

# Kaiser Permanente Mid-Atlantic States Region (KPMAS)

## Virginia Medicaid

### Prior Authorization and Step Therapy Criteria

Effective 06/04/2024

#### Reference:

1. KPMAS Regional Pharmacy and Therapeutics (P&T) Committee  
P&T Approval/Revision Date: 12/01/2023, 10/06/2023, 08/04/2023, 06/02/2023, 04/07/2023, 02/03/2023, 12/06/2022, 10/04/2022, 07/05/2022, 06/07/2022, 04/05/2022; 02/04/2022; 12/3/2021, 05/07/2021, 04/05/2021, 02/05/21, 11/06/20, 9/3/2020; 6/5/2020; 12/6/2019; 10/5/2018
2. DMAS Virginia Medicaid's Preferred Drug List/Common Core Formulary  
<https://www.viriniamedicaidpharmacyservices.com/provider/preferred-drug-list/>

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## Agents to Treat Multiple Sclerosis – Modestly Effective Therapy

*Last revised 06/09/2023 (Effective 07/01/2023)*

Generic	Brand
PEGINTERFERON BETA-1A	PLEGRIDY SOPN
DIROXIMEL FUMARATE	VUMERITY
<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>	
<b>Length of Authorization:</b> 12 months	
<b>Initial Therapy:</b> <ul style="list-style-type: none"> <li>• Member cannot be changed to a preferred drug. (e.g. Avonex, Betaseron, Copaxone, Tecfidera, Kesimpta) Acceptable reasons include: <b>AND</b> <ul style="list-style-type: none"> <li>○ Allergy to preferred drug.</li> <li>○ Contraindication to or drug-to-drug interaction with preferred drug.</li> <li>○ History of unacceptable/toxic side effects to preferred drug.</li> <li>○ Member's condition is clinically stable; changing to a preferred drug might cause deterioration of the member's condition.</li> </ul> </li> <li>• Member has therapeutic failure of at least two preferred drugs within the same class as appropriate for diagnosis</li> </ul>	
<b>Additional criteria for Vumerity only:</b> <ul style="list-style-type: none"> <li>• Member tried and failed at least one preferred injectable (see above) and Tecfidera</li> <li>• Member is using for Vumerity's approved indication - treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and/or active secondary progressive disease?</li> </ul>	

## Agents to Treat Multiple Sclerosis – Highly Effective Therapy

Generic	Brand
CLADRIBINE	MAVENCLAD
SIPONIMOD FUMARATE	MAYZENT
OZANIMOD	ZEPOSIA
<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>	
<b>Length of Authorization:</b> 12 months	
<b>Initial Review Criteria for Mavenclad, Mayzent and Zeposia:</b>	
<ul style="list-style-type: none"> <li>• Member is ≥18 years old AND</li> <li>• Has had a baseline MRI before initiating the first treatment course, within 3 months prior, AND</li> <li>• Has at least one of the following diagnoses, AND:               <ul style="list-style-type: none"> <li>○ Relapsing-remitting Disease (RRMS)</li> <li>○ Secondary Progressive Disease (SPMS) with relapses</li> <li>○ Clinically Isolated Syndrome (CIS)</li> <li>○ Member has had ≥ 1 relapse within the previous two years</li> <li>○ Member has new and unequivocally enlarging T2 contrast enhancing lesions as evidenced by MRI and has had ≥ 1 relapse in the previous 12 months</li> </ul> </li> <li>• Failed an adequate trial (≥3 months) of, or has a documented allergy or intolerance to, or is not a candidate for other preferred MS agents (e.g., Avonex, Betaseron, Copaxone), AND</li> <li>• Member is NOT using requested drug therapy in addition to another DMT, AND</li> <li>• Member has been screened for the presence of tuberculosis according to local guidelines, AND</li> <li>• Member has been tested for antibodies to the varicella zoster virus (VZV) or received immunization for VZV four weeks prior to beginning therapy, AND</li> <li>• Member has been evaluated and screened for the presence of hepatitis B and hepatitis C virus (HBV/HCV) prior to initiating treatment, AND</li> </ul>	
<b>If the authorization is for Mavenclad:</b>	
<ul style="list-style-type: none"> <li>• Lymphocyte count ≥ 800 cells/mL prior to start of therapy, AND</li> <li>• Women of childbearing age are not pregnant AND that members of reproductive potential use effective contraception during treatment with therapy and for at least six months after the last dose, AND</li> <li>• Member does not have human immunodeficiency virus (HIV) infection</li> </ul>	
<b>If the authorization is for Mayzent:</b>	
<ul style="list-style-type: none"> <li>• Member has been tested for CYP2C9 variant status to determine genotyping (required for dosing)</li> <li>• Attest that member does not have CYP2C9*3/*3 Genotype</li> </ul>	
<b>If the authorization is for Mayzent or Zeposia specific</b>	
<ul style="list-style-type: none"> <li>• Member obtained a baseline electrocardiogram (ECG), AND</li> <li>• Member had a baseline ophthalmic evaluation of the fundus, including the macula, before starting treatment, AND</li> <li>• Attest that the member does NOT have any of the following: AND               <ul style="list-style-type: none"> <li>○ Recent Myocardial Infarction</li> </ul> </li> </ul>	

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- Unstable Angina
- Stroke
- Transient Ischemic Attack
- Decompensated Heart Failure with Hospitalization
- Class III/IV Heart Failure within the Previous 6 Months
- Prolonged QTc Interval at Baseline (> 500 msec)
- History of Mobitz Type II second or third-degree atrioventricular block or sick sinus syndrome (unless treated with a functioning pacemaker)

**Mayzent™ will NOT be used in combination with the following:**

- Moderate or strong CYP3A4 inducers (e.g., modafinil, efavirenz, etc.) in members with a CYP2C9\*1/\*3 and CYP2C9\*2/\*3 genotype
- Drug regimens that contain CYP2C9/CY3A4 dual inhibitors (e.g., fluconazole)
- Moderate CYP2C9 inhibitor plus a moderate-to-strong CYP3A4 inhibitor
- Other antineoplastic, immunosuppressive or immunomodulating drugs

**Updated Criteria: Zeposia**

- Confirmation that Zeposia will not be used in the following circumstances:
- Initiating therapy after previous treatment with alemtuzumab; OR
- In combination with:
- Monoamine oxidase inhibitor (MAOI) (e.g., selegiline, phenelzine, linezolid); OR
- Drugs known to prolong the QT-interval (e.g., fluoroquinolone or macrolide antibiotics, venlafaxine, fluoxetine, quetiapine, ziprasidone, sumatriptan, zolmitriptan), OR
- Strong cytochrome p450 2C8 (CYP2C8) inhibitors (e.g., gemfibrozil) or inducers (e.g., rifampin); OR
- BCRP inhibitors (e.g., cyclosporine, eltrombopag); OR Adrenergic or serotonergic drugs which can increase norepinephrine or serotonin (e.g., opioids, selective serotonin reuptake inhibitors [SSRIs], selective norepinephrine reuptake inhibitors [SNRIs], tricyclics, tyramine); OR
- Foods with large amounts of tyramine (e.g., > 150 mg), such as aged cheeses, cured meats, craft/unfiltered beers, beans); OR
- Other antineoplastic, immunosuppressive or immunomodulating drugs (Note: if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects); AND
- Patient will not receive live vaccines during and at least 4 weeks prior to and 12 weeks after treatment; AND
- Patient does not have an active infection, including clinically important localized infections

## Neuromuscular Transmission – Potassium Channel Blocker

Adapted from DMAS Preferred Drug List  
Last revised 10/02/2023 (Effective 12/05/2023)

Generic	Brand
DALFAMPRIDINE	AMPYRA

### Prior Authorization Criteria follows the state's criteria (DMAS)

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member has a documented diagnosis of multiple sclerosis (MS), **AND**
- Member has a gait disorder or difficulty walking, **AND**
- Member has documentation of baseline timed 25-foot walk test, **AND**
- Member's renal function estimated (using glomerular filtration rate (eGFR) or creatinine clearance (CrCl) to be >50 mL/min, **AND**
- Member does not have history of seizures
- Member has tried other preferred agents (e.g., Avonex, Betaseron, Copaxone)

**Continuation of Therapy:**

- Member has current documentation of timed 25-foot walk test

# Neuromuscular Transmission – Potassium Channel Blocker (Cont'd)

Last revised: 2/6/2024

Generic	Brand
AMIFAMPRIDINE PHOSPHATE	FIRDAPSE

<b>Prior Authorization Criteria:</b>
<b>Length of Authorization:</b> <ul style="list-style-type: none"> <li>• Initial: 6 months</li> <li>• Reauthorization: 12 months</li> </ul>
<b>Initial Review Criteria:</b> <ul style="list-style-type: none"> <li>• Prescriber is a Neurologist, AND</li> <li>• Documented confirmed diagnosis of Lambert-Eaton metabolic syndrome (LEMS) based on clinical, serologic, and electrodiagnostic exam AND</li> <li>• Patient is ≥18 years for Firdapse, AND</li> <li>• Patient is ambulatory, AND</li> <li>• Patient does NOT have a history of seizures or active brain metastases</li> <li>• Forced vital capacity (%FVC) ≥60%</li> </ul>
<b>Continuation of Therapy Criteria:</b> <ul style="list-style-type: none"> <li>• ECG, renal function, and liver function testing completed annually AND</li> <li>• Patient is still ambulatory AND</li> <li>• Patient has NOT developed epileptic seizures AND</li> <li>• Patient is adherent to therapy AND</li> <li>• Patient has documented improvement from baseline</li> </ul>



