# Appendix Y

COLORADO
Department of Health Care Policy & Financing

**Physician-Administered Drug Prior Authorization Procedures, Coverage Policies and Drug Utilization Criteria**
**For the Health First Colorado Medical Benefit**

Physician-Administered Drugs (PADs) requiring a prior authorization (PA) for the Health First Colorado medical benefit are listed in this document. Prior authorization criteria is based on FDA product labeling, CMS approved compendia, clinical practice guidelines, and peer-reviewed medical literature.

**Physician-Administered Drugs and Medical Billing**
PADs include any medication or medication formulation that requires administration by a healthcare professional, including cases where FDA package labeling for a medication specifies that administration should be performed by or under the direct supervision of a healthcare professional. PADs administered in a provider's office or clinic should be billed through the Health First Colorado medical benefit using the standard buy-and-bill process following procedures in the PAD Billing Manual (found on the PAD Resources Page at https://www.colorado.gov/hcpf/physician-administered-drugs).

PAD criteria listed on Appendix Y applies specifically to medications billed through the Health First Colorado medical benefit.
- Only PADs administered by a healthcare professional in the member's home or in a long-term care facility should be billed through the Health First Colorado pharmacy benefit (see "Medical VS. Pharmacy Benefit Medication Coverage" section below).

**Prior Authorization Procedures**
- Prior authorization requests may be submitted via the Kepro PAR portal at https://portal.kepro.com/. For PA assistance or questions, you may contact Kepro via the following methods:
  Phone: (720) 689 - 6340
  Fax: (833) 923 - 2359
  Email: COproviderissue@kepro.com
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons cannot sign the PA form.
- Physicians or assistants who are acting as the agents of the physicians may request a PA by phone.
- Please note that initiating therapy with a requested drug product, including non-preferred drugs, prior to a PA request being reviewed and approved does not necessitate approval of the PA request. This includes initiating therapy by administration in the inpatient setting, by using office samples or by any other means.
- All PA requests are coded online into the PA system.

**Trial and Failure**
- Generally, failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to therapy or significant drug-drug interaction. For medications that use a varying definition of failure, the definition will be noted in the medication's specific criteria, below.

**Medical VS. Pharmacy Benefit Medication Coverage**
- For more information about pharmacy benefits versus medical benefits please see the Pharmaceutical Benefit Help Guide (found on the PAD resources page at https://hcpf.colorado.gov/physician-administered-drugs).

- Medications administered by a healthcare professional or self-administered in the member's home or long-term care facility should be billed through the Health First Colorado pharmacy benefit following the standards and procedures outlined in the Pharmacy Billing Manual (found on the Pharmacy Resources Page at https://hcpf.colorado.gov/pharmacy-resources).
- PADs are medications administered in a doctor's office, clinic, outpatient hospital or dialysis unit are only to be billed by those facilities through the Health First Colorado medical benefit using the standard buy-and-bill process and following procedures outlined in the PAD Billing Manual (located at https://www.colorado.gov/hcpf/physician-administered-drugs ). PAD criteria listed on Appendix Y applies specifically to drug products when billed through the Health First Colorado medical benefit, when administered in the clinic or office setting.

| HCPCS | Drug | Criteria | PAR Length |
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| **J0172** | **Aduhelm® (aducanumab-avwa)** | **Aduhelm** (aducanumab-avwa) may be approved if the member meets ALL the following criteria:<br>a. Member has documented diagnosis of mild cognitive impairment or mild dementia stage of Alzheimer's disease, the population in which treatment was initiated in clinical trials, as evidenced by ALL of the following:<br>i. Positron Emission Tomography (PET) scan OR lumbar puncture positive for amyloid beta plaque<br>ii. Clinical Dementia Rating global score (CDR-GS) of 0.5 or 1 (available at https://otm.wustl.edu/cdr-terms-agreement/)<br>iii. Mini-Mental State Examination (MMSE) score of 24-30 OR Montreal Cognitive Assessment (moCA) Test score of 19-25<br>**AND**<br>b. Member is ≥ 50 years of age **AND**<br>c. The prescriber attests that member has been counseled on the approval and safety status of Aduhelm (aducanumab-avwa) being approved under accelerated approval based on reduction in amyloid beta plaques **AND**<br>d. Prior to initiation of Aduhelm (aducanumab-avwa), the prescriber attests that the member meets ALL the following:<br>i. Member has had a brain MRI within the prior one year to treatment initiation, showing no signs or history of localized superficial siderosis, ≥ 10 brain microhemorrhages, and/or brain hemorrhage > 1 cm<br>ii. Attestation that MRI will be completed prior to the 7th (1st dose at 10 mg/kg) and 12th (6th dose at 10 mg/kg) infusion<br>**AND**<br>e. Member does not have any of the following: | See criteria |

