DRUG USE REVIEW BOARD
MCO PRIOR AUTHORIZATION CRITERIA REVIEW FORM

Clinical criteria for drugs or drug classes listed on the appropriate agenda, will be presented at the quarterly Drug Use Review Board meetings. This form will allow Managed Care Organizations to approve or disapprove the proposed criteria and suggest changes to be supported at the quarterly meeting.

DUR Meeting Date: April 28, 2022

Prior Authorization Criteria being reviewed: Austedo

Managed Care Organization name: Molina Healthcare Inc

Please place a check mark in the appropriate box:

☒ I approve the criteria as presented by OptumRx

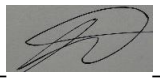
☐ I disapprove of the criteria as presented by OptumRx

I recommend the following changes to the criteria as presented. Please be brief and identify the section of the proposed criteria. If you feel you need more space for proposed changes, you may attach a word document, with only the suggested changes to criteria being presented.

You will have an opportunity to support the recommended changes at the time of the Drug Use Review Board quarterly meeting.

If this form is not completed and returned to the policy specialist with DHCFP by the designated deadline, the assumption will be made that you approve all prior authorization criteria as presented.

Please print the name of the individual completing this form: _Jimmy Tran_____

Signature of individual completing this form: _____  _____

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DUR Meeting Date: April 28, 2022

Prior Authorization Criteria being reviewed: Ingrezza

Managed Care Organization name: Molina Healthcare Inc

Please place a check mark in the appropriate box:

☒ I approve the criteria as presented by OptumRx

☐ I disapprove of the criteria as presented by OptumRx

I recommend the following changes to the criteria as presented. Please be brief and identify the section of the proposed criteria. If you feel you need more space for proposed changes, you may attach a word document, with only the suggested changes to criteria being presented.

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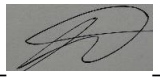
Signature of individual completing this form: _____  _____

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DUR Meeting Date: April 28, 2022

Prior Authorization Criteria being reviewed: Hetlioz

Managed Care Organization name: Molina Healthcare Inc

Please place a check mark in the appropriate box:

☒ I approve the criteria as presented by OptumRx

☐ I disapprove of the criteria as presented by OptumRx

I recommend the following changes to the criteria as presented. Please be brief and identify the section of the proposed criteria. If you feel you need more space for proposed changes, you may attach a word document, with only the suggested changes to criteria being presented.

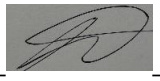
Hetlioz capsule

a. Recommend to add the following to Non-24-Hour Sleep-Wake Disorder: Patient is 18 years of age or older

You will have an opportunity to support the recommended changes at the time of the Drug Use Review Board quarterly meeting.

If this form is not completed and returned to the policy specialist with DHCFP by the designated deadline, the assumption will be made that you approve all prior authorization criteria as presented.

Please print the name of the individual completing this form: _Jimmy Tran_____

Signature of individual completing this form: _____  _____

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Clinical criteria for drugs or drug classes listed on the appropriate agenda, will be presented at the quarterly Drug Use Review Board meetings. This form will allow Managed Care Organizations to approve or disapprove the proposed criteria and suggest changes to be supported at the quarterly meeting.

DUR Meeting Date: April 28, 2022

Prior Authorization Criteria being reviewed: Respiratory Monoclonal Antibody Agents

Managed Care Organization name: Molina Healthcare Inc

Please place a check mark in the appropriate box:

☒ I approve the criteria as presented by OptumRx

☐ I disapprove of the criteria as presented by OptumRx

I recommend the following changes to the criteria as presented. Please be brief and identify the section of the proposed criteria. If you feel you need more space for proposed changes, you may attach a word document, with only the suggested changes to criteria being presented.

You will have an opportunity to support the recommended changes at the time of the Drug Use Review Board quarterly meeting.

1. Cinqair
    a. Recommend to add the following to Bullet 2: as defined as baseline (pre-treatment) blood eosinophil level greater than or equal to 150 cells per microliter or greater than 300 cells/microliter in the past 12 months
    b. Recommend to remove Bullet 6: There is insufficient evidence to recommend routine pneumococcal vaccination in asthmatic patients
    c. There is no Re-auth criteria. Recommend to add the following: Documentation of positive clinical response to Cinqair therapy
2. Dupixent
    a. Recommend to add the following to Bullet 2.2.2.1: or greater than 300 cells/microliter in the past 12 months
    b. Recommend to remove bullet 3.2. dupixent is indicated as an add-on for uncontrolled CRsW NP

If this form is not completed and returned to the policy specialist with DHCFP by the designated deadline, the assumption will be made that you approve all prior authorization criteria as presented.

Please print the name of the individual completing this form: _Jimmy Tran_____

Signature of individual completing this form: _____  _____

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DUR Meeting Date: April 28, 2022

Prior Authorization Criteria being reviewed: Vuity (pilocarpine)

Managed Care Organization name: Molina Healthcare Inc

Please place a check mark in the appropriate box:

☒ I approve the criteria as presented by OptumRx

☐ I disapprove of the criteria as presented by OptumRx

I recommend the following changes to the criteria as presented. Please be brief and identify the section of the proposed criteria. If you feel you need more space for proposed changes, you may attach a word document, with only the suggested changes to criteria being presented.

You will have an opportunity to support the recommended changes at the time of the Drug Use Review Board quarterly meeting.

Vuity

c. Recommend to add the following: Recipient is 18 years of age or older

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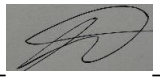
Signature of individual completing this form: _____  _____