# Amyotrophic Lateral Sclerosis Agents

Last Revised 2/6/2024

Generic	Brand	HICL	GSN	Representative NDC
EDARAVONE	RADICAVA ORS STARTER KIT SUSP 105 MG/5 ML	44252	083378	70510232101
EDARAVONE	RADICAVA ORS SUSP 105 MG/5 ML	44252	083378	70510232201

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 3 months</li> <li>• Reauthorization: 6 months</li> </ul> <p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Neurologist,</li> <li>• AND ALS Functional Rating Scale –Revised (ALSFRRS-R) score of 2 points or better on each of the 12 items within past 2 months,</li> <li>• AND clinical ALS diagnosed by a neurologist with duration of 2 years or less from onset for first symptom,</li> <li>• AND forced vital capacity (%FVC) ≥ 80% within past 2 months,</li> <li>• AND patient has had a trial of riluzole</li> </ul> <p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response,</li> <li>• AND specialist follow-up occurred since last review,</li> <li>• AND patient does not have any of the following: <ul style="list-style-type: none"> <li>○ %FVC ≤ 50% and blood gas PaCO<sub>2</sub> &gt;45 mmHg</li> <li>○ Significant clinical decline based on ALSFRRS-R and/or %FVC status</li> <li>○ Non-adherence to follow-up assessments</li> <li>○ Patient is requiring hospice care</li> </ul> </li> </ul>
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## Amyotrophic Lateral Sclerosis Agents (Cont'd)

*Last Revised 2/6/2024*

Generic	Brand	HICL	GSN	Representative NDC
SODIUM PHENYLBUTYRATE- TAURURSODIOL	RELYVRIO PACK 3-1 GM	48081	083686	73063003503

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 3 months</li> <li>• Reauthorization: 6 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Neurologist,</li> <li>• AND clinical ALS diagnosed by a neurologist with duration of 18 months or less from onset for first symptom,</li> <li>• AND forced vital capacity (%FVC) &gt; 60%,</li> <li>• AND patient has had a trial of riluzole</li> <li>• AND patient does not have a tracheostomy</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response,</li> <li>• AND Neurologist follow-up occurred since last review,</li> <li>• AND patient does not have any of the following:                             <ul style="list-style-type: none"> <li>○ %FVC ≤ 50% and blood gas PaCO<sub>2</sub> &gt;45 mmHg</li> <li>○ Patient is requiring a tracheotomy or non-invasive ventilation all day</li> <li>○ Significant clinical decline based on ALSFRS-R and/or %FVC status</li> <li>○ Non-adherence to follow-up assessments</li> <li>○ Patient is requiring hospice care</li> </ul> </li> </ul>

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## Nuclear Factor Erythroid 2-Rel. Factor 2 Activator

*Last Revised 2/6/2024*

Generic	Brand	HICL	GSN	Representative NDC
OMAVELOXOLONE	SKYCLARYS CAPS 50 MG	48741	084475	73179025090

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 3 months</li> <li>• Reauthorization: 6 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Neurologist, Pediatric Neurologist, or Medical Geneticist,</li> <li>• AND patient is <math>\geq 16</math> years and <math>\leq 40</math> years of age,</li> <li>• AND patient has diagnosis of Friedreich's ataxia with confirmatory genetic testing,</li> <li>• AND patient has a modified Friedreich's Ataxia Rating Scale (mFARS) score <math>\geq 20</math> and <math>\leq 80</math>,</li> <li>• AND patient has a left ventricular ejection fraction (LVEF) <math>\geq 40\%</math>,</li> <li>• AND patient is using effective contraception, if patient is of childbearing potential</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response,</li> <li>• AND specialist follow-up occurred since last review,</li> <li>• AND documentation of completing the following labs:                             <ul style="list-style-type: none"> <li>○ SCr, if patient has clinically significant renal disease</li> <li>○ Liver function tests (ALT, AST, bilirubin), BNP, and lipids</li> </ul> </li> <li>• AND patient does not have any of the following:                             <ul style="list-style-type: none"> <li>○ Increase in transaminase levels <math>&gt;5X</math> ULN or <math>&gt;3X</math> ULN with evidence of liver dysfunction</li> <li>○ Becomes wheelchair bound or non-ambulatory</li> <li>○ Intolerance to medication</li> <li>○ Documented non-adherence to medication</li> <li>○ Pregnancy or breastfeeding</li> </ul> </li> </ul>

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## Amyloidosis Agents – Transthyretin (TTR) Suppression

*Last Revised 2/6/2024*

Generic	Brand
INOTERSEN SODIUM	TEGSEDI

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 6 months</li> <li>• Reauthorization: 6 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Neurologist, AND</li> <li>• Patient is ≥18 years, AND</li> <li>• Diagnosis of Neuropathic Heredofamilial Amyloidosis, AND</li> <li>• Documented confirmed transthyretin (TTR) mutation from genetic testing, AND</li> <li>• Patient does not have end stage renal disease (chronic kidney disease Stage 5), AND</li> <li>• Patient has not had a prior liver transplant AND</li> <li>• Patient does not have severe hepatic impairment [alanine transaminase (ALT) &gt;2.5 times the upper limit of normal] and/or cirrhosis, AND</li> <li>• Patient does not have hepatitis B or C infection, human immunodeficiency virus (HIV) infection, or active malignancy, AND</li> <li>• Patient must have documented intolerance or contraindication to Onpattro before being approved for Tegsedi</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• The following assessments have been performed within the past 6 months: Medical research Council (MRC) strength testing scale (0-5), hand grip strength (with or without dynamometer), and 10-meter walk test (10MWT) and Timed Up and Go (TUG) test, if applicable, AND</li> <li>• Karnofsky performance score ≥30, AND</li> <li>• No significant clinical decline, AND</li> <li>• No development of cardiogenic shock requiring inotropic support, AND</li> <li>• Patient is NOT in hospice care</li> </ul>

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## Anthelmintics

Generic	Brand
MEBENDAZOLE	EMVERM

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 1 month</li> <li>• Reauthorization: N/A; treatment may be repeated in 3 weeks if necessary</li> </ul> <p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Infectious Disease Specialist, AND</li> <li>• Diagnosis of <i>enterobius vermicularis</i> (pinworm), AND</li> <li>• Patient has had a trial or contraindication to both pyrantel pamoate and albendazole               <ul style="list-style-type: none"> <li>○ <u>Approve treatment as: 100 mg x 1; may repeat in 3 weeks if necessary</u></li> </ul> </li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Infectious Disease Specialist, AND</li> <li>• Confirmed diagnosis of <i>ascaris lumbricoides</i> (common roundworm), AND</li> <li>• Patient has had a trial or contraindication to both pyrantel pamoate and albendazole               <ul style="list-style-type: none"> <li>○ <u>Approve treatment as: 100 mg BID x 3 days; may repeat in 3 weeks if necessary</u></li> </ul> </li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Infectious Disease Specialist, AND</li> <li>• Confirmed diagnosis of <i>trichuris trichiura</i> (whipworm), AND</li> <li>• Patient has had a trial or contraindication to albendazole               <ul style="list-style-type: none"> <li>○ <u>Approve treatment as: 100 mg BID x 3 days; may repeat in 3 weeks if necessary</u></li> </ul> </li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Infectious Disease Specialist, AND</li> <li>• Confirmed diagnosis of <i>ancylostoma duodenale</i> (common hookworm), AND</li> <li>• Patient has had a trial or contraindication to albendazole               <ul style="list-style-type: none"> <li>○ <u>Approve treatment as: 100 mg BID x 3 days; may repeat in 3 weeks if necessary</u></li> </ul> </li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Infectious Disease Specialist, AND</li> <li>• Confirmed diagnosis of <i>necator americanus</i> (American hookworm), AND</li> <li>• Patient has had a trial or contraindication to albendazole               <ul style="list-style-type: none"> <li>○ <u>Approve treatment as: 100 mg BID x 3 days; may repeat in 3 weeks if necessary</u></li> </ul> </li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Infectious Disease Specialist, AND</li> <li>• Cystic hydatid disease, AND</li> <li>• Patient has had treatment failure or contraindication to albendazole               <ul style="list-style-type: none"> <li>○ <u>Approve treatment as: 100 mg BID x 3 days; may repeat in 3 weeks if necessary</u></li> </ul> </li> </ul>
<p><b>Notes</b></p> <ul style="list-style-type: none"> <li>• Please approve brand formulation, this is KP-preferred and adjudicates as generic</li> </ul>