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| | | i. Any medical or neurological condition other than Alzheimer's Disease that might be a contributing cause of the subject's cognitive impairment including (but not limited to) stroke/vascular dementia, tumor, dementia with Lewy bodies [DLB], frontotemporal dementia [FTD] or normal pressure hydrocephalus<br>ii. Contraindications to PET, CT scan, or MRI<br>iii. History of or increased risk of amyloid related imaging abnormalities ARIA-edema (ARIA-E) or ARIA-hemosiderin deposition (ARIA-H)<br>iv. History of unstable angina, myocardial infarction, chronic heart failure, or clinically significant conduction abnormalities, stroke, transient ischemic attack (TIA), or unexplained loss of consciousness within 1 year prior to initiation of Aduhelm (aducanumab-avwa)<br>v. History of bleeding abnormalities or taking any form of anticoagulation therapy<br>**AND**<br>f. Aduhelm (aducanumab-avwa) is prescribed by or in consultation with a neurologist<br>**AND**<br>g. The prescribed regimen meets FDA-approved labeled dosing:<br>i. Infusion 1 and 2: 1 mg/kg over approximately 1 hour every 4 weeks<br>ii. Infusion 3 and 4: 3 mg/kg over approximately 1 hour every 4 weeks<br>iii. Infusion 5 and 6: 6 mg/kg over approximately 1 hour every 4 weeks<br>iv. Infusion 7 and beyond: 10 mg/kg over approximately 1 hour every 4 weeks<br><br>Initial approval period: 6 months<br><br>Second prior authorization: an additional 6 months of Aduhelm (aducanumab-avwa) therapy may be approved with provider attestation that a follow-up MRI will be (or has been) completed prior to the 7th infusion | |

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| | | Subsequent approval: an additional 6 months of Aduhelm (aducanumab-avwa) therapy may be approved with provider attestation that a follow-up MRI will be (or has been) completed prior to the 12th infusion<br><br>Maximum dose: 10 mg/kg IV every 4 weeks<br><br>The above coverage standards will continue to be reviewed and evaluated for any applicable changes due to the evolving nature of factors including disease course, available treatment options and available peer-reviewed medical literature and clinical evidence. If request is for use outside of stated coverage standards, support with peer reviewed medical literature and/or subsequent clinical rationale shall be provided and will be evaluated at the time of request.<br><br>Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s). | |
| **J0897** | **BONE RESORPTION INHIBITORS**<br>**Prolia®, Xgeva® (denosumab)** | **Prolia®** (denosumab) may be approved for members meeting all the following criteria:<br>a. Member has one of the following diagnoses:<br>i. Postmenopausal osteoporosis with high fracture risk<br>ii. Osteoporosis<br>iii. Bone loss in men receiving androgen deprivation therapy in prostate cancer<br>iv. Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer<br>OR<br>b. Member is considered very high risk for fracture defined as any one of the following: a fracture within the past 12 months, experience of fractures while receiving approved osteoporosis therapy (i.e. ), a history of multiple fractures, experience of a fracture while receiving medications that cause skeletal harm (e.g. long-term glucocorticoids), very low T-score (e.g. < -3.0), high risk for falls or a history of injurious falls, or very high fracture probability by FRAX®<br><br>AND<br>c. Member has serum calcium greater than 8.5mg/dL AND<br>d. Member is taking calcium 1000 mg daily and at least 400 IU vitamin D daily AND<br>e. For members not considered very high risk of fracture, member has trial and failure of bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) | One year |

