DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Therapeutic Class: Colony Stimulating Factors
Last Reviewed by the DUR Board: July 25, 2013

Colony Stimulating Factors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act 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 for medications will be given if the following criteria are met.

   A. The requested agent is being used for an FDA-approved indication.

   B. Requests for a diagnosis of nonmyeloid malignancy must meet one of the following:
      1) The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of ≥ 20%; **or**
      2) The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65, absolute neutrophil count (ANC) <100 cells/µL, or the expected duration of neutropenia is > 10 days); **or**
      3) The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as secondary prophylaxis.

2. **Prior Authorization Guidelines:**

   A. Prior authorization will be given for one month

3. **Quantity Limitations**:
   A. Neulasta: 1.2 mLs/7 days

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Therapeutic Class: μ-opioid receptor agonist/δ-opioid receptor antagonist/κ-receptor agonist
Last Reviewed by the DUR Board: N/A

1. **Coverage and limitations:**

   Approval for eluxadoline (Viberzi®) will be given if the following criteria are met.

   A. The recipient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D)
      AND
   B. The recipient is 18 years of age or older
      AND
   C. The requested agent is prescribed by or in consultation with a gastroenterologist
      AND
   D. The requested dose is 75 mg twice daily or 100 mg twice daily
      AND
   E. One of the following:
      1) Inadequate response or adverse reaction to one of the following: loperamide, diphenoxylate/atropine, bile acid sequestrants (e.g. cholestyramine, colestipol, colesevelam), tricyclic antidepressants (TCAs), or selective serotonin reuptake inhibitors (SSRIs)
         OR
      2) Contraindication to ALL of the alternatives noted above

2. **Prior Authorization Guidelines:**

   A. Prior authorization will be given for one year

3. **Quantity Limitations**:
   A. eluxadoline (Viberzi®): 2/day

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Therapeutic Class: Antihistamine/vitamin B6 analog
Last Reviewed by the DUR Board: N/A

1. **Coverage and limitations:**

   Initial approval for Diclegis® (doxylamine/pyridoxine delayed-release) tablet will be given if the following criteria are met:

   A. The recipient is female
      AND
   B. The recipient is 18 years of age or older
      AND
   C. The recipient has a diagnosis of Nausea and Vomiting of Pregnancy (NVP)
      AND
   D. The requested dose does is 4 tablets/day or less

   Recertification for Diclegis® (doxylamine/pyridoxine delayed-release) tablet will be given if the following is met:

   A. There is documentation that the recipient continues to experience nausea and vomiting of pregnancy

2. **Prior Authorization Guidelines:**

   A. Length of prior authorization will be:
      1) Initial approval: six months
      2) Recertification: three months

3. **Quantity Limitations**:
   A. Doxylamine/pyridoxine delayed-release tablets (Diclegis®): 4 tablets/day

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Therapeutic Class: Neurokinin-1 antagonists and combinations
Last Reviewed by the DUR Board: N/A

1. **Coverage and limitations:**

   Requests that exceed the quantity limit may be approved if the following criteria are met:

   A. The requested agent is being used for an FDA-approved indication.

   B. One of the following:
      1) The recipient is 18 years of age or older; or
      2) The recipient is 12 years of age or older, the requested agent is aprepitant, and the diagnosis is chemotherapy induced nausea and vomiting (CINV)

   C. Medical necessity for exceeding the quantity limit (e.g. duration of chemotherapy cycle) is documented

2. **Prior Authorization Guidelines:**
   A. Prior authorization will be given for 6 months

3. **Quantity Limitations**:
   A. Emend® (aprepitant) 40 mg cap: 1 capsule/Rx; 2 capsules/month
   B. Emend® (aprepitant) 80 mg cap: 2 capsules/Rx; 2 capsules/14 days
   C. Emend® (aprepitant) 125 mg cap: 1 capsule/Rx; 1 capsule/14 days
   D. Emend® (aprepitant) dose pack: 1 pack/Rx; 1 pack/14 days
   E. Emend® (fosaprepitant) 150 mg injection: 1 vial/14 days
   F. Varubi® (rolapitant) 90 mg tablet: 2 tablets/Rx; 2 tablets/14 days
   G. Akynzeo® (netupitant/palonosetron) 300/0.5 mg: 1 capsule/Rx; 1 capsules/14 days

DIVISION OF HEALTH CARE FINANCING AND POLICY
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Therapeutic Class: Narcotic Withdrawal Therapy Agents
Last Reviewed by the DUR Board: July 25, 2013

1. **Coverage and limitations:**

   Nevada Medicaid encourages recipients to participate in formal substance abuse counseling and treatment.