## Anti-Arthritic – Folate Antagonist Agents

Generic	Brand
METHOTREXATE	OTREXUP; RASUVO

**Prior Authorization Criteria follows the state's criteria (DMAS)**

- **Length of Authorization:**  
6 months initial; 12 months continuation (6 months if using for PsO)

**Initial Review Criteria:**

- Member has a diagnosis of at least one of the following
  - Rheumatoid Arthritis (RA)
  - Plaque Psoriasis (PsO)
  - Polyarticular juvenile idiopathic arthritis (pJIA)
- Member has an allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable, AND
- If this is being used for Rheumatoid Arthritis (RA): member had had therapeutic failure to two preferred DMARD agents
- If this is being used for Polyarticular juvenile idiopathic arthritis (pJIA): member has had therapeutic failure to two preferred NSAIDS agents
- If this is being used for Psoriasis: member has had therapeutic failure on a topical psoriasis agent (emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus AND pimecrolimus)

**Continuation criteria:** member is followed by a physician for monitoring of renal and hepatic function and complete blood counts with differential and platelet count

## Anticonvulsant – Cannabinoid Type

Last revised 07.15.2022

Generic	Brand
CANNABIDIOL	EPIDIOLEX SOLN 100 MG/ML

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member is  $\geq 1$  years? AND
- Diagnosed with Epilepsy and recurrent seizures including
  - Dravet Syndrome, or
  - Lennox-Gastaut Syndrome, or
  - Tuberous Sclerosi

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## Antifibrotic Therapy- Pyridone Analogs

Last revised: 1/29/2024; Effective date: 4/2/2024

Generic	Brand
PIRFENIDONE	ESBRIET

<b>Prior Authorization Criteria:</b>
<b>Length of Authorization:</b> <ul style="list-style-type: none"><li>• Initial: 12 months</li><li>• Reauthorization: 12 months</li></ul>
<b>Initial Review Criteria:</b> <ul style="list-style-type: none"><li>• Prescriber is a Pulmonologist,</li><li>• AND if ordering brand Esbriet, patient has tried and failed prior use of pirfenidone (generic Esbriet),</li><li>• AND patient is a non-smoker,</li><li>• AND patient is not receiving concomitant treatment with pirfenidone or any CYP1A2 inhibitors (e.g., fluvoxamine, ciprofloxacin),</li><li>• AND using for one of the following diagnoses:<ul style="list-style-type: none"><li>○ Idiopathic pulmonary fibrosis (IPF):<ul style="list-style-type: none"><li>▪ NO known cause of interstitial lung disease</li></ul></li><li>○ OR diagnosis of systemic sclerosis associated with interstitial lung disease (SSc-ILD) with greater than or equal to 10% fibrosis on a chest HRCT scan (conducted within last 12 months)</li></ul></li></ul>
<b>Continuation of Therapy Criteria:</b> <ul style="list-style-type: none"><li>• Patient continues to be under the care of a pulmonologist,</li><li>• AND hepatic function and spirometry are monitored at least annually,</li><li>• AND patient continues to meet initial criteria with positive clinical response</li></ul>

Kaiser Permanente Mid-Atlantic States Region  
Virginia (Medicaid) Prior Authorization and Step Therapy Criteria





## Anti-Inflammatory – Interleukin-1 Receptor Antagonist

Generic	Brand
ANAKINRA	KINERET SOSY

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Medication is being used for Cryopyrin-Associated Periodic Syndromes (CAPS) or treatment of Neonatal-Onset Multisystem Inflammatory Disease

OR

- Member has diagnosis of one of the following AND
  - Rheumatoid Arthritis (RA)
  - Juvenile Idiopathic Arthritis (JIA)
- Member had therapeutic failure on oral methotrexate AND
- Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND
  - If this is being used for Rheumatoid arthritis (RA): member tried and failed or had a contraindication, or adverse reaction to methotrexate and at least one other DMARD (sulfasalazine, hydroxychloroquine, minocycline)

## Anti-Inflammatory – Interleukin-1 Receptor Antagonist

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Generic	Brand
RILONACEPT	ARCALYST SOLR

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Medication is being used for:
- Cryopyrin-Associated Periodic Syndromes (CAPS)
- Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children  $\geq 12$  years old
- Maintenance of remission of deficiency of interleukin-1 receptor antagonist (DIRA) in adults and pediatric patients weighing  $\geq 10$  kg
- Member had therapeutic failure on oral methotrexate
- Member had therapeutic failure to one of the preferred agents

## Anti-inflammatory – Tumor Necrosis Factor Inhibitor (Cont'd)

Generic	Brand
CERTOLIZUMAB PEGOL	CIMZIA

Prior Authorization Criteria follows the state's criteria (DMAS)
<b>Length of Authorization:</b> 12 months
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Member has diagnosis of one of the following AND               <ul style="list-style-type: none"> <li>○ Rheumatoid Arthritis (RA)</li> <li>○ Adult Crohn's disease (CD)</li> <li>○ Psoriatic Arthritis (PsA)</li> <li>○ Ankylosing Spondylitis (AS)</li> <li>○ Active Non-radiographic Axial Spondylarthritis (nr-axSpA)</li> </ul> </li> <li>• Member had therapeutic failure on oral methotrexate AND</li> <li>• Member is not using Cimzia as combination therapy with methotrexate</li> <li>• Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND</li> <li>• If this is being used for Rheumatoid Arthritis (RA):               <ul style="list-style-type: none"> <li>○ Member tried and failed or have a contraindication, or adverse reaction to methotrexate alone and at least one other DMARD (azathioprine, hydroxychloroquine, leflunomide, sulfasalazine, etc.) AND</li> </ul> </li> <li>• If this is being used for Crohn's disease (CD):               <ul style="list-style-type: none"> <li>○ Member tried and failed a compliant regimen of oral corticosteroids (for moderate to severe CD) unless contraindicated, or intravenous corticosteroids (for severe and fulminant CD or failure to respond to oral corticosteroids) AND</li> <li>○ Member tried and failed a compliant regimen of azathioprine or mercaptopurine for three consecutive months, AND</li> <li>○ Member tried and failed a compliant regimen of parental methotrexate for 3 consecutive months</li> </ul> </li> <li>• If this is being used for Ankylosing Spondylitis (AS):               <ul style="list-style-type: none"> <li>○ Member tried and failed or have a contraindication, or adverse reaction to at least 2 NSAIDs</li> </ul> </li> <li>• If this is being used for Active Non-radiographic Axial Spondylarthritis (nr-axSpA):               <ul style="list-style-type: none"> <li>○ Member has objective signs of inflammation, AND</li> <li>○ Member tried and failed or have a contraindication, or adverse reaction to at least 2 NSAIDs</li> </ul> </li> </ul>

## Anti-Inflammatory – Tumor Necrosis Factor Inhibitor (Cont'd)

Generic	Brand
GOLIMUMAB	SIMPONI

Prior Authorization Criteria follows the state's criteria (DMAS)
<b>Length of Authorization:</b> 12 months
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Member has diagnosis of one of the following AND               <ul style="list-style-type: none"> <li>○ Rheumatoid Arthritis (RA)</li> <li>○ Psoriatic Arthritis (PsA)</li> <li>○ Ankylosing Spondylitis (AS)</li> <li>○ Ulcerative Colitis (UC)</li> </ul> </li> <li>• Member had therapeutic failure on oral methotrexate AND</li> <li>• Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND</li> <li>• If this is being used for Rheumatoid Arthritis (RA):               <ul style="list-style-type: none"> <li>○ Member tried and failed or have a contraindication, or adverse reaction to methotrexate alone and at least one other DMARD (sulfasalazine, hydroxychloroquine, minocycline)? AND</li> <li>○ Simponi is not being used as combination therapy with methotrexate</li> </ul> </li> <li>• If this is being used for Ulcerative Colitis (UC):               <ul style="list-style-type: none"> <li>○ Member tried and failed a compliant regimen of oral or rectal aminosalicylates (i.e., sulfasalazine or mesalamine) for two consecutive months AND</li> <li>○ Member tried and failed a compliant regimen of oral corticosteroids (for moderate to severe CD) unless contraindicated, or intravenous corticosteroids (for severe and fulminant CD or failure to respond to oral corticosteroids) AND</li> <li>○ Member tried and failed a compliant regimen of azathioprine or mercaptopurine for three consecutive months</li> </ul> </li> </ul>

