypes (treatment naïve or dual P/R[2b] treatment-experienced, without cirrhosis)	Viekira Pak+ ribavirin Viekira XR + ribavirin	12 weeks

APPROVAL CRITERIA

Requests for ombitasvir + paritaprevir + ritonavir + dasabuvir (Viekira Pak, Viekira XR) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a], which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**

IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has Genotype 1 and compensated liver disease[1] (with or without cirrhosis);

AND
VI. Individual is using with **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):
   A. As monotherapy for individuals with Genotype 1b, treatment-naïve or dual P/R[2b] treatment-experienced, with compensated[1] cirrhosis or without cirrhosis; **AND**
   B. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
      1. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
      2. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Viekira Pak/Viekira XR; **OR**
      3. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

   OR
   C. In combination with ribavirin for the following:
      1. Individual with Genotype 1a or mixed/unknown Genotype1, treatment-naïve or dual P/R[2] treatment-experienced;
         AND
      2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
         a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
         b. Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Mavyret which is not also in Viekira Pak/Viekira XR; **OR**
         c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

Ombitasvir + paritaprevir + ritonavir + dasabuvir (Viekira Pak, Viekira XR) may **not** be approved for the following:

I. Individual has decompensated[1] cirrhosis; **OR**
II. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: Strong cytochrome (CYP) 2C8 inhibitors [such as but not limited to, gemfibrozil, ritonavir-boosted atazanavir], strong CYP 2C8 inducers (such as but not limited to, carbamazepine, phenobarbital, rifampin, rifabutin, rifapentine), moderate or strong CYP 3A4 inducers (such as but not limited to, phenytoin, St. Johns' Wort, efavirenz-based regimens, agents highly dependent on CYP3A clearance (substrates) [such as but not limited to, dronedarone, amiodarone, flecainide, propafenone, quinidine, ranolazine, lurasidone, cisapride, alfuzosin, colchicine, ergot derivatives, ethinyl estradiol-containing agents, lovastatin, simvastatin, pimozide, Revatio, triazolam, oral midazolam, darunavir, lopinavir/ritonavir, rilpivirine-based regimens, voriconazole,

salmeterol], atorvastatin, everolimus, sirolimus, tacrolimus, tipranavir/ritonavir, etravirine, nevirapine or cobicistat-containing regimens; **OR**

III. Individual is using in combination with a regimen containing another NS3/4A[2c] protease inhibitor; **OR**

IV. Individual is using in combination with a regimen containing another nucleotide NS5B polymerase inhibitor (such as sofosbuvir) or another non-nucleoside NS5B polymerase inhibitor (such as dasabuvir); **OR**

V. Individual is using in combination with a regimen containing another NS5A[2a] inhibitor; **OR**

VI. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS3/4A[2c] protease inhibitor, NS5A[2a] inhibitor, or NS5B polymerase inhibitor (such as sofosbuvir or dasabuvir).

Notes:

[a]Per label, ombitasvir/paritaprevir/ritonavir + dasabuvir agents (Viekira Pak, Viekira XR) may be used in individuals co-infected with HIV-1. Individuals co-infected with HCV/HIV-1 treated with Viekira Pak/Viekira XR should also be on a suppressive antiretroviral drug regimen to reduce the risk of HIV-1 protease inhibitor drug resistance.

1. **Compensated Liver Disease**:
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication)	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
    a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
    b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
    c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
    d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
    e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
Severe CKD (Stage 4): eGFR 15-29 mL/min
End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009)**:

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria.
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Maryland Medicaid	n/a	Maryland has state mandated criteria; please see Maryland State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

Centers for Disease Control and Prevention. Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. *MMWR*. 2013; 62(18):362-365. Available from: https://www.cdc.gov/mmwr/pdf/wk/mm6218.pdf. Accessed on: December 27, 2017.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed on: January 25, 2018.

European Association for the Study of the Liver. EASL Recommendations on Treatment of Hepatitis C 2016. *J Hepatol*. 2017; 66(1):153-194. Available from: http://www.journal-of-hepatology.eu/article/S0168-8278(16)30489-5/pdf. Accessed on: December 27, 2017.

U.S. Food & Drug Administration. Drugs@FDA: FDA Approved Drug Products (Package inserts). Available from: http://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Accessed on: January 25, 2018.

U.S. Department of Health and Human Services AIDSinfo treatment guidelines. Concomitant use of selected antiretroviral drugs and hepatitis C virus direct-acting antiviral drugs for treatment of HCV in adults with HIV. Available at https://aidsinfo.nih.gov/guidelines/htmltables/1/5536. Accessed on: December 27, 2017.

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Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2018; Updated periodically.

PL Detail-Document, Cytochrome P450 Drug Interactions. Pharmacist's Letter/Prescriber's Letter. May 2016.

PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Technivie (ombitasvir/paritaprevir/ritonavir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, or Cirrhosis status

***** IN, SC, WA Medicaid – Hepatitis C benefits are carved out***
******Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid; For all other markets, please see market specific criteria.***

Medication	Quantity Limit
Technivie (ombitasvir/paritaprevir/ritonavir)	2 tablets per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration for Technivie
Genotype 4 (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Technivie + RBV	12 weeks

APPROVAL CRITERIA

Requests for Technivie (ombitasvir/paritaprevir/ritonavir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a] which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has Genotype 4 and compensated[1] liver disease with or without cirrhosis;

AND
VI. Individual is using with the following antiviral treatment regimen(AASLD/IDSA 2017):
   A. In combination with ribavirin for treatment-naïve or dual P/R[2b] treatment-experienced individuals with compensated[1] cirrhosis or without cirrhosis; **AND**
   B. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of Epclusa OR Mavyret; **OR**
      1. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
      2. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Epclusa OR Mavyret which is not also in Technivie; **OR**

3. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens.

Technivie (ombitasvir/paritaprevir/ritonavir) may **not** be approved for the following:

I. Individual has decompensated[1] cirrhosis; **OR**
II. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: Moderate or strong cytochrome (CYP) 3A4 inducers, (such as but not limited to, phenytoin, St. John's Wort, efavirenz-based regimens, phenobarbital, rifampin, rifabutin, rifapentine, carbamazepine), or agents highly dependent on CYP3A clearance (substrates) [such as but not limited to, alfuzosin, colchicine, ranolazine, dronedarone, amiodarone, flecainide, propafenone, quinidine, ergot derivatives, ethinyl estradiol-containing agents, cisapride, lovastatin, simvastatin, lurasidone, pimozide, Revatio , triazolam, oral midazolam, atazanavir (with or without ritonavir), ritonavir-boosted darunavir, lopinavir/ritonavir, rilpivirine-based regimens, voriconazole, or salmeterol], atorvastatin, everolimus, sirolimus, tacrolimus, tipranavir/ritonavir, etravirine, or cobicistat-containing regimens; **OR**
III. Individual is using in combination with a regimen containing another NS3/4A[2c] protease inhibitor; **OR**
IV. Individual is using in combination with a regimen containing another NS5A[2a] inhibitor; **OR**
V. Individual is using in combination with a regimen containing a NS5B polymerase inhibitor (such as sofosbuvir or dasabuvir); **OR**
VI. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS3/4A[2c] protease inhibitor, NS5A[2a] inhibitor, or NS5B polymerase inhibitor (such as sofosbuvir or dasabuvir).

Notes:
[a] Per label, Technivie (ombitasvir/paritaprevir/ritonavir) may be used in individuals co-infected with HIV-1. Individuals co-infected with HCV/HIV-1 treated with Technivie should also be on a suppressive antiretroviral drug regimen to reduce the risk of HIV-1 protease inhibitor drug resistance.

1. **Compensated Liver Disease**:
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication)	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
   a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
   b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
   c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
   d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
   e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009)**:

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

Centers for Disease Control and Prevention. Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. *MMWR*. 2013; 62(18):362-365. Available from: https://www.cdc.gov/mmwr/pdf/wk/mm6218.pdf. Accessed on: December 27, 2017.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed on: January 25, 2018.

European Association for the Study of the Liver. EASL Recommendations on Treatment of Hepatitis C 2016. *J Hepatol*. 2017; 66(1):153-194. Available from: http://www.journal-of-hepatology.eu/article/S0168-8278(16)30489-5/pdf. Accessed on: December 27, 2017.

U.S. Food & Drug Administration. Drugs@FDA: FDA Approved Drug Products (Package inserts). Available from: http://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Accessed on: January 25, 2018.

U.S. Department of Health and Human Services AIDSinfo treatment guidelines. Concomitant use of selected antiretroviral drugs and hepatitis C virus direct-acting antiviral drugs for treatment of HCV in adults with HIV. Available at https://aidsinfo.nih.gov/guidelines/htmltables/1/5536. Accessed on: December 27, 2017.

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PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Olysio (simeprevir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Cirrhosis status, or Transplant status

*****IN, SC, WA Medicaid – Hepatitis C benefits are carved out***
******Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid Only; For all other markets, please see market specific criteria.***

Medication	Quantity Limit
Olysio (simeprevir)	1 capsule per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration for Olysio
Genotype 1(treatment-naïve or dual P/R[2b] treatment-experienced, without cirrhosis)	Olysio + Sovaldi	12 weeks
Genotype 1 or 4 (treatment-naïve or-experienced, post-liver allograft transplant, with compensated cirrhosis or without cirrhosis)	Olysio + Sovaldi ± RBV	12 weeks

APPROVAL CRITERIA

Requests for Olysio (simeprevir) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a], which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
III. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
IV. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
V. Individual has compensated[1] liver disease (with or without cirrhosis);

AND

VI. Individual is using with **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):
    A. In combination with Sovaldi (sofosbuvir) for the following:
        1. Individual is treatment-naïve or dual P/R[2b] treatment-experienced, without cirrhosis, and Genotype 1; **AND**
        2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
            a. Individual is currently on and completing a course of therapy with

requested regimen; **OR**

b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Olysio/Sovaldi; **OR**

c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with Mavyret;

OR

B. In combination with Sovaldi (sofosbuvir) with or without ribavirin for the following:

1. Individual is treatment-naïve or treatment-experienced, post-liver allograft transplant recipient without cirrhosis and Genotypes 1 or 4; **AND**
2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Olysio/Sovaldi; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with Mavyret;

OR

3. Individual is treatment-naïve or treatment-experienced, post-liver allograft transplant recipient with compensated[1] cirrhosis and Genotypes 1 or 4.

Olysio (simeprevir) may not be approved for the following:

I. Individual is using as monotherapy; **OR**
II. Individual has decompensated[1] cirrhosis; **OR**
III. Individual is using with sofosbuvir and has severe or end-stage CKD[3] or requires dialysis; **OR**
IV. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: amiodarone (when used in combination with sofosbuvir), carbamazepine, phenytoin, phenobarbital, oxcarbazepine, erythromycin, clarithromycin, telithromycin, systemic azole antifungals (such as but not limited to ketoconazole, fluconazole), rifabutin, rifampin, rifapentine, systemic dexamethasone, cisapride, St John's Wort, Milk Thistle, cobicistat-containing regimens, efavirenz, delavirdine, etravirine, nevirapine, ritonavir boosted or ritonavir-containing regimens, atazanavir, fosamprenavir, lopinavir, indinavir, nelfinavir, saquinavir, tipranavir, or cyclosporine; **OR**
V. Individual is using in combination with a regimen containing another NS3/4A[2c] protease inhibitor; **OR**
VI. Individual is using with sofosbuvir and requesting in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such as dasabuvir) or another nucleotide NS5B polymerase inhibitor (such as sofosbuvir); **OR**
VII. Individual is using in combination with a regimen containing a NS5A[2a] inhibitor; **OR**

VIII. Individual is requesting for re-treatment in combination with sofosbuvir and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS3/4A[2c] protease inhibitor, NS5B polymerase inhibitor (such as sofosbuvir or dasabuvir), or NS5A[2a] inhibitor; **OR**

IX. Individual is requesting for re-treatment in combination with sofosbuvir and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed triple[2d] therapy treatment regimen, unless requested following post-liver allograft transplant; **OR**

Notes:
[a]Per label and AASLD/IDSA treatment guidance, Olysio (simeprevir) may be used in individuals who are co-infected with HIV-1.

1. **Compensated Liver Disease:**
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. In fact, the AASLD guidelines refer to compensated liver disease as Grade A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2015)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2009, 2015)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
   a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
   b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin

c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
Severe CKD (Stage 4): eGFR 15-29 mL/min
End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

American Association for the Study of Liver Diseases and the Infectious Disease Society of America, in collaboration with the International Antiviral Society-USA. Recommendations for testing, managing and treating hepatitis C. Available at http://www.hcvguidelines.org/. Published on: January 29, 2014. Updated on: September 21, 2017. Accessed on: January 25, 2018.

Centers for Disease Control and Prevention. Testing for HCV Infection: An Update of Guidance for Clinicians and Laboratorians. *MMWR*. 2013; 62(18):362-365. Available from: https://www.cdc.gov/mmwr/pdf/wk/mm6218.pdf. Accessed on: December 27, 2017.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed on: January 25, 2018.

European Association for the Study of the Liver. EASL Recommendations on Treatment of Hepatitis C 2016. *J Hepatol*. 2017; 66(1):153-194. Available from: http://www.journal-of-hepatology.eu/article/S0168-8278(16)30489-5/pdf. Accessed on: December 27, 2017.

U.S. Food & Drug Administration. Drugs@FDA: FDA Approved Drug Products (Package inserts). Available from: http://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Accessed on: January 25, 2018.

U.S. Department of Health and Human Services AIDSinfo treatment guidelines. Concomitant use of selected antiretroviral drugs and hepatitis C virus direct-acting antiviral drugs for treatment of HCV in adults with HIV. Available at https://aidsinfo.nih.gov/guidelines/htmltables/1/5536. Accessed on: December 27, 2017.

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PL Detail-Document, OATP Drug Interactions. Pharmacist's Letter/Prescriber's Letter. March 2014.

PL Detail-Document, P-glycoprotein Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2016.

Sovaldi (sofosbuvir)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	Based on Genotype, Treatment status, Cirrhosis status, or Ribavirin Eligibility status

***** IN, SC, WA Medicaid - Hepatitis C benefits are carved out***
******Criteria applies to Florida Healthy Kids, Kentucky, Nevada and New York Medicaid; For all other markets, please see market specific criteria.***

Medication	Quantity Limit
Sovaldi (sofosbuvir)	1 tablet per day

APPROVAL DURATION

Genotype and Status (HCV mono-infected or HCV/HIV-1 co-infected[a])	Associated Treatment Regimens	Total Approval Duration for Sovaldi
Adolescent[†], Genotype 2 (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Sovaldi + RBV	12 weeks
Adolescent[†], Genotype 3 (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis or without cirrhosis)	Sovaldi + RBV	24 weeks
Genotype 1 (treatment-naïve or dual treatment-experienced[+], without cirrhosis)	Sovaldi + Olysio	12 weeks
Genotype 1 or 4 (treatment-naïve or -experienced, post-liver allograft transplant, with compensated cirrhosis or without cirrhosis)	Sovaldi + Olysio ± RBV	12 weeks
Genotype 1 (treatment-naïve or dual P/R[2b] treatment-experienced, without cirrhosis)	Sovaldi + Daklinza	12 weeks
Genotype 2 (treatment-naïve or dual P/R[2b]treatment-experienced, without cirrhosis)	Sovaldi + Daklinza	12 weeks
Genotype 2 (treatment-naïve or dual P/R[2b] treatment-experienced, with compensated cirrhosis)	Sovaldi + Daklinza	16 or 24 weeks
Genotype 3 (treatment-naive or dual P/R[2b] treatment-experienced, without cirrhosis)	Sovaldi + Daklinza	12 weeks
Genotype 3 (treatment-naïve, with compensated cirrhosis)	Sovaldi + Daklinza ± RBV	24 weeks
Genotypes 1, 2, 3, 4, 5, or 6 (treatment-naïve or -experienced, post-liver allograft transplant, with-compensated cirrhosis or without cirrhosis)	Sovaldi + Daklinza + RBV	12 weeks

Genotypes 2 or 3 (treatment-naïve or -experienced, post-liver allograft transplant, with decompensated cirrhosis)	Sovaldi + Daklinza + RBV	12 weeks
Genotypes 1, 2, 3, or 4 (treatment-naïve or -experienced without sofosbuvir or NS5A[2a], with decompensated cirrhosis)	Sovaldi + Daklinza + RBV	12 weeks
Genotypes 1, 2, 3, or 4 (treatment-naïve or -experienced without sofosbuvir or NS5A[2a], ribavirin ineligible, with decompensated cirrhosis)	Sovaldi + Daklinza	24 weeks
Genotypes 2, 3, 5, or 6 (treatment-naïve or -experienced, post-kidney transplant, with compensated cirrhosis or without cirrhosis)	Sovaldi + Daklinza + RBV	12 weeks
Genotype 3 (dual P/R[2b] treatment-experienced with compensated cirrhosis)	Sovaldi + Zepatier	12 weeks

†The September 2017 AASLD/IDSA treatment guidance defines treatment-eligible adolescents as 12-17 years old or weighing at least 35 kg.

APPROVAL CRITERIA

Requests for Sovaldi (sofosbuvir) may be approved if the following criteria are met:

I. Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection[a], which includes genotype, a reactive HCV antibody, and a subsequent positive HCV RNA result to confirm diagnosis (AASLD/IDSA 2017, CDC 2013); **AND**
II. Individual has received baseline evaluation for liver fibrosis to guide appropriate therapy; **AND**
III. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2017); **AND**
IV. Individual has compensated[1] liver disease (with or without cirrhosis) or decompensated[1] liver disease;

AND

V. Individual is using with **one** of the following antiviral treatment regimens (AASLD/IDSA 2017):
   A. In combination with ribavirin for the following:
      1. Individual is 12 to 17 years of age (or less than 12 years of age and at least 35 kg), with compensated cirrhosis or without cirrhosis, and Genotype 2 or 3;

   OR
   B. Individual is 18 years of age or older; **AND**
   C. In combination with Olysio (simeprevir) for the following:
      1. Individual is treatment-naïve or dual P/R[2b] treatment-experienced, without cirrhosis and Genotype 1; **AND**
      2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret ; **OR**
         a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
         b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Olysio; **OR**
         c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not

recommended for concomitant use with the preferred regimens;

OR

D. Individual is 18 years of age or older; **AND**
E. In combination with Olysio (simeprevir) with or without ribavirin for the following:
    1. Individual is treatment-naïve or treatment-experienced, post-liver allograft transplant recipient with compensated[1] cirrhosis, and Genotype 1;
    OR
    2. Individual is treatment-naïve or treatment-experienced, post-liver allograft transplant recipient with compensated[1] cirrhosis, and Genotype 4;

    OR
    3. Individual is treatment-naïve or treatment-experienced, post-liver allograft transplant recipient without cirrhosis, and Genotypes 1 or 4; **AND**
    4. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
        a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
        b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Olysio; **OR**
        c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimens;

OR

F. Individual is 18 years of age or older; **AND**
G. In combination with Daklinza (daclatasvir) for **one** of the following:
    1. Individual is treatment-naïve, dual P/R[2b] treatment-experienced without cirrhosis and Genotype 1; **AND**
    2. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
        a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
        b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Daklinza; **OR**
        c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimens;

    OR
    3. Individual is treatment-naïve or dual P/R[2b] treatment-experienced with compensated[1] cirrhosis or without cirrhosis, and Genotype 2; **AND**
    4. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
        a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
        b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Daklinza; **OR**

c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens; **OR**
d. Individual is a post-liver allograft transplant recipient;

OR

5. Individual is treatment-naïve without cirrhosis and Genotype 3; **AND**
6. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret ; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Daklinza; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens; **OR**
    d. Individual is a post-liver allograft transplant recipient;

OR

7. Individual is dual P/R[2b] treatment-experienced without cirrhosis and Genotype 3;

OR

8. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, ribavirin ineligible, with decompensated[1] cirrhosis and Genotypes 1, 2, or 3;

OR

9. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, ribavirin ineligible, with decompensated[1] cirrhosis and Genotype 4; **AND**
10. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Epclusa; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Epclusa which is not also in Sovaldi or Daklinza ; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

H. Individual is 18 years of age or older; **AND**
I. In combination with Daklinza (daclatasvir) with or without ribavirin for the following:
    1. Individual is treatment-naïve, with compensated[1] cirrhosis, and Genotype 3;

OR

J. Individual is 18 years of age or older; **AND**
K. In combination with Daklinza (daclatasvir) and ribavirin for **one** of the following:
    1. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, with decompensated[1] cirrhosis and Genotypes 1, 2, or 3;

OR

2. Individual is treatment-naïve or treatment-experienced without a sofosbuvir or NS5A[2a]-containing regimen, with decompensated[1] cirrhosis and Genotype 4; **AND**
3. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Epclusa; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Epclusa which is not also in Sovaldi or Daklinza; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

4. Individual is a post-liver allograft transplant recipient, with compensated[1] cirrhosis and Genotypes 1, 4, 5, or 6;

OR

5. Individual is a post-liver allograft transplant recipient, without cirrhosis and Genotypes 1, 4, 5, or 6; **AND**
6. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Daklinza; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

7. Individual is a post-liver allograft transplant recipient, without cirrhosis, and Genotypes 2 or 3; **AND**
8. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Daklinza; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

9. Individual is a post-liver allograft transplant recipient, with compensated[1] cirrhosis, and Genotypes 2 or 3;

OR

10. Individual is a post-liver allograft transplant recipient, with decompensated[1] cirrhosis, and Genotypes 2 or 3;

OR

11. Individual is a post-kidney transplant recipient, with compensated[1] cirrhosis or without cirrhosis, and Genotypes 2, 3, 5, or 6; **AND**
12. Individual has had a prior trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response to Mavyret; **OR**
    a. Individual is currently on and completing a course of therapy with the requested regimen; **OR**
    b. Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Mavyret which is not also in Sovaldi or Daklinza; **OR**
    c. Individual is concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens;

OR

H. Individual is 18 years of age or older; **AND**
I. In combination with Zepatier with or without ribavirin for the following:
    1. Individual is dual P/R[2b] treatment-experienced, with compensated[1] cirrhosis and Genotype 3.

Sovaldi (sofosbuvir) may **not** be approved for the following:

I. Individual has severe or end-stage CKD3 or requires dialysis; **OR**
II. Individual is using in combination with daclatasvir and a known NS5A polymorphism is present; **OR**
III. Individual is requesting in concurrent therapy with contraindicated or not recommended agents, such as but not limited to the following: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St John's Wort, tipranavir/ritonavir; **OR**
IV. Individual is using in combination with a regimen containing a non-nucleoside NS5B polymerase inhibitor (such as dasabuvir) or another nucleotide NS5B polymerase inhibitor (such as sofosbuvir); **OR**
V. Individual is using in combination with a regimen containing a NS3/4A[2c] protease inhibitor other than simeprevir or elbasvir/grazoprevir; **OR**
VI. Individual is using in combination with a regimen containing a NS5A[2a] inhibitor other than daclatasvir or elbasvir/grazoprevir; **OR**
VII. Individual is requesting for re-treatment in combination with simeprevir and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS3/4A[2c] protease inhibitor NS5B polymerase inhibitor (such as sofosbuvir or dasabuvir), or NS5A[2a] inhibitor; **OR**
VIII. Individual is requesting for re-treatment in combination with simeprevir and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed triple[2d] therapy treatment regimen, unless requested following a liver allograft transplant; **OR**

IX. Individual is requesting for re-treatment in combination with daclatasvir and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a NS5A[2a] inhibitor;

Notes:

[a]Per label Sovaldi (sofosbuvir) may be used in individuals co-infected with HIV-1

1. **Compensated Liver Disease:**
   According to the American Association for the Study of Liver Diseases (AASLD/IDSA 2017), the specific criteria for compensated liver disease include all of the following: a total bilirubin; serum albumin; prothrombin time/INR; presence of ascites; and presence of hepatic encephalopathy. However, these criteria do not establish a comprehensive definition of compensated liver disease. The AASLD guidance refers to compensated liver disease as Class A based on the Child Pugh-Turcotte (CPT) classification scoring system.

   Moderate to Severe (Decompensated) Liver Disease:
   The AASLD guidance refers to decompensated (moderate to severe) liver disease as Class B or C based on the Child-Pugh Turcotte (CPT) classification scoring system.

Child Pugh Classification (AASLD/IDSA 2017)

Parameters			
Points Assigned	1 point	2 points	3 points
Total Bilirubin (µmol/L)	<34	34-50	>50
Serum Albumin (g/L)	>35	28-35	<28
Prothrombin time/INR	<1.7	1.71-2.30	>2.30
Ascites	None	Mild	Moderate to Severe
Hepatic Encephalopathy	None	Grade I-II (or suppressed with medication	Grade III-IV (or refractory)

Child Pugh Score Interpretation (AASLD/IDSA 2017)

Class A	5-6 points	Well compensated liver disease
Class B	7-9 points	Significant functional compromise (moderate hepatic impairment)
Class C	10-15 points	Uncompensated liver disease (severe hepatic impairment)

2. Past Treatment Exposure Definitions (AASLD/IDSA 2017):
    a. NS5A Inhibitor: includes daclatasvir, ledipasvir, elbasvir, ombitasvir, pibrentasvir, or velpatasvir-containing regimens
    b. P/R: includes peginterferon (or non-pegylated interferon) ± ribavirin
    c. NS3/4A Protease Inhibitor: includes simeprevir, grazoprevir, paritaprevir, glecaprevir, and voxilaprevir-containing regimens
    d. Triple therapy: includes NS3 protease inhibitor (simeprevir, boceprevir or telaprevir) plus peginterferon and ribavirin
    e. Direct Acting Antiviral (DAA): includes NS5A inhibitors, NS3/4A protease inhibitors, and NS5B polymerase inhibitors (sofosbuvir, dasabuvir)

3. Chronic Kidney Disease (CKD) Definitions (AASLD/IDSA 2017):
   Severe CKD (Stage 4): eGFR 15-29 mL/min
   End-Stage CKD (Stage 5): eGFR < 15 mL/min

4. **Metavir Scoring Systems for Fibrosis Staging (AASLD 2009):**

Stage (F)	
0	No fibrosis
1	Periportal fibrotic expansion
2	Periportal septae 1 (septum)
3	Porto-central septae
4	Cirrhosis

5. Hepatitis C virus (HCV) direct acting antiviral (DAA) agents have a black box warning for risk of hepatitis B virus (HBV) reactivation in individuals with HCV-HBV co-infection. Individuals should be tested for evidence of current or prior HBV infection prior to initiation of DAA therapy. HBV reactivation has been reported in HCV/HBV co-infected individuals currently taking or previously completed DAA therapy and not concomitantly receiving HBV antiviral therapy. Some cases of HBV reactivation have led to fulminant hepatitis, hepatic failure, and death. Individuals should be monitored for hepatitis flare or HBV reactivation during and following HCV DAA therapy. Individuals should be appropriately managed for HBV infection as indicated.

State Specific Mandates		
State/Market	**Date**	**Description**
California Medicaid	07/2015	California has state mandated criteria; please see California specific document.
Georgia Medicaid	10/2016	Georgia has state mandated criteria; please see Georgia State Specific Criteria.
Louisiana Medicaid	2/1/2018	Louisiana has state criteria; please see Louisiana State Specific Criteria
Maryland Medicaid		Maryland has state mandated criteria; please see Maryland State Specific Criteria
New Jersey Medicaid	7/1/2016	New Jersey Medicaid has state mandated criteria for all Direct Acting Antiviral (DAA) agents for treatment of Hepatitis C. Please see New Jersey State Criteria
Virginia Medicaid	7/1/2016	Virginia has state mandated criteria; please see Virginia State Specific Criteria.
Washington D.C.	2/1/2018	Washington D. C. has state criteria; please see Washington D. C. State Specific Criteria

Key References:

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HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Clinical Pharmacy Program Guidelines for Hepatitis C Agents – Health Plan of Nevada Medicaid

Program	Prior Authorization
Medication	Daklinza® (daclatasvir), Epclusa (sofosbuvir/velpatasvir), Harvoni™ (ledipasvir/sofosbuvir), Mavyret™ (glecaprevir/pibrentasvir), Olysio® (simeprevir), Sovaldi® (sofosbuvir), Technivie™ (ombitasvir, paritaprevir, and ritonavir tablets), Viekira Pak™ (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets), Viekira XR™ (dasabuvir, ombitasvir, paritaprevir, and ritonavir extended-release tablets), Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir), Zepatier™ (elbasvir/grazoprevir)

1. Background:

Mavyret is indicated for the treatment of patients with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis and with compensated cirrhosis (Child-Pugh A). Mavyret is also indicated for the treatment of adult patients with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

Daklinza (daclatasvir) is a hepatitis C virus (HCV) NS5A inhibitor indicated for use with Sovaldi (sofosbuvir), with or without ribavirin, for the treatment of chronic HCV genotype 1 or 3 infection.

Epclusa is indicated for the treatment of adult patients with chronic HCV genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis and also adult patients with decompensated cirrhosis in combination with ribavirin.

Harvoni (ledipasvir/sofosbuvir) is indicated for the treatment of chronic hepatitis C (CHC) genotype 1, 4, 5, or 6 infection in adults and pediatric patients 12 years of age and older or weighing at least 35kg.

Olysio (simeprevir) is indicated for the treatment of chronic hepatitis C (CHC) genotype 1 or 4 infection as a component of a combination antiviral treatment regimen.

Sovaldi is a indicated for the treatment of adult patients with genotype 1, 2, 3, or 4 chronic HCV infection without cirrhosis or with compensated cirrhosis as a component of a combination antiviral treatment regimen and pediatric patients 12 years of age and older or weighing at least 35kg with genotype 2 or 3 chronic HCV without cirrhosis or with compensated cirrhosis in combination with ribavirin.

Technivie is indicated in combination with ribavirin for the treatment of patients with genotype 4 chronic HCV infection without cirrhosis or with compensated cirrhosis.

Viekira Pak and Viekira XR are indicated for the treatment of chronic HCV genotype 1a or 1b in patients without cirrhosis or with compensated cirrhosis.

Vosevi is indicated for the treatment of adult patients with chronic HCV infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor.

Zepatier is indicated for treatment of chronic HCV genotype 1 or 4 infection in adults. Zepatier is indicated for use with ribavirin in certain patient populations.

2. Coverage Criteria:

A. Chronic Hepatitis C

1. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection

-AND-

2. **One** of the following:

a. **All** of the following:

(1) The request is for Mavyret

-AND-

(2) The patient is without cirrhosis or has compensated cirrhosis (Child-Pugh A)

-AND-

(3) **One** of the following:

(a) **Both** of the following:

i. Patient is genotype 1, 2, 3, 4, 5, or 6

ii. Patient is treatment naïve

-OR-

(b) **All** of the following:

i. Patient is treatment-experienced

ii. Patient is genotype 1

iii. **One** of the following:

- Patient previously treated with an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor
- Patient previously treated with an NS3/4 protease inhibitor without prior treatment with an NS5A inhibitor

-OR-

(c) **All** of the following:

i. Patient is treatment-experienced

ii. Patient is genotype 1, 2, 3, 4, 5, or 6

iii. Patient not previously treated with an HCV NS3/4A protease inhibitor or NS5A inhibitor

-AND-

(4) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Mavyret for Treatment Naïve Patients

HCV Genotype	**Treatment Duration**	
	No cirrhosis	Compensated cirrhosis^ (Child-Pugh A)
1, 2, 3, 4, 5, or 6	8 weeks	12 weeks

Mavyret for Treatment Experienced Patients

		Treatment Duration

HCV Genotype	Patients previously treated with a regimen containing:	No cirrhosis	Compensated cirrhosis^ (Child-Pugh A)
1	An NS5A inhibitor[1] without prior treatment with an NS3/4A protease inhibitor	16 weeks	16 weeks
	An NS3/4A PI[2] without prior treatment with an NS5A inhibitor	12 weeks	12 weeks
1, 2, 4, 5, or 6	PRS[3]	8 weeks	12 weeks
3	PRS[3]	16 weeks	16 weeks

1. In clinical trials, subjects were treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.

2. In clinical trials, subjects were treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.

3. PRS = prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor.

-OR-

b. **All** of the following:

(1) The request is for Daklinza

-AND-

(2) **One** of the following:

(a) Patient is genotype 1 or 3 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Daklinza therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

	Patient Population	Treatment and Duration
Genotype 1	Without cirrhosis	Daklinza + sofosbuvir for 12 weeks
	Compensated (Child-Pugh A) cirrhosis^	
	Decompensated (Child-Pugh B or C) cirrhosis^	Daklinza + sofosbuvir + ribavirin for 12 weeks
	Post-transplant	
Genotype 3	Without cirrhosis	Daklinza + sofosbuvir for 12 weeks
	Compensated (Child-Pugh A) or decompensated (Child-Pugh B or C) cirrhosis^	Daklinza + sofosbuvir + ribavirin for 12 weeks

-OR-

c. **All** of the following:

(1) The request is for Epclusa

-AND-

(2) **One** of the following:

(a) Patient is genotype 1, 2, 3, 4, 5, or 6 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Epclusa therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Patient Population	Recommended Treatment Regimen

Patients without cirrhosis and patients with compensated cirrhosis^ (Child-Pugh A)	EPCLUSA for 12 weeks
Patients with decompensated cirrhosis^(Child-Pugh B and C)	EPCLUSA + ribavirin for 12 weeks

-OR-

d. **All** of the following:

(1) The request is for Harvoni

-AND-

(2) **One** of the following:

(a) Patient is genotype 1, 4, 5, or 6 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Harvoni therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Recommended adult treatment regimen and duration:

Genotype	Patient Population	Regimen and Duration
Genotype 1	Treatment-naïve without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	HARVONI 12 weeks*
	Treatment-experienced without cirrhosis	HARVONI 12 weeks
	Treatment-experienced with compensated cirrhosis^ (Child-Pugh A)	HARVONI 24 weeks
	Treatment-naïve and treatment-experienced with decompensated cirrhosis^ (Child-Pugh B or C)	HARVONI + ribavirin 12 weeks

Genotype 1 or 4	Treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis, or with compensated cirrhosis^ (Child-Pugh A)	HARVONI + ribavirin 12 weeks
Genotype 4, 5, or 6	Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	HARVONI 12 weeks

*HARVONI for 8 weeks can be considered in treatment-naïve patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL

Recommended treatment duration for pediatric patients 12 years of age and older or weighing at least 35kg:

	Pediatric patient population 12 years of age and older or weighing at least 35kg	**Regimen and Duration**
Genotype 1	Treatment naïve without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	HARVONI 12 weeks
	Treatment-experienced without cirrhosis	HARVONI 12 weeks
	Treatment-experienced with compensated cirrhosis^ (Child-Pugh A)	HARVONI 24 weeks
Genotype 4, 5, or 6	Treatment naïve and treatment experienced, without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	HARVONI 12 weeks

-OR-

e. **All** of the following:

(1) The request is for Olysio

-AND-

(2) **One** of the following:

(a) Patient is genotype 1 or 4 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Olysio therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Patient Population	Treatment Regimen	Duration
Genotype 1 without cirrhosis	OLYSIO + sofosbuvir	12 weeks
Genotype 1 with compensated cirrhosis^ (Child-Pugh A)	OLYSIO + sofosbuvir	24 weeks
Genotype 1 or 4 without cirrhosis or with compensated cirrhosis^ (Child-Pugh A), with or without HIV-1 co-infection	OLYSIO + Peg-IFN-alfa + RBV	12 weeks*
*Followed by 12 or 36 additional weeks of Peg-IFN-alfa + RBV depending on prior response status and presence of HIV-1 co-infection		

-OR-

f. **All** of the following:

(1) The request is for Sovaldi

-AND-

(2) **One** of the following:

(a) Patient is genotype 1, 2, 3, or 4 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Sovaldi therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Recommended Adult Treatment Regimen and Duration

	Adult Patient Population	**Regimen and Duration**
Genotype 1 or 4	Treatment naïve without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	SOVALDI + peginterferon alfa + ribavirin 12 weeks
Genotype 2	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	SOVALDI + ribavirin 12 weeks
Genotype 3	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	SOVALDI + ribavirin 24 weeks

SOVALDI in combination with ribavirin for 24 weeks can be considered for adult patients with genotype 1 infection who are interferon ineligible.
SOVALDI should be used in combination with ribavirin for treatment of HCV in adult patients with hepatocellular carcinoma awaiting liver transplantation for up to 48 weeks or until liver transplantation, whichever occurs first.

Recommended Treatment Regimen and Duration for Pediatric Patients 12 Years of Age and Older or Weighing at Least 35kg

	Pediatric Patient Population 12 Years of Age and Older or Weighing at Least 35kg	**Regimen and Duration**
Genotype 2	Treatment naïve and treatment experienced	SOVALDI + ribavirin 12 weeks

	without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	
Genotype 3	Treatment naïve and treatment experienced without cirrhosis or with compensated cirrhosis^ (Child-Pugh A)	SOVALDI + ribavirin 24 weeks

-OR-

g. **All** of the following:

(1) The request is for Technivie

-AND-

(2) **One** of the following:

(a) Patient is genotype 4 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Technivie therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Patient Population	Treatment	Duration
Genotype 4 without cirrhosis or with compensated cirrhosis^	TECHNIVIE + ribavirin*	12 weeks
*TECHNIVIE administered without ribavirin for 12 weeks may be considered for treatment-naïve patients who cannot take or tolerate ribavirin		

-OR-

h. **All** of the following:

(1) The request is for Viekira Pak or Viekira XR

-AND-

(2) **One** of the following:

(a) Patient is genotype 1 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Viekira Pak or Viekira XR therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Patient Population	Treatment*	Duration
Genotype 1a, without cirrhosis	VIEKIRA PAK/VIEKIRA XR + ribavirin	12 weeks
Genotype 1a, with compensated cirrhosis^	VIEKIRA PAK/VIEKIRA XR + ribavirin	24 weeks**
Genotype 1b, with or without compensated cirrhosis^	VIEKIRA PAK/VIEKIRA XR	12 weeks

*Note: Follow the genotype 1a dosing recommendations in patients with an unknown genotype 1 subtype or with mixed genotype 1 infection
**VIEKIRA PAK/VIEKIRA XR administered with ribavirin for 12 weeks may be considered in some patients based on prior treatment history

-OR-

i. **All** of the following:

(1) The request is for Vosevi

-AND-

(2) The patient is without cirrhosis or has compensated cirrhosis (Child-Pugh A)

-AND-

(3) **One** of the following:

(a) **Both** of the following:

- Patient is genotype 1, 2, 3, 4, 5, or 6 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing an NS5A inhibitor
- If patient is genotype 1 and has not been previously treated with an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret

-OR-

(b) **All** of the following:

- Patient is genotype 1a or 3 and had virologic failure after completing previous treatment of at least 4 weeks' duration with an HCV regimen containing sofobuvir without an NS5A inhibitor
- If patient is genotype 1a and has been treated with or without an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret
- If patient is genotype 3 and has not been treated with an NS3/4A inhibitor, history of intolerance or contraindication to Mavyret

-OR-

(c) Patient is currently on Vosevi therapy

-AND-

(4) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Genotype	Patients previously treated with an HCV regimen containing:	VOSEVI Duration
1, 2, 3, 4, 5, or 6	An NS5A inhibitor[1]	12 weeks
1a or 3	Sofosbuvir without an NS5A inhibitor[2]	12 weeks

1. In clinical trials, prior NS5A inhibitor experience included daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir.
2. In clinical trials, prior treatment experience included sofosbuvir with or without any of the following: peginterferon alfa/ribavirin, ribavirin, HCV NS3/4A protease inhibitor (boceprevir, simeprevir or telaprevir).

-OR-

j. **All** of the following:

(1) The request is for Zepatier

-AND-

(2) One of the following:

(a) Patient is genotype 1 or 4 and has a history of intolerance or contraindication to Mavyret

-OR-

(b) Patient is currently on Zepatier therapy

-AND-

(3) The requested regimen is an approvable regimen, as outlined below, based on patient genotype and characteristics

Dosage Regimens and Durations for ZEPATIER in Patients with Genotype 1 or 4 HCV with or without Cirrhosis

Patient Population	Treatment	Duration
Genotype 1a: treatment naïve or PegIFN/RBV experienced* without baseline NS5A polymorphisms+	ZEPATIER	12 weeks
Genotype 1a: treatment naïve or PegIFN/RBV experienced* with baseline NS5A polymorphisms+	ZEPATIER + ribavirin	16 weeks

Genotype 1b: treatment naïve or PegIFN/RBV experienced*	ZEPATIER	12 weeks
Genotype 1a or 1b: PegIFN/RBV/PI experienced++	ZEPATIER + ribavirin	12 weeks
Genotype 4: treatment naïve	ZEPATIER	12 weeks
Genotype 4: PegIFN/RBV experienced*	ZEPATIER + ribavirin	16 weeks

*Peginterferon alfa + ribavirin
+Polymorphisms at amino acid positions 28, 30, 31, or 93
++Peginterferon alfa + ribavirin + HCV NS3/4 A protease inhibitor

^ For requests of duration of therapy extended due to cirrhosis, submission of medical records (e.g.: chart notes, laboratory values) documenting stage 4 hepatic fibrosis including ONE of the following is required:

(1) Liver biopsy confirming a METAVIR score of F4, or alternative scoring equivalent

-OR-

(2) Transient elastography (Fibroscan) score greater than or equal to 12.5 kPa

-OR-

(3) FibroTest (FibroSURE) score of greater than or equal to 0.75

-OR-

(4) APRI score greater than 2.0

-OR-

(5) Radiological imaging consistent with cirrhosis (e.g., evidence of portal hypertension)

-OR-

(6) Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician

Comparison of Scoring Systems for Histological Stage (Fibrosis)

METAVIR	Batts-Ludwig	Knodell	Ishak
0	0	0	0
1	1	1	1
1	1	1	2
2	2	--	3
3	3	3	4
4	4	4	5
4	4	4	6

UnitedHealthcare Pharmacy – Community and State Preferred Products						
	Genotype					
	1	**2**	**3**	**4**	**5**	**6**
Daklinza						
Epclusa						
Harvoni						
Mavyret	**X**	**X**	**X**	**X**	**X**	**X**
Olysio						
Solvadi						
Technivie						
Viekira						
Vosevi						
Zepatier						

3. References:

1. Daklinza [package insert]. Princeton, NJ: Bristol-Myers Squibb ; February 2017.
2. Epclusa [package insert]. Foster City, CA: Gilead Sciences, Inc.; June 2016.

3. Harvoni [package insert]. Foster City, CA: Gilead Sciences, Inc.; April 2017.
4. Mavyret [package insert]. North Chicago, IL: AbbVie, Inc.; August 2017.
5. Olysio [package insert]. Titusville, NJ: Janssen Therapeutics; May 2017.
6. Sovaldi [package insert]. Foster City, CA: Gilead Sciences, Inc.; April 2017.
7. Technivie [package insert]. North Chicago, IL: AbbVie, Inc.; March 2017.
8. Viekira Pak [package insert]. North Chicago, IL: AbbVie, Inc.; March 2017.
9. Viekira XR [package insert]. North Chicago, IL: AbbVie, Inc.; March 2017.
10. Vosevi [package insert]. Foster City, CA: Gilead Sciences, Inc.; July 2017.
11. Zepatier [package insert]. Whitehouse Station, NJ: Merck & Co.; February 2017.

Program	Prior Authorization – Hepatitis C Agents
Change Control	
Date	Change
1/2018	New policy hepatitis C policy created to incorporate all direct acting antiviral agents. Mavyret will be the preferred product for all genotypes starting 1/1/18.

Clinical Policy: Glecaprevir/Pibrentasvir (Mavyret)

Reference Number: NV.PHAR.348
Effective Date: 11/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Glecaprevir and pibrentasvir (Mavyret™) is a fixed-dose combination of glecaprevir, a hepatitis C virus (HCV) NS3/4A protease inhibitor, and pibrentasvir, an HCV NS5A inhibitor.

FDA Approved Indication
Mavyret is indicated for the treatment of the following:

- Patients with chronic HCV genotype 1a, 1b, 2, 3, 4, 5, or 6 infection without cirrhosis and with compensated cirrhosis (Child-Pugh A).
- Adult patients with genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Mavyret is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six (6) month period;
3. Confirmed HCV genotype is one of the following (a, b, or c):
   a. For treatment-naïve patients: genotypes 1, 2, 3, 4, 5, or 6;
   b. For patients who are treatment-experienced with interferon (IFN)/pegylated-interferon (pegIFN), ribavirin (RBV), and/or sofosbuvir only: genotypes 1, 2, 3, 4, 5, or 6;
   c. For patients treatment-experienced with either an NS5A inhibitor or an NS3/4A protease inhibitor: genotype 1 (*see Appendix D*);
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration*);
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir,

entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);

8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report, and
   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks;
9. Member has contraindication or intolerance to the following preferred medication(s)
   a. For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated*;
10. Dose does not exceed glecaprevir 300 mg and pibrentasvir 120mg (3 tablets) per day.

Approval Duration: Up to a Total of 16 Weeks*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)

1. Currently receiving medication via SilverSummit Healthplan benefit, or documentation supports that member is currently receiving Mavyret for treatment of chronic HCV infection and has received this medication for at least thirty (30) days;
2. Member is responding positively to therapy (e.g., decreased HCV RNA level, no unacceptable toxicity); and
3. Dose does not exceed glecaprevir 300 mg and pibrentasvir 120 mg (3 tablets) per day.

Approval Duration: Up to a Total of 16 Weeks*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)

1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized:

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Indication	Dosing Regimen	Maximum Dose	Reference
Treatment-naïve Chronic hepatitis C (CHC) infection: Genotypes 1, 2, 3, 4, 5, or 6	Without cirrhosis: 3 tablets by mouth (PO) daily (QD) for 8 weeks With compensated cirrhosis: 3 tablets PO QD for 12 weeks	Glecaprevir 300 mg/Pibrentasvir 120 mg (3 tablets) per day	FDA approved labeling
Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir CHC infection: Genotypes 1, 2, 4, 5, or 6	Without cirrhosis: 3 tablets PO QD for 8 weeks With compensated cirrhosis: 3 tablets PO QD for 12 weeks	Glecaprevir 300 mg/Pibrentasvir 120 mg (3 tablets) per day	FDA approved labeling
Treatment-experienced with IFN/pegIFN + RBV +/- sofosbuvir CHC infection: Genotype 3	Without cirrhosis or with compensated cirrhosis: 3 tablets PO QD for 16 weeks	Glecaprevir 300 mg/Pibrentasvir 120 mg (3 tablets) per day	FDA approved labeling
Treatment-experienced with NS5A inhibitor without prior NS3/4A protease inhibitor CHC infection: Genotype 1	Without cirrhosis or with compensated cirrhosis: 3 tablets PO QD for 16 weeks	Glecaprevir 300 mg/Pibrentasvir 120 mg (3 tablets) per day	FDA approved labeling
Treatment-experienced with NS3/4A protease inhibitor without prior NS5A inhibitor CHC infection: Genotype 1	Without cirrhosis or with compensated cirrhosis: 3 tablets PO QD for 12 weeks	Glecaprevir 300 mg/Pibrentasvir 120 mg (3 tablets) per day	FDA approved labeling

V. Product Availability

Tablets: glecaprevir 100 mg and pibrentasvir 40 mg

VI. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- AASLD: American Association for the Study of Liver Diseases
- DNA: deoxyribonucleic acid
- HBeAg: hepatitis B virus envelope antigen
- HBV: hepatitis B virus
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- FDA: Food and Drug Administration
- FIB-4: Fibrosis-4 index
- IDSA: Infectious Diseases Society of America
- IFN: interferon
- NS3/4A, NS5A/B: nonstructural protein
- PegIFN: pegylated interferon
- PO: by mouth
- QD: once per day
- RBV: ribavirin
- RNA: ribonucleic acid

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Approximate Scoring Equivalencies using METAVIR F3/F4 as Reference

Fibrosis/ Cirrhosis	Serologic Tests*				Radiologic Tests†		Liver Biopsy‡	
	Fibro Test	FIBRO Spect II	APRI	FIB-4	FibroScan (kPa)	MRE (kPa)	METAVIR	Ishak
Advanced fibrosis	≥0.59	≥42	>1.5	>3.25	≥9.5	≥4.11	F3	F4-5
Cirrhosis	≥0.75	≥42	>1.5	>3.25	≥12.0	≥4.71	F4	F5-6

*Serologic tests:
FibroTest (available through Quest as FibroTest or LabCorp as FibroSure)
FIBROSpect II (available through Prometheus Laboratory)
APRI (AST to platelet ratio index)
FIB-4 (Fibrosis-4 index: includes age, AST level, and platelet count)

†Radiologic tests:
FibroScan (transient elastography)
MRE (magnetic resonance elastography)

‡Liver biopsy (histologic scoring systems):
METAVIR F3/F4 is equivalent to Knodell, Scheuer, and Batts-Ludwig F3/F4 and Ishak F4-5/F5-6
METAVIR fibrosis stages: F0 = no fibrosis; F1 = portal fibrosis without septa; F2 = few septa; F3 = numerous septa without cirrhosis; F4 = cirrhosis

Appendix D: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/Pak*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs

VII. References

Mavyret Prescribing Information. North Chicago, IL: AbbVie Inc.; August 2017. Available at: www.mavyret.com. Accessed August 7, 2017.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. SilverSummit Healthplan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Healthplan" means the SilverSummit Healthplan which has adopted this clinical policy and that is operated or administered, in whole or in part, by SilverSummit Healthplan or any of such Healthplan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Healthplan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Healthplan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Healthplan retains the right to change, amend, or withdraw this clinical policy, and additional clinical policies may be developed and adopted, as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Creation Date	Approval Date
Policy created Policy revised with standard formatting and current MSM 1200 information (published date, August 1, 2017)	08/17 12/17	09/17

Clinical Policy: Sofosbuvir/Velpatasvir (Epclusa)

Reference Number: NV.PHAR.268
Effective Date: 07/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Epclusa® is a fixed-dose combination tablet containing sofosbuvir and velpatasvir for oral administration. Sofosbuvir is a nucleotide analog HCV NS5B polymerase inhibitor and velpatasvir is an NS5A inhibitor. Both drugs are direct-acting antiviral agents against the hepatitis C virus (HCV).

FDA Approved Indication

Epclusa is indicated for the treatment of adult patients with chronic HCV genotype 1a, 1b, 2, 3, 4, 5, or 6 infection:

- Without cirrhosis or with compensated cirrhosis; and
- With decompensated cirrhosis in combination with ribavirin.

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Epclusa is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV ribonucleic acid (RNA) levels over a six (6) month period;
3. Confirmed HCV genotype is 1a, 1b, 2, 3, 4, 5, or 6;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration)*;
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member agrees to participate in a medication adherence program meeting both of the following components:
    a. Medication adherence monitored by pharmacy claims data or member report, and
    b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks;
8. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
9. Member has contraindication or intolerance to the following preferred medication(s)

a. For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated);*

10. Dose does not exceed sofosbuvir/velpatasvir 400 mg/100 mg (1 tablet) per day.

Approval Duration: Up to a Total of 12 Weeks
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications:
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized.*

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)

1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen;
5. Dose does not exceed sofosbuvir/velpatasvir 400 mg/100 mg (1 tablet) per day.

Approval Duration: Up to a Total of 24 Weeks*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)

1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is one tab daily

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis or Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1a, 1b, 2, 3, 4	None	Epclusa§

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
	5, 6	None	Epclusa§
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Epclusa§
	1a, 1b, 2, 4	Peg-IFN/RBV	Epclusa§
	2	Sovaldi/RBV	Epclusa + RBV§
	3	Peg-IFN/RBV	Epclusa§
		Sovaldi/RBV	Epclusa + RBV§
	5, 6	Peg-IFN/RBV	Epclusa§
Decompensated Cirrhosis (CTP/Child-Pugh Class B or C)			
Treatment experienced	1*, 4	Sovaldi/NS5A-based regimen	Epclusa + RBV†
Not specified	1*, 2, 3, 4, 5, 6	Not specified	Epclusa + RBV§
	1*, 4	Not specified	Epclusa† *If RBV ineligible.*

*Subtype a or b, or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis or Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1a, 1b, 2, 3, 4	None	Epclusa§
	5, 6	None	Epclusa§
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Epclusa§
	1a, 1b, 2, 4	Peg-IFN/RBV	Epclusa§
	2	Sovaldi/RBV	Epclusa + RBV§
	3	Peg-IFN/RBV	Epclusa§
		Sovaldi/RBV	Epclusa + RBV§
	5, 6	Peg-IFN/RBV	Epclusa§
Decompensated Cirrhosis (CTP/Child-Pugh Class B or C)			
Treatment experienced	1*, 4	Sovaldi/NS5A-based regimen	Epclusa + RBV†
Not specified	1*, 2, 3, 4	Not specified	Epclusa + RBV§
	1*, 4	Not specified	Epclusa† *If RBV ineligible.*

*Subtype a or b, or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks

V. Product Availability

a. Epclusa Formulations:
Tablet, Oral:
- Epclusa: 400 mg of sofosbuvir and 100 mg of velpatasvir

b. Ribavirin Formulations:
Capsule, Oral:
- Rebetol: 200 mg

- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:

- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:

- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

VI. Appendices

Appendix A: Abbreviation Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- CrCl: creatinine clearance
- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- PI: protease inhibitor
- RBV: ribavirin
- RNA: ribonucleic acid

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or

- Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.

- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
.Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

1. Epclusa Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; June 2016. Available at http://www.gilead.com/~/media/files/pdfs/medicines/liver-disease/epclusa/epclusa_pi.pdf?la=en. Accessed July 8, 2016.
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12. Ribavirin (systemic): Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 11, 2016.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. SilverSummit Healthplan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Healthplan" means the SilverSummit Healthplan which has adopted this clinical policy and that is operated or administered, in whole or in part, by SilverSummit Healthplan or any of such Healthplan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Healthplan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Healthplan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Healthplan

retains the right to change, amend, or withdraw this clinical policy, and additional clinical policies may be developed and adopted, as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada MCM 1200 guidelines Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Daclatasvir (Daklinza)

Reference Number: NV.PHAR.274
Effective Date: 07/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Daklinza™ (daclatasvir) is an inhibitor of HCV nonstructural protein 5A (NS5A) and is a direct-acting antiviral (DAA) agent against the hepatitis C virus.

FDA Approved Indications
Daklinza is an HCV NS5A inhibitor/oral tablet formulation indicated for use with sofosbuvir, with or without ribavirin, for:

- Treatment of patients with chronic HCV genotype 1, 2, or 3.
- Limitations of use: Sustained virologic response (SVR12) rates are reduced in HCV genotype 3-infected patients with cirrhosis receiving Daklinza in combination with sofosbuvir for 12 weeks.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Daklinza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six (6) month period;
3. Confirmed HCV genotype is 1, 2, 3 or 4;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration*);
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report, and
   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and
9. Member has contraindication or intolerance to the following preferred medication(s)

a. For genotype 1: Mavyret and Zepatier *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated);and*
b. For genotype 2 and 3: Epclusa.

Approval Duration: Up to a Total of 24 Weeks*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)
1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen

Approval Duration: Up to a Total of 24 Weeks*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)
1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized:

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is one of the following:
60 mg (one tablet) daily; or
30 mg (one tablet) and the recipient is receiving a strong CYP3A inhibitor; or
90 mg (one tablet) daily and the recipient is receiving a concomitant moderate CYP3A inducer.

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis or Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Not specified	1*, 3	Not specified	Sovaldi + Daklinza§
Decompensated Cirrhosis (CTP/Child-Pugh Class B or C)			
Not specified	1*, 3	Not specified	Sovaldi + Daklinza + RBV§
Post-Transplantation			
Not specified	3	Not specified	Sovaldi + Daklinza + RBV§

*Subtype a or b, or unknown subtype
§Treatment duration - 12 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Treatment naive	1*, 2, 3, 4	None	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
	1a, 1b, 2, 3	None	Sovaldi + Daklinza§
	2, 3	None	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Sovaldi + Daklinza§
	1*, 2, 3, 4	Not specified	Sovaldi + Daklinza + RBV§ *If post-liver transplantation.*
	1a, 1b, 2, 3	Peg-IFN/RBV	Sovaldi + Daklinza§
	2, 3	Not specified	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
	3	Sovaldi/RBV	Sovaldi + Daklinza + RBV†
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1*, 2, 3, 4	None	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
	1*, 4	None	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
	1a, 1b	None	Sovaldi + Daklinza +/- RBV†
	2	None	Sovaldi + Daklinza◊
	2, 3	None	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
	3	None	Sovaldi + Daklinza†
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Sovaldi + Daklinza + RBV†
	1*, 2, 3, 4	Not specified	Sovaldi + Daklinza + RBV§ *If post-liver transplantation.*
	1a, 1b	Peg-IFN/RBV	Sovaldi + Daklinza +/- RBV†
	2	Peg-IFN/RBV	Sovaldi + Daklinza◊
		Sovaldi/RBV	Sovaldi + Daklinza†
	2, 3	Not specified	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
	3	Sovaldi/RBV	Sovaldi + Daklinza + RBV†
		Peg-IFN/RBV	Sovaldi + Daklinza + RBV†
Decompensated Cirrhosis (CTP/Child-Pugh Class B or C)			
Treatment naive	1*, 4	None	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
Treatment experienced	1*, 4	Not specified	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
Not specified	1*, 2, 3, 4	Not specified	Sovaldi + Daklinza + RBV*
	1*, 4	Not specified	Sovaldi + Daklinza† *If RBV ineligible.*

*Subtype a or b, or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
§Treatment duration - 12 weeks
◊Treatment duration – 16 to 24 weeks
†Treatment duration - 24 weeks

V. Product Availability

Tablet, Oral Daklinza: 30 mg, 60 mg, 90 mg
Capsule, Oral:

- Rebetol: 200 mg
- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:

- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:

- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

VI. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- DAA: direct acting antiviral
- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- PI: protease inhibitor
- RBV: ribavirin

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

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10. Hsieh YY, Tung SY, Lee K, et al. Routine blood tests to predict liver fibrosis in chronic hepatitis C. World J Gastroenterol. February 28, 2012; 18(8): 746-53. doi: 10.3748/wjg.v18.i8.746.
11. Bruix J and Sherman M. Management of hepatocellular carcinoma: An update. AASLD Practice Guideline. *Hepatology*. 2011; 53(3): 1020-22.
12. Ribavirin (systemic): Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 11, 2016.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

This clinical policy is the property of the Healthplan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members, and

their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada requirements Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Elbasvir/Grazoprevir (Zepatier)

Reference Number: NV.PHAR.275
Effective Date: 07/17
Last Review Date: 11/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Elbasvir/grazoprevir (Zepatier™) is a fixed-dose combination product containing elbasvir, a hepatitis C virus (HCV) NS5A inhibitor, and grazoprevir, a HCV NS3/4A protease inhibitor.

FDA Approved Indication
Zepatier is indicated for treatment of the following:

- Patients with chronic HCV genotype 1a, 1b, or 4 infection in adults; and
- Certain patient populations who use ribavirin

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Zepatier is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six (6) month period;
3. Confirmed HCV genotype is 1a, 1b, or 4;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration)*;
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report, and
   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and
9. Member has contraindication or intolerance to the following preferred medication(s)
   a. For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated).*

Approval Duration: Up to a Total of 16 Weeks*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration*.)

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)
1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen.

Approval Duration: Up to a Total of 16 Weeks*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)**:**
1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents;

B. Treatment-experienced patients with both NS3/4A protease inhibitor AND NS5A inhibitor, such as combination therapies including: Technivie, Viekira, and Zepatier.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is one tablet (50/100 mg) daily

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis or Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1a	None	Zepatier§ *If no baseline NS5A polymorphisms.*
			Zepatier○ *If baseline NS5A polymorphisms.*
	1b, 4	None	Zepatier§

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Zepatier + RBV○ *If baseline NS5A polymorphisms.*
			Zepatier + RBV§
	1a	Peg-IFN/RBV	Zepatier + RBV○ *If baseline NS5A polymorphisms.*
			Zepatier + RBV§ *If no baseline NS5A polymorphisms.*
	1b, 4	Peg-IFN/RBV	Zepatier + RBV§
	4	Peg-IFN/RBV	Zepatier + RBV○

*Subtype a or b, or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
§Treatment duration - 12 weeks
○Treatment duration – 16 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis or Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1a	None	Zepatier§ *If no baseline NS5A polymorphisms.*
			Zepatier + RBV○ *If baseline NS5A polymorphisms.*
	1b, 4	None	Zepatier§
Treatment experienced	1a	Peg-IFN/RBV	Zepatier§ *If no baseline NS5A polymorphisms.*
			Zepatier + RBV○ *If baseline NS5A polymorphisms.*
	1a, 1b	NS3/Peg-IFN/RBV**	Zepatier + RBV§
	1b	Peg-IFN/RBV	Zepatier§
	4	Peg-IFN/RBV	Zepatier + RBV○

**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
§Treatment duration - 12 weeks
○Treatment duration - 16 weeks

V. Product Availability

Zepatier is a fixed-dose combination tablet containing elbasvir and grazoprevir for oral administration. Elbasvir is an HCV NS5A inhibitor, and grazoprevir is an HCV NS3/4A protease inhibitor. Each tablet contains 50 mg elbasvir and 100 mg grazoprevir.

a. *Zepatier Formulations:*
Tablet, Oral:
- Zepatier: 50 mg elbasvir and 100 mg grazoprevir

b. Ribavirin Formulations:
Capsule, Oral:
- Rebetol: 200 mg

- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:

- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:

- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

VI. Appendices/General Information

Appendix A: Abbreviation Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- DAA: direct acting antiviral
- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- PI: protease inhibitor
- RBV: ribavirin

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.

- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals (DAAs) for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

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12. Ribavirin (systemic): Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 11, 2016.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. SilverSummit Healthplan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Healthplan" means the SilverSummit Healthplan which has adopted this clinical policy and that is operated or administered, in whole or in part, by SilverSummit Healthplan or any of such Healthplan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Healthplan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Healthplan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Healthplan retains the right to change, amend, or withdraw this clinical policy, and additional clinical policies may be developed and adopted, as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada requirements Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Ombitasvir/Paritaprevir/Ritonavir (Technivie)
Reference Number: NV.PHAR.276
Effective Date: 07/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Technivie® is a fixed-dose combination tablet containing ombitasvir, paritaprevir, and ritonavir for oral administration. Ombitasvir, paritaprevir, ritonavir fixed dose combination tablet includes a hepatitis C virus NS5A inhibitor (ombitasvir), a hepatitis C virus NS3/4A protease inhibitor (paritaprevir), and a CYP3A inhibitor (ritonavir) that inhibits CYP3A mediated metabolism of paritaprevir, thereby providing increased plasma concentration of paritaprevir.

FDA Approved Indications:
Technivie is a combination fixed-dose oral tablet formulation / NS5A inhibitor/NS3/4A protease inhibitor/CYP3A inhibitor indicated in combination with ribavirin:

- For the treatment of patients with genotype 4 chronic HCV infection without cirrhosis.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Mavyret is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic hepatitis C virus (HCV) infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six-month period;
3. Confirmed HCV genotype is 4;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration*);
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report, and
   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and
9. Member has contraindication or intolerance to the following preferred medication(s)

a. For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated).*

Approval Duration: Up to a Total of 12 Weeks*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)
1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen.

Approval Duration: Up to a Total of 12 Weeks*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)
1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents; and

B. Treatment-experienced patients with both NS3/4A protease inhibitor AND NS5A inhibitor, such as combination therapies including: Technivie, Viekira, and Zepatier.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily (25/150/100 mg)

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Treatment naive	4	None	Technivie§ *If RBV ineligible.*
Not specified	4	Not specified	Technivie + RBV§

§Treatment duration - 12 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis or Compensated Cirrhosis (CTP/Child-Pugh Class A)			
No prior treatment	4	None	Technivie§
Prior treatment failure	4	Peg-IFN/RBV	Technivie + RBV§

§Treatment duration - 12 weeks

V. Product Availability

Technivie: Ombitasvir, paritaprevir and ritonavir film-coated tablets are co-formulated immediate release tablets.

a. Technivie Formulations

Tablet, Oral:

- Technivie 12.5 mg ombitasvir, 75 mg paritaprevir, 50 mg ritonavir

b. Ribavirin Formulations

Capsule, Oral:

- Rebetol: 200 mg
- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:

- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:

- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

VI. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- DAA: direct-acting antiviral
- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma

- HCV: hepatitis C virus
- HIV: human immunodeficiency virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- PAH: pulmonary arterial hypertension
- Peg-IFN: pegylated interferon
- RBV: ribavirin

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals (DAAs) for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

1. Technivie Prescribing Information. North Chicago, IL: AbbVie, Inc.; June 2016. Available at http://www.rxabbvie.com/pdf/technivie_pi.pdf. Accessed August 1, 2016.
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4. Fiel MI. Histologic scoring system for chronic liver disease. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 15, 2016.
5. Bonder A, Afdhal N. Utilization of FibroScan in clinical practice. *Curr Gastroenterol Rep.* 2014; 16(372): 1-7. DOI 10.1007/s11894-014-0372-6.
6. Halfon P, Bourliere M, Deydier R, et al. Independent prospective multicenter validation of biochemical markers (Fibrotest–Actitest) for the prediction of liver fibrosis and activity in patients with chronic hepatitis C: The Fibropaca study. Am J Gastroenterol. 2006; 101: 547-555. DOI: 10.1111/j.1572-0241.2006.0411.x
7. Hepatitis C Virus (HCV) FibroSure. Laboratory Corporation of America Holdings and Lexi-Comp, Inc. Available at https://www.labcorp.com. 2016. Accessed July 15, 2016.
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12. Ribavirin (systemic): Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 11, 2016.

Important Reminder

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is operated or administered, in whole or in part, by SilverSummit Healthplan or any of such Healthplan's affiliates, as applicable.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

This clinical policy is the property of the Healthplan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members, and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada requirements Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Dasabuvir, Ombitasvir, Paritaprevir, Ritonavir (Viekira XR, Viekira Pak)

Reference Number: NV.PHAR.278
Effective Date: 07/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Viekira XR™ and Viekira Pak® include a hepatitis C virus nonnucleoside NS5B palm polymerase inhibitor (dasabuvir), a hepatitis C virus NS5A inhibitor (ombitasvir), a hepatitis C virus NS3/4A protease inhibitor (paritaprevir), and a CYP3A inhibitor (ritonavir) that inhibits CYP3A mediated metabolism of paritaprevir, thereby providing increased plasma concentration of paritaprevir.

FDA Approved Indications:
Viekira XR and Viekira Pak are indicated for the treatment of adult patients with chronic HCV:

- Genotype 1b infection without cirrhosis or with compensated cirrhosis;
- Genotype 1a infection without cirrhosis or with compensated cirrhosis for use in combination with ribavirin.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Viekira XR and Viekira Pak are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six (6) month period;
3. Confirmed HCV genotype is 1a or 1b;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration)*;
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report, and

   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and
9. Member has contraindication or intolerance to the following preferred medication(s)
   a. For genotype 1a and 1b: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated).*

Approval Duration: Up to a Total of 24 Weeks (Genotype 1) and Up to a Total of 12 Weeks (Genotype 2)*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration*.)

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)
1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen.

Approval Duration: Up to a Total of 24 Weeks (Genotype 1) and Up to a Total of 12 Weeks (Genotype 2)*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)
1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents;

B. Treatment-experienced patients with both NS3/4A protease inhibitor AND NS5A inhibitor, such as combination therapies including: Technivie, Viekira, and Zepatier.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily (25/150/100 mg) and one dasabuvir 250 mg tablet twice daily.

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Not specified	1*	Not specified	Viekira XR/PAK + RBV† *If post-liver transplantation and METAVIR ≤F2 (this specific regimen is not covered because Centene requires METAVIR score of F3 or F4)*
	1*, 1a	Not specified	Viekira XR/PAK + RBV§
	1b	Not specified	Viekira XR/PAK§
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Not specified	1*, 1a	Not specified	Viekira XR/PAK + RBV†
	1b	Not specified	Viekira XR/PAK§

*Subtype a or b, or unknown subtype
§Treatment duration - 12 weeks
♦Treatment duration – 12 to 24 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Treatment naive	1a	None	Viekira XR/PAK + RBV§
	1b	None	Viekira XR/PAK§
Treatment experienced	1a, 1b	Peg-IFN/RBV	Viekira XR/PAK + RBV§
Not specified	1*	Not specified	Viekira XR/PAK + RBV† *If post-liver transplantation and METAVIR ≤F2. (Regimen is not covered because Centene requires METAVIR score of F3 or F4)*
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1a	None	Viekira XR/PAK + RBV†
	1b	None	Viekira XR/PAK§
Treatment experienced	1a	Peg-IFN/RBV	Viekira XR/PAK + RBV†
	1b	Peg-IFN/RBV	Viekira XR/PAK + RBV§

*Subtype a or b, or unknown subtype
§Treatment duration - 12 weeks
†Treatment duration – 24 weeks

V. Product Availability

Viekira XR is a fixed dose combination, extended-release oral tablet formulation including dasabuvir, ombitasvir, paritaprevir, and ritonavir as a single tablet.

Viekira Pak is a fixed dose combination oral tablet formulation including ombitasvir, paritaprevir and ritonavir as a single tablet copackaged with dasabuvir as a tablet.

a. *Viekira XR Formulations*
   Combination Bilayer Tablet, Oral (Extended Relase [ER]/Immediate Release [IR]
   - ER Layer: Dasabuvir 200 mg
   - IR Layer: Ombitasvir 8.33 mg, paritaprevir 50 mg, ritonaivr 33.33 mg

b. *Viekira Pak Formulations*
   Combination Package:
   - IR Tablet, Oral: Ombitasvir 12.5 mg, paritaprevir 75 mg, and ritonavir 50 mg
   - IR Tablet, Oral: Dasabuvir 250 mg

c. *Ribavirin Formulations*
   Capsule, Oral:
   - Rebetol: 200 mg
   - Ribasphere: 200 mg
   - Generic: 200 mg

   Solution, Oral:
   - Rebetol: 40 mg/mL (100 mL)

   Tablet, Oral:
   - Copegus: 200 mg
   - Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
   - Ribasphere: 200 mg, 400 mg, 600 mg
   - Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
   - Generic: 200 mg

VI. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- CrCl: creatinine clearance
- CYP: cytochrome P450
- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- HIV: human immunodeficiency virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- RBV: ribavirin
- RNA: ribonucleic acid

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

1. Viekira XR Prescribing Information. North Chicago, IL: AbbVie, Inc.; June 2016. Available at http://www.rxabbvie.com/pdf/viekiraxr_pi.pdf. Accessed August 1, 2016.
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8. Hepatitis C Virus (HCV) FibroSure. Laboratory Corporation of America Holdings and Lexi-Comp, Inc. Available at https://www.labcorp.com. 2016. Accessed July 15, 2016.
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13. Ribavirin (systemic): Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 11, 2016.

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decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Healthplan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Healthplan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Healthplan retains the right to change, amend, or withdraw this clinical policy, and additional clinical policies may be developed and adopted, as needed, at any time.

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Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada requirements Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Ledipasvir/Sofosbuvir (Harvoni)

Reference Number: NV.PHAR.279
Effective Date: 07/16
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Harvoni®is a fixed-dose combination tablet containing ledipasvir and sofosbuvir for oral administration. Ledipasvir is an HCV NS5A inhibitor and sofosbuvir is a nucleotide analog inhibitor of HCV NS5B polymerase. Harvoni is a direct-acting antiviral (DAA) agent against the hepatitis C virus.

FDA Approved Indication

Harvoni is a fixed-dose combination of ledipasvir, a HCV NS5A inhibitor, and sofosbuvir, an HCV nucleotide analog NS5B polymerase inhibitor/oral tablet formulation, indicated with or without ribavirin for:

- Treatment of HCV genotype 1, 4, 5 or 6 infection

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Harvoni is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six (6) month period;
3. Confirmed HCV genotype 1, 4, 5, or 6;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration*);
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report, and
   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and

9. Member has contraindication or intolerance to the following preferred medication(s): For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated).*

Approval Duration: Up to a Total of 12 Weeks*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)

1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen.

Approval Duration: Up to a Total of 24 Weeks*
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration*)

B. Other Diagnoses/Indications (must meet 1 or 2)

1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized :

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is one 90mg/400mg tablet once daily

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Treatment naive	1*	None	Harvoni^ *If pretreatment HCV RNA < 6 million IU/mL.*

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
	1*, 4	None	Harvoni + RBV§ *If post-liver transplantation.*
	1*, 4, 5, 6	None	Harvoni§
Treatment experienced	1*, 4	NS3 PI/Peg-IFN/RBV**	Harvoni + RBV§ *If post-liver transplantation.*
	1*, 4, 5, 6	NS3 PI/Peg-IFN/RBV**	Harvoni§
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1*, 4	None	Harvoni + RBV§ *If post-liver transplantation.*
	1*, 4, 5, 6	None	Harvoni§
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Harvoni + RBV§
			Harvoni† *If RBV ineligible.*
	1*, 4	NS3 PI/Peg-IFN/RBV**	Harvoni + RBV§ *If post-liver transplantation.*
	4, 5, 6	NS3 PI/Peg-IFN/RBV**	Harvoni§
Decompensated Cirrhosis (CTP/Child-Pugh Class B or C)			
Treatment naive	1*, 4	None	Harvoni + RBV§
Treatment experienced	1*, 4	NS3 PI/Peg-IFN/RBV**	Harvoni + RBV§

*Subtype a or b, or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
^Treatment duration - 8 weeks
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No cirrhosis			
Treatment naive	1*, 4	None	Harvoni + RBV§ *If liver transplant recipient.*
	1a, 1b, 4, 5, 6	None	Harvoni§
Treatment experienced	1*	Sovaldi/Peg-IFN/RBV	Harvoni + RBV§
		NS3 PI/Peg-IFN/RBV**	Harvoni§
	1*, 4	Not specified	Harvoni + RBV§ *If post-liver transplantation.*
	1a, 1b, 4, 5, 6	Peg-IFN/RBV	Harvoni§
Compensated cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1*, 4	None	Harvoni + RBV§ *If post-liver transplantation.*
			Harvoni† *If post-liver transplantation and if RBV ineligible.*
	1a, 1b, 4, 5, 6	None	Harvoni§
Treatment experienced	1*	Sovaldi/Peg-IFN/RBV	Harvoni + RBV†
		NS3 PI/Peg-IFN/RBV**	Harvoni + RBV§

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
			Harvoni† *If RBV ineligible.*
	1*, 4	Not specified	Harvoni + RBV§ *If post-liver transplantation.*
	1a, 1b, 4	Peg-IFN/RBV	Harvoni + RBV§
		Peg-IFN/RBV	Harvoni† *If RBV ineligible.*
	5, 6	Peg-IFN/RBV	Harvoni§
Decompensated cirrhosis (CTP/Child-Pugh Class B or C)			
Treatment naive	1*, 4	Not specified	Harvoni + RBV§ *If post-liver transplantation.*
Treatment experienced	1*, 4	Sovaldi-based regimen	Harvoni + RBV†
		Not specified	Harvoni + RBV§ *If post-liver transplantation.*
Not specified	1*, 4	Not specified	Harvoni + RBV§
			Harvoni† *If RBV ineligible.*

*Any or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simprevir)
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks

V. Product Availability

a. Harvoni Formulations

Tablet, Oral

- Harvoni: 90 mg of ledipasvir and 400 mg of sofosbuvir

b. Ribavirin Formulation

Capsule, Oral:

- Rebetol: 200 mg
- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:

- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:

- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

VI. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases

- CTP: Child Turcotte Pugh
- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- PI: protease inhibitor
- RBV: ribavirin
- RNA: ribonucleic acid

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

1. Harvoni Prescribing Information. Foster City, CA: Gilead Sciences, Inc.; June 2016. Available at http://www.gilead.com/~/media/Files/pdfs/medicines/liver-disease/harvoni/harvoni_pi.pdf. Accessed July 26, 2016.
2. AASLD-IDSA. Recommendations for testing, managing, and treating hepatitis C. http://www.hcvguidelines.org. Accessed July 12, 2016.
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11. Bruix J and Sherman M. Management of hepatocellular carcinoma: An update. AASLD Practice Guideline. *Hepatology*. 2011; 53(3): 1020-22.
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Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada requirements Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Simeprevir (Olysio)
Reference Number: NV.PHAR.280
Effective Date: 07/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Simeprevir (Olysio®) is an inhibitor of the HCV NS3/4A protease and a direct-acting antiviral (DAA) agent against the hepatitis C virus.

FDA Approved Indications:
Olysio is an HCV NS3/4A protease inhibitor/oral capsule formulation indicated for:
-Treatment of adults with chronic HCV infection:
- In combination with sofosbuvir in patients with HCV genotype 1 without cirrhosis or with compensated cirrhosis;
- In combination with peginterferon alfa (Peg-IFN-alfa) and ribavirin (RBV) in patients with HCV genotype 1a, 1b, or 4 without cirrhosis or with compensated cirrhosis.

-Limitations of use:
- Efficacy of Olysio in combination with Peg-IFN-alfa and RBV is substantially reduced in patients infected with HCV genotype 1a with an NS3 Q80K polymorphism at baseline compared to patients infected with HCV genotype 1a without the Q80K polymorphism
- Olysio is not recommended in patients who have previously failed therapy with a treatment regimen that included Olysio or other HCV protease inhibitors.

Policy/Criteria
It is the policy of SilverSummit Healthplan that Olysio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV ribonucleic acid (RNA) levels over a six (6) month period;
3. Confirmed HCV genotype is 1a, 1b, or 4;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration)*;
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report;

b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and

9. Member has contraindication or intolerance to the following preferred medication(s)
   a. For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated).*

Approval duration: Up to a Total of 24 Weeks
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Approval

A. Chronic Hepatitis C Infection (must meet all)
1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen.

Approval Duration: Up to a Total of 48 Weeks*
*(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration)*

B. Other Diagnoses/Indications (must meet 1 or 2)
1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for Which Coverage is NOT Authorized:

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Dosage and Administration

FDA-Approved Regimens and Treatment Durations

Dose is 150 mg (one capsule) daily

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen
No Cirrhosis			
Treatment naive	1*	None	Sovaldi + Olysio§
	1*, 4	None	Olysio + Peg-IFN-alfa + RBV (12 weeks) then Peg-IFN-alfa + RBV (12 weeks)† *If genotype 1a, negative for the Q80K variant.* *Also labeled for HCV/HIV-1 coinfection.*
Treatment experienced	1*	Peg-IFN-based therapy	Sovaldi + Olysio§
	1*, 4	Peg-IFN-based therapy	Olysio + Peg-IFN-alfa + RBV (12 weeks) then Peg-IFN-alfa + RBV (12 weeks)† *If genotype 1a, negative for Q80K variant.* *Also labeled for HCV/HIV-1 coinfection.*
			Olysio + Peg-IFN-alfa + RBV (12 weeks) then Peg-IFN-alfa + RBV (36 weeks)‡ *If genotype 1a, negative for the Q80K variant.* *Limited to HCV/HIV-1 coinfection.*
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1*	None	Sovaldi + Olysio†
	1*, 4	None	Olysio + Peg-IFN-alfa + RBV (12 weeks) then Peg-IFN-alfa + RBV (12 weeks)† *If genotype 1a, negative for the Q80K variant.*
			Olysio + Peg-IFN-alfa + RBV (12 weeks) then Peg-IFN-alfa + RBV (36 weeks)‡ *If genotype 1a, negative for Q80K variant.* *Limited to HCV/HIV-1 coinfection.*
Treatment experienced	1*	Peg-IFN-based therapy	Sovaldi + Olysio†
	1*, 4	Peg-IFN-based therapy	Olysio + Peg-IFN-alfa + RBV (12 weeks) then Peg-IFN-alfa + RBV (36 weeks)‡ *If genotype 1a, negative for the Q80K variant.* *Also labeled for HCV/HIV-1 coinfection.*

*Subtype a or b, or unknown subtype
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks
‡Treatment duration – 48 weeks

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Treatment naive	1a, 1b	None	Sovaldi + Olysio§

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
Treatment experienced	1a, 1b	Peg-IFN/RBV	Sovaldi + Olysio§
Not specified	1*, 4	Not specified	Sovaldi + Olysio +/- RBV§ *If post-liver transplantation.*
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1a	None	Sovaldi + Olysio +/- RBV†
	1b	None	Sovaldi + Olysio†
Treatment experienced	1a	Peg-IFN/RBV	Sovaldi + Olysio +/- RBV† *If negative for the Q80K variant.*
	1b	Peg-IFN/RBV	Sovaldi + Olysio +/- RBV†
Not specified	1*, 4	Not specified	Sovaldi + Olysio +/- RBV§ *If post-liver transplantation.*

*Subtype a or b, or unknown subtype
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks

V. Product Availability

a. Olysio Formulations
Capsule, Oral:
- Olysio: 150 mg

b. Ribavirin Formulations
Capsule, Oral:
- Rebetol: 200 mg
- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:
- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:
- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

c. Peginterferon Alfa-2a Formulations:
Solution, Subcutaneous [preservative free]:
- Pegasys: 180 mcg/mL (1 mL); 180 mcg/0.5 mL (0.5 mL)
- Pegasys ProClick: 135 mcg/0.5 mL (0.5 mL)
- Pegasys ProClick: 180 mcg/0.5 mL (0.5 mL)

d. Peginterferon Alfa-2b Formulations:
Kit, Subcutaneous [preservative free]:
- Peg-Intron Redipen: 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, 150 mcg/0.5 mL
- Peg-Intron Redipen Pak 4: 120 mcg/0.5 mL

- PegIntron: 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, 150 mcg/0.5 mL
- Sylatron: 200 mcg, 300 mcg, 600 mcg

VI. Appendices/General Information

Appendix A: Abbreviation Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- CrCl: creatinine clearance
- FIB-4: Fibrosis-4 index
- HIV-1: human immunodeficiency virus
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- PI: protease inhibitor
- RBV: ribavirin
- RNA: ribonucleic acid

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

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16. Pegiterferone alpha-2b: Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 26, 2016.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. SilverSummit Healthplan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Healthplan" means the SilverSummit Healthplan which has adopted this clinical policy and that is operated or administered, in whole or in part, by SilverSummit Healthplan or any of such Healthplan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Healthplan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Healthplan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Healthplan

retains the right to change, amend, or withdraw this clinical policy, and additional clinical policies may be developed and adopted, as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada guidelines Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	02/17 12/17	07/17

Clinical Policy: Sofosbuvir (Sovaldi)

Reference Number: NV.PHAR.281
Effective Date: 07/17
Last Review Date: 12/17

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Sovaldi® is a nucleotide analog HCV NS5B polymerase inhibitor and direct-acting antiviral (DAA) agent against the hepatitis C virus (HCV).

FDA Approved Indication
Sovaldi is an HCV nucleotide analog NS5B polymerase inhibitor/oral tablet formulation indicated for the treatment of genotype 1a, 1b, 2, 3, 4, 5, or 6 chronic HCV infection as a component of a combination antiviral treatment regimen.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) to support that the member has met all approval criteria.

It is the policy of SilverSummit Healthplan that Sovaldi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Hepatitis C Infection (must meet all)

1. Age ≥ 18 years;
2. Diagnosis of chronic HCV infection as evidenced by detectable HCV RNA (ribonucleic acid) levels over a six (6) month period;
3. Confirmed HCV genotype is 1a, 1b, 2, 3, 4, 5, or 6;
4. Life expectancy ≥ 12 months with HCV treatment;
5. Prescribed regimen is consistent with an FDA or AASLD-IDSA recommended regimen (*see Section IV Dosage and Administration)*;
6. If cirrhosis is present, confirmation of Child-Pugh A status;
7. Member is hepatitis B virus (HBV) negative, or if positive, documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
8. Member agrees to participate in a medication adherence program meeting both of the following components:
   a. Medication adherence monitored by pharmacy claims data or member report;
   b. Member's risk for non-adherence identified by adherence program or member/prescribing physician follow-up at least every four (4) weeks; and
9. Member has contraindication or intolerance to the following preferred medication(s): For genotype 1a, 1b and 4: Mavyret and Zepatier. *(Mavyret is the preferred agent; Zepatier should be used if Mavyret is contraindicated*

Approval Duration: Up to a Total of 24 Weeks
Adults vs Pediatrics??

B. Other Diagnoses/Indications
Refer to CP.PMN.53 if diagnosis is NOT specifically listed under *Section III Diagnoses/Indications for Which Coverage is NOT Authorized*.

II. Continued Therapy

A. Chronic Hepatitis C Infection (must meet all)

1. Currently receiving medication via SilverSummit Healthplan benefit;
2. Member is responding positively to therapy, (e.g., decreased HCV RNA level, no unacceptable toxicity);
3. All requirements stated in the most current version of the Nevada Division of Health Care Financing and Policy's (DHCFP) Medicaid Services Manual, Chapter 1200 (MSM 1200) have been/are being met; and
4. Recipient is compliant on all drugs in treatment regimen.

Approval Duration: Up to a Total of 24 Weeks*
Adults vs Pediatrics??
(*Approved duration should be consistent with a regimen in *Section IV Dosage and Administration*)

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via SilverSummit Healthplan benefit and documentation supports positive response to therapy, or
2. Refer to CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized

Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Dosage and Administration
FDA-Approved Regimens and Treatment Durations

Dose is 400mg daily

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
Presence or Absence of Cirrhosis Not Specified			
Not specified	1*	Not specified	Sovaldi + RBV† *If Peg-IFN ineligible.*
	1*, 4	Not specified	Sovaldi + PEG-IFN alfa + RBV§
	2	Not specified	Sovaldi + RBV§
	3	Not specified	Sovaldi + RBV†
	Not specified	Not specified	Sovaldi + RBV‡ *If HCC and awaiting liver transplantation.*

*Subtype a or b, or unknown subtype
§Treatment duration - 12 weeks
†Treatment duration - 24 weeks
‡Treatment duration - up to 48 weeks or until liver transplantation

AASLD-IDSA Recommended Regimens and Treatment Durations

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
No Cirrhosis			
Treatment naive	1*, 2, 3, 4	None	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
	1a, 1b, 2, 3	None	Sovaldi + Daklinza§
			Sovaldi + Olysio§
	2	None	Sovaldi + RBV† *If post-liver transplantation.*
	2, 3	None	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Sovaldi + Daklinza§
	1*, 2, 3, 4	Not specified	Sovaldi + Daklinza + RBV§ *If post-liver transplantation.*
	1a, 1b	Peg-IFN/RBV	Sovaldi + Olysio§
	1a, 1b, 2, 3	Peg-IFN/RBV	Sovaldi + Daklinza§
	2	Not specified	Sovaldi + RBV† *If post-liver transplantation.*
	2, 3	Not specified	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
	3	Sovaldi/RBV	Sovaldi + Daklinza + RBV†
Not specified	1*, 4	Not specified	Sovaldi + Olysio +/- RBV§ *If post-liver transplantation.*
Compensated Cirrhosis (CTP/Child-Pugh Class A)			
Treatment naive	1*, 2, 3, 4	None	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
	1*, 4	None	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*

Treatment Naive/Experienced	Genotype	Failed Treatment Regimen	Recommended Regimen *See footnotes for duration*
	1a	None	Sovaldi + Olysio +/-RBV†
	1a, 1b	None	Sovaldi + Daklinza +/- RBV†
	1b	None	Sovaldi + Olysio†
	2	None	Sovaldi + Daklinza◊
		None	Sovaldi + RBV† *If post-liver transplantation.*
	2, 3	None	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
	3	None	Sovaldi + Daklinza†
Treatment experienced	1*	NS3 PI/Peg-IFN/RBV**	Sovaldi + Daklinza + RBV†
		Olysio/Sovaldi	Sovaldi-based dual DAA therapy +/- RBV†
			Sovaldi-based triple/quadruple DAA therapy +/- RBV♦
		NS5A inhibitor	Sovaldi-based dual DAA therapy +/- RBV†
			Sovaldi-based triple/quadruple DAA therapy +/- RBV♦
	1*, 2, 3, 4	Not specified	Sovaldi + Daklinza + RBV§ *If post-liver transplantation.*
	1a	Peg-IFN/RBV	Sovaldi + Olysio +/- RBV† *If negative for the Q80K variant.*
	1a, 1b	Peg-IFN/RBV	Sovaldi + Daklinza +/- RBV†
	1b	Peg-IFN/RBV	Sovaldi + Olysio +/- RBV†
	2	Peg-IFN/RBV	Sovaldi + Daklinza◊
		Sovaldi/RBV	Sovaldi + Daklinza†
		Not specified	Sovaldi + RBV† *If post-liver transplantation.*
	2, 3	Not specified	Sovaldi + Daklinza† *If post-liver transplantation and RBV ineligible.*
	3	Sovaldi/RBV	Sovaldi + Daklinza + RBV†
		Peg-IFN/RBV	Sovaldi + Daklinza + RBV†
Not specified	1*, 4	Not specified	Sovaldi + Olysio +/- RBV§ *If post-liver transplantation.*
Decompensated Cirrhosis (CTP/Child-Pugh Class B or C)			
Treatment naive	1*, 4	None	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
	2	None	Sovaldi + RBV† *If post-liver transplantation.*
Treatment experienced	1*, 4	Not specified	Sovaldi + Daklinza +RBV§ *If post-liver transplantation.*
	2	Not specified	Sovaldi + RBV† *If post-liver transplantation.*
Not specified	1*, 2, 3, 4	Not specified	Sovaldi + Daklinza + RBV§
	1*, 4	Not specified	Sovaldi + Daklinza† *If RBV ineligible.*

*Subtype a or b, or unknown subtype
**NS3 includes Victrelis (boceprevir), Incivek (telaprevir) or Olysio (simeprevir)
§Treatment duration - 12 weeks
♦Treatment duration – 12 to 24 weeks
◊Treatment duration – 16 to 24 weeks
†Treatment duration - 24 weeks

V. Product Availability

a. *Sovaldi Formulations*
Tablet, Oral:
- Sovaldi: 400 mg of sofosbuvir

b. Ribavirin Formulations:
Capsule, Oral:
- Rebetol: 200 mg
- Ribasphere: 200 mg
- Generic: 200 mg

Solution, Oral:
- Rebetol: 40 mg/mL (100 mL)

Tablet, Oral:
- Copegus: 200 mg
- Moderiba (includes dose packs): 200 mg, 400 mg, 600 mg
- Ribasphere: 200 mg, 400 mg, 600 mg
- Ribasphere RibaPak (dose packs): 200 mg, 400 mg, 600 mg
- Generic: 200 mg

c. Peginterferon Alfa-2a Formulations:
Solution, Subcutaneous [preservative free]:
- Pegasys: 180 mcg/mL (1 mL); 180 mcg/0.5 mL (0.5 mL)
- Pegasys ProClick: 135 mcg/0.5 mL (0.5 mL)
- Pegasys ProClick: 180 mcg/0.5 mL (0.5 mL)

d. Peginterferon Alfa-2b Formulations:
Kit, Subcutaneous [preservative free]:
- Peg-Intron Redipen: 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, 150 mcg/0.5 mL
- Peg-Intron Redipen Pak 4: 120 mcg/0.5 mL
- PegIntron: 50 mcg/0.5 mL, 80 mcg/0.5 mL, 120 mcg/0.5 mL, 150 mcg/0.5 mL
- Sylatron: 200 mcg, 300 mcg, 600 mcg

VI. Appendices/General Information

Appendix A: Abbreviation Key

- APRI: AST to platelet ratio
- AASLD: American Association for the Study of Liver Diseases
- CTP: Child Turcotte Pugh
- CrCl: creatinine clearance
- DAA: direct acting antiviral

- FIB-4: Fibrosis-4 index
- HCC: hepatocellular carcinoma
- HCV: hepatitis C virus
- IDSA: Infectious Diseases Society of America
- MRE: magnetic resonance elastography
- NS3/4A, NS5A/B: nonstructural protein
- Peg-IFN: pegylated interferon
- PI: protease inhibitor
- RBV: ribavirin

Appendix B: General Information

- Hepatitis B reactivation is a Black Box Warning for all direct-acting antiviral drugs for the treatment of HCV. The provider must provide one (1) of the following:
  - Documentation of absence of concurrent HBV infection as evidenced by laboratory values showing absence of hepatitis B virus envelope antigen (HBeAg) and HBV DNA (deoxyribonucleic acid); or
  - Documentation that HBV co-infected patient may not be candidates for therapy as evidenced by one of the following:
    - Absence of HBeAg, HBV DNA less than 2,000 international units/mL, and alanine aminotransferase (ALT) level within one (1) to two (2) times the upper limit of normal; or
    - HBeAg-positive and HBV DNA greater than 1,000,000 international units/mL and ALT level within one (1) to two (2) times the upper limit of normal; or
  - Documentation that concurrent HBV infection is being treated (e.g., tenofovir alafenamide, adefovir, entecavir), unless contraindicated or clinically significant adverse effects are experienced.
- Due to higher rates of virologic failure and treatment-emergent drug resistance, the data does not support labeling for treatment of HCV genotype 1 infected patients who are both NS3/4A PI and NS5A inhibitor-experienced.

Appendix C: Direct-Acting Antivirals (DAAs) for Treatment of HCV Infection

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Daklinza	Daclatasvir				
Epclusa*	Velpatasvir	Sofosbuvir			
Harvoni*	Ledipasvir	Sofosbuvir			
Olysio				Simeprevir	
Sovaldi		Sofosbuvir			
Technivie*	Ombitasvir			Paritaprevir	Ritonavir
Viekira XR/PAK*	Ombitasvir		Dasabuvir	Paritaprevir	Ritonavir

Brand Name	Drug Class				
	NS5A Inhibitor	Nucleotide Analog NS5B Polymerase Inhibitor	Non-Nucleoside NS5B Palm Polymerase Inhibitor	NS3/4A Protease Inhibitor (PI)**	CYP3A Inhibitor
Zepatier*	Elbasvir			Grazoprevir	

*Combination drugs
**Additional PIs no longer recommended: Victrelis (boceprevir), Incivek (telaprevir)

VII. References

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16. Pegiterferone alpha-2b: Drug information. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2016. Available at UpToDate.com. Accessed July 26, 2016.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. SilverSummit Healthplan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Healthplan" means the SilverSummit Healthplan which has adopted this clinical policy and that is operated or administered, in whole or in part, by SilverSummit Healthplan or any of such Healthplan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Healthplan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Healthplan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Healthplan retains the right to change, amend, or withdraw this clinical policy, and additional clinical policies may be developed and adopted, as needed, at any time.