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| | | AND<br>f. Member meets ANY of the following criteria:<br>i. has a history of an osteoporotic vertebral or hip fracture<br>ii. has a pre-treatment T-score of < -2.5<br>iii. has a pre-treatment T-score of < -1 but > -2.5 AND either of the following:<br>1. Pre-treatment FRAX score of > 20% for any major fracture<br>2. Pre-treatment FRAX score of > 3% for hip fracture<br>iv. Maximum dose of Prolia is 60mg every 6 months<br>g. Member who is at very high risk of fracture and is currently stable on Prolia may continue to receive prior authorization approval to continue.<br><br>**Xgeva®** (denosumab) may be approved if member meets ONE of the following indications:<br>a. Prevention of skeletal-related events in members with multiple myeloma or in members with bone metastasis from solid tumors<br>b. Giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity<br>c. Hypercalcemia of Malignancy, refractory to bisphosphonate therapy<br>d. If member is currently receiving and stabilized on Xgeva, they may continue to receive prior authorization approval to continue. | |
| **J0585,**<br>**J0586,**<br>**J0587,**<br>**J0588** | **BOTULINUM TOXIN AGENTS**<br>**Botox®,**<br>**Dysport®,**<br>**Myobloc®,**<br>**Xeomin®** | Botulinum toxin agents may be approved if the member meets the following criteria:<br>**Botox®** (onabotulinumtoxinA) may be approved if the member meets ALL the following criteria:<br>a. If administered for Chronic Migraine, prophylaxis<br>i. Member is 18 years of age or older AND<br>ii. Member has a diagnosis of chronic migraine, which is defined as headaches occurring 15 days or more monthly, where at least 8 of these days per month for at least 3 months are migraine days with or without aura AND<br>iii. Member has trial and failure of topiramate AND<br>iv. Dosing interval no sooner than every 12 weeks<br>v. Reauthorization requests may be approved if member has shown a clinical reduction in number of migraine days per month OR<br>b. If administered for one of the following indications, member must meet the following age requirements and dosing must be no sooner than every 12 weeks<br>i. Overactive Bladder<br>1. Member is 18 years of age or older | One year |

ii. Spasticity
1. Member is 2 years of age or older
iii. Cervical Dystonia
1. Member is 16 years of age or older
iv. Primary Axillary Hyperhidrosis
1. Member is 18 years of age or older
v. Blepharospasm and Strabismus
1. Member is 12 years of age or older

**Dysport®** (abobotulinumtoxinA)may be approved if the member meets ALL the following criteria for each indication:

a. If being administered for cervical dystonia
i. Member has a diagnosis of cervical dystonia AND
ii. Member is 18 years of age or older AND
iii. Dosing interval is no sooner than every 12 weeks AND
iv. Initial dose of 500 units followed by a maximum maintenance dose of 1000 units administered intramuscularly

OR

b. If being administered for spasticity
i. Member is 2 years of age or older AND
ii. Dosing interval is no sooner than every 12 weeks
iii. Maximum dose is 1500 units administered intramuscularly

**Myobloc®** (rimabotulinumtoxinB) may be approved if the member meets ALL the following criteria:

a. Member is 18 years of age or older AND
b. If being administered for cervical dystonia
i. Member has a diagnosis of cervical dystonia AND
ii. Dosing interval is no sooner than every 12 weeks AND
iii. Maximum dose of 10,000 units

OR

c. If being administered for chronic sialorrhea
i. Member has a diagnosis of chronic sialorrhea AND
ii. Dosing interval is no sooner than every 12 weeks AND
iii. Maximum Initial dose is 3,000 units

**Xeomin®** (incobotulinumtoxinA) may be approved if member meets ALL the following criteria for each indication:

a. If being administered for one of the following indications:
1. Blepharospasm

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| | | 2. Cervical dystonia<br>ii. Member is at least 18 years of age AND<br>iii. Dosing frequency is no sooner than every 12 weeks AND<br>iv. If administered for blepharospasm, maximum dose 100 units per treatment session<br>b. If being administered for the chronic sialorrhea<br>i. Member is 2 years of age or older AND<br>ii. Member weighs more than 12 kg AND<br>iii. Dosing frequency is no sooner than every 16 weeks AND<br>iv. Maximum dose of 100 units<br>c. If administered for the treatment of upper limb spasticity<br>i. Member is 2 years of age or older AND<br>ii. For members between 2 and 17 years of age, spasticity is not caused by cerebral palsy AND<br>iii. Dosing frequency is no sooner than every 12 weeks AND<br>iv. Maximum dose of 200 units per single upper limb, or 400 units total<br><br>***Not approved for Cosmetic Purposes*** | |
| **J2786** | **Cinqair® (reslizumab)** | **Cinqair ®** (reslizumab) may be approved for members meeting all the following criteria:<br>a. Member is 18 years of age or older AND<br>b. Member has diagnosis of severe asthma with an eosinophilic phenotype AND<br>c. Member has a blood eosinophil count of greater than or equal to 400 cells/mcL AND<br>d. Cinqair is being used as a maintenance adjunctive therapy AND<br>e. Member's symptoms remain uncontrolled despite adherence to concomitant treatment with a medium to high-dose inhaled corticosteroids and long acting beta2-agonist AND<br>f. Member has uncontrolled disease characterized by the following:<br>i. Asthmatic symptoms occurring throughout the day<br>ii. Nighttime awakenings occurring 7 times per week<br>iii. Use of Short Acting Beta-Agonist for symptom control several times per day<br>iv. Lung Function, characterized by FEV1 is less than 60%<br>v. Asthma exacerbations requiring oral systemic corticosteroids, occurring more frequently and intensely than mild or moderate asthma<br>AND<br>g. Baseline FEV1 and frequency of asthma exacerbations per month are provided AND<br>h. Maximum dose of 3 mg/kg every 4 weeks<br>i. Reauthorization may be approved if member meets one of the following: | One year |