## Anti-inflammatory – Interleukin-1 Beta Blockers

Generic	Brand
CANAKINUMAB	ILARIS SOLN

<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>
<b>Length of Authorization:</b> 12 months
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Member has diagnosis of one of the following             <ul style="list-style-type: none"> <li>○ Cryopyrin-Associated Periodic Syndromes (CAPS)</li> <li>○ Familial Cold Autoinflammatory Syndrome (FCAS)</li> <li>○ Muckle-Wells Syndrome (MWS)</li> <li>○ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS)</li> <li>○ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD)</li> <li>○ Familial Mediterranean Fever (FMF) Member had therapeutic failure on oral methotrexate</li> </ul> </li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• Member has diagnosis of Juvenile Idiopathic Arthritis (JIA), AND</li> <li>• Member failed oral methotrexate, AND</li> <li>• Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• Member is using for Systemic Juvenile Idiopathic Arthritis (SJIA) and is <math>\geq 2</math> years</li> </ul>

## Anti-Inflammatory – Phosphodiesterase-4 (PDE4) Inhibitor

Generic	Brand
APREMILAST	OTEZLA

<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>
<b>Length of Authorization:</b> 12 months
<b>Initial Review Criteria</b> <ul style="list-style-type: none"><li>• Member has a diagnosis of one of the following AND<ul style="list-style-type: none"><li>○ Psoriatic arthritis (PsA)</li><li>○ Plaque Psoriasis (PsO)</li></ul></li><li>• Member had therapeutic failure on oral methotrexate AND</li><li>• Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND</li><li>• If this is being used for Plaque Psoriasis:<ul style="list-style-type: none"><li>○ Member had therapeutic failure on a topical psoriasis agent AND</li><li>○ Member is not a candidate for phototherapy or systemic therapy</li></ul></li></ul>

## Anti-Narcolepsy, Anti-Cataplexy, Sedative-Type Agent

Generic	Brand
SODIUM OXYBATE	XYREM

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is Pulmonologist (Sleep Specialist) and Neurologist, AND</li> <li>• Prescriber must enroll in Xyrem Patient Success Program, AND</li> <li>• Diagnosis of excessive daytime sleepiness in narcolepsy:</li> <li>• Adequate trial (<math>\geq 2</math> months) of a preferred stimulant (methylphenidate, amphetamine salt combination, dextroamphetamine) <u>AND</u> modafinil/armodafinil, unless contraindicated, AND</li> <li>• Adequate trial of Sunosi (<math>\geq 2</math> months) AND Wakix (<math>\geq 2</math> months), unless contraindicated OR if patient initiated Xyrem prior to market release of Sunosi and Wakix AND</li> <li>• Patient is 7 years to 65 years of age, AND</li> <li>• Patient may NOT be on any sedative-hypnotic agents, opioids, benzodiazepines, or alcohol, AND</li> <li>• Patient has had adequate trial (<math>\geq 2</math> months) of Xywav</li> </ul> <p style="text-align: center;">- OR -</p> <ul style="list-style-type: none"> <li>• Diagnosis of cataplexy due to narcolepsy, AND</li> <li>• Adequate trial (<math>\geq 2</math> months) of at least 2 of the following: TCAs, SSRI, or SNRI or there is a contraindication</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Patient continues to be under the care of a specialist, AND</li> <li>• Documentation of positive clinical response</li> </ul>

## Anti-inflammatory – Selective Costimulation Modulator

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Generic	Brand
ABATACEPT	ORENCIA

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member has diagnosis of one of the following AND
    - Rheumatoid Arthritis (RA)
    - Juvenile Idiopathic Arthritis (JIA)
  - Member had therapeutic failure on oral methotrexate AND
  - Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND
  - Member tried and failed another DMARD (other than Methotrexate), such as minocycline, hydroxychloroquine, sulfasalazine if using for RA
-



## Anti-psoriatic Agents

Last revised 12.1.2023; Effective 1.1.2024

Generic	Brand
SECUKINUMAB	COSENTYX

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member has diagnosis of at least one of the following, AND
  - Psoriatic arthritis (PsA)
  - Ankylosing Spondylitis (AS)
  - Plaque Psoriasis (PsO)
  - Active Non-Radiographic Spondyloarthritis
  - Active Enthesitis-related arthritis (ERA) in patients 4 years of age and older
- Member had therapeutic failure on oral methotrexate AND
- Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira), AND
- If this is being used for Plaque Psoriasis: member must have therapeutic failure on a topical psoriasis agent

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## Anti-psoriatic Agents (Cont'd)

Generic	Brand
TILDRAKIZUMAB-ASMN	ILUMYA
RISANKIZUMAB-RZAA	SKYRIZI
GUSELKUMAB	TREMFYA

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member has diagnosis of one of the following
- Plaque Psoriasis (PsO),
- Psoriatic Arthritis (PsA)
- Member failed oral methotrexate, AND
- Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND
- Member has had moderate-to-severe plaque psoriasis for at least 6 months AND
  - There is involvement of at least 10% of body surface area (BSA) OR
  - Psoriasis Area and Severity Index (PASI) score 10 or greater OR
  - Incapacitation due to plaque location (e.g., head and neck, palms, soles or genitalia)
 AND
- Member has not responded adequately (or is not a candidate) to a 3-month minimum trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues) AND
- Member has not responded adequately (or is not a candidate) to a 3-month minimum trial of at least 1 systemic agent (e.g. Immunosuppressives, retinoic acid derivatives, and/or methotrexate) AND
- Member has not responded adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g. Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol)

**Additional criteria for Skyrizi:**

- Diagnosis of Crohn's disease
- Patient is ≥ 18 years, AND
- Diagnosis of moderate to severe Crohn's Disease, AND
- Trial and failure of a compliant regimen of oral corticosteroids unless contraindicated or intravenous corticosteroids, AND
- Patient is not receiving risankizumab-rzaa in combination with another biologic agent for psoriasis or non-biologic immunomodulator (e.g., upadacitinib)
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## Anti-psoriatic Agents (Cont'd)

Generic	Brand
BRODALUMAB	SILIQ

Prior Authorization Criteria follows the state's criteria (DMAS)
<b>Length of Authorization:</b> 12 months initial; 12 months continuation
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Member has diagnosis of Plaque Psoriasis (PsO), AND</li> <li>• Member failed oral methotrexate (at least 3 months) unless contraindication or intolerance , AND</li> <li>• Member had therapeutic failure to both preferred agents (e.g. Enbrel, Humira) AND</li> <li>• Member has had moderate-to-severe plaque psoriasis AND               <ul style="list-style-type: none"> <li>○ There is involvement of at least 5% of body surface area (BSA) OR palmoplantar, facial, genital, or severe scalp psoriasis</li> </ul> </li> <li>• Member has not responded adequately (or is not a candidate) to a 3-month minimum trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues) AND</li> <li>• Member is not receiving Siliq in combination with any of the following:               <ul style="list-style-type: none"> <li>○ Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]</li> <li>○ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]</li> <li>○ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]</li> </ul> </li> </ul> <p><b>Continuation Criteria:</b></p> <ul style="list-style-type: none"> <li>• There is documentation of positive clinical response to Siliq therapy AND</li> <li>• Member is not receiving Siliq in combination with any of the following:               <ul style="list-style-type: none"> <li>○ Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]</li> <li>○ Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]</li> <li>○ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]</li> </ul> </li> </ul>

## Anti-psoriatic Agents (Cont'd)

Generic	Brand
IXEKIZUMAB	TALTZ

<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>
<b>Length of Authorization:</b> 12 months initial
<b>Initial Review Criteria:</b> <ul style="list-style-type: none"> <li>• Member has diagnosis of one of the following, AND: <ul style="list-style-type: none"> <li>○ Plaque Psoriasis (PsO) adults and children 6 years of age or older who are candidates for systemic therapy or phototherapy</li> <li>○ Psoriatic Arthritis (PsA)</li> <li>○ Ankylosing Spondylitis (AS)</li> <li>○ Non-Radiographic spondyloarthritis (nr-axSpA)</li> </ul> </li>   <li>• Member failed oral methotrexate (at least 3 months) unless contraindication or intolerance, AND</li> <li>• Member had therapeutic failure to one preferred agent (e.g. Enbrel, Humira) AND</li> <li>• Member has not responded adequately (or is not a candidate) to a 3-month minimum trial of at least 2 topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)</li> </ul>

## Anti-psoriatic Agents (Cont'd)

Generic	Brand
BIMEKIZUMAB-BKZX	BIMZELX

<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>
<b>Length of Authorization:</b> 12 months
<b>Review Criteria:</b> <ul style="list-style-type: none"><li>• Diagnosis of Plaque Psoriasis (PsO), moderate to severe, adult candidates for systemic therapy or phototherapy</li><li>• Member has a prior failure on a topical agent.</li><li>• Member is candidate for systemic therapy or phototherapy.</li></ul>