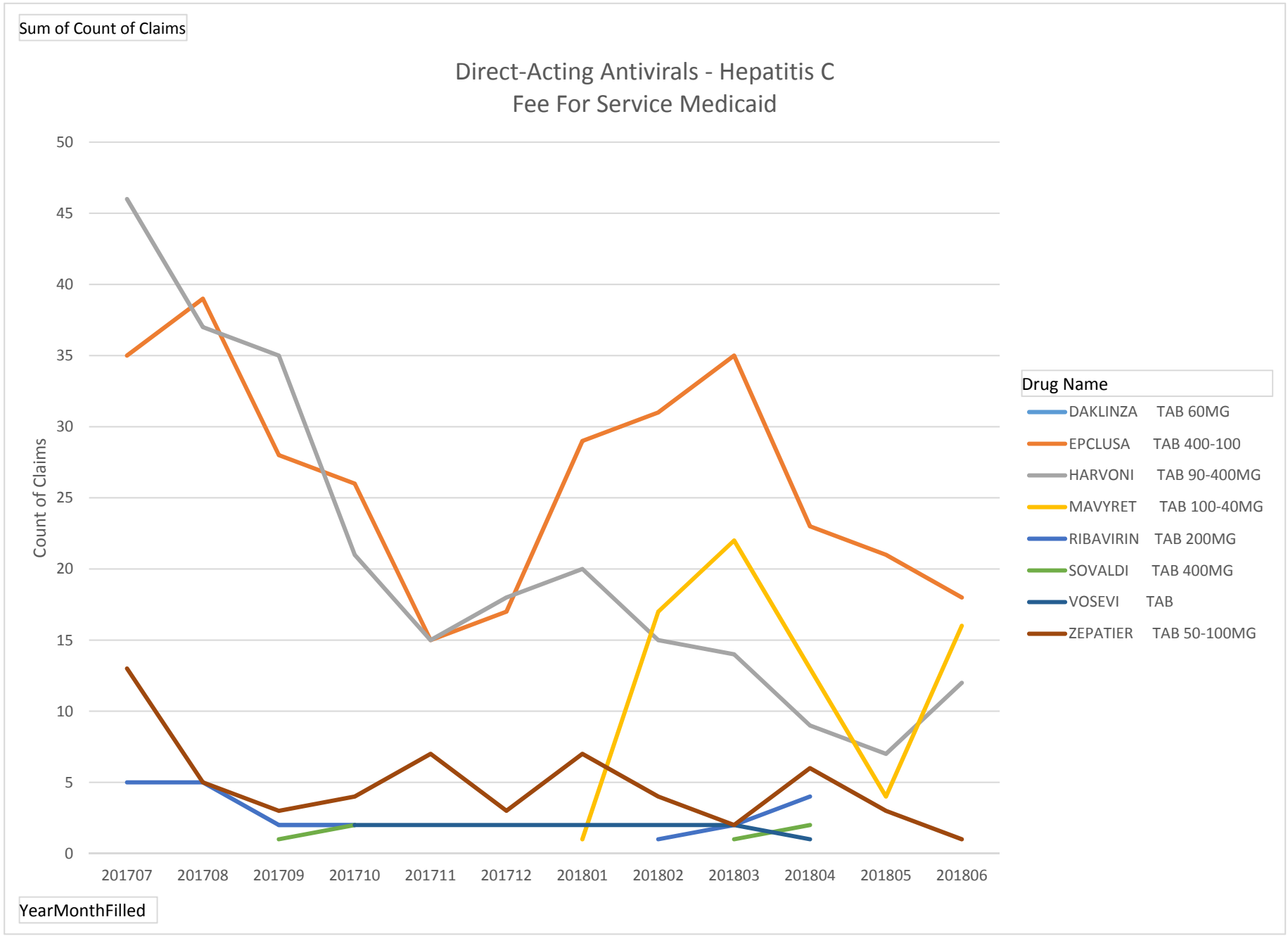
This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Healthplan has no control or right of control. Providers are not agents or employees of the Healthplan.

Note: For Medicaid members, when State Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, State Medicaid coverage provisions take precedence. Please refer to the State Medicaid Manual (MSM 1200, revised August 1, 2017) for any coverage provisions pertaining to this clinical policy. The Medicaid Manual may be located at the Nevada Department of Health and Human Services Division of Health Care Financing and Policy (DHCFP) at http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C1200/Chapter1200/.

Revision Log

Reviews, Revisions, and Approvals	Date	Approval Date
New policy created for SilverSummit based on Nevada requirements	02/17	07/17
Policy revised with standard formatting and current (August 1, 2017) MSM 1200 information	12/17	


Sum of Count of Claims
Direct-Acting Antivirals - Hepatitis C
Fee For Service Medicaid
Count of Claims
50
45
40
35
30
25
20
15
10
5
0
201707
201708
201709
201710
201711
201712
201801
201802
201803
201804
201805
201806
YearMonthFilled
Drug Name
DAKLINZA TAB 60MG
EPCLUSA TAB 400-100
HARVONI TAB 90-400MG
MAVYRET TAB 100-40MG
RIBAVIRIN TAB 200MG
SOVALDI TAB 400MG
VOSEVI TAB
ZEPATIER TAB 50-100MG

Hepatitis C - Direct-Acting Antivirals

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Drug Name		Nbr of Members	Nbr of Claims	Nbr of Days	Qty	Amt Paid
DAKLINZA	**TAB 60MG**	**3**	**4**	**84**	**84**	**$ 40,875.01**
201709		2	2	42	42	$ 10,224.07
201710		1	2	42	42	$ 30,650.94
EPCLUSA	**TAB 400-100**	**245**	**317**	**7090**	**7084**	**$ 5,916,992.18**
201707		24	35	624	630	$ 491,921.20
201708		23	39	694	686	$ 587,892.52
201709		20	28	462	462	$ 396,687.98
201710		18	26	518	518	$ 422,446.82
201711		11	15	294	294	$ 255,339.72
201712		12	17	392	392	$ 316,359.76
201801		24	29	700	700	$ 560,211.47
201802		28	31	784	784	$ 681,968.55
201803		29	35	924	924	$ 779,378.10
201804		22	23	630	630	$ 523,639.78
201805		18	21	592	588	$ 487,102.30
201806		16	18	476	476	$ 414,043.98
HARVONI	**TAB 90-400MG**	**168**	**249**	**5012**	**5012**	**$ 4,882,500.69**
201707		28	46	826	826	$ 840,020.57
201708		24	37	658	658	$ 626,968.46
201709		21	35	658	658	$ 666,264.98
201710		13	21	364	364	$ 398,958.63
201711		12	15	364	364	$ 305,694.23
201712		12	18	350	350	$ 322,610.00
201801		16	20	434	434	$ 322,610.93
201802		11	15	322	322	$ 353,300.99
201803		9	14	336	336	$ 368,861.02
201804		6	9	224	224	$ 215,476.82
201805		6	7	168	168	$ 184,692.70
201806		10	12	308	308	$ 277,041.36
MAVYRET	**TAB 100-40MG**	**66**	**73**	**2044**	**6132**	**$ 911,922.23**
201801		1	1	28	84	$ 866.55
201802		17	17	476	1428	$ 212,229.27
201803		20	22	616	1848	$ 290,623.74
201804		11	13	364	1092	$ 157,205.74
201805		3	4	112	336	$ 52,840.68
201806		14	16	448	1344	$ 198,156.25
RIBAVIRIN	**TAB 200MG**	**18**	**21**	**556**	**2550**	**$ 3,377.22**
201707		4	5	121	586	$ 790.69
201708		4	5	123	604	$ 936.66
201709		2	2	58	288	$ 442.71
201710		2	2	58	288	$ 442.71
201802		1	1	28	112	$ 149.79

201803		2	2	56	224	$	228.56
201804		3	4	112	448	$	386.10
SOVALDI	**TAB 400MG**	**4**	**6**	**140**	**140**	**$**	**139,501.02**
201709		1	1	14	14	$	14,010.17
201710		1	2	42	42	$	42,020.34
201803		1	1	28	28	$	28,010.17
201804		1	2	56	56	$	55,460.34
VOSEVI	**TAB**	**12**	**13**	**336**	**336**	**$**	**299,172.21**
201710		1	2	42	42	$	37,400.34
201711		2	2	56	56	$	49,860.34
201712		2	2	42	42	$	37,400.34
201801		2	2	56	56	$	49,860.34
201802		2	2	56	56	$	49,860.34
201803		2	2	56	56	$	49,860.34
201804		1	1	28	28	$	24,930.17
ZEPATIER	**TAB 50-100MG**	**47**	**58**	**1206**	**1246**	**$**	**559,895.96**
201707		9	13	218	238	$	97,785.42
201708		5	5	92	112	$	35,555.22
201709		3	3	84	84	$	17,776.22
201710		4	4	98	98	$	8,896.90
201711		5	7	140	140	$	53,334.22
201712		3	3	84	84	$	53,306.46
201801		5	7	154	154	$	79,974.96
201802		4	4	98	98	$	62,195.96
201803		2	2	56	56	$	35,537.64
201804		4	6	98	98	$	62,216.32
201805		2	3	56	56	$	35,547.82
201806		1	1	28	28	$	17,768.82
Grand Total		**563**	**741**	**16468**	**22584**	**$**	**12,754,236.52**

YEAR_MONTH	DRUG_NAME	MBR_COUNT	CLM_COUNT	DAYS_SUPPLY	QUANTITY
201703	DAKLINZA	1	2	42	42
201703	EPCLUSA	8	10	196	196
201703	HARVONI	14	20	490	490
201703	SOVALDI	2	3	70	70
201703	ZEPATIER	1	3	56	56
201704	DAKLINZA	1	1	28	28
201704	EPCLUSA	7	9	224	224
201704	HARVONI	8	9	210	210
201704	SOVALDI	2	2	56	56
201704	ZEPATIER	3	4	98	98
201705	EPCLUSA	6	7	182	182
201705	HARVONI	3	4	70	70
201705	SOVALDI	1	1	28	28
201705	ZEPATIER	10	15	238	238
201706	EPCLUSA	3	4	84	84
201706	HARVONI	3	5	98	98
201706	SOVALDI	1	1	28	28
201706	ZEPATIER	20	32	602	602
201707	EPCLUSA	1	1	28	28
201707	HARVONI	3	4	70	70
201707	ZEPATIER	17	20	434	434
201708	DAKLINZA	1	2	42	42
201708	EPCLUSA	5	8	140	140
201708	HARVONI	4	6	98	98
201708	SOVALDI	1	2	42	42
201708	VOSEVI	1	1	28	28
201708	ZEPATIER	25	33	728	728
201709	EPCLUSA	9	10	210	210
201709	HARVONI	3	3	84	84
201709	VOSEVI	1	1	28	28
201709	ZEPATIER	24	31	602	602
201710	EPCLUSA	9	11	252	252
201710	HARVONI	2	2	42	42
201710	VOSEVI	1	1	28	28
201710	ZEPATIER	24	32	672	672
201711	EPCLUSA	11	15	322	322
201711	HARVONI	3	4	56	56
201711	ZEPATIER	21	29	574	574
201712	EPCLUSA	6	9	154	154
201712	HARVONI	3	5	112	112
201712	MAVYRET	1	1	28	84
201712	ZEPATIER	19	27	532	532
201801	EPCLUSA	5	8	182	182
201801	HARVONI	2	2	56	56
201801	MAVYRET	1	1	28	84
201801	ZEPATIER	18	29	630	630

201802	EPCLUSA	4	5	98	98
201802	HARVONI	1	1	28	28
201802	MAVYRET	1	1	28	84
201802	VOSEVI	1	1	28	28
201802	ZEPATIER	16	20	490	490
201803	EPCLUSA	2	2	56	56
201803	HARVONI	2	2	56	56
201803	MAVYRET	9	13	210	630
201803	VOSEVI	1	1	28	28
201803	ZEPATIER	12	14	336	336
201804	EPCLUSA	2	2	56	56
201804	MAVYRET	15	24	364	1,092
201804	VOSEVI	1	1	28	28
201804	ZEPATIER	5	7	182	182
201805	EPCLUSA	2	4	84	84
201805	HARVONI	1	2	28	28
201805	MAVYRET	17	23	504	1,512
201805	ZEPATIER	1	2	28	28

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Hepatitis C Utilization

August 1, 2017 - May 31, 2018

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2017/08	EPCLUSA TAB 400-100	1	1	28
2017/08	RIBAVIRIN TAB 200MG	1	1	84
2017/08	ZEPATIER TAB 50-100MG	8	8	224
2017/09	EPCLUSA TAB 400-100	14	14	392
2017/09	HARVONI TAB 90-400MG	1	1	28
2017/09	RIBAVIRIN TAB 200MG	2	2	280
2017/09	ZEPATIER TAB 50-100MG	25	25	700
2017/10	EPCLUSA TAB 400-100	10	12	336
2017/10	MAVYRET TAB 100-40MG	1	1	84
2017/10	RIBASPHERE CAP 200MG	1	1	28
2017/10	RIBAVIRIN TAB 200MG	5	7	784
2017/10	ZEPATIER TAB 50-100MG	31	33	924
2017/11	EPCLUSA TAB 400-100	17	19	532
2017/11	HARVONI TAB 90-400MG	1	1	28
2017/11	MAVYRET TAB 100-40MG	1	2	168
2017/11	RIBAPAK PAK 1200/DAY	1	1	56
2017/11	RIBASPHERE CAP 200MG	2	2	168
2017/11	RIBAVIRIN TAB 200MG	2	2	196
2017/11	ZEPATIER TAB 50-100MG	37	39	1,092
2017/12	EPCLUSA TAB 400-100	18	21	588
2017/12	HARVONI TAB 90-400MG	2	3	84
2017/12	RIBAPAK PAK 1200/DAY	1	2	112
2017/12	RIBASPHERE CAP 200MG	2	2	168
2017/12	RIBAVIRIN TAB 200MG	3	4	420
2017/12	VOSEVI TAB	1	1	28
2017/12	ZEPATIER TAB 50-100MG	40	44	1,232
2018/01	EPCLUSA TAB 400-100	16	19	532
2018/01	HARVONI TAB 90-400MG	3	3	84
2018/01	MAVYRET TAB 100-40MG	11	11	924
2018/01	RIBAPAK PAK 1200/DAY	1	1	56
2018/01	RIBASPHERE CAP 200MG	1	1	140
2018/01	RIBAVIRIN TAB 200MG	3	3	364
2018/01	VOSEVI TAB	2	2	56
2018/01	ZEPATIER TAB 50-100MG	31	38	1,064
2018/02	EPCLUSA TAB 400-100	9	10	280
2018/02	HARVONI TAB 90-400MG	1	1	28
2018/02	MAVYRET TAB 100-40MG	35	36	3,024
2018/02	RIBAVIRIN TAB 200MG	3	3	364
2018/02	VOSEVI TAB	2	2	56
2018/02	ZEPATIER TAB 50-100MG	14	14	392
2018/03	EPCLUSA TAB 400-100	4	5	140
2018/03	HARVONI TAB 90-400MG	1	1	28
2018/03	MAVYRET TAB 100-40MG	38	42	3,528
2018/03	VOSEVI TAB	1	1	28
2018/03	ZEPATIER TAB 50-100MG	4	4	112
2018/04	EPCLUSA TAB 400-100	1	1	28
2018/04	MAVYRET TAB 100-40MG	31	34	2,856
2018/04	ZEPATIER TAB 50-100MG	1	1	28
2018/05	EPCLUSA TAB 400-100	1	1	28
2018/05	HARVONI TAB 90-400MG	1	1	28
2018/05	MAVYRET TAB 100-40MG	35	37	3,108
2018/05	RIBAVIRIN TAB 200MG	1	1	112
2018/05	ZEPATIER TAB 50-100MG	1	1	28

UU. Hepatitis C direct-acting antivirals

Therapeutic Class: Hepatitis C direct acting antivirals
Last Reviewed by the DUR Board: July 28, 2016
Previously reviewed by the DUR Board: January 28, 2016

Hepatitis C direct-acting antivirals are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

   a. Approval will be given if the following criteria are met and documented.

   b. Recipients must meet all of the following criteria:

      1. The recipient has a diagnosis of chronic Hepatitis C Virus (HCV) infection; and

      2. The recipient is 18 years of age or older; and

      3. All of the following must be included with the PA request:

         a. Medical records and results of laboratory and diagnostic tests which support all of the following:

            1. The HCV genotype (and subtype, if applicable); and

            2. The baseline HCV RNA viral load and date drawn; and

            3. The hepatic fibrosis stage, including tests supporting liver disease staging (e.g., APRI, Fibroscan, Fibrosure, FIB-4). (Results of diagnostic tests or imaging studies that are inconclusive may require additional testing); and

         b. A complete treatment regimen; and

         c. The duration of treatment; and

         d. Any previous treatment experience and length of treatment, if any, including outcome (e.g. discontinued due to side effects, relapsed, non-responder, null-responder); and

      4. The prescriber must certify that the treatment will be discontinued if the viral load is detectable at week four of treatment and has increased by greater than 10-fold (>1 $\log_{10}$ IU/mL) on repeat testing at week six (or

thereafter); and

5. Requests for recipients with decompensated cirrhosis (Child Turcotte Pugh (CTP) class B or C) and requests for recipients who have chronic hepatitis C infection status-post liver transplant will be evaluated on a case by case basis.

2. Harvoni® (ledipasvir/sofosbuvir) Initial Requests

a. The requested dose is one 90 mg/400 mg tablet once daily.

b. Genotype 1:

1. The recipient is treatment naïve and must meet one of the following:

a. No cirrhosis, pre-treatment HCV RNA < six million and the requested duration is eight weeks; or

b. No cirrhosis, pre-treatment HCV RNA ≥ six million and the requested duration is 12 weeks; or

c. Compensated Cirrhosis (CTP class A), requested duration is 12 weeks.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin) and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) will be treated with ribavirin and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), documentation is provided that the recipient is unable to take ribavirin and the requested duration is 24 weeks.

3. The recipient is treatment-experienced (failed peginterferon + ribavirin + an NS3 protease inhibitor) and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with ribavirin and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), documentation is provided that the recipient is unable to take ribavirin and the requested duration is 24 weeks.

4. The recipient is treatment-experienced (failed Sovaldi + ribavirin ± peginterferon) and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with ribavirin and the requested duration is 24 weeks.

c. Genotype 4:

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin) and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with ribavirin and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), documentation is provided the recipient is unable to take ribavirin and the requested duration is 24 weeks.

d. Genotype 5 and 6:

1. The recipient is treatment-naïve and the requested duration is 12 weeks; or

2. The recipient is treatment-experienced (failed peginterferon + ribavirin) and the requested duration is 12 weeks.

3. Viekira Pak® (dasabuvir-ombitasvir-paritaprevir-ritonavir) (Initial Requests)

a. The requested dose is two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily (25/150/100 mg) and one dasabuvir 250 mg tablet twice daily.

b. Genotype 1a:

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, recipient will be treated with ribavirin and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

c. Genotype 1b:

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

2. The recipient is treatment experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

4. Technivie® (ombitasvir/paritaprevir/ritonavir) (Initial Requests)

a. The requested dose is two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily (25/150/100 mg).

b. Genotype 4:

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, the recipient will be treated with ribavirin and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

2. The recipient is treatment-experienced (failed peginterferon and ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, the recipient will be treated with ribavirin and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with ribavirin and the requested duration is 12 weeks.

5. Daklinza® (daclatasvir) (Initial Requests)

a. The requested dose is one of the following:

1. 60 mg (one tablet) daily; or

2. 30 mg (one tablet) and the recipient is receiving a strong CYP3A inhibitor; or

3. 90 mg (one tablet) daily and the recipient is receiving a concomitant moderate CYP3A inducer.

b. Genotype 1

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi + ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks, documentation has been provided showing the recipient is unable to take ribavirin and

documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

c. Compensated cirrhosis (CTP class A) will be treated with Sovaldi, the requested duration is 24 weeks, documentation is provided showing that the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

3. The recipient is treatment-experienced (failed peginterferon + ribavirin + NS3 protease inhibitor) and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks and documentation is provided showing that the recipient is unable to take ribavirin.

c. Genotype 2

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 16 weeks and documentation is provided showing the recipient is unable to take ribavirin.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy), documentation is provided showing the recipient is unable to take

ribavirin and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and the requested duration is 16 to 24 weeks.

3. The recipient is treatment-experienced (failed Sovaldi + ribavirin dual therapy), documentation has been provided showing the recipient is unable to take peginterferon and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

b. No cirrhosis, will be treated with Sovaldi, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take ribavirin; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take ribavirin.

d. Genotype 3

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks and documentation has been provided showing the recipient is unable to take ribavirin.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy), documentation is provided showing that the recipient is unable to receive peginterferon and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take peginterferon.

3. The recipient is treatment-experienced (failed Sovaldi + ribavirin therapy dual therapy), documentation is provided that the recipient is unable to receive peginterferon and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks.

6. Olysio® (simeprevir) (Initial Request)

a. The requested dose is 150 mg (one capsule) daily.

b. Genotype 1a

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and ribavirin and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin, the requested duration is 24 weeks, the recipient is negative for the Q80K polymorphism and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

c. Compensated cirrhosis (CTP class A) will be treated with Sovaldi, the requested duration is 24 weeks, the recipient is negative for the Q80K polymorphism, documentation is provided showing that the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin, the requested duration is 24 weeks and the recipient is negative for the Q80K polymorphism; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks, the recipient is negative for the Q80K polymorphism and documentation has been provided showing that the recipient is unable to take ribavirin.

c. Genotype 1b

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks and documentation has been provided showing that the recipient is unable to take ribavirin.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with Sovaldi and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Sovaldi and ribavirin and the requested duration is 24 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with Sovaldi, the requested duration is 24 weeks and documentation has been provided showing that the recipient is unable to take ribavirin.

7. <u>Sovaldi® (sofosbuvir) (Initial Requests)</u>

a. The requested dose is 400 mg daily.

b. Genotype 1

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with Daklinza and the requested duration is 12 weeks; or

b. No cirrhosis, will be treated with Olysio and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with Daklinza + ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-

recommended regimen; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza, requested duration is 24 weeks, documentation is provided showing the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

e. Compensated cirrhosis (CTP class A), genotype 1a, will be treated with Olysio and ribavirin, the requested duration is 24 weeks, the recipient is negative for the Q80K polymorphism and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

f. Compensated cirrhosis (CTP class A), genotype 1a, will be treated with Olysio, the requested duration is 24 weeks, the recipient is negative for the Q80K polymorphism, documentation is provided showing the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

g. Compensated cirrhosis (CTP class A), genotype 1b, will be treated with Olysio and ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

h. Compensated cirrhosis (CTP class A), genotype 1b, will be treated with Olysio, the requested duration is 24 weeks, documentation has been provided that the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with Daklinza and the requested duration is 12 weeks; or

b. No cirrhosis, will be treated with Olysio and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with Daklinza and ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza, requested duration is 24 weeks, documentation is provided showing

that the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

e. Compensated cirrhosis (CTP class A), genotype 1a, will be treated with Olysio and ribavirin, the requested duration is 24 weeks the recipient is negative for the Q80K polymorphism and documentation is provided why the recipient cannot use a guideline-recommended regimen; or

f. Compensated cirrhosis (CTP class A), genotype 1a, will be treated with Olysio, the requested duration is 24 weeks, the recipient is negative for the Q80K polymorphism, documentation is provided showing that the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

g. Compensated cirrhosis (CTP class A), genotype 1b, will be treated with Olysio and ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

h. Compensated cirrhosis (CTP class A), genotype 1b, will be treated with Olysio, the requested duration is 24 weeks, documentation is provided showing that the recipient is unable to take ribavirin and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

3. The recipient is treatment-experienced (failed peginterferon + ribavirin + NS3 protease inhibitor) and must meet one of the following:

a. No cirrhosis, will be treated with Daklinza and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A), will be treated with Daklinza and ribavirin and the requested duration is 24 weeks; or

c. Compensated cirrhosis (CTP class A) will be treated with Daklinza, the requested duration is 24 weeks and documentation has been provided showing the recipient is unable to take ribavirin.

c. Genotype 2

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and the requested duration is 12 weeks; or

b. No cirrhosis, will be treated with Daklinza and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with ribavirin and the requested duration is 16 weeks to 24 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza, the requested duration is 16 weeks and documentation has been provided showing that the recipient is unable to take ribavirin.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and the requested duration is 12 weeks; or

b. No cirrhosis, will be treated with Daklinza, the requested duration is 12 weeks and documentation is provided showing the recipient is unable to take ribavirin.

c. Compensated cirrhosis (CTP class A), will be treated with ribavirin and the requested duration is 16 weeks to 24 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza and ribavirin and the requested duration is 16 weeks to 24 weeks, and documentation is provided showing the recipient is unable to take ribavirin; or

e. Compensated cirrhosis (CTP class A), will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

3. The recipient is treatment-experienced (failed Sovaldi + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with Daklinza and ribavirin, the requested duration is 24 weeks and documentation has been provided showing the recipient is unable to receive peginterferon; or

b. No cirrhosis, will be treated with Daklinza, the requested duration is 24 weeks and documentation has been provided showing that the recipient is unable to take ribavirin and documentation has been provided showing that the recipient is unable to receive peginterferon; or

c. No cirrhosis, will be treated with ribavirin and peginterferon and the requested duration is 12 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza and ribavirin, the requested duration is 24 weeks and documentation has been provided showing that the recipient is unable to receive peginterferon; or

e. Compensated cirrhosis (CTP class A), will be treated with Daklinza, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take peginterferon and ribavirin.

f. Compensated cirrhosis (CTP class A), will be treated with ribavirin and peginterferon and the requested duration is 12 weeks.

d. Genotype 3

1. The recipient is treatment-naive and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and peginterferon and the requested duration is 12 weeks; or

b. No cirrhosis, will be treated with ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

c. No cirrhosis, will be treated with Daklinza and the requested duration is 12 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with ribavirin and peginterferon and the requested duration is 12 weeks; or

e. Compensated cirrhosis (CTP class A) will be treated with ribavirin, the requested duration is 24 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

f. Compensated cirrhosis (CTP class A) will be treated with Daklinza and ribavirin, the requested duration is 24 weeks; or

g. Compensated cirrhosis (CTP class A) will be treated with Daklinza, the requested duration is 24 weeks and documentation has been provided showing that the recipient is unable to take ribavirin.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with peginterferon and ribavirin and the

requested duration is 12 weeks; or

b. No cirrhosis, will be treated with Daklinza and the requested duration is 12 weeks; or

c. Compensated cirrhosis (CTP class A), will be treated with peginterferon and ribavirin and the requested duration is 12 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza and ribavirin, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take peginterferon.

3. The recipient is treatment-experienced (failed Sovaldi + ribavirin therapy dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with peginterferon and ribavirin and the requested duration is 12 weeks; or

b. No cirrhosis, will be treated with Daklinza and ribavirin, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take peginterferon; or

c. Compensated cirrhosis (CTP class A), will be treated with peginterferon and ribavirin and the requested duration is 12 weeks; or

d. Compensated cirrhosis (CTP class A), will be treated with Daklinza and ribavirin, the requested duration is 24 weeks and documentation is provided showing the recipient is unable to take peginterferon.

e. Genotype 4

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

b. Compensated cirrhosis (CTP class A) will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment-experienced (failed peginterferon alfa + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to

why the recipient cannot use a guideline-recommended regimen; or

b. Compensated cirrhosis (CTP class A) will be treated with ribavirin, the requested duration is 24 weeks, documentation is provided as to why the recipient cannot take peginerferon and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

f. Genotype 5, 6

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

b. Compensated cirrhosis (CTP class A) will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment-experienced (failed peginterferon alfa + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

b. Compensated cirrhosis (CTP class A) will be treated with ribavirin and peginterferon, the requested duration is 12 weeks and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

8. Zepatier® (elbasvir and grazoprevir)

a. The requested dose is one tablet (50/100 mg) daily.

b. Genotype 1a

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis, the requested duration is 12 weeks and there are no baseline NS5A RAVs for elbasvir detected; or

b. No cirrhosis, will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

c. Compensated cirrhosis (CTP class A), requested duration is 12 weeks and there are no baseline NS5A RAVs for elbasvir detected; or

d. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis, the requested duration is 12 weeks and there are no baseline NS5A RAVs for elbasvir detected; or

b. No cirrhosis, will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected and documentation is provided as to why the recipient cannot use a guideline-recommended regimen; or

c. Compensated cirrhosis (CTP class A), requested duration is 12 weeks, and there are no baseline NS5A RAVs for elbasvir detected; or

d. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected and documentation is provided as to why the recipient cannot use a guideline-recommended regimen.

3. The recipient is treatment-experienced (failed peginterferon + ribavirin + NS3 protease inhibitor) and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin, the requested duration is 12 weeks and there are no baseline NS5A RAVs for elbasvir detected; or

b. No cirrhosis, will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected; or

c. Compensated cirrhosis (CTP class A), will be treated with ribavirin, requested duration is 12 weeks, and there are no baseline NS5A RAVs for elbasvir detected; or

d. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected.

c. Genotype 1b

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual therapy) and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

3. The recipient is treatment-experienced (failed peginterferon + ribavirin + NS3 protease inhibitor) and must meet one of the following:

a. No cirrhosis, will be treated with ribavirin, the requested duration is 12 weeks and there are no baseline NS5A RAVs for elbasvir detected; or

b. No cirrhosis, will be treated with ribavirin, the requested duration is 16 weeks and baseline NS5A RAVs for elbasvir have been detected; or

c. Compensated cirrhosis (CTP class A), will be treated with ribavirin, requested duration is 12 weeks and there are no baseline NS5A RAVs for elbasvir detected; or

d. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 16 weeks, baseline NS5A RAVs for elbasvir have been detected.

d. Genotype 4

1. The recipient is treatment-naïve and must meet one of the following:

a. No cirrhosis and the requested duration is 12 weeks; or

b. Compensated cirrhosis (CTP class A) and the requested duration is 12 weeks.

2. The recipient is treatment-experienced (failed peginterferon + ribavirin dual

therapy) and must meet one of the following:

a. No cirrhosis, the requested duration is 12 weeks and documentation is provided showing the recipient experienced virologic relapse to peginterferon + ribavirin dual therapy; or

b. No cirrhosis, will be treated with ribavirin, the requested duration is 16 weeks and documentation has been provided showing the recipient experienced on-treatment virologic failure to peginterferon + ribavirin dual therapy; or

c. Compensated cirrhosis (CTP class A), the requested duration is 12 weeks and documentation is provided showing the recipient experienced virologic relapse to peginterferon + ribavirin dual therapy; or

d. Compensated cirrhosis (CTP class A), will be treated with ribavirin, the requested duration is 16 weeks and documentation has been provided showing the recipient experienced on-treatment virologic failure to peginterferon + ribavirin dual therapy.

9. Recipients who have received previous therapy with an NS5A inhibitor (e.g., daclatasvir, ledipasvir, ombitasvir) or combination therapy with sofosbuvir + simeprevir.

   a. The recipient must meet one of the following:

      1. The recipient has cirrhosis; or

      2. Documentation includes the clinical rationale for urgent retreatment.

   b. Testing for resistance-associated variants (RAVs) have been done and results have been provided.

   c. The requested regimen does not include agents in which RAVs have developed.

   d. The requested regimen includes ribavirin or documentation has been provided that ribavirin is contraindicated.

10. Epclusa® (sofosbuvir/velpatasvir)

   a. The requested dose is one tab daily; and

      1. The recipient is treatment-naïve, with or without cirrhosis and the requested duration is 12 weeks; or

      2. The recipient is treatment-experienced, with or without cirrhosis, the requested duration is 12 weeks and must meet one of the following:

a. Genotype 1a, peginterferon + ribavirin treatment experienced; or

b. Genotype 1b, peginterferon + ribavirin treatment experienced; or

c. Genotype 1, HCV nonstructural protein 3 (NS3) protease inhibitor (telaprevir, boceprevir, or simeprivir) plus peginterferon + ribavirin treatment experienced; or

d. Genotype 2, peginterferon + ribavirin treatment experienced; or

e. Genotype 2, sofosbuvir + ribavirin treatment experienced; or

f. Genotype 3, peginterferon + ribavirin treatment experienced; or

g. Genotpe 3, sofosbuvir + ribavirin treatment experienced; or

h. Genotype 4, peginterferon + ribavirin treatment experienced; or

i. Genotype 5 or 6, peginterferon + ribavirin treatment experienced.

11. For requests for recertification (for treatment beyond 12 weeks), the recipient must meet all of the following:

    a. Laboratory results for HCV RNA viral load at week four and week six (if applicable) have been submitted with the PA request; and

    b. The recipient's HCV viral load must meet one of the following:

        1. Undetectable HCV RNA viral load week four; or

        2. Detectable HCV RNA viral load at treatment week four and HCV RNA increased by $\leq$ 10-fold ($\leq$1 $\log_{10}$ IU/mL) on repeat testing at treatment week six (or thereafter).

        3. And, the recipient is compliant on all drugs in the treatment regimen.

12. Prior Authorization Guidelines:

    a. Prior authorization approval will be for a maximum of 12 weeks (unless the requested regimen is less than 12 weeks long or the remaining duration of therapy is less than 12 weeks).

    b. The initial prescription will be limited to a 14-day supply; subsequent refills can be up to 34 days.

    c. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Nevada Medicaid
Antibiotics
Pharmacy Coverage Guideline

Third Generation Cephalosporin

- cefixime
- cefdinir
- cefpodoxime

Fluroquinolones/Oxazolidinones

- ciprofloxacin
- levofloxacin
- delafloxacin
- moxifloxacin
- ofloxacin
- tedizolid

CRITERIA FOR COVERAGE/NONCOVERAGE

Indications
Susceptible bacterial infections.

Initial Authorization:

Approval Length: As appropriate for a single course

1. Culture and sensitivity-proven susceptibilities suggest the requested drug is necessary.
2. Exception Criteria:
    a. Prescribed by an infectious disease specialist
    b. Cefixime prescribed for gonococcal infection where ceftriaxone is unavailable
    c. Recipient resides in one of the following:
        i. Acute Care
        ii. Long-term Acute Care (LTAC)
        iii. Skilled Nursing Facility (SNF)

References:

IDSA Guidelines: http://www.idsociety.org/PracticeGuidelines/

Non-Formulary Prescription Request

Override(s)	Approval Duration
Prior Authorization	1 year

Medications	Quantity Limit
Non-Formulary Prescription Requests	Subject to possible quantity limits

APPROVAL CRITERIA

I. In order to receive a non-formulary medication, the individual must meet one of the following criteria:

A. Individual has previously tried and failed 2 (two) formulary products (when available): One of which has to be in the same specific drug class; the other product can be in a different drug class however it must have the same indication as the product requested; **OR**
B. For combination products: individual has previously tried and failed 2 (two) formulary products (when available): One of which must be in the same specific class as at least one ingredient in non-formulary combination product; **OR**
C. For Non-Formulary antibiotics/ anti-virals/ anti-fungals, individual has previously tried and failed one formulary antibiotic/ anti-viral/ anti-fungal product within the same route of administration; **OR**
D. The individual has a documented drug interaction with a formulary drug; **OR**
E. The individual has documented adverse drug experiences (side effects, adverse drug reaction) with a formulary drug.

II. Any request for a Non-Formulary medication that does not meet the criteria in section I shall be subject to medical necessity review.

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2016. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2016; Updated periodically.

Health Plan of Nevada

Antimicrobial Resistance Program

Criteria Recommendation

At this time, HPN does not recommend proceeding with prior authorization to ensure appropriate use of antibiotics and promote antibiotic stewardship. While HPN agrees with and supports the recommendations of the guidelines proposed by the AntiMicrobial Stewardship Summit, edits in the pharmacy claims system that require prior authorization are not recommended due to: (1) the delay in acquisition of antibiotics to members who have physicians who are prescribing appropriately; (2) the amount of work from providers both in hospitals, ERs, urgent care, and provider offices; and (3) the increased cost of administering prior authorization on highly utilized and often low-cost products due to increased staffing and/or per case costs as paid to PBMs to administer PAs.

Third Gen Cephalosporins

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Sum of Days	Sum of Sum of Qty
IJ	**4,366**	**5,557**	**6,125**	**213,099**
CEFOTAXIME SODIUM	**1**	**1**	**1**	**1**
NVMNVPAD	1	1	1	1
CEFTAZIDIME	**10**	**30**	**83**	**172**
NVMBASIC	3	10	54	105
NVMNVPAD	6	19	19	37
NVMPARTBD2	1	1	10	30
CEFTRIAXONE SODIUM	**4,352**	**5,520**	**6,035**	**212,920**
NVMBASIC	56	87	440	611
NVMBASIC #	3	5	11	11
NVMBASICP	2	2	2	2
NVMLTC	44	85	211	224
NVMNVPAD	4,242	5,336	5,336	212,037
NVMPARTBD8	5	5	35	35
FORTAZ	**1**	**1**	**1**	**1**
NVMNVPAD	1	1	1	1
TAZICEF	**2**	**5**	**5**	**5**
NVMNVPAD	2	5	5	5
IV	**747**	**971**	**1,298**	**36,447**
CEFTAZIDIME/DEXTROSE	**4**	**4**	**10**	**802**
NVMLTC	1	1	3	300
NVMNVPAD	2	2	2	2
NVMPARTBD4	1	1	5	500
CEFTRIAXONE IN ISO-OSMOTI	**433**	**511**	**648**	**34,700**
NVMBASIC #	3	5	19	950
NVMLTC	27	44	157	8,500
NVMNVPAD	401	458	458	24,050
NVMPARTBD2	1	3	10	1,000
NVMPARTBD4	1	1	4	200
CEFTRIAXONE SODIUM	**108**	**146**	**279**	**374**
NVMBASIC	12	27	160	44
NVMNVPAD	96	119	119	330
CEFTRIAXONE/DEXTROSE	**201**	**304**	**355**	**552**
NVMBASIC #	2	5	13	13
NVMLTC	9	20	57	72
NVMNVPAD	189	278	278	460
NVMPARTBD4	1	1	7	7
TAZICEF	**1**	**6**	**6**	**19**
NVMNVPAD	1	6	6	19
OR	**5,576**	**5,705**	**54,105**	**300,970**
CEFDINIR	**5,433**	**5,544**	**52,848**	**297,647**

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Sum of Days	Sum of Sum of Qty
NVMB340B	4	4	37	74
NVMBASCH	14	14	145	874
NVMBASIC	4,342	4,422	43,192	251,438
NVMBASIC #	389	395	3,728	22,502
NVMBASICC#	7	7	67	374
NVMBASICCU	190	190	1,949	13,226
NVMBASICP	33	34	304	608
NVMBASICP#	2	2	17	34
NVMLTC	52	63	568	1,937
NVMNVPAD	85	96	96	920
NVMPARTBD0	27	27	266	442
NVMPARTBD2	136	138	1,258	2,578
NVMPARTBD4	12	12	107	379
NVMPARTBD8	134	134	1,052	2,167
NVMPB340B	2	2	10	20
NVMPBD2340	1	1	7	14
NVMPRTBD3A	3	3	45	60
CEFIXIME	**5**	**5**	**40**	**233**
NVMBASIC	3	3	31	175
NVMBASIC #	1	1	8	50
NVMNVPAD	1	1	1	8
CEFPODOXIME PROXETIL	**136**	**154**	**1,161**	**3,084**
NVMBASIC	70	71	805	2,371
NVMBASIC #	5	6	42	77
NVMBASICP	1	1	7	14
NVMLTC	3	3	24	27
NVMNVPAD	22	37	37	73
NVMPARTBD0	3	3	26	52
NVMPARTBD2	19	20	117	276
NVMPARTBD8	12	12	96	180
NVMPRTBD3A	1	1	7	14
SUPRAX	**2**	**2**	**56**	**6**
NVMBASIC	2	2	56	6
Grand Total	**10,689**	**12,233**	**61,528**	**550,516**

Fluroquinolone Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Sum of Days	Sum of Sum of Qty
IV	**425**	**543**	**600**	**114,120**
AVELOX	**22**	**25**	**25**	**6,500**
NVMNVPAD	22	25	25	6,500
CIPROFLOXACIN I.V.-IN D5W	**168**	**226**	**247**	**64,400**
NVMBASIC	2	8	14	5,400
NVMLTC	5	17	32	12,000
NVMNVPAD	161	201	201	47,000
LEVOFLOXACIN	**1**	**1**	**1**	**20**
NVMNVPAD	1	1	1	20
LEVOFLOXACIN IN 5% DEXTRO	**19**	**24**	**24**	**3,600**
NVMNVPAD	19	24	24	3,600
LEVOFLOXACIN IN D5W	**213**	**265**	**301**	**39,100**
NVMLTC	10	23	59	7,850
NVMNVPAD	203	242	242	31,250
MOXIFLOXACIN HYDROCHLORI	**1**	**1**	**1**	**250**
NVMNVPAD	1	1	1	250
MOXIFLOXACIN HCL	**1**	**1**	**1**	**250**
NVMNVPAD	1	1	1	250
OR	**9,740**	**10,257**	**79,256**	**134,883**
AVELOX	**18**	**18**	**348**	**348**
NVMBASCH	2	2	60	60
NVMBASIC	14	14	280	280
NVMLTC	1	1	7	7
NVMNVPAD	1	1	1	1
BAXDELA	**2**	**2**	**28**	**56**
NVMBASIC #	2	2	28	56
CIPRO	**47**	**62**	**741**	**7,084**
NVMBASIC	23	31	474	3,800
NVMBASIC #	5	5	52	720
NVMLTC	18	25	208	2,550
NVMPARTBD4	1	1	7	14
CIPROFLOXACIN	**2**	**6**	**6**	**7**
NVMNVPAD	2	6	6	7
CIPROFLOXACIN ER	**7**	**7**	**90**	**139**
NVMBASIC	7	7	90	139
CIPROFLOXACIN HCL	**5,943**	**6,223**	**48,228**	**93,186**
NVMB340B	9	10	86	172
NVMBASCH	52	53	451	857
NVMBASIC	3,897	4,019	32,892	64,238
NVMBASIC #	389	405	3,906	6,979
NVMBASICCU	8	8	38	76
NVMBASICP	27	27	170	342

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Sum of Days	Sum of Sum of Qty
NVMBASICP#	1	1	7	14
NVMLTC	197	247	1,657	3,312
NVMNVPAD	304	377	377	507
NVMPARTBD0	68	68	580	1,052
NVMPARTBD2	480	484	4,030	7,685
NVMPARTBD4	53	53	383	755
NVMPARTBD8	445	458	3,554	7,003
NVMPB340B	5	5	34	68
NVMPBD2340	1	1	7	14
NVMPRTBD3A	7	7	56	112
LEVAQUIN	**9**	**11**	**74**	**79**
NVMBASIC #	5	7	70	70
NVMNVPAD	4	4	4	9
LEVOFLOXACIN	**3,661**	**3,868**	**29,484**	**33,724**
NVMB340B	5	5	46	46
NVMBASCH	32	32	254	317
NVMBASIC	2,127	2,217	18,295	20,265
NVMBASIC #	272	281	2,223	2,442
NVMBASICP	13	13	116	116
NVMLTC	149	188	1,291	1,878
NVMNVPAD	216	254	254	1,317
NVMPARTBD0	96	96	755	741
NVMPARTBD1	1	1	10	10
NVMPARTBD2	378	398	3,093	3,326
NVMPARTBD4	38	42	340	317
NVMPARTBD8	328	335	2,761	2,903
NVMPBD2340	1	1	7	7
NVMPRTBD3A	5	5	39	39
MOXIFLOXACIN HCL	**51**	**60**	**257**	**260**
NVMBASIC	1	1	5	5
NVMBASIC #	7	7	31	34
NVMBASICP#	1	1	10	10
NVMNVPAD	13	21	21	21
NVMPARTBD0	1	1	7	7
NVMPARTBD2	12	12	97	97
NVMPARTBD4	11	12	54	54
NVMPARTBD8	5	5	32	32
Grand Total	**10,165**	**10,800**	**79,856**	**249,003**

YEAR_MONTH	TRADE_NAME	MBR_COUNT	CLM_COUNT	DAYS_SUPPLY
201706	AK-POLY-BAC	1	1	10
201706	AMOXICILLIN	2,860	2,920	27,218
201706	AMOXICILLIN-CLAVULANATE POT ER	3	3	27
201706	AMOXICILLIN-CLAVULANATE POTASS	1,021	1,037	9,908
201706	AMPICILLIN TRIHYDRATE	19	19	168
201706	ANTIBIOTIC	2	2	45
201706	AZASITE	2	2	39
201706	AZITHROMYCIN	1,403	1,424	6,643
201706	BACITRACIN	61	61	716
201706	BACITRACIN/POLYMYXIN	3	3	32
201706	BESIVANCE	2	2	32
201706	BICILLIN L-A	1	1	7
201706	BLEPHAMIDE S.O.P.	1	1	30
201706	CAYSTON	1	1	28
201706	CEFADROXIL	1	1	14
201706	CEFDINIR	501	501	4,941
201706	CEFEPIME HCL	1	3	14
201706	CEFIXIME	2	2	17
201706	CEFPODOXIME PROXETIL	4	4	60
201706	CEFPROZIL	1	1	14
201706	CEFTIN	3	3	30
201706	CEFTRIAXONE	6	13	79
201706	CEFUROXIME AXETIL	16	17	135
201706	CEPHALEXIN	1,091	1,126	10,110
201706	CIPRODEX	4	4	36
201706	CIPROFLOXACIN ER	1	1	7
201706	CIPROFLOXACIN HCL	549	554	4,394
201706	CLARITHROMYCIN	65	66	820
201706	CLARITHROMYCIN ER	1	1	21
201706	CLEOCIN PHOSPHATE	2	2	10
201706	CLINDAMYCIN HCL	427	443	3,708
201706	CLINDAMYCIN PALMITATE HCL	16	16	128
201706	CLINDAMYCIN PEDIATRIC	11	11	89
201706	CLINDAMYCIN PHOSPHATE	198	200	4,932
201706	DAPTOMYCIN	4	10	64
201706	DICLOXACILLIN SODIUM	10	10	117
201706	DOXYCYCLINE HYCLATE	24	26	454
201706	DOXYCYCLINE IR-DR	1	1	30
201706	DOXYCYCLINE MONOHYDRATE	228	230	3,971
201706	ERY-TAB	2	2	60
201706	ERYTHROCIN STEARATE	1	1	7
201706	ERYTHROMYCIN	226	228	2,293
201706	ERYTHROMYCIN ETHYLSUCCINATE	1	1	30
201706	ERYTHROMYCIN-BENZOYL PEROXIDE	6	6	171
201706	ETHAMBUTOL HCL	2	3	58
201706	GENTAK	16	16	137

201706	GENTAMICIN SULFATE	83	83	827
201706	INVANZ	2	6	37
201706	ISONIAZID	14	15	448
201706	LEVOFLOXACIN HEMIHYDRATE	165	170	1,374
201706	LEVOFLOXACIN-D5W	1	4	29
201706	LINEZOLID	7	8	83
201706	MEROPENEM	2	2	14
201706	METHENAMINE HIPPURATE	2	2	60
201706	METRONIDAZOLE	846	881	6,486
201706	MINOCYCLINE HCL	90	93	2,548
201706	MUPIROCIN	438	452	5,174
201706	NEO-POLYCIN HC	1	1	10
201706	NEO/POLYMYXIN/DEXAMETHASONE	64	69	777
201706	NEOMYCIN SULFATE	10	10	104
201706	NEOMYCIN-POLYMYXIN-DEXAMETHASO	8	8	64
201706	NEOMYCIN/BACITRACIN/POLYMYXIN	3	3	24
201706	NEOMYCIN/POLYMYXIN/GRAMICIDIN	1	1	12
201706	NEOMYCIN/POLYMYXIN/HC	189	192	2,224
201706	NITROFURANTOIN	49	51	566
201706	NITROFURANTOIN MACROCRYSTAL	504	513	3,857
201706	OFLOXACIN	190	198	2,549
201706	PCE	1	1	14
201706	PENICILLIN V POTASSIUM	206	213	2,005
201706	PIPERACILLIN-TAZOBACTAM	4	8	48
201706	POLY BACITRACIN	4	4	31
201706	POLYMYXIN B SUL-TRIMETHOPRIM	298	298	4,020
201706	PRIFTIN	1	1	28
201706	RIFABUTIN	1	1	30
201706	RIFAMPIN	6	7	150
201706	SILVER SULFADIAZINE	52	54	1,020
201706	SODIUM SULFACETAMIDE/SULFUR	1	1	30
201706	SSD	11	12	281
201706	SULFACETAMIDE SODIUM	11	11	131
201706	SULFAMETHOXAZOLE/TRIMETHOPRIM	743	765	8,423
201706	SULFATRIM	1	1	7
201706	SUPRAX	1	1	10
201706	TEFLARO	1	4	30
201706	TETRACYCLINE HCL	12	12	219
201706	THALOMID	1	1	28
201706	TOBI PODHALER	1	1	30
201706	TOBRADEX	2	2	13
201706	TOBRAMYCIN SULFATE	119	119	1,468
201706	TOBRAMYCIN-DEXAMETHASONE	52	55	680
201706	TRIPLE ANTIBIOTIC	10	10	159
201706	TRIPLE ANTIBIOTIC PLUS	2	2	21
201706	URO-MP	1	1	30
201706	VANCOMYCIN HCL	9	18	102

201706	VIGAMOX	5	6	55
201706	XIFAXAN	11	13	257
201706	ZERBAXA	1	4	27
201707	AMOXICILLIN	2,149	2,196	20,046
201707	AMOXICILLIN-CLAVULANATE POT ER	4	4	44
201707	AMOXICILLIN-CLAVULANATE POTASS	822	836	8,108
201707	AMPICILLIN TRIHYDRATE	8	8	82
201707	ANTIBIOTIC	3	3	17
201707	AZASITE	1	1	7
201707	AZITHROMYCIN	1,033	1,044	4,822
201707	BACITRACIN	43	44	562
201707	BACITRACIN/POLYMYXIN	1	1	3
201707	BACTROBAN	2	2	15
201707	BICILLIN L-A	1	1	21
201707	CEFADROXIL	2	2	15
201707	CEFAZOLIN SODIUM	1	3	22
201707	CEFDINIR	303	303	3,022
201707	CEFEPIME HCL	3	7	49
201707	CEFIXIME	1	1	10
201707	CEFPODOXIME PROXETIL	6	6	70
201707	CEFTRIAXONE	6	9	44
201707	CEFUROXIME AXETIL	40	40	343
201707	CEPHALEXIN	916	941	8,301
201707	CILOXAN	1	1	5
201707	CIPRO HC	1	1	15
201707	CIPRODEX	11	13	154
201707	CIPROFLOXACIN HCL	477	477	3,903
201707	CLARITHROMYCIN	51	51	631
201707	CLEOCIN PHOSPHATE	2	2	33
201707	CLINDAMYCIN HCL	367	378	3,202
201707	CLINDAMYCIN PALMITATE HCL	13	13	119
201707	CLINDAMYCIN PEDIATRIC	13	13	122
201707	CLINDAMYCIN PHOSPHATE	184	191	4,932
201707	CLINDESSE	1	1	1
201707	CORTISPORIN	1	1	15
201707	DAPSONE	1	1	30
201707	DAPTOMYCIN	5	16	103
201707	DICLOXACILLIN SODIUM	12	12	138
201707	DIFICID	1	1	2
201707	DOXYCYCLINE HYCLATE	24	24	272
201707	DOXYCYCLINE IR-DR	1	1	30
201707	DOXYCYCLINE MONOHYDRATE	210	218	3,778
201707	E.E.S.	1	1	14
201707	ERY	1	1	30
201707	ERY-TAB	1	1	10
201707	ERYTHROCIN STEARATE	1	1	15
201707	ERYTHROMYCIN	206	209	2,139

201707	ERYTHROMYCIN ETHYLSUCCINATE	4	4	60
201707	ERYTHROMYCIN-BENZOYL PEROXIDE	12	12	334
201707	ETHAMBUTOL HCL	2	3	74
201707	GENTAK	12	12	146
201707	GENTAMICIN SULFATE	83	83	885
201707	INVANZ	3	9	62
201707	ISONIAZID	13	13	388
201707	LEVOFLOXACIN HEMIHYDRATE	154	161	1,285
201707	LEVOFLOXACIN-D5W	1	3	19
201707	LINEZOLID	10	13	120
201707	MEROPENEM	1	1	4
201707	METHENAMINE HIPPURATE	1	1	30
201707	METRONIDAZOLE	821	848	6,207
201707	MINOCYCLINE HCL	88	91	2,440
201707	MOXIFLOXACIN HCL	3	3	25
201707	MUPIROCIN	387	399	4,692
201707	NEO/POLYMYXIN/DEXAMETHASONE	59	64	796
201707	NEOMYCIN SULFATE	17	17	158
201707	NEOMYCIN-POLYMYXIN-DEXAMETHASO	4	5	52
201707	NEOMYCIN/BACITRACIN/POLY/HC	1	1	5
201707	NEOMYCIN/BACITRACIN/POLYMYXIN	1	1	7
201707	NEOMYCIN/POLYMYXIN/GRAMICIDIN	2	2	12
201707	NEOMYCIN/POLYMYXIN/HC	216	219	2,705
201707	NITROFURANTOIN	41	43	599
201707	NITROFURANTOIN MACROCRYSTAL	511	525	4,023
201707	OFLOXACIN	215	217	2,630
201707	PENICILLIN V POTASSIUM	180	190	1,806
201707	PIPERACILLIN-TAZOBACTAM	1	2	14
201707	POLY BACITRACIN	2	2	37
201707	POLYMYXIN B SUL-TRIMETHOPRIM	190	191	2,677
201707	PRIFTIN	2	2	56
201707	RIFABUTIN	1	2	60
201707	RIFAMPIN	3	3	50
201707	SILVER SULFADIAZINE	58	61	1,306
201707	SODIUM SULFACETAMIDE/SULFUR	1	1	30
201707	SSD	22	24	469
201707	SULFACETAMIDE SODIUM	5	5	78
201707	SULFAMETHOXAZOLE/TRIMETHOPRIM	629	644	7,125
201707	SULFATRIM	1	1	10
201707	TEFLARO	4	7	51
201707	TETRACYCLINE HCL	11	11	181
201707	TOBRADEX	1	1	10
201707	TOBRAMYCIN SULFATE	86	86	933
201707	TOBRAMYCIN-DEXAMETHASONE	40	41	407
201707	TRIMETHOPRIM	1	1	30
201707	TRIPLE ANTIBIOTIC	10	10	180
201707	URO-MP	1	1	30

201707	VANCOMYCIN HCL	8	18	96
201707	VANDAZOLE	1	1	5
201707	VIGAMOX	1	1	15
201707	XIFAXAN	7	7	176
201708	AMOXICILLIN	2,716	2,795	25,416
201708	AMOXICILLIN-CLAVULANATE POT ER	2	2	15
201708	AMOXICILLIN-CLAVULANATE POTASS	1,002	1,021	9,606
201708	AMPICILLIN TRIHYDRATE	11	11	127
201708	ANTIBIOTIC	3	3	32
201708	AZITHROMYCIN	1,252	1,267	5,756
201708	BACITRACIN	45	46	625
201708	BACITRACIN/POLYMYXIN	9	10	88
201708	CAYSTON	1	1	28
201708	CEFACLOR	1	1	10
201708	CEFAZOLIN SODIUM	1	2	12
201708	CEFDINIR	415	415	4,067
201708	CEFEPIME HCL	6	19	127
201708	CEFPODOXIME PROXETIL	5	5	91
201708	CEFPROZIL	1	1	14
201708	CEFTRIAXONE	6	13	74
201708	CEFUROXIME AXETIL	36	36	317
201708	CEPHALEXIN	1,028	1,061	9,226
201708	CIPRODEX	4	5	50
201708	CIPROFLOXACIN HCL	536	539	4,262
201708	CLARITHROMYCIN	58	60	760
201708	CLARITHROMYCIN ER	1	1	7
201708	CLEOCIN PHOSPHATE	2	2	37
201708	CLINDAMYCIN HCL	407	423	3,513
201708	CLINDAMYCIN PALMITATE HCL	18	18	156
201708	CLINDAMYCIN PEDIATRIC	19	19	199
201708	CLINDAMYCIN PHOSPHATE	237	247	6,226
201708	DALVANCE	1	1	1
201708	DAPSONE	2	2	44
201708	DAPTOMYCIN	9	17	96
201708	DICLOXACILLIN SODIUM	6	6	54
201708	DOXYCYCLINE HYCLATE	16	18	345
201708	DOXYCYCLINE IR-DR	2	2	17
201708	DOXYCYCLINE MONOHYDRATE	261	270	5,025
201708	ERY	2	2	60
201708	ERY-TAB	1	1	30
201708	ERYTHROCIN STEARATE	1	1	8
201708	ERYTHROMYCIN	174	181	1,687
201708	ERYTHROMYCIN ETHYLSUCCINATE	1	1	10
201708	ERYTHROMYCIN-BENZOYL PEROXIDE	8	8	218
201708	ETHAMBUTOL HCL	1	2	28
201708	GENTAK	6	6	45
201708	GENTAMICIN SULFATE	76	76	831

201708	INVANZ	4	7	41
201708	ISONIAZID	22	24	685
201708	LEVOFLOXACIN HEMIHYDRATE	139	143	1,061
201708	LEVOFLOXACIN-D5W	1	4	21
201708	LINEZOLID	7	7	59
201708	METHENAMINE MANDELATE	1	1	30
201708	METRONIDAZOLE	848	900	6,516
201708	MINOCYCLINE HCL	100	102	2,801
201708	MOXIFLOXACIN HCL	3	3	32
201708	MUPIROCIN	461	475	5,408
201708	NEO/POLYMYXIN/DEXAMETHASONE	56	58	747
201708	NEOMYCIN SULFATE	14	14	130
201708	NEOMYCIN-POLYMYXIN-DEXAMETHASO	11	11	92
201708	NEOMYCIN/BACITRACIN/POLY/HC	1	1	7
201708	NEOMYCIN/BACITRACIN/POLYMYXIN	1	1	7
201708	NEOMYCIN/POLYMYXIN/GRAMICIDIN	3	3	29
201708	NEOMYCIN/POLYMYXIN/HC	208	209	2,552
201708	NITROFURANTOIN	47	47	645
201708	NITROFURANTOIN MACROCRYSTAL	480	490	3,583
201708	OFLOXACIN	184	188	2,495
201708	PENICILLIN V POTASSIUM	197	209	1,968
201708	POLY BACITRACIN	7	7	83
201708	POLYMYXIN B SUL-TRIMETHOPRIM	206	206	3,093
201708	PRIFTIN	2	2	56
201708	RIFAMPIN	3	3	90
201708	SILVER SULFADIAZINE	47	48	850
201708	SODIUM SULFACETAMIDE/SULFUR	1	1	30
201708	SSD	24	24	568
201708	SULFACETAMIDE SODIUM	4	4	42
201708	SULFAMETHOXAZOLE/TRIMETHOPRIM	708	726	7,871
201708	SULFATRIM	1	1	10
201708	TEFLARO	1	1	7
201708	TETRACYCLINE HCL	10	10	226
201708	THALOMID	1	2	56
201708	TOBRAMYCIN SULFATE	75	75	1,067
201708	TOBRAMYCIN-DEXAMETHASONE	46	47	708
201708	TRIPLE ANTIBIOTIC	5	6	95
201708	TRIPLE ANTIBIOTIC PLUS	5	5	47
201708	URO-MP	1	2	40
201708	VANCOMYCIN HCL	11	29	164
201708	VANDAZOLE	1	1	7
201708	XIFAXAN	12	12	213
201709	AMOXICILLIN	3,010	3,047	28,125
201709	AMOXICILLIN-CLAVULANATE POT ER	3	3	29
201709	AMOXICILLIN-CLAVULANATE POTASS	1,104	1,135	10,930
201709	AMPICILLIN TRIHYDRATE	8	8	85
201709	ANTIBIOTIC	2	2	17

201709	AZITHROMYCIN	1,588	1,603	7,499
201709	BACITRACIN	40	40	493
201709	BACITRACIN/POLYMYXIN	5	5	38
201709	BENZAMYCIN	1	1	30
201709	BICILLIN L-A	1	1	1
201709	CEFACLOR	2	2	20
201709	CEFADROXIL	3	3	22
201709	CEFDINIR	489	491	4,901
201709	CEFEPIME HCL	4	10	60
201709	CEFPODOXIME PROXETIL	5	5	61
201709	CEFPROZIL	3	3	40
201709	CEFTRIAXONE	10	15	84
201709	CEFUROXIME AXETIL	29	31	270
201709	CEPHALEXIN	981	1,006	8,963
201709	CILOXAN	1	1	3
201709	CIPRODEX	4	4	42
201709	CIPROFLOXACIN ER	1	1	7
201709	CIPROFLOXACIN HCL	480	485	3,858
201709	CLARITHROMYCIN	57	58	711
201709	CLARITHROMYCIN ER	1	1	10
201709	CLEOCIN PHOSPHATE	2	2	33
201709	CLINDAMYCIN HCL	395	406	3,317
201709	CLINDAMYCIN PALMITATE HCL	13	13	125
201709	CLINDAMYCIN PEDIATRIC	27	27	261
201709	CLINDAMYCIN PHOSPHATE	199	204	5,227
201709	DALVANCE	1	1	10
201709	DAPSONE	2	2	60
201709	DAPTOMYCIN	9	22	147
201709	DICLOXACILLIN SODIUM	15	15	136
201709	DOXYCYCLINE HYCLATE	10	11	141
201709	DOXYCYCLINE IR-DR	1	1	30
201709	DOXYCYCLINE MONOHYDRATE	257	264	4,614
201709	ERYTHROMYCIN	201	209	2,292
201709	ERYTHROMYCIN ETHYLSUCCINATE	1	1	27
201709	ERYTHROMYCIN-BENZOYL PEROXIDE	5	5	143
201709	ETHAMBUTOL HCL	1	1	28
201709	GATIFLOXACIN	1	1	3
201709	GENTAK	4	4	34
201709	GENTAMICIN SULFATE	62	62	650
201709	INVANZ	6	19	116
201709	ISONIAZID	13	13	386
201709	LEVOFLOXACIN HEMIHYDRATE	175	183	1,493
201709	LEVOFLOXACIN-D5W	1	1	5
201709	LINEZOLID	9	21	91
201709	MEROPENEM	1	3	21
201709	METRONIDAZOLE	777	806	5,780
201709	MINOCYCLINE HCL	86	88	2,497

201709	MOXIFLOXACIN HCL	3	3	20
201709	MUPIROCIN	431	443	4,900
201709	NEO/POLYMYXIN/DEXAMETHASONE	48	51	641
201709	NEOMYCIN SULFATE	22	22	245
201709	NEOMYCIN-POLYMYXIN-DEXAMETHASO	9	9	102
201709	NEOMYCIN/BACITRACIN/POLYMYXIN	1	1	7
201709	NEOMYCIN/POLYMYXIN/GRAMICIDIN	2	2	37
201709	NEOMYCIN/POLYMYXIN/HC	141	144	1,673
201709	NITROFURANTOIN	49	50	534
201709	NITROFURANTOIN MACROCRYSTAL	442	450	3,329
201709	OFLOXACIN	138	143	1,863
201709	PENICILLIN V POTASSIUM	188	194	1,928
201709	POLY BACITRACIN	6	6	64
201709	POLYCIN	1	1	7
201709	POLYMYXIN B SUL-TRIMETHOPRIM	193	193	3,010
201709	PRIFTIN	2	2	56
201709	RIFAMPIN	7	7	132
201709	SILVER SULFADIAZINE	31	34	634
201709	SODIUM SULFACETAMIDE/SULFUR	1	1	30
201709	SSD	10	10	224
201709	SULFACETAMIDE SODIUM	5	5	87
201709	SULFACLEANSE 8/4	1	1	30
201709	SULFAMETHOXAZOLE/TRIMETHOPRIM	615	630	6,904
201709	SULFATRIM	1	1	7
201709	SUPRAX	1	1	1
201709	TETRACYCLINE HCL	14	14	295
201709	THALOMID	1	1	28
201709	TOBRAMYCIN SULFATE	74	78	901
201709	TOBRAMYCIN-DEXAMETHASONE	35	35	609
201709	TOBREX	1	1	3
201709	TRIPLE ANTIBIOTIC	14	14	221
201709	VANCOMYCIN HCL	10	23	167
201709	XIFAXAN	13	14	258
201709	ZOSYN	1	4	14
201710	AMOXICILLIN	3,469	3,550	32,734
201710	AMOXICILLIN-CLAVULANATE POT ER	1	1	14
201710	AMOXICILLIN-CLAVULANATE POTASS	1,168	1,192	11,573
201710	AMPICILLIN TRIHYDRATE	16	17	113
201710	ANTIBIOTIC	2	2	35
201710	AUGMENTIN	1	1	5
201710	AZITHROMYCIN	1,758	1,776	8,214
201710	BACITRACIN	47	49	777
201710	BACITRACIN/POLYMYXIN	3	3	16
201710	BENZAMYCIN	1	1	30
201710	BESIVANCE	1	1	25
201710	CAYSTON	1	1	28
201710	CEFACLOR	1	1	7

201710	CEFADROXIL	2	2	15
201710	CEFAZOLIN SODIUM	1	2	8
201710	CEFDINIR	576	578	5,789
201710	CEFEPIME HCL	2	5	32
201710	CEFPODOXIME PROXETIL	8	8	80
201710	CEFPROZIL	1	1	14
201710	CEFTIN	1	1	10
201710	CEFTRIAXONE	6	8	33
201710	CEFUROXIME AXETIL	23	23	194
201710	CEPHALEXIN	956	976	8,572
201710	CIPRO HC	1	1	26
201710	CIPRODEX	2	2	22
201710	CIPROFLOXACIN ER	2	2	10
201710	CIPROFLOXACIN HCL	494	495	3,822
201710	CLARITHROMYCIN	79	82	1,045
201710	CLEOCIN PHOSPHATE	1	1	30
201710	CLINDAMYCIN HCL	386	407	3,441
201710	CLINDAMYCIN PALMITATE HCL	9	9	82
201710	CLINDAMYCIN PEDIATRIC	30	30	259
201710	CLINDAMYCIN PHOSPHATE	226	233	5,899
201710	COLISTIMETHATE SODIUM	1	5	5
201710	COLY-MYCIN S	1	1	3
201710	DAPSONE	2	2	60
201710	DAPTOMYCIN	3	17	56
201710	DICLOXACILLIN SODIUM	8	8	78
201710	DOXYCYCLINE HYCLATE	15	16	185
201710	DOXYCYCLINE IR-DR	1	1	30
201710	DOXYCYCLINE MONOHYDRATE	290	299	5,732
201710	ERYTHROMYCIN	194	200	1,936
201710	ERYTHROMYCIN ETHYLSUCCINATE	1	1	14
201710	ERYTHROMYCIN-BENZOYL PEROXIDE	2	2	60
201710	ETHAMBUTOL HCL	1	1	30
201710	GATIFLOXACIN	1	1	3
201710	GENTAK	5	5	36
201710	GENTAMICIN SULFATE	59	62	702
201710	INVANZ	2	16	45
201710	ISONIAZID	16	18	540
201710	LEVOFLOXACIN HEMIHYDRATE	159	166	1,369
201710	LINEZOLID	10	13	102
201710	ME-NAPHOS-MB-HYO 1	1	1	7
201710	MEROPENEM	1	1	7
201710	MEROPENEM-0.9% NACL	1	1	3
201710	METHENAMINE HIPPURATE	1	1	30
201710	METRONIDAZOLE	856	892	6,412
201710	MINOCYCLINE HCL	102	107	2,910
201710	MOXIFLOXACIN HCL	4	4	32
201710	MUPIROCIN	460	473	5,332

201710	NEO/POLYMYXIN/DEXAMETHASONE	68	72	882
201710	NEOMYCIN SULFATE	6	6	52
201710	NEOMYCIN-POLYMYXIN-DEXAMETHASO	9	9	120
201710	NEOMYCIN/BACITRACIN/POLY/HC	1	1	7
201710	NEOMYCIN/POLYMYXIN/HC	118	120	1,499
201710	NITROFURANTOIN	33	34	505
201710	NITROFURANTOIN MACROCRYSTAL	474	484	3,513
201710	OFLOXACIN	161	163	2,280
201710	PENICILLIN V POTASSIUM	212	220	2,155
201710	PIPERACILLIN-TAZOBACTAM	1	1	3
201710	POLY BACITRACIN	3	3	47
201710	POLYMYXIN B SUL-TRIMETHOPRIM	218	218	3,310
201710	RIFAMPIN	6	7	190
201710	SILVER SULFADIAZINE	43	45	925
201710	SODIUM SULFACETAMIDE/SULFUR	2	2	60
201710	SSD	17	17	358
201710	SULFACETAMIDE SODIUM	11	11	187
201710	SULFAMETHOXAZOLE/TRIMETHOPRIM	724	738	8,014
201710	SULFATRIM	2	2	11
201710	TETRACYCLINE HCL	13	13	270
201710	THALOMID	1	1	28
201710	TOBRADEX	1	1	3
201710	TOBRAMYCIN SULFATE	85	87	1,101
201710	TOBRAMYCIN-DEXAMETHASONE	40	41	634
201710	TRIPLE ANTIBIOTIC	3	3	36
201710	TRIPLE ANTIBIOTIC PLUS	1	1	10
201710	URO-MP	1	2	60
201710	VANCOMYCIN HCL	4	5	37
201710	XIFAXAN	15	18	355
201711	AMOXICILLIN	3,496	3,558	33,176
201711	AMOXICILLIN-CLAVULANATE POT ER	3	3	35
201711	AMOXICILLIN-CLAVULANATE POTASS	1,143	1,163	11,176
201711	AMPICILLIN TRIHYDRATE	17	17	167
201711	ANTIBIOTIC	4	4	51
201711	AZITHROMYCIN	1,890	1,906	8,858
201711	BACITRACIN	35	35	484
201711	BACITRACIN/POLYMYXIN	5	5	44
201711	BENZAMYCIN	1	1	30
201711	CEFDINIR	573	575	5,828
201711	CEFEPIME HCL	3	11	73
201711	CEFPODOXIME PROXETIL	7	8	77
201711	CEFPROZIL	2	2	29
201711	CEFTIN	1	1	14
201711	CEFTRIAXONE	12	16	118
201711	CEFUROXIME AXETIL	27	28	248
201711	CEPHALEXIN	829	847	7,522
201711	CIPRO	1	1	10

201711	CIPRO HC	1	1	30
201711	CIPRODEX	5	5	48
201711	CIPROFLOXACIN ER	4	4	40
201711	CIPROFLOXACIN HCL	440	447	3,579
201711	CLARITHROMYCIN	68	68	890
201711	CLARITHROMYCIN ER	1	1	14
201711	CLEOCIN PHOSPHATE	1	1	30
201711	CLINDAMYCIN HCL	378	389	3,178
201711	CLINDAMYCIN PALMITATE HCL	14	14	127
201711	CLINDAMYCIN PEDIATRIC	20	21	198
201711	CLINDAMYCIN PHOSPHATE	247	255	6,607
201711	CLINDESSE	3	3	6
201711	DAPSONE	2	2	60
201711	DAPTOMYCIN	4	12	81
201711	DICLOXACILLIN SODIUM	13	13	119
201711	DOXYCYCLINE HYCLATE	13	15	239
201711	DOXYCYCLINE IR-DR	1	1	30
201711	DOXYCYCLINE MONOHYDRATE	288	293	5,352
201711	ERY-TAB	1	1	7
201711	ERYTHROMYCIN	186	191	2,004
201711	ERYTHROMYCIN ETHYLSUCCINATE	3	3	50
201711	ERYTHROMYCIN-BENZOYL PEROXIDE	1	1	23
201711	ETHAMBUTOL HCL	1	1	30
201711	GENTAK	6	6	42
201711	GENTAMICIN SULFATE	45	45	534
201711	INVANZ	2	3	19
201711	ISONIAZID	14	14	420
201711	LEVOFLOXACIN HEMIHYDRATE	172	175	1,404
201711	LEVOFLOXACIN-D5W	1	2	10
201711	LINEZOLID	8	9	63
201711	ME-NAPHOS-MB-HYO 1	2	2	37
201711	MEROPENEM	1	1	6
201711	METRONIDAZOLE	725	755	5,428
201711	MINOCYCLINE HCL	99	100	2,821
201711	MOXIFLOXACIN HCL	1	1	5
201711	MUPIROCIN	412	425	4,957
201711	NEO/POLYMYXIN/DEXAMETHASONE	66	67	896
201711	NEOMYCIN SULFATE	9	10	125
201711	NEOMYCIN-POLYMYXIN-DEXAMETHASO	5	5	62
201711	NEOMYCIN/POLYMYXIN/GRAMICIDIN	3	3	21
201711	NEOMYCIN/POLYMYXIN/HC	121	121	1,375
201711	NITROFURANTOIN	45	48	509
201711	NITROFURANTOIN MACROCRYSTAL	393	404	3,091
201711	OFLOXACIN	133	137	1,809
201711	PENICILLIN V POTASSIUM	200	204	1,904
201711	PIPERACILLIN-TAZOBACTAM	2	2	15
201711	POLY BACITRACIN	4	4	66

201711	POLYMYXIN B SUL-TRIMETHOPRIM	185	185	2,785
201711	RIFAMPIN	7	7	210
201711	SILVER SULFADIAZINE	31	33	721
201711	SODIUM SULFACETAMIDE/SULFUR	3	3	58
201711	SSD	13	13	272
201711	SULFACETAMIDE SODIUM	4	4	39
201711	SULFAMETHOXAZOLE/TRIMETHOPRIM	583	599	6,438
201711	SULFATRIM	2	3	20
201711	SUPRAX	1	1	1
201711	TETRACYCLINE HCL	10	10	213
201711	TOBI PODHALER	1	1	56
201711	TOBRAMYCIN SULFATE	62	63	737
201711	TOBRAMYCIN-DEXAMETHASONE	35	37	533
201711	TRIMETHOPRIM	1	1	6
201711	TRIPLE ANTIBIOTIC	5	5	43
201711	TRIPLE ANTIBIOTIC PLUS	2	2	21
201711	URO-MP	1	1	30
201711	VANCOMYCIN HCL	5	8	52
201711	XIFAXAN	10	11	246
201712	AMOXICILLIN	4,055	4,110	38,707
201712	AMOXICILLIN-CLAVULANATE POT ER	5	5	54
201712	AMOXICILLIN-CLAVULANATE POTASS	1,389	1,412	13,769
201712	AMPICILLIN TRIHYDRATE	6	6	68
201712	ANTIBIOTIC	6	6	54
201712	AZITHROMYCIN	2,389	2,418	11,476
201712	BACITRACIN	41	41	450
201712	CAYSTON	2	2	56
201712	CEFAZOLIN SODIUM	1	1	8
201712	CEFDINIR	770	772	7,825
201712	CEFEPIME HCL	5	14	90
201712	CEFPODOXIME PROXETIL	4	5	56
201712	CEFPROZIL	2	2	24
201712	CEFTIN	2	3	29
201712	CEFTRIAXONE	3	3	11
201712	CEFUROXIME AXETIL	33	33	315
201712	CEPHALEXIN	930	953	8,297
201712	CILOXAN	1	1	3
201712	CIPRO HC	5	5	51
201712	CIPRODEX	5	5	49
201712	CIPROFLOXACIN ER	1	1	14
201712	CIPROFLOXACIN HCL	393	395	3,243
201712	CLARITHROMYCIN	55	56	722
201712	CLARITHROMYCIN ER	1	1	10
201712	CLEOCIN PHOSPHATE	1	1	30
201712	CLINDAMYCIN HCL	385	402	3,411
201712	CLINDAMYCIN PALMITATE HCL	9	9	64
201712	CLINDAMYCIN PEDIATRIC	29	29	265

201712	CLINDAMYCIN PHOSPHATE	235	241	6,010
201712	CLINDESSE	1	1	1
201712	DAPSONE	2	2	60
201712	DAPTOMYCIN	5	13	91
201712	DICLOXACILLIN SODIUM	6	6	54
201712	DIFICID	1	1	10
201712	DOXYCYCLINE HYCLATE	9	10	125
201712	DOXYCYCLINE MONOHYDRATE	281	285	5,447
201712	ERYTHROMYCIN	183	185	1,967
201712	ERYTHROMYCIN ETHYLSUCCINATE	1	1	10
201712	ERYTHROMYCIN-BENZOYL PEROXIDE	1	1	30
201712	ETHAMBUTOL HCL	2	3	90
201712	GATIFLOXACIN	1	1	3
201712	GENTAK	5	5	46
201712	GENTAMICIN SULFATE	65	65	634
201712	INVANZ	2	4	28
201712	ISONIAZID	14	16	480
201712	LEVOFLOXACIN HEMIHYDRATE	183	188	1,604
201712	LINEZOLID	5	6	50
201712	MEROPENEM	2	2	15
201712	METRONIDAZOLE	711	730	5,279
201712	MINOCYCLINE HCL	88	88	2,557
201712	MOXIFLOXACIN HCL	1	1	21
201712	MUPIROCIN	387	407	4,494
201712	NEO/POLYMYXIN/DEXAMETHASONE	49	53	701
201712	NEOMYCIN SULFATE	11	11	116
201712	NEOMYCIN-POLYMYXIN-DEXAMETHASO	2	2	17
201712	NEOMYCIN/BACITRACIN/POLY/HC	1	1	10
201712	NEOMYCIN/BACITRACIN/POLYMYXIN	1	1	18
201712	NEOMYCIN/POLYMYXIN/GRAMICIDIN	1	1	7
201712	NEOMYCIN/POLYMYXIN/HC	128	129	1,758
201712	NITROFURANTOIN	42	43	483
201712	NITROFURANTOIN MACROCRYSTAL	392	405	3,093
201712	OFLOXACIN	147	154	2,001
201712	PENICILLIN V POTASSIUM	166	172	1,601
201712	PIPERACILLIN-TAZOBACTAM	1	1	7
201712	POLY BACITRACIN	2	2	10
201712	POLYMYXIN B SUL-TRIMETHOPRIM	224	224	3,370
201712	RIFAMPIN	5	6	154
201712	SILVER SULFADIAZINE	25	26	572
201712	SSD	12	12	272
201712	SULFACETAMIDE SODIUM	9	9	154
201712	SULFAMETHOXAZOLE/TRIMETHOPRIM	510	519	5,813
201712	TEFLARO	1	1	3
201712	TETRACYCLINE HCL	12	12	296
201712	TOBRAMYCIN SULFATE	93	96	1,157
201712	TOBRAMYCIN-DEXAMETHASONE	30	31	475

201712	TRIPLE ANTIBIOTIC	4	4	77
201712	TRIPLE ANTIBIOTIC PLUS	1	1	10
201712	URO-MP	1	1	30
201712	VANCOMYCIN HCL	9	12	127
201712	XIFAXAN	12	12	254
201801	AMOXICILLIN	4,431	4,481	42,010
201801	AMOXICILLIN-CLAVULANATE POT ER	3	3	27
201801	AMOXICILLIN-CLAVULANATE POTASS	1,511	1,555	14,994
201801	AMPICILLIN TRIHYDRATE	12	12	100
201801	ANTIBIOTIC	2	2	37
201801	AZASITE	1	1	30
201801	AZITHROMYCIN	2,566	2,590	12,393
201801	BACITRACIN	41	42	471
201801	BACITRACIN/POLYMYXIN	6	6	83
201801	BESIVANCE	1	1	30
201801	CAYSTON	2	2	56
201801	CEFADROXIL	1	1	10
201801	CEFAZOLIN SODIUM	1	3	17
201801	CEFDINIR	862	865	8,592
201801	CEFEPIME HCL	3	6	35
201801	CEFPODOXIME PROXETIL	11	11	99
201801	CEFPROZIL	4	4	48
201801	CEFTIN	3	3	31
201801	CEFTRIAXONE	4	4	42
201801	CEFUROXIME AXETIL	27	30	299
201801	CEPHALEXIN	854	870	7,730
201801	CIPRO HC	2	2	33
201801	CIPRODEX	4	4	43
201801	CIPROFLOXACIN ER	1	1	14
201801	CIPROFLOXACIN HCL	465	467	3,877
201801	CLARITHROMYCIN	71	73	943
201801	CLARITHROMYCIN ER	2	2	19
201801	CLEOCIN PHOSPHATE	2	2	36
201801	CLINDAMYCIN HCL	374	386	3,257
201801	CLINDAMYCIN PALMITATE HCL	13	13	113
201801	CLINDAMYCIN PEDIATRIC	34	35	356
201801	CLINDAMYCIN PHOSPHATE	260	268	6,804
201801	DAPSONE	2	2	60
201801	DAPTOMYCIN	3	6	39
201801	DICLOXACILLIN SODIUM	7	7	70
201801	DOUBLE ANTIBIOTIC	1	1	9
201801	DOXYCYCLINE HYCLATE	14	14	200
201801	DOXYCYCLINE IR-DR	1	1	30
201801	DOXYCYCLINE MONOHYDRATE	339	355	6,496
201801	ERYPED	1	1	30
201801	ERYTHROCIN STEARATE	1	1	7
201801	ERYTHROMYCIN	212	216	2,279

201801	ERYTHROMYCIN-BENZOYL PEROXIDE	4	4	104
201801	ETHAMBUTOL HCL	3	3	120
201801	GENTAK	8	8	90
201801	GENTAMICIN SULFATE	92	93	988
201801	INVANZ	3	7	50
201801	ISONIAZID	14	15	450
201801	LEVOFLOXACIN HEMIHYDRATE	242	257	2,083
201801	LINEZOLID	7	7	62
201801	MEROPENEM	2	4	26
201801	METHENAMINE HIPPURATE	1	1	30
201801	METRONIDAZOLE	773	801	5,893
201801	MINOCYCLINE HCL	100	106	2,995
201801	MOXIFLOXACIN HCL	2	2	24
201801	MUPIROCIN	410	419	4,256
201801	NEO/POLYMYXIN/DEXAMETHASONE	67	68	806
201801	NEOMYCIN SULFATE	10	10	130
201801	NEOMYCIN-POLYMYXIN-DEXAMETHASO	7	7	104
201801	NEOMYCIN/POLYMYXIN/GRAMICIDIN	1	1	9
201801	NEOMYCIN/POLYMYXIN/HC	141	142	1,739
201801	NITROFURANTOIN	44	47	638
201801	NITROFURANTOIN MACROCRYSTAL	411	419	3,132
201801	OFLOXACIN	162	166	2,331
201801	PENICILLIN V POTASSIUM	204	207	2,033
201801	PFIZERPEN	1	22	24
201801	PIPERACILLIN-TAZOBACTAM	1	3	8
201801	POLY BACITRACIN	2	2	25
201801	POLYMYXIN B SUL-TRIMETHOPRIM	308	308	4,434
201801	RIFAMPIN	6	6	180
201801	SILVER SULFADIAZINE	26	27	604
201801	SSD	8	10	225
201801	SULFACETAMIDE SODIUM	14	14	268
201801	SULFAMETHOXAZOLE/TRIMETHOPRIM	563	582	6,292
201801	SULFATRIM	1	1	10
201801	TETRACYCLINE HCL	7	7	172
201801	THALOMID	1	1	28
201801	TOBI PODHALER	1	1	56
201801	TOBRAMYCIN SULFATE	81	82	1,078
201801	TOBRAMYCIN-DEXAMETHASONE	33	35	516
201801	TRIPLE ANTIBIOTIC	6	6	120
201801	URO-MP	1	1	30
201801	VANCOMYCIN HCL	9	13	87
201801	VANCOMYCIN-NS	1	2	2
201801	VANDAZOLE	1	1	5
201801	XIFAXAN	9	11	202
201802	AMOXICILLIN	4,238	4,294	40,310
201802	AMOXICILLIN-CLAVULANATE POT ER	3	3	24
201802	AMOXICILLIN-CLAVULANATE POTASS	1,353	1,375	13,548

201802	AMPICILLIN TRIHYDRATE	14	14	116
201802	ANTIBIOTIC	8	8	60
201802	AZASITE	1	1	30
201802	AZITHROMYCIN	2,170	2,186	10,266
201802	BACITRACIN	30	30	417
201802	BACITRACIN/POLYMYXIN	4	4	29
201802	BESIVANCE	1	7	41
201802	BICILLIN L-A	1	1	1
201802	CEFACLOR	2	2	21
201802	CEFADROXIL	3	3	24
201802	CEFAZOLIN-D5W	1	1	3
201802	CEFDINIR	832	834	8,336
201802	CEFEPIME HCL	4	10	63
201802	CEFPODOXIME PROXETIL	3	3	47
201802	CEFPROZIL	5	5	59
201802	CEFTIN	1	1	12
201802	CEFTRIAXONE	5	5	8
201802	CEFUROXIME AXETIL	26	26	261
201802	CEPHALEXIN	794	814	7,192
201802	CILOXAN	1	1	3
201802	CIPRODEX	3	3	32
201802	CIPROFLOXACIN HCL	418	420	3,438
201802	CLARITHROMYCIN	53	54	688
201802	CLEOCIN PHOSPHATE	1	1	30
201802	CLINDAMYCIN HCL	337	352	2,979
201802	CLINDAMYCIN PALMITATE HCL	9	9	76
201802	CLINDAMYCIN PEDIATRIC	25	25	239
201802	CLINDAMYCIN PHOSPHATE	215	217	5,481
201802	DAPSONE	4	4	120
201802	DAPTOMYCIN	5	10	65
201802	DICLOXACILLIN SODIUM	11	11	110
201802	DOXYCYCLINE HYCLATE	13	13	199
201802	DOXYCYCLINE IR-DR	1	1	30
201802	DOXYCYCLINE MONOHYDRATE	305	311	5,909
201802	E.E.S.	2	2	17
201802	ERY-TAB	1	1	10
201802	ERYGEL	1	1	30
201802	ERYTHROCIN STEARATE	1	1	30
201802	ERYTHROMYCIN	203	206	2,036
201802	ERYTHROMYCIN ETHYLSUCCINATE	1	1	30
201802	ERYTHROMYCIN-BENZOYL PEROXIDE	3	3	90
201802	ETHAMBUTOL HCL	2	2	60
201802	GATIFLOXACIN	1	1	16
201802	GENTAK	5	5	72
201802	GENTAMICIN SULFATE	82	82	938
201802	INVANZ	1	1	8
201802	ISONIAZID	11	11	330

201802	LEVOFLOXACIN HEMIHYDRATE	198	202	1,622
201802	LINEZOLID	5	5	49
201802	METHENAMINE HIPPURATE	1	1	30
201802	METRONIDAZOLE	744	785	5,588
201802	MINOCYCLINE HCL	97	98	2,698
201802	MONUROL	1	1	28
201802	MOXIFLOXACIN HCL	20	20	247
201802	MUPIROCIN	352	359	3,979
201802	NEO/POLYMYXIN/DEXAMETHASONE	55	56	692
201802	NEOMYCIN SULFATE	9	9	84
201802	NEOMYCIN-POLYMYXIN-DEXAMETHASO	8	8	67
201802	NEOMYCIN/BACITRACIN/POLYMYXIN	1	1	9
201802	NEOMYCIN/POLYMYXIN/GRAMICIDIN	5	5	47
201802	NEOMYCIN/POLYMYXIN/HC	140	142	1,863
201802	NITROFURANTOIN	36	36	551
201802	NITROFURANTOIN MACROCRYSTAL	401	409	2,967
201802	OFLOXACIN	167	167	2,139
201802	OTOVEL	1	1	7
201802	PENICILLIN V POTASSIUM	189	195	1,925
201802	PFIZERPEN	1	21	21
201802	POLY BACITRACIN	4	4	70
201802	POLYMYXIN B SUL-TRIMETHOPRIM	291	291	4,049
201802	RIFAMPIN	12	12	328
201802	SILVER SULFADIAZINE	22	22	466
201802	SODIUM SULFACETAMIDE/SULFUR	1	1	14
201802	SSD	18	18	432
201802	SULFACETAMIDE SODIUM	7	7	108
201802	SULFAMETHOXAZOLE/TRIMETHOPRIM	481	488	5,427
201802	SULFATRIM	1	1	3
201802	TETRACYCLINE HCL	8	8	160
201802	TOBRAMYCIN SULFATE	78	83	1,003
201802	TOBRAMYCIN-DEXAMETHASONE	33	33	553
201802	TRIPLE ANTIBIOTIC	11	11	192
201802	TRIPLE ANTIBIOTIC PLUS	1	1	7
201802	URO-MP	2	2	33
201802	VANCOMYCIN HCL	5	18	100
201802	XIFAXAN	7	7	145
201803	AMOXICILLIN	3,864	3,938	36,637
201803	AMOXICILLIN-CLAVULANATE POT ER	2	2	20
201803	AMOXICILLIN-CLAVULANATE POTASS	1,372	1,395	13,548
201803	AMPICILLIN TRIHYDRATE	15	16	158
201803	ANTIBIOTIC	1	1	14
201803	AUGMENTIN	1	1	3
201803	AZITHROMYCIN	2,007	2,021	9,536
201803	BACITRACIN	36	36	464
201803	BACITRACIN/POLYMYXIN	4	4	38
201803	CAYSTON	2	2	56

201803	CEFACLOR	1	1	7
201803	CEFADROXIL	1	1	7
201803	CEFDINIR	769	772	7,733
201803	CEFPODOXIME PROXETIL	5	5	78
201803	CEFPROZIL	3	3	34
201803	CEFTRIAXONE	6	6	35
201803	CEFUROXIME AXETIL	28	28	247
201803	CEPHALEXIN	892	909	8,028
201803	CIPRO HC	1	1	25
201803	CIPRODEX	3	3	34
201803	CIPROFLOXACIN HCL	428	429	3,517
201803	CLARITHROMYCIN	62	63	783
201803	CLINDAMYCIN HCL	347	374	3,099
201803	CLINDAMYCIN PALMITATE HCL	7	7	55
201803	CLINDAMYCIN PEDIATRIC	40	41	386
201803	CLINDAMYCIN PHOSPHATE	251	258	6,707
201803	CLINDESSE	2	2	35
201803	DAPSONE	3	3	90
201803	DICLOXACILLIN SODIUM	7	7	85
201803	DOXYCYCLINE HYCLATE	21	21	241
201803	DOXYCYCLINE IR-DR	2	2	60
201803	DOXYCYCLINE MONOHYDRATE	311	323	5,865
201803	ERYTHROCIN STEARATE	1	1	30
201803	ERYTHROMYCIN	211	216	2,065
201803	ERYTHROMYCIN ETHYLSUCCINATE	1	1	27
201803	ERYTHROMYCIN-BENZOYL PEROXIDE	4	4	97
201803	ETHAMBUTOL HCL	2	2	58
201803	GENTAK	3	3	54
201803	GENTAMICIN SULFATE	75	75	825
201803	ISONIAZID	12	13	390
201803	LEVOFLOXACIN HEMIHYDRATE	210	216	1,720
201803	LINEZOLID	5	6	67
201803	METHENAMINE HIPPURATE	1	1	30
201803	METRONIDAZOLE	842	873	6,343
201803	MINOCYCLINE HCL	95	96	2,785
201803	MONUROL	1	1	28
201803	MOXIFLOXACIN HCL	15	16	179
201803	MUPIROCIN	432	441	5,196
201803	NEO-POLYCIN	1	1	5
201803	NEO/POLYMYXIN/DEXAMETHASONE	81	85	1,055
201803	NEOMYCIN SULFATE	9	9	113
201803	NEOMYCIN-POLYMYXIN-DEXAMETHASO	4	4	55
201803	NEOMYCIN/POLYMYXIN/GRAMICIDIN	1	1	7
201803	NEOMYCIN/POLYMYXIN/HC	127	128	1,744
201803	NITROFURANTOIN	24	25	406
201803	NITROFURANTOIN MACROCRYSTAL	396	402	3,033
201803	OFLOXACIN	165	166	2,314

201803	PENICILLIN V POTASSIUM	176	188	1,848
201803	POLY BACITRACIN	6	6	53
201803	POLYMYXIN B SUL-TRIMETHOPRIM	320	320	4,389
201803	RIFABUTIN	1	1	30
201803	RIFAMPIN	9	9	254
201803	SILVER SULFADIAZINE	26	29	610
201803	SSD	12	12	203
201803	SULFACETAMIDE SODIUM	9	9	152
201803	SULFAMETHOXAZOLE/TRIMETHOPRIM	555	570	6,232
201803	TETRACYCLINE HCL	6	6	128
201803	THALOMID	1	1	28
201803	TOBRADEX	1	1	3
201803	TOBRAMYCIN SULFATE	102	105	1,208
201803	TOBRAMYCIN-DEXAMETHASONE	36	37	641
201803	TRIMETHOPRIM	1	1	30
201803	TRIPLE ANTIBIOTIC	8	9	136
201803	URO-MP	1	1	30
201803	VANCOMYCIN HCL	2	2	35
201803	VANDAZOLE	1	1	5
201803	XIFAXAN	9	10	210
201804	AMOXICILLIN	3,111	3,156	29,426
201804	AMOXICILLIN-CLAVULANATE POT ER	5	5	40
201804	AMOXICILLIN-CLAVULANATE POTASS	1,188	1,212	11,797
201804	AMPICILLIN TRIHYDRATE	8	8	83
201804	ANTIBIOTIC	4	4	29
201804	AZASITE	1	1	29
201804	AZITHROMYCIN	1,583	1,599	7,457
201804	BACITRACIN	38	39	402
201804	BACITRACIN/POLYMYXIN	3	3	28
201804	CAYSTON	1	1	28
201804	CEFADROXIL	2	2	21
201804	CEFDINIR	589	589	5,851
201804	CEFIXIME	1	1	3
201804	CEFPODOXIME PROXETIL	6	6	71
201804	CEFPROZIL	2	2	24
201804	CEFTIN	1	1	10
201804	CEFTRIAXONE	4	4	4
201804	CEFUROXIME AXETIL	24	24	204
201804	CEPHALEXIN	907	930	8,199
201804	CIPRO	1	1	10
201804	CIPRO HC	1	1	14
201804	CIPRODEX	5	5	45
201804	CIPROFLOXACIN HCL	438	441	3,648
201804	CLARITHROMYCIN	76	76	975
201804	CLEOCIN PHOSPHATE	1	1	3
201804	CLINDAMYCIN HCL	384	399	3,470
201804	CLINDAMYCIN PALMITATE HCL	3	3	27