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| | | i. Improvement in lung function, measured in FEV1 OR<br>ii. Reduction in the number of asthma exacerbations, defined as a decrease in use of oral or systemic corticosteroids and/or reduced asthma related hospitalizations and/or ER visits | |
| **J3380** | **Entyvio® (vedolizumab)** | **Entyvio®** (vedolizumab) may be approved for members meeting all the following criteria:<br>a. Member is 18 years of age or older AND<br>b. Member has a diagnosis of moderately-to-severely active ulcerative colitis or moderately-to-severely active Crohn's disease AND<br>c. Member has had an inadequate response with, intolerance to, or demonstrated a dependence on corticosteroids AND<br>d. Member is not receiving Entyvio in combination with Cimzia, Enbrel, Humira, infliximab, Simponi, or Tysabri AND<br>e. For members with Crohn's disease<br>i. Medication is initiated and titrated per FDA-labeled dosing for Crohn's Disease<br>ii. Member has trialed and failed therapy with Humira OR an infliximab-containing product OR the member is ≥ 65 years of age with increased risk of serious infection.<br>f. For members with Ulcerative Colitis<br>i. Medication is initiated and titrated per FDA-labeled dosing for Ulcerative Colitis<br>ii. Member has trialed and failed Humira OR an infliximab-containing product OR Simponi OR the member is ≥ 65 years of age with increased risk of serious infection.<br><br>†Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to therapy, or significant drug-drug interaction.<br><br>Maximum of 300mg IV infusion at 0, 2, and 6 weeks and then every 8 weeks | One year |
| **J0517** | **Fasenra® (benralizumab)** | **Fasenra®** (benralizumab) may be approved for members meeting all the following criteria:<br>a. Member is 12 years of age or older AND<br>b. Member has diagnosis of severe asthma with eosinophilic phenotype AND<br>c. Member has a blood eosinophil count of at least 300 cells/µl AND<br>d. Fasenra is being administered as add-on therapy (not monotherapy) AND | One year |

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| | | e. Member is taking a high dose inhaled corticosteroid and a long-acting beta agonist AND<br>f. Member has had 2 or more asthma exacerbations requiring use of oral or systemic corticosteroids and/or hospitalizations and/or ER visits prior to initiation of Fasenra<br>g. Reauthorization may be approved if member meets one of the following:<br>i. Improvement in lung function, measured in FEV1 OR<br>ii. Reduction in the number of asthma exacerbations, defined as a decrease in use of oral or systemic corticosteroids and/or reduced asthma related hospitalizations and/or ER visits<br><br>Maximum dose: 30mg subcutaneous injection every 4 weeks for 3 doses, then every 8 weeks thereafter | |
| **J1459, J1556, J1557, J1561, J1566, J1568, J1569, J1572, J1599** | **IMMUNE GLOBULINS**<br>**Privigen, Bivigam, Gammaplex, Gammaked, Gamunex-C, Gamunex, Gammagard S/D, Octagam 5%, 10%, Gammagard Liquid, Flebogamma DIF, Asceniv, Panzyga** | May be approved for members meeting one of the approved conditions listed and for doses not exceeding FDA-approved maximum (Table 1).<br>a. Approved Conditions for Immune Globulin Use:<br>i. Primary Humoral Immunodeficiency disorders including:<br>1. Common Variable Immunodeficiency (CVID)<br>2. Severe Combined Immunodeficiency (SCID)<br>3. X-Linked Agammaglobulinemia<br>4. X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency<br>5. Wiskott-Aldrich Syndrome<br>6. Members < 13 years of age with pediatric Human Immunodeficiency Virus (HIV) and CD-4 count > 200/mm3<br>ii. Neurological disorders including:<br>1. Guillain-Barré Syndrome<br>2. Relapsing-Remitting Multiple Sclerosis<br>3. Chronic Inflammatory Demyelinating Polyneuropathy<br>4. Myasthenia Gravis<br>5. Polymyositis and Dermatomyositis<br>6. Multifocal Motor Neuropathy<br>iii. Kawasaki Syndrome<br>iv. Chronic Lymphocytic Leukemia (CLL)<br>v. Autoimmune Neutropenia (AN) with absolute neutrophil count < 800 mm and history of recurrent bacterial infections<br>vi. Autoimmune Hemolytic Anemia (AHA)<br>vii. Liver or Intestinal Transplant<br>viii. Immune Thrombocytopenia Purpura (ITP) including: | One year |