## Arginine Vasopressin (AVP) Receptor Antagonists

*Last revised: 10/3/2023*

Generic	Brand
TOLVAPTAN	JYNARQUE

<p><b>Prior Authorization Criteria: (Jynarque)</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Nephrologist, AND</li> <li>• Patient must be 18 years to 55 years old, AND</li> <li>• eGFR <math>\geq 25</math> mL/min/1.73 m<sup>2</sup>, AND</li> <li>• Baseline labs completed within 30 days and within normal limits: ALT, AST, bilirubin; and negative pregnancy test (if applicable), AND</li> <li>• Patient has a diagnosis of typical autosomal dominant polycystic kidney disease (ADPKD) confirmed by one of the following:             <ul style="list-style-type: none"> <li>○ Ultrasonography:                 <ul style="list-style-type: none"> <li>▪ With family history: <math>\geq 3</math> cysts (unilateral or bilateral) in patients aged 15-39 years OR <math>\geq 2</math> cysts in each kidney in patients aged 40-59 years</li> <li>▪ Without family history: <math>\geq 10</math> cysts per kidney</li> </ul> </li> </ul> </li> </ul> <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> <li>○ Magnetic resonance imaging (MRI) or computed tomography (CT) scan:                 <ul style="list-style-type: none"> <li>▪ With family history: <math>\geq 5</math> cysts per kidney</li> <li>▪ Without family history: <math>\geq 10</math> cysts per kidney</li> </ul> </li> </ul> <p style="text-align: center;">-AND -</p> <ul style="list-style-type: none"> <li>• High risk of disease progression defined by one of the following:             <ul style="list-style-type: none"> <li>○ Mayo ADPKD Classification 1C, 1D, or 1E</li> <li>○ eGFR decline <math>\geq 5</math> mL/min/1.73m<sup>2</sup> in one year OR eGFR decline <math>\geq 2.5</math> mL/min/1.73m<sup>2</sup> per year over a period of <math>\geq 5</math> years</li> <li>○ Truncating PKD1 mutation AND PROPKD score <math>&gt;6</math></li> </ul> </li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Positive clinical response to tolvaptan, AND</li> <li>• eGFR <math>&gt;25</math> mL/min/1.73 m<sup>2</sup>, AND</li> <li>• Patient has followed-up with a Nephrologist within the past 12 months</li> </ul>

## Glucocorticoids

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Generic	Brand
DEFLAZACORT	EMFLAZA

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member is  $\geq 2$  years AND
- Prescribed for Duchenne muscular dystrophy (DMD)

## Interleukin-5 (IL-5) Receptor Alpha Antagonist, MAB

*Last revised: 2/6/2024*

Generic	Brand
BENRALIZUMAB	FASENRA

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 6 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is Pulmonologist, Allergist, or Immunologist</li> <li>• AND diagnosis/documentation of uncontrolled moderate to severe asthma defined as any of the following:                             <ul style="list-style-type: none"> <li>• ≥2 exacerbations in the past 12 months requiring systemic corticosteroids for more than 3 days</li> <li>• ≥1 asthma exacerbation(s) leading to hospitalization in the past 12 months</li> </ul> </li> <li>• Dependence on daily oral corticosteroids (OCS) for asthma control</li> <li>• Poor symptom control (ACT score less than 20)</li> <li>• AND patient has uncontrolled asthma despite good adherence (at least 75% over the past 3 months) to a regimen containing: a high dose inhaled corticosteroid, long-acting beta 2 agonist, AND long-acting muscarinic antagonist, and consideration given to use of a leukotriene receptor antagonist</li> <li>• AND patient is ≥12 years</li> <li>• AND Fasenra is being used for one of the following indications:                             <ul style="list-style-type: none"> <li>○ Eosinophilic asthma (non-OCS dependent) with serum eosinophil count ≥300 cells/microliter in the past 12 months</li> <li>○ OR eosinophilic asthma (OCS-dependent) with serum eosinophil count ≥150 cells/microliter in the past 12 months</li> </ul> </li> <li>• AND Fasenra will NOT be used with Dupixent (dupilumab), Cinqair (reslizumab), Nucala (mepolizumab), Xolair (omalizumab), or Tezspire (tezepelumab-ekko)</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Patient continues to be under the care of a pulmonologist/allergist,</li> <li>• AND documentation of positive clinical response to Fasenra therapy</li> </ul>



## Interleukin-6 (IL-6) Receptor Inhibitors (Actemra and Kevzara)

*Last revised: 12.01.2023; Effective 1.1.2024*

Generic	Brand
TOCILIZUMAB	ACTEMRA
SARILUMAB	KEVZARA
<b>Prior Authorization Criteria follows the state's criteria (DMAS)</b>	
<b>Length of Authorization:</b> 12 months	
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Member has diagnosis of one of the following AND               <ul style="list-style-type: none"> <li>○ Rheumatoid Arthritis (RA)</li> <li>○ Systemic Juvenile Idiopathic Arthritis (SJIA)</li> <li>○ Polyarticular juvenile idiopathic arthritis (pJIA)</li> </ul> </li> <li>• Member had therapeutic failure on oral methotrexate AND</li> <li>• Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND</li> </ul> <p><b>Additional criteria for Actemra:</b></p> <ul style="list-style-type: none"> <li>• Being used for Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA) or Systemic Juvenile Idiopathic Arthritis (SJIA):               <ul style="list-style-type: none"> <li>○ Member tried and failed Methotrexate, OR</li> <li>○ This medication be used in conjunction with Methotrexate OR</li> <li>○ Member has a contraindication to Methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication) AND</li> </ul> </li> <li>• Member tried and failed another DMARD (other than Methotrexate), such as azathioprine, d-penicillamine, cyclophosphamide, cyclosporine, gold salts, hydroxychloroquine, leflunomide, sulfasalazine, or tacrolimus</li> </ul> <p><b>Additional criteria for Kevzara:</b></p> <ul style="list-style-type: none"> <li>• Rheumatoid arthritis (RA)</li> <li>• Initial review Criteria:               <ul style="list-style-type: none"> <li>○ ≥18 years old? AND</li> <li>○ Diagnosis of moderately to severely active rheumatoid arthritis (RA) AND</li> <li>○ Prescribed by or in consultation with a rheumatologist AND</li> </ul> </li> <li>• History of failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex /Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine) AND Renew Criteria               <ul style="list-style-type: none"> <li>○ The member must not be receiving Kevzara in combination with any of the following:                   <ul style="list-style-type: none"> <li>▪ Biologic DMARD (e.g., Enbrel, Humira, Cimzia, Simponi)</li> <li>▪ Janus kinase inhibitor (e.g., Xeljanz, Olumiant)</li> <li>▪ Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]</li> </ul> </li> </ul> </li> <li>• Polymyalgia Rheumatica (PMR):</li> <li>• Initial review Criteria:               <ul style="list-style-type: none"> <li>○ ≥18 years old? AND</li> <li>○ Diagnosis of Polymyalgia Rheumatica (PMR)-AND</li> <li>○ Prescribed by or in consultation with a rheumatologist -AND</li> </ul> </li> </ul>	

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- History of failure, contraindication, or intolerance to corticosteroids or who cannot tolerate a steroid taper.
- Renew Criteria:
  - Patient is not receiving Kevzara in combination with any of the following:
    - Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
    - Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
    - Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

## Interleukin-6 (IL-6) Receptor Inhibitors-Enspryng

Generic	Brand
SATRALIZUMAB-MWGE	ENSPRYNG

<b>Prior Authorization Criteria follows DMAS's criteria</b>
<b>Length of Authorization:</b> 12 months
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Member has diagnosis of Neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive (NMOSD)</li> <li>• Patient has a confirmed diagnosis based on the following:             <ul style="list-style-type: none"> <li>○ Patient was found to be seropositive for aquaporin-4 (AQP4) IgG antibodies; AND</li> <li>○ Patient has ≥ 1 core clinical characteristic (e.g., optic neuritis, acute myelitis, area postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions, symptomatic cerebral syndrome with NMOSD-typical brain lesions); AND</li> </ul> </li> <li>• Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection)</li> </ul>

## Janus Kinase (JAK) Inhibitor

Last Revised 07/15/2022

Generic	Brand
TOFACITINIB CITRATE	XELJANZ XELJANZ XR

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member has diagnosis of one of the following:
  - Rheumatoid Arthritis (RA)
  - Psoriatic arthritis (PsA)
  - Ulcerative Colitis (UC)
  - Ankylosing spondylitis
- Member had therapeutic failure on oral methotrexate AND
- Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND
- If this is being used for Rheumatoid Arthritis (RA) or Psoriatic arthritis (PsO): member had therapeutic failure on or contraindication, or adverse reaction to methotrexate and at least one other DMARD (sulfasalazine, hydroxychloroquine, minocycline)
- If this is being used for Ulcerative Colitis (UC) OR Ankylosing spondylitis: member had therapeutic failure on, inadequate response or intolerant to TNF blockers

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## Janus Kinase (JAK) Inhibitor (Cont'd)

*Last Revised 12.1/2023*

Generic	Brand
BARICITINIB	OLUMIANT
UPADACITINIB	RINVOQ
ABROCITINIB	CIBINQO

**Prior Authorization Criteria follows the state's criteria (DMAS)**

**Length of Authorization:** 12 months

**Initial Review Criteria:**

- Member has diagnosis of Rheumatoid Arthritis (RA)
- Member had therapeutic failure on oral methotrexate AND
- Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira) AND
- Member is not using in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants such as azathioprine or cyclosporine, AND