201804	CLINDAMYCIN PEDIATRIC	40	41	375
201804	CLINDAMYCIN PHOSPHATE	285	296	8,185
201804	DAPSONE	3	3	88
201804	DICLOXACILLIN SODIUM	10	11	109
201804	DOUBLE ANTIBIOTIC	1	1	7
201804	DOXYCYCLINE HYCLATE	13	13	223
201804	DOXYCYCLINE IR-DR	1	1	30
201804	DOXYCYCLINE MONOHYDRATE	332	341	6,917
201804	ERYTHROCIN STEARATE	1	1	30
201804	ERYTHROMYCIN	224	229	2,342
201804	ERYTHROMYCIN ETHYLSUCCINATE	1	2	3
201804	ERYTHROMYCIN-BENZOYL PEROXIDE	4	4	102
201804	ETHAMBUTOL HCL	2	2	60
201804	GATIFLOXACIN	2	2	22
201804	GENTAK	5	5	61
201804	GENTAMICIN SULFATE	92	92	979
201804	ISONIAZID	10	10	300
201804	LEVOFLOXACIN HEMIHYDRATE	157	161	1,320
201804	LINEZOLID	8	8	64
201804	METHENAMINE HIPPURATE	3	3	90
201804	METRONIDAZOLE	761	793	5,730
201804	MINOCYCLINE HCL	93	98	2,787
201804	MONUROL	2	2	31
201804	MOXIFLOXACIN HCL	18	18	150
201804	MUPIROCIN	434	450	4,967
201804	NEO/POLYMYXIN/DEXAMETHASONE	67	69	799
201804	NEOMYCIN SULFATE	8	8	89
201804	NEOMYCIN-POLYMYXIN-DEXAMETHASO	2	2	24
201804	NEOMYCIN/BACITRACIN/POLYMYXIN	2	2	27
201804	NEOMYCIN/POLYMYXIN/GRAMICIDIN	4	4	39
201804	NEOMYCIN/POLYMYXIN/HC	113	119	1,385
201804	NITROFURANTOIN	32	33	526
201804	NITROFURANTOIN MACROCRYSTAL	395	398	2,915
201804	OFLOXACIN	154	158	1,898
201804	PENICILLIN V POTASSIUM	187	197	1,976
201804	POLY BACITRACIN	5	5	47
201804	POLYMYXIN B SUL-TRIMETHOPRIM	337	337	4,738
201804	RIFABUTIN	1	1	30
201804	RIFAMPIN	10	10	215
201804	SILVER SULFADIAZINE	27	29	612
201804	SSD	14	14	326
201804	SULFACETAMIDE SODIUM	11	11	210
201804	SULFACETAMIDE W/PREDNISOLONE	1	1	14
201804	SULFAMETHOXAZOLE/TRIMETHOPRIM	515	531	6,001
201804	SUPRAX	1	1	10
201804	TETRACYCLINE HCL	7	7	115
201804	THALOMID	1	1	28

201804	TOBI PODHALER	1	1	56
201804	TOBRADEX	1	1	3
201804	TOBRAMYCIN SULFATE	107	113	1,348
201804	TOBRAMYCIN-DEXAMETHASONE	46	46	576
201804	TRIPLE ANTIBIOTIC	11	11	169
201804	VANCOMYCIN HCL	3	3	26
201804	VANDAZOLE	4	4	20
201804	XIFAXAN	7	7	167
201805	AMOXICILLIN	2,894	2,935	27,240
201805	AMOXICILLIN-CLAVULANATE POT ER	1	1	10
201805	AMOXICILLIN-CLAVULANATE POTASS	994	1,015	9,776
201805	AMPICILLIN TRIHYDRATE	7	7	40
201805	ANTIBIOTIC	2	2	27
201805	AZITHROMYCIN	1,218	1,233	5,586
201805	BACITRACIN	35	35	451
201805	BACITRACIN/POLYMYXIN	1	1	7
201805	CAYSTON	1	1	28
201805	CEFADROXIL	1	1	14
201805	CEFDINIR	525	528	5,202
201805	CEFIXIME	1	1	3
201805	CEFPODOXIME PROXETIL	2	2	37
201805	CEFPROZIL	1	1	10
201805	CEFTIN	1	1	10
201805	CEFTRIAXONE	1	1	1
201805	CEFUROXIME AXETIL	13	13	124
201805	CEPHALEXIN	781	797	7,149
201805	CIPRODEX	3	3	23
201805	CIPROFLOXACIN HCL	398	401	3,371
201805	CLARITHROMYCIN	55	55	688
201805	CLARITHROMYCIN ER	1	1	10
201805	CLINDAMYCIN HCL	358	368	3,078
201805	CLINDAMYCIN PALMITATE HCL	1	1	5
201805	CLINDAMYCIN PEDIATRIC	25	26	244
201805	CLINDAMYCIN PHOSPHATE	303	312	8,308
201805	DAPSONE	2	2	60
201805	DICLOXACILLIN SODIUM	4	4	34
201805	DOUBLE ANTIBIOTIC	1	1	10
201805	DOXYCYCLINE HYCLATE	15	15	202
201805	DOXYCYCLINE MONOHYDRATE	281	286	5,398
201805	ERYTHROMYCIN	200	205	1,880
201805	ERYTHROMYCIN ETHYLSUCCINATE	1	1	30
201805	ERYTHROMYCIN-BENZOYL PEROXIDE	4	4	86
201805	ETHAMBUTOL HCL	1	1	30
201805	GATIFLOXACIN	3	3	27
201805	GENTAK	2	2	32
201805	GENTAMICIN SULFATE	100	100	1,003
201805	ISONIAZID	9	9	270

201805	LEVOFLOXACIN HEMIHYDRATE	129	133	1,088
201805	LINEZOLID	3	3	38
201805	METHENAMINE HIPPURATE	2	2	60
201805	METRONIDAZOLE	660	696	5,041
201805	MINOCYCLINE HCL	85	86	2,426
201805	MONUROL	1	1	28
201805	MOXIFLOXACIN HCL	15	16	199
201805	MUPIROCIN	451	459	5,329
201805	NEO-POLYCIN	1	1	10
201805	NEO/POLYMYXIN/DEXAMETHASONE	47	49	574
201805	NEOMYCIN SULFATE	9	9	92
201805	NEOMYCIN-POLYMYXIN-DEXAMETHASO	6	6	66
201805	NEOMYCIN/BACITRACIN/POLYMYXIN	2	2	60
201805	NEOMYCIN/POLYMYXIN/GRAMICIDIN	3	3	39
201805	NEOMYCIN/POLYMYXIN/HC	117	119	1,698
201805	NITROFURANTOIN	30	30	491
201805	NITROFURANTOIN MACROCRYSTAL	365	374	2,803
201805	OFLOXACIN	152	153	1,993
201805	PENICILLIN V POTASSIUM	162	167	1,638
201805	POLY BACITRACIN	2	2	37
201805	POLYMYXIN B SUL-TRIMETHOPRIM	265	265	4,067
201805	RIFABUTIN	1	1	30
201805	RIFAMPIN	8	9	207
201805	SILVER SULFADIAZINE	23	23	449
201805	SSD	9	10	194
201805	SULFACETAMIDE SODIUM	7	7	98
201805	SULFAMETHOXAZOLE/TRIMETHOPRIM	511	514	5,551
201805	SULFATRIM	1	1	10
201805	TETRACYCLINE HCL	6	8	73
201805	TOBRADEX	1	2	14
201805	TOBRAMYCIN SULFATE	108	110	1,360
201805	TOBRAMYCIN-DEXAMETHASONE	39	40	613
201805	TRIPLE ANTIBIOTIC	10	10	174
201805	TRIPLE ANTIBIOTIC EXTRA	1	1	15
201805	URO-MP	2	2	33
201805	VANCOMYCIN HCL	1	1	4
201805	VANDAZOLE	1	1	5
201805	XIFAXAN	8	8	179

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2,910
548
3,790
56
3,075
94
18,203
30
340
710
178
308
28
129
84
318
421,803
80
96,635
384
14
150
21,803
748
14
168

21
14
51,493
162
400
6
512
64,990
10
23
5,933
2,332
12,023
1,300
11,375
13,900
10
180
298
422
60
10,296
90
1,201
60
140
114
14
400
420
1,714
996
30
21,620
4,380
4
64
11,104
4
375
342
14
10
1,273
636
5,856
1,100

12,024
168
3,200
30
400
4,340
660
125
22,810
262
28
4
550
200
30
252
120
140
70
432
326,556
140
77,528
221
56
5
16,200
909
14
84
42
36,188
50
142
48
200
4
428
70,866
100
10
38
5,840
2,440
3
13,397
1,000

11,200
16,815
88
408
28
376
30
12,053
90
1,516
4
163
114
5
18
480
300
1,314
128
120
20,181
4,330
7
52
11,443
308
220
7
7
40
1,203
758
5,708
1,080
13,368
140
3,370
60
364
3,505
2,345
155
5
23,386
10
266
28

224
4
880
263
295
128
280
348
298,696
20
64,366
150
28
13,183
764
4
84
28
32,570
50
74
100
100
1
248
55,966
23
5,655
1,484
20
11,934
200
6,400
16,610
60
136
28
357
9,381
909
300
163
24
8
11
635
270

1,059
76
60
17,623
3,817
4
48
11,210
21
221
248
21
7
30
1,190
661
5,445
995
10,233
56
2,650
60
318
1,980
1,185
95
20,217
300
254
7
565
215
252
28
129
28
70
372

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Antimicrobial Utilization

August 1, 2017 - May 31, 2018

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2017/08	Amox/clav	1,391	187	11,367
2017/08	Amoxicillin	678	678	63,906
2017/08	3rd gen cephalosporins	108	108	7,090
2017/08	Cephalexin	2,459	1,275	43,681
2017/08	Fluroquinolones	129	129	1,814
2017/08	Macrolide	357	357	3,987
2017/09	Amox/clav	1,545	1,561	80,587
2017/09	Amoxicillin	4,603	4,706	394,771
2017/09	3rd gen cephalosporins	736	743	46,168
2017/09	Cephalexin	1,479	1,511	104,642
2017/09	Fluroquinolones	953	980	13,538
2017/09	Macrolide	2,526	2,585	28,600
2017/10	4th gen cephalosporins	1	1	404
2017/10	Amox/clav	1,651	1,677	88,386
2017/10	Amoxicillin	5,112	5,237	463,082
2017/10	3rd gen cephalosporins	858	869	52,309
2017/10	Cephalexin	1,520	1,544	107,749
2017/10	Fluroquinolones	973	998	13,215
2017/10	Macrolide	2,687	2,747	32,112
2017/11	4th gen cephalosporins	2	7	27
2017/11	Amox/clav	1,698	1,729	93,831
2017/11	Amoxicillin	5,187	5,306	494,668
2017/11	3rd gen cephalosporins	904	920	59,483
2017/11	Cephalexin	1,383	1,407	102,590
2017/11	Fluroquinolones	941	960	12,604
2017/11	Macrolide	2,948	3,003	35,778
2017/12	Amox/clav	2,040	2,066	116,977
2017/12	Amoxicillin	6,077	6,188	627,788
2017/12	3rd gen cephalosporins	1,044	1,053	67,291
2017/12	Cephalexin	1,334	1,355	89,020
2017/12	Fluroquinolones	952	970	12,770
2017/12	Macrolide	3,648	3,731	42,951
2018/01	4th gen cephalosporins	1	3	14
2018/01	Amox/clav	2,070	2,096	120,270
2018/01	Amoxicillin	6,531	6,664	663,557
2018/01	3rd gen cephalosporins	1,293	1,303	81,564
2018/01	Cephalexin	1,472	1,497	104,002
2018/01	Fluroquinolones	1,065	1,091	13,900
2018/01	Macrolide	4,125	4,219	45,429

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2018/02	4th gen cephalosporins	2	3	1,212
2018/02	Amox/clav	1,984	2,003	123,826
2018/02	Amoxicillin	6,080	6,193	633,849
2018/02	3rd gen cephalosporins	1,198	1,205	77,291
2018/02	Cephalexin	1,248	1,271	81,939
2018/02	Fluroquinolones	892	914	11,763
2018/02	Macrolide	3,378	3,465	41,118
2018/03	Amox/clav	1,974	1,998	116,739
2018/03	Amoxicillin	5,663	5,780	577,892
2018/03	3rd gen cephalosporins	1,049	1,065	65,217
2018/03	Cephalexin	1,276	1,305	85,167
2018/03	Fluroquinolones	934	959	12,142
2018/03	Macrolide	3,183	3,267	38,719
2018/04	Amox/clav	1,620	1,641	89,170
2018/04	Amoxicillin	4,669	4,759	461,616
2018/04	3rd gen cephalosporins	957	972	58,135
2018/04	Cephalexin	1,333	1,349	92,012
2018/04	Fluroquinolones	880	895	12,054
2018/04	Macrolide	2,466	2,525	29,690
2018/05	Amox/clav	1,568	1,597	87,549
2018/05	Amoxicillin	4,608	4,696	443,080
2018/05	3rd gen cephalosporins	893	907	58,325
2018/05	Cephalexin	1,449	1,476	98,870
2018/05	Fluroquinolones	916	947	12,367
2018/05	Macrolide	2,278	2,340	27,982

Nevada Medicaid
Antihemophilia Factor Products
Pharmacy Coverage Guideline

CRITERIA FOR COVERAGE/NONCOVERAGE

Indications
For the prevention and control of hemorrhage in patients with hemophilia A

Approval Length: 3 months

The requested medication must meet the following criteria:

1. One of the following:
    a. Medication is being prescribed for an FDA-approved indication

        OR

    b. One of the following:
        i. Diagnosis is supported as a use of AHFS DI
        ii. Diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table in Background section)
        iii. Both of the following:
            1. Diagnosis is listed in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation and carries a Strength of Recommendation of III or Class Indeterminant (see DRUGDEX Strength of Recommendation table in Background section)
            2. Efficacy is rated as "Effective" or "Evidence Favors Efficacy" (see DRUGDEX Efficacy Rating and Prior Authorization Approval Status table in Background section)
        iv. Diagnosis is supported in any other section in DRUGDEX
        v. The use is supported by clinical research in two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

AND

2. One of the following:
    a. The dosage quantity/duration of the medication is reasonably safe and effective based on information contained in the FDA approved labeling, peer-reviewed medical literature, or accepted standards of medical practice

    OR

    b. The dosage/quantity/duration of the medication is reasonably safe and effective based on one of the following compendia:
        - American Hospital Formulary Service (AHFS) Compendium
        - Thomson Reuters (Healthcare) Micromedex/DrugDex (not Drug Points) Compendium
        - Elsevier Gold Standard's Clinical Pharmacology Compendium
        - National Comprehensive Cancer Network Drugs and Biologics Compendium

AND

3. Dispensing provider will monitor amount of product member has left to avoid over-stock.

AND

4. Prescriber is a specialist in treating hemophilia

Antihemophilic and Clotting Factors

CG-DRUG-78

Override(s)	Approval Duration
Prior Authorization	1 year

Medications	Quantity Limit
ADVATE	N/A
Adynovate	N/A
Afstyla	N/A
Alphanate	N/A
AlphaNine SD	N/A
Alprolix	N/A
BEBULIN	N/A
BeneFix	N/A
Coagadex	N/A
Corifact	N/A
Eloctate	N/A
FEIBA	N/A
Fibryna	N/A
Helixate FS	N/A
Hemlibra	N/A
HEMOFIL M	N/A
HUMATE-P	N/A
Idelvion	N/A
Ixinity	N/A
Koate	N/A
Koate-DVI	N/A
Kogenate FS	N/A
Kovaltry	N/A
Monoclate-P	N/A
Mononine	N/A
Novoeight	N/A

NovoSeven RT	N/A
Nuwiq	N/A
Obizur	N/A
Profilnine SD	N/A
Rebinyn	N/A
RECOMBINATE	N/A
RiaSTAP	N/A
RIXUBIS	N/A
TRETTEN	N/A
Vonvendi	N/A
Wilate	N/A
Xyntha	N/A
Xyntha Solufuse	N/A

APPROVAL CRITERIA

Anti-inhibitor Coagulant Complex (*FEIBA*)

Requests for anti-inhibitor coagulant complex agents (FEIBA) **may be approved** to treat individuals with hemophilia A or B with inhibitors to Factor VIII or Factor IX when the following criteria are met:

I. Treatment of bleeding episodes; **or**
II. Peri-procedural operative management for surgical, invasive or interventional radiology procedures; **or**
III. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

Anti-inhibitor coagulant complex **may not be approved** when the above criteria are not met and for all other indications including, but not limited to treatment of bleeding episodes resulting from coagulation factor deficiencies in the absence of inhibitors to coagulation Factor VIII or coagulation Factor IX.

Note: FEIBA (anti-inhibitor coagulant complex) has a black box warning for thrombotic and thromboembolic events, which have been reported during post marketing surveillance following infusion, particularly following the administration of high doses and/or in individuals with thrombotic risk factors.

Factor VIIa Recombinant (*NovoSeven RT)*

Requests for Factor VIIa recombinant coagulation agents (NovoSeven RT) **may be approved** for the following:

I. For treatment of bleeding episodes when the following criteria are met:
   a. Individual has hemophilia A or B with inhibitors to Factor VIII or Factor IX; **or**
   b. Individual has acquired hemophilia; **or**
   c. Individual has congenital Factor VII deficiency.

OR

II. In the prevention of bleeding in surgical interventions or invasive procedures for the following:
   a. Individual has hemophilia A or B with inhibitors to Factor VIII or Factor IX; **or**
   b. Individual has acquired hemophilia; **or**
   c. Individual has congenital Factor VII deficiency.

OR

III. For the treatment of bleeding episodes and peri-operative management in individuals with Glanzmann's thrombasthenia and a documented refractoriness to platelet transfusions with or without antibodies to platelets.

Recombinant coagulation Factor VIIa (NovoSeven RT) **may not be approved** when the above criteria are not met and for all other indications.

Note: NovoSeven, NovoSeven RT [coagulation Factor VIIa (recombinant)] has a black box warning for serious arterial and venous thrombotic events following administration. Individuals should be monitored for signs and symptoms of activation of the coagulation system and for thrombosis.

Antihemophilic factor (factor VIII) Human plasma-derived (*HEMOFIL M, Koate-DVI, Monoclate-P)*

Requests for antihemophilic factor (Factor VIII) human plasma-derived agents (HEMOFIL M, Koate-DVI, Monoclate-P) **may be approved** for the following:

I. For the treatment of bleeding episodes in an individual with hemophilia A and factor VIII deficiency. **OR**

II. As routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met:
   a. Individual has severe hemophilia A (defined as less than 1 International Unit per deciliter [IU/dL] or 1% endogenous Factor VIII); **or**
   b. Individual has mild to moderate hemophilia A (defined as endogenous Factor VIII less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU); **and**
   c. When the individual has documented history of one of the following:

i. 1 or more episodes of spontaneous bleeding into joint; **or**
ii. 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
iii. 4 or more episodes of soft tissue bleeding in an 8 week period.

Requests for antihemophilic factor (Factor VIII) human plasma-derived agents (*Koate-DVI, Monoclate-P*) **may be approved** for the following:

I. As peri-procedural management for surgical, invasive or interventional radiology procedures in an individual with hemophilia A and factor VIII deficiency.

Antihemophilic factor (Factor VIII) human plasma-derived agents (HEMOFIL M, Koate-DVI, Monoclate-P) **may not be approved** when the above criteria are not met including, but not limited to treatment of individuals with von Willebrand disease (VWD).

Antihemophilic factor (factor VIII) Recombinant (*ADVATE, Afstyla, Helixate FS, Kogenate FS, Kovaltry, Novoeight, Nuwiq, RECOMBINATE, Xyntha)*

Requests for Antihemophilic factor (Factor VIII) recombinant agents (ADVATE, Afstyla, Helixate FS, Kogenate FS, Kovaltry, Novoeight, Nuwiq, RECOMBINATE, Xyntha) **may be approved** for the following:

I. For the treatment of bleeding episodes in an individual with hemophilia A and factor VIII deficiency**; OR**
II. For the treatment of bleeding episodes in an individual with von Willebrand disease (VWD) when the following criteria are met:
    a. Antihemophilic Factor VIII Recombinant is used in combination with recombinant von Willebrand factor, when medically necessary as per Vonvendi criteria below; **AND**
    b. Baseline factor VIII levels are less than 40 IU/dL [less than 40%] or are unknown.
III. As peri-procedural management for surgical, invasive or interventional radiology procedures for an individual with hemophilia A and Factor VIII deficiency.

Requests for Antihemophilic Factor VIII Recombinant (*ADVATE, Afstyla, Helixate FS, Kovaltry, Novoeight, Nuwiq)* **may be approved** as routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met (I alone **OR** II&III):

I. Individual has severe hemophilia A (defined as less than 1 International Unit per deciliter [IU/dL] or 1% endogenous Factor VIII);

OR

II. Individual has mild to moderate hemophilia A (defined as endogenous Factor VIII less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU); **and**
III. When the individual has documented history of one of the following:
    a. 1 or more episodes of spontaneous bleeding into joint; **or**
    b. 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
    c. 4 or more episodes of soft tissue bleeding in an 8 week period.

Requests for Antihemophilic Factor VIII Recombinant (*Helixate FS, Kogenate FS)* **may be approved** for the following:

I. As *routine prophylaxis* for children (age 0-16 years) with hemophilia A and factor VIII deficiency to reduce the risk of joint damage in those without pre-existing joint damage.

Requests for Antihemophilic Factor VIII Recombinant (*Recombinate)* **may be approved** for the following:

I. As treatment of individuals with acquired Factor VIII inhibitors not exceeding 10 Bethesda Unit (BU) per milliliter (mL).

Antihemophilic Factor VIII Recombinate (*ADAVATE, Helixate FS, Kogenate, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha)* **may not be approved** when the above criteria are not met and for all other indications.

Antihemophilic Factor (factor VIII) – Long-Acting Recombinant, pegylated (*Adynovate*); Recombinant Antihemophilic Factor Fc Fusion Protein (*Eloctate*)

Requests for Antihemophilic Factor (factor VIII) – Long-Acting Recombinant, pegylated (Adynovate); Recombinant Antihemophilic Factor Fc Fusion Protein (Eloctate) **may be approved** for the following:

I. Individuals with *severe* hemophilia A (congenital factor VIII deficiency); **AND**
    a. Individual has less than 1 International Unit per deciliter (IU/dL) (less than 1%) endogenous factor VIII; **and**
    b. Use is planned for one of the following indications:
        i. Control and prevention of acute bleeding episodes; **or**
        ii. Peri-procedural management for surgical, invasive or interventional radiology procedures; **or**
        iii. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

OR

II. Individuals with *mild to moderate* hemophilia A (congenital factor VIII deficiency); **AND**

a. Individual has endogenous factor VIII level less than 40 IU/dl (less than 40%) but greater than or equal to 1 IU/dl; **and**
b. Use is planned for one of the following indications:
    i. Control of acute bleeding episodes; **or**
    ii. Peri-procedural management for surgical, invasive or interventional radiology procedures; **or**
    iii. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes
    when the member has documented history of one of the following:
        1) 1 or more episodes of spontaneous bleeding into joint; **or**
        2) 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
        3) 4 or more episodes of soft tissue bleeding in an 8 week period.

Requests for Antihemophilic Factor (factor VIII) Recombinant, pegylated (Adynovate); Recombinant Antihemophilic Factor Fc Fusion Protein (Eloctate) **may not be approved** when the above criteria are not met and for all other indications including, but not limited to treatment of individuals with von Willebrand Disease

Antihemophilic bispecific factor (Factor IXa- and Factor X-), Emicizumab (*Hemlibra*)

Requests for Antihemophilic bispecific factor (Factor IXa- and Factor X-), Emicizumab (Hemlibra) **may be approved** for the following:

I. Emicizumab (Hemlibra) is considered medically necessary for individuals with severe hemophilia A (congenital factor VIII deficiency) when all of the following criteria are met:
    a. Individual has less than 1 International Unit per deciliter (IU/dL) (less than 1%) endogenous factor VIII; **AND**
    b. Individual has a documented history of a high-titer of factor VIII inhibitor (that is: greater than or equal to [>/=] 5 bethesda units [BU]) requiring treatment with episodic or prophylactic bypassing agents; **AND**
    c. Use is planned for routine prophylaxis to prevent or reduce the frequency of bleeding episodes.
II. Emicizumab (Hemlibra) is considered medically necessary for individuals with mild to moderate hemophilia A (congenital factor VIII deficiency) when all of the following criteria are met:
    a. Individual has endogenous factor VIII level less than 40 IU/dl (less than 40%) but greater than or equal to 1 IU/dl; **AND**
    b. Individual has a documented history of a high-titer of factor VIII inhibitor (that is: greater than or equal to [>/=] 5 bethesda units [BU]) requiring treatment with episodic or prophylactic bypassing agents; **AND**
    c. Use is planned for routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the member has documented history of one of the following:
        i. 1 or more episodes of spontaneous bleeding into joint; **OR**
        ii. 1 or more episodes of spontaneous bleeding into the central nervous system;

OR

iii. 4 or more episodes of soft tissue bleeding in an 8 week period.

Emicizumab (Hemlibra) **may not be approved** when the above criteria are not met and for all other indications.

Antihemophilic Factor (Recombinant), Porcine Sequence (*Obizur*)

Requests for Antihemophilic Factor (Recombinant), Porcine Sequence **may be approved** for the following:

I. For treatment of bleeding episodes in adults with acquired hemophilia A.

Antihemophilic Factor (Recombinant), Porcine Sequence (Obizur) **may not be approved** when the above criteria are not met and for all other indications including, but not limited to:

I. Treatment of individuals with congenital hemophilia A with Factor VIII deficiency
II. Treatment of individuals with von Willebrand disease
III. Treatment of individuals with acquired hemophilia A and baseline anti-porcine Factor VIII inhibitor titer greater than 20 BU/mL.

Antihemophilic Factor VIII/von Willebrand Factor Complex (*Alphanate, Humate-P, Wilate*)

Requests for Antihemophilic Factor VIII/von Willebrand Factor Complex (Alphanate, Humate-P, Wilate) **may be approved** as treatment for individuals with von Willebrand disease when the following criteria are met (I alone **OR** II & III):

I. VWD is severe;

OR

II. VWD is mild to moderate and use of desmopressin is known or suspected to be inadequate; **and**
III. Individual is being treated for either:
    a. Spontaneous or trauma-induced bleeding episodes; **or**
    b. Peri-procedural management for surgical, invasive or interventional radiology procedures.

Requests for Antihemophilic Factor VIII/von Willebrand Factor Complex (Alphanate, Humate-P) **may be approved** for the following:

I. For treatment of bleeding episodes in an individual with hemophilia A and Factor VIII deficiency; **OR**
II. As routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met:
    a. Individual has severe hemophilia A (defined as less than 1 International Unit per deciliter [IU/dL] or 1% endogenous Factor VIII); **OR**
    b. Individual has mild to moderate hemophilia A (defined as endogenous Factor VIII less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU); **AND**
    c. When the individual has documented history of one of the following:
        i. 1 or more episodes of spontaneous bleeding into joint; **OR**
        ii. 1 or more episodes of spontaneous bleeding into the central nervous system; **OR**
        iii. 4 or more episodes of soft tissue bleeding in an 8 week period.

Requests for Antihemophilic Factor VIII/von Willebrand Factor Complex (Alphanate) **may be approved** for the following:

I. For treatment of bleeding episodes in an individual with acquired Factor VIII deficiency.

Antihemophilic Factor/von Willebrand Factor Complex (Alphanate, Humate-P, Wilate) **may not be approved** when the above criteria are not met and for any of the following:
I. All other indications including, but not limited to prophylaxis therapy in individuals with VWD.
II. Alphanate for individuals with severe VWD (Type 3) undergoing major surgery.
III. Wilate for individuals with hemophilia A.

<u>von Willebrand factor (Recombinant) (*Vonvendi*)</u>

Requests for von Willebrand factor (Recombinant) (Vonvendi) **may be approved** for the following:

I. von Willebrand factor (Recombinant) is considered **medically necessary** as a treatment for adults (18 years of age and older) with von Willebrand disease when the following criteria are met:
    a. VWD is *severe*; **or**
    b. VWD is *mild to moderate* and use of desmopressin is known or suspected to be inadequate; **and**
    c. Individual is being treated for spontaneous or trauma-induced bleeding episodes.

Requests for von Willebrand factor (Recombinant) (*Vonvendi*) **may not be approved** when the above criteria are are not met and for all other indications.

Coagulation Factor IX, Human plasma-derived (*Alphanine SD, Mononine*)

Requests for Human plasma-derived coagulation Factor IX (Alphanine SD, Mononine) **may be approved** for the following:

I. For treatment of bleeding episodes in an individual with hemophilia B and Factor IX deficiency; **OR**
II. As routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met:
    a. Individual has severe hemophilia B (defined as less than 1 IU/dL or 1% endogenous Factor IX); **or**
    b. Individual has mild to moderate hemophilia B (defined as endogenous Factor IX less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU/dL); **and**
    c. When the member has documented history of one of the following:
        i. 1 or more episodes of spontaneous bleeding into joint; **or**
        ii. 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
        iii. 4 or more episodes of soft tissue bleeding in an 8 week period.

Human plasma-derived coagulation Factor IX (Alphanine SD, Mononine) **may not be approved** when the above criteria are not met, including but not limited to the following:

I. Treatment or reversal of coumarin-induced anticoagulation
II. Hemorrhagic state or coagulopathy associated with liver dysfunction
III. Treatment of individuals with hemophilia A with inhibitors to factor VIII
IV. Replacement therapy of other clotting factors which include factors II, VII and X.

Factor IX Complex, Human plasma-derived (*Bebulin, Profilnine SD)*

Requests for Human plasma-derived Factor IX complex (Bebulin, Profilnine SD) **may be approved** for the following:

I. For treatment of bleeding episodes in an individual with hemophilia B (congenital factor IX deficiency or Christmas disease); **OR**
II. As routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met:
    a. Individual has severe hemophilia B (defined as less than 1 IU/dL or 1% endogenous Factor IX); **or**
    b. Individual has mild to moderate hemophilia B (defined as endogenous Factor IX less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU/dL); **and**
    c. When the member has documented history of one of the following:
        i. 1 or more episodes of spontaneous bleeding into joint; **or**
        ii. 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
        iii. 4 or more episodes of soft tissue bleeding in an 8 week period.

Human plasma-derived Factor IX complex (*Bebulin, Profilnine SD*) **may not be approved** when the above criteria are not met and for all other indications including, but not limited to use for treatment of individuals with Factor VII deficiency.

Factor IX Recombinant (*Benefix, Ixinity, RIXUBIS)*

Requests for Recombinant coagulation Factor IX (Benefix, RIXUBUS*)* **may be approved** to treat individuals with hemophilia B (congenital factor IX deficiency or Christmas disease) when the following criteria are met:

I. To treat bleeding episodes; **or**
II. For peri-procedural management for surgical, invasive or interventional radiology procedures.

Requests for Recombinant coagulation Factor IX (Benefix, RIXUBIS) **may be approved** as routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met (I alone **OR** II & III):

I. Individual has severe hemophilia B (defined as less than 1 IU/dL or 1% endogenous Factor IX);

OR

II. Individual has mild to moderate hemophilia B (defined as endogenous Factor IX less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU/dL); **and**
III. When the member has documented history of one of the following:
    a. 1 or more episodes of spontaneous bleeding into joint; **or**
    b. 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
    c. 4 or more episodes of soft tissue bleeding in an 8 week period.

Recombinant coagulation Factor IX (Ixinity) **may be approved** to treat individuals aged 12 years and older with hemophilia B (congenital factor IX deficiency or Christmas disease) when the following criteria are met:

I. To treat bleeding episodes; **or**
II. Peri-procedural management for surgical, invasive or interventional radiology procedures; **or**
III. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are met:
    a. Individual has severe hemophilia B (defined as less than 1 IU/dL or 1% endogenous Factor IX); **or**
    b. Individual has mild to moderate hemophilia B (defined as endogenous Factor IX less than 40 IU/dL [less than 40%], but greater than or equal to 1 IU/dL); **and**
    c. When the member has documented history of one of the following:
        i. 1 or more episodes of spontaneous bleeding into joint; **or**

ii. 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
iii. 4 or more episodes of soft tissue bleeding in an 8 week period.

Recombinant coagulation Factor IX (*Benefix, Ixinity, RIXUBIS*) **may not be approved** when the above criteria are not met and for all other indications including, but not limited to the following:

I. Treatment of other factor deficiencies (for example factors II, VII, VIII and X)
II. Treatment of individuals with hemophilia A with inhibitors to factor VIII
III. To reverse coumarin-induced anticoagulation
IV. Treatment of bleeding due to low levels of liver-dependent coagulation factors.
V. For the induction of immune tolerance in individuals with hemophilia B.

Coagulation Factor IX - Long-Acting Recombinant, Albumin Fusion Protein *(Idelvion)*; Recombinant Coagulation Factor IX, Fc Fusion Protein *(Alprolix);* Recombinant Coagulation Factor IX, GlycoPEGylated (*Rebinyn*®)

Requests for Coagulation Factor IX - Long Acting Recombinant, Albumin Fusion Protein *(Idelvion)*; Recombinant Coagulation Factor IX, Fc Fusion Protein *(Alprolix)*; Recombinant Coagulation Factor IX, GlycoPEGylated *(Rebinyn)* may be approved for the following:

I. Individual has *severe* hemophilia B (congenital Factor IX deficiency); AND
a. Individual has less than 1 International Unit per deciliter (IU/dl) (less than 1%) endogenous factor IX; **and**
b. Use of rIX-FP is planned for one of the following indications:
i. Treatment of bleeding episodes; **or**
ii. Peri-procedural management for surgical, invasive or interventional radiology procedures; **or**
iii. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes (excluding Recombinant Coagulation Factor IX, GlycoPEGylated [*Rebinyn*].

OR

II. Individuals has *mild to moderate* hemophilia B (congenital Factor IX deficiency); **AND**
a. Individual has endogenous factor IX level less than 40 International Units per deciliter (IU/dl) (less than 40%) but greater than or equal to 1 IU/dl; **and**
b. Use of rIX-FP is planned for one of the following indications:
i. Treatment of bleeding episodes; **or**
ii. Peri-procedural management for surgical, invasive or interventional radiology procedures; **or**
iii. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the member has documented history of one of the following (excluding Recombinant Coagulation Factor IX, GlycoPEGylated [*Rebinyn*]:
1) 1 or more episodes of spontaneous bleeding into joint; **or**
2) 1 or more episodes of spontaneous bleeding into the central nervous system; **or**
3) 4 or more episodes of soft tissue bleeding in an 8 week period.

Coagulation Factor IX - Long-Acting Recombinant, Albumin Fusion Protein (Idelvion); Recombinant Coagulation Factor IX, Fc Fusion Protein *(Alprolix)*; Recombinant Coagulation Factor IX, GlycoPEGylated *(Rebinyn)* **may not be approved** when the above criteria are not met and for all other indications, including but not limited to induction of immune tolerance in individuals with hemophilia B.

Recombinant Coagulation Factor IX, GlycoPEGylated (*Rebinyn*) **may not be approved** for prophylactic use in the prevention or reduction of the frequency of bleeding episodes.

Coagulation Factor X, Human plasma-derived (*Coagadex*)

Requests for Human plasma derived coagulation Factor X (Coagadex) may be approved for individuals aged 12 years or older when the following criteria are met:

I. Individual has severe or moderate hereditary Factor X deficiency (defined as less than 5 International Unit per deciliter (IU/dl) or 5% endogenous Factor X) **and** the factor is to be used for the treatment of bleeding episodes; **OR**
II. Individual has mild hereditary Factor X deficiency (defined as greater than or equal to 5 International Unit per deciliter (IU/dl) or 5% endogenous Factor X) **and** the factor is to be used for peri-procedural management for surgical, invasive or interventional radiology procedures.

Human plasma derived coagulation Factor X (Coagadex) **may not be approved** when the above criteria are not met and for all other indications, including but not limited to perioperative management of bleeding in major surgery in individuals with moderate and severe hereditary Factor X deficiency.

Factor XIII (*Corifact, TRETTEN*)

Requests for Human plasma-derived concentrate Factor XIII (Corifact) **may be approved** for individuals with Factor XIII deficiency for the following indications:

I. As routine prophylactic treatment to prevent or reduce the frequency of bleeding episodes; **or**
II. Peri-procedural management for surgical, invasive or interventional radiology procedures.

Requests for Recombinant coagulation Factor XIII A-Subunit (TRETTEN) **may be** approved for the following:

I. As routine prophylaxis for bleeding in individuals with congenital Factor XIII A-subunit deficiency.

Coagulation Factor XIII (Corifact, TRETTEN) **may not be approved** when the above criteria are not met and for all other indications including, but not limited to treatment of individuals with congenital Factor XIII B-subunit deficiency.

Fibrinogen Concentrate, Human plasma-derived (*RiaSTAP*); Human fibrinogen *(Fibryna)*

Requests for Human plasma-derived fibrinogen concentrate (RiaSTAP) and human fibrinogen *(Fibryna)* **may be approved** for the following:

I. For the treatment of acute bleeding episodes in individuals with congenital fibrinogen deficiency (that is, afibrinogenemia or hypofibrinogenemia).

Human plasma-derived fibrinogen concentrate (RiaSTAP) and human fibrinogen *(Fibryna)* **may not be approved** when the above criteria are not met and for all other indications including, but not limited to treatment of individuals with dysfibrinogenemia.

State Specific Mandates		
State Name	Date Effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

Key References:

1. Athale AH, Marcucci M, Iorio A. Immune tolerance induction for treating inhibitors in people with congenital haemophilia A or B. Cochrane Database Syst Rev. 2014;(4):CD010561.
2. Iorio A, Marchesini E, Marcucci M, et al. Clotting factor concentrates given to prevent bleeding and bleeding-related complications in people with hemophilia A or B. Cochrane Database Syst Rev. 2011;(9):CD003429.
3. Nichols WL, Hultin MB, James AH, et al. von Willebrand disease (VWD): evidence-based diagnosis and management guidelines, the National Heart, Lung, and Blood Institute (NHLBI) Expert Panel report (USA). Haemophilia. 2008; 14(2):171-232.
4. Simpson E, Lin Y, Stanworth S, et al. Recombinant factor VIIa for the prevention and treatment of bleeding in patients without haemophilia. Cochrane Database Syst Rev. 2012; (3):CD005011.
5. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al.; Treatment Guidelines Working Group on Behalf of the World Federation Of Hemophilia. Guidelines for the management of hemophilia. Haemophilia. 2013; 19(1):e1-e47.
6. Yank V, Tuohy CV, Logan AC, et al. Comparative effectiveness of recombinant factor VIIa for off-label indications vs. usual care. Comparative effectiveness review No. 21. Rockville, MD: Agency for Healthcare Research and Quality. May

2010. Available at: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0047460/pdf/PubMedHealth_PMH0047460.pdf. Accessed on December 22, 2017.

CLOTTING FACTORS AND COAGULANT BLOOD PRODUCTS

Policy Number: PHA027 **Effective Date**: April 1, 2018

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INSTRUCTIONS FOR USE

This Drug Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Drug Policy is based. In the event of a conflict, the member specific benefit plan document supersedes this Drug Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Drug Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Drug Policy is provided for informational purposes. It does not constitute medical advice. This drug policy does not govern Medicare Group Retiree members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. See the Policy and Procedure addressing the treatment of serious rare diseases.

Essential Health Benefits for Individual and Small Group
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

This policy refers to the following products:

Product	Brand Name
Factor VIIa (recombinant)	NovoSeven® RT (coagulation factor VIIa (recombinant))
Factor XIII (plasma-derived)	Corifact® (factor XIII concentrate (human))
Factor VIII (plasma-derived)	Hemofil M® (antihemophilic factor (human))
	Koāte®-DVI (antihemophilic factor (human))
	Monoclate-P® (antihemophilic factor (human))
Factor VIII (plasma-derived) / von Willebrand Factor Complex (plasma- derived)	Alphanate® (antihemophilic factor (human))
	Humate-P® (antihemophilic factor (human))
	Wilate® (antihemophilic factor (human))
Factor VIII (recombinant)	Advate® (antihemophilic factor (recombinant))
	Helixate® FS (antihemophilic factor (recombinant))
	Kogenate® FS (antihemophilic factor (recombinant))
	Kovaltry® (antihemophilic factor (recombinant))
	Novoeight® (antihemophilic factor (recombinant))
	Nuwiq® (antihemophilic factor (recombinant))
	Recombinate® (antihemophilic factor (recombinant))
	Xyntha® (antihemophilic factor (recombinant))
	Xyntha® Solofuse™ (antihemophilic factor (recombinant))
Factor IX (plasma-derived)	AlphaNine® SD (coagulation factor IX (human))
	Bebulin® (factor IX complex (human))
	Mononine® (coagulation factor IX (human))
	Profilnine® (factor IX complex human))
Factor IX (recombinant)	BeneFIX® (coagulation factor IX (recombinant))
	Ixinity® (coagulation factor IX (recombinant))
	Rixubis® (coagulation factor IX (recombinant))
Factor IX (recombinant), long-acting	Alprolix® (coagulation factor IX (recombinant), Fc fusion protein)
	Idelvion® (coagulation factor IX (recombinant), albumin fusion protein)
Anti-Inhibitor Coagulant Complex (plasma-derived)	FEIBA® (anti-inhibitor coagulant complex (human))
Fibrinogen Concentrate (plasma-derived)	RiaSTAP® (fibrinogen concentrate (human))
Factor XIII A-subunit (recombinant)	Tretten® (coagulation factor XIII A-subunit (recombinant))
Factor VIII (recombinant), long-acting	Adynovate® (antihemophilic factor (recombinant), PEGylated)
	Afstyla® (antihemophilic factor (recombinant))
	Eloctate® (antihemophilic factor (recombinant), Fc fusion protein)
Factor VIII (recombinant), porcine sequence	Obizur® (antihemophilic factor (recombinant), porcine sequence)
Factor X (plasma-derived)	Coagadex® (coagulation factor X (human))
Von Willebrand Factor (recombinant)	Vonvendi® (von Willebrand factor (recombinant))

The following information provides the indications and criteria for which specific clotting factors and coagulant blood products are considered proven:

I. Congenital Factor XIII Deficiency (i.e., Fibrin Stabilizing Factor Deficiency)

A. Factor XIII (plasma-derived) [Corifact] is proven and medically necessary when both of the following criteria are met:

1. Diagnosis of congenital factor XIII deficiency; **and**
2. **One** of the following:
   a. Routine prophylactic treatment; **or**

b. Peri-operative management of surgical bleeding; **or**
c. Treatment of bleeding episodes.

B. Coagulation Factor XIII A-subunit (recombinant) [Tretten] is **proven and medically necessary** when **both** of the following criteria are met:
1. Diagnosis of congenital factor XIII A-subunit deficiency; **and**
2. **One** of the following:
   a. Routine prophylactic treatment; **or**
   b. Peri-operative management of surgical bleeding; or
   c. Treatment of bleeding episodes.

II. Von Willebrand Disease (VWD)

A. Factor VIII (plasma-derived) / von Willebrand Factor Complex (plasma-derived) [Alphanate or Humate-P] is **proven and medically necessary** when **both** of the following criteria are met:[2,3]
1. **One** of the following:
   a. Diagnosis of severe von Willebrand disease; **or**
   b. **Both** of the following:
      i. Diagnosis of mild or moderate von Willebrand disease; **and**
      ii. History of failure, contraindication or intolerance to treatment with Desmopressin; **and**
2. **One** of the following:
   a. Treatment of spontaneous or trauma-induced bleeding episodes; **or**
   b. Peri-operative management of surgical bleeding.

B. Factor VIII (plasma-derived) / von Willebrand Factor Complex (plasma-derived) [Wilate] is **proven and medically necessary** when **one** of the following criteria is met:[4]
1. **Both** of the following:
   a. Diagnosis of severe von Willebrand disease; **and**
   b. Treatment of spontaneous or trauma-induced bleeding episodes; **or**
2. **Both** of the following:
   a. Diagnosis of mild or moderate von Willebrand disease; **and**
   b. History of failure, contraindication or intolerance to treatment with Desmopressin.

C. Von Willebrand factor (recombinant) [Vonvendi] is **proven and medically necessary** when **both** of the following criteria are met:[53]
1. Diagnosis of von Willebrand disease; **and**
2. Treatment of bleeding episodes.

III. Congenital Factor VII Deficiency

A. Factor VIIa (recombinant) [NovoSeven RT] is **proven and medically necessary** when **both** of the following criteria are met:[5]
1. Diagnosis of congenital factor VII deficiency; **and**
2. **One** of the following:
   a. Routine prophylactic treatment; or
   b. Peri-operative management of surgical bleeding; or
   c. Treatment of bleeding episodes

IV. Hemophilia A (i.e.,Factor VIII Deficiency, Classical Hemophilia)

A. Factor VIII (plasma-derived) / von Willebrand Factor Complex (plasma-derived) [Alphanate or Humate-P], Factor VIII (plasma-derived) [Hemofil M, Koāte-DVI or Monoclate-P), and Factor VIII (recombinant) [Kogenate FS, Kovaltry, NovoEight or Nuwiq] are **proven and medically necessary** when **both** of the following criteria are met:
1. Diagnosis of hemophilia A; **and**
2. **One** of the following:
   a. Routine prophylactic treatment; or
   b. Peri-operative management of surgical bleeding; or
   c. Treatment of bleeding episodes

Additional information to support medical necessity review where applicable:

Antihemophilic Factor (Recombinant) [Helixate] and Antihemophilic Factor (Recombinant), Pegylated [Adynovate] are **not medically necessary** for treatment of hemophilia A for the following:

- Routine prophylactic treatment; or
- Perioperative management of surgical bleeding;
- Treatment of bleeding episodes.

Published clinical evidence does not demonstrate superiority in efficacy and treatment adherence of Helixate or Adynovate to other available recombinant factor products.

B. Antihemophilic Factor (recombinant) [**Advate** or **Recombinate**] is **proven and medically necessary** when **all** of the following criteria are met:
   1. Diagnosis of hemophilia A; **and**
   2. **One** of the following:
      a. Submission of documentation showing failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level) after a trial of **three** of the following recombinant factor products:
         i. Kogenate FS
         ii. Kovaltry
         iii. NovoEight
         iv. Nuwiq

      b. Submission of documentation showing history of hypersensitivity to **three** of the following recombinant factor products:
         i. Kogenate FS
         ii. Kovaltry
         iii. NovoEight
         iv. Nuwiq

      or
   3. Patient is currently on **Advate** or **Recombinate** therapy; and
   4. **One** of the following:
      a. Patient has **not** received a manufacturer supplied sample at no cost in prescriber office or a 30 day free trial from a pharmacy as a means to establish as a current user of **Advate** or **Recombinate**;
      or
      b. **Both** of the following:
         1) Patient has received a manufacturer supplied sample at no cost in prescriber office or a 30 day free trial from a pharmacy as a means to establish as a current user of **Advate** or **Recombinate**;
         and
         2) **One** of the following:
            a) Submission of documentation showing failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level) after a trial of three of the following recombinant factor products:
               (1) Kogenate FS
               (2) Kovaltry
               (3) NovoEight
               (4) Nuwiq

            or

            b) Submission of documentation showing history of hypersensitivity to **three** of the following recombinant factor products:
               (1) Kogenate FS
               (2) Kovaltry
               (3) NovoEight
               (4) Nuwiq

C. Antihemophilic Factor (recombinant) [**Xyntha**] is **proven and medically necessary** when **all** of the following criteria are met:
   1. Diagnosis of hemophilia A; **and**
   2. **One** of the following:
      a. Treatment of bleeding episodes; or
      b. Peri-operative management of surgical bleeding

   and
   3. **One** of the following.
      a. Submission of documentation showing failure to meet clinical goals (e.g., continuation of

spontaneous bleeds, inability to achieve appropriate trough level) after a trial of **three** of the following recombinant factor products:
   i. Kogenate FS
   ii. Kovaltry
   iii. NovoEight
   iv. Nuwiq
b. Submission of documentation showing history of hypersensitivity to **three** of the following recombinant factor products:
   i. Kogenate FS
   ii. Kovaltry
   iii. NovoEight
   iv. Nuwiq

or

4. **All** of the following:
   a. Patient is currently on **Xyntha**; **and**
   b. **One** of the following:
      1) Submission of documentation showing failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level) after a trial of **three** of the following recombinant factor products:
         a) Kogenate FS
         b) Kovaltry
         c) NovoEight
         d) Nuwiq

         or
      2) Submission of documentation showing history of hypersensitivity to **three** of the following recombinant factor products:
         a) Kogenate FS
         b) Kovaltry
         c) NovoEight
         d) Nuwiq

D. Antihemophilic Factor (recombinant), FC Fusion Protein [Eloctate] is **proven** when **all** of the following criteria are met**:**[42]
1. Diagnosis of hemophilia A; **and**
2. **One** of the following:
   a. Routine prophylactic treatment; or
   b. Perioperative management of surgical bleeding; or
   c. Treatment of bleeding episodes

   and
3. Prescribed dosage and interval utilized is within range as defined by the prescribing information.

Additional information to support medical necessity review where applicable:
Antihemophilic Factor (recombinant), FC Fusion Protein [Eloctate] is **medically necessary** for the treatment of Hemophilia A when **one** of the following criteria is met:[42-43,45]
1. **All** of the following:
   a. Diagnosis of severe hemophilia A; **and**
   b. Patient is not a suitable candidate for treatment with shorter half-life Factor VIII (recombinant) products [e.g., Kogenate FS, Kovaltry, Novoeight, or Nuwiq] as attested by the prescribing physician; **and**
   c. One of the following**:**
      i. Routine prophylactic treatment; or
      ii. Perioperative management of surgical bleeding; or
      iii. Treatment of bleeding episodes

      and
   d. One of the following:
      i. Both of the following:
         1. Dose does not exceed 50 IU/kg; **and**
         2. Infusing no more frequently than every 4 days;

         or

      ii. Requested dosage regimen does not exceed 12.5 IU/kg/day

   or
2. **All** of the following:
   a. **One** of the following:

i. **Both** of the following:
1) Moderate hemophilia A; **and**
2) Endogenous factor VIII level 2% < 5% (0.02 IU/mL to less than 0.05 IU/mL);
or
ii. **Both** of the following:
1) Mild hemophilia A; **and**
2) Endogenous factor VIII level > 5% (greater than 0.05 IU/mL);
and

b. Patient is not a suitable candidate for treatment with shorter half-life Factor VIII (recombinant) products [e.g., Kogenate FS, Kovaltry, Novoeight or Nuwiq] as attested by the prescribing physician; **and**

c. **One** of the following:
i. Treatment of bleeding episodes; **or**
ii. Prevention of bleeding in surgical interventions or invasive procedures (e.g., surgical prophylaxis); **or**
iii. Prevention of bleeding episodes (i.e., routine prophylaxis) with documentation of **one** of the following in an 8 week period:
1) ≥1 or more episodes of spontaneous/ traumatic bleeding into joint; **or**
2) ≥1 episode of spontaneous / traumatic bleeding into the central nervous system; **or**
3) ≥1 episode of severe soft tissue bleeding (i.e., ileopsoas);
and

d. Documentation of **both** of the following:
i. Dose does not exceed 50 IU/kg; **and**
ii. Infusing no more frequently than every 4 days.

E. Antihemophilic Factor (recombinant), Single Chain [Afstyla] is **proven** when **both** of the following criteria are met:
1. Diagnosis of hemophilia A; **and**
2. **One** of the following:
a. Routine prophylactic treatment; **or**
b. Perioperative management of surgical bleeding; **or**
c. Treatment of bleeding episodes

Additional information to support medical necessity review where applicable:
Antihemophilic Factor (recombinant), Single Chain [Afstyla] is **medically necessary** for the treatment of Hemophilia A when **all** of the following criteria are met:[49, 58-59]
1. Diagnosis of hemophilia A; **and**
2. Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [Kogenate FS, Kovaltry, Novoeight, or Nuwiq] as attested by the prescribing physician; **and**
3. **One** of the following:
a. Patient is not to receive routine infusions more frequently than 3 times per week; **or**
b. **Both** of the following:
i. Patient is less than 12 years of age; **and**
ii. Pharmacokinetic (PK) testing results suggest that more frequently than 3 times per week dosing is required.

F. **Anti-Inhibitor Coagulant Complex (plasma-derived) [FEIBA] and Factor VIIa (recombinant) [NovoSeven RT] are proven and medically necessary when all of the following criteria are met:**
1. Diagnosis of hemophilia A; **and**
2. Documentation of inhibitors (e.g., Bethesda inhibitor assay); **and**
3. **One** of the following:
a. Routine prophylactic treatment; **or**
b. Perioperative management of surgical bleeding; **or**
c. Treatment of bleeding episodes

G. Factor VIIa (recombinant) [NovoSeven RT] and antihemophilic factor (recombinant), porcine sequence [Obizur] are **proven and medically necessary** when **both** of the following criteria are met:[5,22,29-30,44]
1. Diagnosis of acquired factor VIII hemophilia (e.g., acquired hemophilia A, Factor VIII deficiency) ; **and**
2. Treatment or prevention of bleeding episodes.

V. Hemophilia B (i.e., Congenital Factor IX Deficiency, Christmas Disease)

A. Factor IX (plasma-derived) [AlphaNine SD, Bebulin, Mononine, or Profilnine SD] is **proven and**

medically necessary when **both** of the following criteria are met:[15-18,]
1. Diagnosis of hemophilia B; **and**
2. Prevention and treatment of bleeding episodes.

B. Factor IX (recombinant) [BeneFIX or Rixubis], Coagulation Factor IX (recombinant), Fc Fusion Protein (Alprolix) and Coagulation Factor IX (recombinant), albumin fusion protein (Idelvion) are **proven and medically necessary** when **both** of the following criteria are met:[19,36,40,42,50]
1. Diagnosis of hemophilia B; **and**
2. **One** of the following:
   a. Control and prevention of bleeding episode; **or**
   b. Prevention of bleeding in surgical interventions (i.e., surgical prophylaxis).

Additional information to support medical necessity review where applicable:
Coagulation Factor IX (Recombinant) [Ixinity] is **not medically necessary** for treatment of hemophilia B for the following:
- Control and prevention of bleeding episodes;
- Perioperative management;
- Routine prophylaxis of to prevent or reduce the frequency of bleeding episodes.

Published clinical evidence does not demonstrate superiority in efficacy and treatment adherence of Ixinity to other available recombinant factor products.

C. Anti-Inhibitor Coagulant Complex (plasma-derived) [FEIBA] and Factor VIIa (recombinant) [NovoSeven RT] are **proven and medically necessary** when **all** of the following criteria are met: [5,14.20-21]
1. Diagnosis of hemophilia B; **and**
2. Documentation of inhibitors (e.g., Bethesda inhibitor assay); **and**
3. **One** of the following:
   a. Routine prophylactic treatment; **or**
   b. Perioperative management of surgical bleeding; **or**
   c. Treatment of bleeding episodes.

VI. Fibrinogen Deficiency (i.e., Factor I deficiency)

A. Fibrinogen Concentrate (plasma-derived) [RiaSTAP] is **proven and medically necessary** when **all** of the following criteria are met:[35]
1. Diagnosis of congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia; **and**
2. **One** of the following:
   a. Routine prophylactic treatment; **or**
   b. Perioperative management of surgical bleeding; **or**
   c. Treatment of bleeding episodes.

VII. Glanzmann Thrombasthenia

A. Factor VIIa (recombinant) [NovoSeven RT] is **proven and medically necessary** when **all** of the following criteria are met:[5]
1. Diagnosis of Glanzmann's thrombasthenia; **and**
2. Refractory to platelet transfusions; **and**
3. **One** of the following:
   a. Treatment of bleeding episodes; **or**
   b. Perioperative management of surgical bleeding.

VIII. Congenital Factor X Deficiency

A. Coagulation Factor X (human) [Coagadex] is **proven and medically necessary** when **both** of the following criteria are met:[52]
1. Diagnosis of congenital Factor X deficiency; **and**
2. **One** of the following:
   a. Treatment of bleeding episodes; **or**
   b. Perioperative management of surgical bleeding.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Advate (antihemophilic factor (recombinant)) is approved by the U.S. Food and Drug Administration (FDA) for use in children and adults with hemophilia A for the following: control and prevention of bleeding episodes;

perioperative management; and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Advate is not indicated for the treatment of von Willebrand disease.[9]

Adynovate (antihemophilic factor (recombinant), PEGylated) is FDA-labeled in adolescent and adult patients (12 years and older) with hemophilia A (congenital factor VIII deficiency) for the following: on-demand treatment and control of bleeding episodes; perioperative management; and routine prophylaxis to reduce the frequency of bleeding episodes. Adynovate is not indicated for the treatment of von Willebrand disease.[51]

Afstyla (antihemophilic factor (recombinant)) is FDA-labeled in adults and children with hemophilia A (congenital Factor VIII deficiency) for the following: on-demand treatment and control of bleeding episodes; routine prophylaxis to reduce the frequency of bleeding episodes; and perioperative management of bleeding. Afstyla is not indicated for the treatment of von Willebrand disease.[49]

Alphanate (antihemophilic factor/von Willebrand factor complex (human)) is FDA-labeled for control and prevention of bleeding in adult and pediatric patients with hemophilia A. It is also approved for surgical and/or invasive procedures in adult and pediatric patients with von Willebrand Disease in whom desmopressin (DDAVP) is either ineffective or contraindicated. Alphanate is not indicated for patients with severe VWD (Type 3) undergoing major surgery.[2]

AlphaNine SD (coagulation factor IX (human)) is FDA-labeled for the prevention and control of bleeding in patients with Factor IX deficiency due to hemophilia B. AlphaNine SD contains low, non-therapeutic levels of Factors II, VII, and X, and, therefore, is not indicated for the treatment of Factor II, VII or X deficiencies. This product is also not indicated for the reversal of coumarin anticoagulant-induced hemorrhage, nor in the treatment of hemophilia A patients with inhibitors to Factor VIII.[15]

Alprolix (coagulation factor IX (recombinant), Fc fusion protein) is FDA-labeled in adults and children with hemophilia B for the following: on demand treatment and control of bleeding episodes; perioperative management of bleeding; and for routine prophylaxis to reduce the frequency of bleeding episodes. Alprolix is not indicated for induction of immune tolerance in patients with hemophilia B.[40]

Bebulin (factor IX complex) is FDA-labeled for the prevention and control of bleeding episodes in adult patients with hemophilia B. Bebulin is not indicated for use in the treatment of Factor VII deficiency. No clinical studies have been conducted to show benefit from this product for treating deficiencies other than Factor IX deficiency.[16]

BeneFIX (coagulation factor IX (recombinant)) is FDA-labeled for both control and prevention of bleeding episodes in adult and pediatric patients with hemophilia B, and for peri-operative management in adult and pediatric patients with hemophilia B.[19] BeneFIX is not indicated for the treatment of other factor deficiencies (e.g., factors II, VII, VIII, and X), hemophilia A patients with inhibitors to factor VIII, reversal of coumarin-induced anticoagulation, and bleeding due to low levels of liver-dependent coagulation factors. [19]

Coagadex (coagulation factor X (human)) is FDA-labeled in adults and children (aged 12 years and above) with hereditary Factor X deficiency for the following: on-demand treatment and control of bleeding episodes; and perioperative management of bleeding in patients with mild hereditary Factor X deficiency. Perioperative management of bleeding in major surgery in patients with moderate and severe hereditary Factor X deficiency has not been studied.[52]

Corifact (factor XIII concentrate (human)) is FDA-labeled in adult and pediatric patients with congenital Factor XIII deficiency for the following: routine prophylactic treatment and peri-operative management of surgical bleeding.[1]

Eloctate (antihemophilic factor (recombinant), Fc fusion protein) is FDA-labeled in adults and children with Hemophilia A for the following: on-demand treatment and control of bleeding episodes; perioperative management of bleeding; and routine prophylaxis to reduce the frequency of bleeding episodes. Eloctate is not indicated for the treatment of von Willebrand disease.[42]

FEIBA (anti-inhibitor coagulant complex) is FDA-labeled in hemophilia A and B patients with inhibitors for the following: control and prevention of bleeding episodes; peri-operative management; and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. FEIBA is not indicated for the treatment of bleeding episodes resulting from coagulation factor deficiencies in the absence of inhibitors to factor VIII or factor IX.[14]

Helixate FS (antihemophilic factor (recombinant)) is FDA-labeled for the following: control and prevention of bleeding episodes in adults and children with hemophilia A; peri-operative management in adults and children with hemophilia A; routine prophylaxis to prevent or reduce the frequency of bleeding episodes in children with hemophilia A and to reduce the risk of joint damage in children without pre-existing joint damage; and routine

prophylaxis to prevent or reduce the frequency of bleeding episodes in adults with hemophilia A. Helixate FS is not indicated for the treatment of von Willebrand disease. [10] Hemofil M (antihemophilic factor (human)) is FDA-labeled for the prevention and control of hemorrhagic episodes in hemophilia A. Hemofil M is not indicated in von Willebrand disease.[6]

Humate-P (antihemophilic factor/von Willebrand factor complex (human)) is FDA-labeled for treatment and prevention of bleeding in adults with hemophilia A. It is also indicated in adults and children with von Willebrand disease (VWD) for treatment of spontaneous and trauma-induced bleeding episodes, and for prevention of excessive bleeding during and after surgery. This includes patients with severe VWD as well as patients with mild to moderate VWD where the use of desmospressin is known or suspected to be inadequate. Humate-P is not indicated for the prophylaxis of spontaneous bleeding episodes in VWD.[3]

Idelvion (coagulation factor IX (recombinant), albumin fusion protein) is FDA-labeled in children and adults with hemophilia B (congenital Factor IX deficiency) for the following: on-demand treatment and control of bleeding episodes; perioperative management of bleeding; and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. Idelvion is not indicated for immune tolerance induction in patients with hemophilia B.[50]

IXINITY (coagulation factor IX (recombinant)) is FDA-labeled for control and prevention of bleeding episodes in adults and children ≥ 12 years of age with hemophilia B. It is also indicated for perioperative management. IXINITY is not indicated for induction of immune tolerance in patients with hemophilia B.[46]

Koāte-DVI (antihemophilic factor (human)) is FDA-labeled for the treatment of hemophilia A in which there is a demonstrated deficiency of activity of the plasma clotting factor, Factor VIII, to control or prevent bleeding episodes, or in order to perform emergency and elective surgery on individuals with hemophilia. Koāte-DVI is not approved for the treatment of von Willebrand's disease.[7]

Kogenate FS (antihemophilic factor (recombinant)) is FDA-labeled for the following: on-demand treatment and control of bleeding episodes in adults and children with hemophilia A; peri-operative management in adults and children with hemophilia A; routine prophylaxis to prevent or reduce the frequency of bleeding episodes in children with hemophilia A and to reduce the risk of joint damage in children without preexisting joint damage; and routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults with hemophilia A. Kogenate FS is not indicated for the treatment of von Willebrand disease.[11]

Kovaltry (antihemophilic factor (recombinant)) is FDA-labeled in adults and children with hemophilia A (congenital Factor VIII deficiency) for the following: on-demand treatment and control of bleeding episodes; perioperative management of bleeding; and routine prophylaxis to reduce the frequency of bleeding episodes. Kovaltry is not indicated for the treatment of von Willebrand disease.[47]

Monoclate-P (antihemophilic factor (human)) is FDA-labeled for treatment of hemophilia A. Monoclate-P is not effective in controlling the bleeding of patients with von Willebrand's disease.[8]

Mononine (coagulation factor IX (human)) is FDA-labeled for the prevention and control of bleeding in Factor IX deficiency, also known as hemophilia B or Christmas disease. It is not indicated in the treatment or prophylaxis of hemophilia A patients with inhibitors to Factor VIII. Mononine is not indicated for replacement therapy of clotting Factors II, VII and X. It is also not indicated in the treatment or reversal of coumarin-induced anticoagulation or in a hemorrhagic state caused by hepatitis-induced lack of production of liver dependent coagulation factors.[17]

Novoeight (antihemophilic factor (recombinant)) is FDA-labeled for the control and prevention of bleeding episodes in adults and children with hemophilia A. It is also indicated for peri-operative management and routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and children with hemophilia A. Novoeight is not indicated for the treatment of von Willebrand disease.[38]

NovoSeven RT (coagulation factor VIIa (recombinant)) is FDA labeled for the following: treatment of bleeding episodes in adults and children with hemophilia A or B with inhibitors and in adults with acquired hemophilia; perioperative management in adults and children with hemophilia A or B with inhibitors and in adults with acquired hemophilia; treatment of bleeding episodes and perioperative management in congenital Factor VII (FVII) deficiency; and treatment of Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets.[5]

Nuwiq (antihemophilic factor (recombinant)) is FDA-labeled in adults and children with hemophilia A for the following: on-demand treatment and control of bleeding episodes; perioperative management of bleeding; and routine prophylaxis to reduce the frequency of bleeding episodes. Nuwiq is not indicated for the treatment of von Willebrand disease.[48]

Obizur (antihemophilic factor (recombinant), porcine sequence) is FDA-labeled for the treatment of bleeding episodes in adults with acquired hemophilia A. Safety and efficacy of Obizur has not been established in patients with a baseline anti-porcine factor VIII inhibitor titer of greater than 20 BU. Obizur is not indicated for the treatment of congenital hemophilia A or von Willebrand disease.[44]

Profilnine SD (factor IX complex) is FDA-labeled for the prevention and control of bleeding in patients with Factor IX deficiency due to hemophilia B. It is not indicated for use in the treatment of Factor VII deficiency.[18]

Recombinate (antihemophilic factor (recombinant)) is FDA-labeled for use in hemophilia A (classical hemophilia) for the prevention and control of hemorrhagic episodes. It is also indicated in the perioperative management of patients with hemophilia A (classical hemophilia). Recombinate is not indicated in von Willebrand's disease.[12]

RiaSTAP (fibrinogen concentrate (human) is FDA-labeled for the treatment of acute bleeding episodes in patients with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia.[35]

Rixubis (coagulation factor IX (recombinant)) is FDA-labeled for the following: control and prevention of bleeding episodes in adults with hemophilia B; peri-operative management in adults with hemophilia B; and routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults with hemophilia B. Rixubis is not indicated for induction of immune tolerance in patients with hemophilia B.[36]

Tretten (coagulation factor XIII A-Subunit (recombinant)) is FDA-labeled for routine prophylaxis of bleeding in patients with congenital factor XIII A-subunit deficiency. It is not indicated for use in patients with congenital factor XIII B-subunit deficiency.[39]

Vonvendi (von Willebrand factor (recombinant)) is FDA-labeled for on-demand treatment and control of bleeding episodes in adults diagnosed with von Willebrand disease.[53]

Wilate (von Willebrand factor/coagulation factor VIII complex human)) is FDA-labeled in children and adults with von Willebrand disease for the following on-demand treatment and control of bleeding episodes And perioperative management of bleeding. WILATE is not indicated for treatment of Hemophilia A.

Xyntha, Xyntha Solofuse (antihemophilic factor [recombinant], plasma/albumin-free) is FDA-labeled for control and prevention of bleeding episodes in patients with hemophilia A and for perioperative management in patients with hemophilia A. It is not indicated in patients with von Willebrand disease.[13,37]

BACKGROUND

Factor VIIa (FVIIa) is a vitamin K-dependent glycoprotein made up of 406 amino acid residues, and is structurally similar to human plasma-derived factor VIIa. FVIIa promotes hemostasis by forming complexes with tissue factor and activating coagulation factors in the intrinsic pathway: factor X to factor Xa, and factor IX to factor IXa. Activated factor Xa, complexed with other factors, converts prothrombin to thrombin and fibrinogen to fibrin to form a hemostatic plug.[5,29]

Factor XIII (FXIII) is a naturally occurring glycoprotein in plasma that promotes cross-linking of fibrin during the coagulation process, and protects the newly formed clot from fibrinolysis. FXIII is a proenzyme which is activated in the presence of calcium ion, to form activated factor XIIIa. The activated form is homodimeric, with only the A-subunit having intracellular activity. The B-subunit has no enzymatic activity and functions to stabilize the structure against proteolysis.[1,29]

Coagulation factor XIII A-subunit is a recombinant human factor XIII-A(2) homodimer composed of 2 factor XIII A-subunits. Recombinant coagulation factor XIII A-subunit binds to free human factor XIII B-subunit and is activated by thrombin in the presence of calcium. Once activated, it increases the mechanical strength of fibrin clots, retards fibrinolysis, and enhances platelet adhesion to the site of injury in a dose-dependent manner.[29,39]

Antihemophilic Factor VIII (FVIII) Human is a dried concentrate of Factor VIII derived from pooled human plasma. FVIII is the coagulant portion of the Factor VIII complex in plasma. FVIII acts as a co-factor for Factor IX to activate Factor X, ultimately causing the formation of thrombin and fibrin, promoting platelet aggregation and adhesion to damaged vascular endothelium.[7-8,29]

Antihemophilic Factor VIII / von Willebrand Factor Complex (human) is a lyophilized concentrate of factor VIII and von Willebrand Factor, which facilitates the activation of factor X ultimately causing the formation of thrombin and fibrin promoting platelet aggregation and adhesion to damaged vascular endothelium.[2-4,29]

Antihemophilic Factor (recombinant), FC Fusion Protein is a fusion protein that temporarily replaces the missing

Coagulation Factor VIII needed for effective hemostasis. It contains the Fc 12 region of human immunoglobulin G1 (IgG1), which binds to the neonatal Fc receptor (FcRn). FcRn is part of a naturally occurring pathway that delays lysosomal degradation of immunoglobulins by cycling them back into circulation and prolonging their plasma half-life.[42]

Antihemophilic Factor (recombinant), Porcine Sequence temporarily replaces the inhibited endogenous factor VIII that is needed for effective hemostasis in patients with acquired hemophilia A.[44]

Recombinant antihemophilic Factor VIII is not derived from human blood. It is a lyophilized preparation of factor VIII, which facilitates the activation of factor X ultimately causing the formation of thrombin and fibrin promoting platelet aggregation and adhesion to damaged vascular endothelium.[9-13,29,37-38,47-49]

All forms of factor IX (FIX) achieve hemostasis through the same mechanism. A complex of factor VII and tissue factor (via the extrinsic coagulation pathway) and factor XIa (via the intrinsic pathway) activate factor IX which, in combination with factor VIII:C, activates factor X to Xa. Through this pathway, prothrombin is converted to thrombin which, in turn, converts fibrinogen to fibrin clot.[15-19,29,36,46]

The exact mechanism of action of anti-inhibitor complex (AICC) is unknown. It may be related to one or more of the active clotting factors and their ability to bypass the factor VIII inhibitor. In vitro experiments suggest the possibility of a factor Xa–like substance; or a complex of FVIIIC:Ag, factor IXa, and phospholipid as the active principle, which is only minimally inhibited by an inhibitor.[14,29]

Factor IX Fc fusion protein recombinant transiently replaces missing coagulation factor IX required to achieve hemostasis during bleeding episodes in patients with factor IX deficiency. The Fc region of the drug binds to the neonatal Fc receptor (FcRn). FcRn assists in the delay of lysosomal degradation of immunoglobulins by cycling them back into circulation and increasing their plasma half-life. Hemophilia B patients have a prolonged activated partial thromboplastin time (aPTT), which is an established test for the biological activity of factor IX; factor IX Fc fusion protein recombinant therapy shortens the aPTT over the effective dosing period.[29,40]

Fibrinogen (coagulation factor I) is a soluble plasma glycoprotein and a physiological substrate of 3 enzymes: thrombin, factor XIIIa, and plasmin. Thrombin converts fibrinogen into fibrin. Fibrin is stabilized in the presence of calcium ions and by activated Factor XIII. Factor XIIIa induces cross-linking of fibrin polymers which result in the fibrin clot being more elastic and more resistant to fibrinolysis. The cross-linked fibrin is the end result of the coagulation cascade. Cross-linked fibrin is the end result of the coagulation cascade, and provides tensile strength to a primary hemostatic platelet plug and structure to the vessel wall.[29,35]

Antihemophilic factor VIII (recombinant) pegylated is a temporarily replaces coagulation factor VIII, thereby providing hemostasis in patients with congenital hemophilia A. Pegylation of the parent molecule (antihemophilic factor VIII recombinant) extends the half-life via reduced binding to the factor VIII clearance receptor (LRP1).[29,51]

Coagulation Factor IX (recombinant), albumin fusion protein, temporarily replaces absent coagulation Factor IX to provide adequate hemostasis. The recombinant albumin is fused with recombinant Factor IX to extend the half-life of Factor IX.[29,50]

Coagulation Factor X (human) is converted from its inactive form to the active form (Factor Xa) and with Factor Va on the phospholipid surface forms a prothrombinase complex which activates prothrombin to thrombin in the presence of calcium ions. Thrombin acts upon soluble fibrinogen and Factor XIII to generate a cross-linked fibrin clot.[29,52]

Von Willebrand factor (recombinant) reduces factor VIII clearance by acting as a carrier protein and protecting factor VIII from rapid proteolysis. It promotes hemostasis by mediating platelet adhesion to damaged vascular subendothelial matrix (e.g., collagen) and platelet aggregation.[29,53]

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

HCPCS Code	Description
J7175	Injection, factor x (human), 1 IU

HCPCS Code	Description
J7178	Injection, human fibrinogen concentrate, 1 mg
J7179	Injection, von willebrand factor (recombinant), (Vonvendi), 1 IU vWF:RCo
J7180	Injection, factor XIII (antihemophilic factor, human), 1 IU
J7181	Injection, factor XIII A-subunit, (recombinant), per IU (Tretten)
J7182	Injection, factor VIII, (antihemophilic factor, recombinant), (Novoeight), per IU
J7183	Injection, von Willebrand factor complex (human), Wilate, 1 IU vWF:RCo
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (XYNTHA), per IU
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII i.u.
J7187	Injection, von Willebrand factor complex (Humate-P), per IU VWF:RCO
J7188	Injection, factor VIII (antihemophilic factor, recombinant), per IU
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg
J7190	Factor VIII (antihemophilic factor, human) per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified
J7193	Factor IX (antihemophilic factor, purified, nonrecombinant) per IU
J7194	Factor IX complex, per IU
J7195	Injection, factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified
J7198	Antiinhibitor, per IU
J7199	Hemophilia clotting factor, not otherwise classified
J7200	Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU
J7201	Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1 IU
J7202	Injection, factor IX, albumin fusion protein (recombinant), (Idelvion), 1 IU
J7205	Injection, factor VIII, Fc fusion protein (recombinant), per IU
J7207	Injection, factor VIII, (antihemophilic factor, recombinant), pegylated, 1 IU
J7209	Injection, factor VIII (antihemophilic factor, recombinant), (Nuwiq), 1 IU
J7210	Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.

ICD-10 Diagnosis	Description
D66	Hereditary factor VIII deficiency
D67	Hereditary factor IX deficiency
D68.0	Von Willebrand's disease
D68.2	Hereditary deficiency of other clotting factors
D68.311	Acquired Hemophilia
D69.1	Qualitative platelet defects

CLINICAL EVIDENCE

Proven

Congenital Factor XIII Deficiency

In a multinational, open-label, single-arm, phase 3 trial, researchers evaluated the efficacy and safety of prophylactic treatment with recombinant FXIII (rFXIII) [Tretten] in congenital FXIII-A subunit deficiency. Forty-one patients ≥6 years of age (mean, 26.4; range, 7-60) with confirmed congenital FXIII-A subunit deficiency were enrolled into the trial which consisted of a 4-week run-in period, followed by a 52-week treatment period (visits 2-15) of monthly (28 ± 2 days) IV doses of 35 IU/kg of rFXIII. During the rFXIII treatment period, 5 bleeding episodes (all trauma induced) in 4 patients were treated with FXIII-containing products. Crude mean bleeding rate was significantly lower than the historic bleeding rate (0.138 vs 2.91 bleeds/patient/year, respectively) for on-demand treatment. Transient, non-neutralizing, low-titer anti-rFXIII antibodies (Abs) developed in 4 patients; however, this did not result in allergic reactions, changes in any bleeds requiring treatment, or changes in FXIII pharmacokinetics during the trial or follow-up. These non-neutralizing Abs declined below detection limits in all 4 patients despite further exposure to rFXIII or

other FXIII-containing products. Researchers conclude that prophylactic treatment with rFXIII is safe and effective in preventing bleeding episodes in patients with congenital FXIII-A subunit deficiency.

Factor XIII concentrate (human) [Corifact] labeling included expanded information in regards to use of rFXIII for peri-operative treatment of bleeds.1 Out of the 41 patients included in the trial, 5 patients underwent surgical procedures (4 were elective and 1 was an emergency). Of the 4 elective surgeries, 3 patients received rFXIII prior to surgery (0 to 7 days prior to surgery) with no post-operative bleeding. One patient who received rFXIII 7 days prior to surgery experienced bleeding post-extraction of all four wisdom teeth. The bleeding was stopped four hours after the oral surgery with an additional dose of rFXIII (50% of the patient's routine dose). One patient who required emergency surgery was pre-treated with plasma.

Von Willebrand Disease (VWD)
Gill et al. conducted a prospective, open-label, multinational study which evaluated the safety, efficacy and optimal dosing of a VWF/FVIII concentrate [Humate-P] in patients with von Willebrand disease (VWD) undergoing elective surgery and expected to require at least two consecutive days of perioperative treatment with a VWF/FVIII concentrate.28 Dosing of factor was based on VWF ristocetin cofactor (VWF:RCo) and FVIII pharmacokinetic assessments performed before surgery. The studied population was composed of 33 adults and 9 children who completed the PK infusion phase. Effective haemostasis was achieved in 91.4% (32/35) of subjects immediately after surgery. Reported median terminal VWF:RCo half-life was 11.7 h, and median incremental in vivo recovery was 2.4 IU dL(-1) per IU kg(-1) infused. Three patients developed major hemorrhage after the immediate postoperative period. Median VWF/FVIII concentrate loading doses ranged from 42.6 IU VWF:RCo kg(-1) (oral surgery) to 61.2 IU VWF:RCo kg(-1) (major surgery), with a median of 10 (range, 2-55) doses administered per patient. Eleven patients experienced a total of 25 postoperative bleeding events, most of which were categorized as mild (16) or moderate (8). Researchers conclude that the results of this trial indicate that this VWF/FVIII concentrate is safe and effective in the prevention of excessive bleeding during and after surgery in individuals with VWD.

Researchers conducted a prospective, open-label, multicenter, non-randomized study which evaluated the safety and efficacy of a factor VIII (FVIII)/VWF concentrate [Humate-P] when used in treatment regimens based on VWF: ristocetin cofactor (VWF:RCo) activity in subjects with VWD in which desmopressin was known or suspected to be inadequate in situations requiring urgent and necessary surgery.26 Thirty-nine eligible patients with 42 evaluable surgical treatment events were included. Researchers reported the median loading dose based upon VWF:RCo activity was 82.3 international units/kilogram (IU kg(-1); range 32.5-216.8 IU kg(-1)), and the median maintenance dose per infusion was 52.8 IU kg(-1) (range 24.2-196.5 IU kg(-1)) for a median of 3 days (range 1-50 days). The median number of infusions per event was 6 (range 1-67 infusions). A total of 55 adverse events (AEs) were reported in 24 (57.1%) of 42 surgical treatment events and 3 of those AE events (which included peripheral edema, extremity pain and pseudo-thrombocytopenia) were reported as potentially treatment-related. No serious drug-related AEs or thrombotic events were reported. Researchers concluded that this study supports the safety and efficacy of treatment with FVIII/VWF concentrate for the prevention of surgical haemorrhage in patients with VWD when administered in doses calculated in VWF:RCo units.

Forty-five patients with von Willebrand disease (VWD) who received on demand von Willebrand factor/coagulation factor VIII complex (human) [Wilate] were evaluated in prospective clinical trials.4 bleeding was successfully controlled in 84.1% (95% confidence interval (CI), 81.8% to 86.2%) of episodes (898 of 1068 episodes); additionally, bleeding was successfully controlled in 93% of episodes in the 25 patients with VWD type 3. Non-successful treatment of a bleeding episode was documented if any of the following criteria was met: 1) the episodes was also treated with another VWF-containing product (excluding whole blood); 2) the patient required a blood transfusion during the bleeding episode; 3) the daily dosage of FVIII/VWF complex was 50% or greater above the initial required dose during follow-up treatment (for bleeding episodes requiring more than one day of treatment); 4) except for cases of gastrointestinal bleeding, FVIII/VWF complex was required for more than 4 days for the treatment of severe bleeding, more than 3 days for the treatment of moderate bleeding, or more than 2 days for the treatment of minor bleeding; and 5) the final bleeding episode had a moderate or none efficacy rating. Overall, most bleeding episodes were treated with FVIII/VWF complex for 1 to 3 days; however, patients with gastrointestinal bleeding the duration could be up to 7 days.

Congenital Factor VII Deficiency, Acquired Factor VIII Deficiency, Hemophilia A with Inhibitors, and Hemophilia B with Inhibitors
Mariani et al conducted a multi-center, prospective, observational, web-based study protocol to collect and describe treatment modalities and outcomes in congenital FVII deficiency (STER [Seven Treatment Evaluation Registry]).Forty-one surgical operations (24 'major' and 17 'minor') were performed in 34 patients diagnosed with FVII deficiency and administered recombinant activated Factor VII (rFVIIa) [NovoSeven]. Bleeding occurred during three major interventions of orthopedic surgery; however, rFVIIa was administered at very low dose in each case. An antibody to FVII was observed in one patient who underwent multiple dental extractions. No thromboses were reported during the

30-d follow up period. Replacement therapy with rFVIIa for surgery in FVII deficient patients is effective and safe when minimally effective doses were used, which, during the period of maximum bleeding risk (the day of operation), was calculated (Receiver Operated Characteristic analysis) to be of at least 13 µg/kg/body weight per single dose and no less than three administrations.

Hemophilia A

Mahlangu et al. conducted a multi-center, prospective, open-label, phase 3 study which evaluated the safety, efficacy, and pharmacokinetics of a recombinant FVIII Fc fusion protein (rFVIIIFc) [Eloctate] for prophylaxis, treatment of acute bleeding, and perioperative hemostatic control in 165 previously treated males aged ≥12 years with severe hemophilia A.43 The study participants were divided up into 3 treatment arms: arm 1, individualized prophylaxis (25-65 IU/kg every 3-5 days, n=118); arm 2, weekly prophylaxis (65 IU/kg, n=24); and arm 3, episodic treatment (10-50 IU/kg, n=23). A subgroup compared recombinant FVIII (rFVIII) and rFVIIIFc pharmacokinetics. Annualized bleeding rate (ABR) was the primary measured outcome; and inhibitor development and adverse events were secondary efficacy endpoints evaluated. The terminal half-life of rFVIIIFc (19.0 hours) was extended 1.5-fold vs rFVIII (12.4 hours; P < .001). Across all arms, 757 bleeding episodes were treated with rFVIIIFc during the efficacy period. Overall, 87.3% of bleeding episodes were resolved with 1 injection, and 97.8% were controlled with ≤2 injections. In arm 1, the median weekly dose was 77.9 IU/kg; approximately 30% of subjects achieved a 5-day dosing interval (last 3 months on study). Adverse events were representative of events occurring in the general hemophilia population and no participants developed inhibitors. The study was not designed to compare individualized and weekly prophylactic regimens (arms1 and 2, respectively). Thus, although both the individualized (median twice-weekly dosing) and weekly dosing regimens resulted in a significant reduction in ABR compared with episodic treatment, the superiority of one approach for prophylactic dosing over the other cannot be determined. Authors concluded that rFVIIIFc was well-tolerated and efficacious in the prevention and treatment of bleeding events, including within the setting of major surgery, in adolescents and adults with severe hemophilia A. Additionally, efficacy results supported the potential for rFVIIIFc dosing 1 to 2 times per week (current treatment guidelines recommend dosing 3-4 times weekly).

Three multi-center, open-label, non-controlled trials (n=213) were conducted to evaluate the safety and efficacy of antihemophilic factor (recombinant) [Novoeight] in the control and prevention of breakthrough bleeds, routine prophylaxis and perioperative management in previously treated patients with hemophilia A.38 Of the 213 patients included, 150 patients were 12 years or older and 63 patients were younger than 12 years of age with severe hemophilia A (factor VIII activity less than 1%) and no history of factor VIII inhibitors. The median annual bleeding rate for adults and children 16 years or older was 3.1 bleeds/year. All patients received routine prophylaxis with antihemophilic factor (recombinant); those 12 years or older received 20 to 50 international units/kg 3 times weekly or 20 to 40 international units/kg every other day. Those younger than 12 years of age received either 25 to 60 international units/kg 3 times weekly or 25 to 50 international units/kg every other day. More than 80% received the 3-times-per-week regimen. Bleeding episodes were treated according to the investigator's discretion, with a target factor VIII activity level greater than 0.5 international units/mL. Bleeding episodes and perioperative management with antihemophilic factor (recombinant) were considered successfully treated if the patient (home dosing) or investigator (supervised treatment) rated the response to treatment as excellent or good; moderate or none ratings were considered unsuccessful treatment. Bleeding episodes (89% mild/moderate; 62% spontaneous; 72% localized to joints) occurred 991 times in 158 patients, with 84% successfully treated and 1.7% having no response. Only 1 or 2 injections were necessary to treat 91% of the bleeding episodes. Of the 11 patients (age range, 14 to 55 years) undergoing surgical procedures, 10 of the procedures were major and 1 was minor (tooth extraction). Excellent or good efficacy ratings were given in all cases.

Valentino et al. conducted an open-label, multicenter trial which compared the effectiveness of two prophylactic treatment regimens with antihemophilic factor (recombinant), plasma/albumin free method (rAHF-PFM) [Advate], as well as between on-demand and prophylaxis treatments, in preventing bleeding in hemophilia A.31 Sixty-six previously on-demand-treated patients aged 7-59 years with FVIII levels ≤ 2% received 6 months of on-demand treatment and were then randomized to 12 months of either standard (20-40 IU kg(-1) every other day) or pharmacokinetic (PK)- tailored (20-80 IU kg(-1) every third day) prophylaxis, both regimens intended to maintain FVIII trough levels at or above 1%. The primary endpoint was differences in annualized bleeding rates (ABRs) between the two prophylaxis regimens. Secondary endpoint evaluated included differences in ABRs between patients first treated on-demand and then on prophylaxis. A total of 1640 bleeding episodes occurred in 66 of 66 subjects during the on-demand period, 104 episodes occurred in 19 out of 32 subjects during standard prophylaxis and 141 episodes in 25 out of 34 subjects during the PK-tailored prophylaxis. Twenty-two (33.3%) patients on prophylaxis treatment experienced no bleeding episodes, whereas none treated on-demand were free from an episode of bleeding. ABRs for the two prophylaxis regimens were comparable, however, the differences between on-demand and either prophylaxis were statistically significant (p <0.0001): median (interquartile range [IQR]) ABRs were 43.9 (21.9), 1.0 (3.5), 2.0 (6.9) and 1.1 (4.9) during on-demand treatment, standard, PK-tailored and any prophylaxis, respectively. No differences in FVIII consumption or adverse event rates between prophylaxis regimens were noted. No patient developed FVIII inhibitors. Researchers concluded that the outcomes of this trial demonstrated comparable safety and effectiveness for two prophylaxis regimens and that prophylaxis significantly reduces bleeding compared with on-

demand treatment. Additionally, PK-tailored prophylaxis offers an alternative to standard prophylaxis for the prevention of bleeding in hemophilia A.

Hemophilia B

Powell et al conducted a phase 3, nonrandomized, open-label study which evaluated the safety, efficacy, and pharmacokinetics of coagulation factor IX Fc fusion protein recombinant (rFIXFc) [Alprolix] for prophylaxis, treatment of bleeding, and perioperative hemostasis in patients with severe factor IX deficiency (hemophilia B). Patients (age range, 12 to 71 years; n=123) were evaluated in trials to determine hemostatic efficacy of rFIXFc for prophylaxis, treatment of bleeding, and perioperative management. In the fixed-interval prophylaxis arm, patients received an initial dose of 50 IU/kg, which was then adjusted to maintain a factor IX trough level of at least 1% to 3% above baseline (median dose, 45.2 IU/kg). Patients in the individualized-interval arm received rFIXFc 100 IU/kg every 10 days, with the interval adjusted to maintain a factor IX trough of at least 1% to 3% above baseline (median dosing interval, 12.5 days). Patients in the episodic treatment arm received rFIXFc 20 to 100 IU/kg as needed for bleeding. The primary efficacy end point was the annualized bleeding rate, and safety end points included the development of inhibitors and adverse events. A total of 636 bleeding episodes were assessed in 114 patients, who received a median total dose of 46.99 IU per bleeding episode. During a median follow-up of 51.4 weeks, the annualized bleeding rates were decreased by 83% in the fixed-weekly interval group and 87% in the individualized group compared with the episodic treatment group. Most bleeding episodes (90.4%) were treated with 1 dose; 97.3% required 1 or 2 injections.

The median annualized overall bleeding rates were 2.95% in the fixed-interval prophylaxis group, 1.38% in the individualized-interval prophylaxis group, and 17.69% in the episodic treatment group. Researchers concluded that rFIXFc is safe and effective for the treatment and prevention of bleeding events, including those incurred during major surgeries, in previously treated adolescents and adults with hemophilia B. Fc fusion did not impair factor IX activity or result in increased immunogenicity. The prolonged half-life of rFIXFc allowed for effective prophylaxis, with injections every 1 to 2 weeks. Additionally, the potential for higher trough levels of rFIXFc or longer intervals between doses may lead to greater use of prophylaxis among patients with hemophilia B.

In a prospective, open-label, uncontrolled trial, efficacy of routine prophylaxis with coagulation factor IX [Rixubis] in adult patients with hemophilia B (n=56) was evaluated. Primary endpoint was reduction in frequency of bleeding episodes. Patients received coagulation factor IX recombinant 40 to 60 international units/kg IV twice weekly for 3 months or longer. At screening, all patients had severe (factor IX level < 1%) or moderately severe (factor IX level ≤2%) hemophilia B, with 12 or more documented bleeding episodes requiring treatment within 12 months prior to enrollment. After a mean duration of 6 months of treatment with coagulation factor IX recombinant at a mean twice-weekly dose of 49.4 international units/kg/infusion, the mean total annualized bleeding rate was 4.3 for all bleeds, 1.7 for spontaneous bleeds, and 2.9 for joint bleeds compared with 33.9 +/- 17.37 mean total annualized bleeding rate in the on-demand arm (n=14) during the mean 3.5-month period.

Two studies were conducted to provide coagulation factor IX (human) [Mononine] for treatment of hemophilia B subjects who required extensive Factor IX replacement for surgery, trauma, or spontaneous bleeding (73 unique subjects and eight subjects enrolled twice for a total of 81 subjects), as well as to evaluate the safety and efficacy of coagulation factor IX (human) treatment.17 The overall mean recovery during treatment was determined to be 1.23 ± 0.42 IU/dL rise/IU/kg (K) (range = 0.59 to 2.92 K) among the 55 subjects included in recovery analyses in Study 1 and to be 1. 12 ± 0.52 K (range = 0.61 to 2.08 K) among 10 subjects included in these analyses in Study 2. Five (5/81,6%) subjects reported adverse events attributed to coagulation factor IX (human) across both studies. In these studies, 100 doses of coagulation factor IX (human) were administered at a range of 71 to 161 IU/kg to a total of 36 subjects. Sixty-seven of these infusions were the subject of recovery analyses. Mean recovery tended to decrease as the dose of coagulation factor IX (human) increased:1.09 ± 0.52 K at doses > 75-95 IU/kg (n=38), 0.98 ± 0.45 K at doses > 95-115 IU/kg (n=21), 0.70 ± 0.38 K at doses > 115-135 IU/kg (n=2), 0.67 K at doses > 135-155 IU/kg (n=1), and 0. 73 ± 0. 34 K at doses > 155 IU/kg (n=5). Among the 36 subjects who received these high doses, only one (2. 8%) reported an adverse experience with a possible relationship to coagulation factor IX (human). No thrombogenic complications were observed or reported.

Technology Assessments

As an update to the 2011 intervention review, the Cochrane Collaboration published a 2015 review which evaluated the effectiveness of recombinant Factor VIIa (containing no human proteins) as compared to concentrates derived from plasma for treating acute bleeding episodes in people with haemophilia with inhibitors. Researchers again concluded that although there is a need for further randomized controlled trials, both rFVIIa (NovoSeven®) and aPCC (FEIBA®) are similar in efficacy and safety. Additionally, the review suggested that researchers in the field define commonly agreed objective measures in order to enable the pooling of their results, thus increasing the power of comparisons.

The Cochrane Collaboration also published an intervention review which evaluated the effectiveness of clotting factor concentrate prophylaxis in the management of people with hemophilia A or B in 2011.24 Authors conclude that there is strong evidence from randomized controlled trials and observational trials that prophylaxis started early preserves joint function in children with hemophilia as compared to on-demand treatment. This effect is due to a consistent reduction in total bleeds and hemarthrosis and leads to a significant improvement in quality of life; however, treatment prophylaxis is linked to an increased factor usage and overall cost of therapy. There was insufficient evidence to show that treatment prophylaxis decreased bleeding and related complications in patients with existing joint damage. Randomized controlled trials are warranted to establish the best preventative regimen for these patients.