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1. Requiring preoperative therapy for undergoing elective splenectomy with platelet count < 20,000<br>
2. Members with active bleeding & platelet count <30,000<br>
3. Pregnant members with platelet counts <10,000 in the third trimester<br>
4. Pregnant members with platelet count 10,000 to 30,000 who are bleeding<br>
ix. Multisystem Inflammatory Syndrome in Children (MIS-C)<br><br>
<table>
<tr><th colspan="2">Table 1: FDA-Approved Maximum Immune Globulin Dosing</th></tr>
<tr><td>Gammaked</td><td>2 g/kg</td></tr>
<tr><td>Gamunex-C</td><td>2 g/kg</td></tr>
<tr><td>Octagam</td><td>2 g/kg</td></tr>
<tr><td>Gammagard Liquid</td><td>2.4 g/kg/month</td></tr>
<tr><td>Gammaplex 5% - IV Infusion</td><td>2 g/kg</td></tr>
<tr><td>Privigen - IV Infusion</td><td>2 g/kg</td></tr>
<tr><td>Asceniv</td><td>800 mg/kg every 3 weeks</td></tr>
<tr><td>Panzyga</td><td>2 g/kg</td></tr>
<tr><td>Bivigam</td><td>800 mg/kg every 3 weeks</td></tr>
<tr><td>Flebogamma DIF</td><td>600 mg/kg every 3 weeks</td></tr>
<tr><td>Gammagard S/D</td><td>1 g/kg</td></tr>
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<td>J2182</td>
<td>Nucala® (mepolizumab)</td>
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Nucala® (mepolizumab) may be approved if member meets ALL the following criteria for the appropriate indication:<br>
a. Initial approval if administered for <u>asthma</u>:<br>
i. Member is 6 years of age or older AND<br>
ii. Member has diagnosis of severe asthma with an eosinophilic phenotype AND<br>
iii. Member has a blood eosinophil count of greater than or equal to 150 cells/mcL within 6 weeks of dosing or greater than or equal to 300 cells/mcL in the previous 12 months AND<br>
iv. Member has had 2 or more asthma exacerbations requiring use of oral or systemic corticosteroids and/or hospitalizations and/or ER visits OR<br>
v. Member requires daily use of oral corticosteroids AND
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<td>One year</td>
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vi. Baseline FEV1 and frequency of asthma exacerbations per month are provided
vii. For members 12 years of age and older, dose of 100mg once every 4 weeks OR for members between the ages of 6 and 11 years of age, dose of 40mg every 4 weeks

b. Reauthorization for asthma indication may be approved if member has shown clinical improvement as documented by one of the following
   i. Improvement in lung function, measured in FEV1 OR
   ii. Reduction in the number of asthma exacerbations, defined as a decrease in use of oral or systemic corticosteroids and/or reduced asthma related hospitalizations and/or ER visits

c. If administered for eosinophilic granulomatosis with polyangiitis (EGPA)
   i. Member is 18 years of age or older AND
   ii. Member has been diagnosed with relapsing or refractory EGPA at least 6 months prior to request as demonstrated by ALL the following:
      1. Member has a diagnosis of asthma AND
      2. Member has a blood eosinophil count of greater than or equal to 1000 cells/mcL or a blood eosinophil level of 10% AND
      3. Member has the presence of two of the following EGPA characteristics:
         a. Histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
         b. Neuropathy
         c. Pulmonary infiltrates
         d. Sinonasal abnormality
         e. Cardiomyopathy
         f. Glomerulonephritis
         g. Alveolar hemorrhage
         h. Palpable purpura
         i. Antineutrophil cytoplasmic antibody (ANCA) positive
   iii. Member is on a stable dose of corticosteroids for at least 4 weeks prior to request AND
   iv. Dose of 300 mg once every 4 weeks

d. If administered for hypereosinophilic syndrome (HES):
   i. Member is 12 years of age or older AND
   ii. Member has a diagnosis for HES for at least 6 months that is non-hematologic secondary HES AND