**Additional criteria for Olumiant:**

- Member is ≥18 years, AND
- Member had therapeutic failure on, inadequate response to or intolerant to TNF blockers

**Additional criteria for Rinvoq**

- ≥18 years, and
  - Diagnosis of psoriatic arthritis
  - Ankylosing spondylitis
  - Ulcerative colitis
  - Non-radiographic axial spondylarthritis
  - Moderate to severe Crohn's Disease
- ≥12 years, and
  - Atopic dermatitis

**Additional criteria for Cibinqo:**

- ≥12 years, and
- Diagnosis of moderate to severe atopic dermatitis, and
- Documented trial and failure (or contraindication) of 1 topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) and 1 topical calcineurin inhibitor (tacrolimus or pimecrolimus), and
- Inadequate response to a 3-month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.), and

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- Inadequate response (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc.) provided member has reasonable access to photo treatment

## **Monoclonal Antibodies to Immunoglobulin E (IGE)**

*Last Revised 2/6/2024*

<b>Generic</b>	<b>Brand</b>
OMALIZUMAB	XOLAIR

<b>Prior Authorization Criteria:</b>
<b>Length of Authorization:</b> <ul style="list-style-type: none"> <li>• Initial: 6 months</li> <li>• Reauthorization: 12 months</li> </ul>
<b>Initial Review Criteria:</b> <p><b>If using for asthma:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Pulmonologist or Allergist,</li> <li>• AND diagnosis of uncontrolled moderate to severe asthma defined as any of the following: <ul style="list-style-type: none"> <li>○ ≥2 exacerbations in the past 12 months requiring systemic corticosteroids for more than 3 days</li> <li>○ ≥1 asthma exacerbation(s) leading to hospitalization in the past 12 months</li> <li>○ Dependence on daily oral corticosteroids (OCS) for asthma control</li> <li>○ Poor symptom control (ACT score less than 20)</li> </ul> </li> <li>• AND patient has uncontrolled asthma despite good adherence (at least 75% over the past 3 months) to a regimen containing: a high dose inhaled corticosteroid, long-acting beta 2 agonist, AND long-acting muscarinic antagonist, and consideration given to use of a leukotriene receptor antagonist,</li> <li>• AND patient is ≥6 years,</li> <li>• AND clinical diagnosis of allergic asthma,</li> <li>• AND if requiring Xolair q2week dosing, patient has documented treatment failure, contraindication, or inadequate response to Dupixent,</li> <li>• AND Xolair will NOT be used with Fasentra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Nucala (mepolizumab), or Tezspire (tezepelumab-ekko)</li> </ul> <p><b>If using for nasal polyps:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Allergist or ENT Specialist,</li> <li>• AND diagnosis of rhinosinusitis with nasal polyps,</li> <li>• AND history of failure, inadequate response, contraindication, or intolerance to Dupixent (dupilumab)</li> </ul> <p><b>If using for chronic spontaneous urticaria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Allergist or Dermatologist,</li> <li>• AND diagnosis of chronic spontaneous urticaria,</li> <li>• AND patient is 12 years of age or older,</li> <li>• AND tried and failed therapy for minimum of 4 weeks on ALL of the following, unless contraindicated: <ul style="list-style-type: none"> <li>○ At least two different high-dose second generation H1-antihistamines (e.g. loratadine, cetirizine) 2-4 times normal dose daily OR two second-generation H1-antihistamines in combination (e.g. fexofenadine 180 mg daily in the morning plus cetirizine 10-20 mg daily at bedtime),</li> <li>○ AND montelukast in combination with a high-dose second generation H1-antihistamine,</li> <li>○ AND H2-antihistamines (e.g. famotidine, ranitidine) in combination with a high-dose second generation H1-antihistamine</li> </ul> </li> </ul>

**Continuation of Therapy Criteria:**

- Patient continues to be under the care of a specialist,
- AND documentation of positive clinical response to Xolair therapy since last review



## Monoclonal Antibody Human Interleukin 12/23 Inhibitor

Generic	Brand
USTEKINUMAB	STELARA

### Prior Authorization Criteria follows the state's criteria (DMAS)

- **Length of Authorization:** 12 months

#### Initial Review Criteria:

- Member has diagnosis of at least one of the following, AND
  - Adult Crohn's disease (CD)
  - Psoriatic arthritis (PsA)
  - Ulcerative Colitis (UC)
  - Plaque Psoriasis (PsO), adult and pediatric patient 6 years of age and older
- Member had therapeutic failure on oral methotrexate AND
- Member had therapeutic failure to one of the preferred agents (e.g. Enbrel, Humira)

## Monoclonal Antibody- Interleukin-5 Antagonist

*Last revised: 2/6/2024*

Generic	Brand
MEPOLIZUMAB	NUCALA

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 6 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is Pulmonologist, Allergist, or Rheumatologist,</li> <li>• AND diagnosis of uncontrolled moderate to severe asthma defined as any of the following:               <ul style="list-style-type: none"> <li>○ ≥2 exacerbations in the past 12 months requiring systemic corticosteroids for more than 3 days</li> <li>○ ≥1 asthma exacerbation(s) leading to hospitalization in the past 12 months</li> <li>○ Dependence on daily oral corticosteroids (OCS) for asthma control</li> <li>○ Poor symptom control (ACT score less than 20)</li> </ul> </li> <li>• AND patient has uncontrolled asthma despite good adherence (at least 75% over the past 3 months) to a regimen containing: a high dose inhaled corticosteroid, long-acting beta 2 agonist, AND long-acting muscarinic antagonist, and consideration given to use of a leukotriene receptor antagonist,</li> <li>• AND patient is ≥ 6 years,</li> <li>• AND Nucala will NOT be used with Fasentra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab), or Tezspire (tezepelumab-ekko)</li> <li>• AND Nucala is being used for one of the following indications:               <ul style="list-style-type: none"> <li>○ Eosinophilic asthma (non-OCS dependent) with serum eosinophil count ≥300 cells/microliter in the past 12 months,</li> <li>○ OR eosinophilic asthma (OCS-dependent) with serum eosinophil count ≥150 cells/microliter in the past 12 months,</li> <li>○ OR eosinophilic granulomatosis with polyangiitis in patients ≥18 years</li> </ul> </li> <li>• AND if using for eosinophilic asthma and aged 6-12 years, documented treatment failure, contraindication or inadequate response to Dupixent (dupilumab),</li> <li>• AND if using for eosinophilic asthma and ≥12 years, documented treatment failure, contraindication or inadequate response to Fasentra <u>AND</u> Dupixent</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Patient continues to be under the care of a specialist, AND</li> <li>• Documentation of positive clinical response to Nucala therapy in combination therapy</li> </ul>

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## Pulmonary Fibrosis- Systemic Enzyme Inhibitors

*Last revised: 1/29/2024; Effective date: 4/2/2024*

Generic	Brand
NINTEDANIB ESYLATE	OFEV

<b>Prior Authorization Criteria:</b>
<b>Length of Authorization:</b> <ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>
<b>Initial Review Criteria:</b> <ul style="list-style-type: none"> <li>• Prescriber is a Pulmonologist,</li> <li>• AND patient is a non-smoker,</li> <li>• AND patient is not receiving concomitant treatment with pirfenidone or any CYP3A4 inducers,</li> <li>• AND pregnancy has been excluded in patients of reproductive potential prior to starting treatment, and patient has been provided with contraceptive counseling on the risks of taking nintedanib if the patient were to become pregnant,</li> <li>• AND using for one of the following diagnoses:               <ul style="list-style-type: none"> <li>○ Idiopathic pulmonary fibrosis (IPF):                   <ul style="list-style-type: none"> <li>▪ NO known cause of interstitial lung disease</li> <li>▪ AND patient has tried and failed prior use of pirfenidone (generic Esbriet)</li> </ul> </li> <li>○ OR diagnosis of progressive pulmonary fibrosis</li> <li>○ OR diagnosis of systemic sclerosis associated with interstitial lung disease (SSc-ILD) with greater than or equal to 10% fibrosis on a chest HRCT scan (conducted within last 12 months)</li> </ul> </li> </ul>
<b>Continuation of Therapy Criteria:</b> <ul style="list-style-type: none"> <li>• Patient continues to be under the care of a pulmonologist,</li> <li>• AND hepatic function and spirometry are monitored at least annually,</li> <li>• AND patient continues to meet initial criteria with positive clinical response</li> </ul>

## Antibiotics, Inhaled (Tobi Podhaler) – Step Therapy (ST)

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Generic	Brand
TOBRAMYCIN	TOBI PODHALER

\*representative list

### Step Therapy Criteria:

Adapted from DMAS Preferred Drug List– Step Therapy (ST)