Professional Societies

In February 2016, the National Hemophilia Foundation (NHF) released updated hemophilia treatment guidelines entitled Medical and Scientific Advisory Council (MASAC) Recommendations Concerning Products Licensed for the Treatment of Hemophilia and Other Bleeding Disorders #240.22,55 A summary of the NHF recommendations for physicians treating patients with hemophilia A and B, von Willebrand Disease, and other congenital bleeding disorders are as follows:

Treatment of Patients with Hemophilia A		
Recombinant Factor VIII Concentrates	Advate Helixate FS Kogenate FS Kovaltry NovoEight Nuwiq Recombinate Xyntha	Treatment of choice in Hemophilia A
Prolonged Half-Life Recombinant Factor VIII Concentrate	Adynovate Eloctate	
Plasma-Derived Factor VIII Concentrates	Hemofil M Monoclate-P	Recommended
Plasma-Derived Factor VIII / von Willebrand Factor	Alphanate Humate-P Koate-DVI	Recommended
Cryoprecipitate	Cryoprecipitate	Not recommended except in life- and limb-threatening emergencies when no factor VIII concentrate is available.
Desmopressin	DDAVP Injection Stimate Nasal Spray for Bleeding	Recommended for use in mild hemophilia A. Children < 2 years of age and patients with mild hemophilia A in whom desmopressin does not provide adequate Factor VIII levels should be treated with either recombinant or plasma-derived FVIII concentrates. Use with caution in pregnant women during labor and delivery.
Treatment of Patients with Hemophilia B		
Recombinant Factor IX Concentrate	BeneFIX	Treatment of choice in Hemophilia B.
Prolonged Half Life Recombinate Factor IX Concentrate	Alprolix Idelvion	
Plasma Derived Factor IX Concentrates	AlphaNine SD Mononine	Recommended
Treatment of Patients with von Willebrand Disease (VWD)		
Desmopressin	DDAVP Injection Stimate Nasal Spray	Recommended for most persons with VWD Type 1. Some Type 2A patients may respond to DDAVP, however clinical testing should be done to determine whether DDAVP can be used. Do not use in children < 2 years of age. Use with caution in pregnant women during labor and delivery.
Recombinant von Willebrand Factor Concentrate	Vonvendi	Treatment of choice n von Willebrand disease. May be used to treat patients with type 2B and type 3 VWD; it can also be used in patients with types 1, 2A, 2M, and 2N VWD who are not responsive to DDAVP and in children <2 years of age regardless of VWD type.

Plasma-Derived Factor VIII /von Willebrand Factor	Alphanate Humate-P Wilate	Recommended in certain types of vWD that do not respond to DDAVP (i.e. Type 2B VWD and Type 3 VWD), and for use in Type 1 or 2A VWD patients who have become transiently unresponsive to DDAVP and in surgical situations, especially in young under the age of 2 years. In certain patients, Koate-DVI may also be effective.
Cryoprecipitate	Cryoprecipitate	Not recommended except in life- and limb-threatening emergencies when VWD-containing factor VIII concentrate is not immediately available.
Treatment of Patients with Inherited Hemophilia A or B and Inhibitors to Factor VIII or Factor IX		
Plasma-Derived Activated Prothrombin Complex Concentrate (aPCC)	FEIBA	Recommended, however, products are not interchangeable. Choice of product depends on multiple factors, including type of inhibitor (low- or high-responding), current titer of inhibitor, location of the bleed, and previous response to these products. For high-titer inhibitors, immune tolerance induction is the best option for inhibitor eradication. Do not exceed recommended doses to reduce the risk of thrombosis.
Recombinant Factor VIIa Concentrate	NovoSeven RT	
Treatment of Patients with Acquired Inhibitors to Factor VIII		
Recombinant Factor VIIa Concentrate	NovoSeven RT	Recommended
Recombinant Porcine Factor VIII Concentrate	Obizur	
Treatment of Patients with Factor VII Deficiency		
Recombinant Factor VIIa Concentrate	NovoSeven RT	Recommended
Treatment of Patients with Factor XIII Deficiency		
Plasma-Derived Factor XIII Concentrate	Corifact	Recommended
Treatment of Patients with Factor XIII-A Subunit Deficiency		
Plasma-Derived Factor XIII- A Subunit Concentrate	Tretten	Recommended. It is not effective in those patients that lack FXIII-B subunit.
Treatment of Patients with Factor II or Factor X Deficiencies		
Plasma-Derived Prothrombin Complex Concentrates (pd- PCCs)	Bebulin Profilnine	Recommended to treat patients with deficiencies of factors II and X. However, it should be noted that the content of these factors varies from lot to lot and product to product. Note the relative content of factors Bebulin (X>II>IX>VII) and Profilnine (II>IX=X>VII).
Treatment of Patients with Factor I Deficiency		
Treatment of Patients with Factor I Deficiency	RiaSTAP	Recommended for treatment of congenital hypofibrinogenemia and afibrinogenemia but not dysfibrinogenemia.
Cryoprecipitate	Cryoprecipitate	The only currently available product for dysfibrinogenemia. Not recommended in patients with afibrinogenemia except in life- and limb-threatening emergencies when fibrinogen concentrate is not immediately available.
Treatment of Patients with Factor X Deficiencies		
Plasma-Derived Factor X Concentrate	Coagadex	Recommended

The World Federation of Hemophilia developed 2013 guidelines which provides practical guidelines on the general management of hemophilia (level 1 corresponding to the strongest evidence and level 5 the weakest) as outlined below:[21]

- Prophylaxis prevents bleeding and joint destruction and should be the goal of therapy to preserve normal musculoskeletal function. (Level 2) In patients with repeated bleeding, particularly into target joints, short-term prophylaxis for 4–8 weeks can be used to interrupt the bleeding cycle. This may be combined with intensive physiotherapy or synoviorthesis. (Level 3)

- Prophylactic administration of clotting factor concentrates is advisable prior to engaging in activities with higher risk of injury. (Level 4) Preoperative assessment should include inhibitor screening and inhibitor assay, particularly if the recovery of the replaced factor is significantly less than expected. (Level 4)
- Patients with mild hemophilia A, as well as patients receiving intensive factor replacement for the first time, are at particular risk of inhibitor development and should be re-screened 4–12 weeks postoperatively. (Level 4)
- The WFH strongly recommends the use of viral-inactivated plasma-derived or recombinant concentrates in preference to cryoprecipitate or fresh frozen plasma (FFP) for the treatment of hemophilia and other inherited bleeding disorders.(Level 5)
- For treatment of FIX deficiency, a product containing only FIX is more appropriate than prothrombin complex concentrates, which also contain other clotting factors such as factors II, VII, and X, some of which may become activated during manufacture. Products containing activated clotting factors may predispose to thromboembolism. (Level 2) Whenever possible, the use of pure FIX concentrates is preferable for the treatment of hemophilia B as opposed to PCC (Level 2)
- Cryoprecipitate is preferable to FFP for the treatment of hemophilia A and VWD. (Level 4) Due to concerns about the safety and quality of FFP, its use is not recommended, if avoidable. (Level 4)
- DDAVP may be the treatment of choice for patients with mild or moderate hemophilia A when FVIII can be raised to an appropriate therapeutic level because it avoids the expense and potential hazards of using a clotting factor concentrate. (Level 3) Although DDAVP is not licensed for use in pregnancy, there is evidence that it can be safely used during delivery and in the postpartum period in an otherwise normal pregnancy. Its use should be avoided in pre-eclampsia and eclampsia because of the already high levels of VWF. (Level 3)
- Regular treatment with tranexamic acid alone is of no value in the prevention of hemarthroses in hemophilia. (Level 4) It is valuable, however, in controlling bleeding from skin and mucosal surfaces (e.g., oral bleeding, epistaxis, menorrhagia). (Level 2) Tranexamic acid is particularly valuable in the setting of dental surgery and may be used to control oral bleeding associated with eruption or shedding of teeth. (Level 4)
- Management of bleeding in patients with inhibitors must be in consultation with a center experienced in their management. (Level 5) Choice of treatment product should be based on titer of inhibitor, records of clinical response to product, and site and nature of bleed. (Level 4) Patients with a low-responding inhibitor may be treated with specific factor replacement at a much higher dose, if possible, to neutralize the inhibitor with excess factor activity and stop bleeding. (Level 4) Patients with a history of a high responding inhibitor but with low titers may be treated similarly in an emergency until an anamnestic response occurs, usually in 3–5 days, precluding further treatment with concentrates that only contain the missing factor. (Level 4)

The British Committee for Standards in Haematology released updated inhibitor treatment guidelines in 2013 entitled, "Diagnosis and treatment of factor VIII and IX inhibitors in congenital haemophilia."57 A summary of the recommendations for the management of inhibitors is outlined below. Designations for the quality of evidence (A – highest, C – lowest) and strength of recommendation (1 – strong, 2 – weak) are given at the end of each recommendation.

- Bleeds may be managed with large doses of FVIII/IX in low responders and FVIII inhibitor bypassing activity (FEIBA) or activated recombinant FVII (rFVIIa) in high responders. FVIII can be considered for major bleeds in high responding patients with low-titre antibodies. For low-responding patients with low-titre inhibitors it is better to increase the frequency of FVIII/FIX infusions rather than increase the dose (2C).
- Bleeds may be managed with large doses of FVIII/IX in low responders and FVIII inhibitor bypassing activity (FEIBA) or activated recombinant FVII (rFVIIa) in high responders. FVIII can be considered for major bleeds in high responding patients with low-titre antibodies. For low-responding patients with low-titre inhibitors it is better to increase the frequency of FVIII/FIX infusions rather than increase the dose (2C).
- Patients who have experienced allergic reactions to FIX should be treated with rFVIIa (1C).
- Single dose FEIBA (50-100 µg/kg), single high dose (270 µg/kg) rFVIIa or 1-3 standard doses (90 µg/kg) of rFVIIa are all treatment options for early haemarthroses (1B).
- Treatment of non-joint bleeds should be with FVIII/FIX or standard doses of FEIBA or rFVIIa until further data are available (2C).
- Tranexamic acid should be considered in all patients who are not receiving high doses of FEIBA (>200 iu/kg/d) but is especially important for mucosal bleeds (2C).
- Some bleeds, unresponsive to bypassing agents, may be successfully treated by removal of the inhibitor using plasmaphaeresis and immunoadsorption together with high dose FVIII/IX concentrate (2B).
- Combined treatment with rFVIIa and FEIBA should only be considered for life- or limb-threatening bleeds unresponsive to either agent used alone (2C).

The guidelines also address recommendations for the prophylaxis for inhibitor patients:

- Prophylaxis with a bypassing agent should be considered in young children after the first haemarthosis to reduce the risk of arthropathy (2C).
- If prophylaxis is required in patients awaiting ITI, rFVIIa should be used (2C).

- Prophylaxis with bypassing agents in patients on ITI should undergo a trial reduction when FVIII recovery is measureable and stopped when the Bethesda titre is negative, assuming significant break-through bleeds do not result (2C).
- Prophylaxis may be considered in older patients with recurrent bleeds or progressive arthropathy (2C).
- The choice of product for prophylaxis should be considered on an individual basis, taking into account previous response to treatment, logistics of administration and cost (2C).
- If the initial regimen is unsuccessful, increasing the frequency of infusion is more likely to be effective than increasing the dose (2C).

The American Society of Hematology released an updated reference guide entitled 2012 Clinical Practice Guideline on the Evaluation and Management of von Willebrand Disease (VWD)32 which provides a summary of the 2007 von Willebrand Disease (VWD): Evidence-based Diagnosis and Management Guidelines, the National Heart, Lung, and Blood Institute (NHLBI) Expert Panel report (USA).33,56 A summary of the recommendations for the management of VWD is as follows:

- Therapeutic trial of DDAVP is recommended prior to use. VWF:RCo and FVIII activities should be measured at baseline and within 1 hour. Additional testing 2-4 hours after DDAVP should be considered to evaluate for shortened survival.
- Most type 1 VWD patients will respond to DDAVP, although patients with VWF:RCo <10 IU/dL and FVIII activity <20 IU/dL are less likely to have a clinically significant response. In type 2 VWD, DDAVP will increase the VWF concentration, but the VWF dysfunction will still be present. In type 2B VWD, DDAVP may result in transient thrombocytopenia. Therefore, DDAVP should be used with caution in type 2 VWD.
- To avoid tachyphylaxis, DDAVP therapy is typically discontinued after 2 or 3 daily doses.
- Minor bleeding should be treated with intravenous or nasal DDAVP, if results of a DDAVP trial support its use.
- In presence of inadequate DDAVP response, VWF concentrate should be used, with dosing primarily based on VWF:RCo units and secondarily on FVIII units.
- For patients with mild to moderate VWD undergoing oral surgery, antifibrinolytics combined with DDAVP are generally effective.
- For severe bleeding (e.g. intracranial, retroperitoneal) or major surgery prophylaxis, initial target VWF:RCo and Factor VIII activity levels should be >100 IU/dL, and levels >50 IU/dL should be maintained for at least 7-10 days. In all patients receiving VWF concentrate, clinicians should perform proper thrombotic-risk assessment and institute appropriate strategies to prevent thrombosis.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare does cover blood clotting factors for hemophilia patients when criteria have been met. Refer to the National Coverage Determination (NCD) for Anti-Inhibitor Coagulant Complex (AICC) (110.3). Local Coverage Determinations (LCDs) exist; see the LCDs for Hemophilia Clotting Factors and Hemophilia Factor Products.

For additional coverage information see the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, § 50.5.5 - Hemophilia Clotting Factors at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf .

(Accessed January 2018)

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
04/26/2018 01/25/2018 09/28/2017 01/26/2017 02/25/2016 10/29/2015 04/23/2015 03/26/2015 01/29/2015 06/26/2014 02/27/2014 12/19/2013	Corporate Medical Affairs Committee

Clinical Policy: Factor VIII (Human, Recombinant)

Reference Number: CP.PHAR.215
Effective Date: 05.01.16
Last Review Date: 02.18 Coding Implications
Line of Business: Medicaid Revision Log
See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are Factor VIII products (human, recombinant) requiring prior authorization: (Human – Hemofil M®, Koate®, Koate-DVI®, Monoclate-P®; Recombinant - Advate®, Adynovate®, Afstyla®, Eloctate®, Helixate FS®, Kogenate FS®, Kogenate FS with Vial Adapter®, Kogenate FS with Bio-Set®, Kovaltry®, NovoEight®, Nuwiq®, Obizur®, Recombinate®, ReFacto®, Xyntha®, Xyntha®, Solofuse™).

FDA Approved Indication(s)

Factor VIII products are indicated for patients with hemophilia A for the following uses:

- Control and prevention of bleeding episodes:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Hemofil M, Koate-DVI, Kogenate FS, Kovaltry, Monoclate-P, Novoeight, Nuwiq, Recombinate, ReFacto, Xyntha
- Perioperative management:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Hemofil M, Koate-DVI, Kogenate FS, Kovaltry, Monoclate-P, Novoeight, Nuwiq, Recombinate, ReFacto, Xyntha
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes:
  - Children and adults: Advate, Adynovate, Afstyla, Eloctate, Helixate FS, Kogenate FS, Kovaltry, Novoeight, Nuwiq, ReFacto (short-term)
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes and to reduce the risk of joint damage in children without pre-existing joint damage:
  - Children: Helixate FS, Kogenate FS
- Treatment of acquired hemophilia A:
  - Adults: Obizur

Limitation(s) of use:

- Factor VIII products are not indicated for treatment of von Willebrand disease.
- Obizur is not indicated for the treatment of congenital hemophilia A.
- Safety and efficacy of Obizur have not been established in patients with a baseline anti-porcine factor VIII inhibitor titer of > 20 BU.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Factor VIII products are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia A (must meet all):

1. Diagnosis of congenital hemophilia A;
2. Prescribed by or in consultation with a hematologist;
3. The requested product is prescribed for one of the following purposes (a, b, or c):
   a. Control and prevention of bleeding episodes (all products except Obizur);
   b. Perioperative management (all products except Obizur);
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes, and
      i. Request is for Advate, Adynovate, Eloctate, Helixate FS, Kogenate FS, Novoeight, Nuwiq, or ReFacto;
4. Member does not have von Willebrand disease (VWD);
5. If factor VIII coagulant activity levels are > 5%, member has failed a trial of desmopressin acetate, unless contraindicated or clinically significant adverse effects are experienced, or an appropriate formulation of desmopressin acetate is not available;
6. If Xyntha is prescribed, member has failed a trial of Advate (e.g., inhibitor production or hypersensitivity), unless contraindicated or clinically significant adverse effects are experienced, or Advate is not available;
7. Dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Acquired Hemophilia A (must meet all):

1. Request is for Obizur;
2. Diagnosis of acquired hemophilia A;
3. Prescribed by or in consultation with a hematologist;
4. Request is for the control and prevention of bleeding episodes;
5. Member does not have congenital hemophilia A or VWD;
6. Dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months (acute bleed) or 6 months (prophylaxis)

C. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Congenital Hemophilia A (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Acquired Hemophilia A (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months (acute bleed) or 6 months (prophylaxis)

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
VWD: von Willebrand disease

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
desmopressin acetate (Stimate® nasal spray; generic injection solution)	When Factor VIII coagulant activity levels are > 5% Injection: 0.3 mcg/kg IV every 48 hours Nasal spray: < 50 kg: 1 spray intranasally in one nostril only; may repeat based on laboratory response and clinical condition ≥ 50 kg: 1 spray intranasally in each nostril; may repeat based on laboratory response and clinical condition	Injection: 0.3 mcg/kg IV every 48 hours Nasal spray: 1 spray intranasally in each nostril

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Antihemophilic factor – recombinant (Advate, Adynovate, Afstyla, Kovaltry, Novoeight, Nuwiq, Recombinate, ReFacto, Xyntha)	Control and prevention of bleeding episodes	Minor episodes: 10-20 IU/kg IV every 12-24 hours (Advate: 8-24 hours for age < 6 years) Moderate episodes: 15-30 IU/kg IV every 12-24 hours (Advate: 8-24 hours for age < 6 years) Major episodes: 30-50 IU/kg IV every 8-24 hours (Advate: 6-12 hours for age < 6 years)	50 IU/kg every 6 hours until the bleeding episode is resolved
Antihemophilic factor – recombinant (Eloctate)	Control and prevention of bleeding episodes	Minor and moderate episodes: 20-30 IU/kg every 24-48 hours (12-24 hours for age < 6 years) Major episodes: 40-50 IU/kg every 12-24 hours (8 to 24 hours for age < 6 years)	50 IU/kg every 8 hours until the bleeding episode is resolved
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Control and prevention of bleeding episodes	Minor episodes: 10-20 IU/kg IV; repeat dose if there is evidence of further bleeding Moderate episodes: 15-30 IU/kg IV every 12-24 hours Major episodes: initial 40-50 IU/kg	50 IU/kg single dose or 30 IU/kg/repeated dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		IV followed by 20-25 IU/kg IV every 8-24 hours (Kogenate FS: every 8-12 hours)	
Antihemophilic factor – recombinant (Advate, Adynovate)	Perioperative management	Minor surgery: 30-50 IU/kg IV as a single dose within 1 hour of the operation and every 12-24 hours (Adynovate: 24 hours) thereafter as needed to control bleeding Major surgery: 40-60 IU/kg IV as a single dose preoperatively to achieve 100% activity and every 8-24 hours thereafter to keep factor VIII activity in desired range (Advate: every 6-24 hours for age < 6 years; Adynovate: every 6-24 hours if age < 12 years)	Minor surgery: 50 IU/kg/dose Major surgery: 60 IU/kg/dose
Antihemophilic factor – recombinant (Eloctate)	Perioperative management	Minor surgery: 25-40 IU/kg every 24 hours (12-24 hours age < 6 years) Major surgery: pre-operative dose of 40-60 IU/kg followed by a repeat dose of 40-50 IU/kg after 8-24 hours (6-24 hours for age < 6 years) and then every 24 hours to maintain Factor VIII	Minor surgery: 40 IU/kg/dose Major surgery: 60 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		activity within the target range	
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Perioperative management	Minor surgery: 15-30 IU/kg IV every 12-24 hours Major surgery: pre-operative dose of 50 IU/kg followed by a repeat dose every 6-12 hours to maintain Factor VIII activity within the target range	Minor surgery: 30 IU/kg/dose Major surgery: 50 IU/kg/dose
Antihemophilic factor – recombinant (Afstyla, Kovaltry, Novoeight, Nuwiq, Recombinate, Xyntha)	Perioperative management	Minor surgery: 15-30 IU/kg IV every 24 hours (Xyntha: every 12-24 hours) (Recombinate: 30-40 IU/kg as a single infusion) Major surgery: 40-50 IU/kg every 8-24 hours (Xyntha: 30-50 IU/kg)	Minor surgery: 30 IU/kg/dose (Recombinate: 40 IU/kg/dose) Major surgery: 50 IU/kg every 8 hours
Antihemophilic factor – recombinant (Advate)	Routine prophylaxis	20-40 IU/kg IV every other day (3 to 4 times weekly) OR Use every third day dosing regimen targeted to maintain Factor VIII trough levels ≥ 1%	40 IU/kg every other day
Antihemophilic factor – recombinant (Adynovate)	Routine prophylaxis	≥ 12 years of age: 40-50 IU/kg IV 2 times per week	70 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		< 12 years of age: 55 IU/kg IV 2 times per week	
Antihemophilic factor – recombinant (Afstyla)	Routine prophylaxis	≥ 12 years of age: 20-50 IU/kg IV 2-3 times per week < 12 years of age: 30-50 IU/kg IV 2-3 times per week	50 IU/kg/dose
Antihemophilic factor – recombinant (Eloctate)	Routine prophylaxis	50 IU/kg IV every 4 days For children < 6 years of age: 50 IU/kg IV twice weekly	65 IU/kg/dose
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS)	Routine prophylaxis	Adults: 25 IU/kg IV three times per week Children: 25 IU/kg every other day	25 IU/kg/dose
Antihemophilic factor – recombinant (Novoeight)	Routine prophylaxis	≥ 12 years of age: 20-50 IU/kg IV 3 times per week OR 20-40 IU/kg IV every other day < 12 years of age: 25-60 IU/kg IV 3 times per week OR 25-50 IU every other day	60 IU/kg/dose
Antihemophilic factor – recombinant (Nuwiq)	Routine prophylaxis	≥ 12 years of age: 30-40 IU/kg IV every other day < 12 years of age: 30-50 IU/kg IV every other day or 3 times/week	50 IU/kg/dose
Antihemophilic factor – recombinant (Kovaltry)	Routine prophylaxis	> 12 years of age: 20-40 IU/kg IV 2-3 times per week	50 IU/kg every other day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		≤ 12 years of age: 25-50 IU/kg twice or three times weekly or every other day according to individual requirements	
Antihemophilic factor – recombinant, porcine sequence (Obizur)	Treatment of bleeding episodes in acquired hemophilia A	200 IU/kg every 4-12 hours	200 IU every 4 hours
Antihemophilic factor – human (Hemofil M)	Control and prevention of bleeding episodes	Minor episodes: 20-40 IU/kg IV every 12-24 hours Moderate episodes: 30-60 IU/kg IV every 12-24 hours Major episodes: 60-100 IU/kg IV every 8-24 hours	100 IU/kg every 8 hours
Antihemophilic factor – human (Koate-DVI)	Control and prevention of bleeding episodes	Minor episodes: 10 IU/kg IV as a single dose; repeat only if there is evidence of further bleeding Moderate episodes: 15-25 IU/kg IV as a single dose followed by 10-15 IU/kg every 8-12 hours if needed Major episodes: 40-50 IU/kg IV as a single dose followed by 20-25 IU/kg IV every 8-12 hours	25 IU/kg every 8 hours until the bleeding episode is resolved
Antihemophilic factor – human (Monoclate-P)	Control and prevention of bleeding episodes	Minor episodes: will generally subside with a single	25 IU/kg every 8 hours until the

Drug Name	Indication	Dosing Regimen	Maximum Dose
		infusion if a level of 30% or more is attained Moderate episodes: 15-25 IU/kg IV as a single dose followed by 10-15 IU/kg every 8-12 hours if needed Major episodes: 40-50 IU/kg IV as a single dose followed by 20-25 IU/kg IV every 8-12 hours	bleeding episode is resolved
Antihemophilic factor – human (Hemofil M)	Perioperative management	Minor surgery: 60-80 IU/kg as a single infusion Major surgery: 80-100 IU/kg every 8-24 hours	Minor surgery: 80 IU/kg/dose Major surgery: 100 IU/kg every 8 hours
Antihemophilic factor – human (Koate-DVI)	Perioperative management	Major surgery: 50 IU/kg pre-operative dose followed by 50 IU/kg every 6-12 hours as needed Minor surgery: less intensive schedules may be adequate	Major surgery: 50 IU/kg every 6 hours
Antihemophilic factor – human (Monoclate-P)	Perioperative management	Minor surgery: 15-25 IU/kg IV as a single dose followed by 10-15 IU/kg every 8-12 hours if needed Major surgery: a dose sufficient to achieve a level 80-100% of normal is given one hour prior	Minor surgery: 25 IU/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		to surgery. A second dose, half the size of the priming dose, is given 5 hours after the first dose.	

VI. Product Availability

Drug Name	Availability
Antihemophilic factor – recombinant (Advate)	Vial: 250, 500, 1000, 1500, 2000, 3000, 4000 IU
Antihemophilic factor – recombinant (Adynovate)	Vial: 250, 500, 750, 1000, 1500, 2000, 3000 IU
Antihemophilic factor – recombinant (Afstyla)	Vial: 250, 500, 1000, 1500, 2000, 2500, 3000 IU
Antihemophilic factor – recombinant (Eloctate)	Vial: 250, 500, 750, 1000, 1500, 2000, 3000 4000, 5000, 6000 IU
Antihemophilic factor – recombinant (Helixate FS, Kogenate FS, Kovaltry)	Vial: 250, 500, 1000, 2000, 3000 IU
Antihemophilic factor – recombinant (Novoeight)	Vial: 250, 500, 1000, 1500, 2000, 3000 IU
Antihemophilic factor – recombinant (Nuwiq)	Vial: 250, 500, 1000, 2000, 2500, 3000, 4000 IU
Antihemophilic factor – recombinant (Recombinate, Xyntha)	Vial: 250, 500, 1000, 2000 IU
Antihemophilic factor – recombinant (Xyntha Solofuse)	Prefilled syringe: 250, 500, 1000, 2000, 3000 IU
Antihemophilic factor – recombinant (Obizur)	Vial: 500 IU
Antihemophilic factor – human (Hemofil M)	Vial: 250, 500, 1000, 1700 IU
Antihemophilic factor – human (Koate-DVI)	Vial: 250, 500, 1000 IU
Antihemophilic factor – human (Monoclate-P)	Vial: 250, 500, 1000, 1500 IU

VII. References

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15. Obizur Prescribing Information. Westlake Village, CA: Baxalta US, Inc.; October 2015. Available at: www.obizur.com. Accessed November 27, 2017.
16. Kovaltry Prescribing Information. Whippany, NJ: Bayer HealthCare LLC; March 2016. Available at: www.kovaltry-us.com. Accessed November 27, 2017.
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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9137	Injection, factor VIII (antihemophilic factor, recombinant) PEGylated, 1 IU
C9138	Injection, factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 IU
J7182	Injection, factor VIII, (antihemophilic factor, recombinant), (NovoEight), per IU
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per IU
J7188	Injection, factor VIII (antihemophilic factor, recombinant), per IU
J7190	Factor VIII (antihemophilic factor, human) per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Added Kovaltry; removed requests for documentation; added 12 and older per PI indications if Adynovate. Removed preferencing for Helixate before Kogenate and Refacto. Under initial criteria, removed requirement for "severe hemophilia" and "history of 2 or more joint bleeds for prophylaxis indication." Non-prophylactic approval duration changed to 3 months initially with one 3-month re-auth. Removed denial based on inhibitor titer of ≥5 BU/mL. Reviewed by specialist.	04.01.16	05.16
Product updates: Afstyla added (new drug); Adynovate updated to include perioperative management and use in children; Koate added - Koate-DVI being phased out; Kogenate is available via three different PIs as Kogenate FS, Kogenate FS with Vial Adapter and Kogenate FS with Bio-Set; Obizur added (new drug for acquired hemophilia); ReFacto – removed "short term" use from criteria; Xyntha Solofuse added (same indications as Xyntha). Required trial of desmopressin is edited to avoid necessity of testing for coagulation factors. Safety information removed. Removed age >18 age restriction for Obizur per specialist recommendation. Wording for uses of all blood factor products made consistent across all policies. Per specialist review, for congenital hemophilia A, opened indications for routine prophylaxis up to all drugs listed in the policy, except Obizur. Approval periods across all blood factor policies made consistent. Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Reviewed by specialist- hematologist/internal medicine.	04.01.17	05.17
Changed to new Centene Medicaid template	10.01.17	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: - No significant changes. - References reviewed and updated.	11.27.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Clinical Policy: Factor VIII/von Willebrand Factor Complex (Human - Alphanate, Humate-P, Wilate)

Reference Number: CP.PHAR.216
Effective Date: 05.01.16
Last Review Date: 02.18
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are factor VIII/von Willebrand factor complexes (human) requiring prior authorization: Alphanate®, Humate®-P, and Wilate®.

FDA Approved Indication(s)

Alphanate is indicated for:

- Hemophilia A:
  - Control and prevention of bleeding episodes and perioperative management in adults and pediatric patients with Factor VIII deficiency due to hemophilia A.
- Von Willebrand disease:
  - Surgical and/or invasive procedures in adults and pediatric patients with von Willebrand Disease (VWD) in whom desmopressin (DDAVP) is either ineffective or contraindicated.

Limitation(s) of use: Alphanate is not indicated for patients with severe VWD (Type 3) undergoing major surgery.

Humate-P is indicated:

- For hemophilia A:
  - Treatment and prevention of bleeding in adults with hemophilia A (classical hemophilia).
- In adult and pediatric patients with Von Willebrand disease (VWD):
  - Treatment of spontaneous and trauma-induced bleeding episodes;
  - Prevention of excessive bleeding during and after surgery in patients with severe VWD as well as patients with mild to moderate disease where use of desmopressin (DDAVP) is known or suspected to be inadequate.

Limitation(s) of use: Controlled clinical trials to evaluate the safety and efficacy of prophylactic dosing with Humate-P to prevent spontaneous bleeding have not been conducted in VWD subjects.

Wilate is indicated:

- For von Willebrand disease:
  - In children and adults with von Willebrand disease (VWD) disease for:
    - On-demand treatment and control of bleeding episodes;
    - Perioperative management of bleeding.

Limitation(s) of use: Wilate is not indicated for the treatment of hemophilia A.

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Alphanate, Humate-P, and Wilate are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia A – Alphanate/Humate-P (must meet all):
1. Diagnosis of congenital hemophilia A (factor VIII deficiency);
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following (a or b):
   a. Control or prevention of bleeding episodes;
   b. Perioperative management (Alphanate only);
4. If factor VIII coagulant activity levels are >5%, member has failed a trial of desmopressin acetate, unless contraindicated or clinically significant adverse effects are experienced, or an appropriate formulation of desmopressin acetate is unavailable;
5. Dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months

B. Von Willebrand Disease (must meet all)**:**
1. Diagnosis of VWD (types 1, 2, or 3);
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following (a or b):
   a. Spontaneous and trauma-induced bleeding episodes (Humate-P and Wilate only);
   b. Perioperative management;
4. Dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months

C. Other diagnoses/indications
1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
VWD: von Willebrand disease
VWF: von Willebrand factor

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
desmopressin acetate (Stimate® nasal spray; generic injection solution)	When Factor VIII coagulant activity levels are > 5% Injection: 0.3 mcg/kg IV every 48 hours Nasal spray: < 50 kg: 1 spray intranasally in one nostril only; may repeat based on laboratory response and clinical condition ≥ 50 kg: 1 spray intranasally in each nostril; may repeat based on laboratory response and clinical condition	Injection: 0.3 mcg/kg IV every 48 hours Nasal spray: 1 spray intranasally in each nostril

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Factor VIII/von Willebrand factor complex (Alphanate)	Hemophilia A - control and prevention of bleeding episodes	Minor episodes: 15 IU/kg IV every 12 hours	100 IU/kg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Moderate episodes: 25 IU/kg IV every 12 hours Major episodes: 40-50 IU/kg IV initially followed by 25 IU/kg IV every 12 hours	
Factor VIII/von Willebrand factor complex (Humate-P)	Hemophilia A - control and prevention of bleeding episodes	Minor episodes: 15 IU/kg IV loading dose followed by half of the loading dose given once or twice daily if needed Moderate episodes: 25 IU/kg IV loading dose followed by 15 IU/kg IV every 8-12 hours Major episodes: 40-50 IU/kg IV initially followed by 20-25 IU/kg IV every 8 hours	75 IU/kg/day
Factor VIII/von Willebrand factor complex (Alphanate)	Hemophilia A – perioperative management	Pre-operative: 40-50 IU/kg IV once as a single dose Post-operative: 30-50 IU/kg IV every 12 hours	100 IU/kg/day
Factor VIII/von Willebrand factor complex (Humate-P)	VWD – control and prevention of bleeding episodes	Type 1 VWD, mild disease Minor or major episodes: 40-60 IU/kg IV loading dose followed by 40-50 IU/kg IV every 8-12 hours	240 IU/kg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Type 1 VWD, moderate or severe disease Minor episodes: 40-50 IU/kg IV as one or two doses Major episodes: 50-75 IU/kg loading dose followed by 40-60 IU/kg every 8-12 hours Type 2 or 3 VWD Minor episodes: 40-50 IU/kg IV as one or two doses Major episodes: 60-80 IU/kg IV loading dose followed by 40-60 IU/kg every 8-12 hours	

VI. Product Availability

Drug Name	Availability
Factor VIII/von Willebrand factor complex (Alphanate)	Vial: 250, 500, 1000, 1500 IU and 2000 IU FVIII
Factor VIII/von Willebrand factor complex (Humate-P)	Vial: 250/600, 500/1200, 1000/2400 IU FVIII/VWF:RCo
Factor VIII/von Willebrand factor complex (Wilate)	Vial: 500/500, 1000/1000 IU FVIII/VWF:RCo

VII. References

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2. Humate-P Prescribing Information. Kankakee, IL: CSL Behring, LLC; September 2016. Available at http://labeling.cslbehring.com/PI/US/Humate-P/EN/Humate-P-Prescribing-Information.pdf. Accessed November 27, 2017.
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4. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
5. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 27, 2017.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7183	Injection, von Willebrand factor complex (human), Wilate, 1 IU vWF:RCo
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII i.u.
J7187	Injection, von Willebrand factor complex (Humate-P), per IU VWF:RCO

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Removed requests for documentation. Removed indication for prophylaxis after 2 joint bleeds/approval period 6 months as there is no FDA approved indication for long-term prophylaxis. Approval period is edited to be 3 months initial and one 3-month re-auth as, in some circumstances, treatment could be necessary for up to six months (e.g., intracranial hemorrhage per Alphanate PI). Reviewed by specialist.	04.01.16	05.16
Removed “major surgery” restriction for Alphanate. Required trial of desmopressin is edited to avoid necessity of testing for coagulation factors. Safety information removed. Uses and approval periods across all blood factor policies worded consistently. Efficacy statement added to renewal criteria. Hemophilias are specified as “congenital” versus “acquired” across blood factor policies where indicated. Reviewed by specialist- hematology/internal medicine	04.01.17	05.17
1Q18 annual review: - Converted to new template -No significant changes - References reviewed and updated.	11.27.17	02.18

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Clinical Policy: Anti-Inhibitor Coagulant Complex, Human (Feiba)

Reference Number: CP.PHAR.217
Effective Date: 05.01.16
Last Review Date: 02.18
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Anti-inhibitor coagulant complex, human (Feiba®) is a human plasma fraction with factor VIII inhibitor bypassing activity. It contains mainly non-activated factors II, IX, and X and activated factor VII.

FDA Approved Indication(s)

Feiba is an anti-inhibitor coagulant complex/intravenous formulation indicated for use in hemophilia A and B patients with inhibitors for:

- Control and prevention of bleeding episodes;
- Perioperative management;
- Routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

Limitation(s) of use: Feiba is not indicated for the treatment of bleeding episodes resulting from coagulation factor deficiencies in the absence of inhibitors to coagulation factor VIII or coagulation factor IX.

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Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Feiba is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia A and B (must meet all):

1. Diagnosis of congenital hemophilia A (factor VIII deficiency) or B (factor IX deficiency) with inhibitors (antibodies to factor VIII or IX);
2. Prescribed by or in consultation with a hematologist;
3. Request is for any of the following:
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes;
4. Dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Congenital Hemophilia A and B (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Adminsitration

Appendix B: Therapeutic Alternatives
Not Applicable

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Control and prevention of bleeding episodes	Joint hemorrhage: 50-100 units/kg IV every 12 hours Mucous membrane bleeding: 50-100 units/kg IV every 6 hours Soft tissue hemorrhage (e.g., retroperitoneal bleeding): 100 units/kg IV every 12 hours	400 units/kg/day

Indication	Dosing Regimen	Maximum Dose
	Other severe hemorrhage: 100 units/kg IV every 6-12 hours	
Perioperative management	Pre-operative: 50-100 units/kg IV as a single dose Post-operative: 50-100 units/kg IV every 6-12 hours	400 units/kg/day
Routine prophylaxis	85 units/kg IV every other day	85 units/kg/dose

VI. Product Availability

Vial: 500, 1000, 2500 units

VII. References

1. Feiba Prescribing Information. Westlake Village, CA: Baxter Healthcare Corporation; April 2017. Available at http://www.shirecontent.com/PI/PDFs/FEIBA_USA_ENG.pdf. Accessed November 28, 2017
2. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
3. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 28, 2017.

Coding Implications

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HCPCS Codes	Description
J7198	Antiinhibitor, per IU

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Removed requests for documentation. Dosing details removed. Approval period for non-prophylactic use is edited to provide 3 months on initial approval and one 3-month re-auth; approval period for prophylactic use is added at 6 months initial/6 months continuing therapy. Reviewed by specialist.	04.01.16	05.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Safety information removed. Wording for uses made consistent across all blood factor policies. Approval periods across all blood factor policies are worded as follows: 3 months (bleeding episodes/surgery); 6 months (routine prophylaxis). Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Reviewed by specialist-hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes - Converted to new template - References reviewed and updated.	11.28.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Clinical Policy: Factor IX (Human, Recombinant)

Reference Number: CP.PHAR.218
Effective Date: 05.01.16
Last Review Date: 02.18 Coding Implications
Line of Business: Medicaid Revision Log
See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The following Factor IX products require prior authorization: AlphaNine SD®, Alprolix®, BeneFIX®, Idelvion®, Ixinity®, Mononine®, Rebinyn®, and Rixubis®.

FDA Approved Indication(s)
AlphaNine SD and Mononine are indicated for the prevention and control of bleeding in patients with Factor IX deficiency due to hemophilia B, also known as Christmas disease.

Limitation(s) of use:
- AlphaNine SD and Mononine contain low, non-therapeutic levels of Factors II, VII, and X, and, therefore, are not indicated for the treatment of Factor II, VII or X deficiencies.
- These products are also not indicated for the reversal of coumarin anticoagulant-induced hemorrhage, nor in the treatment of hemophilia A patients with inhibitors to Factor VIII.
- Mononine is also not indicated in a hemorrhagic state caused by hepatitis-induced lack of production of liver dependent coagulation factors.

Alprolix, Idelvion, and Rixubis are indicated in adults and children with hemophilia B (congenital Factor IX deficiency) for:
- On-demand treatment and control of bleeding episodes;
- Perioperative management of bleeding;
- Routine prophylaxis to reduce the frequency of bleeding episodes.

Limitation(s) of use:
- Alprolix, Idelvion, and Rixubis are not indicated for induction of immune tolerance in patients with hemophilia B.

BeneFIX is indicated in:
- Adult and pediatric patients with hemophilia B (congenital factor IX deficiency or Christmas disease) for
  - Control and prevention of bleeding episodes;
  - Perioperative management.

Limitation(s) of use: BeneFIX is NOT indicated for:
- Treatment of other factor deficiencies (e.g., factors II, VII, VIII, and X);
- Treatment of hemophilia A patients with inhibitors to factor VIII;
- Reversal of coumarin-induced anticoagulation;
- Treatment of bleeding due to low levels of liver-dependent coagulation factors.

Ixinity is indicated in:
- Adults and children ≥ 12 years of age with hemophilia B for:
  - Control and prevention of bleeding episodes;
  - Perioperative management.

Limitation(s) of use:
- Ixinity is not indicated for induction of immune tolerance in patients with hemophilia B.

Rebinyn is indicated in adults and children with hemophilia B for:
- On demand treatment and control of bleeding episodes
- Perioperative management of bleeding

Limitation(s) of use:
- Rebinyn is not indicated for routine prophylaxis in the treatment of patients with hemophilia B.
- Rebinyn is not indicated for induction of immune tolerance in patients with hemophilia B.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that AlphaNine SD, Alprolix, BeneFIX, Idelvion, Ixinity, Mononine, Rebinyn, and Rixubis are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia B (must meet all):
1. Diagnosis of congenital hemophilia B (factor IX deficiency);
2. Prescribed by or in consultation with a hematologist;
3. Request is for any of the following:
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes (Alprolix, Idelvion, or Rixubis only);
4. Dose does not exceed the FDA approved maximum recommended dose for the relevant indication.

Approval duration: 3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Other diagnoses/indications
1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Congenital Hemophilia B (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member has responded positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indication.

Approval duration: 3 months (bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Factor IX, human (AlphaNine SD)	Control and prevention of bleeding episodes	Minor episodes: 20-30 IU/kg IV twice daily Moderate episodes: 25-50 IU/kg IV twice daily Major episodes: 30-50 IU/kg IV twice daily for at least 3-5 days, followed by 20 IU/kg IV twice daily Surgery: 50-100 IU/kg IV twice daily before surgery, followed by the same regimen for 7-10 days thereafter	Bleeding episodes: 100 IU/kg/day Surgery: 200 IU/kg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
Factor IX, human (Mononine)	Control and prevention of bleeding episodes	Minor episodes: 20-30 IU/kg IV every 24 hours Major trauma or surgery: 75 IU/kg IV every 18-30 hours	Minor episodes: 30 IU/kg/day Major trauma or surgery: 750 IU/kg/18 hours
Factor IX, recombinant (Alprolix)	Control and prevention of bleeding episode	Minor and moderate episodes: 30-60 IU/dL/kg IV every 48 hours if there is further evidence of bleeding after the first dose Major episodes: 80-100 IU/dL/kg IV initially; consider a repeat dose after 6-10 hours and then every 24 hours for the first 3 days. May extend to dosing every 48 hours or longer after the first 3 days Minor surgery: 50-80 IU/dL/kg IV initially followed by every 24-48 hours until bleeding stops and healing is achieved Major surgery: 60-80 IU/dL/kg IV initially; consider a repeat dose after 6-10 hours and then every 24 hours for the first 3 days. May extend to dosing every 48 hours or longer after the first 3 days	Bleeding episodes: 100 IU/dL/kg/dose Surgery: 80 IU/dL/kg/dose
Factor IX, recombinant (Alprolix)	Routine prophylaxis	50 IU/dL/kg IV once weekly or 100 IU/dL/kg IV once every 10 days	100 IU/dL/kg/dose
Factor IX, recombinant (BeneFIX)	Control and prevention of bleeding episodes	Minor episodes: 20-30 IU/dL/kg IV every 12-24 hours Moderate episodes: 25-50 IU/dL/kg IV every 12-24 hours Major episodes: 50-100 IU/dL/kg IV every 12-24 hours	200 IU/dL/kg/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Surgery: 50-100 IU/dL/kg IV every 12-24 hours	
Factor IX, recombinant (Idelvion)	Control and prevention of bleeding episodes	Minor and moderate episodes: 30-60 IU/dL/kg IV every 48-72 hours Major episodes: 60-100 IU/dL/kg IV every 48-72 hours until bleeding stops and healing is achieved; maintenance dose is weekly Minor surgery: 50-80 IU/dL/kg IV every 48-72 hours until healing is achieved Major surgery: 60-80 IU/dL/kg IV every 48-72 hours until bleeding stops and healing is achieved; maintenance dose is 1-2 times per week	Bleeding episodes: 100 IU/dL/kg/48 hours Surgery: 80 IU/dL/kg/48 hours
Factor IX, recombinant (Idelvion)	Routine prophylaxis	≥ 12 years of age: 25-40 IU/dL/kg IV every 7 days followed by 50-75 IU/dL/kg IV every 14 days once well-controlled < 12 years of age: 40-55 IU/dL/kg IV every 7 days	55 IU/dL/kg/week
Factor IX, recombinant (Ixinity)	Control and prevention of bleeding episodes	Minor episodes: 30-60 IU/dL/kg IV every 24 hours Moderate episodes: 40-60 IU/dL/kg IV every 24 hours Major episodes: 60-100 IU/dL/kg IV every 12-24 hours Minor surgery: 50-80 IU/dL/kg IV pre-operatively followed by 30-80 IU/dL/kg every 24 hours Major surgery: 60-80 IU/dL/kg IV pre-operatively followed by	Bleeding episodes: 102 IU/dL/kg/dose Surgery: 81.6 IU/dL/kg/dose

Drug Name	Indication	Dosing Regimen	Maximum Dose
		40-60 IU/dL/kg IV every 8-24 hours on Days 1-3, then 30-50 IU/dL/kg IV every 8-24 hours for Days 4-6, then 20-40 IU/dL/kg IV every 8-24 hours on Days 7-14	
Factor IX, recombinant (Rixubis)	Control and prevention of bleeding episodes	Minor episodes: 20-30 IU/dL/kg IV every 12-24 hours until healing is achieved Moderate episodes: 25-50 IU/dL/kg IV every 12-24 hours until bleeding stops and healing is achieved Major episodes: 50-100 IU/dL/kg IV every 12-24 hours until bleeding stops and healing is achieved Minor surgery: 30-60 IU/dL/kg IV every 24 hours until healing is achieved Major surgery: 80-100 IU/dL/kg IV every 8-24 hours until bleeding stops and healing is achieved	100 IU/dL/kg/dose
Factor IX, recombinant (Rixubis)	Routine prophylaxis	≥ 12 years of age: 40-60 IU/dL/kg IV twice weekly < 12 years of age: 60-80 IU/dL/kg IV twice weekly	80 IU/dL/kg/dose
Factor IX, recombinant, glycopegylated (Rebinyn)	On-demand treatment and control of bleeding episodes	40 IU/kg body weight for minor and moderate bleeds, and 80 IU/kg body weight for major bleeds. Additional doses of 40 IU/kg can be given	80 IU/kg/dose
	Perioperative management of bleeding	Pre-operative dose of 40 IU/kg body weight for minor surgery, and 80 IU/kg body weight for major surgery. As clinically needed for the perioperative management of bleeding, repeated doses of 40 IU/kg (in 1-3	80 IU/kg pre-operatively; 40 IU/kg/dose after surgery

Drug Name	Indication	Dosing Regimen	Maximum Dose
		day intervals) within the first week after major surgery may be administered. Frequency may be extended to once weekly after the first week until bleeding stops and healing is achieved	

VI. Product Availability

Drug Name	Availability
Factor IX, human (AlphaNine SD)	Vial: 500, 1000, 1500 IU
Factor IX, human (Mononine)	Vial: 500, 1000 IU
Factor IX, recombinant (Alprolix)	Vial: 250, 500, 1000, 2000, 3000, 4000 IU
Factor IX, recombinant (BeneFIX)	Vial: 250, 500, 1000, 2000, 3000 IU
Factor IX, recombinant (Idelvion)	Vial: 250, 500, 1000, 2000 IU
Factor IX, recombinant (Ixinity)	Vial: 250, 500, 1000, 1500, 2000, 3000 IU
Factor IX, recombinant (Rixubis)	Vial: 250, 500, 1000, 2000, 3000 IU
Factor IX, recombinant, glycopegylated (Rebinyn)	Vial: 500, 1000, 2000 IU

VII. References

1. Alphanine SD Prescribing Information. Los Angeles, CA: Grifols Biologicals, Inc.; January 2013. Available at: www.alphaninesd.com. Accessed November 28, 2017.
2. Alprolix Prescribing Information. Cambridge, MA: Biogen Idec, Inc.; November 2017. Available at: www.alprolix.com. Accessed November 28, 2017.
3. BeneFix Prescribing Information. Philadelphia, PA: Wyeth Pharmaceuticals, Inc.; June 2017. Available at: www.benefix.com. Accessed November 28, 2017.
4. Idelvion Prescribing Information. Kankakee, IL: CSL Behring LLC; February 2017. Available at: www.idelvion.com. Accessed November 28, 2017.
5. Ixinity Prescribing Information. Berwyn, PA: Aptevo BioTherapeutics LLC; August 2016. Available at: www.ixinity.com. Accessed November 28, 2017.
6. Mononine Prescribing Information. Kankakee, IL: ZLB Behring, LLC; April 2016. Available at: www. http://labeling.cslbehring.com/PI/US/Mononine/EN/Mononine-Prescribing-Information.pdf. Accessed November 28, 2017.
7. Rixubis Prescribing Information. Westlake Village, CA: Baxalta US Inc.; March 2016. Available at: http://www.rixubis.com. Accessed November 28, 2017.
8. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. *Haemophilia.* Jan 2013; 19(1): e1-47.
9. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 28, 2017.
10. Rebinyn Prescribing Information. Plainsboro, NJ: Novo Nordisk; May 2017. Available at: www.rebinyn.com. Accessed February 9, 2018.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7194	Factor IX complex, per IU
J7195	Injection, factor IX (antihemophilic factor, recombinant) per IU, not otherwise specified
J7200	Injection, factor IX, (antihemophilic factor, recombinant), Rixubis, per IU
J7201	Injection, factor IX, FC fusion protein (recombinant), per IU
J7202	Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, per IU.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Removed requests for documentation. Added age requirement per PI for Ixinity. Under initial criteria, removed requirement for"history of 2 or more joint bleeds." Delineated Alprolix and Rixubis for prophylaxis per Pis. Approval period for non-prophylactic use is edited to provide 3 months on initial approval and one 3-month re-auth; approval period for prophylactic use is retained at 6 months initial/6 months continuing therapy. Removed denial based on inhibitor titer of ≥5 BU/mL as Pis do not specify a limit. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording for uses of all blood factor products made consistent across all policies. Added indication for Alprolix and Rixubis for routine prophylaxis. Approval periods across all blood factor policies made consistent. Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Reviewed by specialist-hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - Converted to new template - Added Idelvion to the policy under the same coverage criteria as the other recombinant factor IX agents. - Specified routine prophylaxis indication is only for certain agents, per package labeling for those agents. - Added age limit for AlphaNine per package labeling	11.28.17	02.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
- References reviewed and updated.		
No significant changes: added Rebinyn (new dosage form).	03.19.18	

Important Reminder

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The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Clinical Policy: Factor IX Complex, Human (Bebulin, Profilnine)

Reference Number: CP.PHAR.219
Effective Date: 05.01.16 Coding Implications
Last Review Date: 02.18 Revision Log
Line of Business: Medicaid
See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description
Bebulin® and Profilnine® are human factor IX complexes.

FDA Approved Indication(s)
Bebulin is indicated for:
- Prevention and control of bleeding episodes in adult patients with hemophilia B (congenital factor IX deficiency or Christmas disease).

Limitation(s) of use: Bebulin is not indicated for use in the treatment of factor VII deficiency. No clinical studies have been conducted to show benefit from this product for treating deficiencies other than factor IX deficiency.

Profilnine is indicated for:
- Prevention and control of bleeding in patients with factor IX deficiency (hemophilia B).

Limitation(s) of use: Profilnine contains non-therapeutic levels of factor VII and is not indicated for use in the treatment of factor VII deficiency.

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Bebulin and Profilnine are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia B (must meet all)**:**
1. Diagnosis of congenital hemophilia B (factor IX deficiency);
2. Prescribed by or in consultation with a hematologist;
3. Age ≥ 18 years;
4. Request is for control and prevention of bleeding episodes;
5. Dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months

B. Other diagnoses/indications
1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Congenital Hemophilia B (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed the FDA approved maximum recommended dose for the relevant indications.

Approval duration: 3 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 3 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Factor IX complex (Bebulin)	Minor bleeding episodes: 25-35 IU/kg IV; repeat dose if there is evidence of further bleeding Moderate bleeding episodes: 50-65 IU/kg IV every 24 hours Major bleeding episodes: initial 75-90 IU/kg IV followed by 50-60 IU/kg IV every 12-24 hours Minor surgery: 50-75 IU/kg IV one hour prior to surgery, followed	90 IU/kg single dose or 75 IU/kg/repeated dose	Factor IX complex (Bebulin)

Drug Name	Indication	Dosing Regimen	Maximum Dose
	by 25-65 IU/kg IV post-operatively every 12 hours Major surgery: 75-90 IU/kg IV one hour prior to surgery, followed by 25-75 IU/kg IV post-operatively every 12 hours for the first two weeks, then 25-35 IU/kg IV every 24 hours thereafter		
Factor IX complex (Profilnine)	Minor to moderate bleeding episodes: 20-30 IU/kg IV every 16-24 hours Major bleeding episodes: 30-50 IU/kg IV followed by 20 IU/kg IV every 16-24 hours Surgery: 30-50 IU/kg IV prior to surgery, followed by the same dose every 16-24 hours thereafter	50 IU/kg	Factor IX complex (Profilnine)

VI. Product Availability

Drug Name	Availability
Factor IX complex (Bebulin)	Vial: 200-1200 IU; Factor IX activity in IU is stated on the label of each vial
Factor IX complex (Profilnine)	Vial: 500, 1000, 1500 IU

VII. References

1. Bebulin Prescribing Information. Westlake Village, CA: Baxter Healthcare Corporation; September 2015. Available at http://www.shirecontent.com/PI/PDFs/BEBULIN_USA_ENG.pdf. Accessed November 28, 2017.
2. Profilnine Prescribing Information. Los Angeles, CA: Grifols Biologicals, Inc.; May 2014. Available at http://www.grifolsusa.com/documents/10192/89476/ft-profilnine-us-en/03a3eed9-2e02-4e7f-ae7b-9bff623d8535. Accessed November 28, 2017.
3. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
4. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 28, 2017.

Coding Implications

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HCPCS Codes	Description
J7194	Factor IX complex, per IU

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Removed requests for documentation. Added age requirement per PIs. Neither drug is approved for prophylaxis so the "history of 2 or more episodes of bleeding into joints" is removed; approval period for non-prophylactic use is edited to provide 3 months on initial approval and one 3-month re-auth. Removed denial based on inhibitor titer of ≥5 BU/mL. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording, approval periods, and use of "congenital" versus "acquired hemophilia descriptions made consistent across all blood factor policies. Efficacy statement added to renewal criteria. Reviewed by specialist- hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - Converted to new template - Changed age limit for Profilnine to 18 years, per PI - References reviewed and updated	11.28.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Clinical Policy: Factor VIIa, Recombinant (NovoSeven RT)

Reference Number: CP.PHAR.220
Effective Date: 05.01.16
Last Review Date: 02.18
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Recombinant factor VIIa (NovoSeven® RT) is a vitamin K-dependent glycoprotein that promotes hemostasis by activating the extrinsic pathway of the coagulation cascade.

FDA Approved Indication(s)

NovoSeven RT is a recombinant factor VIIa concentrate/intravenous injection indicated for:

- Treatment of bleeding episodes and perioperative management in adults and children with hemophilia A or B with inhibitors, congenital FVII deficiency, and Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets;
- Treatment of bleeding episodes and perioperative management in adults with acquired hemophilia.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that NovoSeven RT is a **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Hemophilia A or B with Inhibitors (must meet all):

1. Diagnosis of congenital hemophilia A (factor VIII deficiency) or B (factor IX deficiency) with inhibitors (factor VIII or IX antibodies);
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following:
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;
4. Dose does not exceed 90 mcg/kg every two hours.

Approval duration: 3 months

B. Congenital Factor VII Deficiency (must meet all):

1. Diagnosis of congenital factor VII deficiency;
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following:
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;

4. Dose does not exceed 30 mcg/kg every four hours.

Approval duration: 3 months

C. Glanzmann's Thrombasthenia (must meet all):

1. Diagnosis of Glanzmann's thrombasthenia;
2. Prescribed by or in consultation with a hematologist;
3. Condition is refractory to platelet transfusions;
4. Request is for one of the following:
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;
5. Dose does not exceed 90 mcg/kg every two hours.

Approval duration: 3 months

D. Acquired Hemophilia (must meet all):

1. Prescribed by or in consultation with a hematologist;
2. Diagnosis of acquired hemophilia as evidenced by the presence of coagulation factor VIII inhibitors (autoantibodies);
3. Request is for one of the following:
   a. Control and prevention of bleeding episodes;
   b. Perioperative management;
4. Dose does not exceed 90 mcg/kg every two hours.

Approval duration: 3 months

E. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 90 mcg/kg every two hours (30 mcg/kg every four hours for congenital factor VII deficiency).

Approval duration: 3 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 3 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Treatment of bleeding episodes	Congenital hemophilia A or B with inhibitors: • 90 mcg/kg IV every 2 hours, adjustable based on severity of bleeding until hemostasis is achieved • 90 mcg/kg IV every 3-6 hours after hemostasis is achieved for severe bleeds Congenital factor VII deficiency: 15-30 mcg/kg IV every 4-6 hours until hemostasis is achieved Glanzmann's thrombasthenia: 90 mcg/kg IV every 2-6 hours until hemostasis is achieved Acquired hemophilia: 70-90 mcg/kg IV every 2-3 hours until hemostasis is achieved	Congenital factor VII deficiency: 30 mcg/kg every 4 hours All other indications: 90 mcg/kg every 2 hours
Peri-operative management	Congenital hemophilia A or B with inhibitors: *Minor surgery:* • 90 mcg/kg IV immediately before surgery, repeat every 2 hours during surgery • 90 mcg/kg IV every 2 hours after surgery for 48 hours, then every 2-6 hours until healing has occurred *Major surgery:* • 90 mcg/kg IV immediately before surgery, repeat every 2 hours during surgery • 90 mcg/kg IV every 2 hours after surgery for 5 days, then every 4 hours until healing has occurred	Congenital factor VII deficiency: 30 mcg/kg every 4 hours All other indications: 90 mcg/kg every 2 hours

Indication	Dosing Regimen	Maximum Dose
	Congenital factor VII deficiency: 15-30 mcg/kg IV immediately before surgery and every 4-6 hours for the duration of surgery and until hemostasis is achieved Glanzmann's thrombasthenia: • 90 mcg/kg IV immediately before surgery and repeat every 2 hours for the duration of the procedure • 90 mcg/kg IV every 2-6 hours to prevent postoperative bleeding Acquired hemophilia: 70-90 mcg/kg immediately before surgery and every 2-3 hours for the duration of surgery and until hemostasis is achieved	

VI. Product Availability

Vial: 1, 2, 5, 8 mg

VII. References

1. NovoSeven RT Prescribing Information. Plainsboro, NJ: Novo Nordisk, Inc.; October 2017. Available at http://www.novo-pi.com/novosevenrt.pdf. Accessed November 29, 2017.
2. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
3. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 29, 2017.

Coding Implications

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HCPCS Codes	Description
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Removed specific titer levels and factor VIII dose increases. Approval period for non-prophylactic use is edited to provide 3 months on initial approval and one 3-month re-auth. Added criteria for Glanzmann's thrombasthenia. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording for uses and approval periods for all blood factor products made consistent across all policies. Efficacy statement added to renewal criteria. Hemophilias are specified as "congenital" versus "acquired" across blood factor policies where indicated. Added requirement that acquired hemophilia be evidenced by the presence of factor VIII inhibitors. Reviewed by specialist-hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes - Converted to new template - References reviewed and updated.	11.29.17	02.18

Important Reminder

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Clinical Policy: Factor XIII, Human (Corifact)

Reference Number: CP.PHAR.221
Effective Date: 05.01.16
Last Review Date: 02.18
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Factor XIII, human (Corifact®) is a plasma-derived factor XIII concentrate.

FDA Approved Indication(s)

Corifact is a human factor XIII concentrate/intravenous formulation indicated for adult and pediatric patients with congenital factor XIII deficiency for:

- Routine prophylactic treatment;
- Perioperative management of surgical bleeding.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Corifact is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Factor XIII Deficiency (must meet all):

1. Diagnosis of congenital factor XIII deficiency;
2. Prescribed by or in consultation with a hematologist;
3. Request is for one of the following uses:
   a. Control and prevention of acute bleeding;
   b. Perioperative management;
   c. Routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

Approval duration: 3 months (acute bleeding episodes/surgery)
6 months (routine prophylaxis)

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Congenital Factor XIII Deficiency (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy.

Approval duration: 3 months (acute bleeding episodes/surgery)

6 months (routine prophylaxis)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
N/A

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Routine prophylaxis	40 IU/kg IV every 28 days Adjust dose ± 5 IU/kg to maintain 5% to 20% trough level of FXIII activity.	N/A
Peri-operative management and management of acute bleeding episodes	Dosing is individualized and depends on the time since the patient's last prophylactic dose. -If the patient's last dose was within the past 7 days, then an additional dose may not be needed. -If the last dose was 8-21 days prior, then an additional partial or full dose may be needed based on Factor XIII activity level. -If the last dose was 21-28 days prior, then a full prophylactic dose can be given.	N/A

VI. Product Availability

Vial: 1000-1600 units/vial

VII. References

1. Corifact Prescribing Information. Kankalee, IL: CSL Behring LLC; July 2016. Available at http://labeling.cslbehring.com/PI/US/Corifact/EN/Corifact-Prescribing-Information.pdf. Accessed November 28, 2017.

2. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. Haemophilia. Jan 2013; 19(1): e1-47.
3. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 28, 2017.

Coding Implications

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HCPCS Codes	Description
J7180	Injection, factor XIII (antihemophilic factor, human), 1 IU

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12.Blood Factors and converted to new template. Use is edited to include routine prophylaxis per PI, with approval period for non-prophylactic use edited to provide 3 months on initial approval and one 3-month re-auth; prophylactic approval is 6 months/6 months. Added indication for acute bleeding. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording for uses, approval periods, and specification as “congenital” versus “acquired” made consistent across all blood factor policies. Efficacy statement added to renewal criteria. Reviewed by specialist- hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes -Converted to new template - References reviewed and updated.	11.28.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

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Clinical Policy: Factor XIII A-Subunit, Recombinant (Tretten)

Reference Number: CP.PHAR.222
Effective Date: 05.01.16 Revision Log
Last Review Date: 02.18
Line of Business: Medicaid
See Important Reminder **at the end of this policy for important regulatory and legal information.**

Description
Factor XIII A-subunit, recombinant (Tretten®) is a recombinant factor XIII concentrate.

FDA Approved Indication(s)
Tretten is a recombinant factor XIII A-subunit concentrate/intravenous formulation indicated for routine prophylaxis for bleeding in patients with congenital factor XIII A-subunit deficiency.

Limitation(s) of use: Tretten is not for use in patients with congenital factor XIII B-subunit deficiency.

Policy/Criteria
Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Tretten is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Congenital Factor XIII A-Subunit Deficiency (must meet all):
1. Diagnosis of congenital factor XIII A-subunit deficiency;
2. Prescribed by or in consultation with a hematologist;
3. Request is for routine prophylaxis to prevent or reduce the frequency of bleeding episodes.

Approval duration: 6 months

B. Other diagnoses/indications
1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Congenital Factor XIII A-Subunit Deficiency (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Routine bleeding prophylaxis	35 IU/kg IV once monthly to achieve a target trough level of Factor XIII activity ≥ 10%. Consider dose adjustment if adequate coverage is not achieved with the 35 IU/kg dose.	N/A

VI. Product Availability

Vial: nominally 2500 IU/vial (2000 – 3125 IU)

VII. References

1. Tretten Prescribing Information. Plainsboro, NJ: Novo Nordisk; November 2016. Available at http://www.novo-pi.com/tretten.pdf. Accessed November 28, 2017.
2. Srivastava A, Brewer AK, Mauser-Bunschoten EP, et al. Guidelines for the management of hemophilia. *Haemophilia.* Jan 2013; 19(1): e1-47.
3. Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation (NHF): Database of treatment guidelines. Available at https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations. Accessed November 28, 2017.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7181	Injection, factor XIII A-subunit, (recombinant), per IU

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.12 Blood Factors and converted to new template. Diagnosis is edited to XIII A-Subunit deficiency per PI; use is edited per PI to prophylactic use; approval period is edited to 6 months/6 months. Reviewed by specialist.	04.01.16	05.16
Safety information removed. Wording for uses, approval duration, and use of "congenital" versus "acquired" for describing hemophilias, made consistent across all blood factor policies. Efficacy statement added to renewal criteria. Reviewed by specialist- hematology/internal medicine.	04.01.17	05.17
1Q18 annual review: - No significant changes - Converted to new template - Referenced reviewed and updated.	11.28.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Antihemophilia Factor Product Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Count of Members	Count of Claims	Sum of Sum of Days	Sum of Sum of Qty	Sum of Sum of Amt Paid
ADVATE	**42**	**65**	**1,401**	**10,897,104**	**$ 16,900,355.73**
201707	2	4	90	703,950	$ 1,070,044.68
201708	3	5	120	894,396	$ 1,359,532.77
201709	5	9	168	966,913	$ 1,469,799.29
201710	4	5	108	927,480	$ 1,409,820.45
201711	4	7	138	946,975	$ 1,439,473.19
201712	2	3	75	665,630	$ 1,011,788.11
201801	4	6	109	922,345	$ 1,445,957.12
201802	3	4	105	914,940	$ 1,445,645.88
201803	3	4	105	879,360	$ 1,389,429.48
201804	4	5	107	892,148	$ 1,409,644.69
201805	4	5	120	969,017	$ 1,531,097.71
201806	4	8	156	1,213,950	$ 1,918,122.36
ADYNOVATE	**22**	**41**	**1,172**	**1,269,397**	**$ 1,084,130.60**
201707	2	3	90	111,645	$ 95,786.65
201708	2	4	120	198,030	$ 124,613.22
201709	2	3	90	114,650	$ 97,136.55
201710	2	3	32	96,082	$ 60,351.57
201711	2	3	90	115,150	$ 98,126.55
201712	2	3	90	114,880	$ 98,036.48
201801	2	3	90	111,175	$ 91,992.37
201802	2	5	150	111,175	$ 91,869.24
201803	2	5	150	111,550	$ 88,356.68
201804	2	5	150	110,800	$ 87,815.41
201805	1	2	60	37,130	$ 75,022.94
201806	1	2	60	37,130	$ 75,022.94
ALPHANATE/VON WILLEBRAND	**25**	**39**	**1,074**	**1,435,660**	**$ 1,665,741.89**
201707	2	4	116	106,340	$ 123,395.08
201708	2	2	58	109,920	$ 127,527.54
201709	2	3	88	109,040	$ 126,516.91
201710	2	4	62	105,840	$ 122,794.74
201711	2	5	144	107,520	$ 124,774.05
201712	2	3	86	113,440	$ 131,620.91
201801	2	3	88	121,400	$ 140,854.51
201802	1	1	28	90,720	$ 105,245.37
201803	2	4	118	130,680	$ 151,629.48
201804	2	2	58	112,130	$ 130,091.14
201805	4	6	170	218,140	$ 253,103.42
201806	2	2	58	110,490	$ 128,188.74
ALPROLIX	**17**	**27**	**704**	**274,226**	**$ 831,179.37**
201707	2	2	56	21,008	$ 63,674.58
201708	2	2	56	21,008	$ 63,674.58
201709	2	2	56	20,896	$ 63,335.22

Row Labels	Count of Members	Count of Claims	Sum of Sum of Days	Sum of Sum of Qty	Sum of Sum of Amt Paid
201710	2	2	56	20,896	$ 63,335.22
201711	2	4	60	31,512	$ 95,522.04
201712	1	2	56	20,444	$ 61,965.66
201801	1	4	112	38,480	$ 116,635.08
201802	1	2	56	19,836	$ 60,123.42
201803	1	1	28	18,436	$ 55,871.25
201804	1	2	56	20,438	$ 61,947.48
201805	1	2	56	20,624	$ 62,511.06
201806	1	2	56	20,648	$ 62,583.78
BENEFIX	**14**	**32**	**703**	**257,233**	**$ 352,724.48**
201707	1	2	56	18,888	$ 25,896.90
201708	1	2	56	18,420	$ 25,255.74
201709	1	2	56	18,420	$ 25,255.74
201710	1	2	56	18,252	$ 25,025.58
201711	2	5	65	23,969	$ 32,878.21
201712	3	4	62	28,745	$ 39,421.33
201801	1	2	60	22,365	$ 30,660.39
201802	1	3	90	22,848	$ 31,332.27
201803	1	4	74	33,792	$ 46,335.72
201804	1	4	68	28,854	$ 39,570.66
201806	1	2	60	22,680	$ 31,091.94
CORIFACT	**12**	**13**	**339**	**18,033**	**$ 178,658.91**
201707	1	1	28	1,416	$ 14,028.57
201708	1	1	30	1,416	$ 14,028.57
201709	1	1	28	1,416	$ 14,028.57
201710	1	2	29	2,832	$ 28,057.14
201711	1	1	28	1,416	$ 14,028.57
201712	1	1	28	1,416	$ 14,028.57
201801	1	1	28	1,416	$ 14,028.57
201802	1	1	28	1,341	$ 13,286.07
201803	1	1	28	1,341	$ 13,286.07
201804	1	1	28	1,341	$ 13,286.07
201805	1	1	28	1,341	$ 13,286.07
201806	1	1	28	1,341	$ 13,286.07
ELOCTATE	**24**	**51**	**1,060**	**278,139**	**$ 587,381.79**
201707	2	5	86	20,621	$ 43,561.16
201708	2	5	88	21,742	$ 45,926.47
201709	2	3	57	20,280	$ 42,821.31
201710	2	2	56	18,720	$ 39,519.54
201711	2	3	84	18,712	$ 39,512.83
201712	2	6	120	33,656	$ 71,075.18
201801	2	9	146	37,355	$ 78,910.58
201802	1	1	28	8,192	$ 17,295.29
201803	2	7	142	34,395	$ 72,644.64
201804	2	3	84	20,760	$ 43,834.11
201805	3	4	85	22,946	$ 48,446.57
201806	2	3	84	20,760	$ 43,834.11

Row Labels	Count of Members	Count of Claims	Sum of Sum of Days	Sum of Sum of Qty	Sum of Sum of Amt Paid
HUMATE-P	**16**	**22**	**355**	**126,536**	**$ 159,046.18**
201707	4	5	92	34,376	$ 42,323.16
201708	1	2	56	6,036	$ 7,444.62
201709	1	2	56	5,528	$ 6,819.78
201710	1	2	2	5,468	$ 6,944.36
201711	3	3	57	33,548	$ 42,626.30
201712	2	2	56	19,512	$ 24,800.58
201801	1	1	26	9,188	$ 11,678.93
201802	1	3	6	5,048	$ 6,441.47
201804	1	1	2	3,986	$ 5,072.39
201806	1	1	2	3,846	$ 4,894.59
IDELVION	**1**	**3**	**84**	**10,978**	**$ 48,333.71**
201712	1	3	84	10,978	$ 48,333.71
KCENTRA	**1**	**1**	**1**	**2**	**$ 4.62**
201804	1	1	1	2	$ 4.62
KOGENATE FS	**23**	**37**	**934**	**3,693,220**	**$ 5,588,394.89**
201707	2	3	68	299,600	$ 446,434.51
201708	2	3	68	299,600	$ 446,434.51
201709	2	3	68	302,680	$ 451,023.71
201710	2	4	86	418,720	$ 623,933.48
201711	2	3	68	309,260	$ 460,827.91
201712	2	3	68	298,040	$ 444,110.11
201801	2	3	68	295,160	$ 451,625.31
201802	1	2	60	219,800	$ 336,314.34
201803	2	3	88	305,000	$ 466,680.51
201804	2	3	88	293,280	$ 448,748.91
201805	2	4	116	361,920	$ 553,778.28
201806	2	3	88	290,160	$ 458,483.31
MONOCLATE-P	**1**	**1**	**2**	**2,000**	**$ 2,170.17**
201707	1	1	2	2,000	$ 2,170.17
NOVOEIGHT	**10**	**10**	**262**	**1,316,760**	**$ 2,275,546.50**
201707	1	1	30	128,700	$ 220,087.17
201708	1	1	30	128,700	$ 220,087.17
201709	1	1	13	125,640	$ 214,854.57
201710	1	1	13	125,640	$ 214,854.57
201711	1	1	30	137,220	$ 234,656.37
201712	1	1	30	137,220	$ 234,656.37
201801	1	1	30	137,220	$ 234,656.37
201802	1	1	30	137,220	$ 242,889.57
201803	1	1	28	129,600	$ 229,402.17
201804	1	1	28	129,600	$ 229,402.17
NOVOSEVEN RT	**11**	**24**	**720**	**5,040,000**	**$ 10,785,844.08**
201707	1	2	60	420,000	$ 873,620.34
201708	1	2	60	420,000	$ 873,620.34
201709	1	2	60	420,000	$ 873,620.34
201710	1	2	60	420,000	$ 907,220.34
201711	1	2	60	420,000	$ 907,220.34

Row Labels	Count of Members	Count of Claims	Sum of Sum of Days	Sum of Sum of Qty	Sum of Sum of Amt Paid
201712	1	2	60	420,000	$ 907,220.34
201801	1	2	60	420,000	$ 907,220.34
201803	1	2	60	420,000	$ 907,220.34
201804	1	2	60	420,000	$ 907,220.34
201805	1	4	120	840,000	$ 1,814,440.68
201806	1	2	60	420,000	$ 907,220.34
NUWIQ	**13**	**23**	**548**	**364,392**	**$ 616,046.22**
201707	1	1	30	28,200	$ 47,668.17
201708	1	1	30	29,145	$ 49,265.22
201709	1	1	30	29,145	$ 49,265.22
201710	1	1	1	9,147	$ 15,458.43
201711	1	2	60	36,315	$ 61,392.69
201801	1	3	90	36,999	$ 62,558.82
201802	1	2	60	36,810	$ 62,229.24
201803	1	2	60	36,810	$ 62,229.24
201804	1	2	60	38,235	$ 64,637.49
201805	1	2	60	38,235	$ 64,637.49
201806	3	6	67	45,351	$ 76,704.21
VONVENDI	**1**	**5**	**5**	**17,883**	**$ 35,459.19**
201804	1	5	5	17,883	$ 35,459.19
WILATE	**8**	**9**	**103**	**420,082**	**$ 247,552.95**
201707	1	1	30	29,400	$ 38,230.17
201708	1	1	30	29,400	$ 38,230.17
201709	1	1	30	29,400	$ 38,230.17
201710	1	1	1	9,402	$ 12,222.60
201711	1	2	2	4,290	$ 5,577.00
201801	1	1	1	303,000	$ 94,536.00
201805	1	1	4	11,760	$ 15,886.17
201806	1	1	5	3,430	$ 4,640.67
XYNTHA SOLOFUSE	**11**	**15**	**363**	**179,889**	**$ 284,377.17**
201707	1	1	30	14,745	$ 23,307.27
201708	1	2	31	15,728	$ 24,870.58
201709	1	1	30	14,745	$ 23,307.27
201710	1	1	30	14,745	$ 23,307.27
201711	1	2	31	15,728	$ 24,870.58
201712	1	1	30	14,745	$ 23,307.27
201801	1	1	30	14,745	$ 23,307.27
201802	1	1	30	14,745	$ 23,307.27
201804	1	1	30	14,745	$ 23,307.27
201805	1	3	61	30,473	$ 48,177.85
201806	1	1	30	14,745	$ 23,307.27
Grand Total	**252**	**418**	**9,830**	**25,601,534**	**$ 41,642,948.45**

DRUG_NAME	MEMBER_AGE	CLM_COUNT	DAYS_SUPPLY	QUANTITY
Alphanate/VWF Complex/Human	0	1	30	540
Humate-P	25	1	3	3,988
Humate-P	25	1	3	1,952
Humate-P	25	1	3	1,347
Humate-P	43	1	4	3,988
Humate-P	43	1	4	7,904
NovoSeven RT	6	1	30	15,000
NovoSeven RT	6	1	12	12,000
NovoSeven RT	6	1	30	15,000
NovoSeven RT	6	1	30	15,000
Wilate	11	1	3	1,470
Wilate	11	1	3	3,120

PRESCRIBER_NPI	PRESCRIBER_SPECIALTY
1386680718	Pediatric Hematology-Oncology
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
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1942446042	Nurse Practitioner
1942446042	Nurse Practitioner
1942446042	Nurse Practitioner

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada Medicaid

Hemophilia Products

March 1, 2017 through April 30, 2018

Year/Month Filled/Paid	Drug Name	Count of Claims	Sum of Units
2017/03	HEMOPHILIA (various)	4	6
2017/04	HEMOPHILIA (various)	1	2
2017/05	HEMOPHILIA (various)	2	5
2017/06	HEMOPHILIA (various)	4	5
2017/07	HEMOPHILIA (various)	5	8
2017/08	HEMOPHILIA (various)	6	13
2017/09	HEMOPHILIA (various)	6	10
2017/10	HEMOPHILIA (various)	6	13
2017/11	HEMOPHILIA (various)	5	10
2017/12	HEMOPHILIA (various)	7	8
2018/01	HEMOPHILIA (various)	3	8
2018/02	HEMOPHILIA (various)	5	16

PLEASE NOTE: Capitated claims are not included in this data

J-Codes processed include: J7182, J7185, J7186, J7192, J7199, J7202, J7205

Nevada Medicaid
Irritable-Bowel Syndrome Agents
Pharmacy Coverage Guideline

Drug Name: Trulance (plecanatide)

Drug Name: Linzess (linaclotide)

Drug Name: Amitiza (lubiprostone)

CRITERIA FOR COVERAGE/NONCOVERAGE

Drug Name: Trulance (plecanatide)

Indications

Chronic Idiopathic Constipation Indicated in adults for the treatment of chronic idiopathic constipation (CIC).

Irritable Bowel Syndrome with Constipation (IBS-C) Indicated in adults for the treatment of irritable bowel syndrome with constipation (IBS-C).

Approval Length: 12 Months

1. Coverage and Limitations
    a. Approval will be given if the following criteria are met and documented
        i. The recipient is 18 years of age or older;

        AND

        ii. The requested agent is being prescribed based on FDA approved guidelines;

        AND

        1. For requests for a diagnosis of Irritable-Bowel Syndrome with Constipation (IBS-C):
            a. For requests for lubiprostone, the recipient must be female
            b. The requested dose is appropriate based on indication and age
                i. Linaclotide: 290 µg daily
                ii. Lubiprostone: 16 µg daily
                iii. Plecanatide: 3 mg daily

OR

2. For requests for a diagnosis of Irritable-Bowel Syndrome with Diarrhea (IBS-D):
    a. The medication is being prescribed by or in consultation with a gastroenterologist; and
    b. The requested dose is appropriate based on indication and age
        i. Alosetron: 0.5 mg twice daily or 1 mg twice daily
        ii. Eluxadoline: 75 mg twice daily or 100 mg twice daily
        iii. Rifaximin: 550 mg three times a day for 14 days

Amitiza (lubiprostone)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

***** *Maryland Medicaid see specific mandates below***

Medications	Quantity Limit
Amitiza (lubiprostone)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Amitiza (lubiprostone) may be approved if the following criteria is met:

I. Individual is 18 years of age or older; **AND**
II. Individual has a diagnosis of non-cancer pain-related opioid-induced* constipation (OIC);**AND**
III. The individual must have a previous trial of, or insufficient response to polyethylene glycol (generic MiraLax);

OR
IV. Individual is 18 years of age or older; **AND**
V. Individual has a diagnosis of irritable bowel syndrome with constipation (IBS-C); **AND**
VI. The individual must have a previous trial of, or insufficient response to polyethylene glycol (generic MiraLax);

OR
VII. Individual is 18 years of age or older; **AND**
VIII. Individual has a diagnosis of chronic idiopathic constipation (CIC); **AND**
IX. The individual must have a previous trial of, or insufficient response to polyethylene glycol (generic MiraLax).

Amitiza (lubiprostone) may not be approved for the following:

I. Individual has a known or suspected mechanical gastrointestinal obstruction.

*__Note__: Effectiveness of Amitiza in individuals taking diphenylheptane opioids (for example, methadone) has not been established.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
Maryland		Trial of polyethylene glycol (PEG) is not required

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed January 30, 2017.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

Linzess (linaclotide)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

****** Maryland Medicaid see specific mandates below***

Medications	Quantity Limit
Linzess (linaclotide)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Linzess (linaclotide) may be approved if the following criteria are met:

I. Individual is 18 years of age or older; **AND**
II. Individual has a diagnosis of chronic idiopathic constipation (CIC); **AND**
III. Individual must have a previous trial of, or insufficient response to polyethylene glycol (generic MiraLax);

OR

IV. Individual is 18 years of age or older; **AND**
V. Individual has a diagnosis of irritable bowel syndrome with constipation (IBS-C). **AND**
VI. Individual must have a previous trial of, or insufficient response to polyethylene glycol (generic MiraLax)

Linzess (linaclotide) **may not** be approved for the following:

I. Individual has a known or suspected mechanical gastrointestinal obstruction.

Note: Linzess (linaclotide) has a black box warning for pediatric risk. Use is contraindicated in individuals up to 6 years of age. Use should be avoided in individuals 6 through 17. Linzess has caused deaths in young juvenile mice at clinically relevant adult doses.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
Maryland		Trial of polyethylene glycol (PEG) is not required

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed January 30, 2017.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

Trulance (plecanatide)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

***** *Maryland Medicaid see specific mandates below***

Medications	Quantity Limit
Trulance (plecanatide)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Trulance (plecanatide) may be approved if the following criteria is met:

I. Individual is 18 years of age or older; **AND**

II. Individual has chronic idiopathic constipation (CIC); **AND**

III. The individual must have a previous trial of or insufficient response to polyethylene glycol (generic MiraLax) (AGA 2013).

Note: Trulance (plecanatide) is contraindicated in pediatric patients less than 6 years of age; in nonclinical studies in young juvenile mice, administration of a single oral dose of plecanatide caused deaths due to dehydration. Avoid use of plecanatide in patients 6 years to less than 18 years of age. The safety and efficacy of plecanatide has not been established in patients less than 18 years of age.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
Maryland		Trial of polyethylene glycol (PEG) is not required

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed January 30, 2017.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

Viberzi (eluxadoline)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Viberzi (eluxadoline)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Viberzi (eluxadoline) may be approved for individuals who meet the following criteria:

I. Individual has been on Viberzi (eluxadoline) in the past 180 days (medication samples/ coupons/ discount cards are excluded from consideration as a trial) **(DOES NOT APPLY FOR EXCHANGE BUSINESS)**;

OR

II. Individual is 18 years of age or older; **AND**

III. Individual is using for the treatment of irritable bowel syndrome with diarrhea (IBS-D); **AND**

IV. Individual has had a trial and inadequate response or intolerance to two of the following medications or has a contraindication to all of the following medications:

   A. Loperamide; **OR**

   B. Antispasmodics (hyoscyamine, dicyclomine); **OR**

   C. Tricyclic antidepressants (AGA 2014).

Viberzi (eluxadoline) may **not** be approved for an individual with any of the following:

I. History of severe constipation or complications resulting from constipation; **OR**

II. Biliary duct obstruction or sphincter of Oddi dysfunction; **OR**

III. History of pancreatitis or structural disease of the pancreas; **OR**

IV. Excessive alcohol intake (more than 3 alcoholic beverages per day); **OR**

V. Severe hepatic impairment (Child-Pugh Class C); **OR**

VI. Concomitant use with Lotronex (alosetron);**OR**

VII. History of cholecystectomy or absence of a gallbladder.

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed January 30, 2017.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

Lotronex (alosetron)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Lotronex (alosetron) 0.5mg, 1mg tablets	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Lotronex (alosetron) may be approved based on the following criteria:

I. Individual is female age 18 or over; **AND**
II. Individual has a diagnosis of severe diarrhea-predominant Irritable Bowel Syndrome (IBS) defined as including diarrhea and one or more of the following:
   A. Frequent and severe abdominal pain/discomfort; **OR**
   B. Frequent bowel urgency or fecal incontinence; **OR**
   C. Disability or restriction of daily activities due to IBS;

AND
III. Individual has chronic symptoms of IBS that have persisted for 6 months or longer; **AND**
IV. Individual does NOT have an anatomic or biochemical abnormality of the gastrointestinal tract (e.g., intestinal obstruction, stricture, hypercoagulable state); **AND**
V. Individual has had a trial and inadequate response or intolerance to two of the following medications or has a contraindication to all of the following medications
   A. Loperamide; **OR**
   B. Antispasmodics (hyoscyamine, dicyclomine); **OR**
   C. Tricyclic antidepressants (AGA 2014).

Lotronex (alosetron) may not be approved for any of the following:

I. Individuals with constipation, history of chronic or severe constipation, or complications resulting from constipation; **OR**
II. Individuals with a history of severe bowel disorders (such as but not limited to, intestinal obstruction, ischemic colitis, Crohn's disease, ulcerative colitis, or diverticulitis); **OR**
III. Individual has a diagnosis of severe hepatic impairment (Child-Pugh Class C); **OR**
IV. Concomitant use with fluvoxamine; **OR**
V. Concomitant use with Viberzi (eluxadoline).

Note:
Lotronex (alosetron) has a black box warning for serious gastrointestinal adverse reactions. Infrequent but serious gastrointestinal adverse reactions, including ischemic colitis and serious complications of constipation, have resulted in hospitalization, and rarely, blood transfusion, surgery, and death. The FDA has required the manufacturer to develop a comprehensive risk management program that includes the enrollment of physicians in the Lotronex REMS Program. Additional information and forms for individuals, prescribers, and pharmacists may be found on the manufacturer's website: http://www.lotronexrems.com.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

Health Plan of Nevada

Irritable Bowel Syndrome Agents

Criteria Recommendation

HPN does not have an official policy for the products in this class. Coverage is below and class is currently under review from a formulary perspective.

COVERED AGENTS:
- Linzess - diagnosis required

NON-FORMULARY AGENTS: (require appropriate use per label and failure of formulary alternatives)
- Amitiza
- Viberzi
- Xifaxan
- Lotronex
- Trulance

Clinical Policy: Linaclotide (Linzess)

Reference Number: CP.PMN.71
Effective Date: 11.01.15
Last Review Date: 02.18
Line of Business: Health Insurance Marketplace, Medicaid Revision Log
See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Linaclotide (Linzess®) is a guanylate cyclase-C agonist.

FDA Approved Indication(s)

Linzess is indicated:

- For the treatment of irritable bowel syndrome with constipation (IBS-C) in adults
- For the treatment of chronic idiopathic constipation (CIC) in adults

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Linzess is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Irritable Bowel Syndrome with Constipation (must meet all)**:**

1. Diagnosis of IBS-C;
2. Age ≥ 18 years;
3. Failure of one bulk forming laxative (e.g., psyllium [Metamucil], methylcellulose [Citrucel], calcium polycarbophil [FiberCon]), unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 290 mcg per day (1 capsule per day).

Approval duration: 12 months

B. Chronic Idiopathic Constipation (must meet all)**:**

1. Diagnosis of CIC;
2. Age ≥ 18 years;
3. Failure of one bulk forming laxative (e.g., psyllium [Metamucil], methylcellulose [Citrucel], calcium polycarbophil [FiberCon]), unless all are contraindicated or clinically significant adverse effects are experienced;
4. Failure of one stimulant laxative (e.g., bisacodyl, senna), unless all are contraindicated or clinically significant adverse effects are experienced;
5. Failure of polyethylene glycol (MiraLax) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 145 mcg per day (1 capsule per day).

Approval duration: 12 months

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed:
   a. IBS-C: 290 mcg per day (1 capsule per day);
   b. CIC: 145 mcg per day (1 capsule per day).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CIC: chronic idiopathic constipation
FDA: Food and Drug Administration
IBS-C: irritable bowel syndrome with constipation

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
psyllium (Metamucil®)	1 rounded teaspoonful, tablespoonful, or premeasured packet in 240 mL of fluid	7.2 g (as soluble dietary fiber) per day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	PO, 1 to 3 times per day (2.4 g of soluble dietary fiber per dose)	
calcium polycarbophil (FiberCon®)	1,000 mg 1 to 4 times per day or as needed	6,000 mg per day
methylcellulose (Citrucel®)	Caplet: 2 caplets (total 1 g methylcellulose) PO with at least 240 ml (8 oz) of liquid, up to 6 times per day as needed Powder: 1 heaping tablespoonful (2 g methylcellulose per 19 g powder) in at least 240 ml (8 oz) of water PO, given 1 to 3 times per day as needed	Caplet: 12 caplets per day Powder: 6 grams per day
sennosides (Senokot®)	1 to 2 tablets (8.6 to 17.2 mg sennosides) PO twice daily	68.8 mg sennosides per day
bisacodyl (Dulcolax®)	5 to 15 mg/day (1 to 3 tablets) PO given as a single dose, or 1 suppository or retention enema (10 mg) PR once daily Either a suppository or oral tablet(s) may be used up to 3 times per week	15 mg per day PO or 10 mg per day PR
polyethylene glycol 3350 (MiraLax®)	17 g (approximately 1 heaping tablespoon) of powder in 120 to 240 mL of fluid PO once daily	34 grams per day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IBS-C	290 mcg PO once daily	290 mcg per day
CIC	72 mcg or 145 mcg PO once daily	145 mcg per day

VI. Product Availability

Capsules: 72 mcg, 145 mcg, and 290 mcg

VII. References

1. Linzess Prescribing Information. Irvine, CA: Allergan; January 2017. Available at: https://www.linzess.com/. Accessed November 7, 2017.
2. Ford AC, Moayyedi P, Lacy BE, et al. American College of Gastroenterology monograph on the management of irritable bowel syndrome and chronic idiopathic constipation. Am J Gastroenterol 2014; 109: S2-S26.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New guideline created	09.15	11.15
Converted to new integrated template. Added FDA max recommended dose and health plan approved QL requirement; -IBS-C: removed requirement related to failure of adherent use of polyethylene glycol (PEG) per recommendations from American College of Gastroenterology that there is no evidence that PEG formulations alleviate pain or provide overall symptom relief in IBS. -CIC: Added language of "unless contraindicated to such therapies" to requirement related to aforementioned medication trials must have occurred within the past 90 days; Updated references to reflect current literature search	08.16	11.16
Converted to new template. Updated max dose requirement to include specific QL. Added a requirement that member is responding positively to therapy on re-auth.	08.22.17	11.17
1Q18 annual review. - Policies combined for Medicaid and marketplace lines of business - Removed duration and timeframe of trial related to laxative use since they are available OTC and may not be verifiable via claims history - Medicaid: modified initial approval duration from 6 to 12 months for both indications - References reviewed and updated.	11.07.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

Clinical Policy: Mesalamine Oral Therapy

Reference Number: CP.PST.08
Effective Date: 11/11
Last Review Date: 05/17
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Mesalamine is an aminosalicylate. The following mesalamine products require prior authorization: Apriso™, Asacol® HD, Pentasa®, and Delzicol®.

FDA Approved Indication(s)

Oral mesalamine is indicated for ulcerative colitis.

Limitation of use:

- Asacol HD: Safety and effectiveness of Asacol HD beyond 6 weeks have not been established.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that mesalamine (Apriso, Asacol HD, Pentasa) is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Step Therapy for Oral Mesalamine (must meet all)**:**

1. One of the following applies (a or b)
   a. Request for Delzicol: previous use of Lialda at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced; **Generic Lialda is a preferred agent*
   b. Request for all other agents: must meet the following (i and ii):
      i. Previous use of 3 consecutive months of sulfasalazine, sulfasalazine EC, or balsalazide at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
      ii. Previous use of 3 consecutive months of two preferred oral mesalamine agents at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
2. Dose does not exceed FDA approved maximum recommended dose.

Approval duration: 12 months

II. Continued Therapy

A. Step Therapy for Oral Mesalamine (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. If request is for a dose increase, new dose does not exceed FDA approved maximum recommended dose.

Approval duration: 12 months

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food & Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
sulfasalazine, sulfasalazine EC (Azulfidine®)	1 g by mouth every 6 to 8 hours EC: 3 to 4 g by mouth every 8 hours	4 g/day
Balsalazide (Colazal®)	Three 750 mg capsules by mouth three times per day	6.75 g/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

IV. Dosage and Administration

Drug	Dosing Regimen	Maximum Dose
Apriso (mesalamine)	Four 0.375 g capsules daily	1.5 g/day
Asacol HD (mesalamine)	1600 mg three times a day	4.8 g/day
Lialda (mesalamine)	Two to four 1.2 g tablets daily	4.8 g/day
Pentasa (mesalamine)	1 g four times a day (total of 4 g daily)	4 g/day
Delzicol (mesalamine)	Two 400 mg capsules three times daily	2.4 g/day

V. Product Availability

Drug Name	Availability
Apriso (mesalamine)	0.375 mg extended-release capsule
Asacol HD (mesalamine)	800 mg delayed-release tablet
Lialda (mesalamine)	1.2 g delayed-release tablet
Pentasa (mesalamine)	250 mg, 500 mg controlled-release capsule
Delzicol (mesalamine)	Delayed-release capsules (containing four 100 mg tablets): 400 mg

VI. Workflow Document

N/A

VII. References

1. Kornbluth A and Sachar DB, "Ulcerative Colitis Practice Guidelines in Adults: American College of Gastroenterology, Practice Parameters Committee," Am J Gastroenterol, 2010, 105(3):501-23.

2. Mottet C, Vader JP, Felley C, et al, "Appropriate Management of Special Situations in Crohn's Disease (Upper Gastro-Intestinal; Extra-Intestinal Manifestations; Drug Safety during Pregnancy and Breastfeeding): Results of a Multidisciplinary International Expert Panel-EPACT II," J Crohns Colitis, 2009, 3(4):257-63.
3. Mesalamine. In: Clinical Pharmacology. Tampa, FL: Gold Standard; 2015. Available athttp://www.clinicalpharmacology-ip.com. Accessed November 2017.
4. Asacol HD Prescribing Information. Irvine, CA: Allergan USA, Inc.; May 2016. Available at http://www.allergan.com. Accessed November 2017.
5. Apriso Prescribing Information. Raleigh, NC: Salix Pharmaceuticals, Inc., July 2009. Available at https://www.aprisorx.com. Accessed November 2017.
6. Lialda Prescribing Information. Lexington, MA: Shire US Inc., November 2015. Available at http://pi.shirecontent.com. Accessed November 2017.
7. Pentasa Prescribing Information. Lexington, MA: Shire US Inc.,October 2015. Available at https://www.pentasaus.com/. Accessed November 2017.
8. Delzicol Prescribing Information. Irvine, CA: Allergan USA, Inc. July 2017. Available at https://www.delzicol.com/. Accessed November 5, 2017.