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| | | iii. Member has a blood eosinophil count of greater than or equal to 1000 cells/mcL AND<br>iv. Member has a history of two or more HES flares (defined as worsening clinical symptoms or blood eosinophil counts requiring an increase in therapy) AND<br>v. Member has been on stable dose of HES therapy for at least 4 weeks, at time of request, including at least one of the following:<br>1. Oral corticosteroids<br>2. Immunosuppressive therapy<br>3. Cytotoxic therapy<br>AND<br>vi. Dose of 300 mg once every 4 weeks | |
| **J2350** | **Ocrevus® (ocrelizumab)** | **Ocrevus®** (ocrelizumab) may be approved for initial therapy if the following criteria are met:<br>a. <u>If administered for Relapsing Forms of Multiple Sclerosis (MS)</u><br>i. Member is 18 years of age or older AND<br>ii. Member has a relapsing form of multiple sclerosis AND<br>iii. Member has experienced one relapse within the prior year or two relapses within the prior two years AND<br>iv. Member has trial and failure of three of the following: Tysabri (natalizumab), Lemtrada (alemtuzumab), or the preferred agents in the "Disease Modifying Therapies" PDL drug class that are FDA-labelled for use for the same prescribed indication." Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy. Lack of efficacy will be defined as one of the following:<br>1. One of the following on MRI: presence of any new spinal lesions, cerebellar or brainstem lesions, or change in brain atrophy<br>2. On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer OR<br>b. <u>If administered for Primary Progressive Multiple Sclerosis</u><br>i. Member is 18 years of age or older AND<br>ii. Member is not concomitantly taking disease modifying therapies.<br>AND<br>c. Member does not have active hepatitis B infection AND<br>d. Ocrevus is administered by or in consultation with a neurologist or a physician that specializes in the treatment of multiple sclerosis<br>e. Maximum maintenance dose: 600mg every 6 months<br>f. Exemption: If member is currently receiving and stabilized on Ocrevus, they may continue to receive prior authorization approval to continue. | One year |

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| **J1745** | **Remicade® (infliximab)** | **Remicade®** (infliximab) may be approved with trial & failure of Renflexis® (infliximab abda) AND if meeting all the following criteria:<br>a. Member has one of the following diagnoses:<br>i. Crohn's disease and is 6 years or older<br>ii. Ulcerative colitis and is 6 years or older<br>iii. Rheumatoid arthritis and is 4 years or older<br>iv. Psoriatic arthritis and is 18 years or older<br>v. Ankylosing spondylitis and is 18 years or older<br>vi. Juvenile idiopathic arthritis and is 4 years or older<br>vii. Plaque psoriasis in adults<br>viii. Hydradenitis suppurativa (HS)<br>AND<br>b. Member meets one of the following, based on prescribed indication:<br>i. For continuation of infliximab therapy that was initiated in the hospital setting for treating severe ulcerative colitis, no additional medication trial is required OR<br>ii. For treatment of moderate to severe hidradenitis suppurativa, no additional medication trial is required OR<br>iii. For all other prescribed indications, the member has trialed and failed†* all preferred agents in the Targeted Immune Modulators PDL drug class that are FDA labeled for use for the prescribed indication (with only one preferred TNF inhibitor trial required).<br><br>** Members ≥ 50 years of age with an additional CV risk factor, will not need a trial and failure of Xeljanz IR.<br><br>*Renflexis does not require a prior authorization on the medical benefit. | One year |
| **J1300** | **Soliris® (eculizumab)** | **Soliris®** (eculizumab) may be approved for members meeting all the following criteria:<br>a. Member is diagnosed with either Paroxysmal Nocturnal Hemoglobinuria (PNH), Atypical Hemolytic Uremic Syndrome (aHUS), Generalized Mysthenia Gravis (gMG), or Neuromyleitis Optica Spectrum Disorder (NMOSD) AND<br>b. Member does not have a systemic infection AND<br>c. Member must be administered a meningococcal vaccine at least two weeks prior to initiation of Soliris therapy and revaccinated according to current medical guidelines for vaccine use AND<br>d. Prescriber is enrolled in the Soliris (eculizumab) Risk Evaluation and Mitigation Strategy (REMS) program AND | One year |