#### Length of Authorization:

- Initial: 1 year
- Reauthorization: 1 year

#### Initial Review Criteria:

- Patient must be  $\geq 6$  years old
- Must provide a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used

#### Continuation of Therapy Criteria:

- Documentation of continued medical necessity

## Antiemetic Agents (Cannabinoid Derivatives)

Generic	Brand
DRONABINOL	MARINOL, SYNDROS
NABILONE	CESAMET

\*representative list

### **Prior Authorization Criteria:** *Adapted from DMAS Preferred Drug List*

#### **Length of Authorization:**

- Initial: 6 months
- Reauthorization: 6 months

#### **Initial Review Criteria:**

- Patient must have diagnosis of HIV or Cancer (FDA-approved age indication)
- Non-preferred agents must have documented trial and treatment failure with dronabinol (generic) prior to approval

#### **Continuation of Therapy Criteria:**

- Documentation of continued medical necessity

## Antimigraine

*Last revised 12/18/2023 06/09/2023 (Effective 02/06/2024)*

Generic	Brand
ERENUMAB-AOOE	AIMOVIG
FREMANEZUMAB-VFRM	AJOVY
GALCANEZUMAB-GNLM	EMGALITY
LASMIDTAN	REYVOW
UBROGEPANT	UBRELVY
RIMEGEPANT SULFATE	NURTEC
ATOGEANT	QULIPTA
DIHYDROERGOTAMINE MESYLATE	TRUDHESA
ZAVEGEPANT	ZAVZEPRET

\*representative list

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**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 6 months
- Reauthorization: 1 year

**Initial Review Criteria:**

- Patient must be 18 years old or older

For preventative treatment of migraine:

- Preferred agents are Aimovig, Ajovy, Emgality 120 mg, and Nurtec ODT
- Diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria, AND
- Patient has  $\geq 4$  migraine days per month for at least 3 months, AND
- Tried and failed a  $\geq 1$ -month trial of any 2 of the following oral generic medications:
  - Antidepressants (e.g., amitriptyline, venlafaxine)
  - Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
  - Anti-epileptics (e.g., valproate, topiramate)
  - Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)
- For the non-preferred agents, Emgality 100 mg and Qulipta, the above criteria apply and non-formulary exception is required for using the non-preferred product.

For acute treatment of migraine:

- Preferred Nurtec ODT and Ubrelvy require trial of 2 generic triptans
- Non-preferred Reyvow and Trudhesa must meet the following criteria:
  - Diagnosis of migraine with or without aura, AND
  - Trial and failure, or has contraindications to, two preferred triptans, AND
  - Non-formulary exception is required for using the non-preferred product.
  - Additional criteria for Trudhesa (dihydroergotamine mesylate) only:
    - Completion of cardiovascular evaluation prior to initiation of Trudhesa

For Episodic Cluster Headache:

- Diagnosis of episodic cluster headache, AND
- Patient experienced at least two cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months, AND
- Medication requested will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines, AND
- Trial and failure (or has contraindications to) of at least one formulary preferred therapy for cluster headache

**Continuation of Therapy Criteria:**

- Patient demonstrates a significant decrease in the number, frequency, and/or intensity of headache

## Weight Loss Drugs

*Revised January 18, 2024 ; Effective 02.06.2024*

Generic	Brand
ORLISTAT	XENICAL
BENZPHETAMINE HCL	DIDREX, REGIMEX
PHENTERMINE HCL	ADIPEX-P, OBY-CAP, LOMAIRA
DIETHYLPROPION HCL	DIETHYLPROPION HCL
PHENDIMETRAZINE TARTRATE	BONTRIL PDM, BONTRIL SLOW-RELEASE
PHENTERMINE HCL-TOPIRAMATE	QSYMIA
NALTREXONE HCL-BUPROPION HCL	CONTRAVE ER
LIRAGLUTIDE	SAXENDA
SEMAGLUTIDE	WEGOVY
LIRAGLUTIDE	SAXENDA
SETMELANOTIDE ACETATE	IMCIVREE
TIRZEPATIDE	ZEPBOUND

\*representative list



**Prior Authorization Criteria:**  
**Adapted from DMAS Preferred Drug List**

Length of Authorization:

- Initial:
  - 3 months: Benzphetamine, diethylpropion, phendimetrazine, phentermine, Qsymia, Contrave
  - 4 months: Saxenda, Imcivree
  - 6 months: Wegovy, Zepbound, Xenical/Alli

Initial Review Criteria:

- Body Mass Index (BMI) Requirements:
  - BMI  $\geq$  30, if no applicable risk factors
  - BMI  $\geq$  27, with 2 or more of the following risk factors:
    - Coronary heart disease
    - Dyslipidemia
    - Hypertension
    - Sleep apnea
    - Type 2 Diabetes
- Pediatric Patients  
**Imcivree**
  - BMI  $\geq$  30 or  $\geq$  95th percentile on pediatric growth chart (Imcivree™)
- Wegovy®, Saxenda®, and Zepbound**
  - Patient 12–18 years of age, with a BMI of  $\geq$  140% of the 95th percentile by age and sex
  - Patient 12 – 18 years of age, with an initial BMI that is  $\geq$  120% of the 95th percentile by age and sex with two or more of the following risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes
- Age Restrictions:
  - Must be  $\geq$  16 years old, except for
  - Saxenda and Wegovy covered for patients  $\geq$  12 years old
  - Imcivree covered for members  $\geq$  6 years old
  - Zepbound, Contrave covered for members  $\geq$  18 years old
- No contraindications to use including: no malabsorption syndromes, cholestasis, pregnancy and/or lactation, no history of eating disorders, previous failure of a weight loss treatment plan in the past 6 months and will continue to follow as a part of the total treatment plan (excludes Imcivree);
- Provider attest patient's obesity is disabling and life threatening (i.e., puts the patient at risk for high-morbidity conditions)

**Additional Criteria for Imcivree™**

- Prescribed by or in consultation with an endocrinologist or geneticist; AND

- Member has proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test; AND
- Member's genetic variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS)
- Member has Bardet-Biedl syndrome (BBS)

**Additional Criteria for Saxenda, Wegovy, Zepbound**

- Trail and failure of a 30-day therapy of a non-GLP-1 weight loss drug in the last 6 months with listed outcomes, OR
- A documented intolerance or allergy to a non-GLP-1 weight loss drug:
- Member is not concurrently on Victoza® or Ozempic® or other GLP-1 inhibitors

**Written Documentation Required for:**

- Current medical status including nutritional or dietetic assessment
- Current therapy for all medical condition(s) including obesity, identifying specific treatments including medications
- Current accurate height and weight measurements
- Current weight loss plan or program including diet and exercise plan
- No medical contraindications to use a reversible lipase inhibitor (Xenical®)
- No chronic opioid use concurrently with Contrave®

## Continuation of Therapy Criteria Weight Loss drugs

**Note:** *Applicable to all WL therapies:*

- *Members lacking a weight loss response may still be considered for renewal with two or more of the following weight related risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes.*
- *At this time, authorization requests over one year are subject to initial criteria including all documentation.*
- *In the event of an FDA recognized shortage, approved members will be eligible for the full allotment of approved drug once the shortage is resolved.*

Renewal requests: Varies (drug specific)

- Benzphetamine, diethylpropion, phendimetrazine, phentermine – If the member achieves at least a 10 lb. weight loss during the initial 3 months of therapy, an additional 3-month approval may be granted. Maximum length of continuous drug therapy is 6 months (waiting period of 6 months before next request).
- Qsymia® – If the member achieves a weight loss of at least 3% of baseline weight, an additional 3-month approval may be granted. For a subsequent renewal, member must meet a weight loss of at least 5% of baseline weight to qualify for an additional 6-month SA. Maximum length of continuous drug therapy is 12 months (waiting period of 6 months before next request).
- Alli®/Xenical® – If the member achieves at least a 10 lb. weight loss, an additional 6-month approval may be granted. Maximum length of continuous drug therapy is 24 months (waiting period of 6 months before next request).
- Contrave® – Approve for 6 months with each renewal if weight reduction continues.
- Saxenda® – If the member achieves a weight loss of at least 4% of baseline weight, an additional 6-month approval may be granted as long as weight reduction continues.
- Imcivree™ – If the member has experienced  $\geq 5\%$  reduction in body weight (or  $\geq 5\%$  of baseline BMI in those with continued growth potential), an additional 1 year SA may be granted.
- Wegovy™, Zepbound - If the member achieves a weight loss of at least 5% of baseline weight, an additional 6 month SA may be granted.
- Members lacking a weight loss response may still be considered for renewal with two or more of the following weight related risk factors: coronary heart disease, dyslipidemia, hypertension, sleep apnea, type 2 diabetes.
- At this time, authorization requests over one year are subject to initial criteria including all documentation.
- In the event of an FDA recognized shortage, approved members will be eligible for the full allotment of approved drug once the shortage is resolved.