Reviews, Revisions, and Approvals	Date	Approval Date
Updated reference section to reflect current literature search.	11.12	11.12
Deleted Asacol and added Delzicol from “Brand” because it has been discontinued by manufacturer and replaced with Delzicol. Added Apriso and Lialda to available brand and separated PDL and non PDL brands. Modified FDA labeled indication to be applicable to all oral mesalamine formulation. Deleted the criteria A and B because the relevant medication currently have no step therapy edit and changed it to request trial and failure of PDL ulcerative colitis agents. Updated approval criteria to initial approval period to 6 months and renewal to 12 months to allow monitoring for compliance during the initial 6 months of approval. Added supporting references for the new criteria and updated previous references to reflect current literature search.	11.13	11.13
Updated preferred/non-preferred language. Updated references	12.14	12.14
Guideline converted to new template Clarified that a PDL oral mesalamine must be used for 3 “consecutive” months Added that request must not exceed the FDA approve dose to criteria Reviewed and updated references	11.15	11.15
Converted to integrated template; Updated references.	09.16	11.16
Require failure of 2 PDL mesalamine products instead of only one mesalamine product Updated references	03.17	05.17

Reviews, Revisions, and Approvals	Date	Approval Date
Liadal removed from list of drug requiring PA based on addition of generic Lialda to formulary. Added criteria for Delzicol requiring a step through Lialda based on SDC decision.	11.01.17	
1Q18 annual review: - No significant changes. - References reviewed and updated.	11.05.17	02.18

Important Reminder

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Irritable Bowel Syndrome Medications

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Sum of Days	Sum of Sum of Qty	Sum of Sum of Amt Paid
AMITIZA	**668**	**714**	**23,215**	**42,062**	**$ 156,568.29**
201707	59	62	2,028	3,433	$ 9,008.68
201708	58	60	1,835	3,240	$ 11,840.39
201709	55	59	1,962	3,573	$ 15,652.84
201710	54	61	1,841	3,441	$ 14,535.49
201711	53	54	1,816	3,512	$ 16,240.30
201712	56	60	1,820	3,308	$ 13,338.71
201801	63	68	2,160	3,840	$ 11,233.29
201802	50	50	1,613	2,986	$ 11,696.61
201803	55	58	1,915	3,530	$ 11,376.97
201804	58	67	2,402	4,294	$ 15,552.40
201805	52	57	1,944	3,627	$ 13,558.53
201806	55	58	1,879	3,278	$ 12,534.08
LINZESS	**1,923**	**2,023**	**71,214**	**71,374**	**$ 359,464.84**
201707	146	153	5,280	5,338	$ 22,682.35
201708	153	169	5,783	5,743	$ 28,353.10
201709	156	163	5,340	5,323	$ 26,896.55
201710	155	163	5,788	5,818	$ 30,335.89
201711	135	141	4,755	4,738	$ 27,434.72
201712	136	141	4,738	4,798	$ 27,455.43
201801	183	198	7,215	7,258	$ 34,131.77
201802	168	171	5,906	5,906	$ 28,575.46
201803	175	185	6,897	6,910	$ 33,479.27
201804	170	177	6,498	6,528	$ 36,338.75
201805	180	190	6,866	6,866	$ 32,304.37
201806	166	172	6,148	6,148	$ 31,477.18
MOVANTIK	**749**	**790**	**25,439**	**25,544**	**$ 200,954.83**
201707	58	60	1,845	1,875	$ 14,216.68
201708	64	76	2,231	2,261	$ 17,046.07
201709	64	67	2,250	2,235	$ 18,045.74
201710	75	78	2,640	2,625	$ 20,728.14
201711	62	65	2,001	2,031	$ 17,352.85
201712	49	52	1,611	1,611	$ 14,540.31
201801	68	72	2,354	2,414	$ 19,487.16
201802	57	58	1,959	1,959	$ 14,019.61
201803	61	64	2,100	2,085	$ 16,583.92
201804	67	68	2,257	2,257	$ 17,846.44
201805	64	68	2,211	2,211	$ 16,729.84
201806	60	62	1,980	1,980	$ 14,358.07
RELISTOR	**293**	**305**	**7,708**	**19,385**	**$ 320,610.45**
201707	18	19	495	1,150	$ 20,840.84

Row Labels	Sum of Count of Members	Sum of Count of Claims	Sum of Sum of Days	Sum of Sum of Qty	Sum of Sum of Amt Paid
201708	22	22	569	1,265	$ 27,723.32
201709	22	22	513	1,232	$ 23,970.71
201710	20	21	568	1,312	$ 28,310.76
201711	20	21	541	1,407	$ 25,841.84
201712	19	19	570	1,346	$ 23,525.22
201801	26	29	678	1,645	$ 25,653.30
201802	32	32	740	1,827	$ 28,845.36
201803	29	31	760	2,100	$ 31,982.50
201804	37	38	821	2,139	$ 34,326.55
201805	26	29	673	1,884	$ 25,945.75
201806	22	22	780	2,078	$ 23,644.30
SYMPROIC	**44**	**45**	**1,410**	**1,410**	**$ 14,867.60**
201711	5	5	150	150	$ 1,620.60
201712	7	7	210	210	$ 2,268.84
201801	21	22	720	720	$ 7,758.54
201802	2	2	60	60	$ 648.24
201803	2	2	60	60	$ 648.24
201804	3	3	90	90	$ 972.36
201805	2	2	60	60	$ 327.82
201806	2	2	60	60	$ 622.96
TRULANCE	**70**	**76**	**2,940**	**2,940**	**$ 32,484.16**
201707	5	5	210	210	$ 2,504.66
201708	4	5	150	150	$ 1,740.50
201709	10	10	480	480	$ 5,498.55
201710	8	9	330	330	$ 3,808.75
201711	5	5	150	150	$ 1,740.50
201712	7	8	300	300	$ 2,771.85
201801	8	8	480	480	$ 5,645.55
201802	5	5	150	150	$ 1,529.90
201803	3	4	120	120	$ 1,148.35
201804	6	6	240	240	$ 2,654.20
201805	3	4	120	120	$ 1,526.20
201806	6	7	210	210	$ 1,915.15
VIBERZI	**11**	**11**	**450**	**900**	**$ 13,811.07**
201707	2	2	60	120	$ 1,014.26
201709	1	1	30	60	$ 1,013.12
201710	2	2	120	240	$ 4,032.14
201712	1	1	30	60	$ 3.70
201802	1	1	30	60	$ 1,109.74
201803	1	1	90	180	$ 3,308.89
201804	1	1	30	60	$ 1,109.74
201805	1	1	30	60	$ 1,109.74
201806	1	1	30	60	$ 1,109.74
Grand Total	**3,758**	**3,964**	**132,376**	**163,615**	**$ 1,098,761.24**

YEAR_MONTH	DRUG_NAME	MBR_COUNT	CLM_COUNT	DAYS_SUPPLY	QUANTITY
201706	AMITIZA	11	11	360	660
201706	LINZESS	27	27	810	810
201706	VIBERZI	1	1	30	60
201707	AMITIZA	16	17	483	846
201707	LINZESS	33	35	1,050	1,050
201707	TRULANCE	1	1	30	30
201707	VIBERZI	1	1	30	60
201708	AMITIZA	7	7	210	390
201708	LINZESS	32	37	1,110	1,110
201708	VIBERZI	1	1	30	60
201709	AMITIZA	14	14	405	780
201709	LINZESS	32	32	960	960
201709	TRULANCE	1	1	30	30
201709	VIBERZI	1	1	30	60
201710	AMITIZA	12	12	360	690
201710	LINZESS	31	35	1,050	1,050
201711	AMITIZA	10	10	300	600
201711	LINZESS	33	37	1,110	1,110
201712	AMITIZA	9	9	270	510
201712	LINZESS	31	32	960	960
201712	TRULANCE	1	1	30	30
201801	AMITIZA	14	15	450	840
201801	LINZESS	37	39	1,170	1,170
201802	AMITIZA	14	14	420	840
201802	LINZESS	35	36	1,110	1,110
201803	AMITIZA	17	18	540	1,020
201803	LINZESS	39	41	1,230	1,230
201803	VIBERZI	1	1	30	60
201804	AMITIZA	19	20	577	1,154
201804	LINZESS	42	45	1,350	1,350
201804	VIBERZI	1	1	30	60
201805	AMITIZA	17	18	540	1,020
201805	LINZESS	42	43	1,290	1,290
201805	TRULANCE	1	1	30	30
201805	VIBERZI	2	2	60	120

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Irritable Bowel Syndrome Utilization

August 1, 2017 - May 31, 2018

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2017/08	AMITIZA CAP 24MCG	1	1	60
2017/08	LINZESS CAP 145MCG	2	2	60
2017/08	LINZESS CAP 290MCG	10	10	300
2017/08	LINZESS CAP 72MCG	1	1	30
2017/09	AMITIZA CAP 24MCG	5	5	270
2017/09	AMITIZA CAP 8MCG	2	2	120
2017/09	LINZESS CAP 145MCG	43	44	1,320
2017/09	LINZESS CAP 290MCG	61	63	1,890
2017/09	LINZESS CAP 72MCG	5	5	150
2017/09	VIBERZI TAB 75MG	2	2	120
2017/09	XIFAXAN TAB 550MG	14	14	786
2017/10	AMITIZA CAP 24MCG	7	9	510
2017/10	AMITIZA CAP 8MCG	5	5	250
2017/10	LINZESS CAP 145MCG	50	51	1,515
2017/10	LINZESS CAP 290MCG	67	71	2,130
2017/10	LINZESS CAP 72MCG	4	4	120
2017/10	VIBERZI TAB 75MG	3	3	180
2017/10	XIFAXAN TAB 550MG	15	15	800
2017/11	AMITIZA CAP 24MCG	7	8	445
2017/11	AMITIZA CAP 8MCG	2	2	120
2017/11	LINZESS CAP 145MCG	47	47	1,440
2017/11	LINZESS CAP 290MCG	61	64	1,920
2017/11	LINZESS CAP 72MCG	5	5	150
2017/11	VIBERZI TAB 75MG	2	2	120
2017/11	XIFAXAN TAB 550MG	16	16	879
2017/12	AMITIZA CAP 24MCG	10	10	690
2017/12	AMITIZA CAP 8MCG	2	2	120
2017/12	LINZESS CAP 145MCG	42	44	1,320
2017/12	LINZESS CAP 290MCG	64	66	1,980
2017/12	LINZESS CAP 72MCG	6	6	180
2017/12	VIBERZI TAB 100MG	2	2	120
2017/12	VIBERZI TAB 75MG	1	1	60
2017/12	XIFAXAN TAB 550MG	14	15	854
2018/01	AMITIZA CAP 24MCG	11	11	580
2018/01	AMITIZA CAP 8MCG	2	2	120
2018/01	LINZESS CAP 145MCG	53	53	1,575
2018/01	LINZESS CAP 290MCG	63	69	2,070
2018/01	LINZESS CAP 72MCG	10	10	300

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2018/01	VIBERZI TAB 100MG	1	1	60
2018/01	VIBERZI TAB 75MG	1	1	60
2018/01	XIFAXAN TAB 550MG	13	14	804
2018/02	AMITIZA CAP 24MCG	9	9	510
2018/02	AMITIZA CAP 8MCG	2	2	90
2018/02	LINZESS CAP 145MCG	48	49	1,500
2018/02	LINZESS CAP 290MCG	65	65	1,950
2018/02	LINZESS CAP 72MCG	11	11	330
2018/02	VIBERZI TAB 100MG	2	2	120
2018/02	VIBERZI TAB 75MG	1	1	60
2018/02	XIFAXAN TAB 550MG	8	10	600
2018/03	AMITIZA CAP 24MCG	9	9	510
2018/03	AMITIZA CAP 8MCG	3	3	150
2018/03	LINZESS CAP 145MCG	46	51	1,515
2018/03	LINZESS CAP 290MCG	64	67	2,010
2018/03	LINZESS CAP 72MCG	11	13	390
2018/03	VIBERZI TAB 100MG	1	1	60
2018/03	VIBERZI TAB 75MG	1	1	60
2018/03	XIFAXAN TAB 200MG	1	1	120
2018/03	XIFAXAN TAB 550MG	11	11	570
2018/04	AMITIZA CAP 24MCG	7	8	450
2018/04	AMITIZA CAP 8MCG	2	2	120
2018/04	LINZESS CAP 145MCG	46	47	1,410
2018/04	LINZESS CAP 290MCG	69	72	2,160
2018/04	LINZESS CAP 72MCG	11	12	360
2018/04	VIBERZI TAB 100MG	3	3	180
2018/04	VIBERZI TAB 75MG	1	1	60
2018/04	XIFAXAN TAB 200MG	2	2	128
2018/04	XIFAXAN TAB 550MG	12	12	702
2018/05	AMITIZA CAP 24MCG	10	10	570
2018/05	AMITIZA CAP 8MCG	2	2	90
2018/05	LINZESS CAP 145MCG	56	61	1,830
2018/05	LINZESS CAP 290MCG	74	83	2,490
2018/05	LINZESS CAP 72MCG	10	10	300
2018/05	VIBERZI TAB 100MG	2	2	120
2018/05	XIFAXAN TAB 200MG	1	2	40
2018/05	XIFAXAN TAB 550MG	14	14	754

WW. Irritable-Bowel Syndrome Agents

Therapeutic Class: Irritable-Bowel Syndrome Agents
Last Reviewed by the DUR Board: July 28, 2016
Viberzi® last reviewed April 28, 2016

Irritable-Bowel Syndrome Agents are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

    a. Approval will be given if the following criteria are met and documented:

        1. The recipient is 18 years of age or older; and

        2. The requested agent is being prescribed based on FDA approved guidelines; and

            a. For requests for a diagnosis of Irritable-Bowel Syndrome with Constipation (IBS-C):

                1. For requests for lubiprostone, the recipient must be female.

                2. The requested dose is appropriate based on indication and age.

                    a. Linaclotide: 290 μg daily.

                    b. Lubiprostone: 16 μg daily.

            b. For requests for a diagnosis of Irritable-Bowel Syndrome with Diarrhea (IBS-D):

                1. The medication is being prescribed by or in consultation with a gastroenterologist; and

                2. The requested dose is appropriate based on indication and age.

                    a. Alosetron: 0.5 mg twice daily or 1 mg twice daily.

                    b. Eluxadoline: 75 mg twice daily or 100 mg twice daily.

                    c. Rifaximin: 550 mg three times a day for 14 days.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be given for an appropriate length of therapy based on the requested agent and diagnosis, not to exceed one year.

   b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Nevada Medicaid
Symdeko (tezacaftor/ivacaftor)
Pharmacy Coverage Guideline

Drug Name: Symdeko (tezacaftor/ivacaftor)

CRITERIA FOR COVERAGE/NONCOVERAGE

Indications

Drug Name: Symdeko (tezacaftor/ivacaftor)

Indications

Cystic Fibrosis (CF) Indicated for the treatment of patients with cystic fibrosis (CF) aged 12 years and older who are homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.

Initial Authorization:

Approval Length: 12 Months

Approval Criteria

1 Patient is 12 years of age or older

AND

2 Diagnosis of cystic fibrosis (CF)

AND

3 One of the following:

3.1 Patient is homozygous for the F508del mutation as detected by a FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility

OR

3.2 Patient has one of the FDA Approved Package Insert listed mutations on at least one allele in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility.

AND

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

- Pulmonologist
- Specialist affiliated with a CF care center

Reauthorization:

Approval Length: 12 Months

Approval Criteria:

1 Documentation of a positive clinical response to Symdeko (tezacaftor/ivacaftor) therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations)

Symdeko (tezacaftor/ivacaftor)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Symdeko (tezacaftor/ivacaftor)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Symdeko (tezacaftor/ivacaftor) may be approved if the following are met:

I. Individual has a diagnosis of cystic fibrosis (CF); **AND**
II. Individual is 12 years of age or older; **AND**
III. A copy of the CF mutation analysis test result must be provided; **AND**
IV. Individual has a mutation-positive result in the cystic fibrosis transmembrane conductance regulator (CFTR) gene with one of the following mutation types:

E56K	R117C	A455E	S945L	R1070W	3272-26A→G
P67L	E193K	F508del*	S977F	F1074L	3849+10kbC→T
R74W	L206W	D579G	F1052V	D1152H	
D110E	R347H	711+3A→G	K1060T	D1270N	
D110H	R352Q	E831X	A1067T	2789+5G→A	

*Individual must have two copies of the F508del mutation.

NOTE: All requests for California Medicaid individuals less than 21 years of age will be reviewed by the health plan.

State Specific Mandates		
State name California Medicaid	Date effective 3/5/2018	Request from California Children's Services to have all requests for Symdeko in individuals less than 21 years of age to be reviewed by the health plan.

Key References:

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: February 13, 2018.

UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Symdeko

Program	Prior Authorization
Medication	Symdeko (tezacaftor/ivacaftor)
Markets in Scope	Arizona, California, Florida-CHIP, Hawaii, Maryland, Nevada, New Mexico, New York, New York EPP, Ohio, Rhode Island
Issue Date	2/2018
Pharmacy and Therapeutics Approval Date	2/2018
Effective Date	4/2018

1. Background:

Symdeko is a combination of tezacaftor and ivacaftor, indicated for the treatment of patients with cystic fibrosis (CF) aged 12 years and older who are homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence.

If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.

2. Coverage Criteria:

A. <u>Initial Authorization</u>

1. **Symdeko** will be approved based upon **<u>all</u>** of the following criteria:

   a. Diagnosis of cystic fibrosis (CF)

   -AND-

   b. Submission of laboratory resulting documenting **<u>one</u>** of the following:

      (1) The patient is homozygous for the F508del mutation in the CFTR gene

      -OR-

      (2) The patient has at least **<u>one</u>** of the following mutations in the CFTR gene that is responsive to Symdeko:

A1067T	D1270N	F1052V	R1070W	S945L	3272-26A→G
A455E	D579G	F1074L	R117C	S977F	3849+10kbC→T
D110E	E193K	K1060T	R347H		711+3A→G
D110H	E56K	L206W	R352Q		2789+5G→A
D1152H	E831X	P67L	R74W		

-AND-

c. The patient is ≥ 12 years of age

-AND-

d. Prescribed by or in consultation with a specialist affiliated with a CF care center

Authorization will be issued for 6 months.

B. Reauthorization

1. **Symdeko** will be approved based on **both** of the following criteria:

a. Provider attests that the patient has achieved a clinically meaningful response while on Symdeko therapy to **one** of the following:

(1) Lung function as demonstrated by percent predicted expiratory volume in 1 second ($ppFEV_1$)
(2) Body mass index (BMI)
(3) Pulmonary exacerbations
(4) Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

-AND-

b. Prescribed by or in consultation with a specialist affiliated with a CF care center

Authorization will be issued for 12 months.

3. References:

1. Symdeko. Cambridge, MA: Vertex Pharmaceuticals, Inc.; February 2018.

Program	Prior Authorization
Change Control	
Date	Change
2/2018	New Program

Clinical Policy: Tezacaftor/Ivacaftor; Ivacaftor (Symdeko)

Reference Number: CP.PHAR.377
Effective Date: 04.03.18
Last Review Date: 05.18
Line of Business: Commercial, Medicaid Revision Log
See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tezacaftor/ivacaftor; ivacaftor (Symdeko™) is a combination drug for cystic fibrosis (CF).

- Tezacaftor facilitates the cellular processing and trafficking of normal and select mutant forms of cystic fibrosis transmembrane conductance regulator [*CFTR*; (including *F508del-CFTR*)] to increase the amount of mature *CFTR* protein delivered to the cell surface.
- Ivacaftor is a *CFTR* potentiator that facilitates increased chloride transport by potentiating the channel-open probability (or gating) of the *CFTR* protein at the cell surface.
- The combined effect of tezacaftor and ivacaftor is increased quantity and function of *CFTR* at the cell surface, resulting in increases in chloride transport.

FDA Approved Indication(s)

Symdeko is indicated for the treatment of patients with CF aged 12 years and older who are homozygous for the *F508del* mutation or who have at least one mutation in the *CFTR* gene that is responsive to tezacaftor/ivacaftor based on *in vitro* data and/or clinical evidence.

If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Symdeko is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cystic Fibrosis (must meet all)**:**

1. Diagnosis of CF;
2. Age ≥ 12 years;
3. One of the following (a or b):
   a. Member is homozygous for the *F508del* mutation in the *CFTR* gene;
   b. Presence of at least one mutation in the *CFTR* gene that is responsive to Symdeko based on *in vitro* data and/or clinical evidence (*see Appendix C*);
4. Dose does not exceed tezacaftor 100 mg/ivacaftor 300 mg per day (1 tablet tezacaftor; ivacaftor and 1 tablet ivacaftor per day).

Approval duration:
Medicaid/HIM – 6 months

Commercial – Length of benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Cystic Fibrosis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed tezacaftor 100 mg/ivacaftor 300 mg per day (1 tablet tezacaftor; ivacaftor and 1 tablet ivacaftor per day).

Approval duration:
Medicaid/HIM – 12 months
Commercial – Length of benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CF: cystic fibrosis
CFTR: cystic fibrosis transmembrane conductance regulator
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: List of CFTR Gene Mutations that Produce CFTR Protein and are Responsive to Symdeko

CFTR Gene Mutations that Produce CFTR Protein and are Responsive to Symdeko					
2789+5G→A	*A455E*	*D579G*	*F1074L*	*R1070W*	*S945L*

3272-26A→G	*D110E*	*E193K*	*F508del**	*R117C*	*S977F*
3849+10kbC→T	*D110H*	*E56K*	*K1060T*	*R347H*	
711+3A→G	*D1152H*	*E831X*	*L206W*	*R352Q*	
A1067T	*D1270N*	*F1052V*	*P67L*	*R74W*	
*A patient must have two copies of the *F508del* mutation or at least one copy of a responsive mutation presented in this table to be indicated.					

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CF	Adults, adolescents, and children ≥ 12 years: one tablet (tezacaftor 100 mg/ivacaftor 150 mg) PO in the morning and one tablet (ivacaftor 150 mg) in the evening, approximately 12 hours apart with fat-containing food. Reduce dose in patients with moderate and severe hepatic impairment. Reduce dose when co-administered with drugs that are moderate or strong CYP3A inhibitors.	tezacaftor 100 mg/ivacaftor 300 mg per day

VI. Product Availability

Tablets: Symdeko is co-packaged as tezacaftor 100 mg/ivacaftor 150 mg fixed dose combination tablets and ivacaftor 150 mg tablets

VII. References

1. Symdeko Prescribing Information. Boston, MA: Vertex Pharmaceuticals Incorporated; February 2018. Available at: https://www.symdeko.com/. Accessed February 28, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	04.03.18	05.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Symdeko Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

YearMonthFilled	Drug Name	Count of Members	Count of Claims	Sum of Days	Sum of Qty	Sum of Amt Paid
201805	SYMDEKO	1	1	28	56	$ 22,410.17
201806	SYMDEKO	1	1	28	56	$ 22,410.17

There is no Anthem pdf for the Symdeko since there were no claims for those NDC's in this market during the specified time period

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Symdeko Utilization

May 1, 2017 - May 31, 2018

Year/Month Filled/Paid	Drug Name		Count of Members	Count of Claims	Sum of Qty
2018/03	SYMDEKO	TAB 100-150	1	1	56
2018/04	SYMDEKO	TAB 100-150	1	1	56

Nevada Medicaid

Kalydeco® (ivacaftor)

Pharmacy Coverage Guideline

CRITERIA FOR COVERAGE/NONCOVERAGE

Indications

Cystic fibrosis Indicated for the treatment of cystic fibrosis (CF) in patients age 2 years and older who have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor based on clinical and/or in vitro assay data

Coverage and Limitations

1. Approval will be given if the following criteria are met and documented:
   a. The recipient is two years of age or older; and
   b. The recipient has a diagnosis of cystic fibrosis; and
   c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the gene mutations listed in the FDA-approved package insert.
2. Prior Authorization Guidelines
   a. Prior authorization approval will be for one year.

Kalydeco (ivacaftor)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Kalydeco (ivacaftor)	May be subject to quantity limit

APPROVAL CRITERIA

Requests for Kalydeco (ivacaftor) may be approved if the following are met:

I. Individual has a diagnosis of cystic fibrosis (CF); **AND**
II. Individual is 2 years of age or older; **AND**
III. A copy of the CF mutation analysis test results must be provided; **AND**
IV. Individual has a mutation-positive result in the cystic fibrosis transmembrane conductance regulator (CFTR) gene with **one** of the following mutation types:
    A. G551D; **OR**
    B. G1244E; **OR**
    C. G1349D; **OR**
    D. G178R; **OR**
    E. G551S; **OR**
    F. S1251N; **OR**
    G. S1255P; **OR**
    H. S549N; **OR**
    I. S549R; **OR**
    J. R117H; **OR**
    K. E193K; **OR**
    L. F1052V; **OR**
    M. D1152H; **OR**
    N. G1069R; **OR**
    O. D579G; **OR**
    P. K1060T; **OR**
    Q. S945L; **OR**
    R. R74W; **OR**
    S. A1067T; **OR**
    T. R1070W; **OR**
    U. D110H; **OR**
    V. R347H; **OR**
    W. D1270N; **OR**
    X. P67L: **OR**
    Y. D110E; **OR**
    Z. R352Q; **OR**
    AA. E56K; **OR**
    BB. A455E; **OR**
    CC. L206W; **OR**
    DD. F1074L; **OR**

EE. R117C; **OR**
FF. S977F; **OR**
GG. R1070Q; **OR**
HH. 2789+5G→A; **OR**
II. 3272-26A→G; **OR**
JJ. 3849+10kbC→T; **OR**
KK. 711+3A→G; **OR**
LL. E831X.

Kalydeco (ivacaftor) monotherapy, without concurrent use of lumacaftor, may not be approved for the following:

I. Individual is homozygous for F508del mutation in the CFTR gene.

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: June 9, 2017.

DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Kalydeco

Program	Prior Authorization
Medication	Kalydeco™ (ivacaftor)
Issue Date	6/2015
Pharmacy and Therapeutics Approval Date	8/2017
Effective Date	10/2017

1. Background:

Kalydeco (ivacaftor) is a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator indicated for the treatment of cystic fibrosis (CF) in patients age 2 years and older who have who have one of the following mutations in the CFTR gene:

A1067T	*E193K*	*G1349D*	*R1070W*	*S1255P*
A455E	*E56K*	*G178R*	*R117C*	*S549N*
D110E	*F1052V*	*G551S*	*R117H*	*S549R*
D110H	*F1074L*	*K1060T*	*R347H*	*S945L*
D1152H	*G1069R*	*L206W*	*R352Q*	*S977F*
D1270N	*G551D*	*P67L*	*R74W*	
D579G	*G1244E*	*R1070Q*	*S1251N*	

If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Kalydeco is not effective in patients with CF who are homozygous for the *F508del* mutation in the *CFTR* gene.[1]

Members will be required to meet the coverage criteria below.

2. Coverage Criteria:

A. <u>Initial Authorization</u>

1. Kalydeco will be approved based upon **<u>all</u>** of the following criteria:

a. Diagnosis of cystic fibrosis (CF)

-AND-

b. Submission of laboratory results confirming that patient has **<u>one</u>** of the following mutations in the CFTR gene:

A1067T	*E193K*	*G1349D*	*R1070W*	*S1255P*
A455E	*E56K*	*G178R*	*R117C*	*S549N*
D110E	*F1052V*	*G551S*	*R117H*	*S549R*
D110H	*F1074L*	*K1060T*	*R347H*	*S945L*
D1152H	*G1069R*	*L206W*	*R352Q*	*S977F*
D1270N	*G551D*	*P67L*	*R74W*	
D579G	*G1244E*	*R1070Q*	*S1251N*	

-AND-

c. Prescribed by or in consultation with a specialist affiliated with a CF care center

Authorization will be issued for 12 months.

B. Reauthorization

1. Kalydeco will be approved based on **both** of the following criteria:

a. Provider attests that the patient has achieved a clinically meaningful response while on Kalydeco therapy to **one** of the following:

(1) Lung function as demonstrated by percent predicted expiratory volume in 1 second ($ppFEV_1$)
(2) Body mass index (BMI)
(3) Pulmonary exacerbations
(4) Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

-AND-

b. Prescribed by or in consultation with specialist affiliated with a CF care center

Authorization will be issued for 12 months.

3. References:

1. Kalydeco [Package Insert]. Cambridge, MA: Vertex Pharmaceuticals, Inc.; May 2017.

Program	Prior Authorization - Kalydeco (ivacaftor)
Change Control	
6/2015	New Program

7/2016	Updated policy template. Aligning with Employer & Individual on clinical criteria but changed reauthorization duration from 24 to 12 months.
11/2016	Revised prescriber criterion
3/2017	Changed initial authorization duration to 12 months
8/2017	Added 23 additional CFTR mutations based on labeling change

Clinical Policy: Ivacaftor (Kalydeco)

Reference Number: CP.PHAR.210
Effective Date: 05.01.16
Last Review Date: 02.18
Line of Business: Commercial, Health Insurance Marketplace, Medicaid Revision Log
See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Ivacaftor (Kalydeco®) is a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator.

FDA Approved Indication(s)

Kalydeco is indicated for the treatment of cystic fibrosis (CF) in patients age 2 years and older who have one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data.

If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Kalydeco is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cystic Fibrosis (must meet all)**:**

1. Diagnosis of CF;
2. Age ≥ 2 years;
3. Presence of one mutation in the CFTR gene responsive to ivacaftor based on clinical and/or in vitro assay data *(see Appendix D)*;
4. Confirmation that a homozygous F508del mutation in the CFTR gene is not present;
5. Dose does not exceed one of the following (a, b, or c):
   a. Age ≥ 6 years: 300 mg/day (2 tablets/day);
   b. Age 2 to < 6 years and weight < 14 kg: 100 mg/day (2 packets/day);
   c. Age 2 to < 6 years and weight ≥ 14 kg: 150 mg/day (2 packets/day).

Approval duration:
Medicaid/Health Insurance Marketplace – 6 months
Commercial – Length of Benefit

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is

NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Cystic Fibrosis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following:
   a. Age ≥ 6 years: 300 mg/day (2 tablets/day);
   b. Age 2 to < 6 years and weight < 14 kg: 100 mg/day (2 packets/day);
   c. Age 2 to < 6 years and weight ≥ 14 kg: 150 mg/day (2 packets/day).

Approval duration:
Medicaid/Health Insurance Marketplace – 12 months
Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CF: cystic fibrosis
CFTR: cystic fibrosis transmembrane conductance regulator
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: General Information

- The Cystic Fibrosis Foundation's Mutation Analysis Program (MAP; available here: http://www.cfpaf.org/ResourceCenter/MutationAnalysisProgram) offers free and confidential genetic testing to patients with a confirmed diagnosis of CF. It can take up to 60 days to receive genotyping results and additional time if further testing is needed.

- Kalydeco is not effective in patients with CF who are homozygous for the F508del mutation in the CFTR gene.
- It is recommended that transaminases (ALT and AST) be assessed prior to initiating Kalydeco, every 3 months during the first year of treatment, and annually thereafter. Dosing should be interrupted in patients with ALT or AST of greater than 5 times the upper limit of normal.
- Data from the study of CF patients with nine *CFTR* mutations did not support approval of the drug in patients with the G970R mutation. As of 2014, it is estimated that there are about 10 people worldwide who have this mutation, including two in the United States.

Appendix D: CFTR Gene Mutations that are Responsive to Kalydeco

CFTR Gene Mutations that are Responsive to Kalydeco				
A1067T	E56K	G551S	R347H	S977F
A455E	F1052V	K1060T	R352Q	2789+5G→A (28)
D110E	F1074L	L206W	R74W	3272-26A→G (23)
D110H	G1069R	P67L	S1251N	3849+10kBc→T (40)
D115H	G1244E	R1070Q	S1255P	711+3A→G (2)
D1270N	G1349D	R1070W	S459R	E831X (1)
D579G	G178R	R117C	S549N	
E193K	G551D	R117H	S945L	

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CF	*Adults and pediatric patients age 6 years and older:* one 150 mg tablet taken orally every 12 hours with fat-containing food.	Age ≥ 6 years: 300 mg/day
	Pediatric patients 2 to less than 6 years of age weighing less than 14 kg: one 50 mg packet mixed with 1 teaspoon (5 mL) of soft food or liquid and administered orally every 12 hours with fat containing food.	Age 2 to < 6 years and weight < 14 kg: 100 mg/day
	Pediatric patients 2 to less than 6 years of age weighing 14 kg or greater: one 75 mg packet mixed with 1 teaspoon (5 mL) of soft food or liquid and administered orally every 12 hours with fat-containing food.	Age 2 to < 6 years and weight ≥ 14 kg: 150 mg/day

VI. Product Availability

- Tablets: 150 mg
- Unit-dose packets containing oral granules: 50 mg and 75 mg

VII. References

1. Kalydeco Prescribing Information. Boston, MA: Vertex Pharmaceuticals, Inc.; July 2017. Available at https://www.kalydeco.com/. Accessed October 26, 2017.
2. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines: Chronic medications for maintenance of lung health. Am J Respir Crit Care Med. April 1, 2013; 187(7): 680-689.
3. Farrell PM, White TB, Ren CL et al. Diagnosis of cystic fibrosis: Consensus guidelines from the Cystic Fibrosis Foundation. J Pediatr 2017;181S:S4-15.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.54 CF Treatments. Evidence of a "significant improvement in FEV1" under continued approval is replaced with "Member continues to respond positively to Kalydeco therapy in one or more of the following areas: pulmonary function, quality of life, pulmonary exacerbations". Not having increased LFTs is removed as a discontinuation reason. Continuation approval period is extended from 6 to 12 months.	05.16	05.16
Dosing criteria expanded by age. Efficacy statement edited to indicate general positive response to therapy.	05.17	05.17
Removed the requirement of specific gene mutations, G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R, there are now over 20 gene mutation susceptible to Kalydeco. Appendix B added. Added maximum dose for pediatric patients.	06.17	11.17
1Q18 annual review: - Policies combined for Centene Medicaid, Marketplace, and Commercial lines of business. - No significant changes. - References reviewed and updated.	10.26.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

Kalydeco (Ivacaftor) Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

YearMonthFilled	Drug Name	Count of Members	Count of Claims	Sum of Days	Sum of Qty	Sum of Amt Paid
201712	KALYDECO	1	1	28	56	$ 23,906.30
201801	KALYDECO	1	1	28	56	$ 23,906.30
201802	KALYDECO	1	1	28	56	$ 23,906.30
201803	KALYDECO	1	1	28	56	$ 23,906.30
201806	KALYDECO	1	1	28	56	$ 23,906.30

There is no Anthem pdf for the Kalydeco since there were no claims for those NDC's in this market during the specified time period

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Kalydeco Utilization

May 1, 2017 - May 31, 2018

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2017/06	KALYDECO PAK 50MG	1	1	56
2017/09	KALYDECO PAK 50MG	1	1	56
2017/09	KALYDECO TAB 150MG	1	1	56
2017/10	KALYDECO PAK 50MG	1	1	56
2017/10	KALYDECO TAB 150MG	1	1	56
2017/11	KALYDECO TAB 150MG	1	2	112
2017/12	KALYDECO PAK 50MG	1	1	56
2017/12	KALYDECO TAB 150MG	1	1	56
2018/01	KALYDECO PAK 50MG	1	1	56
2018/01	KALYDECO TAB 150MG	1	1	56
2018/02	KALYDECO PAK 50MG	1	1	56
2018/02	KALYDECO TAB 150MG	1	1	56
2018/03	KALYDECO PAK 50MG	1	1	56
2018/03	KALYDECO TAB 150MG	1	1	56
2018/04	KALYDECO PAK 50MG	1	1	56
2018/04	KALYDECO TAB 150MG	1	2	112
2018/05	KALYDECO PAK 50MG	1	1	56

LL. Kalydeco® (ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent
Last Reviewed by the DUR Board: September 3, 2015

Kalydeco® (ivacaftor) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The recipient is two years of age or older; and

b. The recipient has a diagnosis of cystic fibrosis; and

c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the following gene mutations: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N or S549R.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

Nevada Medicaid
Topical Immunomodulators
Pharmacy Coverage Guideline

Elidel (pimecrolimus)

Protopic (tacrolimus)

Eucrisa (crisaborole)

CRITERIA FOR COVERAGE/NONCOVERAGE

Indications
For the treatment of mild to moderate atopic dermatitis

Initial Authorization:

Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. Patient must have a therapeutic failure with the use of a topical steroid.
b. Patient has a documented diagnosis of Atopic Dermatitis:
    1. Elidel®: for mild to moderate, for ages > two years.
    2. Eucrisa®: for mild to moderate, for ages > two years.
    3. Protopic® 0.03%; moderate to severe, for ages > two years.
    4. Protopic® 0.1%; moderate to severe, for ages > 18 years.
c. Not for chronic use.
d. Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.
e. Not recommended for use in immunocompromised patients.

Elidel (pimecrolimus) and Protopic (tacrolimus)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	3 months

Medications	Quantity Limit
Elidel (pimecrolimus)	100 grams per 90 days
Protopic (tacrolimus)	100 grams per 90 days

APPROVAL CRITERIA

Requests for Elidel or Protopic 0.03% may be approved for the following:

I. Individual is equal to or greater than 2 years of age **AND**
II. Individual has had a trial of and inadequate response or intolerance to one topical prescription corticosteroid; **OR**
III. Use of a topical prescription corticosteroid agent may not be appropriate due to concomitant clinical situations such as but not limited to the following (AAD 2014):
- **a.** Individual has atopic dermatitis recalcitrant to topical corticosteroids; **OR**
- **b.** Individual has atopic dermatitis lesions in sensitive areas (such as face, anogenital area or skin folds; **OR**
- **c.** Individual has steroid-induced atrophy; **OR**
- **d.** Individual has history of long-term or uninterrupted topical steroid use.

Requests for Protopic 0.1% may be approved for the following:

I. Individual is equal to or greater than (≥) 16 years of age; **AND**
II. Individual has had a trial of and inadequate response or intolerance to one topical prescription corticosteroid; **OR**
III. Use of topical prescription corticosteroid agent may not be appropriate due to concomitant clinical situations such as but not limited to the following (AAD 2014):
- a. Individual has atopic dermatitis recalcitrant to topical corticosteroids; **OR**
- b. Individual has atopic dermatitis lesions in sensitive areas (such as face, anogenital area or skin folds); **OR**
- c. Individual has steroid-induced atrophy; **OR**
- d. Individual has history of long-term or uninterrupted topical steroid use.

Note: Elidel (pimecrolimus) and Protopic (tacrolimus) both have a black box warning for malignancy (for example, skin and lymphoma). Continuous long-term use of any age and application to areas not involved with atopic dermatitis should be avoided. Use of Elidel and Protopic 0.03% should be limited to individuals aged 2 years or older. Protopic 0.1% is not indicated for use in children less than 16 years of age.

State Specific Mandates		
N/A	N/A	N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2015. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: July 9, 2015.

DRUGDEX® System [Internet Database]. Greenwood Village, CO: Thomson Reuters (Healthcare) Inc. Updated periodically.

Eichenfield LL. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies.. Journal of the American Academy of Dermatology. 2014-01;71:116.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2015; Updated periodically.

Eucrisa (crisaborole)

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Medications	Quantity Limit
Eucrisa (crisaborole) 2% ointment	May be subject to quantity limit.

APPROVAL CRITERIA

Requests for Eucrisa (crisaborole) may be approved when the following criteria are met:

I. Individual is 2 years of age or older; **AND**

II. Individual has a diagnosis of mild to moderate atopic dermatitis; **AND**

III. Individual has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) of and inadequate response or intolerance to one topical corticosteroid unless use is not acceptable due to the following concomitant clinical conditions (AAD 2014):
   A. Individual has atopic dermatitis recalcitrant to topical corticosteroids; **OR**
   B. Individual has atopic dermatitis lesions in sensitive areas (such as face, anogenital area or skin folds); **OR**
   C. Individual has steroid-induced atrophy; **OR**
   D. Individual has history of long-term or uninterrupted topical steroid use.

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A

Key References:

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2017. URL: http://www.clinicalpharmacology.com. Updated periodically.

DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.

DrugPoints® System (electronic version). Truven Health Analytics, Greenwood Village, CO. Updated periodically.

Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2017; Updated periodically.

Eichenfield L. Guidelines of care for the management of atopic dermatitis: section 2. Management and treatment of atopic dermatitis with topical therapies. Journal of the American Academy of Dermatology. 2014-01;71:116.

Eucrisa (crisaborole) [package insert]. Palo Alto, CA. Anacor Pharmaceuticals; December 2016. Available at: http://labeling.pfizer.com/ShowLabeling.aspx?id=5331 Accessed March 7, 2017.

Paller A., Tom W., Lebwohl M. Efficacy and safety of crisaborole ointment, a novel, nonsteroidal phosphodiesterase 4 (PDE4) inhibitor for the topical treatment of atopic dermatitis (AD) in children and adults. J Am Acad Dermatol. 2016 Sep;75(3):494-503.e4. doi: 10.1016/j.jaad.2016.05.046. Epub 2016 Jul 11.

Health Plan of Nevada

Topical Immunomodulators

Criteria Recommendation

HPN does not have an official step-therapy policy for the products in this class but step-therapy is in place and provided in the preamble of the provider PDL (relevant sections pasted below). Coverage is below.

COVERED AGENTS:
- Elidel (pimecrolimus) cream - minimum age of two. Trial of one topical corticosteroid.
- tacrolimus 0.03% ointment - minimum age of two. Trial of one topical corticosteroid.
- tacrolimus 0.1% ointment - minimum age of sixteen. Trial of one topical corticosteroid.

NON-FORMULARY AGENTS: (require appropriate use per label and failure of formulary alternatives)
- NA

Per the provider PDL document:

Elidel	Minimum age of 2. Trial of one topical corticosteroid.
tacrolimus 0.03%	Minimum age of 2. Trial of one topical corticosteroid.
tacrolimus 0.1%	Minimum age of 16. Trial of one topical corticosteroid.

Clinical Policy: Topical Immunomodulators

Reference Number: CP.PMN.107
Effective Date: 09.01.06
Last Review Date: 02.18
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

The following are topical immunomodulators requiring prior authorization: pimecrolimus (Elidel®) and tacrolimus (Protopic®).

FDA Approved Indication(s)

Elidel cream is indicated for second‑line therapy for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable

Protopic ointment is indicated for second-line therapy for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable

Limitation(s) of use: Protopic ointment and Elidel cream are not indicated for children younger than 2 years of age.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Protopic and Elidel/generics are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Atopic Dermatitis (must meet all)**:**

1. Diagnosis of atopic dermatitis;
2. If request is for tacrolimus 0.03% ointment, member is ≥ 2 years of age;
3. If request is for tacrolimus 0.1% ointment, member is ≥ 16 years of age;
4. Member is immunocompetent;
5. Member must meet one of the following (a, b, or c):
   a. Children and adolescents: Failure of 2 medium potency corticosteroids in the previous 6 months, unless member has contraindication(s) to all PDL topical corticosteroids;
   b. Adults: Failure of 2 high or very high potency corticosteroids in the previous 6 months, unless member has contraindication(s) to all PDL topical corticosteroids;

c. Use on the face or skinfolds;

6. Request does not exceed a 30 gm tube per month.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Atopic Dermatitis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed a 30 gm tube per month.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to CP.PMN.53 if requested indication is NOT listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy - CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
augmented betamethasone 0.05% (Diprolene®), gel	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
clobetasol propionate 0.05% (Temovate®) cream, ointment, gel, solution	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
diflorasone diacetate 0.05% (Apexicon®Psorcon ®) ointment	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
halobetasol propionate 0.05% (Ultravate®) cream, ointment	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
augmented betamethasone 0.05% (Diprolene® AF, Diprolene®) cream, ointment, lotion	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
diflorasone 0.05% (Apexicon®Psorcon ®) cream	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
fluocinonide acetonide 0.05% cream, ointment, gel, solution	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
triamcinolone acetonide 0.5% cream, ointment	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
Desoximetasone 0.25% (Topicort®) cream, ointment	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
desoximetasone 0.05% (Topicort ®) cream, gel	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
fluocinolone acetonide 0.025% (Synalar®) cream, ointment	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
mometasone 0.1% (Elocon®) cream, ointment, lotion	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
triamcinolone acetonide 0.025%, 0.1% cream, ointment	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: General Information

- On March 10, 2005, the FDA issued a public health advisory about a potential cancer risk from Elidel. The FDA recommends that Elidel should be used second-line, avoided in children below the age of 2, and used in minimum amounts intermittently to control symptoms. Black box warning and Medication Guide for patients have been instituted, as recommended by the FDA.
- A Consensus Conference on Atopic Dermatitis sponsored by the American Academy of Dermatology recommended that topical immunomodulator agents should be reserved for second line therapy in patients who fail standard interventions, including low to mid potency topical corticosteroids.

V. Dosage and Administration

Drug	Dosing Regimen	Maximum Dose
Elidel	A thin layer to affected skin twice daily	30 gm tube/month
Protopic	A thin layer to affected skin twice daily	30 gm tube/month

VI. Product Availability

Drug	Availability
Elidel	1% cream
Protopic	0.03% ointment, 0.1% ointment

VII. References

1. Elidel Package Insert. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC, June 2017. Available at http://www.elidel-us.com. Accessed November 24, 2017.
2. Protopic Package Insert. Madison, NJ: LEO Pharma Inc., November 2016. Available at https://www.protopic.com. Accessed November 24, 2017.
3. Eichenfield LF, Tom WL, Berger TG et al. Guidelines of care for the management of atopic dermatitis: Section 2. Management and treatment of atopic dermatitis with topical therapies. J Am Acad Dermatol. 2014 Aug;71(1):116-32.

Reviews, Revisions, and Approvals	Date	P & T Approval Date
Added Protopic to criteria document. Revised the description to create category language (formerly referred only to pimecrolimus). Added references for Protopic.	02.13	02.13
Updated reference section to reflect current literature search.	02.14	02.14
Updated reference section to reflect current literature search.	02.15	02.15
Converted into new policy template; Added that member must be immunocompetent; Added that topical steroid must have been trialed and failed in the last 6 months; Added that disease on the skinfolds could be approved without use of steroid to avoid skin atrophy; Updated reference section to reflect current literature search.	12.15	02.16
Converted to new integrated template; Updated literature search; Removed the following age requirement: Pimecrolimus 1%	11.16	02.17

Reviews, Revisions, and Approvals	Date	P & T Approval Date
cream ≥ 2 years of age, because age restrictions are not absolute contraindications per FDA labeling; added positive response to therapy requirement for re-authorization.		
1Q18 annual review: - Policy changed from CP.PPA to CP.PMN. - Changed authorization duration limits from 3/6 months to 6/12 months - Removed restriction against coverage for vitiligo - References reviewed and updated.	12.5.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

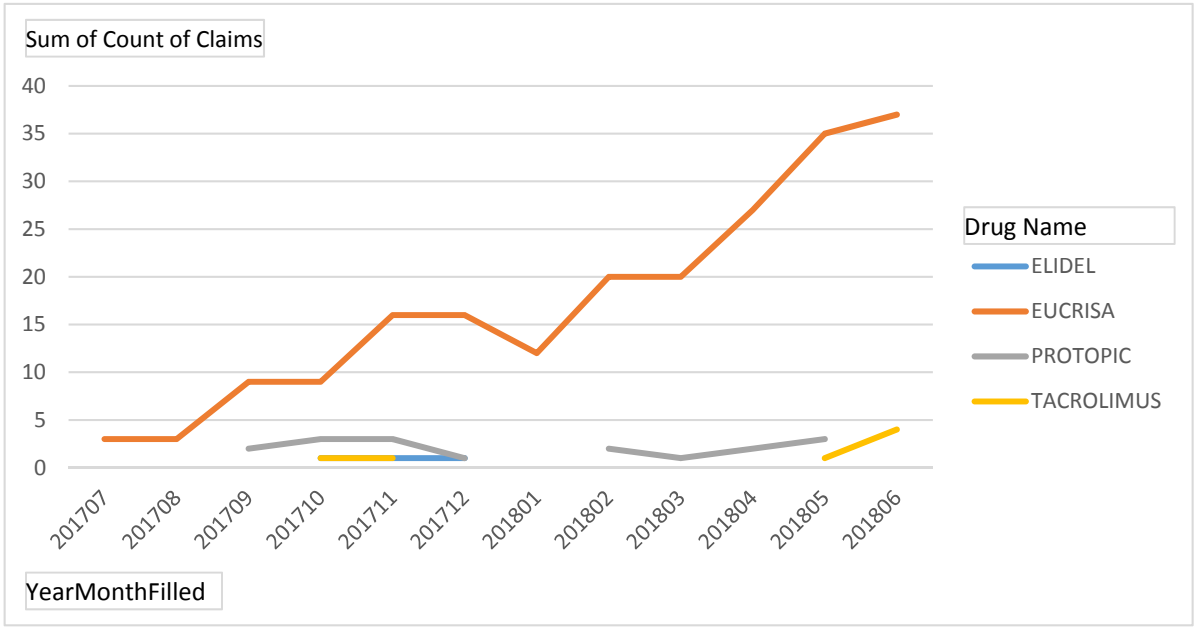
Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Topical Immunomodulator Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Cnt Members	Cnt of Claims	Days	Qty	Amt Paid
ELIDEL	7	7	136	210	$ 1,878.26
EUCRISA	200	207	5690	13260	$ 131,391.67
PROTOPIC	16	17	412	640	$ 4,880.70
TACROLIMUS	6	7	163	360	$ 1,717.53
Grand Total	**229**	**238**	**6401**	**14470**	**$ 139,868.16**



YEAR_MONTH	DRUG_NAME	MBR_COUNT	CLM_COUNT	DAYS_SUPPLY	QUANTITY
201706	EUCRISA	3	3	61	180
201706	TACROLIMUS	3	3	75	150
201707	ELIDEL	2	2	60	90
201707	EUCRISA	3	3	80	180
201707	TACROLIMUS	3	3	74	180
201708	ELIDEL	1	1	30	60
201708	EUCRISA	5	5	112	300
201708	TACROLIMUS	3	3	63	150
201709	ELIDEL	1	1	30	60
201709	EUCRISA	5	6	165	360
201709	TACROLIMUS	4	4	95	190
201710	ELIDEL	7	7	158	310
201710	EUCRISA	13	13	375	780
201710	TACROLIMUS	12	12	314	640
201711	EUCRISA	6	6	148	360
201711	TACROLIMUS	7	7	114	330
201712	ELIDEL	4	4	47	120
201712	EUCRISA	3	3	80	180
201712	TACROLIMUS	9	9	175	390
201801	ELIDEL	2	2	60	90
201801	EUCRISA	12	12	261	720
201801	TACROLIMUS	14	14	334	640
201802	ELIDEL	3	3	55	120
201802	EUCRISA	9	9	258	540
201802	TACROLIMUS	5	5	101	310
201803	ELIDEL	4	4	80	120
201803	EUCRISA	16	16	430	960
201803	TACROLIMUS	11	11	246	550
201804	ELIDEL	4	4	62	180
201804	EUCRISA	17	17	474	1,020
201804	TACROLIMUS	10	10	239	490
201805	ELIDEL	4	4	104	220
201805	EUCRISA	25	26	665	1,560
201805	TACROLIMUS	14	14	323	600

Health Plan of Nevada

Topical Immunomodulators Utilization

May 1, 2017 - May 31, 2018

Year/Month Filled/Paid	Drug Name	Count of Members	Count of Claims	Sum of Qty
2017/05	TACROLIMUS OIN 0.03%	6	6	650
2017/05	TACROLIMUS OIN 0.1%	7	8	390
2017/05	ELIDEL CRE 1%	1	1	90
2017/06	TACROLIMUS OIN 0.03%	11	11	620
2017/06	ELIDEL CRE 1%	1	1	90
2017/06	TACROLIMUS OIN 0.1%	13	13	770
2017/08	TACROLIMUS OIN 0.1%	1	1	30
2017/08	ELIDEL CRE 1%	2	2	60
2017/09	TACROLIMUS OIN 0.1%	7	7	400
2017/09	TACROLIMUS OIN 0.03%	6	6	210
2017/09	ELIDEL CRE 1%	6	8	270
2017/10	TACROLIMUS OIN 0.03%	8	8	330
2017/10	TACROLIMUS OIN 0.1%	3	3	90
2017/10	ELIDEL CRE 1%	7	7	240
2017/11	TACROLIMUS OIN 0.1%	2	2	60
2017/11	ELIDEL CRE 1%	9	9	360
2017/11	TACROLIMUS OIN 0.03%	2	2	60
2017/12	ELIDEL CRE 1%	3	3	120
2017/12	TACROLIMUS OIN 0.1%	4	4	120
2017/12	TACROLIMUS OIN 0.03%	4	4	150
2018/01	TACROLIMUS OIN 0.1%	5	5	210
2018/01	TACROLIMUS OIN 0.03%	6	6	300
2018/01	ELIDEL CRE 1%	6	6	250
2018/02	TACROLIMUS OIN 0.1%	7	7	240
2018/02	TACROLIMUS OIN 0.03%	4	4	180
2018/02	ELIDEL CRE 1%	11	11	490
2018/03	TACROLIMUS OIN 0.1%	10	13	450
2018/03	TACROLIMUS OIN 0.03%	13	14	480
2018/03	ELIDEL CRE 1%	14	14	580
2018/04	TACROLIMUS OIN 0.03%	7	7	240
2018/04	TACROLIMUS OIN 0.1%	6	6	180
2018/04	ELIDEL CRE 1%	8	8	240
2018/05	TACROLIMUS OIN 0.1%	11	11	360
2018/05	ELIDEL CRE 1%	23	23	810
2018/05	TACROLIMUS OIN 0.03%	8	8	240

M. Topical Immunomodulators

Therapeutic Class: Immumomdulators, Topical
Last Reviewed by the DUR Board: April 26, 2007

Elidel®
Protopic®

Topical Immunomodulators drugs are a subject to prior authorization and quantity limitations and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Authorization will be given if the following criteria are met and documented:

   a. Patient must have a therapeutic failure with the use of a topical steroid.

   b. Patient has a documented diagnosis of Atopic Dermatitis:

      1. Elidel®: for mild to moderate, for ages ≥ two years.

      2. Protopic® 0.03%; moderate to severe, for ages ≥ two years.

      3. Protopic® 0.1%; moderate to severe, for ages ≥ 18 years.

   c. Not for chronic use.

   d. Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.

   e. Not recommended for use in immunocompromised patients.

2. Prior Authorization forms are available at:
   http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Nevada Medicaid
Compounded Drugs
Pharmacy Coverage Guideline

CRITERIA FOR COVERAGE/NONCOVERAGE

Coverage and Limitations

Approval Length: 6 months, unless the provider requests for a shorter length of therapy.

Approval Criteria

All of the following are met:

1. Each active ingredient in the compounded drug is FDA-approved or national compendia* supported for the condition being treated
2. The therapeutic amounts are supported by national compendia* or peer-reviewed literature for the condition being treated in the requested route of delivery
3. If any prescription ingredients require prior authorization and/or step therapy, all drug-specific criteria must be also met
4. The compounded drug must not include any ingredient that has been withdrawn or removed from the market due to safety reasons (refer to Table 1)
5. The patient has tried and failed therapy or had an intolerance to two FDA-approved commercially-available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless **one** of the following criteria are met:
    a. Patient has a contraindication to commercially available products
    b. One or no other therapeutic alternatives are commercially available
    c. Prepared in a strength not commercially available or currently in short supply
    d. Prepared in a different dosage form for a patient who is unable to take the commercially available formulation (mixing or reconstituting commercially available products based on the manufacturer's instructions or the product's approved labeling does NOT meet this criteria).
    e. Patient has an allergy or sensitivity to inactive ingredients (e.g. dyes, preservatives, sugars, etc.) that are found in commercially available products.
6. The compounded drug must not be used for a cosmetic purpose.
7. If the compound is subject to the drug-specific/targeted compound program, the member meets all the applicable drug-specific criteria below for all the targeted ingredient(s) used in the requested compound product.

UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Compounds and Bulk Powders

Program	Prior Authorization
Medication	Compounds and Bulk Powders
Issue Date	7/2013
Pharmacy and Therapeutics Approval Date	10/2017
Effective Date	12/2017

1. Background:

Compounded medications can provide a unique route of delivery for certain patient-specific conditions and administration requirements. Compounded medications should be produced for a single individual and not produced on a large scale. A dollar threshold may be used to identify compounds which require Prior Authorization and must meet the criteria below in order to be covered. Drugs included in the compound must be a covered product.

NV $$$ Threshold is $200

2. Coverage Criteria:

A. **Authorization** for compounds and bulk powders will be approved based on **all** of the following criteria:

1. The requested drug component is a covered medication

-AND-

2. One of the following:
   a. The requested drug component is to be administered for an FDA-approved indication

-OR-

   b. The use of this drug is supported by information from the appropriate compendia of current literature*.

-AND-

3. If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

-AND-

4. If the drug component is no longer available commercially it must not have been withdrawn for safety reasons

-AND-

5. **<u>One</u>** of the following:

   a. A unique vehicle is required for topically administered compounds

   -OR-

   b. A unique dosage form is required for a commercially available product due to patient's age, weight or inability to take a solid dosage form.

   -OR-

   c. A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

   -AND-

6. Coverage for compounds and bulk powders will **NOT** be approved for any of the following:

   a. For topical compound preparations (e.g. creams, ointments, lotions or gels to be applied to the skin for transdermal, transcutaneous or any other topical route), requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use.

   -OR-

   b. Requested compound contains topical fluticasone. Topical fluticasone will NOT be approved unless:

      (1) Topical fluticasone is intended to treat a dermatologic condition. Scar treatments are considered cosmetic and will not be covered (refer to criteria "e" below).

      -AND-

      (2) Patient has a contraindication to all commercially available topically fluticasone formulations

   -OR-

   c. Requested compound contains any ingredients when used for cosmetic purposes.

UnitedHealthcare Community Plan

-OR-

d. Requested compound contains any ingredient(s) which are on the FDA's Do Not Compound List.

Authorization will be issued for 12 months

*Compendia of Current Literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical Pharmacology • United States Pharmacopoeia-National Formulary (USP-NF) • United States Pharmacopoeia Drug Information (USP DI)

APPENDIX

Example topical compound preparations (e.g. creams, ointments, lotions or gels to be applied to the skin for transdermal, transcutaneous or any other topical route) that contain any FDA approved ingredient that are not FDA approved for TOPICAL use, including but NOT LIMITED TO the following:

(1) Ketamine
(2) Gabapentin
(3) Flurbiprofen (topical ophthalmic use not included)
(4) Ketoprofen
(5) Morphine
(6) Nabumetone
(7) Oxycodone
(8) Cyclobenzaprine
(9) Baclofen
(10) Tramadol
(11) Hydrocodone
(12) Meloxicam
(13) Amitriptyline
(14) Pentoxifylline
(15) Orphenadrine
(16) Piroxicam
(17) Levocetirizine
(18) Amantadine
(19) Oxytocin
(20) Sumatriptan
(21) Chorionic gonadotropin (human)
(22) Clomipramine
(23) Dexamethasone
(24) Hydromorphone
(25) Methadone
(26) Papaverine
(27) Mefenamic acid
(28) Promethazine

(29) Succimer DMSA
(30) Tizanidine
(31) Apomorphine
(32) Carbamazepine
(33) Ketorolac
(34) Dimercaptopropane-sulfonate
(35) Dimercaptosuccinic acid
(36) Duloxetine
(37) Fluoxetine
(38) Bromfenac (topical ophthalmic use not included)
(39) Nepafenac (topical ophthalmic use not included)

Example compounds that contain ingredients for cosmetic purposes:
(1) Hydroquinone
(2) Acetyl hexapeptide-8
(3) Tocopheryl Acid Succinate
(4) PracaSil TM-Plus
(5) Chrysaderm Day Cream
(6) Chrysaderm Night Cream
(7) PCCA Spira-Wash
(8) Lipopen Ultra
(9) Versapro
(10) Fluticasone
(11) Mometasone
(12) Halobetasol
(13) Betamethasone
(14) Clobetasol
(15) Triamcinolone
(16) Minoxidil
(17) Tretinoin
(18) Dexamethasone
(19) Spironolactone
(20) Cycloserine
(21) Tamoxifen
(22) Sermorelin
(23) Mederma Cream
(24) PCCA Cosmetic HRT Base
(25) Sanare Scar Therapy Cream
(26) Scarcin Cream
(27) Apothederm
(28) Stera Cream
(29) Copasil
(30) Collagenase
(31) Arbutin Alpha
(32) Nourisil
(33) Freedom Cepapro
(34) Freedom Silomac Anhydrous
(35) Retinaldehyde
(36) Apothederm

Example ingredients on the FDA's Do Not Compound List:

(1) 3,3′,4′,5-tetrachlorosalicylanilide
(2) Adenosine phosphate
(3) Adrenal cortex
(4) Alatrofloxacin mesylate
(5) Aminopyrine
(6) Astemizole
(7) Azaribine
(8) Benoxaprofen
(9) Bithionol
(10) Camphorated oil
(11) Carbetapentane citrate
(12) Casein, iodinated
(13) Cerivastatin sodium
(14) Chlormadinone acetate
(15) Chloroform
(16) Cisapride
(17) Dexfenfluramine hydrochloride
(18) Diamthazole dihydrochloride
(19) Dibromsalan
(20) Dihydrostreptomycin sulfate
(21) Dipyrone
(22) Encainide hydrochloride
(23) Etretinate
(24) Fenfluramine hydrochloride
(25) Flosequinan
(26) Glycerol, iodinated
(27) Grepafloxacin
(28) Mepazine
(29) Metabromsalan
(30) Methapyrilene
(31) Methopholine
(32) Methoxyflurane
(33) Mibefradil dihydrochloride
(34) Nomifensine maleate
(35) Novobiocin sodium
(36) Oxyphenisatin acetate
(37) Oxyphenisatin
(38) Pemoline
(39) Pergolide mesylate
(40) Phenacetin
(41) Phenformin hydrochloride
(42) Phenylpropanolamine
(43) Pipamazine
(44) Potassium arsenite
(45) Propoxyphene
(46) Rapacuronium bromide
(47) Rofecoxib

(48) Sibutramine hydrochloride
(49) Sparteine sulfate
(50) Sulfadimethoxine
(51) Sweet spirits of nitre
(52) Tegaserod maleate
(53) Temafloxacin hydrochloride
(54) Terfenadine
(55) Ticrynafen
(56) Tribromsalan
(57) Trichloroethane
(58) Troglitazone
(59) Trovafloxacin mesylate:
(60) Urethane
(61) Valdecoxib
(62) Zomepirac sodium

3. References:

1. Food and Drug Administration (2014, July 02). Additions and Modifications to the List of Drug Products That Have Been Withdrawn or Removed From the Market for Reasons of Safety and Effectiveness. Retrieved from http://federalregister.gov/a/2014-15371

Program	Prior Authorization - Compounds and Bulk Powders
Change Control	
Date	Change
7/2013	Topical use section updated to include all medications that are not FDA approved for topical use. Reformatted to standard.
10/2013	Added the following to the list of compound ingredients that are not covered: ibuprofen, lipoic acid, beta glucan, ubiquinol, chrysin, glutathione, lactobacillus, vitamin E, ascorbic acid, melatonin, meloxicam, amitriptyline, pentoxifylline, orphenadrine, piroxicam, acetyl hexapeptide-8, tocopheryl acid succinate, PracaSil TM-Plus, Chrysaderm Day Cream, Chrysaderm Night Cream, PCCA Spira-Wash and Lipopen Ultra.
11/2013	Added criteria for topical fluticasone.
2/2014	Added criteria for cholestyramine.
4/2014	Added pyridoxal-5-phosphate (Vitamin B6) and loperamide to list of ingredients that will not be coverage as they are available OTC. Added levocetirizine, amantadine, oxytocin, sumatriptan and chorionic gonadotropin to list of ingredients that will not be covered for topical use. Added Versapro to list of ingredients that will not be covered for cosmetic use.
10/2014	Added Dextromethorphan, Dehydroepiandrosterone, Pregnenolone, Biotin, L-Glutamine, Serotonin, Aloe vera, Sodium butyrate, L-Isoleucine and Vitamin D3 to the list of ingredients that will not be covered as they are available OTC. Added Clomipramine, Dexamethasone, Hydromorphone, Methadone, Papaverine, Mefenamic

	acid, Promethazine, Succimer DMSA, Tizanidine, Apomorphine, Carbamazepine, Ketorolac, Dimercaptopropane-sulfonate and Dimercaptosuccinic acid to the list of ingredients that will not be covered for topical use. Added Fluticasone, Mometasone, Halobetasol, Betamethasone, Clobetasol, Triamcinolone, Minoxidil, Tretinoin, Dexamethasone, Spironolactone, Cycloserine, Tamoxifen and Sermorelin to the list of ingredients that will not be covered for cosmetic use. Removed criterion that a similar commercially available product is not available.
4/2015	Updated criteria to reflect that if any drug ingredient of the compound requires prior authorization and/or step therapy, that clinical criteria must also be met. Added ginseng, phosphatidylserine and resveratrol to the ingredients that will not be covered as they are available OTC. Added Mederma Cream, PCCA Cosmetic HRT Base, Sanare Scar Therapy Cream, and Scarcin Cream to the ingredients that will not be covered for cosmetic use.
7/2015	Added to the criteria ingredients that should not be compounded as they reside on the FDA's Do Not Compound List. Clarified language around commercially available products.
4/2016	Added criteria to allow for coverage when patient has an allergy to the commercially available product. Added methionine and naproxen to ingredients that will not be covered as they are available OTC. Added Apothederm to the list of ingredients that will not be covered for cosmetic use.
10/2016	Removed language that a unique dosage form is required and the commercially available product is excluded. Added carnosine L to the ingredients that will not be covered as they are available OTC. Added duloxetine and fluoxetine to the ingredients that will not be covered for topical use. Added Stera cream, Copasil, collagenase, arbutin alpha, and Nourisil to the list of ingredients that will not be covered for cosmetic use.
12/2016	Moved examples of drugs not approved for topical use, cosmetic use, and FDA's do not compound list to the appendix. Removed statements about leuprolide and cholestyramine since both pertain to off-label use and this would be covered elsewhere in the criteria.
4/2017	Added approval for compendia supported uses in addition to FDA approved indications.
10/2017	Added bromfenac and nepafenac to the ingredients that will not be covered for topical use. Added Freedom Cepapro, Silomac Anhydrous, Retinaldehyde and Apothederm to the list of ingredients that will not be covered for cosmetic use.

SILVERSUMMIT HEALTHPLAN
POLICY AND PROCEDURE

DEPARTMENT: Ambetter Health Plans	**DOCUMENT NAME:** Compounded Medications
PAGE: 1 of 2	**REPLACES DOCUMENT:**
APPROVED DATE: 05/16	**RETIRED:**
EFFECTIVE DATE: 05/16	**REVIEWED/REVISED:** 05/17, 05/18
PRODUCT TYPE: Health Insurance Marketplace (HIM)	**REFERENCE NUMBER:** HIM.PHAR.20

SCOPE:
Health Insurance Marketplace (Ambetter) Health Plans

PURPOSE:
The purpose of this policy is to define Ambetter's policy to provide HIM members with coverage of compounded medications.

POLICY:
It is the policy of Ambetter to assure that members who need compounded medications are afforded access to compounded products.

PROCEDURE:

A. Health Insurance Marketplace plans (Ambetter) will provide coverage for compounded medications when the following criteria have been met:

1. Comparable commercial product is not available. Comparable in the sense of this criteria means that there is no product commercially available that is FDA approved to treat the same condition. Comparable products are considered all formulations regardless of route of administration. Exceptions to this section of the policy can be granted in pediatric cases, where commercial product is available in different formulation, however pediatric dosing would render use of that formulation impossible; (i.e. commercially available 250mg tablet can't be used for 5mg dose and liquid dosage form is otherwise not commercially available)
2. Compound must be listed in reputable compendia as safe and effective for the indicated treatment.
3. Member will be responsible for Tier 3 copayment for compounded medications.
4. Compounded medications under $100 per claim will pay without the need for prior authorization.

REFERENCES: N/A

ATTACHMENTS: N/A

DEFINITIONS: N/A

POLICY AND PROCEDURE

DEPARTMENT: Ambetter Health Plans	**DOCUMENT NAME:** Compounded Medications
PAGE: 2 of 2	**REPLACES DOCUMENT:**
APPROVED DATE: 05/16	**RETIRED:**
EFFECTIVE DATE: 05/16	**REVIEWED/REVISED:** 05/17, 05/18
PRODUCT TYPE: Health Insurance Marketplace (HIM)	**REFERENCE NUMBER:** HIM.PHAR.20

REVISION LOG

REVISION	DATE
Removed reference to Envolve Pharmacy Solutions as this is an Ambetter benefit policy	05/17
Policy reviwed. No changes	05/18

POLICY AND PROCEDURE APPROVAL

Pharmacy & Therapeutics Committee: Approval on file

EPS Pharmacy Director, Marketplace: Approval on file

Sr. V.P., Chief Medical Officer: Approval on file

NOTE: The electronic approval is retained in Compliance 360.

Compounded Medication Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Summary of over $500

Row Labels	Count of RxClaimNbr	Sum of PhrDueAmt
	8	$ 13,977.25
EX	53	$ 153,207.94
IJ	56	$ 135,955.51
IV	302	$ 1,874,349.98
OR	68	$ 145,021.90
TD	65	$ 196,465.89
XX	103	$ 281,353.32
Total	**655**	**$ 2,800,331.79**

Summary of under $500

Row Labels	Count of RxClaimNbr	Sum of PhrDueAmt
	141	$ 4,942.96
EX	34	$ 3,230.89
IJ	803	$ 74,336.23
IR	85	$ 2,443.78
IV	3,306	$ 331,960.37
MT	112	$ 1,487.44
OR	1,864	$ 49,946.22
RE	1	$ 26.24
SC	4	$ 473.78
TD	6	$ 578.46
XX	339	$ 16,630.54
Total	**6,695**	**$ 486,056.91**

Medications > $500 (Oral and topical only)

Row Labels	Count of RxClaimNbr	Sum of PhrDueAmt
DOXEPIN HCL CRE 5%	132	$ 383,128.34
DICLOFENAC GEL 3%	128	$ 378,779.11
ORA-PLUS LIQ	65	$ 143,220.48
CIALIS TAB 10MG	23	$ 42,431.79
VIAGRA TAB 50MG	17	$ 48,989.06
REVATIO TAB 20MG	15	$ 42,510.67
VIAGRA TAB 100MG	7	$ 6,591.24
OMEPRAZOLE CAP 20MG	6	$ 3,867.09
TACROLIMUS POW MONOHYD	5	$ 4,568.33
GLYCERIN SOL SYNTHETC	5	$ 4,568.33
LIDOCAINE OIN 5%	5	$ 3,093.27
PCCA-PLUS SUS	5	$ 4,568.33
PROGRAF CAP 5MG	2	$ 1,674.50
XIFAXAN TAB 200MG	1	$ 1,023.22

Top 45 Medications < $500 (Oral and topical only)

Row Labels	Count of RxClaimNbr	Sum of PhrDueAmt
ORA-PLUS LIQ	673	$ 24,743.26
LIDOCAINE SOL 2% VISC	252	$ 3,612.14
SYRSPEND SF LIQ	193	$ 3,841.08
BANOPHEN LIQ 12.5/5ML	134	$ 2,013.15
TACROLIMUS CAP 5MG	128	$ 5,255.27
BACLOFEN TAB 10MG	109	$ 2,498.53
LANSOPRAZOLE CAP 30MG DR	91	$ 1,826.79
RULOX SUS	84	$ 1,191.01
SILDENAFIL TAB 20MG	81	$ 2,947.62
HYDROXYUREA CAP 500MG	78	$ 1,932.77
OMEPRAZOLE CAP 20MG	77	$ 2,082.19
ORAL SUSPEND LIQ	70	$ 2,577.66
BACLOFEN TAB 20MG	60	$ 1,389.92
ATENOLOL TAB 50MG	60	$ 733.90
FLAVOR PLUS LIQ	56	$ 1,457.06
CLONIDINE TAB 0.2MG	53	$ 594.38
LEVOTHYROXIN TAB 100MCG	51	$ 782.55
NYSTATIN SUS 100000	45	$ 1,060.44
AZATHIOPRINE TAB 50MG	44	$ 1,326.46
AMLODIPINE TAB 5MG	44	$ 501.08
AMLODIPINE TAB 10MG	41	$ 500.00
ENALAPRIL TAB 20MG	39	$ 437.33
URSODIOL CAP 300MG	39	$ 2,567.75
GLYCOPYRROL TAB 1MG	37	$ 1,044.97
TACROLIMUS CAP 1MG	35	$ 1,596.00
CARVEDILOL TAB 25MG	32	$ 365.05
GLYCOPYRROL TAB 2MG	28	$ 642.55
ENALAPRIL TAB 2.5MG	26	$ 373.22
HYDROCORT TAB 10MG	24	$ 395.11
SPIRONOLACT TAB 100MG	23	$ 286.20
SULFASALAZIN TAB 500MG	22	$ 810.78
METRONIDAZOL TAB 500MG	22	$ 342.46
SODIUM BICAR TAB 10GR	21	$ 345.32
SM ANTACID/ SUS ANTIGAS	20	$ 239.29
Q-DRYL LIQ 12.5/5ML	19	$ 246.60
DANTROLENE CAP 50MG	18	$ 1,297.83
METOPROL TAR TAB 100MG	18	$ 233.39
LIDO/PRILOCN CRE 2.5-2.5%	18	$ 3,330.45
ANTACID SUS MAX ST	18	$ 329.20
AMIODARONE TAB 200MG	16	$ 184.18
SPIRONOLACT TAB 25MG	16	$ 180.52
LABETALOL TAB 300MG	16	$ 229.38
OMEPRAZOLE TAB 20MG	15	$ 249.74
TOPIRAMATE TAB 200MG	15	$ 199.99
ENALAPRIL TAB 5MG	15	$ 260.10

Anthem- 19 claims in reporting period (1 year) > $500

Top 10 ingredients used in compounds

Row Labels	Count of DATE_FILLED
LIDOCAINE HCL VISCOUS SOLN 2%	404
ENALAPRIL MALEATE TAB 10 MG	47
DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML	44
PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT	42
URSODIOL CAP 300 MG	40
NYSTATIN SUSP 100000 UNIT/ML	31
HYDROXYUREA CAP 500 MG	31
TACROLIMUS CAP 5 MG	27
PROGESTERONE MICRONIZED (BULK) POWDER	24
AMIODARONE HCL TAB 200 MG	23

Top Pharmacies- names hidden

Row Labels	Count of DATE_FILLED
C	424
S	268
Spe	92
O	90
Sc	39
Spw	33
Ac	29
Ss	13
C2	12
Ic	12

Top Prescribers- names hidden

Row Labels	Count of DATE_FILLED
SR	42
TR	29
AI	28
JM	27
SH	25
RS	22
WA	22
RS2	22
HB	21
SN	20

DATE_FILLED	INGRED_NM
01Jun2017	TESTOSTERONE (BULK) POWDER
02Jun2017	NYSTATIN SUSP 100000 UNIT/ML
02Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
02Jun2017	HYDROXYUREA CAP 500 MG
02Jun2017	AMINOCAPROIC ACID (BULK) POWDER
02Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
04Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
05Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
05Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
05Jun2017	AMIODARONE HCL TAB 200 MG
06Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
06Jun2017	FLECAINIDE ACETATE TAB 50 MG
06Jun2017	VALACYCLOVIR HCL TAB 500 MG
07Jun2017	DESMOPRESSIN ACETATE TAB 0.1 MG
07Jun2017	METRONIDAZOLE TAB 500 MG
07Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
07Jun2017	SULFASALAZINE TAB 500 MG
08Jun2017	ENALAPRIL MALEATE TAB 5 MG
08Jun2017	ATENOLOL TAB 25 MG
09Jun2017	PROGESTERONE MICRONIZED (BULK) POWDER
09Jun2017	CLONIDINE HCL TAB 0.2 MG
09Jun2017	RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
09Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
09Jun2017	ENALAPRIL MALEATE TAB 10 MG
09Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
11Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
12Jun2017	LIDOCAINE OINT 5%
12Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
12Jun2017	AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
12Jun2017	TACROLIMUS CAP 5 MG
12Jun2017	ENALAPRIL MALEATE TAB 10 MG
13Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
13Jun2017	PROGESTERONE MICRONIZED (BULK) POWDER
13Jun2017	ENALAPRIL MALEATE TAB 10 MG
13Jun2017	ENALAPRIL MALEATE TAB 10 MG
13Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
14Jun2017	DEXAMETHASONE SOLN 0.5 MG/5ML
14Jun2017	NYSTATIN SUSP 100000 UNIT/ML
14Jun2017	METRONIDAZOLE TAB 500 MG
14Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
15Jun2017	DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
15Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
15Jun2017	LIDOCAINE HCL VISCOUS SOLN 2%
16Jun2017	BUDESONIDE DELAYED RELEASE PARTICLES CAP 3 MG
16Jun2017	ENALAPRIL MALEATE TAB 5 MG
16Jun2017	VALACYCLOVIR HCL TAB 500 MG

16Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
16Jun2017 NYSTATIN SUSP 100000 UNIT/ML
16Jun2017 SODIUM BICARBONATE INJ 8.4%
16Jun2017 ENALAPRIL MALEATE TAB 10 MG
16Jun2017 URSODIOL CAP 300 MG
17Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Jun2017 DIPHENHYDRAMINE HCL ELIXIR 12.5 MG/5ML
19Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Jun2017 ENALAPRIL MALEATE TAB 10 MG
21Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Jun2017 HYDROXYUREA CAP 500 MG
21Jun2017 PROPRANOLOL HCL TAB 40 MG
21Jun2017 FLECAINIDE ACETATE TAB 50 MG
22Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
22Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
22Jun2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
23Jun2017 SULFASALAZINE TAB 500 MG
23Jun2017 SILDENAFIL CITRATE TAB 20 MG
23Jun2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
23Jun2017 URSODIOL CAP 300 MG
25Jun2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
26Jun2017 NYSTATIN SUSP 100000 UNIT/ML
26Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Jun2017 ENALAPRIL MALEATE TAB 20 MG
27Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Jun2017 VANCOMYCIN HCL FOR INJ 5000 MG
27Jun2017 VALACYCLOVIR HCL TAB 500 MG
28Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Jun2017 DESMOPRESSIN ACETATE TAB 0.1 MG
28Jun2017 NYSTATIN TOPICAL POWDER 100000 UNIT/GM
28Jun2017 NYSTATIN SUSP 100000 UNIT/ML
28Jun2017 ATENOLOL TAB 25 MG
29Jun2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
29Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Jun2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Jun2017 ATENOLOL TAB 25 MG
30Jun2017 BUDESONIDE DELAYED RELEASE PARTICLES CAP 3 MG
02Jul2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
02Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Jul2017 HYDROCORTISONE TAB 10 MG

03Jul2017 AMIODARONE HCL TAB 200 MG
03Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Jul2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
03Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Jul2017 AMINOCAPROIC ACID (BULK) POWDER
05Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Jul2017 HYDROXYUREA CAP 500 MG
05Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
06Jul2017 TACROLIMUS CAP 5 MG
07Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Jul2017 PROGESTERONE MICRONIZED (BULK) POWDER
07Jul2017 MICAFUNGIN SODIUM FOR IV SOLN 100 MG
07Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
08Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
10Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
10Jul2017 VALACYCLOVIR HCL TAB 1 GM
10Jul2017 NYSTATIN SUSP 100000 UNIT/ML
10Jul2017 ENALAPRIL MALEATE TAB 10 MG
10Jul2017 URSODIOL CAP 300 MG
10Jul2017 ATENOLOL TAB 25 MG
11Jul2017 PROGESTERONE MICRONIZED (BULK) POWDER
11Jul2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
11Jul2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
12Jul2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
12Jul2017 NYSTATIN SUSP 100000 UNIT/ML
12Jul2017 ENALAPRIL MALEATE TAB 10 MG
13Jul2017 NITROGLYCERIN OINT 2%
13Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
13Jul2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
14Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Jul2017 HYDROCHLOROTHIAZIDE TAB 25 MG
14Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
15Jul2017 VANCOMYCIN HCL FOR INJ 10 GM
17Jul2017 ENALAPRIL MALEATE TAB 10 MG
17Jul2017 ENALAPRIL MALEATE TAB 10 MG
17Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
17Jul2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
18Jul2017 VANCOMYCIN HCL FOR INJ 10 GM
18Jul2017 ENALAPRIL MALEATE TAB 10 MG
18Jul2017 VANCOMYCIN HCL FOR INJ 10 GM
18Jul2017 NYSTATIN SUSP 100000 UNIT/ML
19Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%

19Jul2017 HYDROXYUREA CAP 500 MG
19Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Jul2017 FLECAINIDE ACETATE TAB 50 MG
20Jul2017 LANSOPRAZOLE CAP DELAYED RELEASE 30 MG
20Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Jul2017 LANSOPRAZOLE CAP DELAYED RELEASE 30 MG
20Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Jul2017 VALACYCLOVIR HCL TAB 1 GM
21Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Jul2017 ENALAPRIL MALEATE TAB 10 MG
23Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Jul2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
24Jul2017 DESMOPRESSIN ACETATE TAB 0.1 MG
24Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
24Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
24Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
24Jul2017 SULFASALAZINE TAB 500 MG
24Jul2017 ENALAPRIL MALEATE TAB 20 MG
24Jul2017 URSODIOL CAP 300 MG
25Jul2017 METRONIDAZOLE TAB 500 MG
25Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
25Jul2017 PROGESTERONE MICRONIZED (BULK) POWDER
25Jul2017 VANCOMYCIN HCL FOR INJ 1000 MG
25Jul2017 VANCOMYCIN HCL FOR INJ 10 GM
26Jul2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
26Jul2017 AMIODARONE HCL TAB 200 MG
26Jul2017 SILDENAFIL CITRATE TAB 20 MG
27Jul2017 LIDOCAINE OINT 5%
27Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Jul2017 VANCOMYCIN HCL FOR INJ 10 GM
28Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Jul2017 FLECAINIDE ACETATE TAB 50 MG
28Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Jul2017 VANCOMYCIN HCL FOR INJ 1000 MG
30Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
31Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
31Jul2017 LIDOCAINE HCL VISCOUS SOLN 2%
31Jul2017 VANCOMYCIN HCL FOR INJ 10 GM
01Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
01Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
01Aug2017 AMIODARONE HCL TAB 200 MG
01Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
02Aug2017 METRONIDAZOLE TAB 500 MG
02Aug2017 AMINOCAPROIC ACID (BULK) POWDER

02Aug2017 URSODIOL CAP 300 MG
02Aug2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
03Aug2017 AMINOCAPROIC ACID (BULK) POWDER
03Aug2017 WATER FOR INJECTION
03Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
03Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
04Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Aug2017 NYSTATIN SUSP 100000 UNIT/ML
04Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
04Aug2017 TACROLIMUS CAP 5 MG
04Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Aug2017 TACROLIMUS CAP 5 MG
04Aug2017 ATENOLOL TAB 25 MG
05Aug2017 HYDROXYUREA CAP 500 MG
07Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Aug2017 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
07Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Aug2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
07Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
08Aug2017 NYSTATIN SUSP 100000 UNIT/ML
08Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
08Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
09Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
09Aug2017 NITROGLYCERIN OINT 2%
09Aug2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
09Aug2017 ENALAPRIL MALEATE TAB 10 MG
09Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
10Aug2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
10Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
10Aug2017 ENALAPRIL MALEATE TAB 20 MG
11Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Aug2017 NITROGLYCERIN OINT 2%
11Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Aug2017 VANCOMYCIN HCL FOR INJ 10 GM
11Aug2017 ATENOLOL TAB 25 MG
11Aug2017 ENALAPRIL MALEATE TAB 10 MG
13Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Aug2017 NYSTATIN SUSP 100000 UNIT/ML
14Aug2017 METRONIDAZOLE TAB 500 MG
14Aug2017 ENALAPRIL MALEATE TAB 20 MG
15Aug2017 ENALAPRIL MALEATE TAB 10 MG
15Aug2017 VALACYCLOVIR HCL TAB 1 GM
16Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
16Aug2017 HYDROCORTISONE TAB 10 MG

17Aug2017 URSODIOL CAP 300 MG
17Aug2017 NITROGLYCERIN OINT 2%
18Aug2017 URSODIOL CAP 300 MG
18Aug2017 ENALAPRIL MALEATE TAB 10 MG
18Aug2017 PROGESTERONE MICRONIZED (BULK) POWDER
18Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Aug2017 PROGESTERONE MICRONIZED (BULK) POWDER
21Aug2017 PREDNISOLONE SYRUP 15 MG/5ML (USP SOLUTION EQUIVALENT)
21Aug2017 URSODIOL CAP 300 MG
22Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
22Aug2017 HYDROXYUREA CAP 500 MG
23Aug2017 SUCRALFATE SUSP 1 GM/10ML
23Aug2017 SUCRALFATE SUSP 1 GM/10ML
23Aug2017 PROGESTERONE MICRONIZED (BULK) POWDER
23Aug2017 AMIODARONE HCL TAB 200 MG
24Aug2017 SULFASALAZINE TAB 500 MG
24Aug2017 NYSTATIN SUSP 100000 UNIT/ML
24Aug2017 ENALAPRIL MALEATE TAB 20 MG
25Aug2017 SPIRONOLACTONE POWDER
25Aug2017 SODIUM CHLORIDE GRANULES
25Aug2017 TACROLIMUS CAP 5 MG
25Aug2017 AMLODIPINE BESYLATE TAB 10 MG (BASE EQUIVALENT)
26Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Aug2017 URSODIOL CAP 300 MG
28Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Aug2017 ENALAPRIL MALEATE TAB 10 MG
28Aug2017 VALACYCLOVIR HCL TAB 1 GM
29Aug2017 DEXAMETHASONE SOLN 0.5 MG/5ML
29Aug2017 NYSTATIN SUSP 100000 UNIT/ML
30Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Aug2017 LIDOCAINE HCL VISCOUS SOLN 2%
31Aug2017 TACROLIMUS CAP 5 MG
31Aug2017 PROGESTERONE MICRONIZED (BULK) POWDER
31Aug2017 FLECAINIDE ACETATE TAB 50 MG
01Sep2017 SPIRONOLACTONE TAB 25 MG
01Sep2017 SILDENAFIL CITRATE TAB 20 MG
03Sep2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
05Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Sep2017 AMIODARONE HCL TAB 200 MG
05Sep2017 METRONIDAZOLE TAB 500 MG
05Sep2017 ENALAPRIL MALEATE TAB 20 MG
05Sep2017 ATENOLOL TAB 25 MG

05Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
06Sep2017 PREDNISOLONE SYRUP 15 MG/5ML (USP SOLUTION EQUIVALENT)
07Sep2017 ENALAPRIL MALEATE TAB 10 MG
07Sep2017 ENALAPRIL MALEATE TAB 10 MG
07Sep2017 METRONIDAZOLE TAB 500 MG
08Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
08Sep2017 ATENOLOL TAB 25 MG
08Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
09Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
09Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
09Sep2017 NYSTATIN SUSP 100000 UNIT/ML
11Sep2017 LIDOCAINE OINT 5%
11Sep2017 HYDROXYUREA CAP 500 MG
11Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Sep2017 ENALAPRIL MALEATE TAB 10 MG
11Sep2017 VALACYCLOVIR HCL TAB 500 MG
11Sep2017 HYDROXYUREA CAP 500 MG
11Sep2017 VALACYCLOVIR HCL TAB 1 GM
12Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Sep2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
12Sep2017 ENALAPRIL MALEATE TAB 20 MG
13Sep2017 LIDOCAINE OINT 5%
13Sep2017 PROGESTERONE MICRONIZED (BULK) POWDER
13Sep2017 URSODIOL CAP 300 MG
14Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Sep2017 TACROLIMUS CAP 5 MG
15Sep2017 *SODIUM BICARBONATE POWDER**
15Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
15Sep2017 METRONIDAZOLE TAB 500 MG
17Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
17Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
17Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Sep2017 ENALAPRIL MALEATE TAB 20 MG
19Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Sep2017 ENALAPRIL MALEATE TAB 10 MG
19Sep2017 AMIODARONE HCL TAB 200 MG
19Sep2017 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
20Sep2017 NITROGLYCERIN OINT 2%

20Sep2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
20Sep2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
20Sep2017 FLECAINIDE ACETATE TAB 50 MG
20Sep2017 DAPTOMYCIN FOR IV SOLN 500 MG
20Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Sep2017 PROGESTERONE MICRONIZED (BULK) POWDER
21Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Sep2017 GLYCOPYRROLATE TAB 1 MG
21Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Sep2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
22Sep2017 SILDENAFIL CITRATE TAB 50 MG
22Sep2017 BACLOFEN TAB 10 MG
23Sep2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
23Sep2017 VALACYCLOVIR HCL TAB 1 GM
24Sep2017 NYSTATIN SUSP 100000 UNIT/ML
24Sep2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
25Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
25Sep2017 CLONIDINE HCL TAB 0.2 MG
25Sep2017 ENALAPRIL MALEATE TAB 2.5 MG
25Sep2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
25Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Sep2017 ENALAPRIL MALEATE TAB 10 MG
27Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Sep2017 HYDROXOCOBALAMIN (BULK) POWDER
27Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Sep2017 DEXAMETHASONE SOLN 0.5 MG/5ML
27Sep2017 HYDROXYUREA CAP 500 MG
28Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Sep2017 ENALAPRIL MALEATE TAB 10 MG
28Sep2017 SULFASALAZINE TAB 500 MG
28Sep2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
29Sep2017 SUCRALFATE SUSP 1 GM/10ML
29Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Sep2017 FLECAINIDE ACETATE TAB 50 MG
29Sep2017 ENALAPRIL MALEATE TAB 20 MG
29Sep2017 URSODIOL CAP 300 MG
30Sep2017 LIDOCAINE HCL VISCOUS SOLN 2%
01Oct2017 COLISTIMETHATE SOD FOR INJ 150 MG (COLISTIN BASE ACTIVITY)
01Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
02Oct2017 COLISTIMETHATE SOD FOR INJ 150 MG (COLISTIN BASE ACTIVITY)
02Oct2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
02Oct2017 TACROLIMUS CAP 5 MG
03Oct2017 COLISTIMETHATE SOD FOR INJ 150 MG (COLISTIN BASE ACTIVITY)
03Oct2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)

03Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Oct2017 METRONIDAZOLE TAB 500 MG
04Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Oct2017 VALACYCLOVIR HCL TAB 1 GM
05Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Oct2017 METRONIDAZOLE TAB 500 MG
05Oct2017 HYDROXYUREA CAP 500 MG
06Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
06Oct2017 ENALAPRIL MALEATE TAB 2.5 MG
06Oct2017 PROGESTERONE MICRONIZED (BULK) POWDER
06Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
06Oct2017 TACROLIMUS CAP 5 MG
07Oct2017 ENALAPRIL MALEATE TAB 10 MG
07Oct2017 HYDROXYUREA CAP 500 MG
08Oct2017 COLISTIMETHATE SOD FOR INJ 150 MG (COLISTIN BASE ACTIVITY)
09Oct2017 COLISTIMETHATE SOD FOR INJ 150 MG (COLISTIN BASE ACTIVITY)
09Oct2017 ZONISAMIDE CAP 100 MG
09Oct2017 SILDENAFIL CITRATE TAB 20 MG
09Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
09Oct2017 URSODIOL CAP 300 MG
10Oct2017 LIDOCAINE OINT 5%
10Oct2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
10Oct2017 PROGESTERONE MICRONIZED (BULK) POWDER
10Oct2017 ATENOLOL TAB 25 MG
10Oct2017 ENALAPRIL MALEATE TAB 20 MG
10Oct2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
10Oct2017 URSODIOL CAP 300 MG
10Oct2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
11Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Oct2017 ATENOLOL TAB 25 MG
11Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Oct2017 ENALAPRIL MALEATE TAB 20 MG
12Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
13Oct2017 TRIAMCINOLONE ACETONIDE CREAM 0.1%
13Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Oct2017 ENALAPRIL MALEATE TAB 10 MG
16Oct2017 URSODIOL CAP 300 MG
16Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
16Oct2017 SPIRONOLACTONE TAB 25 MG
16Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
16Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG

16Oct2017 AMIODARONE HCL TAB 200 MG
16Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
17Oct2017 SUCRALFATE SUSP 1 GM/10ML
17Oct2017 NITROGLYCERIN OINT 2%
17Oct2017 GLYCOPYRROLATE TAB 1 MG
17Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
17Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
17Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
18Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
18Oct2017 SILDENAFIL CITRATE TAB 50 MG
18Oct2017 URSODIOL CAP 300 MG
18Oct2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
18Oct2017 BACLOFEN TAB 10 MG
18Oct2017 PROGESTERONE MICRONIZED (BULK) POWDER
18Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
18Oct2017 ENALAPRIL MALEATE TAB 10 MG
18Oct2017 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
18Oct2017 VALACYCLOVIR HCL TAB 1 GM
19Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
19Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
20Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Oct2017 NYSTATIN SUSP 100000 UNIT/ML
20Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
20Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
21Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
21Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
22Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
22Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
22Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 HYDROXYUREA CAP 500 MG
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 NITROGLYCERIN OINT 2%
23Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 ENALAPRIL MALEATE TAB 10 MG
23Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
23Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
24Oct2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
24Oct2017 ALLOPURINOL TAB 100 MG