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| | | e. Medication is administered by or in consultation with a hematologist for PNH and by or in consultation with a hematologist or nephrologist for aHUS and by or in consultation with a neurologist for gMG or NMOSD AND<br>f. Member meets criteria listed below based on specific diagnosis:<br><u>Paroxysmal Nocturnal Hemoglobinuria</u><br>a. Member is 18 years of age or older AND<br>b. Diagnosis of PHN must be accompanied by detection of PNH clones by flow cytometry diagnostic testing AND<br>c. Member demonstrate the presence of at least 2 different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g. CD55, CD59, etc.) within at least 2 different cell lines (granulocytes, monocytes, erythrocytes) AND<br>d. Member has one of the following indications for therapy:<br>i. Presence of a thrombotic event<br>ii. Presence of organ damage secondary to chronic hemolysis<br>iii. Member is pregnant and potential benefit outweighs potential fetal risk<br>iv. Member is transfusion dependent<br>v. Member has high LDH activity (defined as ≥1.5 x ULN) with clinical symptoms<br>AND<br>e. Member has documented baseline values for one or more of the following:<br>i. Serum lactate dehydrogenase (LDH)<br>ii. Hemoglobin level<br>iii. Packed RBC transfusion requirement<br><u>Atypical Hemolytic Uremic Syndrome</u><br>a. Member is 2 months or older AND<br>b. Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out by evaluating ADAMTS13 level (ADAMTS-13 activity level > 10%); AND<br>c. Shiga toxin E. coli related hemolytic uremic syndrome (STECHUS) has been ruled out; AND<br>d. Other causes have been identified and are being treated appropriately such as coexisting diseases or conditions (e.g. bone marrow transplantation, solid organ transplantation, malignancy, autoimmune disorder, drug-induced, malignant hypertension, HIV infection, etc.), Streptococcus pneumonia or Influenza A (H1N1) infection, or cobalamin deficiency AND<br>e. Documented baseline values for one or more of the following:<br>i. Serum lactate dehydrogenase (LDH)<br>ii. Serum creatinine/eGFR<br>iii. Platelet count<br>iv. Plasma exchange/infusion requirement | |

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| | | Generalized Myasthenia Gravis<br>a. Member is 18 years or older AND<br>b. Member has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease; AND<br>c. Member has a positive serologic test for anti-acetylcholine receptor (AchR) antibodies; AND<br>d. Physician has assessed the baseline Quantitative Myasthenia Gravis (QMG) score; AND<br>e. Member has a MG-Activities of Daily Living (MG-ADL) total score of ≥6; AND<br>f. Member has failed treatment over at least 1 year with at least 2 immunosuppressive therapies (e.g. azathioprine, cyclosporine, mycophenolate, etc), or has failed at least 1 immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG)<br>Neuromyelitis Optica Spectrum Disorder<br>a. Member is 18 years or older AND<br>b. Member has a past medical history of one of the following:<br>i. Optic neuritis<br>ii. Acute myelitis<br>iii. Area postrema syndrome; episode of otherwise unexplained hiccups or nausea and vomiting<br>iv. Acute brainstem syndrome<br>v. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions<br>vi. Symptomatic cerebral syndrome with NMOSD-typical brain lesions AND<br>c. Member has a positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMP-IgG antibodies; AND<br>d. Diagnosis of multiple sclerosis or other diagnoses have been ruled out AND<br>e. Member has not failed a previous course of Soliris (eculizumab) therapy AND<br>f. Member has a history of failure, contraindication, or intolerance to rituximab therapy AND<br>g. Member has at least one of the following:<br>i. History of at least two relapses during the previous 12 months prior to initiating Soliris (eculizumab)<br>ii. History of at least three relapses during the previous 24 months, at least one relapse occurring within the past 12 months prior to initiating Soliris (eculizumab) AND<br>h. Member is not receiving Soliris in combination with any of the following: | |

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| | | i. Disease modifying therapies for the treatment of multiple sclerosis (such as Gilenya (fingolimod), Tecfidera (dimethyl fumarate), Ocrevus (ocrelizumab), etc.) OR<br>ii. Anti-IL6 therapy<br><br>If a member is currently receiving and stabilized on Soliris, they may continue to receive prior authorization approval to continue if the member meets the appropriate diagnosis and age requirements<br><br>Maximum dose: 900mg weekly for 4 weeks induction followed by 1200mg every 2 weeks maintenance dose | |
| **J2323** | **Tysabri® (natalizumab)** | **Tysabri®** (natalizumab) may be approved for initial therapy if the following criteria are met:<br>a. Medication is not currently being used in combination with immunosuppressants (azathioprine, 6-mercaptopurine, methotrexate) or TNF-alpha inhibitors (adalimumab, certolizumab pegol, infliximab) AND<br>b. <u>If administered for induction of remission of moderate to severe Crohn's disease</u><br>i. The member is ≥ 18 years of age AND<br>ii. Member has tried and failed Aminosalicylates AND<br>iii. Member has tried and failed Corticosteroids AND<br>iv. Member has tried and failed immunomodulators AND<br>v. Member has tried and failed two TNF-alpha inhibitors (e.g. adalimumab, • certolizumab pegol, infliximab) AND<br>vi. Tysabri is administered by or in consultation with a gastroenterologist.<br>c. <u>If administered for relapsing remitting multiple sclerosis (RRMS)</u><br>i. The member is ≥ 18 years of age; AND<br>ii. Member has trial and failure of three of the following: Ocrevus (ocrelizumab), Lemtrada (alemtuzumab), or the preferred agents in the "Disease Modifying Therapies" PDL drug class that are FDA-labelled for use for the same prescribed indication. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy indicated by one of the following:<br>1. One of the following on MRI: presence of any new spinal lesions, cerebellar or brainstem lesions, or change in brain atrophy<br>2. On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer OR<br>iii. Member with highly active relapsing MS has trial and failure of one of the following: Ocrevus (ocrelizumab), Lemtrada (alemtuzumab), or a | One year |