   A. The recipient is 16 years of age or older

   B. The recipient has a diagnosis of opioid dependence

   C. Requests for a diagnosis of chronic pain will not be approved

   D. There is documentation the recipient has honored all of their office visits

   E. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique "X" DEA number

   F. All of the following:
      1) The recipient will not utilize opioids, including tramadol, concurrently with the requested agent; and
      2) If the recipient is currently utilizing an opioid, medical documentation must be provided stating the recipient will discontinue the opioid prior to initiation of buprenorphine or buprenorphine/naloxone

   G. Requests for buprenorphine will be approved if one of the following is met:
      1) The recipient is a pregnant female; or
      2) There is documentation that the recipient is breastfeeding an infant who is dependent on methadone or morphine
      3) The recipient has had an allergy to a buprenorphine/naloxone
      4) The recipient has moderate to severe hepatic impairment (Child-Pugh B to C)

   H. Requests that exceed the quantity limit must meet ALL of the following:
      1) There is documentation in the recipient's medical record that the requested dose is the lowest effective dose for the recipient
      2) Treatment plan has been provided

2. **Prior Authorization Guidelines:**
   A. Prior authorization will be given for one year

3. **Quantity Limitations**:
   A. buprenorphine sublingual tablets: 3/day
   B. buprenorphine/naloxone sublingual film (Suboxone®): 2/day
   C. buprenorphine/naloxone sublingual tablet (Zubsolv®): 1/day
   D. buprenorphine/naloxone sublingual tablet: 3/day
   E. buprenorphine/naloxone buccal film (Bunavail®): 2 units/day

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Therapeutic Class: Opioid-Induced Constipation Agents
Last Reviewed by the DUR Board: N/A

1. **Coverage and limitations:**

   Approval of medications will be given if the following criteria are met:

   A. The recipient is 18 years of age or older
      AND
   B. The requested agent is being used for an appropriate indication
      AND
   C. Requests for a diagnosis of opioid-induced constipation must meet all of the following criteria:
      1) There is documentation in the recipient's medical record indicating an inadequate response, adverse reaction, or contraindication to 1 agent from three of the four traditional laxative therapy classes:
         a. Bulk forming laxatives
         b. Osmotic laxatives
         c. Saline laxatives
         d. Stimulant laxatives

      AND
   D. Requests for methylnaltrexone bromide that exceed the quantity limit must meet all of the following criteria:
      1) The recipient has opioid-induced constipation in advanced illness and is receiving palliative care; and
      2) The requested dose is 0.15 mg/kg; and
      3) The recipient's current weight is >114 kg

2. **Prior Authorization Guidelines:**

   A. Prior authorization will be given for one year

3. **Quantity Limitations**:
   A. Lubiprostone (Amitiza®): 2 capsules/day
   B. Methylnaltrexone bromide (Relistor®): 1 vial or syringe/day
   C. Naloxegol oxylate (Movantik®): 1 tablet/day

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Long-Acting Narcotics

Therapeutic Class: Analgesics, Narcotic

Long-Acting Narcotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act 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:

The current policy for use of fentanyl transdermal patches or oxycodone/acetaminophen ER tablets is to be followed. For all other long-acting narcotics:

Requests that exceed the quantity limit must meet the following criteria:

A. The recipient has a diagnosis of terminal cancer;
OR
B. All of the following
   1. The recipient 18 years of age or older;
      AND
   2. The requested agent will be used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment;
      AND
   3. There is documentation in the recipient's medical record that alternative agents (e.g. non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated or would be otherwise inadequate to provide sufficient management of pain.

2. Prior Authorization Guidelines:

Prior Authorization approval will be for a three months

3. Quantity Limits:
- buprenorphine transdermal patch (Butrans): 4 patches/30 days
- hydrocodone ER capsule (Zohydro ER): 2/day
- hydrocodone ER tablet (Hysingla ER): 1/day
- hydromorphone ER tablet (Exalgo): 1/day
- morphine sulfate ER capsule (Avinza): 1/day
- morphine sulfate ER capsule (Kadian): 2/day
- morphine sulfate ER tablet (MS Contin): 3/day
- oxycodone ER tablet (OxyContin): 3/day
- oxymorphone ER tablet (Opana ER): 2/day
- tapentadol ER tablet (Nucynta ER): 2/day
- oxycodone/acetaminophen ER (Xartemis XR): 4/day
- morphine sulfate/naltrexone ER (Embeda): 1/day