24Oct2017 GENTAMICIN SULFATE INJ 40 MG/ML
24Oct2017 NYSTATIN SUSP 100000 UNIT/ML
24Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
24Oct2017 DAPTOMYCIN FOR IV SOLN 500 MG
25Oct2017 NYSTATIN SUSP 100000 UNIT/ML
25Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
25Oct2017 TACROLIMUS CAP 5 MG
25Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
26Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Oct2017 SODIUM CHLORIDE IV SOLN 0.9%
27Oct2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
27Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Oct2017 PREDNISOLONE SYRUP 15 MG/5ML (USP SOLUTION EQUIVALENT)
30Oct2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
30Oct2017 DEXTROAMPHETAMINE SULFATE TAB 10 MG
30Oct2017 URSODIOL CAP 300 MG
30Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Oct2017 ERTAPENEM SODIUM FOR INJ 1 GM (BASE EQUIVALENT)
30Oct2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Oct2017 AZATHIOPRINE TAB 50 MG
31Oct2017 AMIODARONE HCL TAB 200 MG
31Oct2017 HYDROXYUREA CAP 500 MG
31Oct2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
31Oct2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
01Nov2017 ENALAPRIL MALEATE TAB 2.5 MG
01Nov2017 FLECAINIDE ACETATE TAB 50 MG
01Nov2017 VALACYCLOVIR HCL TAB 500 MG
02Nov2017 SULFASALAZINE TAB 500 MG
02Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Nov2017 NYSTATIN SUSP 100000 UNIT/ML
03Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Nov2017 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
06Nov2017 ZONISAMIDE CAP 100 MG
06Nov2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
06Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
06Nov2017 DIPHENHYDRAMINE HCL ELIXIR 12.5 MG/5ML
06Nov2017 ENALAPRIL MALEATE TAB 20 MG
06Nov2017 SULFASALAZINE TAB 500 MG
06Nov2017 HYDROXYUREA CAP 500 MG
07Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Nov2017 ENALAPRIL MALEATE TAB 10 MG
07Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
08Nov2017 GENTAMICIN SULFATE INJ 40 MG/ML
08Nov2017 SILDENAFIL CITRATE (BULK) POWDER
08Nov2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
09Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
09Nov2017 ENALAPRIL MALEATE TAB 10 MG

09Nov2017 ATENOLOL TAB 25 MG
09Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
10Nov2017 LISINOPRIL TAB 10 MG
10Nov2017 PROGESTERONE MICRONIZED (BULK) POWDER
10Nov2017 HYDROXYUREA CAP 500 MG
10Nov2017 URSODIOL CAP 300 MG
10Nov2017 URSODIOL CAP 300 MG
11Nov2017 VALACYCLOVIR HCL TAB 500 MG
12Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
13Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
13Nov2017 AMIODARONE HCL TAB 200 MG
14Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Nov2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
14Nov2017 ATENOLOL TAB 25 MG
14Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
14Nov2017 ENALAPRIL MALEATE TAB 10 MG
15Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
15Nov2017 TACROLIMUS CAP 5 MG
16Nov2017 SILDENAFIL CITRATE TAB 50 MG
16Nov2017 GLYCOPYRROLATE TAB 1 MG
17Nov2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
17Nov2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
17Nov2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
17Nov2017 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
17Nov2017 TACROLIMUS CAP 5 MG
17Nov2017 ENALAPRIL MALEATE TAB 20 MG
18Nov2017 PROGESTERONE MICRONIZED (BULK) POWDER
18Nov2017 ALUM & MAG HYDROXIDE-SIMETHICONE SUSP 200-200-20 MG/5ML
18Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Nov2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
19Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
20Nov2017 PROGESTERONE MICRONIZED (BULK) POWDER
20Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Nov2017 TRIAMCINOLONE ACETONIDE CREAM 0.1%
21Nov2017 ALUM & MAG HYDROXIDE-SIMETHICONE SUSP 200-200-20 MG/5ML
21Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
22Nov2017 URSODIOL CAP 300 MG
22Nov2017 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
22Nov2017 VALACYCLOVIR HCL TAB 500 MG
24Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%

24Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
24Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
25Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
25Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
27Nov2017 DEXTROAMPHETAMINE SULFATE TAB 10 MG
27Nov2017 ENALAPRIL MALEATE TAB 10 MG
28Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Nov2017 PROGESTERONE MICRONIZED (BULK) POWDER
28Nov2017 NYSTATIN SUSP 100000 UNIT/ML
28Nov2017 AMIODARONE HCL TAB 200 MG
28Nov2017 HYDROXYUREA CAP 500 MG
28Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Nov2017 METRONIDAZOLE TAB 500 MG
29Nov2017 ENALAPRIL MALEATE TAB 2.5 MG
29Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Nov2017 HYDROCHLOROTHIAZIDE TAB 25 MG
30Nov2017 SUCRALFATE SUSP 1 GM/10ML
30Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Nov2017 LIDOCAINE HCL VISCOUS SOLN 2%
30Nov2017 ZONISAMIDE CAP 100 MG
01Dec2017 DILTIAZEM HCL TAB 120 MG
01Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
03Dec2017 DIPHENHYDRAMINE HCL ELIXIR 12.5 MG/5ML
03Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
04Dec2017 VALACYCLOVIR HCL TAB 500 MG
04Dec2017 HYDROXYUREA CAP 500 MG
05Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
05Dec2017 FLECAINIDE ACETATE TAB 50 MG
05Dec2017 SULFASALAZINE TAB 500 MG
05Dec2017 ENALAPRIL MALEATE TAB 10 MG
06Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
06Dec2017 SILDENAFIL CITRATE TAB 20 MG
06Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Dec2017 PROGESTERONE MICRONIZED (BULK) POWDER
07Dec2017 ENALAPRIL MALEATE TAB 20 MG
07Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%

07Dec2017 LIDOCAINE OINT 5%
07Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
07Dec2017 ENALAPRIL MALEATE TAB 10 MG
08Dec2017 TACROLIMUS CAP 5 MG
09Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
10Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
11Dec2017 FLECAINIDE ACETATE TAB 50 MG
11Dec2017 ATENOLOL TAB 25 MG
11Dec2017 AMIODARONE HCL TAB 200 MG
12Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Dec2017 URSODIOL CAP 300 MG
12Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Dec2017 NYSTATIN SUSP 100000 UNIT/ML
12Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
12Dec2017 HYDROXYUREA CAP 500 MG
13Dec2017 TACROLIMUS CAP 5 MG
13Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
13Dec2017 URSODIOL CAP 300 MG
14Dec2017 ATENOLOL TAB 25 MG
14Dec2017 GLYCOPYRROLATE TAB 1 MG
14Dec2017 SILDENAFIL CITRATE TAB 50 MG
14Dec2017 AZATHIOPRINE TAB 50 MG
14Dec2017 PROGESTERONE MICRONIZED (BULK) POWDER
14Dec2017 VALACYCLOVIR HCL TAB 500 MG
16Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
16Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
17Dec2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
17Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
18Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
19Dec2017 NYSTATIN SUSP 100000 UNIT/ML
19Dec2017 ENALAPRIL MALEATE TAB 20 MG
21Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
21Dec2017 HYDROCHLOROTHIAZIDE TAB 50 MG
22Dec2017 PROGESTERONE MICRONIZED (BULK) POWDER
22Dec2017 METRONIDAZOLE TAB 500 MG
22Dec2017 HYDROCORTISONE TAB 10 MG
22Dec2017 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
26Dec2017 URSODIOL CAP 300 MG
26Dec2017 SODIUM BICARBONATE INJ 8.4%
26Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Dec2017 PROGESTERONE MICRONIZED (BULK) POWDER
26Dec2017 NYSTATIN SUSP 100000 UNIT/ML
26Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Dec2017 HYDROXYUREA CAP 500 MG
26Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
26Dec2017 DEXTROAMPHETAMINE SULFATE TAB 10 MG
27Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%

27Dec2017 VALACYCLOVIR HCL TAB 500 MG
27Dec2017 LISINOPRIL TAB 10 MG
27Dec2017 ENALAPRIL MALEATE TAB 10 MG
27Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Dec2017 AMIODARONE HCL TAB 200 MG
28Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Dec2017 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
28Dec2017 ENALAPRIL MALEATE TAB 10 MG
28Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
28Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
29Dec2017 TACROLIMUS CAP 1 MG
29Dec2017 PREDNISOLONE SYRUP 15 MG/5ML (USP SOLUTION EQUIVALENT)
29Dec2017 ENALAPRIL MALEATE TAB 2.5 MG
29Dec2017 HYDROXYUREA CAP 500 MG
29Dec2017 TACROLIMUS CAP 5 MG
31Dec2017 LIDOCAINE HCL VISCOUS SOLN 2%
31Dec2017 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
01Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Jan2018 ZONISAMIDE CAP 100 MG
02Jan2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
02Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Jan2018 ENALAPRIL MALEATE TAB 10 MG
03Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
03Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
04Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
04Jan2018 ENALAPRIL MALEATE TAB 20 MG
04Jan2018 URSODIOL CAP 300 MG
05Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
06Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Jan2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
07Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Jan2018 SILDENAFIL CITRATE TAB 20 MG
08Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Jan2018 HYDROXYUREA CAP 500 MG
09Jan2018 URSODIOL CAP 300 MG
09Jan2018 ENALAPRIL MALEATE TAB 10 MG
09Jan2018 VALACYCLOVIR HCL TAB 500 MG
10Jan2018 FLECAINIDE ACETATE TAB 50 MG
10Jan2018 GABAPENTIN POWDER
10Jan2018 TACROLIMUS CAP 5 MG
11Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
11Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
11Jan2018 SULFASALAZINE TAB 500 MG
11Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT

12Jan2018 METRONIDAZOLE TAB 500 MG
12Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
12Jan2018 CIPROFLOXACIN HCL TAB 250 MG (BASE EQUIV)
12Jan2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
12Jan2018 AMIODARONE HCL TAB 200 MG
12Jan2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
12Jan2018 NYSTATIN SUSP 100000 UNIT/ML
12Jan2018 NYSTATIN SUSP 100000 UNIT/ML
12Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
13Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
13Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
13Jan2018 HYDROXYUREA CAP 500 MG
13Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
14Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
15Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
16Jan2018 ENALAPRIL MALEATE TAB 20 MG
16Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
17Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
17Jan2018 TACROLIMUS CAP 1 MG
17Jan2018 LIDOCAINE OINT 5%
17Jan2018 URSODIOL CAP 300 MG
17Jan2018 FLECAINIDE ACETATE TAB 50 MG
18Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Jan2018 SODIUM BICARBONATE INJ 8.4%
18Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Jan2018 METRONIDAZOLE TAB 500 MG
18Jan2018 URSODIOL CAP 300 MG
18Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
19Jan2018 TACROLIMUS CAP 5 MG
19Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
20Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
20Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
20Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
21Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
21Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
21Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
22Jan2018 AMIODARONE HCL TAB 200 MG
22Jan2018 BACLOFEN TAB 10 MG
22Jan2018 VALACYCLOVIR HCL TAB 500 MG
22Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
23Jan2018 ATENOLOL TAB 25 MG
23Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
24Jan2018 HYDROCORTISONE TAB 5 MG

24Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
24Jan2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
24Jan2018 PIPERACILLIN SOD-TAZOBACTAM SOD FOR INJ 4.5 GM (4-0.5 GM)
24Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
25Jan2018 PIPERACILLIN SOD-TAZOBACTAM SOD FOR INJ 4.5 GM (4-0.5 GM)
25Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
25Jan2018 ENALAPRIL MALEATE TAB 2.5 MG
25Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
25Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
26Jan2018 HYDROCORTISONE POWDER
26Jan2018 METRONIDAZOLE TAB 500 MG
26Jan2018 DEXTROAMPHETAMINE SULFATE TAB 10 MG
26Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
27Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
28Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
29Jan2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
29Jan2018 *SODIUM BICARBONATE POWDER**
29Jan2018 PIPERACILLIN SOD-TAZOBACTAM SOD FOR INJ 4.5 GM (4-0.5 GM)
29Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
30Jan2018 URSODIOL CAP 300 MG
30Jan2018 LISINOPRIL TAB 10 MG
30Jan2018 ZONISAMIDE CAP 100 MG
30Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
31Jan2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
31Jan2018 LIDOCAINE HCL VISCOUS SOLN 2%
31Jan2018 ENALAPRIL MALEATE TAB 10 MG
31Jan2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
01Feb2018 VALACYCLOVIR HCL TAB 500 MG
01Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
02Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
03Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
04Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
05Feb2018 WATER FOR INJECTION
05Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
05Feb2018 URSODIOL CAP 300 MG
05Feb2018 NYSTATIN TOPICAL POWDER 100000 UNIT/GM
05Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
05Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
05Feb2018 ENALAPRIL MALEATE TAB 20 MG
05Feb2018 AMIODARONE HCL TAB 200 MG
06Feb2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
06Feb2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
06Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
06Feb2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
06Feb2018 TACROLIMUS CAP 5 MG
06Feb2018 SILDENAFIL CITRATE TAB 20 MG

06Feb2018 HYDROXYUREA CAP 500 MG
06Feb2018 HYDROXYUREA CAP 500 MG
06Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
06Feb2018 ENALAPRIL MALEATE TAB 10 MG
07Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Feb2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
07Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Feb2018 ENALAPRIL MALEATE TAB 10 MG
07Feb2018 AZATHIOPRINE TAB 50 MG
07Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
08Feb2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
08Feb2018 TACROLIMUS CAP 1 MG
08Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
08Feb2018 NYSTATIN SUSP 100000 UNIT/ML
09Feb2018 SPIRONOLACTONE TAB 25 MG
09Feb2018 TACROLIMUS CAP 5 MG
09Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
09Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
09Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
10Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
10Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
10Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
11Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
12Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
12Feb2018 NITROFURANTOIN MACROCRYSTALLINE CAP 100 MG
12Feb2018 AMIODARONE HCL TAB 200 MG
12Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
13Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
13Feb2018 ZIDOVUDINE CAP 100 MG
13Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
13Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
13Feb2018 ENALAPRIL MALEATE TAB 10 MG
13Feb2018 HYDROXYUREA CAP 500 MG
13Feb2018 ENALAPRIL MALEATE TAB 20 MG
13Feb2018 VALACYCLOVIR HCL TAB 500 MG
13Feb2018 SULFASALAZINE TAB 500 MG
13Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
14Feb2018 LIDOCAINE-PRILOCAINE CREAM 2.5-2.5%
14Feb2018 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
14Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
14Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
14Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
15Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%

15Feb2018 AMIODARONE HCL TAB 200 MG
15Feb2018 OMEPRAZOLE (BULK) POWDER
15Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
16Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
16Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
16Feb2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
16Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
16Feb2018 OSELTAMIVIR PHOSPHATE CAP 75 MG (BASE EQUIV)
16Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
16Feb2018 URSODIOL CAP 300 MG
16Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
16Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
16Feb2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
16Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
17Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
18Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
19Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
19Feb2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
20Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
20Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
21Feb2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
21Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
21Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
21Feb2018 PENICILLIN G POTASSIUM FOR INJ 5000000 UNIT
22Feb2018 URSODIOL CAP 300 MG
23Feb2018 METRONIDAZOLE TAB 500 MG
23Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Feb2018 CIPROFLOXACIN HCL TAB 250 MG (BASE EQUIV)
23Feb2018 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
23Feb2018 FLECAINIDE ACETATE TAB 50 MG
23Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Feb2018 ATENOLOL TAB 25 MG
24Feb2018 NALTREXONE HCL TAB 50 MG
24Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
25Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
26Feb2018 HYDROXYUREA CAP 500 MG
26Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
26Feb2018 DEXTROAMPHETAMINE SULFATE TAB 10 MG
26Feb2018 ENALAPRIL MALEATE TAB 2.5 MG
26Feb2018 LIDOCAINE HCL VISCOUS SOLN 2%
27Feb2018 NITROGLYCERIN OINT 2%
27Feb2018 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
27Feb2018 VALACYCLOVIR HCL TAB 500 MG
28Feb2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
28Feb2018 GLYCOPYRROLATE TAB 1 MG

28Feb2018 TACROLIMUS CAP 5 MG
28Feb2018 URSODIOL CAP 300 MG
01Mar2018 ZONISAMIDE CAP 100 MG
01Mar2018 TACROLIMUS CAP 5 MG
02Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Mar2018 SODIUM BICARBONATE INJ 8.4%
02Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Mar2018 SPIRONOLACTONE TAB 25 MG
02Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
03Mar2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
04Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
05Mar2018 *SODIUM BICARBONATE POWDER**
05Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
05Mar2018 LISINOPRIL TAB 10 MG
06Mar2018 AMIODARONE HCL TAB 200 MG
06Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Mar2018 CIPROFLOXACIN HCL TAB 500 MG (BASE EQUIV)
08Mar2018 ENALAPRIL MALEATE TAB 10 MG
09Mar2018 HYDROCORTISONE TAB 5 MG
09Mar2018 HYDROXYUREA CAP 500 MG
09Mar2018 VALACYCLOVIR HCL TAB 500 MG
11Mar2018 ALUM & MAG HYDROXIDE-SIMETHICONE SUSP 200-200-20 MG/5ML
11Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
12Mar2018 GLYCOPYRROLATE TAB 1 MG
13Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
14Mar2018 CLONIDINE HCL TAB 0.2 MG
14Mar2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
14Mar2018 HYDROCHLOROTHIAZIDE TAB 25 MG
15Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
15Mar2018 ENALAPRIL MALEATE TAB 20 MG
15Mar2018 SULFASALAZINE TAB 500 MG
15Mar2018 AMIODARONE HCL TAB 200 MG
16Mar2018 TACROLIMUS CAP 1 MG
17Mar2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
18Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
19Mar2018 NYSTATIN SUSP 100000 UNIT/ML
19Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
20Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
20Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
20Mar2018 URSODIOL CAP 300 MG
21Mar2018 NYSTATIN SUSP 100000 UNIT/ML
22Mar2018 LANSOPRAZOLE CAP DELAYED RELEASE 30 MG
22Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
22Mar2018 VALACYCLOVIR HCL TAB 500 MG

23Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Mar2018 HYDROXYUREA CAP 500 MG
23Mar2018 AZATHIOPRINE TAB 50 MG
23Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
26Mar2018 HYDROXYUREA CAP 500 MG
26Mar2018 ATROPINE SULFATE OPHTH SOLN 1%
26Mar2018 DEXTROAMPHETAMINE SULFATE TAB 10 MG
26Mar2018 URSODIOL CAP 300 MG
27Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
27Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
27Mar2018 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
28Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
28Mar2018 TACROLIMUS CAP 5 MG
29Mar2018 ZONISAMIDE CAP 100 MG
30Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
30Mar2018 LIDOCAINE HCL VISCOUS SOLN 2%
30Mar2018 ATROPINE SULFATE OPHTH SOLN 1%
30Mar2018 ENALAPRIL MALEATE TAB 10 MG
30Mar2018 TACROLIMUS CAP 5 MG
01Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
02Apr2018 SODIUM BICARBONATE INJ 8.4%
02Apr2018 ENALAPRIL MALEATE TAB 2.5 MG
02Apr2018 PREDNISOLONE SYRUP 15 MG/5ML (USP SOLUTION EQUIVALENT)
02Apr2018 URSODIOL CAP 300 MG
03Apr2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
03Apr2018 VALACYCLOVIR HCL TAB 500 MG
04Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
05Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
05Apr2018 ATENOLOL TAB 25 MG
05Apr2018 ATROPINE SULFATE OPHTH SOLN 1%
06Apr2018 AMLODIPINE BESYLATE TAB 10 MG (BASE EQUIVALENT)
06Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
06Apr2018 NYSTATIN SUSP 100000 UNIT/ML
07Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
07Apr2018 ENALAPRIL MALEATE TAB 10 MG
07Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
08Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
09Apr2018 SUCRALFATE SUSP 1 GM/10ML
09Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
09Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
10Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
10Apr2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
10Apr2018 NITROGLYCERIN OINT 2%
11Apr2018 LIDOCAINE HCL GEL 2%
12Apr2018 TOPIRAMATE TAB 200 MG
13Apr2018 SULFASALAZINE TAB 500 MG
13Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%

13Apr2018 METRONIDAZOLE TAB 500 MG
13Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
13Apr2018 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
13Apr2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
13Apr2018 PROPRANOLOL HCL TAB 40 MG
13Apr2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
16Apr2018 METRONIDAZOLE TAB 250 MG
16Apr2018 ATROPINE SULFATE OPHTH SOLN 1%
16Apr2018 VALACYCLOVIR HCL TAB 500 MG
17Apr2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
17Apr2018 ENALAPRIL MALEATE TAB 10 MG
17Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Apr2018 HYDROXYUREA CAP 500 MG
18Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
18Apr2018 ENALAPRIL MALEATE TAB 20 MG
19Apr2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
19Apr2018 BETAMETHASONE VALERATE OINT 0.1% (BASE EQUIVALENT)
19Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
19Apr2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
19Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
19Apr2018 AMIODARONE HCL TAB 200 MG
20Apr2018 METRONIDAZOLE TAB 500 MG
20Apr2018 URSODIOL CAP 300 MG
22Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
23Apr2018 CIPROFLOXACIN HCL TAB 250 MG (BASE EQUIV)
23Apr2018 AMIODARONE HCL TAB 200 MG
23Apr2018 METRONIDAZOLE TAB 500 MG
23Apr2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
23Apr2018 LISINOPRIL TAB 10 MG
23Apr2018 TACROLIMUS CAP 5 MG
23Apr2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
23Apr2018 URSODIOL CAP 300 MG
24Apr2018 ZONISAMIDE CAP 100 MG
25Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
25Apr2018 ATENOLOL TAB 25 MG
25Apr2018 TACROLIMUS CAP 5 MG
26Apr2018 NITROGLYCERIN OINT 2%
26Apr2018 DEXTROAMPHETAMINE SULFATE TAB 10 MG
26Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
26Apr2018 METRONIDAZOLE TAB 500 MG
26Apr2018 SULFASALAZINE TAB 500 MG
27Apr2018 SPIRONOLACTONE TAB 25 MG
27Apr2018 HYDROCHLOROTHIAZIDE TAB 25 MG

28Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
30Apr2018 LIDOCAINE HCL VISCOUS SOLN 2%
01May2018 LIDOCAINE HCL VISCOUS SOLN 2%
01May2018 LIDOCAINE HCL VISCOUS SOLN 2%
01May2018 URSODIOL CAP 300 MG
03May2018 LIDOCAINE HCL VISCOUS SOLN 2%
03May2018 LIDOCAINE HCL VISCOUS SOLN 2%
03May2018 HYDROXYUREA CAP 500 MG
03May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
04May2018 OMEPRAZOLE DELAYED RELEASE TAB 20 MG
04May2018 LIDOCAINE HCL VISCOUS SOLN 2%
04May2018 LIDOCAINE HCL VISCOUS SOLN 2%
04May2018 URSODIOL CAP 300 MG
05May2018 LIDOCAINE HCL VISCOUS SOLN 2%
05May2018 LIDOCAINE HCL VISCOUS SOLN 2%
06May2018 LIDOCAINE HCL VISCOUS SOLN 2%
06May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
07May2018 LIDOCAINE HCL VISCOUS SOLN 2%
07May2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
08May2018 NYSTATIN SUSP 100000 UNIT/ML
08May2018 PROGESTERONE MICRONIZED (BULK) POWDER
08May2018 PROGESTERONE MICRONIZED (BULK) POWDER
08May2018 ENALAPRIL MALEATE TAB 10 MG
08May2018 LIDOCAINE HCL VISCOUS SOLN 2%
09May2018 NYSTATIN SUSP 100000 UNIT/ML
09May2018 LIDOCAINE HCL VISCOUS SOLN 2%
09May2018 ENALAPRIL MALEATE TAB 2.5 MG
10May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
10May2018 ALUM & MAG HYDROXIDE-SIMETHICONE SUSP 200-200-20 MG/5ML
10May2018 LIDOCAINE HCL VISCOUS SOLN 2%
11May2018 VANCOMYCIN HCL CAP 125 MG
11May2018 SODIUM BICARBONATE INJ 8.4%
12May2018 LIDOCAINE HCL VISCOUS SOLN 2%
12May2018 LIDOCAINE HCL VISCOUS SOLN 2%
13May2018 LIDOCAINE HCL VISCOUS SOLN 2%
13May2018 LIDOCAINE HCL VISCOUS SOLN 2%
14May2018 DEXAMETHASONE SODIUM PHOSPHATE INJ 20 MG/5ML
14May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
14May2018 ZONISAMIDE CAP 100 MG
14May2018 SULFASALAZINE TAB 500 MG
14May2018 LIDOCAINE HCL VISCOUS SOLN 2%
15May2018 TACROLIMUS CAP 5 MG
15May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
15May2018 LIDOCAINE HCL VISCOUS SOLN 2%
15May2018 ENALAPRIL MALEATE TAB 10 MG
15May2018 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
16May2018 URSODIOL CAP 300 MG

16May2018 LIDOCAINE HCL VISCOUS SOLN 2%
16May2018 LIDOCAINE HCL VISCOUS SOLN 2%
16May2018 LIDOCAINE HCL VISCOUS SOLN 2%
16May2018 LIDOCAINE HCL VISCOUS SOLN 2%
17May2018 LIDOCAINE HCL VISCOUS SOLN 2%
17May2018 ENALAPRIL MALEATE TAB 20 MG
17May2018 OMEPRAZOLE CAP DELAYED RELEASE 20 MG
17May2018 LIDOCAINE HCL VISCOUS SOLN 2%
17May2018 LIDOCAINE HCL VISCOUS SOLN 2%
18May2018 LIDOCAINE HCL VISCOUS SOLN 2%
18May2018 LANSOPRAZOLE CAP DELAYED RELEASE 30 MG
20May2018 LIDOCAINE HCL VISCOUS SOLN 2%
20May2018 LIDOCAINE HCL VISCOUS SOLN 2%
20May2018 LIDOCAINE HCL VISCOUS SOLN 2%
21May2018 LANSOPRAZOLE CAP DELAYED RELEASE 30 MG
21May2018 LIDOCAINE HCL VISCOUS SOLN 2%
21May2018 URSODIOL CAP 300 MG
21May2018 LIDOCAINE HCL VISCOUS SOLN 2%
21May2018 ATROPINE SULFATE OPHTH SOLN 1%
21May2018 LIDOCAINE HCL VISCOUS SOLN 2%
21May2018 AMIODARONE HCL TAB 200 MG
21May2018 AZATHIOPRINE TAB 50 MG
22May2018 LIDOCAINE HCL VISCOUS SOLN 2%
22May2018 TACROLIMUS CAP 5 MG
22May2018 ATROPINE SULFATE OPHTH SOLN 1%
22May2018 LIDOCAINE HCL VISCOUS SOLN 2%
23May2018 LISINOPRIL TAB 10 MG
23May2018 RANITIDINE HCL SYRUP 15 MG/ML (75 MG/5ML)
24May2018 LANSOPRAZOLE CAP DELAYED RELEASE 30 MG
25May2018 LIDOCAINE HCL VISCOUS SOLN 2%
25May2018 AMLODIPINE BESYLATE TAB 5 MG (BASE EQUIVALENT)
25May2018 LIDOCAINE HCL VISCOUS SOLN 2%
25May2018 LIDOCAINE HCL VISCOUS SOLN 2%
26May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
26May2018 LIDOCAINE HCL VISCOUS SOLN 2%
26May2018 LIDOCAINE HCL VISCOUS SOLN 2%
26May2018 LIDOCAINE HCL VISCOUS SOLN 2%
26May2018 DIPHENHYDRAMINE HCL LIQUID 12.5 MG/5ML
27May2018 LIDOCAINE HCL VISCOUS SOLN 2%
27May2018 LIDOCAINE HCL VISCOUS SOLN 2%

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Top 10 Compounds

January 1, 2018 -May 31, 2018

By Claims over $500

Count of Members	Count of Claims
78	439

By Product

Drug Name	Count of Members	Count of Claims
LIDO/PRILOCN CRE 2.5-2.5%	463	1,543
LIDOCAINE SOL 2% VISC	199	203
ANTACID LIQ SUS	85	86
BANOPHEN LIQ 12.5/5ML	79	80
RULOX SUS	56	56
NYSTATIN SUS 100000	18	18
BUDESONIDE POW	1	1
OMEPRAZOLE POW	6	6
AMLODIPINE TAB 10MG	12	12
ORA-PLUS LIQ	5	5

By Pharmacy

Blinded Pharmacy ID	Count of Members	Count of Claims
A	468	1,548
B	413	425
C	129	129
D	64	69
E	51	54
F	41	43
G	39	39
H	35	35
I	33	33
J	24	24

By Prescriber

Blinded Provider ID	Count of Members	Count of Claims
A	287	968
B	48	161
C	45	136
D	6	7
E	9	11
F	6	7
G	28	86
H	22	76
I	26	26
J	10	11

Botulinum Toxin

DRUG.00006

Override(s)	Approval Duration
Prior Authorization	Migraine indication: **Initial** 6 month approval, then ongoing treatment 1 year All other indications: 1 year

******Washington Medicaid – See State Specific Mandate below for diagnoses of migraine headache and tension-type headache***

Medications
Botox (onabotulinumtoxinA)
Dysport (abobotulinumtoxinA)
Myobloc (rimabotulinumtoxinB)
Xeomin (incobotulinumtoxinA)

APPROVAL CRITERIA

I. The use of botulinum toxin may be approved for treatment of:
   A. Strabismus
   B. Achalasia
   C. Anal fissures

II. The use of botulinum toxin may be approved for the treatment of the following disorders if associated with spasticity or dystonia:
   A. Blepharospasm
   B. Cerebral palsy
   C. Facial nerve (VII) dystonia
   D. Hereditary spastic paraparesis
   E. Hemifacial Spasm
   F. Idiopathic torsion dystonia
   G. Multiple sclerosis
   H. Neuromyelitis optica
   I. Organic writer's cramp
   J. Orofacial dyskinesia (that is, jaw closure dystonia)
   K. Schilder's disease
   L. Spasmodic dysphonia or laryngeal dystonia (a disorder of speech due to abnormal control of the laryngeal muscles present only during the specific task of speaking)
   M. Spastic hemiplegia
   N. Spasticity related to stroke, spinal cord injury, or traumatic brain injury
   O. Symptomatic torsion dystonia

P. Other forms of upper motor neuron spasticity

III. The use of botulinum toxin may be approved for the treatment of significant drooling in individuals who are unable to tolerate scopolamine

IV. The use of botulinum toxin may be approved in the initial treatment of Cervical Dystonia (spasmodic torticollis) of moderate or greater severity when all of the following criteria are met:

A. History of recurrent clonic and/or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, splenius, trapezius and/or posterior cervical muscles; **AND**
B. Sustained head tilt and/or abnormal posturing with limited range of motion in the neck; **AND**
C. The duration of the condition is greater than 6 months

Subsequent injections of botulinum toxin for the treatment of cervical dystonia (spasmodic torticollis) of moderate or greater severity may be approved when:

A. There is a response to the initial treatment documented in the medical records; **AND**
B. The individual still meets the medical criteria above

V. The use of botulinum toxin may be approved as a treatment of neurogenic overactive bladder (also referred to as detrusor overactivity or detrusor sphincter dyssynergia) that is inadequately controlled with anticholinergic therapy

VI. The use of botulinum toxin may be approved as a treatment of idiopathic overactive bladder in adults who are unresponsive to or intolerant of a trial of anticholinergic therapy.

VII. The use of botulinum toxin may be approved for the treatment of functional obstruction caused by the inability of the internal anal sphincter to relax in individuals with Hirschsprung disease who have undergone prior surgical treatment.

VIII. Botulinum toxin **may be approved** in the treatment of *primary* hyperhidrosis only for those individuals who have failed a 6-month trial of any one or more types of nonsurgical treatment (i.e., topical dermatologics such as aluminum chloride, tannic acid, glutaraldehyde or anticholinergics, systemic anticholinergics, tranquilizers or non-steroid anti-inflammatory drugs) and meet any **ONE** of the following criteria:

A. Presence of medical complications or skin maceration with secondary infection; **OR**
B. Significant functional impairment, as documented in the medical record.

IX. Botulinum toxin **may be approved** in the treatment of *secondary* hyperhidrosis when the condition is related to surgical complications and **BOTH** of the following criteria are met:

A. Presence of medical complications or skin maceration with secondary infection; **AND**
B. Significant functional impairment, as documented in the medical record.

X. An **initial** 6-month trial of botulinum toxin for prevention of chronic migraine headaches may be approved when all of the following are met:
A. Adult individual diagnosed with chronic migraine; **AND**
B. Fifteen (15) or more headache-days per month with headache lasting four (4) hours per day or longer; **AND**
C. First episode at least six (6) months ago; **AND**
D. Symptoms persist despite trials of at least one agent in any two of the following classes of medications used to prevent migraines or reduce migraine frequency:
1. Antidepressants (for example, amitriptyline, nortriptyline, doxepin)
2. Antihypertensives (for example, propranolol, timolol)
3. Antiepileptics (for example, valproate, topiramate, gabapentin)

XI. Continuing treatment with botulinum toxin injection for ongoing prevention of chronic migraine headaches may be approved for individuals who have previously met criteria above and completed an initial 6-month trial when:
A. Migraine headache frequency was reduced by at least 7 days per month (when compared to pre-treatment average) by the end of the initial trial; **OR**
B. Migraine headache duration was reduced by at least 100 total hours per month (when compared to the pre-treatment average) by the end of the initial trial

XII. Botulinum toxin ***may not*** be approved in the treatment of cervical dystonia (spasmodic torticollis) when the above criteria have not been met.

XIII. Botulinum toxin ***may not*** be approved for the treatment of primary or secondary hyperhidrosis when the criteria above have not been met.

XIV. Botulinum toxin is considered **cosmetic** as a treatment of skin wrinkles or other cosmetic indications and is **NOT** approvable.

XV. Botulinum toxin is considered investigational and ***may not*** **be approved** for the treatment of any other conditions including, but not limited to, the following:

A. For the treatment of headache other than chronic migraine meeting the criteria above, including but not limited to tension, episodic, migraine (14 days per month or less), or chronic daily headaches.
B. For the treatment of individuals with Hirschsprung disease when the above criteria are not met.
C. The use of botulinum toxin, whether the same or a different product, following failure of an initial trial for the treatment of an approvable condition (as listed above) is considered **investigational and may not be approved**. **Note**: when the initial product was stopped due to a product specific intolerance or allergic reaction

(rather than clinical failure), this investigational and non-approvable statement does not apply.

D. Anismus (pelvic floor dyssynergia)
E. Bechet's syndrome
F. Benign Prostatic Hypertrophy
G. Brachial Plexus Palsy
H. Carpal tunnel syndrome
I. Chronic motor tic disorder
J. Disorders of the esophagus (except as listed above)
K. Epicondylitis
L. Fibromyalgia/fibromyositis
M. Gastroparesis
N. Low back pain
O. Myofascial pain syndrome
P. Neck pain not related to conditions mentioned above
Q. Nystagmus
R. Parkinson's disease
S. Post-mastectomy reconstruction syndrome
T. Reynaud's syndrome
U. Sphincter of Oddi dysfunction
V. Stuttering
W. Tics associated with Tourette's Syndrome
X. Tinnitus
Y. Tourette's Syndrome
Z. Tremors
AA. Urinary and anal sphincter dysfunction (except as listed above)
BB. Vaginismus
CC. Whiplash related disorders
DD. Zygomatic Fractures

State Specific Mandates		
State name N/A	Date effective N/A	Mandate details (including specific bill if applicable) N/A
Washington	1/1/18	For treatment of chronic migraine (as defined by the International Headache Society defined as headaches on >= 15 days per month of which >= 8 days are with migraine), OnabotulinumtoxinA is covered when the following criteria are met:

		1) Has not responded to at least three prior pharmacological prophylaxis therapies from two different classes of drugs AND 2) Condition is appropriately managed for medication overuse OnabotulinumtoxinA injections **must be discontinued** when the condition: 1) Has shown inadequate response to treatment (defined as <50% reduction in headache days per month after two treatment cycles) OR 2) Has changed to episodic migraine (defined as <15 headache days per month) for three consecutive months. Maximum of five treatment cycles. Additional treatment cycles may be considered at health plan discretion. • Migraine indication (onabotulinum toxin A only): **Initial** 1 dose (up to 155 units) per 12 weeks; 1 dose (up to 155 units) per 12 week approval for continued therapy if criteria met until 5 doses have been received. Treatment of chronic tension-type headache with OnabotulinumtoxinA is **not a covered benefit**.

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BOTULINUM TOXINS A AND B

Policy Number: CS2018D0017S **Effective Date**: January 1, 2018

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Related Community Plan Policy

- Occipital Neuralgia and Headache Treatment

Commercial Policy

- Botulinum Toxins A and B

INSTRUCTIONS FOR USE

This Drug Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Drug Policy is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Drug Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Drug Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this policy, please check the federal, state or contractual requirements for benefit coverage.

COVERAGE RATIONALE

This policy refers to the following drug products:

- Botulinum toxin types A and B
  - Dysport® (abobotulinumtoxinA)
  - Xeomin® (incobotulinumtoxinA)
  - Botox® (onabotulinumtoxinA)
  - Myobloc® (rimabotulinumtoxinB)

The Following Information Pertains to Medical Necessity Review

General Requirements (Applicable to ALL Medical Necessity Requests)

I. For initial therapy, **both** of the following:
   A. Diagnosis; **and**
   B. Medical records documenting **both** of the following:
      1. History and physical examination documenting the severity of the condition; **and**
      2. Laboratory results or diagnostic evidence supporting the indication for which botulinum toxin is requested**; and**

II. For continuation of therapy, **both** of the following:
   A. Documentation of positive clinical response to botulinum toxin therapy; **and**

B. Statement of expected frequency and duration of proposed botulinum toxin treatment;
and

III. Botulinum toxin administration is no more frequent than every 12 weeks, regardless of diagnosis.

Diagnosis-Specific Requirements

The information below indicates additional requirements for those indications having specific medical necessity criteria in the list of proven indications.

I. **Dysport (abobotulinumtoxinA) is medically necessary in the treatment of the following conditions**:

A. Achalasia[81]
Dysport is medically necessary for the treatment of achalasia when ALL of the following criteria are met:
1. Diagnosis of achalasia as confirmed by esophageal manometry; **and**
2. Patient has failed or is not a candidate for pneumatic dilation or myotomy; **and**
3. History of failure, contraindication, or intolerance to **one** of the following:
   a. Calcium channel blocker
   b. Long-acting nitrate;
   and
4. Other causes of dysphagia (e.g., peptic stricture, carcinoma, extrinsic compression) ruled out by upper gastrointestinal endoscopy.

B. Anal fissures, chronic[7,8,81]
Dysport is medically necessary for the treatment of chronic anal fissures when ALL of the following criteria are met:
1. Diagnosis of chronic anal fissure; **and**
2. At least 2 months of symptoms including **one** of the following:
   a. Nocturnal pain and bleeding
   b. Postdefecation pain;
   and
3. History of failure, contraindication, or intolerance to **one** of the following conventional therapies:
   a. Topical nitrate
   b. Topical calcium channel blocker (e.g., diltiazem, nifedipine).

C. Blepharospasm associated with dystonia[10,81]

D. Cervical dystonia (also known as spasmodic torticollis)[10,19,81,83,84]
Dysport is medically necessary for the treatment of cervical dystonia when BOTH of the following criteria are met:
1. Diagnosis of cervical dystonia; **and**
2. Symptoms including **both** of the following:
   a. Sustained head tilt or abnormal posturing resulting in pain and/or functional impairment
   b. Recurrent involuntary contraction of one or more muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, posterior cervical).

E. Detrusor overactivity (also known as detrusor hyperreflexia) or detrusor-sphincter dyssynergia due to spinal cord injury or disease[15,17,18,53,54,63,81]
Dysport is medically necessary when BOTH of the following criteria are met:
1. **One** of the following:
   a. Diagnosis of detrusor overactivity
   b. Diagnosis of detrusor-sphinctor dyssynergia due to spinal cord injury or disease;
   and
2. History of failure, contraindication, or intolerance to two anticholinergic medications (e.g., oxybutynin, trospium, darifenacin, tolterodine).

F. Hand dystonia (writer's, musician's or typist's cramp)[19,81,83]

G. Hand tremor[19,81]

H. Hemifacial spasm (seventh cranial nerve disorders)[19,81]

I. Hyperhidrosis[1,15,81] including gustatory sweating (Frey's Syndrome)[9,15,38]

J. Oromandibular dystonia

K. Sialorrhea[15,57,81]

L. Spasmodic dysphonia (laryngeal dystonia)[3,19]

M. Spasticity associated with cerebral palsy; multiple sclerosis; neuromyelitis optica (NMO); stroke; or other injury, disease, or tumor of the brain or spinal cord[1,6,39,81]

N. Strabismus[1,19,81]

O. Tongue dystonia

P. Torsion dystonia

Q. Voice tremor[4]

II. **Xeomin (incobotulinumtoxinA) is medically necessary in the treatment of the following conditions**:

A. Blepharospasm associated with dystonia, defined by **both** of the following:[70,76]
1. Diagnosis of blepharospasm associated with dystonia; **and**
2. History of failure, contraindication, or intolerance to Botox (onabotulinumtoxinA).

B. Cervical dystonia (spasmodic torticollis)[70,76,83-4]
Xeomin is medically necessary for the treatment of cervical dystonia (spasmodic torticollis) when BOTH of the following criteria are met:
1. Diagnosis of cervical dystonia; **and**
2. Symptoms including **both** of the following:
   a. Sustained head tilt or abnormal posturing resulting in pain and/or functional impairment
   b. Recurrent involuntary contraction of one or more muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, posterior cervical).

C. Spasticity associated with cerebral palsy; multiple sclerosis; neuromyelitis optica (NMO); stroke; or other injury, disease, or tumor of the brain or spinal cord[65-6,70,76]

III. **Botox (onabotulinumtoxinA) is medically necessary in the treatment of the following conditions**:

A. Achalasia[80]
Botox is medically necessary for the treatment of achalasia when ALL of the following criteria are met:
1. Diagnosis of achalasia as confirmed by esophageal manometry; **and**
2. Patient has failed or is not a candidate for pneumatic dilation or myotomy; **and**
3. History of failure, contraindication, or intolerance to **one** of the following:
   a. Calcium channel blocker
   b. Long-acting nitrate;
   and
4. Other causes of dysphagia (e.g., peptic stricture, carcinoma, extrinsic compression) ruled out by upper gastrointestinal endoscopy.

B. Anal fissures, chronic[8,80]
Botox is medically necessary for the treatment of chronic anal fissures when ALL of the following criteria are met:
1. Diagnosis of chronic anal fissure; **and**
2. At least 2 months of symptoms including **one** of the following:
   a. Nocturnal pain and bleeding
   b. Post defecation pain;
   and
3. History of failure, contraindication, or intolerance to **one** of the following conventional therapies:
   a. Topical nitrates
   b. Topical calcium channel blockers (e.g., diltiazem, nifedipine).

C. Blepharospasm associated with dystonia[1,19,80]

D. Cervical dystonia (also known as spasmodic torticollis)[1,10,80,83-4]
Botox is medically necessary for the treatment of cervical dystonia when BOTH of the following criteria are met:
1. Diagnosis of cervical dystonia; **and**
2. Symptoms including **both** of the following:
   a. Sustained head tilt or abnormal posturing resulting in pain and/or functional impairment
   b. Recurrent involuntary contraction of one or more muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, posterior cervical).

E. Detrusor overactivity (also known as detrusor hyperreflexia) or detrusor-sphincter dyssynergia due to spinal cord injury or disease[15,17,18,53,54,63,80]
Botox is medically necessary when BOTH of the following criteria are met:
1. **One** of the following:
   a. Diagnosis of detrusor overactivity
   b. Diagnosis of detrusor-sphinctor dyssynergia due to spinal cord injury or disease;
   and
2. History of failure, contraindication, or intolerance to two anticholinergic medications (e.g., oxybutynin, trospium, darifenacin, tolterodine).

F. Hand dystonia (writer's, musician's or typist's cramp)[19,80,83]

G. Hand tremor[19,80]

H. Hemifacial spasm (seventh cranial nerve disorders)[19,80]

I. Hyperhidrosis[1,80] including gustatory sweating (Frey's Syndrome)[9,15,38]

J. Migraine headache, chronic[1,71,80]
Botox is medically necessary for the prophylaxis of chronic migraine when ALL of the following criteria are met:
1. Diagnosis of chronic migraine, defined by **both** of the following:
   a. Greater than or equal to 15 headache days per month, of which at least 50% are migraine or probable migraine
   b. Headaches last 4 hours per day or longer;
   and
2. History of failure (after a trial of at least two months), contraindication, or intolerance to prophylactic therapy with one agent from **two** of the following therapeutic classes:
   a. Antidepressant [i.e., Elavil (amitriptyline), Effexor (venlafaxine)]
   b. Antiepileptic drug [i.e., Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)]
   c. Beta blocker [i.e., atenolol, Inderal (propranolol), nadolol, timolol, Toprol XL (metoprolol extended-release)];
   and
3. OnabotulinumtoxinA dose does not exceed 155 units administered intramuscularly divided over 31 injection sites divided across 7 head and neck muscles every 12 weeks.

K. Oromandibular dystonia

L. Overactive bladder[1,80]
Botox is medically necessary for the treatment of overactive bladder when ALL of the following criteria are met:
1. Diagnosis of overactive bladder; **and**
2. **One** of the following symptoms:
   a. Urge urinary incontinence
   b. Urgency
   c. Frequency;
   and
3. History of failure, contraindication, or intolerance to two anticholinergic medications (e.g., oxybutynin, trospium, darifenacin, tolterodine); **and**
4. OnabotulinumtoxinA dose does not exceed 100 units divided over 20 injection sites every 12 weeks.

M. Sialorrhea[15,57,80]

N. Spasmodic dysphonia (laryngeal dystonia)[3,5,19,80]

O. Spasticity associated with cerebral palsy; multiple sclerosis; neuromyelitis optica (NMO); stroke; or other injury, disease, or tumor of the brain or spinal cord[1,6,39,80]

P. Strabismus[1,19,80]

Q. Tongue dystonia[80]

R. Torsion dystonia[80]

S. Voice tremor[4]

IV. **Myobloc (rimabotulinumtoxinB) is medically necessary in the treatment of the following conditions**:

A. Cervical dystonia (also known as spasmodic torticollis)[2,83-4]
Myobloc is medically necessary for the treatment of cervical dystonia when BOTH of the following criteria are met:
1. Diagnosis of cervical dystonia; **and**
2. Symptoms including **both** of the following:
   a. Sustained head tilt or abnormal posturing resulting in pain and/or functional impairment
   b. Recurrent involuntary contraction of one or more muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, posterior cervical).

B. Detrusor overactivity (also known as detrusor hyperreflexia)[15,18]
Myobloc is medically necessary when BOTH of the following criteria are met:
1. Diagnosis of neurogenic detrusor overactivity; **and**
2. History of failure, contraindication, or intolerance to two anticholinergic medications (e.g., oxybutynin, trospium, darifenacin, tolterodine).

C. Sialorrhea[15,56-7]

D. Spasticity associated with cerebral palsy; multiple sclerosis; neuromyelitis optica (NMO); stroke; or other injury, disease, or tumor of the brain or spinal cord[89]

Unproven

Dysport, Myobloc, and Xeomin are unproven and not medically necessary for the treatment of chronic migraine headache.[14,15,24,25-6,64,75,81]

Botox, Dysport, Myobloc, and Xeomin are unproven and not medically necessary for the treatment of the following conditions:

- Acquired nystagmus
- Anismus (pelvic floor dyssynergia)[16]
- Benign prostatic hyperplasia[13,18,33,68,80,81]
- Brachial plexus palsy[46,80,81]
- Chronic daily headache[15,36,80,81]
- Chronic low back pain[36,80]
- Chronic prostatic pain[18]
- Cricopharyngeal dysphagia[20-23]
- Epiphora following salivary gland transplantation
- Esophageal spasm[37]
- Gastroparesis (including diabetic gastroparesis)[58-62,90-91]
- Gustatory epiphora (crocodile tears)
- Head tremor
- Lateral epicondylitis (tennis elbow)[51,52]
- Lichen simplex
- Lower urinary tract (voiding) dysfunction[11,18]
- Motor tics
- Myofascial pain syndrome[45.72,81]
- Nasal hypersecretion[50,67]
- Pain and/or wound healing after hemorrhoidectomy
- Pancreas divisum
- Pelvic floor spasticity (and associated pain conditions)[18]
- Piriformis syndrome[49]

- Postparotidectomy sialoceles
- Post-thoracotomy pseudoangina
- Proctalgia fugax[18]
- Severe bruxism[41-42]
- Severe paradoxical vocal cord movement[40]
- Sphincter of Oddi dysfunction[12]
- Stiff-person syndrome
- Temporomandibular disorders[43-44,48]
- Tension headache[15,27,78]
- Thyroid associated ophthalmopathy[47]
- Tourette's syndrome[55]
- Traumatic sixth nerve palsy
- Trigeminal neuralgia[32,73-4]
- Trismus and stridor in amyotrophic lateral sclerosis

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

For non-cosmetic use, abobotulinumtoxinA (Dysport) is FDA approved for the treatment of adults with cervical dystonia. Dysport is also indicated for the treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors, wrist flexors and finger flexors. Dysport is also indicated for the treatment of lower limb spasticity in pediatric patients 2 years of age and older.[10]

IncobotulinumtoxinA (Xeomin) is FDA approved for the treatment of adults with cervical dystonia in both botulinum toxin-naïve and previously treated patients. Xeomin is also indicated for the treatment of adults with blepharospasm who were previously treated with onabotulinumtoxinA (Botox). Xeomin is also indicated for the treatment of upper limb spasticity in adult patients.[70]

For non-cosmetic use, onabotulinumtoxinA (Botox) is FDA approved for the prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer). Safety and effectiveness of Botox have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month).[1] Botox is also approved for treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), finger flexors (flexor digitorum profundus and flexor dititorum sublimis), and thumb flexors (adductor pollicis and flexor pollicis longus). Botox is indicated for the treatment of lower limb spasticity in adult patients to decrease the severity of increased muscle tone in ankle and toe flexors (gastrocnemius, soleus, tibialis posterior, flexor hallucis longus, and flexor digitorum longus). Safety and effectiveness of Botox have not been established for the treatment of other upper or lower limb muscle groups. Safety and effectiveness of Botox have not been established for the treatment of spasticity in pediatric patients under age 18 years. Botox has not been shown to improve upper extremity functional abilities, or range of motion at a joint affected by a fixed contracture. Treatment with Botox is not intended to substitute for usual standard of care rehabilitation regimens.[1]

Botox is also indicated for reducing the severity of abnormal head position and neck pain associated with cervical dystonia in adults; for the treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above; for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency in adults who have an inadequate response or are intolerant to an anticholinergic medication; for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication; and for the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents.[1] Safety and efficacy of Botox for hyperhidrosis in other body areas have not been established. Weakness of hand muscles and blepharoptosis may occur in patients who receive Botox for palmar hyperhidrosis and facial hyperhidrosis, respectively. Patients should be evaluated for potential causes of secondary hyperhidrosis (e.g., hyperthyroidism) to avoid symptomatic treatment of hyperhidrosis without the diagnosis and/or treatment of the underlying disease. Safety and effectiveness of Botox have not been established for the treatment of axillary hyperhidrosis in pediatric patients under age 18.

RimabotulinumtoxinB (Myobloc) is FDA approved for the treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.[2]

All botulinum toxin products approved by the FDA carry a black box warning regarding the possibility of the distant spread of toxin effect.[1,2,10,70] The warning states that post marketing reports indicate that the effects of all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence and breathing difficulties. These symptoms have been reported hours to weeks after injection.

Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for spasticity and other conditions, particularly in those patients who have an underlying condition that would predispose them to these symptoms. In unapproved uses, including spasticity in children, and in approved indications, cases of spread of effect have been reported at doses comparable to those used to treat cervical dystonia and upper limb spasticity and at lower doses.

BACKGROUND

There are seven serologically distinct forms of botulinum toxin, A through G. All seven neurotoxins share a common structure consisting of one heavy chain and one light chain. They all inhibit acetylcholine release at the neuromuscular junction via the enzymatic inactivation of a protein that is required for the docking and fusion process involved in the release of acetylcholine. Each neurotoxin works at a distinct site. Botulinum toxin type A cleaves the protein SNAP-25 and botulinum toxin type B cleaves synaptobrevin, both of these proteins are part of a protein complex necessary for proper docking and fusion.[1,2,10,70]

The potency units of botulinum toxins are specific to the preparation and assay method utilized. They are not interchangeable and, therefore, the units of biological activity cannot be compared to nor converted into units of any other botulinum toxin products assessed with any other specific assay method.[1,2,10,70]

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

HCPCS Code	Description
J0585	Injection, onabotulinumtoxinA, 1 unit
J0586	Injection, abobotulinumtoxinA, 5 units
J0587	Injection, rimabotulinumtoxinB, 100 units
J0588	Injection, incobotulinumtoxinA, 1 unit

ICD-10 Diagnosis Code	Description
G04.1	Tropical spastic paraplegia
G11.4	Hereditary spastic paraplegia
G24.09	Other drug induced dystonia
G24.1	Genetic torsion dystonia
G24.2	Idiopathic nonfamilial dystonia
G24.3	Spasmodic torticollis
G24.4	Idiopathic orofacial dystonia
G24.5	Blepharospasm
G24.8	Other dystonia
G24.9	Dystonia, unspecified
G25.89	Other specified extrapyramidal and movement disorders
G36.0	Neuromyelitis optica
G43.701	Chronic migraine without aura, not intractable, with status migrainosus
G43.709	Chronic migraine without aura, not intractable, without status migrainosus
G43.711	Chronic migraine without aura, intractable, with status migrainosus
G43.719	Chronic migraine without aura, intractable, without status migrainosus
G51.0	Bell's palsy
G51.1	Geniculate ganglionitis
G51.2	Melkersson's syndrome
G51.3	Clonic hemifacial spasm

ICD-10 Diagnosis Code	Description
G51.4	Facial myokymia
G51.8	Other disorders of facial nerve
G51.9	Disorder of facial nerve, unspecified
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G80.9	Cerebral palsy, unspecified
G81.10	Spastic hemiplegia affecting unspecified side
G81.11	Spastic hemiplegia affecting right dominant side
G81.12	Spastic hemiplegia affecting left dominant side
G81.13	Spastic hemiplegia affecting right nondominant side
G81.14	Spastic hemiplegia affecting left nondominant side
G83.4	Cauda equina syndrome
H50.89	Other specified strabismus
H51.0	Palsy (spasm) of conjugate gaze
J38.5	Laryngeal spasm
K11.7	Disturbances of salivary secretion
K22.0	Achalasia of cardia
K59.4	Anal spasm
K60.1	Chronic anal fissure
K60.2	Anal fissure, unspecified
L74.510	Primary focal hyperhidrosis, axilla
L74.511	Primary focal hyperhidrosis, face
L74.512	Primary focal hyperhidrosis, palms
L74.513	Primary focal hyperhidrosis, soles
L74.519	Primary focal hyperhidrosis, unspecified
L74.52	Secondary focal hyperhidrosis
N31.0	Uninhibited neuropathic bladder, not elsewhere classified
N31.1	Reflex neuropathic bladder, not elsewhere classified
N31.9	Neuromuscular dysfunction of bladder, unspecified
N32.81	Overactive bladder
N36.44	Muscular disorders of urethra
N39.41	Urge incontinence
N39.46	Mixed incontinence
R25.0	Abnormal head movements
R25.1	Tremor, unspecified
R25.2	Cramp and spasm
R25.3	Fasciculation
R25.8	Other abnormal involuntary movements
R25.9	Unspecified abnormal involuntary movements
R29.891	Ocular torticollis
R49.0	Dysphonia
R49.9	Unspecified voice and resonance disorder
S04.50XA	Injury of facial nerve, unspecified side, initial encounter

ICD-10 Diagnosis Code	Description
S04.51XA	Injury of facial nerve, right side, initial encounter
S04.52XA	Injury of facial nerve, left side, initial encounter

CLINICAL EVIDENCE

Proven

Cervical Dystonia

In a randomized, double-blind, multicenter, non-inferiority, two-period crossover study, Yun et al compared the efficacy and safety of Dysport and Botox at a 2.5:1 ratio in the treatment of cervical dystonia (CD).[14] The lower ratio than 3:1 was suggested as a more appropriate conversion ratio, due to the higher efficacy of Botox and more frequent incidence of adverse effects in CD and other focal movement disorders. Patients who were over 20 years old and have experienced CD for at least 18 months were eligible, and were allowed to continue on a stable dose of medications for CD for the duration of the trial. Both products were diluted so that the 2.5:1 ratio resulted in the same volume to be administered. The patients received either Dysport or Botox, and were followed monthly for the first 16 weeks. After the 4 week washout period, each group was crossed over to receive the other product, respectively. Patients were also followed up with monthly for 16 weeks in the second period. Results from both periods were merged and compared according to the two different products. The primary efficacy outcome was the change in the Tsui scale between the baseline value and that at 1 month after each injection (peak effect). One hundred and two patients enrolled in the study. Patients were allocated 49 and 53 to two different arms of the trial. Arm 1 received Dysport during the first phase and Botox during the crossover phase. Arm 2 received Botox during the first phase and Dysport during the second phase. Only 94 of the 102 patients completed the entire study and were included in the final analysis. Mean changes in the Tsui scale between baseline and 4 weeks after each injection trended to favor Botox, however, this was not statistically significant (4.0 ± 3.9 points Dysport vs. 4.8 ± 4.1 points for Botox; 95% CI, -0.1 – 1.7; p = 0.091). The mean change of the Toronto western spasmodic torticollis rating scale score, the proportion of improvement in clinical global impression and patient global impression, and the incidences of adverse events were not significantly different between the two treatments. The authors concluded that, in terms of efficacy and safety, Dysport at a ratio of 2.5:1 to Botox was not inferior to Botox in patients with CD.

Detrusor Overactivity

In a prospective, long-term (3 year), multicenter, open-label extension study following a 52-week, phase III trial of onabotulinumtoxinA, patients were treated on an "as needed" basis with intradetrusor onabotulinumtoxinA (200U or 300U) for urinary incontinence (UI) due to neurogenic detrusor overactivity.[94] Patients received treatment ≥ 12 weeks since the previous treatment and a UI episode threshold. The primary efficacy endpoint was the change from study baseline in UI episodes/day at week 6 after each treatment. Additional efficacy measurements included: percent change in UI episodes, the proportions of patients with ≥ 50% and 100% reductions from baseline in UI episodes/day, changes from baseline in volume/void and Incontinence Quality of Life (I-QOL) total summary scores, IQOL responder rates (proportion of patients achieving a ≥ 11-point increase from baseline in I-QOL total score, which is defined as the minimally important difference for I-QOL in NDO), and duration of treatment effect (time to patient request for retreatment). OnabotulinumtoxinA 200U consistently reduced UI episodes/day; reductions from baseline ranged from −3.2 to −4.1 across six treatments. Volume/void consistently increased, nearly doubling after treatment. I-QOL improvements were consistently greater than twice the minimally important difference (+11 points). Overall median duration of effect was 9.0 months (200U). Results were similar for onabotulinumtoxinA 300U. Most common AEs were urinary tract infections and urinary retention. De novo CIC rates were 29.5, 3.4, and 6.0% (200U), and 43.0, 15.0, and 4.8% (300U) for treatments 1−3, respectively; de novo CIC rates were 0% for treatments 4−6. The authors concluded that OnabotulinumtoxinA treatments consistently improve UI, volume/void, and QOL in patients with UI due to NDO in this 4-year study, with no new safety signals.

Migraine Headache

OnabotulinumtoxinA is beneficial for the prophylaxis of chronic migraine headaches based upon FDA approval, published practice guidelines, professional society evidence reviews, randomized controlled clinical trials, and smaller randomized exploratory studies.[15,24,25-6]

Aurora et al performed a secondary analysis of the data to assess patients who received all five treatment cycles and completed the PREEMPT-1 and PREEMPT-2 trials. Both studies were 24 week double-blind, placebo controlled, parallel-group phase, with a 32-week open-label phase, that evaluated the efficacy and safety of onabotulinumtoxinA (BoNT-A). Out of a total of 1,384 total patients, 1,005 received all five treatment cycles and were included in the analysis. Of these, 513 received all 5 cycles with BTA, whereas 492 underwent 2 cycles of placebo followed by 3 cycles of BoNT-A treatment. After 56 weeks of treatment, significant between group differences were found favoring BoNT-A treatment vs. placebo, even after those receiving placebo switching to BoNT-A. The following headache symptoms were evaluated: mean change in frequency of headache days (-12.0 vs -11.0, p=0.035); total migraine days (-11.6 vs -10.7, p=0.038), and moderate/severe headache days (-11.0 vs -10.1 n=0.042). There were also

large mean improvements from baseline in the following measures: cumulative hours of headache on headache days, frequency of headache episodes, percentage with severe Headache Impact Test (HIT)-6 scores, and total HIT-6 and Migraine-Specific Quality of Life Questionnaire scores). The percent of patients with a ≥ 50% reduction from baseline in frequency of headache days was significantly greater for the BoNT-A only group at week 56 (69.6% vs 62.8%, p = 0.023). Treatment-related adverse event rates were 28.5% for the BoNT-A group vs. 12.4% for the placebo group during the double-blind phase of the trials. The most frequently reported treatment related adverse events were neck pain (4.3%), muscular weakness (1.6%), injection site pain (2.1%), and eyelid ptosis (1.9%). This data supports the use of onabotulinumtoxinA for the treatment of migraine headaches.

In a follow up analysis of the PREEMPT clinical trials, Lipton et al., assessed the effects of treatment with onabotulinumtoxinA on health-related quality of life (HRQoL) and headache impact in adults with chronic migraine.[28] In the PREEMPT trials, Headache Impact Test (HIT)-6 scores were obtained at baseline and every 4 weeks. In terms of change in total HIT-6 scores, a negative value reflects reduced headache impact and an improvement in the patient's functionality. HRQoL was measured by the Migraine-Specific Quality of Life Questionnaire (MSQ v2.1). This score was obtained at baseline and every 12 weeks. A positive change in MSQ v2.1 scores reflects improvement in HRQoL during the PREEMPT study. An analysis of the combined data looked at 688 subjects who received treatment with Botox vs. 696 who received saline placebo injections. Baseline mean total HIT-6 and MSQ v2.1 scores were comparable between groups; 93.1% were severely impacted based on HIT-6 scores ≥ 60. At 24 weeks, in comparison with placebo, Botox treatment significantly reduced HIT-6 scores at all time periods during the double-blind phase of the trials (p≤0.014). Additionally, HIT-6 measures of headache impact scores showed significant benefit for the Botox group at 24 weeks of treatment (p<0.001). Botox treatment significantly improved all domains of the MSQ v2.1 at 24 weeks (p<0.001). There was also a significant benefit shown for the Botox group compared to placebo with regard to the proportion of subjects who received clinically meaningful reduction in the number of headache days at all-time points in the double-blind study periods (p≤0.025). The authors concluded that Botox treatment reduces headache impact and improves HRQoL.

The pooled results of two phase 3, randomized, double-blind, multicenter, placebo controlled trials addressing the use of botulinum toxin for the treatment of chronic migraine headaches were reported by Dodick et al., in 2010.[29-31] These studies were from the Phase III REsearch Evaluating Migraine Prophylaxis Therapy (PREEMPT) clinical program, involving a 24 week randomized, double-blind phase followed by a 32 week open-label phase. Subjects were randomized (1:1) to receive either 155 units of onabotulinumtoxinA (BoNT-A) or placebo injections every 12 weeks. A total of 1384 adult patients were randomized to onabotulinumtoxinA (n=688) or placebo (n=696), with study visits every 4 weeks. Both studies were identical in design, with the exception being the designation of the primary (mean change from baseline in frequency of headache days for the 28-day period ending with week 24) and secondary endpoints (frequency of migraine days, number of cumulative hours of headache on headache days, proportion of patients with severe HIT-6 score, and others). Injections of BoNT-A or placebo were injected as 31 fixed-sites, fixed-dose injections across 7 specific head/neck muscle areas. A discretionary 40 units could be administered using a "follow-the-pain" strategy, resulting in 195 units over 39 sites. Pooled analyses demonstrated a large mean decrease from baseline in frequency of headache days, with statistically significant between-group differences favoring onabotulinumtoxinA over placebo at week 24 (-8.4 vs. -6.6; p<0.001) and at all other time points. Significant differences favoring onabotulinumtoxinA were also observed for all secondary efficacy variables at all time points, including frequency of headache days, cumulative headache hours, and the proportion of subjects with severe headaches. No significant difference was noted in the frequency of acute headache pain medication taken. There was a significantly greater proportion of experimental group subjects that had a greater that 50% decrease from baseline in headache days. Adverse events occurred in 62.4% of experimental group subjects and 51.7% of placebo subjects, with a greater than 5% incidence of neck pain and muscular weakness in the experimental group. The authors concluded that the use of onabotulinumtoxinA treatment for chronic migraine was effective, safe, and well tolerated.

Overactive Bladder

Nitti et al examined the efficacy and safety of onabotulinumtoxinA for the treatment of overactive bladder and urinary incontinence (UI) in a phase 3, randomized, multicenter, placebo controlled trial.[93] Adult patients (18 years or older) with idiopathic overactive bladder who experienced 3 or more urgency UI episodes in a 3-day period and an average of 8 or more micturitions per day were enrolled in the study. Patients were randomized 1:1 to either receive onabotulinumtoxinA 100 U or placebo over 20 evenly distributed intradetrusor injections. Co-primary end points were the change from baseline in the number of urinary incontinence episodes per day and the proportion of patients with a positive response on the treatment benefit scale at posttreatment week 12. Secondary end points included other overactive bladder symptoms and health related quality of life. OnabotulinumtoxinA significantly decreased the daily frequency of urinary incontinence episodes vs placebo (−2.65 vs −0.87, p <0.001) and 22.9% vs 6.5% of patients became completely continent. A larger proportion of onabotulinumtoxinA than placebo treated patients reported a positive response on the treatment benefit scale (60.8% vs 29.2%, p <0.001). All other overactive bladder symptoms improved vs placebo (p <0.05). OnabotulinumtoxinA improved patient health related quality of life across multiple measures (p <0.001). Uncomplicated urinary tract infection was the most common adverse event. A 5.4% rate of urinary retention was observed. The authors concluded that OnabotulinumtoxinA showed significant, clinically

relevant improvement in all overactive bladder symptoms and health related quality of life in patients inadequately treated with anticholinergics and was well tolerated.

Spasticity (Associated with Cerebral Palsy)

In a global, randomized, placebo-controlled study, the efficacy and safety of abobotulinumtoxinA was evaluated for the treatment of spasticity in cerebral palsy children with dynamic equinus foot deformity.[95] Two hundred and forty-one patients were randomized 1:1:1 to receive either abobotulinumtoxinA 10 U/kg/leg, 15 U/kg/leg, or placebo injections into the gastrocnemius-soleus complex of either one or both legs. The primary endpoint was the demonstration of benefit for each dose over placebo on the Modified Ashworth Scale from baseline to week 4. Secondary endpoint includes the change of the Physician's Global Assessment at week 4 from baseline. Two hundred and twenty-six patients completed the study. At week 4, Modified Ashworth Scale scores significantly improved with abobotulinumtoxinA; mean (95% confidence interval) treatment differences versus placebo were −0.49 (−0.75 to −0.23; P = 0.0002) for 15 U/kg/leg and −0.38 (−0.64 to −0.13; P = 0.003) for 10 U/kg/leg. The Physician's Global Assessment treatment differences versus placebo of 0.77 (0.45 to 1.10) for 15 U/kg/leg and 0.82 (0.50 to 1.14) for 10 U/kg/leg were also significant (both Ps < .0001). The most common treatment-related adverse event was muscular weakness (10 U/Kg/leg = 2; placebo = 1). The authors concluded that treatment with abobotulinumtoxinA improves muscle tone in children with dynamic equinus resulting in an improved overall clinical impression and is well tolerated.

Unproven

Benign Prostatic Hyperplasia

The efficacy and tolerability of botulinum toxin A (BoNT-A) for the treatment of lower urinary tract symptoms in men with benign prostatic hyperplasia (LUTS/BPH) was evaluated in a randomized placebo controlled trial involving 315 subjects assigned to either 200 U of BoNT-A (Botox) (n=157) or placebo (n=156).[33] Patients with International Prostate Symptom Score (I-PSS) 14 or greater, with peak urinary flow rate 4 to 15 ml per second and total prostate volume 30 to 80 ml were randomized 1:1 to a single intraprostatic injection of BoNT-A or placebo. A single-blind sham procedure, followed by a 4 week run in was included to minimize potential placebo effect. The primary endpoint from baseline is total I-PSS at week 12. Additional endpoints assessed at weeks 6, 12, and 24 were peak urinary flow rate (Qmax), total prostate volume (TPV), and post-void residual urine volume (PVR). At all time points there was no difference in I-PSS between the BoNT-A and placebo groups, included at the primary time point at 12 weeks, however both groups experienced a decrease (-6.3 vs -5.6 points, p <0.001). There were no differences between treatment groups for TPV, PSA, or PVR at 12 or 24 weeks. The authors concluded that BoNT-A is unlikely to be a therapy for male LUTS/BPH.

Chronic Daily Headache

Four studies were published in the American Academy of Neurology's 2008 assessment of botulinum neurotoxin for pain disorders.[15] Each of the studies specifically referenced chronic daily headache (CDH) and had a large population of patients with transformed migraine. The primary outcome measure for all the studies was mean change in headache-free days per month. The first study, which used a technique of modifying injection site based on location of pain, showed a significant benefit (11 days vs. 8 days) in the BoNTA treated population. The second study, the largest of patients with CDH, was a randomized, double-blind, placebo-controlled, phase II study, enrolling 702 patients. This trial used a fixed-site strategy. Eligible patients were injected with BoNTA at 225 U, 150 U, 75 U, or placebo and returned for additional masked treatments at day 90 and day 180. Patients were assessed every 30 days for 9 months. The primary efficacy end point was the mean change from baseline in the frequency of headache-free days at day 180 for the placebo nonresponder group. The primary efficacy end point was not met. Mean improvements from baseline at day 180 of 6.0, 7.9, 7.9, and 8.0 headache-free days per month were observed with BoNTA at 225 U, 150 U, 75 U, or placebo, respectively (p=0.44). However, a priori-defined analysis of headache change from baseline in headache frequency revealed that the 225 U and 150 U Botox A groups had statistically significant greater reductions in headache frequency compared with placebo at day 240 (p=0.03). In conclusion, BoNTA was safe and well tolerated. Although the primary efficacy end point was not met, all groups responded to treatment. The 225 U and 150 U groups experienced a greater decrease in headache frequency than the placebo group at day 240, but the placebo response was higher than expected. The third study was a subgroup of patients not taking prophylactic medications from a larger overall study. Only this subgroup showed a significant mean increase in headache-free days although there was a decrease in the frequency per 30 days. An additional study evaluated 82 patients with chronic daily headache treated with botulinum neurotoxin A.[36] 76.1% of the chronic migraine patients and 36.4% of the chronic tension-type headache patients were considered responders. Because studies of botulinum A for the prevention of chronic daily headache show mixed results, further studies are recommended.

Tension Headache

Four studies of patients with tension-type headache were reviewed in the American Academy of Neurology's 2008 assessment of botulinum neurotoxin for pain disorders.[15] Patients in these studies were randomized to either botulinum neurotoxin (BoNT) or placebo. After 6 weeks, the first study (n = 112) showed no significant difference

compared to a baseline 6 week period in the primary outcome measure of area under the headache curve in the subjects' headache diary. In another of the studies, both the BoNT and the placebo group showed improvement in the primary outcome of mean change from baseline in number of headache-free days from 30 to 60 after injection, but BoNT was not more beneficial and a power analysis was not provided. A third study showed no significant benefit of BoNT after 12 weeks for decrease of headache, intensity on visual analog scale, mean number of headache days, headache hours per day, days on which symptomatic treatment was taken, number of analgesics taken per day, or patient's assessment of improvement.[5] The fourth study, a smaller trial, included 16 patients in a prospective double-blind, placebo-controlled crossover study and thirty patients in an open-label long-term study. These patients showed reduction in headache severity and pericranial muscle tenderness, and increased headache-free days with botulinum treatment.

Additional small randomized controlled trials have found conflicting results similar to those presented above.[27] Until larger randomized trials are conducting showing a beneficial effect of BTX-A, its use in tension headache is unproven.

Miscellaneous

Botulinum toxin A has been studied in a number of other disorders including: cricopharyngeal dysphagia,[20-23] gustatory epiphora (crocodile tears), Sphincter of Oddi dysfunction,[12] pancreas divisum, anismus,[16] lower urinary tract dysfunction,[11,18] pelvic floor spasticity,[18] chronic prostatic pain,[18] severe paradoxical vocal cord movement,[40] postparotidectomy sialoceles, severe bruxism,[41-42] temporomandibular disorders,[43-44,48] myofascial pain syndrome,[45,72,81] brachial plexus palsy,[46,80,81] thyroid associated ophthalmopathy,[47] esophageal spasm,[37] post-thoracotomy pseudoangina, epiphora following salivary gland transplantation, trigeminal neuralgia,[32,73-74] trismus and stridor in amyotrophic lateral sclerosis, proctalgia fugax, nasal hypersecretion,[50,67] gastroparesis (including diabetic gastroparesis),[58-62,80,90-91] Lichen simplex, lateral epicondylitis,[51,52] Stiff-person syndrome, traumatic sixth nerve palsy, Tourette's syndrome,[55] and pain and/or wound healing after hemorrhoidectomy. The studies in these disorders have been small and/or uncontrolled open-label trials. Larger, well-designed studies must occur to demonstrate the effectiveness of botulinum toxin in the treatment of these conditions.

Technology Assessments

Achalasia

A 2014 Cochrane review was published evaluating and comparing endoscopic pneumatic dilation (PD) versus botulinum toxin injection in the management of primary achalasia.[34] Seven studies involving 178 participants were included. Two studies were excluded from the meta-analysis of remission rates on the basis of clinical heterogeneity of the initial endoscopic protocols. There was no significant difference between PD or botulinum treatment in remission within four weeks of the initial intervention; with a risk ratio of remission of 1.11 (95% CI 0.97 to 1.27). There was also no significant difference in the mean esophageal pressures between the treatment groups; with a weighted mean difference for PD of -0.77 (95% CI -2.44 to 0.91, P = 0.37). Data on remission rates following the initial endoscopic treatment were available for three studies at six months and four studies at 12 months. At six months 46 of 57 PD participants were in remission compared to 29 of 56 in the botulinum group, giving a risk ratio of 1.57 (95% CI 1.19 to 2.08, P = 0.0015); whilst at 12 months 55 of 75 PD participants were in remission compared to 27 of 72 botulinum participants, with a risk ratio of 1.88 (95% CI 1.35 to 2.61, P = 0.0002). No serious adverse outcomes occurred in participants receiving botulinum, while PD was complicated by perforation in three cases. The authors concluded that PD is the more effective endoscopic treatment in the long term (greater than six months) for patients with achalasia.

Chronic Migraine Headache

Hayes compiled a Medical Technology Directory on botulinum toxin treatment for migraine headache dated September 22, 2011.[75] Although a relatively large number of well-designed randomized controlled trials (RCTs) have evaluated onabotulinumtoxinA (onaBTX-A) and abobotulinumtoxinA (aboBTX-A) [BTX-A] for prevention of migraine, the clinical role of this treatment remains to be established. Many of the available placebo-controlled RCTs found that BTX-A did not provide statistically significant benefits or found that the benefits obtained were inconsistent, for instance, occurring at some time points but not at others. In contrast, the largest available RCT and one of the older RCTs found that patients who underwent treatment with onaBTX-A experienced statistically significant improvements such as reductions in migraine frequency and severity. This divergence in study results cannot be resolved based solely on differences in study size and a more likely explanation was that the benefits obtained with onaBTX-A were relatively small, perhaps too small to be clinically significant. Moreover, due to lack of long-term follow-up, the available RCTs do not provide any data concerning the durability of potential benefits from treatment with onaBTX-A. In addition, there was insufficient evidence to support conclusions regarding the efficacy of onaBTX-A relative to other types of medication for prevention of migraine. Likewise, there was very limited evidence regarding the effectiveness of aboBTX-A, and no evidence regarding other types of BTX, for the management of chronic or recurrent headache. Therefore, Hayes has assigned a D rating (no proven benefit and/or not safe) to abobotulinumtoxinA for prevention of migraine and to rimabotulinumtoxinB as a treatment for migraine headache. Overall, onaBTX-A was safe with few serious complications reported, earning onabotulinumtoxinA a Hayes rating of C (potential but unproven benefit) for prevention of migraine headache. Further studies are needed to determine the clinical role of BTX-A relative to current

treatments for prevention of migraine. An annual review of the Hayes Directory on August 26, 2015 resulted in no changes to the original findings.

Chronic Tension Headache

Hayes compiled a Medical Technology Directory on botulinum toxin treatment for chronic tension-type headache dated December 30, 2011.[78] A relatively large number of well-designed, randomized, placebo-controlled trials (RCTs) have evaluated the effects of botulinum toxin A (BTX-A) on patients diagnosed with chronic tension-type headache (CTTH). The majority of these studies found no benefit of BTX-A relative to placebo. The two studies that did report beneficial effects of BTX on headache frequency and intensity were very small. Overall, BTX-A was safe. None of the studies compared BTX-A with other prophylactic treatments for CTTH. An annual review of the Hayes Directory on January 13, 2015 resulted in no changes to the original findings.

Detrusor Overactivity

Hayes compiled a Medical Technology Directory on botulinum toxin treatment for detrusor instability, dated December 30, 2011.[86] The results of the available studies provide some evidence that onabotulinumtoxinA (onaBTX-A) improves outcomes for patients who have idiopathic or neurogenic detrusor overactivity; however, these studies do not provide sufficient evidence to establish the clinical role of botulinum toxin type A (BTX-A) for these indications. Although randomized clinical trials (RCTs) consistently found that BTX-A provided statistically significant improvements in urinary incontinence (UI) compared with placebo treatment, the largest available RCT of BTX-A for idiopathic detrusor overactivity found a placebo effect that was nearly as large as the treatment effect when expressed in terms of decrease in number of episodes of UI per week. In the largest available RCT of BTX-A for neurogenic detrusor overactivity, BTX-A treatment was associated with statistically significant increases in urinary retention and urinary tract infections. None of the studies that met the criteria for review involved long-term follow-up of patients who underwent treatment with multiple doses of BTX-A, and none of the studies compared BTX-A with augmentation cystoplasty or neuromodular implantation. At least six of the studies were sponsored by the manufacturer, creating the potential for bias. Additional controlled studies are needed to determine the long-term efficacy and safety of BTX-A relative to other current invasive treatments for idiopathic and neurogenic detrusor overactivity. An annual review of the Hayes Directory on January 9, 2015 resulted in no changes to the the original findings.

Strabismus

A 2012 Cochrane review was published evaluating botulinum toxin injections for the treatment of strabismus.[35] The authors included 4 randomized controlled trials in their analysis. Two trials found that there was no difference between the use of botulinum toxin and surgery for patients requiring retreatment for acquired esotropia or infantile esotropia. There was no evidence for a prophylactic effect of botulinum toxin in a treatment trial of acute onset sixth nerve palsy. Botulinum toxin had a poorer response than surgery in a trial of patients requiring treatment for horizontal strabismus in the absence of binocular vision. It was not possible to establish dose effect information. Complication rates for use of Botox® or Dysport® ranged from 24% to 55.54%.[72]

Professional Societies

Achalasia

In 2013, the American College of Gastroenterology published an evidence-based clinical guideline for the diagnosis and management of achalasia based on a comprehensive review of the pertinent evidence and examination of relevant published data.[85] The recommendations for the treatment of achalasia from this guideline are as follows:

- Either graded pneumatic dilation (PD) or laparoscopic surgical myotomy with a partial fundoplication are recommended as initial therapy for the treatment of achalasia in those fit and willing to undergo surgery (strong recommendation, moderate-quality evidence).
- PD and surgical myotomy should be performed in high-volume centers of excellence (strong recommendation, low-quality evidence).
- The choice of initial therapy should be guided by patients' age, gender, preference, and local institutional expertise (weak recommendation, low-quality evidence).
- Botulinum toxin therapy is recommended in patients who are not good candidates for more definitive therapy with PD or surgical myotomy (strong recommendation, moderate quality evidence).
- Pharmacologic therapy for achalasia is recommended for patients who are unwilling or cannot undergo definitive treatment with either PD or surgical myotomy and have failed botulinum toxin therapy (strong recommendation, low-quality evidence).

Autonomic & Movement Disorders, Pain, & Spasticity

In a 2013 update to the 2008 Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published evidence-based (studies classified as Class I to IV and recommendations classified as levels A to U)[69] assessments on the use of botulinum neurotoxin in the treatment of autonomic disorders and pain,[15] movement disorders,[19] and spasticity.[39] In addition, in 2013 authors performed an assessment on the use of botulinum neurotoxin in the treatment of urologic conditions and secretory disorders[88] based on the AAN

methodology.[286] The Quality Standards Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society also published an evidence-based review of the pharmacologic treatment of spasticity in children and adolescents with cerebral palsy in 2010.[6]

Recommendations from these reviews are classified as follows:
- Level A - Established as effective, ineffective, or harmful for the given condition in the specified population, requiring at least two consistent Class I studies.
- Level B - Probably effective, ineffective, or harmful for the given condition in the specified population, requiring at least one Class I study or at least two consistent Class II studies.
- Level C - Possibly effective, ineffective, or harmful for the given condition in the specified population, requiring at least one Class II study or two consistent Class III studies.
- Level U - Data inadequate or conflicting; given current knowledge, treatment is unproven.

Recommendations from these reviews are:
- BoNT should be offered as a treatment option for axillary hyperhidrosis and detrusor overactivity (detrusor hyperreflexia) (Level A). BoNT should be considered for palmar hyperhidrosis, sialorrhea, and detrusor sphincter dyssynergia after spinal cord injury (Level B).
- BoNT is probably effective for the treatment of benign prostatic hyperplasia induced lower urinary tract symptoms (Level B).
- BoNT may be considered for low back pain (Level C). BoNT is probably ineffective in episodic migraine and chronic tension-type headache (Level B).
- Evidence does not permit drawing conclusions on BoNT's efficacy in chronic daily headache (mainly transformed migraine) (Level U). Evidence does not support BoNT's efficacy for the treatment of gustatory sweating (Level U)
- BoNT should be offered as an option for the treatment of blepharospasm, cervical dystonia (Level A).
- BoNT may be offered for , hemifacial spasm, focal upper extremity dystonia, , and upper extremity essential tremor (Level B).
- BoNT may be considered for, adductor laryngeal dystonia, focal lower limb dystonia, oromandibular dystonia, and motor tics (Level C).
- BoNT should be offered as an option for the treatment of spasticity in adults (Level A). Spasticity in adults results from a variety of causes such as stroke, trauma, multiple sclerosis, and neoplasm involving the central nervous system.
- For localized/segmental spasticity that warrants treatment in children and adolescents with cerebral palsy, botulinum toxin type A should be offered as an effective and generally safe treatment (Level A) and there is insufficient data to support or refute the use of botulinum toxin type B (Level U).

Blepharospasm, Cervical Dystonia, Adult Spasticity, and Headache

In a 2016 update to the 2008 guidelines, the American Academy of Neurology (AAN) published evidence-based (studies classified as Class I to IV and recommendations classified as levels A to U)[286] assessments on the use of botulinum neurotoxins in the treatment of blepharospasm, cervical dystonia, headache, and adult spasticity.[89]

Recommendations from this review are classified as follows:
- Level A - Established as effective, ineffective, or harmful for the given condition in the specified population, requiring at least two consistent Class I studies.
- Level B - Probably effective, ineffective, or harmful for the given condition in the specified population, requiring at least one Class I study or at least two consistent Class II studies.
- Level C - Possibly effective, ineffective, or harmful for the given condition in the specified population, requiring at least one Class II study or two consistent Class III studies.
- Level U - Data inadequate or conflicting; given current knowledge, treatment is unproven.

Recommendations from this review for abobotulinumtoxinA (aboBoNT-A, Dysport) are as follows:
- AboBoNT-A should be offered as a treatment option for cervical dystonia, focal manifestations of upper limb spasticity, and focal manifestations of lower limb spasticity that warrant treatment (Level A).
    - AboBoNT-A has been established as safe and effective for the reduction of adult upper limb spasticity and improvement of passive function (multiple Class I studies). AboBoNT-A has also been established as safe and effective for the reduction of adult lower limb spasticity (multiple Class I studies).
    - Data is inadequate to determine the efficacy of aboBoNT-A for improvement of active function associated with adult upper limb spasticity (Class I studies, inconsistent results dependent on active functional outcomes). Data is also inadequate to determine the efficacy of aboBoNT-A for improvement of active function associated with adult lower limb spasticity (no studies available or inconsistent results dependent on specific outcome from multiple Class I studies).
- AboBoNT-A may be considered as a treatment option for blepharospasm (Level C).

Recommendations from this review for incobotulinumtoxinA (incoBoNT-A, Xeomin) are as follows:

- IncoBoNT-A should be offered as a treatment option for focal manifestations of upper limb spasticity (Level A).
  - IncoBoNT-A has been established as safe and effective for the reduction of adult upper limb spasticity and improvement of passive function (multiple Class I studies).
  - Data is inadequate to determine the efficacy of incoBoNT-A for improvement of active function associated with adult upper limb spasticity (Class I studies, inconsistent results dependent on active functional outcomes).
- IncoBoNT-A should be considered as a treatment option for blepharospasm and cervical dystonia (Level B).
- There is insufficient evidence to support or refute the use of incoBoNT-A for the treatment of lower limb spasticity (Level U).

Recommendations from this review for onabotulinumtoxinA (onaBoNT-A, Botox) are as follows:

- OnaBoNT-A should be offered as a treatment option for focal manifestations of upper limb spasticity, focal manifestations of lower limb spasticity that warrant treatment, and chronic migraine (Level A).
  - OnaBoNT-A has been established as safe and effective for the reduction of adult upper limb spasticity and improvement of passive function (multiple Class I studies). OnaBoNT-A has also been established as safe and effective for the reduction of adult lower limb spasticity (multiple Class I studies).
  - Data is inadequate to determine the efficacy of onaBoNT-A for improvement of active function associated with adult upper limb spasticity (Class I studies, inconsistent results dependent on active functional outcomes). Data is also inadequate to determine the efficacy of onaBoNT-A for improvement of active function associated with adult lower limb spasticity (no studies available or inconsistent results dependent on specific outcome from multiple Class I studies).
- OnaBoNT-A should be considered as a treatment option for blepharospasm and cervical dystonia (Level B).
- OnaBoNT-A should not be offered as a treatment option for episodic migraine (Level A).
- OnaBoNT-A should not be considered as a treatment option for tension-type headache (Level B).

Recommendations from this review for rimabotulinumtoxinB (rimaBoNT-B, Myobloc) are as follows:

- RimaBoNT-B should be offered as a treatment option for cervical dystonia (Level A).
- RimaBoNT-B should be considered as a treatment option for focal manifestations of upper limb spasticity (Level B).
  - RimaBoNT-B is probably safe and effective for the reduction of adult upper limb spasticity (1 Class I study).
  - Data is inadequate to determine the efficacy of rimaBoNT-B for improvement of active function associated with adult upper limb spasticity (Class I studies, inconsistent results dependent on active functional outcomes).
- There is insufficient evidence to support or refute the use of rimaBoNT-B for the treatment of blepharospasm and lower limb spasticity (Level U).

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

National Coverage Determinations (NCDs) do not exist for botulinum toxins at this time. Local Coverage Determinations (LCDs) do exist; see the LCDs for Botulinum Toxin Type A & Type B, Botulinum Toxin Types A and B, Botulinum Toxin Types A and B Policy, Botulinum Toxins, Chemodenervation and Drugs and Biologicals: Botulinum Toxins.

Medicare covers outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. See the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf. (Accessed August 11, 2017)

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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

01/01/2018	• Updated coverage rationale/diagnosis-specific requirements:
	  ○ Updated references to brand name drugs to include generic product names
	  ○ Replaced language indicating "[treatment of the listed conditions] is *proven* when criteria is met" with "[treatment of the listed conditions] is *medically necessary* when criteria is met"
	  ○ Removed duplicative language pertaining to medical necessity review
	• Updated supporting information to reflect the most current clinical evidence and references
	• Archived previous policy version CS2017D0017R

Clinical Policy: OnabotulinumtoxinA (Botox)

Reference Number: CP.PHAR.232
Effective Date: 07.01.16
Last Review Date: 05.18
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

OnabotulinumtoxinA (Botox®) is an acetylcholine release inhibitor and a neuromuscular blocking agent.

FDA Approved Indication(s)

Botox is indicated for:

- Treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication
- Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication
- Prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer)
- Treatment of spasticity in adult patients
- Treatment of cervical dystonia (CD) in adult patients, to reduce the severity of abnormal head position and neck pain
- Treatment of severe axillary hyperhidrosis that is inadequately managed by topical agents in adult patients
- Treatment of blepharospasm associated with dystonia in patients ≥ 12 years of age
- Treatment of strabismus in patients ≥ 12 years of age

Limitation(s) of use:

- Safety and effectiveness of Botox have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month) in seven placebo-controlled studies.
- Safety and effectiveness of Botox have not been established for the treatment of other upper or lower limb muscle groups. Safety and effectiveness of Botox have not been established for the treatment of spasticity in pediatric patients under age 18 years. Botox has not been shown to improve upper extremity functional abilities, or range of motion at a joint affected by a fixed contracture. Treatment with Botox is not intended to substitute for usual standard of care rehabilitation regimens.
- The safety and effectiveness of Botox for hyperhidrosis in other body areas have not been established. Weakness of hand muscles and blepharoptosis may occur in patients who receive Botox for palmar hyperhidrosis and facial hyperhidrosis, respectively. Patients should be evaluated for potential causes of secondary hyperhidrosis (e.g., hyperthyroidism) to avoid symptomatic treatment of hyperhidrosis without the diagnosis and/or treatment of the underlying disease. Safety and effectiveness of Botox have not been established for the treatment of axillary hyperhidrosis in pediatric patients under age 18.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Botox is **medically necessary** when one of the following criteria is met:

I. Initial Approval Criteria

A. Cervical Dystonia (must meet all):

1. Diagnosis of CD (*see Appendix C*):
2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;

3. Age ≥ 16 years;
4. Experiencing involuntary contractions of the neck and shoulder muscles (e.g., splenius, sternocleidomastoid, levator scapulae, scalene, trapezius, semispinalis capitis) resulting in abnormal postures or movements of the neck, shoulder or head;
5. Contractions are causing pain and functional impairment;
6. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
7. Dose does not exceed 400 units per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

B. Blepharospasm *(a focal dystonia)* or Strabismus (must meet all)**:**

1. Diagnosis (a or b):
   a. Blepharospasm (i.e., abnormal contraction of eyelid muscles);
   b. Strabismus (i.e., misalignment of the eyes);
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age ≥ 12 years;
4. Member has significant disability in daily functional activities due to interference with vision;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed (a or b):
   a. Blepharospasm: 5 units per site per treatment session (maximum of 200 units total in a 30-day period);
   b. Strabismus: 25 units per muscle per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

C. Other Dystonias (off-label) (must meet all)**:**

1. Diagnosis of dystonia (*see definitions and types in Appendices C and D*);
2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;
3. Failure of a trial of carbidopa/levodopa or trihexyphenidyl unless contraindicated or clinically significant adverse effects are experienced;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Dose does not exceed 400 units per single treatment with the following exceptions:
   a. Oromandibular dystonia: 25 units per muscle per treatment session;
   b. Laryngeal dystonia (spasmodic dysphonia): 3 units per treatment session.

Approval duration:

Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

D. Upper and Lower Limb Spasticity (must meet all)**:**
1. Diagnosis of upper or lower limb spasticity (a or b):
2. Prescribed by or in consultation with a neurologist, orthopedist , physiatrist, or physical medicine and rehabilitation specialist ;
3. Age ≥ 18 years;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Dose does not exceed 400 units per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

E. Spasticity Associated with Cerebral Palsy (off-label) (must meet all)**:**
1. Diagnosis of spasticity associated with cerebral palsy (CP);
2. Prescribed by or in consultation with a neurologist , physiatrist, or physical medicine and rehabilitation specialist;
3. Age ≥ 2 years;
4. Focal increased muscle tone interferes with function or is likely to lead to joint contracture with growth;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 400 units per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

F. Chronic Migraine (must meet all)**:**
1. Diagnosis of chronic migraine (≥ 15 days per month for at least 3 months with headache lasting 4 hours a day or longer);
2. Prescribed by or in consultation with a neurologist or pain specialist;
3. Age ≥ 18 years;
4. Failure of an 8-week trial of at least 2 oral migraine preventative therapies (e.g., antiepileptic drugs: divalproex sodium, sodium valproate, topiramate; beta-blockers: metoprolol, propranolol, timolol; antidepressants: amitriptyline, venlafaxine), unless contraindicated or clinically significant adverse effects are experienced;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 200 units per treatment session.

Approval duration:

Medicaid/HIM - 24 weeks (two 12-week treatment sessions)
Commercial – 6 months or to member's renewal date, whichever is longer

G. Primary Axillary Hyperhidrosis (must meet all)**:**
1. Diagnosis of severe primary axillary hyperhidrosis (e.g., resulting in medical complications such as skin maceration and infection or significant disruption of professional/social life);
2. Prescribed by or in consultation with a neurologist or dermatologist;
3. Age ≥ 18 years;
4. Failure of a 6-month trial of topical aluminum chloride, unless contraindicated or clinically significant adverse effects are experienced;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 50 units per axilla per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

H. Overactive Bladder and Urinary Incontinence (must meet all)**:**
1. Diagnosis (a or b):
   a. Overactive bladder
   b. Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, MS);
2. Prescribed by or in consultation with a neurologist or urologist;
3. Age ≥ 18 years;
4. Failure of a trial of at least two anticholinergic agents and one oral beta-3 agonist medication (e.g., oxybutynin chloride, tolterodine tartrate, mirabegron), each used for at least 30 days, unless contraindicated or clinically significant adverse effects are experienced;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed (a or b):
   a. Overactive bladder: 100 units per treatment session;
   b. Urinary incontinence: 200 units per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

I. Esophageal Achalasia (off-label) (must meet all)**:**
1. Diagnosis of esophageal achalasia (i.e., failure of relaxation of the lower esophageal sphincter accompanied by loss of peristalsis in the distal esophagus);
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;

4. Member is not a good candidate for pneumatic dilation or myotomy (e.g., high surgical risk due to age, comorbidities);
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 100 units.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

J. Hirschsprung's Disease and Internal Anal Sphincter Achalasia (off-label) (must meet all):

1. Diagnosis (a or b):
   a. Hirschsprung's disease (HD) (i.e., heritable motor disorder of the gut with failure of the colon to relax causing functional obstruction; usually diagnosed infancy or childhood) (i or ii):
      i. Botox will be used for constipation due to increased internal anal sphincter tone after surgery;
      ii. Member is diagnosed with ultra-short segment HD;
   b. Internal anal sphincter (IAS) achalasia (i.e., lack of rectoanal inhibitory reflex on anal manometry; presents in infancy – may mimic HD);
2. Prescribed by or in consultation with a gastroenterologist;
3. Failure of a trial of stool softeners and laxatives;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Dose does not exceed 100 units.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

K. Chronic Anal Fissure (off-label) (must meet all)**:**

1. Diagnosis of chronic anal fissures;
2. Prescribed by or in consultation with a gastroenterologist or colorectal surgeon;
3. Age ≥ 18 years;
4. Failure of a trial of nitroglycerin 0.2% ointment, unless contraindicated or clinically significant side effects are experienced;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 100 units.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

L. Other diagnoses/indications:

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Approval

A. Chronic Migraine (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
3. If member has received 2 or more Botox treatment sessions, has experienced and maintained a 30% reduction in monthly migraine headache frequency from baseline;
4. It has been at least 12 weeks since the last injection of Botox;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. If request is for a dose increase, new dose does not exceed 200 units per treatment session.