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| | | preferred agent in the "Disease Modifying Therapies" PDL drug class that are FDA-labelled for use for the same prescribed indication.<br>iv. Tysabri is administered by or in consultation with a neurologist or a physician that specializes in the treatment of multiple sclerosis<br>d. Exemption: If member is currently receiving and stabilized on Tysabri, they may continue to receive prior authorization approval to continue. | |
| **J2357** | **Xolair® (omalizumab)** | **Xolair®** (omalizumab) may be approved if member meets ALL the following criteria for the appropriate indication:<br>a. If administered for the treatment of asthma:<br>i. Member is 6 years of age or older AND<br>ii. Member has a diagnosis of moderate to severe asthma with one of the following:<br>1. A pre-treatment IgE serum concentration greater than or equal to 30 IU per mL OR<br>2. A positive skin test or in vitro reactivity to a perennial inhaled allergen AND<br>iii. Member's symptoms remain uncontrolled despite adherence to concomitant treatment with a high-dose inhaled corticosteroids and long acting beta2-agonist AND<br>iv. Xolair is not being used as a monotherapy AND<br>v. Xolair will not be used concomitantly with other biologics indicated for asthma AND<br>vi. Maximum dose of 750mg every 4 weeks<br>b. Reauthorization for asthma indication may be approved if member has shown clinical improvement as documented by one of the following<br>i. Improvement in lung function, measured in FEV1 OR<br>ii. Reduction in the number of asthma exacerbations, defined as a decrease in use of oral or systemic corticosteroids and/or reduced asthma related hospitalizations and/or ER visits<br>c. If administered for the treatment of chronic idiopathic urticaria (CIU)<br>i. Member is 12 years of age or older AND<br>ii. Member is diagnosed with chronic idiopathic urticaria AND<br>iii. Member is symptomatic despite H1 antihistamine treatment AND<br>iv. Member has tried and failed at least three of the following:<br>1. Hydroxyzine or doxepin (**must include**)<br>2. High-dose second generation H1 antihistamine<br>3. H2 antihistamine<br>4. First-generation antihistamine<br>5. Leukotriene receptor antagonist | One year |

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| | | AND<br>v. Prescriber attests that the need for continued therapy will be periodically reassessed (as the appropriate duration of Xolair therpay for CIU has currently not been evaluated) AND<br>vi. Member who is currently stable on Xolair for chronic idiopathic urticaria may continue to receive prior authorization approval to continue.<br>d. If administered for the treatment of chronic rhinosinusitis with nasal polyps:<br>i. If the member has a concomitant diagnosis of asthma or chronic idiopathic urticaria, then criteria listed above for the respective diagnoses are met AND<br>ii. Member is 18 years of age or older AND<br>iii. Member has a pre-treatment IgE level greater than or equal to 30 IU per mL AND<br>iv. Member has tried and failed at least two intranasal corticosteroids (see Intranasal Rhinitis Agents PDL class). Failure is defined as lack of efficacy with a 2-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction<br>v. AND<br>vi. Member is *currently* adherent to intranasal corticosteroid therapy AND<br>vii. Member has a baseline bilateral endoscopic nasal polyps score indicating the need for treatment AND<br>viii. Xolair is being prescribed by or in consultation with a qualified subspecialist such as an allergist, ear/nose/throat specialist, immunologist, rheumatologist, or pulmonologist AND<br>ix. Maximum dose of Xolair for nasal polyps is 600 mg subcutaneously every 2 weeks<br>e. Reauthorization for the chronic rhinosinusitis with nasal polyps indication may be approved if member has shown clinical improvement as indicated by the following:<br>i. Initial approval criteria were met at the time of initiation of therapy AND<br>ii. Provider attests that member has documented improvement in bilateral endoscopic nasal polyps score, AND<br>iii. Provider attests that member is being periodically reassessed for need for continued therapy based on disease severity and/or level of symptom control | |