Approval duration:
Medicaid/HIM – 24 weeks (two 12-week treatment sessions)
Commercial – 6 months or to member's renewal date, whichever is longer

B. Esophageal Achalasia (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
3. It has been at least 24 weeks since the last injection of Botox;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. If request is for a dose increase, new dose does not exceed 100 units per treatment session.

Approval duration:
Medicaid/HIM - 24 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

C. All Other Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. It has been at least 12 weeks since the last injection of Botox;

4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Botox administration has not exceeded 400 units over the last 3 months;
6. If request is for a dose increase, new dose does not exceed the following indication-specific maximums if applicable:
    a. Dystonias:
        i. CD, upper/lower limb spasticity, CP: 400 units per treatment session;
        ii. Blepharospasm: 5 units per site per treatment session (maximum of 200 units total in a 30-day period);
        iii. Strabismus: 25 units per muscle per treatment session;
        iv. Oromandibular dystonia: 25 units per muscle per treatment session;
        v. Laryngeal dystonia (spasmodic dysphonia): 3 units per treatment session;
    b. Primary axillary hyperhidrosis: 50 units per axilla per treatment session;
    c. Overactive bladder, HD, IAS achalasia, chronic anal fissures: 100 units per treatment session;
    d. Urinary incontinence: 200 units per treatment session.

Approval duration:
Medicaid/HIM - 12 weeks (single treatment session)
Commercial – 6 months or to member's renewal date, whichever is longer

D. Other diagnoses/indications (1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: 12 weeks (single treatment session); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Cosmetic treatment of hyperfunctional wrinkles of the upper face including glabellar frown lines, deep forehead wrinkles and periorbital wrinkles (crow's feet).

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: cervical dystonia
CP: cerebral palsy
HD: Hirschsprung's disease
IAS: internal anal sphincter
MS: multiple sclerosis
SCI: spinal cord injury
TMD: temporomandibular disorders
TMJ: temporomandibular joint

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
carbidopa/levodopa (Sinemet®, Duopa®, Rytary®)	**Other Dystonias** (*see appendices C and D*) 25 mg/100 mg PO QD, and increase by 1 tablet every 3 to 5 days.	1,200 mg/day of levodopa
trihexyphenidyl	**Other Dystonias** (*see appendices C and D*) 30 mg PO QD	30 mg/day
lactulose	**Hirschsprung's Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure** 15-30 ml PO QD	60 mL/day
Senokot® (sennosides)	**Hirschsprung's Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure** Two 8.6 mg tabs PO QD-BID	34.4 mg/day
Metamucil® (psyllium)	**Chronic anal fissure** One rounded tsp in 8 oz liquid PO up to TID	3 doses/day
Dulcolax® (bisacodyl)	**Hirschsprung's Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure** 5 to 15 mg PO or 10 mg PR QD	30 mg/day
FiberCon® (Calcium polycarbophil)	**Chronic anal fissure** Two 625 mg tabs PO QD-QID	5000 mg/day
Citrucel® (Methylcellulose)	**Chronic anal fissure** Caplet: 2 caplets up to 6 times daily Powder: 2 grams in 8 oz of cold water by mouth up to 3 times daily	12 caplets/day or 6 grams/day
MiraLax® (Polyethylene glycol 3350)	**Hirschsprung's Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure** 17 grams of polyethylene glycol 3350 in 4-8 oz water by mouth once daily	17 grams/day
Colace® (Docusate sodium)	**Hirschsprung's Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure** 50-200 mg PO QD-QID	200 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
nitroglycerin 0.2% ointment (Rectiv®)	**Chronic anal fissure** 15 to 30 mg (2.5 to 5 cm as squeezed from the tube, about 1 to 2 inches), applied topically to the skin every 8 hours while awake and at bedtime; frequency of application may be increased to every 6 hours if needed. Alternatively, a regimen providing a 12-hour nitrate-free interval may be used; apply dosage once each morning, then reapply 6 hours later	75 mg (12.5 cm as squeezed from the tube)/day
oxybutynin (Ditropan®/XL, Gelnique®)	**Overactive Bladder** Immediate-release tablets: 5 mg orally two to three times daily Extended-release tablets: 5-10 mg orally once daily Topical gel: Apply contents of one sachet topically once daily	Immediate-release: 20 mg/day Extended-release: 30 mg/day Gel: one sachet/day
tolterodine tartrate (Detrol®/LA)	**Overactive Bladder** Immediate-release tablets: 2 mg orally twice daily Extended-release tablets: 4 mg orally once daily	4 mg/day
Myrbetriq® (mirabegron)	**Overactive Bladder** 25 mg orally once daily	50 mg/day
Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®)	**Chronic Migraines** *Refer to prescribing information*	*Refer to prescribing information*
Beta blockers such as: propranolol (Inderal®), metoprolol (Lopressor®), timolol	**Chronic Migraines** *Refer to prescribing information*	*Refer to prescribing information*
Antidepressants/tricyclic antidepressants such as: amitriptyline (Elavil®), venlafaxine (Effexor®)	**Chronic Migraines** *Refer to prescribing information*	*Refer to prescribing information*
Non-steroidal anti-inflammatory drugs (NSAIDs) such as:	**Chronic Migraines** *Refer to prescribing information*	*Refer to prescribing information*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
fenoprofen (Nalfon®), ibuprofen (Motrin®), ketoprofen (Orudis®), naproxen (Naprosyn®)		
Drysol ® (aluminum chloride)	**Primary Axillary Hyperhidrosis** Apply topically once daily	One application/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Definition and Classification of Dystonia[11]

Dystonia is defined as a movement disorder characterized by sustained or intermittent muscle contractions causing abnormal, often repetitive, movements, postures, or both.

- Dystonic movements are typically patterned and twisting, and may be tremulous.
- Dystonia is often initiated or worsened by voluntary action and associated with overflow muscle activation.

Dystonia is classified along two axes:

- Clinical characteristics: Age at onset, body distribution, temporal pattern, associated features (additional movement disorders or neurological features) - *the clinical characteristics fall into several specific dystonia syndromes that help to guide diagnosis and treatment*;
- Etiology: Nervous system pathology, inheritance.

*Appendix D: Descriptions and Examples of Dystonia Syndromes**

Category	Subcategory	Description and Examples
Isolated dystonias	Early-onset generalized isolated dystonia	Dystonia with focal-onset in childhood often progresses to generalized involvement. Cases may be sporadic, familial, genetically defined or without known cause. • Early-onset generalized dystonia (DYT-TOR1A) • Adolescent-onset dystonia of mixed type (DYT-THAP1)
	Adult-onset focal or segmental isolated dystonia	Usually begins after age 30 years. Most are sporadic without identifiable cause. Rarely progress to generalized dystonia but can extend to contiguous body regions. • Adult-onset segmental dystonia (DYT-GNAL) • Cervical dystonia • Blepharospasm • Writer's cramp • Oromandibular dystonia • Laryngeal dystonia (spasmodic dysphonia) • Limb dystonia

Category	Subcategory	Description and Examples
Combined dystonias	Dystonia-parkinsonism	Disorders that combine dystonia and parkinsonian features. May be accompanied by pyramidal tract involvement or nonmotor features including cognitive decline. Many are inherited. • Dopa-responsive dystonia (DYT-GCH1, DYT-TH, and DYT-SPR) • Wilson disease • Early-onset parkinsonism (PARK-PARKIN) • Conditions associated with neurodegeneration with brain iron accumulation
	Myclonus-dystonia	Disorders in which there is a combination of dystonia and myoclonus. Dystonia may be mild and myoclonus generally predominates. • Myoclonus-dystonia (DYT-SGCE)
	Paroxysmal dyskinesia with dystonia	Disorders characterized by episodes of spontaneous or induced dyskinesia with dystonia. • Paroxysmal nonkinesigenic dyskinesia (DYT-MR1)

**Table adapted with permission from: Comella C. Classification and evaluation of dystonia. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. Available at www.uptodate.com. Accessed on June 22, 2017.*

Appendix E: General Information

- All botulinum toxin products have a black box warning which cautions patients that the effects of the drug may spread from the area of injection and cause symptoms similar to botulism, including potentially life-threatening swallowing and breathing difficulty.
- The potency units of botulinum toxin products are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, units of biological activity of one product cannot be compared to nor converted into units of any other botulinum toxin products assessed with any other specific assay method.
- Safety and effectiveness have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month) and is a Class III recommendation in Micromedex.
- Indication specific dosage and administration recommendations should be followed for Botox. When initiating treatment, the lowest recommended dose should be used. In treating adult patients for one or more indications, the maximum cumulative dose should not exceed 400 Units, in a 3 month interval.
- For detrusor overactivity associated with a neurologic condition there was no additional benefit of Botox 300 Units over 200 Units.
- Safety and effectiveness have not been uniformly established for the treatment of temporomandibular disorders (TMD). Use of botulinumtoxin for this indication is a Class IIb recommendation in Micromedex based on a single study from 1999. A review of two clinical studies (from 2002 and 2011) (15 and 21 patients) found no significant differences in pain reduction between botulinumtoxin and placebo. Other small studies (from 2005 - Italy and 2008 - Turkey) have been performed and showed improvement in objective measures of pain (20 patients and 26 patients). The most common total dose of

BTX-A used in the studies was 25u for each temporalis muscle and 50u for each masseter muscle. The studies did not repeat the dosing, but measured efficacy at 16 weeks post dose. The 2003 Guidelines for diagnosis and management of disorders involving the temporomandibular joint and related musculoskeletal structures mention Botox as a possible treatment option for temporomandibular joint (TMJ) based on its mechanism of action and the pathophysiology of TMD.
  - TMD "gold standard" treatment continues to be: 1) TMJ intraoral orthotic; 2) Muscle relaxants by mouth; and 3) Home muscle relaxation exercises/techniques.
- Limb spasticity may be caused by Heredity spastic paraplegia; multiple sclerosis or other demyelinating diseases of the central nervous system; Spastic hemiplegia; infantile cerebral palsy; Stroke.

V. Dosage and Administration

Botox (onabotulinumtoxin A) Dose Chart			
Condition	**Average Duration of Effect**	**Average Dose**	**Maximum dose per treatment session**
Blepharospasm	12.5 weeks	5 units per site	200 units total in a 30-day period
Strabismus	6-8 weeks to 6-12 months	2.5 to 5 units per muscle (max 25 units)	25 units
Cervical dystonia	4 weeks to 3 months	200 to 300 units divided among affected muscles	400 units
Oromandibular dystonia*	10 to 14 weeks	25 units per muscle per treatment	100 units
Spasmodic dysphonia*	3-6 months	0.031 to 10 units per vocal cord. 5 to 30 units in abductor muscle	400 units
Overactive bladder	12 weeks	Total dose 100 Units, as 0.5 mL (5 Units) injections across 20 sites into the detrusor. Repeat doses should be 12 weeks apart	400 units
Spastic muscle contracture of pediatric cerebral palsy*	1-6 months	3 to 6 units/kg (maximum 12 units/kg). total dose 82 to 220 units divided among affected muscles	100 units
Childhood myoclonus following failure of Baclofen, benzodiazepines, and antiseizure medications*	4-8 months	8 to 80 units/kg	400 units

Botox (onabotulinumtoxin A) Dose Chart			
Condition	**Average Duration of Effect**	**Average Dose**	**Maximum dose per treatment session**
Chronic anal fissure*	Single Injection	20 units both sides	80 units/kg
Internal anal sphincter achalasia*	Single treatment. Patient may require repeat treatment. Adults or children	15 units to 25 units in each quadrant or up to 50 units on either side of IAS	100 units
Axillary Hyperhidrosis	4-12 months	50 units per axilla	100 units
Migraines	3-4 months	155 to 195 total units given in 5 to 40 units/site	200 units
Neurogenic bladder	8-12 months	200 units given in multiple sites	200 units
Upper Limb Spasticity	12 weeks	12.5 Units-50 Units in one site	400 units

**off-label uses*

VI. Product Availability

Vial of powder for solution for injection: 100 units, 200 units

VII. References

1. Botox Prescribing Information. Irvine, CA: Allergan, Inc.; April 2017. Available at http://www.allergan.com/assets/pdf/botox_pi.pdf. Accessed February 8, 2018.
2. OnabotulinumtoxinA. In: Micromedex. Ann Arbor, MI: Truven Health Analytics; 2018. Available from: www.micromedexsolutions.com. Accessed February 16, 2018.

Dystonias, Spasticity, Chronic Migraine

3. Simpson DM, Hallett M, Ashman EJ et al. Practice guideline update summary: botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016; 86(19): 1818-1826.
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12. Cloud LJ, Jinnah HA. Treatment strategies for dystonia. Expert Opin Pharmacother 2010; 11(1):5-15.
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Primary Axillary Hyperhidrosis, Overactive Bladder, Urinary Incontinence

14. Naumann M, So Y, Argoff, CE, et al. Assessment: Botulinum neurotoxin in the treatment of autonomic disorders and pain (an evidence-based review) Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology.* 2008; 70: 1707-1714.
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16. Gormley EA, Lightner DJ, Burgio KL et al. Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: AUA (American Urological Association)/SUFU guideline. American Urological Association Education and Research, Inc. Available at http://www.auanet.org/education/guidelines/overactive-bladder.cfm. Published May 2014. Accessed June 14, 2017.
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Esophageal Achalasia

19. Vaezi MF, Pandolfino JE, Vela MF. ACG (American College of Gastroenterology) clinical guideline: Diagnosis and management of achalasia. Am J *Gastroenterol.* 2013; 108(8): 1238-1259.

Hirschsprung's Disease, Internal Anal Sphincter Achalasia

20. Koivusalo AI, Pakarinen MP, Rintala RJ. Botox injection treatment for anal outlet obstruction in patients with internal anal sphincter achalasia and Hirschsprung's disease. *Pediatr Surg Int.* 2009; 25: 873-876.

Chronic Anal Fissures

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Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0585	Injection, onabotulinumtoxinA, 1 unit

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.09. Added new FDA indication of lower limb spasticity per FDA labeling. Added compendial indication of laryngeal spasm/spasmodic dysphonia. -Overactive bladder: modified requirement for trial/failure of previous therapy to include oral beta-3 agonist medications per AUA guidelines. -Migraine: modified continuation criteria to require 30% reduction in headache frequency after 2 injections rather than just 1 per literature review and NICE guidelines. -Added general max dosing limit for cerebral palsy and spastic conditions and indication-specific max dosing limit for cervical dystonia, strabismus, primary axillary hyperhidrosis, upper limb spasticity, overactive bladder, urinary incontinence, and chronic migraine per PI. -Added indication-specific max dosing limit for chronic anal fissures, esophageal achalasia, laryngeal spasm/spasmodic dysphonia, Hirschsprung's disease, and dystonias per literature review. -Added prescriber requirement for overactive bladder, urinary incontinence, chronic migraines, upper limb spasticity, primary axillary hyperhidrosis, chronic anal fissures, cerebral palsy, esophageal achalasia, dystonias, Hirschsprung's disease, and spastic conditions. -Added age restriction for upper limb spasticity and primary axillary hyperhidrosis per PI, and for chronic anal fissures, esophageal achalasia, and Hirschsprung's disease per literature review. -Added route of administration for each labeled indication per PI. -Removed reauthorization criteria requiring attestation of significant improvement in symptoms and/or health-related quality of life.	05.16	07.16

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added positive response to therapy to continuation criteria.		
-Chronic migraine initial approval duration lengthened from 12 to 24 weeks (from one to two treatment sessions) to allow assessment of response as outlined in continuation criteria.	11.16	
The off-label criteria set entitled "Spastic Conditions" is deleted due to its broad scope; off-label requests not covered elsewhere in the policy are referred to the CP.PHAR.57.Global Biopharm policy so that they may be reviewed individually. Requirement that provider submits detailed treatment plan added to curtail abuse	02.17	
Indications reorganized. Definition of CD is edited per AAN guidelines. Laryngeal dystonia is merged with off-label dystonias which in turn are entitled "Other Dystonias". Clarified "blepharospasm" as a focal dystonia. Deleted causes and classifications of blepharospasm; blepharospasm and strabismus definitions are added. Dystonia information is added at Appendices B and C. Added esophageal achalasia definition. IAS achalasia is given its own line item. HD and IAS achalasia definitions added. Background FDA indication section and references categorized. "Non-cosmetic" parenthetical added to the background FDA indication section; cosmetic coverage restriction reworded under the "Other Diagnoses/Indications" section to include notation of glabellar lines.	06.17	07.17
2Q 2018 annual review: combined Medicaid and Commercial lines of business; added HIM line of business; expanded maximum dose for chronic migraine treatment to 200 units per treatment per 2012 NICE guidelines; Hirschsprung's Disease and Internal Anal Sphincter Achalasia: removed requirement for dietary and fluid control; added physical medicine and rehabilitation specialist for cervical dystonia, other dystonia, upper and lower limb spasticity, and spasticity associated with CP; added pain specialist for migraine; Medicaid: lowered age limit for CD to 16 from 18 years; added physiatrist to accepted specialist for spasticity associated with CP; Commercial: approval durations changed from length of benefit to 6 months or to member's renewal date, whichever is longer for initial and continued approval; references reviewed and updated.	04.24.18	05.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

Neuromuscular Blocker Agent - Toxin, Utilization

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Count of Members	Count of Claims	Sum of Qty	Sum of Days	Sum of Amt Paid
BOTOX INJ 100UNIT	154	158	270.59	1135	$ 156,230.34
BOTOX INJ 200UNIT	533	540	194884	4730	$ 847,442.76
BOTOX COSMET INJ 100UNIT	3	3	52	3	$ 1,695.04
DYSPORT INJ 300UNIT	17	17	23.4	483	$ 10,071.96
DYSPORT INJ 500UNIT	20	22	661.6	583	$ 36,795.63
MYOBLOC INJ 10000/2	10	10	608	10	$ 7,783.00
MYOBLOC INJ 2500/0.5	2	2	4.5	2	$ 2,614.50
MYOBLOC INJ 5000/ML	1	1	1	1	$ 581.00
XEOMIN INJ 100UNIT	4	4	4	33	$ 1,948.34
XEOMIN INJ 200UNIT	115	120	2625	2377	$ 149,713.81
XEOMIN INJ 50 UNIT	5	6	157	35	$ 3,431.17
Total	**864**	**883**	**199291.09**	**9392**	**$ 1,218,307.55**

DIV_ID	YR	MO	BRAND_NA	METRIC_DI	DAYS_SUPI	CLM_CNT	MBR_CNT
WKQ	2017	6	BOTOX	20.000	1332	17	17
WKQ	2017	7	BOTOX	16.000	1086	14	14
WKQ	2017	8	BOTOX	8.000	606	7	7
WKQ	2017	9	BOTOX	16.000	1056	13	13
WKQ	2017	10	BOTOX	19.000	1374	18	18
WKQ	2017	11	BOTOX	13.000	936	11	11
WKQ	2017	12	BOTOX	15.000	1284	15	15
WKQ	2018	1	BOTOX	14.000	1080	14	14
WKQ	2018	2	BOTOX	12.000	1026	12	12
WKQ	2018	3	BOTOX	12.000	1038	12	12
WKQ	2018	4	BOTOX	15.000	1164	14	14
WKQ	2018	5	BOTOX	10.000	864	10	10

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada Medicaid

Botulinum Toxins

March 1, 2017 through April 30, 2018

Year/Month Filled/Paid	Drug Name	Count of Claims	Sum of Units
2017/03	BOTOX (J0585)	10	11
2017/04	BOTOX (J0585)	2	2
2017/05	BOTOX (J0585)	11	15
2017/06	BOTOX (J0585)	10	15
2017/07	BOTOX (J0585)	5	5
2017/07	XEOMIN (J0588)	1	1
2017/08	BOTOX (J0585)	8	8
2017/09	BOTOX (J0585)	9	11
2017/10	BOTOX (J0585)	6	7
2017/11	BOTOX (J0585)	7	8
2017/12	BOTOX (J0585)	10	11
2017/12	XEOMIN (J0588)	1	1
2018/01	BOTOX (J0585)	7	7
2018/02	BOTOX (J0585)	1	1

PLEASE NOTE: Capitated claims are not included in this data

A. DESCRIPTION

1. Botulinum toxin is a neuromodulator derived from neurotoxins produced by the bacteria Clostridium botulinum, a gram positive bacillus. Botulinum toxin inhibits the release of acetylcholine at presynaptic cholinergic nerve terminals of the peripheral nervous system and atganglionic nerve terminals of the autonomic nervous system, thereby preventing neurotransmission and inducing flaccid paralysis. Three botulinum toxin type A products are approved by the Food and Drug Administration (FDA), including abobotulinumtoxinA (Dysport®), incobotulinumtoxinA (Xeomin®) and onabotulinumtoxinA (Botox®). RimabotulinumtoxinB (Myobloc®) is the only botulinum toxin B product approved by the FDA. FDA-approved indications differ among the individual botulinum toxin products.

2. The botulinum toxin products are not interchangeable with one another. The potency (in units) of one botulinum toxin product is specific to the preparation and assay method utilized by the manufacturer and units of biological activity of one product cannot be compared to or converted into units of any other botulinum toxin products assessed with any other specific assay method. All botulinum toxin products include a boxed warning in their labeling regarding the risk of botulinum toxin spreading beyond the site of injection, resulting in adverse events and death in some cases. Follow CPT guidelines for chemodenervation. Bill using the National Drug Code (NDC) for agents administered. See billing guide for billing instructions.

Current Medications Available in Therapeutic Class

Non-Proprietary Name (Trade Name)	**FDA-Approved Indication(s)**
OnabotulinumtoxinA (BOTOX®)	• Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., SCI, MS) in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting four hours a day or longer); • Treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis); • Treatment of adults with cervical dystonia, to reduce the severity of abnormal head position and neck pain associated with cervical dystonia; • Treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents; and • Treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above.

AbobotulinumtoxinA (DYSPORT®)	• Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients.
IncobotulinumtoxinA (XEOMIN®)	• Treatment of adults with cervical dystonia to decrease the severity of abnormal head position and neck pain in both botulinum toxin-naïve and previously treated patients; and • Treatment of adults with blepharospasm who were previously treated with onabotulinumtoxinA (Botox).
RimabotulinumtoxinB (MYOBLOC®)	• Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

B. POLICY

Botulinum Toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries, and multiple sclerosis. The injections may also reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow better range of motion, to permit better physical therapy, and provide adequate perineal hygiene.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. For a complete list of covered indications, please refer to the "Provider Type 20, 24 and 77 Billing Guide," applicable to botulinum toxins. It is expected that physicians will be familiar with and experienced in the use of the botulinum toxin product(s), and utilize FDA-approved product labeling, compendia, and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each patient condition.

2. Before consideration of coverage can be made, it must be established that the patient has been unresponsive to conventional methods of treatment such as medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions.

3. Coverage is limited to certain conditions listed in the covered diagnosis code section of the billing manual.

4. In order to determine the proper injection(s) site, electromyography (EMG) guidance may be required.

5. The patient who has a spastic or excessive muscular contraction condition is usually started with a low dose of Botulinum Toxin with increases as required. Some spastic or muscular contraction conditions, e.g., eye muscle disorders, (e.g., blepharospasm) may require lesser amounts. For larger muscle groups, it is generally agreed that once a maximum dose per site has been reached, and there is no response, the treatment is discontinued. Treatments may be resumed at a later date if indicated. If a response is positive, the effect of the injections generally continues for three

months, at which time the patient may need to repeat the injections for continued control. It is seldom medically necessary to repeat injections more frequently than every 90 days, unless acceptable justification is documented for more frequent use in the initial therapy.

6. Medicaid will allow payment for one injection per site, regardless of the number of injections made into the site. A site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, neck, etc.

7. Coverage will not be provided for injections given for cosmetic or for investigational purposes.

8. Anesthesia for Botulinum injections is usually provided as a local anesthetic (e.g., for blepharospasm), or conscious sedation, although some patients, such as pediatric, may require more than conscious sedation. (See appropriate anesthesia CPT codes listed below).

Nevada Medicaid
Opioid Cough Medications
Pharmacy Coverage Guideline

Opioid Cough Medications

CRITERIA FOR COVERAGE/NONCOVERAGE

Approval Criteria:

Approval Length: 6 months

1. Patient is 18 years of age or older.

Anthem
Excerpt from Short-Acting Opioid Analgesics for Acute Pain Duration of Use Policy

Tramadol containing agents may be subject to the following age requirements via prior authorization:
I. Individual is 18 years of age or older; **OR**
II. Individual is 12 years of age or older and treating for pain conditions other than postsurgical removal of tonsils and/or adenoids. (FDA Safety Announcement 2017)

NOTE: An FDA Safety advisory released on 4-20-2017 noted that the label for tramadol containing agents would be updated to include the following contraindications: contraindication for use in children younger than 18 years to treat pain after surgery to remove the tonsils and/or adenoids, and contraindication for use in treating pain in children younger than 12 years. This is due to serious risks, including slowed or difficult breathing and death, which appear to be a greater risk in children younger than 12 years (https://www.fda.gov/drugs/drugsafety/ucm549679.htm

Codeine containing agents may be subject to the following age requirements via prior authorization:
I. Individual is 12 years of age or older. (FDA Safety Announcement 2017)

NOTE: An FDA Safety advisory released on 4-20-2017 noted that the label for codeine containing agents would be updated to include a contraindication for use in treating pain or cough in children younger than 12 years. This is due to serious risks, including slowed or difficult breathing and death, which appear to be a greater risk in children younger than 12 years (https://www.fda.gov/drugs/drugsafety/ucm549679.htm).

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Clinical Pharmacy Program Guidelines for Short-Acting Opioid Products – Health Plan of Nevada Medicaid

Program	Prior Authorization/Medical Necessity – Short-Acting Opioid Products- Nevada Medicaid
Medication	**Short-Acting Opioids:** **Includes both brand and generic versions of the listed products unless otherwise noted:** All salt forms, single and combination ingredient products, and all brand and generic formulations of the following: butorphanol tartrate nasal spray, codeine, morphine, hydrocodone, hydromorphone, oxycodone, oxymorphone, pentazocine, tramadol, tapentadol, meperidine, levorphanol tartrate, dihydrocodeine, opium **Short-Acting Opioids – Cough and cold products:** **Includes both brand and generic versions of the listed products unless otherwise noted:** Products containing codeine or hydrocodone in combinations with one or more of the following: homatropine, chlorpheniramine, guaifenesin, pyrilamine, brompheniramine, phenylephrine, triprolidine, dexchlorpheniramine, promethazine, pseudoephedrine.
Markets in Scope	Nevada

(i) Background:

The CDC and the American Academy of Neurology recommends the following best practices in the prescription of opioids:

- Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.
- Before starting opioid therapy, treatment goals should be established with patients that include realistic goals for pain and function and should consider how therapy will be discontinued if benefits do not outweigh risks. Track pain and function at every visit (at least every 3 months) using a brief, validated instrument. Continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended release/long-acting opioids.
- Document the daily morphine equivalent dose (MED) in mg/day from all sources of opioids. Access the state prescription drug monitoring program (PDMP) data at

treatment initiation and periodically during treatment. Currently all states except for Missouri have a PDMP.

- To avoid increased risk of respiratory depression, long-acting opioids should not be prescribed concurrently with benzodiazepines. Screen for past and current substance abuse and for severe depression, anxiety, and PTSD prior to initiation.
- Use random urine drug screening prior to initiation and periodically during treatment with a frequency according to risk.
- Use a patient treatment agreement, signed by both the patient and prescriber that addresses risks of use and responsibilities of the patient.
- Methadone should not be the first choice for a long-acting opioid. Only clinicians who are familiar with methadone's unique risk profile and who are prepared to educate and closely monitor their patients should consider prescribing methadone for pain.
- CDC recommends avoiding escalating doses above 50-90 mg/day MED unless sustained meaningful improvement in pain and function is attained, and not without consultation with a pain management specialist. A list of MED for the long-acting opioids is available in Table 1.
- The American Academy of Neurology recommends avoiding escalating doses above 80-120 mg/day MED unless sustained meaningful improvement in pain and function is attained, and not without consultation with a pain management specialist. A list of MED for the long-acting opioids is available in Table 1.
- Clinicians should evaluate benefits and harms of continued therapy at least every 3 months. If benefits do not outweigh harms, opioids should be tapered and discontinued. Evaluation should include assessment of substance use disorder/opioid dependence. Validated scales (such as the DAST-10) are available at www.drugabuse.gov.

Table 1. CDC Recommended Opioid Maximum Morphine Equivalents per Day*

Active Ingredient	FDA Label Max Daily Doses	180 MED Equivalent (mg/day) (non treatment naïve)
Morphine	None	180mg
Hydromorphone	None	45mg
Hydrocodone	None	180mg
Tapentadol	600mg IR products	450mg
Oxymorphone	None	60mg
Oxycodone	None	120mg
Codeine	360mg	1200mg
Pentazocine	None	486mg
Tramadol	400mg IR products	1800mg
Meperidine	600mg	1800mg

Butorphanol	None	25.8mg
Opium	4 suppositories/day Deodorized tincture: 24mg/day Camphorated tincture: 16mg/day	90mg

*Doses are not considered equianalgesic and table does not represent a dose conversion chart.

Max MED is the maximum dose per day based on morphine equivalent dose allowed without consultation or prescription by a pain specialist. Max MED is based upon the CDC guidelines and adjusted for currently available product strengths. Fentanyl is dosed in mcg/hr rather than mg/day.

Coverage Criteria:

(ii) Short-Acting Opioids: Criteria for Opioid Naïve Members, including Non-Preferred Reviews and Quantity Limits

NOTE: An opioid-naïve member is defined as not having filled an opioid in the past 60 days.

Patients will be limited to a 7 days supply and less than 50 MED/day for their initial short-acting opioid fill

NOTE: This section does NOT apply to cough and cold products.

A. Short-Acting Opioids

1. Opioid naïve members (defined as not having filled an opioid in the past 60 days) may receive greater than a 7 day supply and/or greater than 50 MED based on **ALL** of the following:

a. If the request is for greater than a 7 days supply **ONE** of the following:

(1) Cancer diagnosis
(2) End- of- life care, including hospice care
(3) Palliative care
(4) Sickle cell anemia
(5) **Both** of the following:
(a) **ONE** of the following:
i. Traumatic injury
ii. Post-surgical procedures, excluding dental procedures
iii. Prescriber attests that the patient has received an opioid within the past 60 days

-AND-

(b) Prescriber attests to **both** of the following:
i. The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.
ii. If requested for traumatic injury or post-surgical procedure, prescriber attests that based on injury or surgical procedure performed the member requires greater than a 7 day supply of short-acting opioid to adequately control pain.

-AND-

b. If the request is for 50 MED or greater **ONE** of the following:
NOTE: If the request exceeds 180 MED, please skip Section b-Requests for 50 MED or greater and proceed to Section IV-Morphine Equivalent Dosing (MED) Reviews

(1) Diagnosis of cancer, end of life pain (including hospice care), palliative care or sickle cell anemia
(2) Patient new to the plan is currently exceeding 50 MED and prescriber attests patient has been on a short-acting opioid in the past 60 days.
(3) All of the following:
(a) Document **all** of the following:
i. The diagnosis associated with the need for pain management with opioids.
ii. If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression.
iii. The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment.
iv. Prescriber attests the member requires more than 50 MED per day to adequately control pain.

-AND-

c. If the request is for a non-preferred medication the patient must have a history of failure, contraindication or intolerance to a trial of at least three preferred short-acting opioids.
Authorization for cancer, end of life, palliative care, or sickle cell pain will be issued for 12 months. All other approvals will be issued for the requested duration, not to exceed one month.

(iii) Short-Acting Opioids: Criteria for Opioid Experienced Members: Non-Preferred Reviews

NOTE: This section does NOT apply to cough and cold products.

A. If the request is for a non-preferred medication the patient must have a history of failure, contraindication or intolerance to a trial of at least three preferred short-acting opioids.

Authorization will be issued for 12 months.

(iv) Morphine Equivalent Dosing (MED) Reviews: For Requests Exceeding the 180MED Cumulative Threshold.

NOTE: This section does NOT apply to cough and cold products.

A. Criteria for Morphine Equivalent Dosing (MED) Reviews:

1. Cancer/Hospice/End-of-life Related Pain

i. Doses exceeding the cumulative MED of 180mg will be approved up to the requested amount for ALL opioid products if the member has cancer pain, hospice, or an end-of-life diagnosis.

Authorization will be issued for 12 months for cancer pain/hospice/end-of-life related pain. The authorization should be entered for an MED of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

2. Non-cancer/non-hospice/non-end-of-life related pain

i. If the dose exceeds the maximum cumulative MED of 180mg, must meet ALL of the following:

1. Provides diagnosis associated with the need for pain management with opioids.

-AND-

2. Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement).

-AND-

3. Both of the following:
   a. Identify rationale for not tapering and discontinuing opioid. (Document rationale).
   b. Opioid medication doses of less than 180 MED have been tried

and did not adequately control pain (document drug regimen or MED and dates of therapy)

-AND-

4. Prescriber attests to ALL of the following:
    - The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.
    - Treatment goals are defined, including estimated duration of treatment.
    - Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
    - Patient has been screened for substance abuse/opioid dependence
    - If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression.
    - Pain is moderate to severe and expected to persist for an extended period of time
    - Pain is chronic
    - Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)
    - If the request is for a long-acting opioid, pain management is required around the clock with a long-acting opioid

Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-life-life related pain up to the current requested MED plus 90 MED.

If the member has been established on the requested MED dose for at least 30 days and does not meet the supply limit criteria requirements for non-cancer pain/non-hospice/non-end-of-life related pain, a denial should be issued for the supply limit and a maximum 60-day authorization may be authorized one time for the requested

MED dose.

(v) Cough and Cold Products
Quantity Limit Rules:

- **120mL/fill**
- **360mL/30 days**

A. Criteria for Morphine Equivalent Dosing (MED) Reviews

1. Doses exceeding the cumulative MED of 90 mg will be approved up to the requested amount if the prescriber attests they are aware of patient's current opioid therapy and MED dose and feels the treatment with the requested product is medically necessary.

   Authorization will be issued for up to 30 days for cough and cold related treatment. The authorization should be entered for the MED requested.

B. Criteria for Reviews for Members Under the Age of 18 Years

1. **Opioid containing cough and cold products** will be approved based on **all** of the following criteria:

   a. Prescriber attests they are aware of FDA labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary. (Document rationale for use)

   -AND-

   b. Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30)

   -AND-

   c. Patient has tried and failed at least one non-opioid containing cough and cold remedy

   Authorization will be issued for 30 days.

C. Criteria for Requests Exceeding the Quantity Limit

1. Requests exceeding the quantity limit will be approved based on **both** of the following:
   a. Doses exceeding the quantity limit will be approved up to the requested amount if the prescriber attests that a larger quantity is medically necessary.

-AND-

b. The requested dose is within FDA maximum dose per day, where an FDA maximum dose per day exists.

Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.

D. Criteria for Non-Preferred Reviews

1. If the request is for a non-preferred medication the patient must have a history of failure, contraindication or intolerance to a trial of at least three preferred cough and cold products.

Authorization will be issued for 30 days.

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Program	Prior Authorization - Long-Acting Opioid Pain Medications-NEVADA
Change Control	
Date	Change
10/2017	Created Nevada specific criteria since they will not be going live with the MED edit on 10/1.
1/1/2018	Added MED section- Nevada MED limit is 180. Separated short- and long-acting opioids into individual policies. Added maximum dosage for tapentadol. Updated background.
3/2018	Added criteria for members new to therapy (days supply and MED limit). Removed efficient medication dosing question and FDA max dosing questions from quantity limit section to accommodate operational edits for new to therapy limits. Expanded attestation for the MED section: treatment goals, treatment plan, screening for substance abuse/opioid dependence, and medical comorbidities questions combined into an attestation and documentation requirements removed.
5/2018	Added criteria for opioid containing cough and cold products for members who are under the age of 18 and for patients exceeding the quantity limit. Removed prescriber check. Go-live 7/1/2018.
5/2018 v2	Updated MED language to include confirmation that less than 180 MED is not adequate.

Opoid Cough Preparation for Under 18 Years Old

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Row Labels	Count of Members	Count of Claims	Sum of Days	Sum of Qty	Sum of Amt Paid
CHERATUSSIN AC	25	25	181	2,726	$ 329.68
CODEINE/GUAIFENESIN	12	13	175	1,697	$ 155.59
GUAIATUSSIN AC	17	17	107	3,220	$ 269.52
GUAIFENESIN AC	1	1	6	60	$ 11.10
GUAIFENESIN/CODEINE	36	36	252	3,945	$ 432.03
HYDROCODONE POLISTIREX/CH	29	29	359	2,845	$ 1,362.19
HYDROCODONE/HOMATROPINE	4	4	16	228	$ 53.99
HYDROMET	2	2	12	240	$ 42.62
PROMETHAZINE VC/CODEINE	7	7	43	838	$ 268.75
PROMETHAZINE/CODEINE	133	136	1,056	14,487	$ 1,479.96
ROBAFEN AC	1	1	5	100	$ 7.88
VIRTUSSIN A/C	52	54	587	6,728	$ 691.67
VIRTUSSIN DAC	1	1	4	120	$ 31.39
Grand Total	**320**	**326**	**2,803**	**37,234**	**$ 5,136.37**

Top 25 All Cough Preparations for Age under 18

Row Labels	Count of Members	Count of Claims	Sum of Days	Sum of Qty	Sum of Amt Paid
BROMPHEN/PSEUDOEPHEDRINE	1,766	1,804	17,813	271,709	$ 50,941.08
BENZONATATE	558	569	4,747	14,908	$ 7,111.62
PROMETHAZINE-DM	546	554	4,681	77,790	$ 5,889.75
SODIUM CHLORIDE	124	143	4,166	90,720	$ 6,075.98
PROMETHAZINE/CODEINE	133	136	1,056	14,487	$ 1,479.96
COUGH SYRUP	99	101	794	17,393	$ 469.96
VIRTUSSIN A/C	52	54	587	6,728	$ 691.67
EXTRA ACTION COUGH	47	47	406	8,594	$ 321.56
GUAIFENESIN/CODEINE	36	36	252	3,945	$ 432.03
ROBAFEN	35	35	275	5,101	$ 251.87
HYDROCODONE POLISTIREX/CH	29	29	359	2,845	$ 1,362.19
PROMETHAZINE/DEXTROMETHOR	28	28	267	4,224	$ 287.59
MUCINEX COUGH CHILDRENS	25	26	239	3,278	$ 259.25
DEXTROMETHORPHAN POLISTIR	25	25	264	3,180	$ 364.74
CHERATUSSIN AC	25	25	181	2,726	$ 329.68
GUAIFENESIN	19	20	115	2,147	$ 80.49
GUAIATUSSIN AC	17	17	107	3,220	$ 269.52
ACETYLCYSTEINE	14	15	379	2,580	$ 1,697.18
ROBAFEN DM	15	15	238	2,073	$ 140.72
PROMETHAZINE/PHENYLEPHRIN	15	15	101	1,745	$ 553.20
PROMETHAZINE VC PLAIN	14	14	122	1,935	$ 519.00
LORATADINE-D 24HR	14	14	345	345	$ 252.31
CODEINE/GUAIFENESIN	12	13	175	1,697	$ 155.59
CETIRIZINE HCL/PSEUDOEPHE	11	11	192	360	$ 319.09
SM TUSSIN MUCUS + CHEST C	10	11	122	1,142	$ 54.60

YEAR_MONTH	DRUG_NAME	MBR_COUNT	CLM_COUNT	DAYS_SUPPLY
201706	ACETAMINOPHEN W/CODEINE	53	55	257
201706	CHERATUSSIN AC	1	1	5
201706	GUAIFENESIN WITH CODEINE	4	4	24
201706	HYDROCODONE W/ACETAMINOPHEN	136	138	763
201706	MORPHINE SULFATE	1	1	5
201706	OXYCODONE HCL	3	3	14
201706	OXYCODONE W/ACETAMINOPHEN	8	8	43
201706	TRAMADOL HCL	6	6	23
201706	TRAMADOL HCL-ACETAMINOPHEN	2	2	10
201707	ACETAMINOPHEN W/CODEINE	75	77	377
201707	GUAIFENESIN WITH CODEINE	3	3	15
201707	HYDROCODONE W/ACETAMINOPHEN	113	116	514
201707	HYDROMORPHONE HCL	1	1	7
201707	MEPERIDINE HCL	1	1	3
201707	OXYCODONE HCL	4	4	16
201707	OXYCODONE W/ACETAMINOPHEN	11	11	54
201707	PROMETHAZINE VC W/CODEINE	1	1	30
201707	PROMETHAZINE W/CODEINE	2	2	14
201707	TRAMADOL HCL	6	6	34
201707	TRAMADOL HCL-ACETAMINOPHEN	3	3	15
201708	ACETAMINOPHEN W/CODEINE	72	73	352
201708	CHERATUSSIN AC	3	3	20
201708	GUAIFENESIN WITH CODEINE	5	5	34
201708	GUIATUSSIN AC	1	1	6
201708	HYDROCODONE W/ACETAMINOPHEN	141	147	613
201708	HYDROMORPHONE HCL	1	1	7
201708	METHADONE HCL	2	2	60
201708	MORPHINE SULFATE ER	1	1	3
201708	OXYCODONE HCL	3	3	13
201708	OXYCODONE W/ACETAMINOPHEN	15	15	76
201708	PROMETHAZINE W/CODEINE	2	3	18
201708	TRAMADOL HCL	5	5	27
201708	TRAMADOL HCL-ACETAMINOPHEN	2	2	12
201709	ACETAMINOPHEN W/CODEINE	48	48	231
201709	GUAIFENESIN WITH CODEINE	6	6	32
201709	GUIATUSSIN AC	1	1	20
201709	HYDROCODONE W/ACETAMINOPHEN	135	136	588
201709	HYDROMORPHONE HCL	1	2	37
201709	MORPHINE SULFATE	4	4	20
201709	OXYCODONE HCL	1	1	2
201709	OXYCODONE W/ACETAMINOPHEN	19	19	85
201709	PROMETHAZINE VC W/CODEINE	1	1	8
201709	PROMETHAZINE W/CODEINE	2	2	16
201709	TRAMADOL HCL	4	4	14
201709	TRAMADOL HCL-ACETAMINOPHEN	2	2	10
201710	ACETAMINOPHEN W/CODEINE	59	62	303

201710	CHERATUSSIN AC	2	2	17
201710	GUAIFENESIN WITH CODEINE	2	2	13
201710	GUIATUSSIN AC	1	1	6
201710	HYDROCODONE W/ACETAMINOPHEN	138	140	574
201710	LORTAB	1	1	3
201710	METHADONE HCL	1	1	3
201710	OXYCODONE HCL	3	3	12
201710	OXYCODONE W/ACETAMINOPHEN	13	15	52
201710	PROMETHAZINE VC W/CODEINE	1	1	20
201710	PROMETHAZINE W/CODEINE	3	3	20
201710	TRAMADOL HCL	5	5	23
201710	TRAMADOL HCL-ACETAMINOPHEN	1	1	5
201711	ACETAMINOPHEN W/CODEINE	49	50	216
201711	CHERATUSSIN AC	1	1	3
201711	GUAIFENESIN AC	1	1	6
201711	GUAIFENESIN WITH CODEINE	9	9	45
201711	HYDROCODONE W/ACETAMINOPHEN	141	145	603
201711	HYDROCODONE/HOMATROPINE	2	2	18
201711	MORPHINE SULFATE	1	1	7
201711	OXYCODONE HCL	3	3	12
201711	OXYCODONE W/ACETAMINOPHEN	12	13	56
201711	PROMETHAZINE VC W/CODEINE	4	4	24
201711	PROMETHAZINE W/CODEINE	3	3	25
201711	TRAMADOL HCL	5	5	26
201711	TRAMADOL HCL-ACETAMINOPHEN	1	1	5
201712	ACETAMINOPHEN W/CODEINE	52	53	238
201712	BUTALBITAL/CAFF/APAP/CODEINE	1	1	3
201712	GUAIFENESIN WITH CODEINE	14	14	92
201712	HYDROCODONE W/ACETAMINOPHEN	107	109	440
201712	HYDROMORPHONE HCL	1	1	15
201712	OXYCODONE HCL	6	6	23
201712	OXYCODONE W/ACETAMINOPHEN	9	10	43
201712	PROMETHAZINE W/CODEINE	6	6	56
201712	TRAMADOL HCL	4	4	22
201712	TRAMADOL HCL-ACETAMINOPHEN	2	2	10
201712	VIRTUSSIN AC	2	2	10
201801	ACETAMINOPHEN W/CODEINE	25	25	138
201801	CHERATUSSIN AC	1	1	2
201801	GUAIFENESIN WITH CODEINE	1	1	3
201801	HYDROCODONE W/ACETAMINOPHEN	82	83	406
201801	HYDROMORPHONE HCL	1	1	14
201801	OXYCODONE HCL	1	1	7
201801	OXYCODONE W/ACETAMINOPHEN	8	8	48
201801	PROMETHAZINE W/CODEINE	1	1	3
201801	TRAMADOL HCL	2	3	21
201801	TRAMADOL HCL-ACETAMINOPHEN	1	1	5
201802	ACETAMINOPHEN W/CODEINE	18	18	78

201802	HYDROCODONE W/ACETAMINOPHEN	54	54	240
201802	OXYCODONE HCL	2	2	8
201802	OXYCODONE W/ACETAMINOPHEN	10	10	57
201802	PROMETHAZINE W/CODEINE	1	1	6
201803	ACETAMINOPHEN W/CODEINE	11	11	57
201803	GUIATUSSIN AC	1	1	4
201803	HYDROCODONE W/ACETAMINOPHEN	63	64	313
201803	HYDROMORPHONE HCL	1	1	14
201803	OXYCODONE HCL	7	7	42
201803	OXYCODONE W/ACETAMINOPHEN	12	13	71
201803	PROMETHAZINE VC W/CODEINE	1	1	7
201804	ACETAMINOPHEN W/CODEINE	11	11	68
201804	HYDROCODONE W/ACETAMINOPHEN	62	63	298
201804	HYDROMORPHONE HCL	1	1	5
201804	OXYCODONE HCL	3	3	13
201804	OXYCODONE W/ACETAMINOPHEN	6	6	60
201804	PROMETHAZINE W/CODEINE	1	1	5
201804	TRAMADOL HCL-ACETAMINOPHEN	1	1	3
201804	VIRTUSSIN AC	1	1	6
201805	ACETAMINOPHEN W/CODEINE	8	8	42
201805	CHERATUSSIN AC	1	1	7
201805	HYDROCODONE W/ACETAMINOPHEN	40	41	223
201805	HYDROMORPHONE HCL	1	1	14
201805	MORPHINE SULFATE	1	1	10
201805	MORPHINE SULFATE ER	1	1	5
201805	OXYCODONE HCL	4	4	26
201805	OXYCODONE W/ACETAMINOPHEN	7	7	48
201805	PROMETHAZINE W/CODEINE	1	1	14

QUANTITY
3,553
100
400
6,922
100
65
202
88
60
5,711
290
5,316
14
3
120
289
120
270
139
90
6,247
360
600
120
5,151
28
40
6
131
366
460
126
60
3,921
718
100
6,092
78
120
10
376
120
320
92
60
4,011

240
240
120
5,354
90
9
95
278
240
290
74
30
3,821
40
120
868
5,917
240
15
110
325
450
390
69
30
3,080
15
1,678
3,585
30
172
255
875
77
60
240
2,061
120
120
3,948
30
60
197
60
39
30
758

2,368
35
262
120
652
120
3,185
28
145
335
180
498
4,042
20
48
171
120
18
120
336
120
2,672
56
30
10
78
155
180

Health Plan of Nevada

Opioids Utilization for Members Under 18 Years Old

May 1, 2017 - May 31, 2018

Drug Name	Member Count (0-5 years)	Member Count (6-11 years)	Member Count (12-17 years)	Total
APAP/CODEINE SOL 120-12/5	130	228	108	466
APAP/CODEINE TAB 300-15MG	0	3	4	7
APAP/CODEINE TAB 300-30MG	0	29	340	369
APAP/CODEINE TAB 300-60MG	0	0	2	2
ASCOMP/COD CAP 30MG	0	0	1	1
BUT/APAP/CAF CAP CODEINE	0	0	3	3
CHERATUSSIN SYP 100-10/5	2	8	28	38
GG/CODEINE SOL 100-10/5	8	34	100	142
GUAIATUSSIN SYP 100-10/5	0	0	12	12
HYDROCO/APAP SOL 7.5-325	193	309	145	647
HYDROCO/APAP TAB 10-325MG	4	1	38	43
HYDROCO/APAP TAB 5-325MG	3	42	707	752
HYDROCO/APAP TAB 7.5-325	1	2	172	175
HYDROMORPHON TAB 2MG	0	0	1	1
LORCET TAB 5-325MG	0	0	1	1
LORCET PLUS TAB 7.5-325	0	0	1	1
LORTAB ELX 10-300MG	0	2	0	2
METHADONE SOL 5MG/5ML	11	0	0	11
METHADONE TAB 10MG	0	0	2	2
METHADONE TAB 5MG	0	0	1	1
MORPHINE SUL SOL 10MG/5ML	1	2	2	5
MORPHINE SUL TAB 15MG	0	1	6	7
MORPHINE SUL TAB 15MG ER	0	0	1	1
MORPHINE SUL TAB 30MG	0	0	1	1
MORPHINE SUL TAB 30MG ER	0	0	1	1
OXYCOD/APAP TAB 10-325MG	0	0	8	8
OXYCOD/APAP TAB 5-325MG	0	7	122	129
OXYCOD/APAP TAB 7.5-325	0	1	5	6
OXYCODONE SOL 5MG/5ML	8	10	0	18
OXYCODONE SOL 5MG/5ML	0	0	12	12
OXYCODONE TAB 10MG	0	0	1	1
OXYCODONE TAB 15MG	0	1	0	1
OXYCODONE TAB 5MG	0	5	0	5
OXYCODONE TAB 5MG	0	0	54	54
PROMETH/COD SOL 6.25-10	2	30	44	76
ROBAFEN AC SOL 100-10/5	0	8	4	12
TRAMADL/APAP TAB 37.5-325	0	0	4	4
TRAMADOL HCL TAB 50MG	0	6	75	81
VIRTUSSIN AC SOL 100-10/5	8	52	128	188

Lock In Program Comparison

	FFS	Anthem	HPN	Silver Summit
Notification			HPN will receive quarterly notification from Community and State (C&S) teams with members meeting criteria based on national program.	Claims will be audited on a monthly basis using selected criteria from the list below.
Procedure/ Clinical Review	Recipient has utilized more than 1 pharmacy in the past 60 days, has utilized more than 3 physicians in the past 60 days, has utilized emergency room services for receiving controlled substances, has been diagnosed with a drug dependency related condition, or dispensed quantity per prescription of controlled substances appears excessive by the clinical review team, or has other noted drug seeking behavior.	Identified by data available that may indicate drug seeking behavior including but not limited to lab data, medical claims, repeated ER visits for pain medication, authorizations and referrals from health plans or providers. ≥2 pharmacies & ≥5 controlled substances with ≥3 opiates in the last 45 days, or ≥3 providers & ≥ 5 controlled substances in the last 45 days.	HPN will receive periodic leads from C&S Payment Integrity with members meeting criteria based on a fill History of the Holy Trinity. (Holy Trinity is three controlled substances when taken together create a euphoric effect similar to heroin.)	Prescriptions written on a stolen, forged or altered prescription, prescribed medications do not correlate with the Member's medical condition, as identified by his/her PCP, or ICD-10 code, filled at more than two pharmacies per month or more than five pharmacies/year, receives more than five therapeutic agents/month, member receives more than three controlled substances /month, receives controlled substances from more than one pharmacy and 3 or more prescribers, receives duplicative therapy from different prescribers, receives prescriptions from more than two prescribers in a month, has been seen in Hospital Emergency Room more than two times/year, has a diagnosis of narcotic poisoning or drug abuse on file, # of prescriptions for controlled substances exceeds 10% of total # of prescriptions, and referrals from the

	FFS	Anthem	HPN	Silver Summit
				providers reporting suspected abuse.
Locked Into Pharmacy/ Provider	Pharmacy	Pharmacy	Pharmacy	Pharmacy/Provider
Change of Lock In Pharmacy	Recipients may change their lock-in pharmacy at any time.	The member will have 10 days from the date of the notification letter to request a different pharmacy. Once the member has been restricted to a pharmacy, a request to change pharmacies will be considered only for good cause.	Members have 30 days to change their lock-in pharmacy after receiving their notification letter.	Members will be permitted to change pharmacies only if a change of address which places the member at a great distance from the designated pharmacy or if the lock-in pharmacy requests that the member be removed from that pharmacy. The member will be permitted to change prescribing providers for controlled substances if deemed medically necessary or if the provider refuses to see the patient.
Review	Medicaid beneficiaries stay in the Lock-In program for the duration of their coverage.	Member's lock-in status will be reviewed on an annual basis to determine if further coordination of care is necessary. Members may be removed from restriction if: medical necessity requires the member to use multiple pharmacies and/or prescribers, if the PCP requests the restriction be removed.	Members will be reviewed for removal every twelve months	All members will be reviewed periodically (at least every year from the original lock-in effective date) for program adherence and prescription utilization.

Lock-In Summary

Fee for Service Medicaid

April 1,2018 - June 30, 2018

Apr-18	Active Recipients	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims April 2018	Total Amount April 2018	Total Savings April 2018
	804	9,374	$734,581.86	5,666	$671,987.83	$ 62,594.03

May-18	Active Recipients	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims May 2018	Total Amount May 2018	Total Savings May 2018
	795	9,215	$737,297.81	5,558	$602,089.40	$ 135,208.41

Jun-18	Active Recipients	Total Claims Month Before Lock-In	Total Amount Month Before Lock-In	Total Claims June 2018	Total Amount June 2018	Total Savings June 2018
	789	9,106	$696,619.04	4,811	$457,654.39	$ 238,964.65

Medicaid Business Unit
Policies and Procedures

Nevada 672 members locked in May 2018

Section (Primary Department)		**SUBJECT (Document Title)**	
Pharmacy		**A67 - Pharmacy Restriction (Lock-In) Program - NV**	
Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
03/10/2016	05/10/2018	05/10/2018	05/10/2018

Procedure applies to Medicaid products offered by health plans operating in the following State(s)

California	**Kentucky**		**South Carolina**
District of Columbia	**Louisiana**		**Tennessee**
Florida	**Maryland**		**Texas**
Georgia	**Nevada**	**X**	**Virginia**
Indiana	**New Jersey**		**Washington**
Iowa	**New York**		**Wisconsin**
Kansas	**New York (WNY)**		**West Virginia**

POLICY:

To establish a policy and procedure for identifying recipients showing drug seeking behaviors and limiting members to the use of one pharmacy for all controlled substance prescriptions. The restriction to one pharmacy for all controlled substance prescriptions is put in place to promote the members safety through coordination of care. The program is based on the member's utilization of providers, medications and pharmacies and when requested by a provider, outside agency, health plan or in cases of fraud and abuse.

DEFINITIONS:

Appeal: A formal request to an organization by a practitioner or member for reconsideration of a decision (e.g. utilization review recommendation, benefit payment, administrative action, quality of care or service issue) with the goal of finding a mutually acceptable solution.

Good Cause: Acceptable reasons to allow the member to permanently change their assigned pharmacy.

PCP: Primary Care Provider

Permanent Pharmacy Change: A permanent re-assignment of a member to another designated pharmacy

Temporary Override: A short term (usually one calendar day) authorization that enables the member to access pharmacy services at a non-designated pharmacy.

PROCEDURE:

1) **Identification** of members for pharmacy restriction consideration include, but are not limited to:
   a) Monthly reports provided by state agencies identifying members previously locked into a single pharmacy while in fee-for-service or other MCOs.

Nevada 672 members locked in May 2018

Section (Primary Department) Pharmacy		**SUBJECT (Document Title)** A67 - Pharmacy Restriction (Lock-In) Program - NV	
Effective Date 03/10/2016	**Date of Last Review** 05/10/2018	**Date of Last Revision** 05/10/2018	**Dept. Approval Date** 05/10/2018

Procedure applies to Medicaid products offered by health plans operating in the following State(s)

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District of Columbia	**Louisiana**		**Tennessee**
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Georgia	**Nevada**	**X**	**Virginia**
Indiana	**New Jersey**		**Washington**
Iowa	**New York**		**Wisconsin**
Kansas	**New York (WNY)**		**West Virginia**

b) Data available that may indicate drug seeking behavior including, but not limited to lab data, medical claims, repeated ER visits for pain medication, authorizations and referrals from health plans or providers.
c) Members identified through, but not limited to the following criteria:
   i. ≥2 pharmacies & ≥5 controlled substances with ≥3 opiates in the last 45 days.
   ii. ≥ 3 providers & ≥5 controlled substances in the last 45 days

2) **Review by Health Plan -** Once members are identified as potential candidates for a pharmacy restriction, member medication profiles will be forwarded to the Nevada health plan representative(s) for review. The Health Plan representative will review the recommendations to determine if there is any significant reason to not restrict a member to a single pharmacy.
3) **Communications -** For the members that the Health Plan concurs with pharmacy's recommendations for pharmacy restriction, the following communications will occur.
   a) Pharmacy Restriction (Lock-In) Member Letter: The member will be notified, prior to lock-in, in writing via certified mail, of the decision to restrict the member to a pharmacy. The letter will contain, at a minimum, the following information:
      i. General information on the pharmacy restriction program
      ii. Identification of the pharmacy to which the member is being restricted
      iii. Timeframe available for member to comment on the assigned pharmacy or request a different pharmacy
         1. The member will have 10 days from the date of the letter to request a different pharmacy. Once the member has been restricted to a pharmacy, a request to change pharmacies will be considered only for good cause.
      iv. Member Appeal Rights
      v. Any additional state specified information required
   b) Pharmacy Restriction (Lock-In) PCP/Prescriber Letter: The PCP and other identified prescribers are notified in writing of the decision to lock the member in to a pharmacy 10 days from the date of the letter. The PCP/Prescriber letter will contain at a minimum:
      i. General information on the pharmacy restriction program
      ii. Identification of the pharmacy where the member is being assigned
      iii. 6 months of pharmacy claims data (including the claims used to identify the member as a candidate for the lock-in program)

Nevada 672 members locked in May 2018

Section (Primary Department) Pharmacy		**SUBJECT (Document Title)** A67 - Pharmacy Restriction (Lock-In) Program - NV	
Effective Date 03/10/2016	**Date of Last Review** 05/10/2018	**Date of Last Revision** 05/10/2018	**Dept. Approval Date** 05/10/2018

Procedure applies to Medicaid products offered by health plans operating in the following State(s)

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Indiana	New Jersey		Washington
Iowa	New York		Wisconsin
Kansas	New York (WNY)		West Virginia

iv. An education piece for the PCP and other prescribers to review with the member regarding the advantages of using a limited number of pharmacies.

c) Pharmacy Restriction (Lock-In) Pharmacy Letter: The pharmacy will be notified that the particular member is being locked in to their pharmacy and the date that the restriction begins. The pharmacy letter will contain at a minimum:
   i. Identification of the member being assigned
   ii. General information on the pharmacy restriction program
   iii. Anthem's 72-hour emergency supply protocol

4) **Member Appeal Rights**
   a) Members have the right to request an appeal if the member does not agree with Anthem's decision to restrict the member to a single pharmacy
      i. Members are directed to file an appeal over the phone by calling Anthem Member Services at [1-844-396-2329].
      ii. Written appeals are to be sent to:

Central Appeals Processing
Anthem Blue Cross and Blue Shield Healthcare Solutions
P.O. Box 62429
Virginia Beach, VA 23466-2429

5) **Pharmacy Restriction (Lock-In) Administration**
   a) **Length of Lock-In**
      i. Member's lock-in status will be reviewed on an annual basis to determine if further coordination of care necessary
      ii. Members may be removed from restriction for the following reasons:
         1. Medical necessity requires the member to use multiple pharmacies and/or prescribers
         2. The PCP requests the restriction be removed
   b) **Pharmacy Changes/Overrides** -Request for temporary overrides and permanent changes will be reviewed by a pharmacy associate. The outcome of this review will be documented and the member will be notified by phone or in writing within 7 days.
      i. **Temporary Overrides** - Anthem will provide members with a temporary override in emergent and urgent situations where it is medically necessary the member fill at

Nevada 672 members locked in May 2018

Section (Primary Department) Pharmacy		**SUBJECT (Document Title)** A67 - Pharmacy Restriction (Lock-In) Program - NV	
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Kansas	**New York (WNY)**		**West Virginia**

a pharmacy other than the assigned pharmacy. Members may receive a temporary override in non-urgent situations when one of the following conditions are true:

1. The member does not have access to the assigned pharmacy at the time of the fill
2. The assigned pharmacy is temporarily out of the needed medication at the time of fill

ii. **Permanent Pharmacy Change-** Anthem will allow the member to permanently change their assigned pharmacy for good cause. **Good cause** acceptable reasons are as follows:

1. The member has moved out of the assigned pharmacy area
2. The assigned pharmacy is consistently unable to provide the needed medication at the time of fill
3. The assigned pharmacy is no longer in the pharmacy network
4. The assigned pharmacy refuses to provide services to the member
5. The PCP or specialist changes location or the member has changed or been re-assigned to a different PCP

c) **Emergency Fill-** If there is an urgent or interim need, due to member access to the assigned pharmacy or stock issue by the assigned pharmacy for a particular medication, a pharmacy other than the assigned pharmacy will be allowed to dispense at least a 72 hour emergency supply of covered medication.

d) **Care Management -** During the administration of the program, Anthem will coordinate with the member and their provider to provide care management and education reinforcement of appropriate education/pharmacy use, if necessary. The case manager will take the following actions, when deemed necessary:

i. Educate the member regarding appropriate pharmacy utilization
ii. Discuss the risks of the current pattern of medication use
iii. Inform the member of the importance of coordination of care among physicians and regular medication renewal
iv. Provide the member information on the availability and process for accessing mental health and substance abuse services

Nevada 672 members locked in May 2018

Section (Primary Department) Pharmacy		**SUBJECT (Document Title)** A67 - Pharmacy Restriction (Lock-In) Program - NV	
Effective Date 03/10/2016	**Date of Last Review** 05/10/2018	**Date of Last Revision** 05/10/2018	**Dept. Approval Date** 05/10/2018

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Georgia	**Nevada**	**X**	**Virginia**
Indiana	**New Jersey**		**Washington**
Iowa	**New York**		**Wisconsin**
Kansas	**New York (WNY)**		**West Virginia**

e) **Regulatory Reporting** - Anthem will submit reports regarding members with pharmacy restriction to Regulatory Compliance for submission to State agencies, as required by State contract.

REFERENCES:

None

RESPONSIBLE DEPARTMENTS:

Primary Department:
Pharmacy

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
05/10/2018	• Annual review - updated Amerigroup references to Anthem. Updated phone number and mailing address.
05/18/2017	• Annual review • Updated policy to reflect NV requirement to restrict only controlled substances. Updated verbiage to reflect single pharmacy restriction. Added language from 7/1/17 contract in the "Identification" section
03/10/2016	• New P&P created for NV to replace A12 - Corporate Pharmacy Restriction Process (Lock-In)

Policy Name:	**Managed Medicaid Pharmacy Lock-In Program**		
Master Policy #:	**PHARM001**	**Original Effective Date:**	**7/1/16**
Application:	**Health Plan of Nevada**	**Last Review/Revision Date:**	**7/1/16**

Review/Approval:

Ryan Bitton, **Date**
Director, Pharmacy Services

Review/Revision History:

As of June 1, 2018 there were 654 HPN recipients in the Lock-In Program

I. Title:
Managed Medicaid Pharmacy Lock-In Program

II. Scope:
Health Plan of Nevada Medicaid

III. Purpose:
This Policy establishes the guidelines to be used for the maintenance and implementation of a Lock-In program on Health Plan of Nevada's Medicaid line of business.

IV. Definitions:
1. C&S: UnitedHealthcare Community & State
2. Lock-In Program: Program whereby members are identified by national criteria based on their fill history are required to use a single pharmacy for their medications.
3. DHCFP: Nevada Division of Health Care Financing and Policy
4. FFS: Nevada's Fee For Service Medicaid plan
5. Holy Trinity: Three controlled substances when taken together create a euphoric effect similar to heroin.

V. Policy:
It is the policy of Health Plan of Nevada to have a consistent process for pharmacy lock-in that meets the needs of DHCFP and leverages the analytics of C&S. The C&S policy is RX-020 "High Prescription Utilization Program" and is leveraged for this process. The procedures below refer to potential differences between the national program and its administration within Health Plan of Nevada.

VI. Procedure:
A. HPN Member Previously Locked-In by FFS:

1. HPN will receive notification from the DHCFP on members with current eligibility on HPN who were previously part of the FFS Lock-In Program. Notification should include the following information as available:
    - Member Name
    - Member Date of Birth
    - Member ID
    - Original Lock-In Date
    - Lock-In Pharmacy Name/Address
2. HPN will proceed to enroll member in the HPN Lock-In program from the original lock-in date as received from DHCFP or in the case the date is not received, from the date of notification. Members will be reviewed and notified according to the HPN Lock-In program parameters.

B. HPN Member – Multiple Scripts/Multiple Pharmacies/Multiple Providers

1. HPN will receive quarterly notification from C&S teams with members meeting criteria based on national program.
2. HPN Pharmacy Services staff will select at least thirty members from the report when sorted by number of providers.
3. HPN will notify member via letter of their lock-in pharmacy and the date that lock-in program will start. Members will have 30 days from the date of the letter to change their lock-in pharmacy if desired.
4. Members will be reviewed for removal every twelve months.

C. HPN Member – "Holy Trinity" Fill History

1. HPN will receive periodic leads from C&S Payment Integrity with members meeting criteria based on a fill History of the Holy Trinity.
2. HPN Pharmacy Services staff will lock-in all members from the report.
3. HPN will notify member via letter of their lock-in pharmacy and the date that lock-in program will start. Members will have 30 days from the date of the letter to change their lock-in pharmacy if desired.
4. Members will be reviewed for removal every twelve months.

D. Appeal Rights

1. Members can request changes to their lock-in pharmacy by notifying the plan.
2. Members have the right to appeal their inclusion in the program by contacting the plan and requesting an appeal.

VII. Related Policies: N/A
VIII. Reference: Medicaid Services Manual 1203.1B 2.e "Lock-In Program"
IX. Attachments: UnitedHealthcare Community & State Policy RX-020 "High Prescription Utilization Program"

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SILVERSUMMIT HEALTHPLAN
POLICY AND PROCEDURE

DEPARTMENT: Pharmacy	**DOCUMENT NAME:** Pharmacy Lock-In Program
PAGE: 1 of 5	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE: 7/1/17	**REVIEWED/REVISED:**
PRODUCT TYPE: All	**REFERENCE NUMBER:** NV.PHAR.01

SCOPE:
SilverSummit Health Medical Management and Pharmacy Departments.

PURPOSE:
The purpose of the Pharmacy Lock-In Program is to detect and prevent abuse of the pharmacy benefit, as defined by specific criteria, by restricting members to one specific pharmacy and controlled substance provider (if one is chosen) for a defined period of time.

POLICY:
To monitor and control suspected abuse of the pharmacy benefit by SilverSummit members, as identified and confirmed through analysis and audit by the Pharmacy Department, by restricting the members to only one specific pharmacy and controlled substance provider (if one is chosen) for a defined period of time.

PROCEDURE:
Pharmacy claims will be audited on a monthly basis using selected criteria from the list below to identify potential misuse of the prescription benefit.

- Prescriptions written on a stolen, forged or altered prescription blank issued by a licensed prescriber;
- Prescribed medications do not correlate with the Member's medical condition, as identified by his/her PCP, or ICD-10 code from encounter data;
- Member has filled prescriptions at more than two pharmacies per month or more than five pharmacies per year;
- Member receives more than five therapeutic agents per month;
- Member receives more than three Controlled Substances per month;
- Member receives controlled substances from more than one pharmacy and 3 or more prescribers
- Member receives duplicative therapy from different prescribers;
- Member receives prescriptions from more than two prescribers per month;
- Member has been seen in Hospital Emergency Room more than two times per year;
- Member has diagnosis of narcotic poisoning or drug abuse on file;
- Number of prescriptions for controlled substances exceeds 10 % of total number of prescriptions;
- Referrals from the providers reporting suspected abuse

Once audits have been performed, and members identified and confirmed to have abused the pharmacy benefit, the following process shall occur:

1. SilverSummit's Pharmacy staff will research cases of potential abuse to validate if inappropriate use of the pharmacy benefit has occurred or is occurring.

2. When a case of inappropriate use is documented, the Pharmacy staff presents the details of the case to the Pharmacy and/or Medical Directors. A decision is then made to determine if member lock-in to a pharmacy and provider is warranted. While in lock-in status, the member will be restricted to one pharmacy to obtain their controlled substance prescriptions; other pharmacies will not be paid if they fill controlled substance prescriptions for the member. If the member is also locked into one provider, only controlled substances prescribed by the designated provider will be reimbursed.

3. If the case is designated inappropriate use, the member will be assigned to a new pharmacy to which the filling of controlled substance prescriptions will be restricted. If necessary, the member will also be restricted to one provider for controlled substances prescribing. Pharmacy Services sends a letter summarizing the decision to the member, with a copy sent to the designated pharmacy, the primary care provider (PCP) and/or other prescribers. If the member wishes to appeal the decision to be placed in lock-in or to designate an alternate pharmacy or prescribing provider, they may submit that request to the Silver Summit Appeals and Grievances Department. The initial request may be made orally, but must be followed within 30 days of the effective date on the lock-in letter by a written request for administrative review. The request must be sent to the following address:

Address: SilverSummit Health Plan
Appeals and Grievance Coordinator
2500 North Buffalo Drive
Suite XXX

4. Upon designation of the pharmacy and prescribing provider for lock-in, SilverSummit's Director of Pharmacy coordinates the changes to the contracted Pharmacy Benefits Management Company to initiate the lock-in.

5. The member will be permitted to change pharmacies only if a change of address which places the member at a great distance from the designated pharmacy or if the lock-in pharmacy requests that the member be removed from that pharmacy. The member will be permitted to change prescribing providers for controlled substances if deemed medically necessary or if the provider refuses to see the patient.

6. If at any time the pharmacy is out of stock of a member's controlled substance, the member or pharmacy can request an override to use an alternative pharmacy.

7. If the member is out of the area and needs their controlled medication the member or the pharmacy can request an emergency supply override.

8. Case management and education reinforcement of appropriate medication/pharmacy use shall be provided by SilverSummit to "lock-in" members.

9. All "lock-in" members will be reviewed periodically (at least every year from the original lock-in effective date) for program adherence and prescription utilization.
    - Members who still utilize multiple prescribers for duplicative controlled substances during the initial lock-in year will be placed into the lock-in program for another year.

10. Prescriptions, within the limits of the Plan PDL, from all participating prescribers shall be honored and may not be required to be written by the PCP only, unless the member has been restricted to one prescriber for controlled substances.

11. Each member is given the opportunity to dispute the Lock-In determination by submitting an appeal to SilverSummit Appeals and Grievance Department.

12. Provision shall be made for the member to obtain a 72 hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy to assure the provision of necessary medication required in an emergency (e.g. when the designated pharmacy is closed, the member cannot readily access the pharmacy, or the pharmacy does not have the required medication in inventory).

13. If the Member is compliant in the program for a period of four consecutive quarters, the Member, pharmacy, and prescribing provider will be notified by the SilverSummit Pharmacy Department that the lock-in is being removed and the Member is free to access any SilverSummit network pharmacy or provider.

14. SilverSummit's Compliance Officer will provide program reports to the appropriate State agency of all members participating in the lock-in program in the time frame established by the state. The report will be formatted according to state requirements. This report will include the grand total of individuals admitted and released from the program during the designated quarter.

REFERENCES:
Scope of Work – Pharmacy Services 3.4.6.6

ATTACHMENTS:

DEFINITIONS:

REVISION LOG

POLICY AND PROCEDURE

DEPARTMENT: Pharmacy	**DOCUMENT NAME:** Pharmacy Lock-In Program
PAGE: 5 of 5	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE: 7/1/17	**REVIEWED/REVISED:**
PRODUCT TYPE: All	**REFERENCE NUMBER:** NV.PHAR.01

REVISION	**DATE**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Vice President of Department:

Director of Department:

Top 10 Prescribers by Count of Claims
Fee for Service Medicaid

	Encrypted ID	Specialty	Degree	City	Member Count	Claim Count	Sum of Days Supply	Sum of Qty	Sum of Pd Amt
July 1, 2017 - June 30, 2018	A	Anesthesiology	DO	Henderson	194	1,875	54,512	218,486	$ 181,679.56
	B	Pain Management	NP	Las Vegas	175	1,739	51,500	162,349	$ 121,582.36
	C		NP	Fallon	227	1,694	29,590	153,364	$ 51,492.40
	D		PA	Las Vegas	102	1,383	40,774	154,529	$ 57,075.23
	E	Pain Management	MD	Carson City	140	1,367	34,663	93,943	$ 464,673.50
	F		PA	Las Vegas	188	1,218	36,377	108,195	$ 101,216.53
	G			Las Vegas	311	1,129	33,076	98,196	$ 73,725.49
	H		PB	Las Vegas	148	1,019	28,488	95,163	$ 67,075.63
	I	Maxillofacial Surgery	PA	Henderson	262	994	29,440	89,448	$ 47,210.92
	J		PA	Las Vegas	130	889	25,180	87,764	$ 45,036.41
April 1, 2017 - March 31, 2018	B	Pain Management	NP	Las Vegas	188	1,954	57,840	182,956	$ 144,870.24
	C		NP	Fallon	242	1,757	29,589	158,382	$ 52,436.24
	A	Anesthesiology	DO	Henderson	192	1,533	44,362	179,610	$ 140,313.70
	D		PA	Las Vegas	114	1,439	42,549	163,079	$ 69,479.80
	F		PA	Las Vegas	172	1,312	38,637	117,085	$ 111,393.76
	E	Pain Management	MD	Carson City	135	1,306	34,277	98,128	$ 430,613.14
	G			Las Vegas	261	1,183	34,829	103,241	$ 80,918.60
	H		PB	Las Vegas	155	1,177	32,794	111,536	$ 83,786.71
	M	Oncology	PA	Las Vegas	165	1,084	30,342	103,253	$ 58,354.66
	J		PA	Las Vegas	135	964	27,222	94,231	$ 52,491.49
Oct 1, 2016 - Sept 30, 2017	B	Pain Management	NP	Las Vegas	218	2,193	64,905	205,568	$ 195,919.94
	D		PA	Las Vegas	138	1,608	47,212	182,787	$ 112,334.23
	F		PA	Las Vegas	172	1,300	38,341	115,709	$ 124,161.90
	H		PB	Las Vegas	180	1,279	36,064	125,230	$ 93,265.21
	M	Oncology	PA	Las Vegas	196	1,277	35,538	124,461	$ 76,039.34
	E	Pain Management	MD	Carson City	123	1,204	32,714	105,283	$ 352,220.02
	G			Las Vegas	238	1,133	33,419	97,989	$ 83,486.40
	K	Oral Surgery	DDS	Reno	997	1,117	4,780	19,138	$ 12,620.70
	L	Pain Management	MD	Las Vegas	141	1,069	29,508	99,031	$ 39,848.09
	C		NP	Fallon	202	1,011	17,596	94,364	$ 30,799.03

Anthem 6/1/2017-5/31/2018

Prescriber	Location-Specialty	Count of Member ID Client	Sum of Net Rxs	Sum of Quantity	Sum of Days of Therapy
L	Las Vegas- PA	1578	1560	146836	44116
C	Las Vegas- PA	1354	1309	117290	37237
C2	Las Vegas- NP	1294	1288	116585	38012
V	Las Vegas- PA Surgery	1251	1239	117721	34881
A	Henderson-PA	1109	1093	87961	32081
F	Las Vegas- MD Pain	979	965	85082	26222
R	Wisconsin- DO Pain	950	935	85680	25670
P	Las Vegas- MD Pain	931	919	88029	27029
T	Las Vegas- PA	859	851	80680	24293
A	Las Vegas- MD IM	858	837	83939	22806
S	Henderson- MD Oral Surg	815	809	18704	3167

Anthem 6/1/2016-5/31/2017

Row Labels	Location-Specialty	Count of Member ID Client	Sum of Net Rxs	Sum of Quantity	Sum of Days of Therapy
R	Wisconsin- DO Pain	2467	2438	234576	67599
C	Las Vegas- PA	1926	1913	172712	56511
B	Las Vegas- PA	1863	1833	179331	54019
C2	Las Vegas- PA	1678	1647	136399	47435
C3	Boulder City- PA	1626	1584	142264	45818
S	Henderson- MD Oral Surg	1332	1316	25982	4556
G	Las Vegas- MD Pain	1235	1211	104866	33285
F	Las Vegas- MD Pain	1203	1191	109675	34594
L	Las Vegas- PA	1055	1029	93237	29278
T	Las Vegas- PA	997	993	98229	29339

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Top 10 Prescriber of Opiolds

January 1, 2018 -March 31, 2018

By Member Count

Blinded Provider ID	Member Count	Claim Count	Sum of Days	Sum of Qty
A	530	1,118	244	100,721
B	493	1,113	241	87,560
C	480	1,020	111	87,736
E	344	618	85	60,682
F	337	541	37	51,799
G	309	457	60	42,734
H	273	282	32	5,372
I	258	400	264	34,497
J	257	634	132	62,181
K	257	553	149	53,530

By Count of Claims

Blinded Provider ID	Member Count	Claim Count	Sum of Days	Sum of Qty
A	530	1,118	244	100,721
B	493	1,113	241	87,560
C	480	1,020	111	87,736
J	257	634	132	62,181
E	344	618	85	60,682
L	199	592	173	70,538
K	257	553	149	53,530
F	337	541	37	51,799
G	309	457	60	42,734
M	135	444	86	42,270

DHCFP DUR MEETING 7/26/18 - HPN DOCUMENT

By Days Supply

Blinded Provider ID	Member Count	Claim Count	Sum of Days	Sum of Qty
N	168	336	310	26,125
O	258	400	264	34,497
A	530	1,118	244	100,721
B	493	1,113	241	87,560
P	72	128	241	9,678
Q	71	114	231	10,158
R	71	103	224	6,339
S	69	164	216	13,875
T	76	155	198	12,352
U	51	84	193	6,738

By Sum of QTY

Blinded Provider ID	Member Count	Claim Count	Sum of Days	Sum of Qty
A	530	1,118	244	100,721
C	480	1,020	111	87,736
B	493	1,113	241	87,560
L	199	592	173	70,538
J	257	634	132	62,181
E	344	618	85	60,682
K	257	553	149	53,530
F	337	541	37	51,799
G	309	457	60	42,734
M	135	444	86	42,270

By Pharmacy Paid Amt

Blinded Provider ID	Member Count	Claim Count	Sum of Days	Sum of Qty
V	13	24	118	2,270
W	168	336	310	26,125
B	493	1,113	241	87,560
J	257	634	132	62,181
L	199	592	173	70,538
A	530	1,118	244	100,721
C	480	1,020	111	87,736
K	257	553	149	53,530
E	344	618	85	60,682
G	309	457	60	42,734

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Top 10 Opioid Prescriber Reports for Nevada SSHP

Top 10 Opioid Prescribers by Unique Util

7/1/2017 - 3/31/2018

Rank	Physician NPI	Unique Utilizers	Claim Count	Sum Metric Qty	Sum Days Supply
1	1457808941	140	459	39,552	13,437
2	1972521730	127	428	38,938	12,465
3	1700883014	122	158	12,904	4,519
4	1497091870	88	417	39,532	12,197
5	1104804756	74	339	34,379	9,959
6	1578538195	69	373	19,379	8,866
7	1285171686	68	254	22,248	7,003
8	1760828552	64	70	1,530	374
9	1750473005	57	58	1,187	294
10	1477641504	45	244	21,874	7,264

Top 10 Opioid Prescribers by Claim Count

7/1/2017 - 3/31/2018

Rank	Physician NPI	Unique Utilizers	Claim Count	Sum Metric Qty	Sum Days Supply
1	1457808941	140	459	39,552	13,437
2	1972521730	127	428	38,938	12,465
3	1497091870	88	417	39,532	12,197
4	1578538195	69	373	19,379	8,866
5	1730272709	36	356	9,242	5,357
6	1104804756	74	339	34,379	9,959
7	1285171686	68	254	22,248	7,003
8	1477641504	45	244	21,874	7,264
9	1164670634	33	241	21,444	6,851
10	1700883014	122	158	12,904	4,519

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Top 10 Opioid Prescribers by Sum Days Supply

7/1/2017 - 3/31/2018

Rank	Physician NPI	Unique Utilizers	Claim Count	Sum Metric Qty	Sum Days Supply
1	1457808941	140	459	39,552	13,437
2	1972521730	127	428	38,938	12,465
3	1497091870	88	417	39,532	12,197
4	1104804756	74	339	34,379	9,959
5	1578538195	69	373	19,379	8,866
6	1477641504	45	244	21,874	7,264
7	1285171686	68	254	22,248	7,003
8	1164670634	33	241	21,444	6,851
9	1730272709	36	356	9,242	5,357
10	1700883014	122	158	12,904	4,519

Top 10 Opioid Prescribers by Sum Metric Quantity

7/1/2017 - 3/31/2018

Rank	Physician NPI	Unique Utilizers	Claim Count	Sum Metric Qty	Sum Days Supply
1	1457808941	140	459	39,552	13,437
2	1497091870	88	417	39,532	12,197
3	1972521730	127	428	38,938	12,465
4	1104804756	74	339	34,379	9,959
5	1285171686	68	254	22,248	7,003
6	1477641504	45	244	21,874	7,264
7	1164670634	33	241	21,444	6,851
8	1578538195	69	373	19,379	8,866
9	1700883014	122	158	12,904	4,519
10	1730272709	36	356	9,242	5,357

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Top 10 Opioid Prescribers by Billed Amount					
7/1/2017 - 3/31/2018					
Rank	**Physician NPI**	**Unique Utilizers**	**Claim Count**	**Sum Metric Qty**	**Sum Days Supply**
1	1578538195	69	373	19,379	8,866
2	1730272709	36	356	9,242	5,357
3	1104804756	74	339	34,379	9,959
4	1972521730	127	428	38,938	12,465
5	1457808941	140	459	39,552	13,437
6	1477641504	45	244	21,874	7,264
7	1497091870	88	417	39,532	12,197
8	1285171686	68	254	22,248	7,003
9	1164670634	33	241	21,444	6,851
10	1700883014	122	158	12,904	4,519

Inhaled Albuterol Use
Fee for Service Medicaid
July 1, 2017 - June 30, 2018

Drug Name	Year/Month filled	Member Count	Claims Count	Sum of Days	Sum of Qty	Amount Paid
PROAIR HFA	201707	27	31	828	366	$ 2,638.03
PROAIR HFA	201708	18	20	502	221	$ 1,607.87
PROAIR HFA	201709	21	27	566	272	$ 2,003.18
PROAIR HFA	201710	24	27	667	272	$ 2,003.18
PROAIR HFA	201711	25	30	637	281	$ 2,087.52
PROAIR HFA	201712	29	33	803	374	$ 2,709.51
PROAIR HFA	201801	27	31	688	289	$ 2,211.14
PROAIR HFA	201802	21	24	650	255	$ 1,959.78
PROAIR HFA	201803	19	19	642	238	$ 1,794.55
PROAIR HFA	201804	16	17	524	196	$ 1,488.26
PROAIR HFA	201805	11	11	271	111	$ 855.34
PROAIR HFA	201806	15	17	500	187	$ 1,431.07
PROAIR RESPICLICK	201707	2	2	46	2	$ 122.42
PROAIR RESPICLICK	201803	1	1	17	1	$ 59.35
PROAIR RESPICLICK	201806	1	1	75	3	$ 172.18
PROVENTIL HFA	201707	2,698	2,955	72,263	22,720	$ 273,069.82
PROVENTIL HFA	201708	2,966	3,293	80,601	25,708	$ 308,783.15
PROVENTIL HFA	201709	2,937	3,190	78,054	24,623	$ 295,976.37
PROVENTIL HFA	201710	3,098	3,394	83,156	26,110	$ 314,153.09
PROVENTIL HFA	201711	3,003	3,284	81,451	25,453	$ 306,023.86
PROVENTIL HFA	201712	3,159	3,449	83,212	26,324	$ 317,432.67
PROVENTIL HFA	201801	3,462	3,821	94,356	29,319	$ 360,813.69
PROVENTIL HFA	201802	3,079	3,320	82,147	25,507	$ 322,231.96
PROVENTIL HFA	201803	3,204	3,528	86,772	27,088	$ 342,408.62
PROVENTIL HFA	201804	3,070	3,354	84,300	26,076	$ 332,425.55
PROVENTIL HFA	201805	2,921	3,263	81,772	25,286	$ 320,861.99
PROVENTIL HFA	201806	2,690	2,918	73,098	22,740	$ 288,044.77
VENTOLIN HFA	201707	15	17	424	378	$ 1,227.55
VENTOLIN HFA	201708	20	21	620	450	$ 1,463.83
VENTOLIN HFA	201709	22	23	556	486	$ 1,589.49
VENTOLIN HFA	201710	23	26	726	594	$ 1,921.75
VENTOLIN HFA	201711	26	31	836	702	$ 2,272.71
VENTOLIN HFA	201712	26	29	751	576	$ 1,898.13
VENTOLIN HFA	201801	27	30	721	612	$ 2,043.23
VENTOLIN HFA	201802	14	16	333	288	$ 988.48
VENTOLIN HFA	201803	26	28	684	558	$ 1,884.67
VENTOLIN HFA	201804	19	20	534	414	$ 1,390.43
VENTOLIN HFA	201805	22	28	724	576	$ 1,936.28
VENTOLIN HFA	201806	19	23	577	486	$ 1,627.38

Other Asthma med use

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Drug Name	Member Count	Claim Count	Sum of Days	Sum of Qty	Amt Paid
ADVAIR DISKUS	6,798	7,152	239,999	476,783	$ 3,084,803.16
ADVAIR HFA	655	678	22,487	8,772	$ 283,869.70
ALVESCO	6	6	180	37	$ 1,426.62
ANORO ELLIPTA	1,308	1,356	51,994	102,468	$ 635,126.01
ARNUITY ELLIPTA	517	538	18,180	18,306	$ 111,744.93
ASMANEX HFA	249	255	9,482	3,640	$ 56,750.22
ASMANEX TWISTHALER 120 ME	49	50	1,940	50	$ 15,908.26
ASMANEX TWISTHALER 30 MET	347	358	10,986	379	$ 70,855.47
ASMANEX TWISTHALER 60 MET	148	153	4,563	162	$ 36,321.37
ASTHMANEFRIN REFILL	1	1	7	30	$ 35.17
ATROVENT HFA	775	858	27,014	12,423	$ 326,152.08
BEVESPI AEROSPHERE	33	33	915	375	$ 12,208.51
BREO ELLIPTA	206	224	7,328	14,280	$ 77,505.72
BROVANA	33	34	1,170	4,320	$ 32,822.74
BUDESONIDE	449	483	14,163	49,800	$ 111,604.97
COMBIVENT RESPIMAT	1,283	1,378	45,996	6,428	$ 563,906.34
DALIRESP	254	268	8,171	8,141	$ 89,836.05
DULERA	1,355	1,426	47,163	19,986	$ 452,062.20
EPINEPHRINE HCL	2	2	2	4	$ 28.66
FASENRA	2	2	56	2	$ 9,524.56
FLOVENT DISKUS	148	154	4,575	9,240	$ 31,231.48
FLOVENT HFA	2,079	2,147	76,846	26,787	$ 546,872.18
INCRUSE ELLIPTA	36	40	1,320	1,320	$ 14,069.33
IPRATROPIUM BROMIDE	662	728	17,192	159,798	$ 14,927.36
IPRATROPIUM BROMIDE/ALBUT	2,738	3,078	67,656	766,725	$ 79,004.22
LEVALBUTEROL HCL	186	217	4,349	46,275	$ 21,798.94
LEVALBUTEROL TARTRATE HFA	183	199	5,206	4,335	$ 17,948.61
MONTELUKAST SODIUM	19,088	19,962	718,121	722,646	$ 348,011.05
NUCALA	5	7	196	7	$ 19,901.23
PERFOROMIST	4	4	180	720	$ 5,403.91
PULMICORT	884	931	27,226	83,340	$ 410,800.62
PULMICORT FLEXHALER	229	247	8,545	481	$ 82,715.73
QVAR	2,352	2,454	88,833	22,577	$ 514,246.92
QVAR REDIHALER	21	24	824	276	$ 5,548.30
SEREVENT DISKUS	130	132	3,956	7,920	$ 47,102.60
SPIRIVA HANDIHALER	4,242	4,456	159,021	158,678	$ 1,929,515.39
SPIRIVA RESPIMAT	227	243	7,893	1,044	$ 98,339.24
STIOLTO RESPIMAT	517	544	19,523	2,612	$ 227,293.23
STRIVERDI RESPIMAT	12	12	480	64	$ 3,020.21
SYMBICORT	5,869	6,229	209,461	69,609	$ 2,053,518.62
TERBUTALINE SULFATE	13	14	314	905	$ 1,717.67
THEO-24	106	110	4,025	5,960	$ 16,967.38
THEOPHYLLINE	4	4	116	3,963	$ 664.88
THEOPHYLLINE CR	3	3	90	150	$ 81.61
THEOPHYLLINE ER	166	176	6,905	11,887	$ 9,010.37
TRELEGY ELLIPTA	2	2	60	120	$ 1,039.00

TUDORZA PRESSAIR	33	34	1,144	38	$	11,931.20
XOLAIR	253	264	7,302	789	$	838,725.77
XOPENEX	45	48	834	8,208	$	26,899.21
XOPENEX HFA	105	112	3,115	2,160	$	10,506.86
ZAFIRLUKAST	60	62	2,220	3,870	$	5,581.38

Members without Maintenance treatment

Fee for Service Medicaid

July 1, 2017 - June 30, 2018

Encrypted ID	Drug Name	Count of Claims	Sum of Days	Sum of Qty	Amount Paid
1	ALBUTEROL SULFATE	6	180	1,920	$ 137.10
1	PROAIR HFA	1	17	9	$ 64.19
1	PROVENTIL HFA	11	268	74	$ 937.43
1	VENTOLIN HFA	2	60	36	$ 120.66
2	ALBUTEROL SULFATE	10	86	1,050	$ 364.98
2	PROVENTIL HFA	15	375	101	$ 1,269.71
3	ALBUTEROL SULFATE	11	88	1,650	$ 172.16
3	PROVENTIL HFA	12	300	80	$ 1,011.56
4	ALBUTEROL SULFATE	14	310	3,630	$ 372.19
4	PROVENTIL HFA	15	321	101	$ 1,267.62
5	ALBUTEROL SULFATE	12	295	5,130	$ 310.03
5	PROVENTIL HFA	11	316	74	$ 936.38
6	ALBUTEROL SULFATE	9	204	2,430	$ 190.98
6	PROVENTIL HFA	13	226	87	$ 1,102.53
7	ALBUTEROL SULFATE	12	360	3,690	$ 271.53
7	PROVENTIL HFA	13	390	87	$ 1,098.31
8	ALBUTEROL SULFATE	11	330	990	$ 152.42
8	PROVENTIL HFA	10	300	67	$ 846.46
9	PROVENTIL HFA	21	337	141	$ 1,770.23
10	ALBUTEROL SULFATE	16	309	3,750	$ 299.91
10	PROVENTIL HFA	12	420	80	$ 1,018.93
11	ALBUTEROL SULFATE	4	64	1,200	$ 84.14
11	PROVENTIL HFA	15	240	101	$ 1,263.39
12	ALBUTEROL SULFATE	4	82	1,425	$ 92.95
12	PROVENTIL HFA	19	346	127	$ 1,593.56
13	ALBUTEROL SULFATE	9	270	3,240	$ 224.78
13	PROVENTIL HFA	12	225	80	$ 1,003.14
14	ALBUTEROL SULFATE	21	322	5,670	$ 435.85
14	PROVENTIL HFA	2	32	13	$ 169.31
15	ALBUTEROL SULFATE	8	191	2,400	$ 123.72
15	PROVENTIL HFA	19	304	127	$ 194.38
16	PROVENTIL HFA	21	425	141	$ 1,775.51
17	ALBUTEROL SULFATE	8	220	1,500	$ 433.67
17	PROVENTIL HFA	17	286	114	$ 1,447.41

Anthem Asthma and Albuterol Use

- Total number of recipients utilizing albuterol = 26,134
- Total number of recipients utilizing more than one inhaler = 8,337
- Total number of recipients on inhaled maintenance therapy = 6,284
- Total number of recipients on other maintenance therapy = 8,428*
    - What that maintenance therapy is= Montelukast

*Unable to determine if montelukast is being used for asthma

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Asthma and Albuterol Utilization

May 1, 2018 -May 31, 2018

Albuterol Inhalers (Ventolin, ProAir, Proventil)

Count of Members	Count of Claims
5,212	5,786

Recipient Specifics in May 2018

Members With Albuterol Scripts	Members Who Received More than One Script
1,120	210

Other Maintenance Therapies

Drug Name	Count of Members
BREO ELLIPTA INH 100-25	2418
BREO ELLIPTA INH 200-25	2075
ARNUITY ELPT INH 100MCG	947
ASMANEX HFA AER 100 MCG	798
ASMANEX 30 AER 110MCG	751
DULERA AER 100-5MCG	715
ANORO ELLIPT AER 62.5-25	675
INCRUSE ELPT INH 62.5MCG	606
ASMANEX 30 AER 220MCG	568
DULERA AER 200-5MCG	567

Asthma and Albuterol Use - Q3 2017–Q1 2018

SilverSummith Healthplan

REPORT TYPE	REPORT DATE RANGE	ALBUTEROL USAGE	CLAIM COUNT
Asthma and Albuterol Use	07/01/2017 - 03/31/2018	Albuterol Users	3,238
Asthma and Albuterol Use	07/01/2017 - 03/31/2018	Albuterol and Another Inhaler	662
Asthma and Albuterol Use	07/01/2017 - 03/31/2018	Other Maintenance Users	1

Top 10 Drug Group by Paid Amt

Fee for Service Medicaid

Q3 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
85	HEMATOLOGICAL AGENTS - MISC.*	3,278	$ 10,640,081.06
12	ANTIVIRALS*	3,884	$ 6,931,296.33
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	31,096	$ 5,817,206.78
27	ANTIDIABETICS*	18,872	$ 5,324,357.36
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	4,225	$ 5,248,531.03
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	38,520	$ 4,618,115.93
72	ANTICONVULSANTS*	44,913	$ 4,004,509.88
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	3,688	$ 3,169,159.32
90	DERMATOLOGICALS*	17,632	$ 2,176,520.77
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	5,151	$ 2,173,017.99

Q4 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
85	HEMATOLOGICAL AGENTS - MISC.*	2,904	$ 10,758,751.62
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,056	$ 5,871,009.27
12	ANTIVIRALS*	4,436	$ 5,553,514.06
27	ANTIDIABETICS*	17,269	$ 5,284,226.72
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	39,715	$ 4,715,098.00
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	3,604	$ 4,179,899.65
72	ANTICONVULSANTS*	42,649	$ 3,908,909.37
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	3,278	$ 3,094,916.09
74	NEUROMUSCULAR AGENTS*	356	$ 3,017,053.42
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	4,721	$ 2,199,798.18

Q1 2018

Class	Drug Class Name	Count of Claims	Pharmacy Paid
85	HEMATOLOGICAL AGENTS - MISC.*	3,188	$ 10,478,484.39
12	ANTIVIRALS*	6,577	$ 7,762,477.83
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	4,377	$ 5,944,037.60
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	32,817	$ 5,909,563.28
27	ANTIDIABETICS*	20,841	$ 5,636,301.14
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	44,101	$ 5,082,129.59
72	ANTICONVULSANTS*	45,878	$ 4,267,432.38
30	ENDOCRINE AND METABOLIC AGENTS - MISC.*	4,292	$ 3,900,938.60
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENT	5,292	$ 2,612,714.21
19	PASSIVE IMMUNIZING AND TREATMENT AGENTS*	768	$ 2,459,251.17

Top 10 Drug Group by Claim Count

Fee for Service Medicaid

Q3 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	55,736	$ 1,824,685.78
72	ANTICONVULSANTS*	44,913	$ 4,004,509.88
58	ANTIDEPRESSANTS*	42,299	$ 846,772.67
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	38,520	$ 4,618,115.93
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	31,096	$ 5,817,206.78
57	ANTIANXIETY AGENTS*	25,552	$ 280,676.13
49	ULCER DRUGS*	23,688	$ 1,128,662.84
36	ANTIHYPERTENSIVES*	23,578	$ 369,229.85
66	ANALGESICS - ANTI-INFLAMMATORY*	23,256	$ 1,915,622.40
39	ANTIHYPERLIPIDEMICS*	22,456	$ 716,877.01

Q4 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	50,563	$ 1,733,043.38
72	ANTICONVULSANTS*	42,649	$ 3,908,909.37
58	ANTIDEPRESSANTS*	40,379	$ 845,943.59
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	39,715	$ 4,715,098.00
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	30,056	$ 5,871,009.27
57	ANTIANXIETY AGENTS*	23,658	$ 277,872.17
66	ANALGESICS - ANTI-INFLAMMATORY*	23,370	$ 2,037,887.69
36	ANTIHYPERTENSIVES*	22,242	$ 371,772.47
49	ULCER DRUGS*	21,223	$ 1,071,391.16
39	ANTIHYPERLIPIDEMICS*	20,483	$ 681,151.03

Q1 2018

Class	Drug Class Name	Count of Claims	Pharmacy Paid
65	ANALGESICS - OPIOID*	46,549	$1,590,769.72
72	ANTICONVULSANTS*	45,878	$4,267,432.38
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	44,101	$5,082,129.59
58	ANTIDEPRESSANTS*	43,674	$868,863.95
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS*	32,817	$5,909,563.28
66	ANALGESICS - ANTI-INFLAMMATORY*	25,409	$2,163,691.39
36	ANTIHYPERTENSIVES*	25,402	$404,905.80
57	ANTIANXIETY AGENTS*	23,952	$268,796.39
49	ULCER DRUGS*	22,985	$1,077,154.68
39	ANTIHYPERLIPIDEMICS*	22,121	$695,237.95

Top 10 Drug Classes by Paid Amt

Fee for Service Medicaid

Q3 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	100	$ 9,946,107.33
1235	HEPATITIS AGENTS**	281	$ 3,791,464.82
2710	INSULIN**	6,088	$ 3,318,260.58
4420	SYMPATHOMIMETICS**	26,233	$ 3,078,454.32
1210	ANTIRETROVIRALS**	2,136	$ 3,047,759.79
7260	ANTICONVULSANTS - MISC.**	33,010	$ 2,812,377.81
5907	BENZISOXAZOLES**	7,244	$ 2,189,734.24
2153	ANTINEOPLASTIC ENZYME INHIBITORS**	230	$ 1,578,071.49
2135	ANTINEOPLASTIC - ANTIBODIES**	364	$ 1,564,842.71
6240	MULTIPLE SCLEROSIS AGENTS**	315	$ 1,555,193.63

Q4 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	106	$ 10,231,948.35
2710	INSULIN**	5,671	$ 3,257,227.12
4420	SYMPATHOMIMETICS**	27,699	$ 3,154,566.99
1210	ANTIRETROVIRALS**	2,083	$ 3,013,382.63
7260	ANTICONVULSANTS - MISC.**	31,581	$ 2,689,322.15
7470	SPINAL MUSCULAR ATROPHY AGENTS (SMA)**	16	$ 2,375,162.72
1235	HEPATITIS AGENTS**	166	$ 2,357,004.30
5907	BENZISOXAZOLES**	7,044	$ 2,200,274.40
5940	ANTIPSYCHOTICS - MISC.**	2,746	$ 1,573,118.02
6240	MULTIPLE SCLEROSIS AGENTS**	325	$ 1,539,570.79

Q1 2018

Class	Drug Class Name	Count of Claims	Pharmacy Paid
8510	ANTIHEMOPHILIC PRODUCTS**	100	$ 9,623,686.67
1235	HEPATITIS AGENTS**	318	$ 3,934,799.29
4420	SYMPATHOMIMETICS**	31,307	$ 3,450,086.12
2710	INSULIN**	6,925	$ 3,404,808.09
1210	ANTIRETROVIRALS**	2,445	$ 3,399,138.63
7260	ANTICONVULSANTS - MISC.**	34,017	$ 2,956,120.07
5907	BENZISOXAZOLES**	7,492	$ 2,290,111.69
2135	ANTINEOPLASTIC - ANTIBODIES**	394	$ 2,059,367.58
6240	MULTIPLE SCLEROSIS AGENTS**	307	$ 1,910,973.30
5940	ANTIPSYCHOTICS - MISC.**	3,099	$ 1,837,738.18

Top 10 Drug Classes by Claim Count

Fee for Service Medicaid

Q3 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
7260	ANTICONVULSANTS - MISC.**	33,010	$ 2,812,377.81
6599	OPIOID COMBINATIONS**	30,381	$ 651,846.97
4420	SYMPATHOMIMETICS**	26,233	$ 3,078,454.32
6510	OPIOID AGONISTS**	24,446	$ 944,031.43
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	22,729	$ 279,932.70
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	20,136	$ 258,890.76
3940	HMG COA REDUCTASE INHIBITORS**	18,681	$ 381,431.02
5710	BENZODIAZEPINES**	18,205	$ 178,287.81
7510	CENTRAL MUSCLE RELAXANTS**	15,346	$ 256,906.13
5025	5-HT3 RECEPTOR ANTAGONISTS**	12,956	$ 196,647.93

Q4 2017

Class	Drug Class Name	Count of Claims	Pharmacy Paid
7260	ANTICONVULSANTS - MISC.**	31,581	$ 2,689,322.15
4420	SYMPATHOMIMETICS**	27,699	$ 3,154,566.99
6599	OPIOID COMBINATIONS**	27,697	$ 586,127.34
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	22,851	$ 298,000.41
6510	OPIOID AGONISTS**	21,948	$ 912,093.39
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	19,141	$ 254,226.75
3940	HMG COA REDUCTASE INHIBITORS**	17,062	$ 374,381.72
5710	BENZODIAZEPINES**	16,330	$ 173,109.24
7510	CENTRAL MUSCLE RELAXANTS**	14,971	$ 259,985.27
2210	GLUCOCORTICOSTEROIDS**	13,819	$ 449,969.11

Q1 2018

Class	Drug Class Name	Count of Claims	Pharmacy Paid
7260	ANTICONVULSANTS - MISC.**	34,017	$ 2,956,120.07
4420	SYMPATHOMIMETICS**	31,307	$ 3,450,086.12
6599	OPIOID COMBINATIONS**	25,082	$ 479,509.26
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)*	24,850	$ 309,860.44
6510	OPIOID AGONISTS**	20,482	$ 878,117.97
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)**	20,326	$ 247,248.78
3940	HMG COA REDUCTASE INHIBITORS**	18,558	$ 373,057.66
2210	GLUCOCORTICOSTEROIDS**	15,973	$ 515,912.21
7510	CENTRAL MUSCLE RELAXANTS**	15,907	$ 261,402.72
5710	BENZODIAZEPINES**	15,836	$ 157,418.95

Anthem Top 10 by Cost

Therapeutic Chapter Description	Ing Cost Rank
HIV/AIDS THERAPY	1
MISCELLANEOUS ANTIVIRALS	2
INSULIN THERAPY	3
NON-INSULIN HYPOGLYCEMIC AGENTS	4
MISCELLANEOUS PULMONARY AGENTS	5
ANTIPSYCHOTICS	6
ANTICONVULSANTS	7
MISCELLANEOUS ANTINEOPLASTIC DRUGS	8
MISCELLANEOUS RHEUMATOLOGICAL AGENTS	9
BETA AGONISTS INHALERS	10

Anthem Top 10 by RX Count

Therapeutic Chapter Description	Rx Count Rank
ANTIDEPRESSANT AGENTS	1
NSAIDS/COX II INHIBITORS	2
ANTICONVULSANTS	3
ANTIHISTAMINES	4
COMBINATION NARCOTIC /ANALGESICS	5
BETA AGONISTS INHALERS	6
VITAMINS & HEMATINICS	7
PENICILLINS	8
LIPID/CHOLESTEROL LOWERING AGENTS	9
NON-INSULIN HYPOGLYCEMIC AGENTS	10

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Top 10 Drugs by Group by Paid Amount

Q4_2017		
Class	**Drug Class Name**	**Count of Claims**
12	ANTIVIRALS	8,563
27	ANTIDIABETICS	33,346
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	44,840
66	ANALGESICS - ANTI-INFLAMMATORY	38,928
65	ANALGESICS - OPIOID	45,641
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS	11,555
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	1,701
90	DERMATOLOGICALS	21,588
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	1,582
94	DIAGNOSTIC PRODUCTS	9,821

Q1_2018		
Class	**Drug Class Name**	**Count of Claims**
12	ANTIVIRALS	11,111
27	ANTIDIABETICS	32,595
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	48,221
66	ANALGESICS - ANTI-INFLAMMATORY	39,485
59	ANTIPSYCHOTICS/ANTIMANIC AGENTS	11,754
62	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	1,752
90	DERMATOLOGICALS	22,253
65	ANALGESICS - OPIOID	35,905
21	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	1,503
72	ANTICONVULSANTS	29,908

Health Plan of Nevada

Top 10 Drugs by Group by Claim Count

Q4_2017

Class	Drug Class Name	Count of Claims
65	ANALGESICS - OPIOID	45,641
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	44,840
58	ANTIDEPRESSANTS	41,758
66	ANALGESICS - ANTI-INFLAMMATORY	38,928
36	ANTIHYPERTENSIVES	34,948
27	ANTIDIABETICS	33,346
72	ANTICONVULSANTS	30,398
49	ULCER DRUGS	24,107
39	ANTIHYPERLIPIDEMICS	23,934
01	PENICILLINS	23,315

Q1_2018

Class	Drug Class Name	Count of Claims
44	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	48,221
58	ANTIDEPRESSANTS	41,305
66	ANALGESICS - ANTI-INFLAMMATORY	39,485
65	ANALGESICS - OPIOID	35,905
36	ANTIHYPERTENSIVES	34,162
27	ANTIDIABETICS	32,595
72	ANTICONVULSANTS	29,908
01	PENICILLINS	25,785
49	ULCER DRUGS	23,887
39	ANTIHYPERLIPIDEMICS	23,423

Health Plan of Nevada

Top 10 Drugs by Class by Paid Amount

Q4_2017

Class	Drug Class Name	Count of Claims
1210	ANTIRETROVIRALS	2,600
2710	INSULIN	9,113
1235	HEPATITIS AGENTS	230
4420	SYMPATHOMIMETICS	30,206
6627	ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	432
9410	DIAGNOSTIC TESTS	9,820
6240	MULTIPLE SCLEROSIS AGENTS	188
2153	ANTINEOPLASTIC ENZYME INHIBITORS	119
7260	ANTICONVULSANTS - MISC.	24,486
6110	AMPHETAMINES	5,421

Q1_2018

Class	Drug Class Name	Count of Claims
1210	ANTIRETROVIRALS	2,658
2710	INSULIN	9,100
1235	HEPATITIS AGENTS	224
4420	SYMPATHOMIMETICS	32,630
6627	ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	393
6240	MULTIPLE SCLEROSIS AGENTS	184
2153	ANTINEOPLASTIC ENZYME INHIBITORS	118
7260	ANTICONVULSANTS - MISC.	24,469
9410	DIAGNOSTIC TESTS	9,497
6110	AMPHETAMINES	5,463

Health Plan of Nevada

Top 10 Drugs by Class by Claim Count

Q4_2017

Class	Drug Class Name	Count of Claims
6610	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	38,108
6599	OPIOID COMBINATIONS	30,738
4420	SYMPATHOMIMETICS	30,206
7260	ANTICONVULSANTS - MISC.	24,486
3940	HMG COA REDUCTASE INHIBITORS	21,093
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	20,662
7510	CENTRAL MUSCLE RELAXANTS	16,953
0120	AMINOPENICILLINS	16,780
3610	ACE INHIBITORS	16,378
4927	PROTON PUMP INHIBITORS	15,230

Q1_2018

Class	Drug Class Name	Count of Claims
6610	ONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	38,723
4420	SYMPATHOMIMETICS	32,630
7260	ANTICONVULSANTS - MISC.	24,469
6599	OPIOID COMBINATIONS	23,779
3940	HMG COA REDUCTASE INHIBITORS	20,796
5816	SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	20,155
0120	AMINOPENICILLINS	18,700
7510	CENTRAL MUSCLE RELAXANTS	16,088
3610	ACE INHIBITORS	15,917
4155	ANTIHISTAMINES - NON-SEDATING	15,653

Top 10 Drug Class By Claim Volume- Q3 2017–Q1 2018

SilverSummith Healthplan

REPORT TYPE	REPORT DATE RANGE	RANK NUMBER	RANK NAME	CLAIM COUNT	UTILIZER COUNT
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	1	Nonsteroidal Anti-inflammatory Agents (NSAIDs)	9,241	5,420
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	2	Anticonvulsants - Misc.	7,078	2,177
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	3	Sympathomimetics	6,851	3,338
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	4	Opioid Combinations	6,659	3,277
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	5	Selective Serotonin Reuptake Inhibitors (SSRIs)	6,166	2,125
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	6	HMG CoA Reductase Inhibitors	4,790	1,574
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	7	Central Muscle Relaxants	4,581	2,043
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	8	Aminopenicillins	3,699	3,197
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	9	Benzodiazepines	3,477	1,294
Top Drug Class By Claim Volume	07/01/2017 - 03/31/2018	10	ACE Inhibitors	3,440	1,292

Top 10 Drugs By Claims- Q3 2017–Q1 2018

SilverSummith Healthplan

REPORT TYPE	REPORT DATE RANGE	RANK NUMBER	RANK NAME	SPECIALTY INDICATOR	CLAIM COUNT	UTILIZER COUNT
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	1	VENTOLIN HFA AER	No	3,453	2,099
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	2	IBU TAB 800MG	No	2,105	1,546
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	3	FLUTICASONE SPR 50MCG	No	1,904	1,269
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	4	AMOXICILLIN CAP 500MG	No	1,776	1,547
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	5	GABAPENTIN CAP 300MG	No	1,763	760
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	6	AZITHROMYCIN TAB 250MG	No	1,687	1,508
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	7	HYDROCO/APAP TAB 5-325MG	No	1,600	1,254
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	8	HYDROCO/APAP TAB 10-325MG	No	1,518	571
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	9	IBUPROFEN TAB 800MG	No	1,506	1,141
Top Drugs By Claim Volume	07/01/2017 - 03/31/2018	10	CYCLOBENZAPR TAB 10MG	No	1,382	753

Top 10 Drugs By Paid Amount- Q3 2017–Q1 2018

SilverSummith Healthplan

REPORT TYPE	REPORT DATE RANGE	RANK NUMBER	RANK NAME	SPECIALTY INDICATOR	CLAIM COUNT	UTILIZER COUNT
Top Drug By Spend	07/01/2017 - 03/31/2018	1	GENVOYA TAB	No	179	53
Top Drug By Spend	07/01/2017 - 03/31/2018	2	TRUVADA TAB 200-300	No	200	67
Top Drug By Spend	07/01/2017 - 03/31/2018	3	TIVICAY TAB 50MG	No	191	55
Top Drug By Spend	07/01/2017 - 03/31/2018	4	TRIUMEQ TAB	No	108	29
Top Drug By Spend	07/01/2017 - 03/31/2018	5	DESCOVY TAB 200/25	No	143	45
Top Drug By Spend	07/01/2017 - 03/31/2018	6	SUBOXONE MIS 8-2MG	No	745	127
Top Drug By Spend	07/01/2017 - 03/31/2018	7	EPCLUSA TAB 400-100	Yes	8	3
Top Drug By Spend	07/01/2017 - 03/31/2018	8	STRIBILD TAB	No	61	22
Top Drug By Spend	07/01/2017 - 03/31/2018	9	VENTOLIN HFA AER	No	3,453	2,099
Top Drug By Spend	07/01/2017 - 03/31/2018	10	MAVYRET TAB 100-40MG	Yes	12	7

Top 50 Drugs by Amount - Q3 2017

Fee for Service Medicaid

Drug Code	Drug Name	Claim Count		Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	18.00	$	3,899,376.74	91,616	14
8510002620	COAGULATION FACTOR VIIA (RECOMBINANT)	6.00	$	2,620,861.02	210,000	30
1235990240	LEDIPASVIR-SOFOSBUVIR	118.00	$	2,133,254.01	11	11
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	12.00	$	1,998,921.64	91,780	20
5907005010	PALIPERIDONE PALMITATE	755.00	$	1,653,655.12	1	24
1235990265	SOFOSBUVIR-VELPATASVIR	102.00	$	1,476,501.70	8	8
5940002310	LURASIDONE HCL	1,080.00	$	1,272,259.09	18	15
2710400300	INSULIN GLARGINE	2,277.00	$	1,077,244.58	15	35
4420101010	ALBUTEROL SULFATE	16,649.00	$	1,037,850.13	33	16
7260005700	PREGABALIN	2,669.00	$	988,670.56	46	19
9410003000	GLUCOSE BLOOD	6,779.00	$	973,265.80	76	25
6627001500	ADALIMUMAB	183.00	$	894,868.87	1	9
4420990270	FLUTICASONE-SALMETEROL	2,642.00	$	893,321.42	43	23
4927002510	ESOMEPRAZOLE MAGNESIUM	3,034.00	$	805,679.93	23	22
5925001500	ARIPIPRAZOLE	4,663.00	$	731,882.96	18	17
3030001000	CORTICOTROPIN	15.00	$	727,792.55	2	3
1910002010	IMMUNE GLOBULIN (HUMAN) IV	137.00	$	713,444.05	417	3
2710400500	INSULIN LISPRO	1,023.00	$	709,724.40	15	28
3010002000	SOMATROPIN	203.00	$	684,273.28	2	9
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	320.00	$	614,478.43	17	17
2153253000	EVEROLIMUS	37.00	$	606,155.30	11	9
5915307010	QUETIAPINE FUMARATE	8,142.00	$	595,131.16	29	20
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	1,924.00	$	568,204.09	23	25
8240157000	PEGFILGRASTIM	102.00	$	563,850.93	1	1
8580005000	ECULIZUMAB	25.00	$	562,596.00	90	1
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	22.00	$	553,982.60	15,450	19
7260003600	LACOSAMIDE	1,024.00	$	553,165.70	53	13
4530402000	DORNASE ALFA	175.00	$	550,790.62	42	14
2710400200	INSULIN ASPART	976.00	$	540,071.62	13	27
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2,417.00	$	538,996.09	8	24
7210000700	CLOBAZAM	392.00	$	525,704.10	60	14
3090685000	IDURSULFASE	38.00	$	498,015.68	10	4
6135303010	GUANFACINE HCL (ADHD)	1,800.00	$	495,255.80	19	18
6629003000	ETANERCEPT	100.00	$	477,040.91	2	13
9037403530	DICLOFENAC SODIUM (ACTINIC KERATOSES)	581.00	$	463,675.54	207	19
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,748.00	$	445,462.31	22	21
2133502000	BEVACIZUMAB	316.00	$	420,783.81	7	1
6140002010	METHYLPHENIDATE HCL	2,250.00	$	412,423.83	34	19
9085006000	LIDOCAINE	2,216.00	$	401,866.39	87	15
2135304100	NIVOLUMAB	93.00	$	400,638.80	15	3
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	293.00	$	385,355.74	18	18
9310002500	DEFERASIROX	57.00	$	382,737.38	20	10
4530990230	LUMACAFTOR-IVACAFTOR	19.00	$	376,784.20	33	8
7470005000	NUSINERSEN	3.00	$	375,030.51	2	14
2710400600	INSULIN DETEMIR	868.00	$	374,256.46	13	27
6240552500	DIMETHYL FUMARATE	54.00	$	368,829.18	16	8
7460003500	ETEPLIRSEN	6.00	$	364,861.02	21	8
2755007010	SITAGLIPTIN PHOSPHATE	836.00	$	345,196.73	33	33
1210301510	DOLUTEGRAVIR SODIUM	239.00	$	326,196.14	19	19
6510007510	OXYCODONE HCL	8,229.00	$	319,867.13	67	17

Top 50 Drugs by Amount - Q4 2017

Fee for Service Medicaid

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	15	$ 3,861,081.75	72,574	9
8510002620	COAGULATION FACTOR VIIA (RECOMBINANT)	6	$ 2,721,661.02	210,000	30
7470005000	NUSINERSEN	16	$ 2,375,162.72	3	16
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	13	$ 2,213,038.81	95,073	20
5907005010	PALIPERIDONE PALMITATE	747	$ 1,701,137.98	1	24
5940002310	LURASIDONE HCL	1082	$ 1,270,883.76	18	15
1950206000	PALIVIZUMAB	415	$ 1,266,412.21	1	26
4420101010	ALBUTEROL SULFATE	18418	$ 1,122,535.78	36	15
6627001500	ADALIMUMAB	191	$ 1,068,310.03	1	10
2710400300	INSULIN GLARGINE	2047	$ 1,049,529.08	14	33
1235990240	LEDIPASVIR-SOFOSBUVIR	54	$ 1,027,262.86	8	8
1235990265	SOFOSBUVIR-VELPATASVIR	58	$ 994,146.30	11	11
9410003000	GLUCOSE BLOOD	6557	$ 960,063.54	75	24
7260005700	PREGABALIN	2398	$ 925,052.06	44	19
4420990270	FLUTICASONE-SALMETEROL	2461	$ 880,044.40	41	22
3030001000	CORTICOTROPIN	10	$ 764,123.70	2	4
3010002000	SOMATROPIN	204	$ 757,204.88	2	9
4927002510	ESOMEPRAZOLE MAGNESIUM	2684	$ 750,765.50	23	23
5925001500	ARIPIPRAZOLE	4592	$ 745,330.20	17	16
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	346	$ 664,130.13	16	16
4530402000	DORNASE ALFA	186	$ 660,085.40	49	16
2710400500	INSULIN LISPRO	933	$ 659,405.85	13	26
4530990230	LUMACAFTOR-IVACAFTOR	31	$ 586,078.20	39	10
8240157000	PEGFILGRASTIM	100	$ 548,897.82	1	2
7260003600	LACOSAMIDE	956	$ 548,146.29	56	14
7210000700	CLOBAZAM	395	$ 542,066.20	62	14
5915307010	QUETIAPINE FUMARATE	7964	$ 542,007.05	30	21
2710400200	INSULIN ASPART	912	$ 534,069.09	14	27
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2223	$ 527,676.73	8	23
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	1705	$ 520,907.74	22	24
6240552500	DIMETHYL FUMARATE	68	$ 491,731.56	17	9
6135303010	GUANFACINE HCL (ADHD)	1877	$ 486,639.20	18	18
1910002010	IMMUNE GLOBULIN (HUMAN) IV	105	$ 484,572.17	362	5
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	21	$ 465,235.74	11,932	12
3090685000	IDURSULFASE	35	$ 444,859.08	6	3
8580005000	ECULIZUMAB	20	$ 443,564.00	68	1
6110002510	LISDEXAMFETAMINE DIMESYLATE	1720	$ 441,076.56	21	21
2153253000	EVEROLIMUS	28	$ 438,115.47	9	8
6140002010	METHYLPHENIDATE HCL	2300	$ 423,075.05	32	18
9085006000	LIDOCAINE	2304	$ 415,329.84	75	15
6629003000	ETANERCEPT	95	$ 412,422.12	2	11
2710400600	INSULIN DETEMIR	812	$ 377,934.28	13	28
7460003500	ETEPLIRSEN	6	$ 377,661.02	26	9
4016000700	AMBRISENTAN	40	$ 370,591.20	18	18
9037403530	DICLOFENAC SODIUM (ACTINIC KERATOSES)	690	$ 369,511.59	168	19
2160005500	RADIUM RA 223 DICHLORIDE	12	$ 368,220.00	108	1
2755007010	SITAGLIPTIN PHOSPHATE	749	$ 358,272.62	35	35
9310002500	DEFERASIROX	53	$ 356,233.90	19	9
1210301510	DOLUTEGRAVIR SODIUM	243	$ 348,735.50	21	20
6510007510	OXYCODONE HCL	7735	$ 318,857.91	68	17

Top 50 Drugs by Amount - Q1 2018

Fee for Service Medicaid

Drug Code	Drug Name	Claim Count		Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
8510001025	ANTIHEMOPHILIC FACTOR RAHF-PFM	14	$	4,281,032.48	104,486	12
1235990265	SOFOSBUVIR-VELPATASVIR	95	$	2,021,558.12	12	12
8510001020	ANTIHEMOPHILIC FACTOR (RECOMBINANT)	11	$	1,961,568.27	72,000	18
8510002620	COAGULATION FACTOR VIIA (RECOMBINANT)	4	$	1,814,440.68	210,000	30
5907005010	PALIPERIDONE PALMITATE	893	$	1,782,514.40	1	24
5940002310	LURASIDONE HCL	1,281	$	1,430,387.78	19	16
1950206000	PALIVIZUMAB	473	$	1,365,369.98	1	23
4420101010	ALBUTEROL SULFATE	20,684	$	1,230,782.52	36	15
6627001500	ADALIMUMAB	203	$	1,142,057.13	1	9
2710400300	INSULIN GLARGINE	2,617	$	1,075,648.42	14	32
1235990240	LEDIPASVIR-SOFOSBUVIR	49	$	1,044,772.94	10	10
3030001000	CORTICOTROPIN	14	$	1,008,824.38	3	6
7260005700	PREGABALIN	2,695	$	987,946.28	42	18
4420990270	FLUTICASONE-SALMETEROL	2,692	$	977,238.94	41	22
9410003000	GLUCOSE BLOOD	6,237	$	836,657.49	76	25
5925001500	ARIPIPRAZOLE	4,841	$	762,545.22	18	17
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	381	$	761,836.47	16	16
4530402000	DORNASE ALFA	199	$	748,583.39	37	12
4927002510	ESOMEPRAZOLE MAGNESIUM	2,676	$	746,286.65	24	23
8580005000	ECULIZUMAB	32	$	730,576.00	105	1
8240157000	PEGFILGRASTIM	131	$	726,236.02	0	1
3010002000	SOMATROPIN	171	$	712,687.56	2	8
1910002010	IMMUNE GLOBULIN (HUMAN) IV	148	$	705,699.06	452	4
2710400500	INSULIN LISPRO	1,097	$	677,326.34	13	25
7210000700	CLOBAZAM	436	$	636,858.61	66	14
7470005000	NUSINERSEN	5	$	625,050.85	1	8
2710400200	INSULIN ASPART	1,118	$	596,207.84	13	27
4420990241	BUDESONIDE-FORMOTEROL FUMARATE DIHYDRATE	2,573	$	581,795.82	8	23
7260003600	LACOSAMIDE	1,016	$	573,241.20	54	14
4410008010	TIOTROPIUM BROMIDE MONOHYDRATE	1,875	$	568,857.18	23	26
3090522510	CINACALCET HCL	865	$	545,944.90	30	5
2133502000	BEVACIZUMAB	338	$	522,184.81	7	1
6240552500	DIMETHYL FUMARATE	68	$	512,993.82	14	7
8510001510	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	13	$	510,385.76	24,446	10
2135304100	NIVOLUMAB	104	$	509,189.66	99	2
1235990235	GLECAPREVIR-PIBRENTASVIR	40	$	503,719.56	41	14
4530990230	LUMACAFTOR-IVACAFTOR	29	$	502,545.60	36	9
2153253000	EVEROLIMUS	26	$	478,220.98	10	8
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,721	$	474,857.44	21	20
3090404500	NITISINONE	6	$	449,633.19	50	10
1210301510	DOLUTEGRAVIR SODIUM	302	$	427,225.69	18	18
2135305300	PEMBROLIZUMAB	46	$	417,472.66	8	1
6629003000	ETANERCEPT	89	$	407,899.05	1	10
7460003500	ETEPLIRSEN	6	$	403,261.02	14	5
3090685000	IDURSULFASE	28	$	400,479.12	12	6
2710400600	INSULIN DETEMIR	996	$	383,636.27	13	28
2755007010	SITAGLIPTIN PHOSPHATE	849	$	383,133.21	33	33
6140002010	METHYLPHENIDATE HCL	2,264	$	380,455.71	26	18
2135306000	RITUXIMAB	74	$	377,622.73	44	1
1250406020	OSELTAMIVIR PHOSPHATE	2,224	$	366,676.32	23	3

Top 50 Drugs by Claim Count - Q3 2017

Fee for Service Medicaid

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
6599170210	HYDROCODONE-ACETAMINOPHEN	18956	$ 294,328.10	54	14
4420101010	ALBUTEROL SULFATE	16649	$ 1,037,850.13	33	16
7260003000	GABAPENTIN	13293	$ 178,773.71	72	23
3940001010	ATORVASTATIN CALCIUM	10533	$ 109,591.74	30	29
6610002000	IBUPROFEN	10310	$ 92,146.81	39	11
5710001000	ALPRAZOLAM	9907	$ 103,862.69	48	21
6599000220	OXYCODONE W/ ACETAMINOPHEN	9803	$ 318,971.65	52	14
2810001010	LEVOTHYROXINE SODIUM	8974	$ 142,492.98	31	31
3610003000	LISINOPRIL	8605	$ 64,890.20	43	39
6510007510	OXYCODONE HCL	8229	$ 319,867.13	67	17
5915307010	QUETIAPINE FUMARATE	8142	$ 595,131.16	29	20
5812008010	TRAZODONE HCL	7803	$ 85,596.76	29	22
5025006505	ONDANSETRON HCL	7780	$ 33,770.95	4	1
3400000310	AMLODIPINE BESYLATE	7058	$ 42,305.37	40	38
6510005510	MORPHINE SULFATE	7028	$ 127,788.57	20	9
9410003000	GLUCOSE BLOOD	6779	$ 973,265.80	76	25
5816007010	SERTRALINE HCL	6603	$ 72,312.75	28	23
2725005000	METFORMIN HCL	6485	$ 297,320.90	78	38
4450505010	MONTELUKAST SODIUM	6462	$ 97,049.66	24	24
6410001000	ASPIRIN	6440	$ 33,814.79	23	22
7975001000	SODIUM CHLORIDE	6299	$ 15,761.89	470	1
7720203200	CHOLECALCIFEROL	6225	$ 47,403.26	25	24
4220003230	FLUTICASONE PROPIONATE (NASAL)	6213	$ 70,245.88	12	25
5907007000	RISPERIDONE	5826	$ 90,098.45	36	21
4927007010	PANTOPRAZOLE SODIUM	5496	$ 51,971.56	22	22
4920002010	RANITIDINE HCL	4946	$ 63,013.12	48	24
5816004000	FLUOXETINE HCL	4919	$ 90,438.22	31	24
7510005010	CYCLOBENZAPRINE HCL	4860	$ 53,081.39	45	18
120001010	AMOXICILLIN	4855	$ 50,472.11	54	6
6510009510	TRAMADOL HCL	4851	$ 44,358.31	56	16
4155003000	LORATADINE	4807	$ 52,645.06	32	22
7250001010	DIVALPROEX SODIUM	4805	$ 169,686.47	53	19
7210001000	CLONAZEPAM	4786	$ 48,562.42	38	19
5025006500	ONDANSETRON	4746	$ 49,894.55	7	3
5710006000	LORAZEPAM	4670	$ 38,977.22	17	8
5925001500	ARIPIPRAZOLE	4663	$ 731,882.96	18	17
2210004500	PREDNISONE	4377	$ 38,296.73	16	9
7260004000	LAMOTRIGINE	4372	$ 207,100.68	43	21
3320003010	METOPROLOL TARTRATE	4350	$ 33,181.04	59	32
4920003000	FAMOTIDINE	4336	$ 33,295.51	20	13
3940007500	SIMVASTATIN	4171	$ 31,022.25	30	30
4155002010	CETIRIZINE HCL	4106	$ 44,810.65	43	22
7510009010	TIZANIDINE HCL	4091	$ 90,470.96	48	19
6610005200	MELOXICAM	4089	$ 32,437.67	28	25
7260004300	LEVETIRACETAM	3907	$ 167,522.66	125	20
7720203000	ERGOCALCIFEROL	3864	$ 41,381.49	4	27
5816002010	CITALOPRAM HYDROBROMIDE	3850	$ 36,158.37	26	25
5830004010	BUPROPION HCL	3774	$ 82,217.70	31	22
3720003000	FUROSEMIDE	3647	$ 25,700.33	39	30
4650001030	DOCUSATE SODIUM	3622	$ 26,786.40	38	19

Top 50 Drugs by Claim Count - Q4 2017

Fee for Service Medicaid

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
4420101010	ALBUTEROL SULFATE	18418	$ 1,122,535.78	36	15
6599170210	HYDROCODONE-ACETAMINOPHEN	17475	$ 274,972.07	52	14
7260003000	GABAPENTIN	12790	$ 182,980.11	74	23
6610002000	IBUPROFEN	10590	$ 96,790.93	46	11
3940001010	ATORVASTATIN CALCIUM	9909	$ 112,903.78	30	30
5710001000	ALPRAZOLAM	9092	$ 100,721.08	48	21
6599000220	OXYCODONE W/ ACETAMINOPHEN	8582	$ 269,514.23	50	13
2810001010	LEVOTHYROXINE SODIUM	8140	$ 141,063.27	31	31
3610003000	LISINOPRIL	8069	$ 66,038.04	45	41
5915307010	QUETIAPINE FUMARATE	7964	$ 542,007.05	30	21
6510007510	OXYCODONE HCL	7735	$ 318,857.91	68	17
5812008010	TRAZODONE HCL	7414	$ 85,626.74	30	23
5025006505	ONDANSETRON HCL	7216	$ 33,929.28	4	1
9410003000	GLUCOSE BLOOD	6557	$ 960,063.54	75	24
3400000310	AMLODIPINE BESYLATE	6520	$ 46,402.68	39	38
0120001010	AMOXICILLIN	6464	$ 69,245.86	59	6
5816007010	SERTRALINE HCL	6399	$ 72,993.00	29	24
4220003230	FLUTICASONE PROPIONATE (NASAL)	6313	$ 74,805.08	13	26
7720203200	CHOLECALCIFEROL	6249	$ 48,678.67	26	24
6510005510	MORPHINE SULFATE	6220	$ 138,638.26	21	9
4450505010	MONTELUKAST SODIUM	6208	$ 91,868.91	25	25
6410001000	ASPIRIN	6058	$ 33,821.83	22	22
2725005000	METFORMIN HCL	6039	$ 251,679.37	80	40
5907007000	RISPERIDONE	5690	$ 93,012.22	35	21
7975001000	SODIUM CHLORIDE	5451	$ 13,359.89	460	1
0340001000	AZITHROMYCIN	5317	$ 69,434.58	6	3
2210004500	PREDNISONE	5046	$ 43,208.41	14	8
5025006500	ONDANSETRON	4968	$ 50,715.43	6	3
4155003000	LORATADINE	4895	$ 54,439.01	34	22
4927007010	PANTOPRAZOLE SODIUM	4892	$ 51,323.27	23	22
7510005010	CYCLOBENZAPRINE HCL	4796	$ 51,985.97	43	19
5816004000	FLUOXETINE HCL	4702	$ 87,473.59	32	25
4920002010	RANITIDINE HCL	4626	$ 61,795.57	49	25
7250001010	DIVALPROEX SODIUM	4597	$ 158,284.40	52	19
5925001500	ARIPIPRAZOLE	4592	$ 745,330.20	17	16
6510009510	TRAMADOL HCL	4418	$ 41,233.45	55	16
7210001000	CLONAZEPAM	4370	$ 46,204.59	39	19
7260004000	LAMOTRIGINE	4166	$ 206,097.02	44	22
4155002010	CETIRIZINE HCL	4116	$ 45,824.57	42	22
3320003010	METOPROLOL TARTRATE	4081	$ 33,708.72	64	35
7510009010	TIZANIDINE HCL	4048	$ 90,323.17	48	20
6610005200	MELOXICAM	4042	$ 36,483.87	27	24
5710006000	LORAZEPAM	3889	$ 40,713.00	19	9
4920003000	FAMOTIDINE	3888	$ 30,930.95	23	14
7260004300	LEVETIRACETAM	3838	$ 178,959.13	131	21
7720203000	ERGOCALCIFEROL	3731	$ 39,885.89	5	28
3940007500	SIMVASTATIN	3630	$ 29,028.61	31	31
5830004010	BUPROPION HCL	3541	$ 79,397.11	32	23
5816002010	CITALOPRAM HYDROBROMIDE	3528	$ 34,659.83	27	25
4650001030	DOCUSATE SODIUM	3486	$ 25,513.68	37	19

Top 50 Drugs by Claim Count - Q1 2018

Fee for Service Medicaid

Drug Code	Drug Name	Claim Count	Pharmacy Paid	Avg Qty/Rx	Avg Day Supply
4420101010	ALBUTEROL SULFATE	20684	$ 1,230,782.52	36	15
6599170210	HYDROCODONE-ACETAMINOPHEN	15593	$ 236,136.11	53	15
7260003000	GABAPENTIN	14223	$ 195,262.36	70	22
6610002000	IBUPROFEN	11456	$ 101,008.94	39	11
3940001010	ATORVASTATIN CALCIUM	11024	$ 116,909.28	28	28
3610003000	LISINOPRIL	9058	$ 70,819.65	44	40
5710001000	ALPRAZOLAM	8716	$ 93,467.85	47	20
2810001010	LEVOTHYROXINE SODIUM	8713	$ 148,823.57	32	32
5915307010	QUETIAPINE FUMARATE	8545	$ 167,250.14	30	21
5812008010	TRAZODONE HCL	8324	$ 90,861.20	29	22
6599000220	OXYCODONE W/ ACETAMINOPHEN	8252	$ 212,572.55	51	14
3400000310	AMLODIPINE BESYLATE	7642	$ 51,555.98	38	37
6510007510	OXYCODONE HCL	7604	$ 293,997.80	63	17
0120001010	AMOXICILLIN	7375	$ 79,438.13	61	6
5025006505	ONDANSETRON HCL	7347	$ 34,220.72	4	2
4220003230	FLUTICASONE PROPIONATE (NASAL)	7113	$ 81,487.19	13	26
5816007010	SERTRALINE HCL	6946	$ 77,501.60	30	25
2725005000	METFORMIN HCL	6943	$ 219,457.68	81	40
4450505010	MONTELUKAST SODIUM	6617	$ 98,286.00	25	24
0340001000	AZITHROMYCIN	6613	$ 83,476.74	6	3
7720203200	CHOLECALCIFEROL	6475	$ 51,225.47	26	25
9410003000	GLUCOSE BLOOD	6237	$ 836,657.49	76	25
6410001000	ASPIRIN	6068	$ 34,409.97	20	20
5907007000	RISPERIDONE	5892	$ 95,517.55	35	20
2210004500	PREDNISONE	5832	$ 46,937.73	14	8
6510005510	MORPHINE SULFATE	5822	$ 154,335.03	22	9
7975001000	SODIUM CHLORIDE	5444	$ 13,134.75	455	1
5025006500	ONDANSETRON	5415	$ 53,335.85	6	3
4927007010	PANTOPRAZOLE SODIUM	5216	$ 52,010.24	23	22
7250001010	DIVALPROEX SODIUM	5189	$ 150,563.53	49	18
7510005010	CYCLOBENZAPRINE HCL	5041	$ 48,613.22	42	19
4920002010	RANITIDINE HCL	4923	$ 64,749.99	52	26
5816004000	FLUOXETINE HCL	4920	$ 73,955.55	30	23
4155003000	LORATADINE	4850	$ 54,202.47	31	20
5925001500	ARIPIPRAZOLE	4841	$ 762,545.22	18	17
3320003010	METOPROLOL TARTRATE	4803	$ 37,811.22	61	33
7210001000	CLONAZEPAM	4448	$ 45,616.05	36	18
7510009010	TIZANIDINE HCL	4409	$ 90,971.66	43	18
7260004000	LAMOTRIGINE	4391	$ 228,997.58	40	20
6610005200	MELOXICAM	4347	$ 38,887.26	27	24
4920003000	FAMOTIDINE	4246	$ 31,389.76	22	14
5710006000	LORAZEPAM	4149	$ 36,429.28	17	8
4155002010	CETIRIZINE HCL	4089	$ 46,089.67	43	22
7260004300	LEVETIRACETAM	3948	$ 180,794.76	120	20
3720003000	FUROSEMIDE	3910	$ 27,467.86	40	31
3615004020	LOSARTAN POTASSIUM	3904	$ 32,528.02	38	36
5830004010	BUPROPION HCL	3865	$ 81,094.67	33	23
0199000220	AMOXICILLIN & POT CLAVULANATE	3822	$ 72,194.47	30	6
3940007500	SIMVASTATIN	3759	$ 28,872.23	32	32
6610003710	KETOROLAC TROMETHAMINE	3707	$ 17,369.19	2	1

Anthem Top 50 drugs by cost

Drug Name	Ing Cost Rank
GENVOYA	1
ZEPATIER	2
BASAGLAR KWIKPEN U-100	3
VENTOLIN HFA	4
HUMIRA PEN	5
APIDRA SOLOSTAR	6
TRUVADA	7
TRIUMEQ	8
TIVICAY	9
EPCLUSA	10
XOLAIR	11
STRIBILD	12
H.P. ACTHAR	13
JANUVIA	14
DESCOVY	15
VICTOZA 3-PAK	16
TECFIDERA	17
JARDIANCE	18
HARVONI	19
ENBREL SURECLICK	20
SUBOXONE	21
PREZCOBIX	22
ODEFSEY	23
ABILIFY MAINTENA	24
TRUE METRIX GLUCOSE TEST STRIP	25
MAKENA	26
COMPLERA	27
MAVYRET	28
ATRIPLA	29
TRADJENTA	30
XARELTO	31
GAMUNEX-C	32
BREO ELLIPTA	33
ONDANSETRON ODT	34
INVEGA SUSTENNA	35
IMATINIB MESYLATE	36
GABAPENTIN	37
SYNAGIS	38
ELIQUIS	39
VICTOZA 2-PAK	40
AUBAGIO	41
BREO ELLIPTA	42
DAPTOMYCIN	43
PREZISTA	44

Anthem Top 50 drugs by RX Count

Drug Name	Rx Count Rank
VENTOLIN HFA	1
IBU	2
LORATADINE	3
TRUE METRIX GLUCOSE TEST STRIP	4
VITAMIN D2	5
AMOXICILLIN	6
AZITHROMYCIN	7
ALBUTEROL SULFATE	8
BASAGLAR KWIKPEN U-100	9
MONTELUKAST SODIUM	10
ONDANSETRON ODT	11
AMOXICILLIN	12
NAPROXEN	13
METFORMIN HCL	14
GABAPENTIN	15
ATORVASTATIN CALCIUM	16
METFORMIN HCL	17
CHILDREN'S LORATADINE	18
HYDROCODONE-ACETAMINOPHEN	19
TRAMADOL HCL	20
OMEPRAZOLE	21
ATORVASTATIN CALCIUM	22
MONTELUKAST SODIUM	23
CEPHALEXIN	24
HYDROCODONE-ACETAMINOPHEN	25
CYCLOBENZAPRINE HCL	26
AMLODIPINE BESYLATE	27
TRAZODONE HCL	28
LISINOPRIL	29
TRAZODONE HCL	30
HYDROCHLOROTHIAZIDE	31
AMOXICILLIN-CLAVULANATE POTASS	32
IBUPROFEN	33
PROMETHAZINE-DM	34
IBUPROFEN	35
MELOXICAM	36
SERTRALINE HCL	37
IBU	38
FLUTICASONE PROPIONATE	39
PREDNISONE	40
SERTRALINE HCL	41
LISINOPRIL	42
FLUCONAZOLE	43
ALPRAZOLAM	44

OSELTAMIVIR PHOSPHATE	45
DULERA	46
REBIF REBIDOSE	47
ARNUITY ELLIPTA	48
LATUDA	49
DULERA	50

HYDROCODONE-ACETAMINOPHEN	45
METRONIDAZOLE	46
PREDNISOLONE	47
POLYETHYLENE GLYCOL 3350	48
SULFAMETHOXAZOLE-TRIMETHOPRIM	49
HYDROCODONE-ACETAMINOPHEN	50

STATE OF NEVADA - DUR MEETING - JULY 26, 2018

Health Plan of Nevada

Top 50 Drugs by Paid Amount

Q4_2017		
Class	**Drug Class Name**	**Count of Claims**
1235990230	ELBASVIR-GRAZOPREVIR	116
6627001500	ADALIMUMAB	414
2710400300	INSULIN GLARGINE	4,373
2710400500	INSULIN LISPRO	2,255
1235990265	SOFOSBUVIR-VELPATASVIR	52
9410003000	GLUCOSE BLOOD	9,675
4420101010	ALBUTEROL SULFATE	25,690
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMID	337
1210990315	ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE	317
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	445
4420990275	FLUTICASONE FUROATE-VILANTEROL	2,078
2710400200	INSULIN ASPART	1,154
6629003000	ETANERCEPT	133
6240552500	DIMETHYL FUMARATE	82
3010002000	SOMATROPIN	92
1210990430	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR DF	161
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	4,068
2717001500	DULAGLUTIDE	645
1210301510	DOLUTEGRAVIR SODIUM	270
5940002310	LURASIDONE HCL	333
6599000220	OXYCODONE W/ ACETAMINOPHEN	7,897
7260005700	PREGABALIN	797
4440003620	MOMETASONE FUROATE (INHALATION)	1,743
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,291
1250406020	OSELTAMIVIR PHOSPHATE	2,583
2770005000	EMPAGLIFLOZIN	761
5925001500	ARIPIPRAZOLE	1,404
6520001020	BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE	1,050
6599170210	HYDROCODONE-ACETAMINOPHEN	20,491
1210990339	EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE	121
9939405000	LENALIDOMIDE	20
8337006000	RIVAROXABAN	726
2770002000	CANAGLIFLOZIN	661
8582004010	ICATIBANT ACETATE	3
9025058500	USTEKINUMAB	18
5907005010	PALIPERIDONE PALMITATE	105
8337001000	APIXABAN	671
1210990330	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	95
1210990229	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE	157
5250502010	CERTOLIZUMAB PEGOL	56
1210990340	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE	80
3890004000	EPINEPHRINE (ANAPHYLAXIS)	710
2153402000	DASATINIB	20
1210990227	DARUNAVIR-COBICISTAT	120
7260003000	GABAPENTIN	13,788
9025057500	SECUKINUMAB	29
6240003010	GLATIRAMER ACETATE	34
2153106000	PALBOCICLIB	17
6240306045	INTERFERON BETA-1A	28
2710400600	INSULIN DETEMIR	415

Q1_2018		
Class	**Drug Class Name**	**Count of Claims**
6627001500	ADALIMUMAB	380
2710400300	INSULIN GLARGINE	4,362
2710400500	INSULIN LISPRO	2,267
4420101010	ALBUTEROL SULFATE	28,236
1235990235	GLECAPREVIR-PIBRENTASVIR	89
1235990230	ELBASVIR-GRAZOPREVIR	56
1210990429	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	344
9410003000	GLUCOSE BLOOD	9,336
1210990315	ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE	329
1235990265	SOFOSBUVIR-VELPATASVIR	34
1210990230	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	437
1250406020	OSELTAMIVIR PHOSPHATE	5,109
4420990275	FLUTICASONE FUROATE-VILANTEROL	1,872
2710400200	INSULIN ASPART	1,176
6629003000	ETANERCEPT	113
2717001500	DULAGLUTIDE	795
1210301510	DOLUTEGRAVIR SODIUM	302
6240552500	DIMETHYL FUMARATE	71
5940002310	LURASIDONE HCL	365
3010002000	SOMATROPIN	82
1210990430	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR DF	144
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	4,040
6110002510	LISDEXAMFETAMINE DIMESYLATE	1,355
7260005700	PREGABALIN	781
2770005000	EMPAGLIFLOZIN	852
4440003620	MOMETASONE FUROATE (INHALATION)	1,829
5925001500	ARIPIPRAZOLE	1,434
6520001020	BUPRENORPHINE HCL-NALOXONE HCL DIHYDRATE	1,109
6599000220	OXYCODONE W/ ACETAMINOPHEN	6,495
1210990229	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE	201
9025058500	USTEKINUMAB	21
8337006000	RIVAROXABAN	746
2770002000	CANAGLIFLOZIN	619
8337001000	APIXABAN	701
5907005010	PALIPERIDONE PALMITATE	113
1210990339	EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE	100
6599170210	HYDROCODONE-ACETAMINOPHEN	15,721
1210990330	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	95
2153406020	NILOTINIB HCL	22
9939405000	LENALIDOMIDE	19
3890004000	EPINEPHRINE (ANAPHYLAXIS)	800
1210990227	DARUNAVIR-COBICISTAT	130
5250502010	CERTOLIZUMAB PEGOL	49
1210990340	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE	86
4440001500	BUDESONIDE (INHALATION)	1,019
6240407000	TERIFLUNOMIDE	34
6240306045	INTERFERON BETA-1A	31
4420990295	UMECLIDINIUM-VILANTEROL	497
7260003000	GABAPENTIN	13,598
8582004010	ICATIBANT ACETATE	2

Health Plan of Nevada

Top 50 Drugs by Group by Claim Count

Q4_2017		
Class	**Drug Class Name**	**Count of Claims**
4420101010	ALBUTEROL SULFATE	25,690
6610002000	IBUPROFEN	23,621
6599170210	HYDROCODONE-ACETAMINOPHEN	20,491
0120001010	AMOXICILLIN	16,739
3610003000	LISINOPRIL	15,034
2725005000	METFORMIN HCL	14,136
3940001010	ATORVASTATIN CALCIUM	13,838
7260003000	GABAPENTIN	13,788
4220003230	FLUTICASONE PROPIONATE (NASAL)	11,646
2810001010	LEVOTHYROXINE SODIUM	11,104
3400000310	AMLODIPINE BESYLATE	10,714
4927006000	OMEPRAZOLE	10,440
4450505010	MONTELUKAST SODIUM	10,306
5710001000	ALPRAZOLAM	9,818
9410003000	GLUCOSE BLOOD	9,675
0340001000	AZITHROMYCIN	9,061
4155003000	LORATADINE	8,038
6599000220	OXYCODONE W/ ACETAMINOPHEN	7,897
5816007010	SERTRALINE HCL	6,705
3615004020	LOSARTAN POTASSIUM	6,618
2210004500	PREDNISONE	6,479
4155002010	CETIRIZINE HCL	6,275
5025006500	ONDANSETRON	6,218
7510005010	CYCLOBENZAPRINE HCL	5,972
5812008010	TRAZODONE HCL	5,891
3760004000	HYDROCHLOROTHIAZIDE	5,756
6610005200	MELOXICAM	5,559
0199000220	AMOXICILLIN & POT CLAVULANATE	5,477
6610006000	NAPROXEN	5,442
6510009510	TRAMADOL HCL	5,216
6510007510	OXYCODONE HCL	5,184
7720203200	CHOLECALCIFEROL	5,067
3320003010	METOPROLOL TARTRATE	4,827
7510009010	TIZANIDINE HCL	4,760
5915307010	QUETIAPINE FUMARATE	4,733
9720202500	LANCETS	4,687
5830004010	BUPROPION HCL	4,561
2710400300	INSULIN GLARGINE	4,373
4927007010	PANTOPRAZOLE SODIUM	4,366
5816004000	FLUOXETINE HCL	4,324
0210002000	CEPHALEXIN	4,308
3940007500	SIMVASTATIN	4,264
9055008510	TRIAMCINOLONE ACETONIDE (TOPICAL)	4,247
6410001000	ASPIRIN	4,173
5816003410	ESCITALOPRAM OXALATE	4,153
4920002010	RANITIDINE HCL	4,099
6020408010	ZOLPIDEM TARTRATE	4,098
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	4,068
4399580332	PSEUDOEPHED-BROMPHEN-DM	3,971
7210001000	CLONAZEPAM	3,892

Q1_2018

Class	Drug Class Name	Count of Claims
4420101010	ALBUTEROL SULFATE	28,236
6610002000	IBUPROFEN	24,120
0120001010	AMOXICILLIN	18,649
6599170210	HYDROCODONE-ACETAMINOPHEN	15,721
3610003000	LISINOPRIL	14,634
3940001010	ATORVASTATIN CALCIUM	14,015
2725005000	METFORMIN HCL	13,601
7260003000	GABAPENTIN	13,598
4220003230	FLUTICASONE PROPIONATE (NASAL)	12,289
2810001010	LEVOTHYROXINE SODIUM	10,916
4450505010	MONTELUKAST SODIUM	10,813
0340001000	AZITHROMYCIN	10,506
3400000310	AMLODIPINE BESYLATE	10,425
4927006000	OMEPRAZOLE	10,050
9410003000	GLUCOSE BLOOD	9,336
5710001000	ALPRAZOLAM	8,482
4155003000	LORATADINE	8,425
2210004500	PREDNISONE	7,112
5816007010	SERTRALINE HCL	6,690
3615004020	LOSARTAN POTASSIUM	6,677
4155002010	CETIRIZINE HCL	6,538
6599000220	OXYCODONE W/ ACETAMINOPHEN	6,495
0199000220	AMOXICILLIN & POT CLAVULANATE	6,104
5812008010	TRAZODONE HCL	6,075
5025006500	ONDANSETRON	6,055
7510005010	CYCLOBENZAPRINE HCL	5,819
6610006000	NAPROXEN	5,643
3760004000	HYDROCHLOROTHIAZIDE	5,480
6610005200	MELOXICAM	5,406
4399580332	PSEUDOEPHED-BROMPHEN-DM	5,121
1250406020	OSELTAMIVIR PHOSPHATE	5,109
7720203200	CHOLECALCIFEROL	5,094
5915307010	QUETIAPINE FUMARATE	4,869
6510007510	OXYCODONE HCL	4,581
3320003010	METOPROLOL TARTRATE	4,560
9720202500	LANCETS	4,511
7510009010	TIZANIDINE HCL	4,496
5830004010	BUPROPION HCL	4,455
2710400300	INSULIN GLARGINE	4,362
4927007010	PANTOPRAZOLE SODIUM	4,350
9055008510	TRIAMCINOLONE ACETONIDE (TOPICAL)	4,349
5816004000	FLUOXETINE HCL	4,277
4920002010	RANITIDINE HCL	4,132
3940007500	SIMVASTATIN	4,105
0210002000	CEPHALEXIN	4,077
5816003410	ESCITALOPRAM OXALATE	4,054
6110990210	AMPHETAMINE-DEXTROAMPHETAMINE	4,040
6410001000	ASPIRIN	3,983
1140701500	FLUCONAZOLE	3,765
4310201000	BENZONATATE	3,579

Top 50 Drugs By Claims- Q3 2017–Q1 2018

SilverSummith Healthplan

REPORT TYPE	REPORT DATE RANGE	RANK NUMBER	RANK NAME	SPECIALTY INDICATOR	CLAIM COUNT	UTILIZER COUNT
Top Drug By Claims	07/01/2017 - 03/31/2018	1	VENTOLIN HFA AER	No	3,453	2,099
Top Drug By Claims	07/01/2017 - 03/31/2018	2	IBU TAB 800MG	No	2,105	1,546
Top Drug By Claims	07/01/2017 - 03/31/2018	3	FLUTICASONE SPR 50MCG	No	1,904	1,269
Top Drug By Claims	07/01/2017 - 03/31/2018	4	AMOXICILLIN CAP 500MG	No	1,176	1,547
Top Drug By Claims	07/01/2017 - 03/31/2018	5	GABAPENTIN CAP 300MG	No	1,763	760
Top Drug By Claims	07/01/2017 - 03/31/2018	6	AZITHROMYCIN TAB 250MG	No	1,687	1,508
Top Drug By Claims	07/01/2017 - 03/31/2018	7	HYDROCO/APAP TAB 5-325MG	No	1,600	1,254
Top Drug By Claims	07/01/2017 - 03/31/2018	8	HYDROCO/APAP TAB 10-325MG	No	1,518	571
Top Drug By Claims	07/01/2017 - 03/31/2018	9	IBUPROFEN TAB 800MG	No	1,506	1,141
Top Drug By Claims	07/01/2017 - 03/31/2018	10	CYCLOBENZAPR TAB 10MG	No	1,382	753
Top Drug By Claims	07/01/2017 - 03/31/2018	11	NAPROXEN TAB 500MG	No	1,358	912
Top Drug By Claims	07/01/2017 - 03/31/2018	12	ALBUTEROL NEB 0.083%	No	1,256	958
Top Drug By Claims	07/01/2017 - 03/31/2018	13	ONDANSETRON TAB 4MG ODT	No	1,214	987
Top Drug By Claims	07/01/2017 - 03/31/2018	14	ATORVASTATIN TAB 20MG	No	1,198	421
Top Drug By Claims	07/01/2017 - 03/31/2018	15	AMLODIPINE TAB 10MG	No	1,193	465
Top Drug By Claims	07/01/2017 - 03/31/2018	16	MONTELUKAST TAB 10MG	No	1,181	468
Top Drug By Claims	07/01/2017 - 03/31/2018	17	METFORMIN TAB 1000MG	No	1,176	421
Top Drug By Claims	07/01/2017 - 03/31/2018	18	OXYCOD/APAP TAB 10-325MG	No	1,145	363
Top Drug By Claims	07/01/2017 - 03/31/2018	19	LORATADINE TAB 10MG	No	1,120	638
Top Drug By Claims	07/01/2017 - 03/31/2018	20	METFORMIN TAB 500MG	No	1,112	488
Top Drug By Claims	07/01/2017 - 03/31/2018	21	TIZANIDINE TAB 4MG	No	1,053	405
Top Drug By Claims	07/01/2017 - 03/31/2018	22	AMOXICILLIN SUS 400/5ML	No	1,025	924
Top Drug By Claims	07/01/2017 - 03/31/2018	23	VITAMIN D CAP 50000UNT	No	1,018	446
Top Drug By Claims	07/01/2017 - 03/31/2018	24	LISINOPRIL TAB 10MG	No	1,013	424
Top Drug By Claims	07/01/2017 - 03/31/2018	25	OMEPRAZOLE CAP 20MG	No	977	456
Top Drug By Claims	07/01/2017 - 03/31/2018	26	AMOX/K CLAV TAB 875-125	No	971	877
Top Drug By Claims	07/01/2017 - 03/31/2018	27	ATORVASTATIN TAB 40MG	No	967	367
Top Drug By Claims	07/01/2017 - 03/31/2018	28	TRAMADOL HCL TAB 50MG	No	949	675
Top Drug By Claims	07/01/2017 - 03/31/2018	29	SERTRALINE TAB 100MG	No	948	343
Top Drug By Claims	07/01/2017 - 03/31/2018	30	LISINOPRIL TAB 20MG	No	947	401
Top Drug By Claims	07/01/2017 - 03/31/2018	31	PREDNISONE TAB 20MG	No	946	824
Top Drug By Claims	07/01/2017 - 03/31/2018	32	TRAZODONE TAB 50MG	No	923	422
Top Drug By Claims	07/01/2017 - 03/31/2018	33	CEPHALEXIN CAP 500MG	No	916	838
Top Drug By Claims	07/01/2017 - 03/31/2018	34	METRONIDAZOL TAB 500MG	No	906	800
Top Drug By Claims	07/01/2017 - 03/31/2018	35	ALPRAZOLAM TAB 1MG	No	905	279
Top Drug By Claims	07/01/2017 - 03/31/2018	36	AMLODIPINE TAB 5MG	No	904	400
Top Drug By Claims	07/01/2017 - 03/31/2018	37	SERTRALINE TAB 50MG	No	903	456
Top Drug By Claims	07/01/2017 - 03/31/2018	38	PANTOPRAZOLE TAB 40MG	No	868	390
Top Drug By Claims	07/01/2017 - 03/31/2018	39	OMEPRAZOLE CAP 40MG	No	849	337
Top Drug By Claims	07/01/2017 - 03/31/2018	40	HYDROCO/APAP TAB 7.5-325	No	844	526
Top Drug By Claims	07/01/2017 - 03/31/2018	41	METHYLPRED TAB 4MG	No	842	747
Top Drug By Claims	07/01/2017 - 03/31/2018	42	TRAZODONE TAB 100MG	No	831	329
Top Drug By Claims	07/01/2017 - 03/31/2018	43	MELOXICAM TAB 15MG	No	808	374
Top Drug By Claims	07/01/2017 - 03/31/2018	44	ZOLPIDEM TAB 10MG	No	777	266
Top Drug By Claims	07/01/2017 - 03/31/2018	45	FLUCONAZOLE TAB 150MG	No	765	548
Top Drug By Claims	07/01/2017 - 03/31/2018	46	SUBOXONE MIS 8-2MG	No	745	127
Top Drug By Claims	07/01/2017 - 03/31/2018	47	ALPRAZOLAM TAB 0.5MG	No	723	322
Top Drug By Claims	07/01/2017 - 03/31/2018	48	SMZ/TMP DS TAB 800-160	No	712	620
Top Drug By Claims	07/01/2017 - 03/31/2018	49	BROM/PSE/DM SYP	No	706	651
Top Drug By Claims	07/01/2017 - 03/31/2018	50	GABAPENTIN TAB 600MG	No	693	240

Top 50 Drugs By Paid Amount- Q3 2017–Q1 2018

SilverSummith Healthplan

REPORT TYPE	REPORT DATE RANGE	RANK NUMBER	RANK NAME	SPECIALTY INDICATOR	CLAIM COUNT	UTILIZER COUNT
Top Drug By Spend	07/01/2017 - 03/31/2018	1	GENVOYA TAB	No	179	53
Top Drug By Spend	07/01/2017 - 03/31/2018	2	TRUVADA TAB 200-300	No	200	67
Top Drug By Spend	07/01/2017 - 03/31/2018	3	TIVICAY TAB 50MG	No	191	55
Top Drug By Spend	07/01/2017 - 03/31/2018	4	TRIUMEQ TAB	No	108	29
Top Drug By Spend	07/01/2017 - 03/31/2018	5	DESCOVY TAB 200/25	No	143	45
Top Drug By Spend	07/01/2017 - 03/31/2018	6	SUBOXONE MIS 8-2MG	No	745	127
Top Drug By Spend	07/01/2017 - 03/31/2018	7	EPCLUSA TAB 400-100	Yes	8	3
Top Drug By Spend	07/01/2017 - 03/31/2018	8	STRIBILD TAB	No	61	22
Top Drug By Spend	07/01/2017 - 03/31/2018	9	VENTOLIN HFA AER	No	3,453	2,099
Top Drug By Spend	07/01/2017 - 03/31/2018	10	MAVYRET TAB 100-40MG	Yes	12	7
Top Drug By Spend	07/01/2017 - 03/31/2018	11	ZEPATIER TAB 50-100MG	Yes	8	4
Top Drug By Spend	07/01/2017 - 03/31/2018	12	OXYCOD/APAP TAB 10-325MG	No	1,145	363
Top Drug By Spend	07/01/2017 - 03/31/2018	13	COMPLERA TAB	No	41	8
Top Drug By Spend	07/01/2017 - 03/31/2018	14	LEMTRADA INJ 12/1.2ML	Yes	1	1
Top Drug By Spend	07/01/2017 - 03/31/2018	15	VICTOZA INJ 18MG/3ML	No	151	51
Top Drug By Spend	07/01/2017 - 03/31/2018	16	LATUDA TAB 40MG	No	84	40
Top Drug By Spend	07/01/2017 - 03/31/2018	17	PREZCOBIX TAB 800-150	No	54	18
Top Drug By Spend	07/01/2017 - 03/31/2018	18	BASAGLAR INJ 100UNIT	No	240	95
Top Drug By Spend	07/01/2017 - 03/31/2018	19	LANTUS INJ SOLOSTAR	No	226	118
Top Drug By Spend	07/01/2017 - 03/31/2018	20	PRIVIGEN INJ 20GRAMS	Yes	6	1
Top Drug By Spend	07/01/2017 - 03/31/2018	21	LENVIMA CAP 20 MG	Yes	5	1
Top Drug By Spend	07/01/2017 - 03/31/2018	22	HUMALOG KWIK INJ 100/ML	No	145	69
Top Drug By Spend	07/01/2017 - 03/31/2018	23	SYMBICORT AER 160-4.5	No	252	131
Top Drug By Spend	07/01/2017 - 03/31/2018	24	TECFIDERA CAP 240MG	Yes	11	3
Top Drug By Spend	07/01/2017 - 03/31/2018	25	SYNAGIS INJ 100MG/ML	Yes	27	11
Top Drug By Spend	07/01/2017 - 03/31/2018	26	SUBOXONE MIS 12-3MG	No	108	24
Top Drug By Spend	07/01/2017 - 03/31/2018	27	JANUVIA TAB 100MG	No	156	60
Top Drug By Spend	07/01/2017 - 03/31/2018	28	XYREM SOL 500MG/ML	Yes	6	1
Top Drug By Spend	07/01/2017 - 03/31/2018	29	TAGRISSO TAB 80MG	Yes	5	1
Top Drug By Spend	07/01/2017 - 03/31/2018	30	TECFIDERA CAP 120MG	Yes	6	2
Top Drug By Spend	07/01/2017 - 03/31/2018	31	ELIQUIS TAB 5MG	No	183	71
Top Drug By Spend	07/01/2017 - 03/31/2018	32	HUMIRA PEN INJ 40MG/0.8	Yes	15	5
Top Drug By Spend	07/01/2017 - 03/31/2018	33	HUMALOG INJ 100/ML	No	154	66
Top Drug By Spend	07/01/2017 - 03/31/2018	34	XARELTO TAB 20MG	No	172	50
Top Drug By Spend	07/01/2017 - 03/31/2018	35	NOVOLOG INJ FLEXPEN	No	121	50
Top Drug By Spend	07/01/2017 - 03/31/2018	36	AUBAGIO TAB 14MG	Yes	10	2
Top Drug By Spend	07/01/2017 - 03/31/2018	37	COPAXONE INJ 40MG/ML	Yes	11	4
Top Drug By Spend	07/01/2017 - 03/31/2018	38	LIDOCAINE OIN 5%	No	121	81
Top Drug By Spend	07/01/2017 - 03/31/2018	39	ISENTRESS TAB 400MG	No	41	12
Top Drug By Spend	07/01/2017 - 03/31/2018	40	TRULICITY INJ 1.5/0.5	No	75	25
Top Drug By Spend	07/01/2017 - 03/31/2018	41	ATRIPLA TAB	No	20	7
Top Drug By Spend	07/01/2017 - 03/31/2018	42	OSELTAMIVIR SUS 6MG/ML	No	282	278
Top Drug By Spend	07/01/2017 - 03/31/2018	43	LATUDA TAB 80MG	No	44	23
Top Drug By Spend	07/01/2017 - 03/31/2018	44	DICLOFENAC GEL 3%	No	51	33
Top Drug By Spend	07/01/2017 - 03/31/2018	45	ZYTIGA TAB 250MG	Yes	5	2
Top Drug By Spend	07/01/2017 - 03/31/2018	46	LYRICA CAP 150MG	No	95	32
Top Drug By Spend	07/01/2017 - 03/31/2018	47	TOUJEO SOLO INJ 300IU/ML	No	119	33
Top Drug By Spend	07/01/2017 - 03/31/2018	48	PREZISTA TAB 800MG	No	32	12
Top Drug By Spend	07/01/2017 - 03/31/2018	49	ODEFSEY TAB	No	18	6
Top Drug By Spend	07/01/2017 - 03/31/2018	50	LEVEMIR INJ FLEXTOUC	No	127	55

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

Jul 17, 2018 9:30:02 AM

Client Totals:

Total Rxs	Plan Paid	Member Paid
645,194	$78,073,785	$0

DUR Information as a percent of total:

DUR Type	Total Rxs	Percent of Total Rxs - Paid	Cases	Rejected Rxs	Percent of Total Rxs - Rejects
Total Claims Paid	645,194	0.0%	0	0	0.0%
Cases / Rxs	482,832	74.8%	637,499	335,432	52.0%
DD - Drug-Drug Interaction	214,648	33.3%	412,680	158,078	24.5%
TD - Therapeutic Duplication	101,584	15.7%	87,573	107,179	16.6%
ID - Ingredient Duplication	52,586	8.2%	23,036	53,084	8.2%
LR - Underuse Precaution	47,622	7.4%	48,109	6,393	1.0%
LD - Low Dose Alert	25,875	4.0%	25,928	4,058	0.6%
MN - Insufficnt Duration Alert	15,994	2.5%	15,828	970	0.2%
HD - High Dose Alert	15,828	2.5%	15,619	3,245	0.5%
MX - Excessive Duration Alert	8,660	1.3%	8,681	2,425	0.4%
PA - Drug-Age Precaution	35	0.0%	45	0	0.0%

* More than one DUR message per paid, rejected or reversed claim(Cases > Rxs)
* Same claims could have multiple DUR messages. And there could multiple of the same DUR message on a claim
* This report does not include reversals.

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

Jul 17, 2018 9:30:02 AM

DD

Curr Rank	Top Drug Drug Interaction	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	LISINOPRIL - FUROSEMIDE	Message Only	3,250	1,054	$24,405.54	$7.51	$0.00	50.68	59.45
2	SIMVASTATIN - LISINOPRIL	Message Only	2,869	711	$22,484.23	$7.84	$0.00	56.17	58.70
3	HYDROCODONE/ ACETAMINOPHEN - ALPRAZOLAM	Message Only	2,767	303	$48,656.19	$17.58	$0.00	24.43	88.34
4	HYDROCO/APAP - ALPRAZOLAM	Message Only	2,363	402	$22,674.61	$9.60	$0.00	27.24	62.00
5	OXYCODONE HCL - ALPRAZOLAM	Message Only	1,992	367	$47,461.43	$23.83	$0.00	26.66	104.89
6	CLOPIDOGREL - ATORVASTATIN	Message Only	1,968	621	$19,179.83	$9.75	$0.00	43.46	43.46
7	QUETIAPINE FUMARATE - DIVALPROEX	Message Only	1,805	1,304	$23,536.75	$13.04	$0.00	24.72	38.53
8	OXYCODONE - ALPRAZOLAM	Message Only	1,798	366	$18,065.07	$10.05	$0.00	27.35	67.66
9	CLOPIDOGREL - ATORVASTATIN CALCIUM	Message Only	1,712	407	$18,140.02	$10.60	$0.00	44.98	45.73
10	MORPHINE SULFATE ER - GABAPENTIN	Message Only	1,697	229	$39,843.37	$23.48	$0.00	25.89	54.55
All Others			390,459	152,314	$24,021,857.28	$61.52	$0.00	33.18	60.16
Summary			**412,680**	**158,078**	**$24,306,304.32**	**$58.90**	**$0.00**	**33.36**	**60.33**

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

Jul 17, 2018 9:30:02 AM

HD

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	KETOROLAC TROMETHAMINE	GERIATRIC MAX DLY = 2.00UN	Message Only	484	65	$4,654.41	$9.62	$0.00	1.00	5.13
2	ZOLPIDEM TARTRATE	GERIATRIC MAX DLY = .50UN	Message Only	357	10	$1,136.56	$3.18	$0.00	29.32	29.26
3	OXYCODONE HCL	ADULT MAX DLY = 4.00 UN	Message Only	347	53	$14,881.07	$42.88	$0.00	25.73	146.81
4	MONTELUKAST SODIUM	PEDIATRIC MAX DLY = .50UN	Message Only	268	15	$3,440.66	$12.84	$0.00	35.09	35.09
5	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	189	152	$419,223.70	$2,218.11	$0.00	26.29	1.50
5	MIDAZOLAM HCL	GERIATRIC MAX DLY = 3.50UN	Message Only	189	17	$408.83	$2.16	$0.00	1.00	5.08
7	INVEGA SUSTENNA	ADULT MAX DLY = .05 UN	Message Only	180	0	$673,053.36	$3,739.19	$0.00	23.47	2.34
8	DEXAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 4.00UN	Message Only	156	2	$1,790.60	$11.48	$0.00	1.00	9.71
9	BETAMETHASONE SODIUM PHOS	GERIATRIC MAX DLY = 1.50UN	Message Only	138	1	$3,995.51	$28.95	$0.00	1.00	5.04
10	ESCITALOPRAM OXALATE	GERIATRIC MAX DLY = .50UN	Message Only	136	44	$683.20	$5.02	$0.00	38.37	38.37
All Others				13,175	2,886	$8,624,592.99	$654.62	$0.00	17.82	156.49
HD				**15,619**	**3,245**	**$9,747,860.89**	**$624.10**	**$0.00**	**17.86**	**137.28**

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

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ID

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	PROVENTIL HFA	PROVENTIL AER HFA	Message Only	418	26	$44,998.36	$107.65	$0.00	29.56	8.56
2	GABAPENTIN	GABAPENTIN CAP 300MG	Message Only	285	16	$3,846.69	$13.50	$0.00	38.53	110.43
3	SERTRALINE HCL	SERTRALINE TAB 100MG	Message Only	239	11	$2,888.75	$12.09	$0.00	35.19	48.29
4	AMLODIPINE BESYLATE	AMLODIPINE TAB 10MG	Message Only	189	7	$1,939.61	$10.26	$0.00	72.34	72.19
5	CLONIDINE HCL	CLONIDINE TAB 0.1MG	Message Only	181	13	$2,247.71	$12.42	$0.00	76.40	119.70
5	FLUTICASONE PROPIONATE	FLUTICASONE SPR 50MCG	Message Only	181	11	$2,415.16	$13.34	$0.00	37.03	17.39
7	TRAZODONE HCL	TRAZODONE TAB 50MG	Message Only	169	5	$1,744.61	$10.32	$0.00	35.14	39.13
8	SERTRALINE HCL	SERTRALINE TAB 50MG	Message Only	164	20	$1,899.49	$11.58	$0.00	39.20	43.04
9	METFORMIN HCL	METFORMIN TAB 500MG	Message Only	161	12	$1,747.13	$10.85	$0.00	72.18	140.94
10	ATORVASTATIN CALCIUM	ATORVASTATIN TAB 40MG	Message Only	160	5	$2,269.08	$14.18	$0.00	55.46	54.52
All Others				20,889	52,958	$3,564,179.71	$170.62	$0.00	40.77	94.04
ID				**23,036**	**53,084**	**$3,630,176.30**	**$157.59**	**$0.00**	**41.26**	**90.93**

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

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LD

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	ONDANSETRON ODT	GERIATRIC MIN DLY = 2.00UN	Message Only	964	23	$513.06	$0.53	$0.00	1.50	1.46
2	IPRATROPIUM BROMIDE/ ALBUT	GERIATRIC MIN DLY = 9.00UN	Message Only	683	24	$414.88	$0.61	$0.00	2.27	9.39
3	HEPARIN SODIUM	GERIATRIC MIN DLY = 4.00UN	Message Only	584	31	$1,429.61	$2.45	$0.00	1.24	1.89
4	POTASSIUM CHLORIDE ER	ADULT MIN DLY = 2.00 UN	Message Only	513	102	$8,352.92	$16.28	$0.00	41.67	40.92
5	METOPROLOL TARTRATE	ADULT MIN DLY = 2.00 UN	Message Only	405	77	$3,816.24	$9.42	$0.00	54.76	53.51
6	METOPROLOL TARTRATE	GERIATRIC MIN DLY = 2.00UN	Message Only	391	41	$970.79	$2.48	$0.00	25.91	25.18
7	ALBUTEROL SULFATE	GERIATRIC MIN DLY = 9.00UN	Message Only	382	13	$1,002.56	$2.62	$0.00	5.85	27.85
8	VITAMIN D3	ADULT MIN DLY = 1.50 UN	Message Only	380	20	$2,662.81	$7.01	$0.00	36.15	35.85
9	POTASSIUM CHLORIDE ER	GERIATRIC MIN DLY = 2.00UN	Message Only	319	35	$2,012.27	$6.31	$0.00	43.32	42.61
10	VITAMIN D3	GERIATRIC MIN DLY = 1.50UN	Message Only	312	16	$2,456.48	$7.87	$0.00	32.13	31.91
All Others				20,995	3,676	$3,363,087.01	$160.19	$0.00	29.28	56.45
LD				**25,928**	**4,058**	**$3,386,718.63**	**$130.62**	**$0.00**	**27.46**	**49.92**

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RXT6050D - Summarized DUR Activity Report

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LR

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	GABAPENTIN	7 DAYS LATE REFILLING	Message Only	82	6	$1,083.40	$13.21	$0.00	29.23	94.11
2	ATORVASTATIN CALCIUM	7 DAYS LATE REFILLING	Message Only	61	8	$637.37	$10.45	$0.00	31.08	32.56
3	PROVENTIL HFA	8 DAYS LATE REFILLING	Message Only	60	7	$5,527.50	$92.12	$0.00	23.30	7.48
3	PROVENTIL HFA	12 DAYS LATE REFILLING	Message Only	60	4	$5,706.69	$95.11	$0.00	21.98	7.48
3	GABAPENTIN	8 DAYS LATE REFILLING	Message Only	60	7	$815.49	$13.59	$0.00	29.50	98.53
3	PROVENTIL HFA	10 DAYS LATE REFILLING	Message Only	60	0	$5,714.52	$95.24	$0.00	23.07	7.70
7	PROVENTIL HFA	9 DAYS LATE REFILLING	Message Only	57	2	$5,103.78	$89.54	$0.00	21.86	7.29
8	PROVENTIL HFA	7 DAYS LATE REFILLING	Message Only	53	1	$5,070.65	$95.67	$0.00	23.02	7.71
9	LEVOTHYROXINE SODIUM	7 DAYS LATE REFILLING	Message Only	48	2	$525.42	$10.95	$0.00	31.29	29.23
10	PROVENTIL HFA	14 DAYS LATE REFILLING	Message Only	47	3	$4,683.10	$99.64	$0.00	23.26	7.84
10	PROVENTIL HFA	11 DAYS LATE REFILLING	Message Only	47	4	$4,463.46	$94.97	$0.00	21.32	7.41
All Others				47,474	6,349	$6,756,308.17	$142.32	$0.00	32.91	62.60
LR				**48,109**	**6,393**	**$6,795,639.55**	**$141.26**	**$0.00**	**32.81**	**62.19**

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

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MN

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	IPRATROPIUM BROMIDE/ ALBUT	MIN. DAYS THERAPY = 30	Message Only	1,528	220	$12,774.16	$8.36	$0.00	5.66	72.05
2	LISINOPRIL	MIN. DAYS THERAPY = 7	Message Only	556	12	$106.50	$0.19	$0.00	1.04	1.50
3	PANTOPRAZOLE SODIUM	MIN. DAYS THERAPY = 7	Message Only	467	6	$93.08	$0.20	$0.00	1.04	1.09
4	LEVETIRACETAM	MIN. DAYS THERAPY = 14	Message Only	440	30	$2,100.01	$4.77	$0.00	2.89	22.32
5	SENSIPAR	MIN. DAYS THERAPY = 7	Message Only	418	4	$228,910.06	$547.63	$0.00	1.08	57.66
6	METOPROLOL TARTRATE	MIN. DAYS THERAPY = 7	Message Only	362	18	$106.22	$0.29	$0.00	1.09	1.55
7	AMLODIPINE BESYLATE	MIN. DAYS THERAPY = 7	Message Only	350	6	$81.02	$0.23	$0.00	1.05	1.20
8	ATORVASTATIN CALCIUM	MIN. DAYS THERAPY = 7	Message Only	292	6	$144.02	$0.49	$0.00	1.15	1.64
9		ING01 MIN DAYS THERAPY = 5	Message Only	284	0	$28,129.18	$99.05	$0.00	1.52	65.78
9	QUETIAPINE FUMARATE	MIN. DAYS THERAPY = 7	Message Only	284	24	$304.87	$1.07	$0.00	1.25	3.51
All Others				10,847	644	$1,510,698.25	$139.27	$0.00	2.12	21.21
MN				**15,828**	**970**	**$1,783,447.37**	**$112.68**	**$0.00**	**2.29**	**25.05**

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RXT6050D - Summarized DUR Activity Report

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MX

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	CYCLOBENZAPRINE HCL	MAX DAYS THERAPY = 21	Message Only	2,413	1,791	$23,325.13	$9.67	$0.00	31.86	67.50
2	CYCLOBENZAPRINE HCL	MAX DAYS THERAPY = 21	Message Only	1,536	0	$16,177.83	$10.53	$0.00	32.39	72.77
3	FLUCONAZOLE	MAX DAYS THERAPY = 1	Message Only	533	132	$6,144.21	$11.53	$0.00	7.02	3.16
4	EPINEPHRINE	MAX DAYS THERAPY = 1	Message Only	502	15	$155,711.55	$310.18	$0.00	11.72	2.33
5	AZITHROMYCIN	MAX DAYS THERAPY = 5	Message Only	302	50	$6,541.87	$21.66	$0.00	15.25	23.04
6	PHENAZOPYRIDINE HCL	MAX DAYS THERAPY = 2	Message Only	253	5	$7,086.99	$28.01	$0.00	7.00	18.45
7	MAPAP	MAX DAYS THERAPY = 10	Message Only	222	16	$1,987.15	$8.95	$0.00	27.54	109.92
8	POLYETHYLENE GLYCOL 3350	MAX DAYS THERAPY = 14	Message Only	209	19	$6,822.37	$32.64	$0.00	34.31	36.02
9	SENEXON-S	MAX DAYS THERAPY = 14	Message Only	191	13	$1,561.38	$8.17	$0.00	31.15	59.04
10	DIPHENOXYLATE/ ATROPINE	MAX DAYS THERAPY = 14	Message Only	167	12	$5,374.37	$32.18	$0.00	30.80	96.84
All Others				2,353	372	$527,359.25	$224.12	$0.00	32.70	71.86
MX				**8,681**	**2,425**	**$758,092.10**	**$87.33**	**$0.00**	**28.10**	**59.63**

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RXT6050D - Summarized DUR Activity Report

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PA

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	PROMETHAZINE HCL PLAIN	AGE LESS THAN 4	Message Only	10	0	$73.26	$7.33	$0.00	21.60	44.80
2	NITROFURANTOIN	AGE LESS THAN 4	Message Only	7	0	$1,901.02	$271.57	$0.00	8.29	220.00
2	ACETAMINOPHEN/ CODEINE	AGE LESS THAN 10	Message Only	7	0	$84.75	$12.11	$0.00	7.86	211.86
4	PROMETHAZINE-DM	AGE LESS THAN 4	Message Only	4	0	$32.29	$8.07	$0.00	6.50	48.75
5	PROMETHAZINE/ CODEINE	AGE LESS THAN 10	Message Only	3	0	$28.00	$9.33	$0.00	11.00	100.00
5	NITROFURANTOIN MACROCRYST	AGE LESS THAN 4	Message Only	3	0	$1,373.64	$457.88	$0.00	90.00	90.00
5	ACETAMINOPHEN/ CODEINE	AGE LESS THAN 4	Message Only	3	0	$28.48	$9.49	$0.00	4.67	43.33
8		ING01 AGE LESS THAN 4	Message Only	2	0	$27.65	$13.82	$0.00	30.00	80.00
8	PHENADOZ	AGE LESS THAN 4	Message Only	2	0	$88.78	$44.39	$0.00	2.00	6.00
8	TRAMADOL HCL	AGE LESS THAN 10	Message Only	2	0	$20.52	$10.26	$0.00	7.50	5.00
All Others				2	0	$35.04	$17.52	$0.00	4.00	30.25
PA				**45**	**0**	**$3,693.43**	**$82.08**	**$0.00**	**16.87**	**102.41**

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RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

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TD

Curr Rank	Top Drug	Therapy / Reason	DUR Response	Paid Rxs	Rejected Rxs	Plan Paid	Plan Paid Per Rx	Member Paid Per Rx	Days Supply Per Rx	Quantity Per Rx
1	QUETIAPINE FUMARATE	ORAL ANTIPSYCHOTICS	Message Only	2,789	0	$39,577.29	$14.19	$0.00	30.22	42.52
2	RISPERIDONE	ORAL ANTIPSYCHOTICS	Message Only	1,706	0	$21,089.87	$12.36	$0.00	30.34	51.97
3	GABAPENTIN	GABAPENTIN AND RELATED	Message Only	1,392	0	$22,420.69	$16.11	$0.00	36.56	116.00
4	ARIPIPRAZOLE	ORAL ANTIPSYCHOTICS	Message Only	1,173	0	$28,960.47	$24.69	$0.00	30.93	33.61
5	LISINOPRIL	ANGIOTENSIN BLOCKERS	Message Only	1,077	0	$11,005.74	$10.22	$0.00	68.58	74.05
6	LEVOTHYROXINE SODIUM	THYROID HORMONES	Message Only	1,009	0	$18,905.34	$18.74	$0.00	52.38	51.51
7	SERTRALINE HCL	SSRIS AND SNRIS	Message Only	902	0	$10,336.02	$11.46	$0.00	37.00	43.23
8	OLANZAPINE	ORAL ANTIPSYCHOTICS	Message Only	877	0	$12,580.21	$14.34	$0.00	29.44	37.34
9	ATORVASTATIN CALCIUM	STATINS	Message Only	849	0	$10,371.00	$12.22	$0.00	56.09	56.38
10	QUETIAPINE FUMARATE	ANTIPSYCHOTICS	Message Only	820	0	$12,013.74	$14.65	$0.00	29.99	42.69
All Others				74,979	107,179	$15,093,405.73	$201.30	$0.00	32.47	81.32
TD				**87,573**	**107,179**	**$15,280,666.10**	**$174.49**	**$0.00**	**33.29**	**77.56**

RXT6050D - Summarized DUR Activity Report

Between 2018-04-01 and 2018-06-30

Selected Filters

Client(s): Nevada Medicaid - HPES

Carrier(s): NVM-NEVADA MEDICAID

Account(s): ALL

Group(s): ALL

Date Type:	Date Filled Submitted
Start Date:	2018-04-01
End Date:	2018-06-30
Relative Description:	Select Date Range
Display Report Description:	No
Top Values to Display:	10

C DUR Q4 2017 SilverSummit Healthplan

Count of CLAIM PAID/REJECTED	Column Labels			
Row Labels	OCTOBER	NOVEMBER	DECEMBER	Grand
Apparent Drug Misuse	**158**	**321**	**658**	**1137**
Paid	97	241	472	810
Rejected	51	55	113	219
Reversal	10	25	73	108
Buprenorphine with Opioid	**1**	**8**	**14**	**23**
Rejected	1	8	14	23
Cumulative APAP Check	**10**	**14**	**5**	**29**
Rejected	10	14	5	29
Cumulative Morphine Equivalent Dose	**165**	**126**	**148**	**439**
Paid	6	5		11
Rejected	159	120	148	427
Reversal		1		1
Drug-Age Precaution	**3**	**6**	**7**	**16**
Paid	2	6	3	11
Rejected			4	4
Reversal	1			1
Drug-Disease Precaution	**355**	**461**	**524**	**1340**
Paid	261	323	404	988
Rejected	62	66	82	210
Reversal	32	72	38	142
Drug-Drug Interaction	**951**	**1128**	**1505**	**3584**
Paid	690	834	1035	2559
Rejected	180	185	339	704
Reversal	81	109	131	321
Drug-Pregnancy Alert	**20**	**24**	**28**	**72**
Paid	11	15	19	45
Rejected	2	6	4	12
Reversal	7	3	5	15
Excessive Duration Alert	**280**	**363**	**463**	**1106**
Paid	215	271	327	813
Rejected	37	39	43	119
Reversal	28	53	93	174
High Dose Alert	**352**	**430**	**647**	**1429**
Paid	226	277	427	930
Rejected	61	81	127	269
Reversal	65	72	93	230
Ingredient Duplication	**1179**	**1430**	**1903**	**4512**
Paid		4	5	9
Rejected	1179	1425	1898	4502
Reversal		1		1
Low Dose Alert	**670**	**775**	**1135**	**2580**
Paid	468	572	801	1841
Rejected	85	86	137	308
Reversal	117	117	197	431
Refill too Soon	**385**	**470**	**579**	**1434**
Rejected	385	470	579	1434
Therapeutic Duplication	**2138**	**2628**	**3736**	**8502**
Paid	770	941	1186	2897
Rejected	1211	1468	2264	4943
Reversal	157	219	286	662
Underuse Precaution	**509**	**881**	**1527**	**2917**
Paid	369	656	1103	2128
Rejected	64	82	148	294
Reversal	76	143	276	495
Grand Total	**7176**	**9065**	**12879**	**29120**

C DUR Q1 2018 SilverSummit Healthplan

Count of CLAIM PAID/REJECTED	Column Labels					
Row Labels	January	February		March December	(blank)	Grand Total
Apparent Drug Misuse	**702**	**601**		**764**	**1**	**2068**
Paid	540	496		620	1	1657
Rejected	99	58		74		231
Reversal	63	47		70		180
Buprenorphine with Opioid	**5**	**5**		**5**		**15**
Rejected	5	5		5		15
Cumulative APAP Check	**14**	**9**		**7**		**30**
Paid	4	1		1		6
Rejected	10	8		6		24
Cumulative Morphine Equivalent Dose	**176**	**186**		**202**	**1**	**565**
Paid	9	5		8	1	23
Rejected	163	176		192		531
Reversal	4	5		2		11
Drug-Age Precaution	**5**	**7**		**11**		**23**
Paid	3	5		11		19
Rejected			1			1
Reversal	2		1			3
Drug-Disease Precaution	**563**	**498**		**673**	**5**	**1739**
Paid	408	360		468	5	1241
Rejected	84	79		131		294
Reversal	71	59		74		204
Drug-Drug Interaction	**1325**	**1217**		**1579**	**10**	**4131**
Paid	933	895		1120	10	2958
Rejected	236	199		295		730
Reversal	156	123		164		443
Drug-Gender Alert		**1**		**7**		**8**
Rejected		1		7		8
Drug-Pregnancy Alert	**24**	**30**		**41**		**95**
Paid	20	23		26		69
Rejected	2	3		5		10
Reversal	2	4		10		16
Excessive Duration Alert	**514**	**446**		**541**		**1501**
Paid	381	330		397		1108
Rejected	58	47		77		182
Reversal	75	69		67		211
High Dose Alert	**551**	**544**		**614**	**3**	**1712**
Paid	376	382		408	2	1168
Rejected	85	85		98	1	269
Reversal	90	77		108		275
Ingredient Duplication	**1862**	**1966**		**2550**	**3**	**6381**
Paid	8	5		5		18
Rejected	1854	1958		2545	3	6360
Reversal			3			3
Low Dose Alert	**1192**	**1129**		**1395**	**2**	**3718**
Paid	828	811		961	2	2602
Rejected	172	128		195		495
Reversal	192	190		239		621
Refill too Soon	**641**	**2057**		**3828**		**6526**
Rejected	641	2057		3828		6526
Therapeutic Duplication	**3447**	**3505**		**4576**	**13**	**11541**
Paid	1246	1175		1539	10	3970
Rejected	1933	2050		2695	2	6680
Reversal	268	280		342	1	891
Underuse Precaution	**1757**	**1968**		**2407**	**3**	**6135**
Paid	1344	1474		1776	1	4595
Rejected	161	155		241		557
Reversal	252	339		390	2	983
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Grand Total	**12778**	**14169**		**19200**	**41**	**46188**