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Continuation of Therapy Criteria:

- BMI  $\geq$  24
- Continue to meet all Initial Criteria
- Documentation of continued weight loss

## Antipsychotic Agents -Atypical, long acting injectable

Generic	Brand
CLOZAPINE	FAZACLO, CLOZARIL
OLANZAPINE, OLANZAPINE PAMOATE	ZYPREXA, ZYPREXA RELPREVV
HALOPERIDOL LACTATE, HALOPERIDOL , HALOPERIDOL DECANOATE	HALDOL
FLUPHENAZINE HCL, FLUPHENAZINE DECANOATE	
THIORIDAZINE HCL	
THIOTHIXENE	
CHLORPROMAZINE HCL	
TRIFLUOPERAZINE HCL	
PERPHENAZINE	
QUETIAPINE FUMARATE	SEROQUEL
ARIPIRAZOLE	ABILIFY
PIMOZIDE	ORAP
RISPERIDONE, RISPERIDONE MICROSPHERES	RISPERDAL, PERSERIS RISPERDAL CONSTA
ZIPRASIDONE HCL, ZIPRASIDONE MESYLATE	GEODON
ARIPIRAZOLE LAUROXIL	ARISTADA, ARISTADA INITIO
PALIPERIDONE, PALIPERIDONE PALMITATE	INVEGA
LOXAPINE, LOXAPINE SUCCINATE	ADASUVE
ILOPERIDONE	FANAPT
BREXPIRAZOLE	REXULTI
CARIPRAZINE HCL	VRAYLAR
ASENAPINE MALEATE	SAPHRIS
LURASIDONE HCL	LATUDA
MOLINDONE HCL	
PIMAVANSERIN TARTRATE	NUPLAZID
OLANZAPINE-SAMIDORPHAN L-MALATE	LYBALV

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Required for use of antipsychotics in children ≤ 17 years old
- Prescribing provider must be either a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician or have consulted with one of these providers before prescribing the requested medication
- Documentation of a developmentally appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target, and treatment plans clearly identified
- Documentation of psychosocial treatment without adequate clinical response
- Documentation of patient's current behavior health program and pharmaceutical agents attempted with outcomes
- Treatment plan includes psychosocial treatment with parental involvement for the duration of medication therapy
- Documentation of informed consent for this medication from the parent or guardian
- Documentation of a family assessment having been performed, including parental psychopathology and treatment needs
- Documentation of evaluation of family functioning and parent-child relationship

**Continuation of Therapy Criteria:**

- Documentation of continued medical necessity

## Cardiac Drugs, Miscellaneous

*Last revised: 12/6/2022*

Generic	Brand
TAFAMIDIS MEGLUMINE	VYNDAQEL
TAFAMIDIS	VYNDAMAX
<b>Prior Authorization Criteria:</b>	
<b>Length of Authorization:</b> <ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>	
<b>Initial Review Criteria:</b> <ul style="list-style-type: none"> <li>• Prescriber is a Cardiologist,</li> <li>• AND patient is <math>\geq 18</math> years,</li> <li>• AND diagnosis of cardiac amyloidosis on the problem list or per cardiologist documentation,</li> <li>• AND evidence of cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) demonstrated by positive biopsy demonstrating transthyretin (TTR)-amyloid deposition OR meeting all 3 of the following:               <ul style="list-style-type: none"> <li>○ Diagnosis of heart failure (defined as stage C heart failure plus NYHA Class I, II, or III).</li> <li>○ Pyrophosphate (PYP) scintigraphy cardiac uptake visual score of either grade 2 or 3 using Perugini Grade 1-3 scoring system, calculated heart-to-contralateral (H/CL) ration <math>\geq 1.5</math>.</li> <li>○ Absence of monoclonal gammopathy after testing for serum immunofixation (IFE) and serum free light chains</li> </ul> </li> <li>• AND medical history of heart failure with at least 1 prior hospitalization for heart failure or clinical evidence of heart failure (without hospitalization) manifested by signs or symptoms of volume overload or elevated intracardiac pressures that require treatment diuretic</li> <li>• AND patient is NOT receiving inotersen or patisiran</li> <li>• AND patient has NOT had prior heart or liver transplantation</li> <li>• Patient does NOT have an implanted cardiac mechanical assist device</li> </ul>	
<b>Continuation of Therapy Criteria:</b> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response AND</li> <li>• Office visit or telephone visit with a specialist within the past 12 months</li> </ul>	

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## Cardiac Myosin Inhibitor

*Last revised: 2/6/2024*

<b>Generic</b>	<b>Brand</b>	<b>HICL</b>	<b>GSN</b>	<b>Representative NDC</b>
MAVACAMTEN	CAMZYOS CAPS 2.5 MG	47972	083317	73625011111
MAVACAMTEN	CAMZYOS CAPS 5 MG	47972	083318	73625011211
MAVACAMTEN	CAMZYOS CAPS 10 MG	47972	083319	73625011311
MAVACAMTEN	CAMZYOS CAPS 15 MG	47972	083320	73625011411

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Virginia (Medicaid) Prior Authorization and Step Therapy Criteria





<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 3 months</li> <li>• Reauthorization: 6 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a Cardiologist,</li> <li>• AND patient is 18 years of age or older,</li> <li>• AND diagnosed with oHCM consistent with current AHA/ACC guidelines and satisfies both of the following: <ul style="list-style-type: none"> <li>○ Left ventricular ejection fraction (LVEF) <math>\geq 55\%</math></li> <li>○ NYHA class II or III</li> </ul> </li> <li>• AND peak Valsalva LVOT gradient <math>\geq 50</math> mmHg,</li> <li>• AND symptomatic oHCM despite highest tolerated dose of a non-vasodilating beta-blocker (or non-dihydropyridine calcium channel blocker if beta-blocker is not tolerated),</li> <li>• AND if clinically indicated, consider other AHA/ACC Guideline Class I therapies before mavacamten: <ul style="list-style-type: none"> <li>○ Disopyramide</li> <li>○ Septal reduction therapy for NYHA class III patients</li> </ul> </li> <li>• AND using effective contraception, if patient is of childbearing potential,</li> <li>• AND recommend not to initiate if any of the following situations apply: <ul style="list-style-type: none"> <li>○ Known infiltrative or storage disorder causing cardiac hypertrophy that mimics oHCM (e.g. Fabry disease, amyloidosis, or Noonan syndrome with LV hypertrophy)</li> <li>○ History of syncope or sustained ventricular tachyarrhythmia with exercise within 6 months prior</li> <li>○ History of resuscitated sudden cardiac arrest (at any time) or known history of appropriate implantable cardioverter defibrillator discharge for life-threatening ventricular arrhythmia within 6 months prior</li> <li>○ Poorly controlled atrial fibrillation</li> <li>○ Treatment with disopyramide or ranolazine within 14 days prior to initiation of mavacamten</li> <li>○ Taking a beta blocker in combination with a calcium channel blocker</li> <li>○ Successfully treated with invasive septal reduction therapy within 6 months prior</li> <li>○ QTc interval <math>&gt;500</math> milliseconds</li> </ul> </li> <li>•</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• LVEF remains <math>\geq 50\%</math>,</li> <li>• AND patient has not developed heart failure symptoms or worsening clinical status,</li> <li>• AND patient is adherent to labs and monitoring as required by the REMS program (e.g. ECHO with Valsalva LVOT gradient, NYHA classification at least every 12 weeks),</li> <li>• AND patient continues to be managed by Cardiologist with expertise in hypertrophic cardiomyopathy</li> </ul>

## Cystic Fibrosis (CFTR) Correctors-Trikafta

Generic	Brand
ELEXACAFTOR-TEZACAFTOR-IVACAFTOR	TRIKAFTA TBPK

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Age ≥12 years, AND</li> <li>• Diagnosis of CF confirmed by a clinician with expertise in providing CF care, AND</li> <li>• At least one F508del mutation in the CFTR gene detected using either an FDA-cleared CF mutation test or testing was completed by a CLIA certified laboratory, AND</li> <li>• Patient does not have either of the following:               <ul style="list-style-type: none"> <li>○ Severe liver impairment (Child-Pugh Class C), OR</li> <li>○ Prior solid organ or hematological transplantation, unless use of the medication is approved by the transplant center</li> </ul> </li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response AND</li> <li>• Specialist follow-up has occurred in the past 12 months, AND</li> <li>• AST, ALT, bilirubin, and ophthalmic changes (patients up to 17 years) are monitored at least annually</li> </ul>

## Cystic Fibrosis (CFTR) Correctors-Symdeko

<b>Generic</b>	<b>Brand</b>
TEZACAFTOR-IVACAFTOR	SYMDEKO

<b>Prior Authorization Criteria:</b>						
<b>Length of Authorization:</b>						
<ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>						
<b>Initial Review Criteria:</b>						
<ul style="list-style-type: none"> <li>• Age ≥6 years, AND</li> <li>• Diagnosis of CF confirmed by a clinician with expertise in providing CF care, AND</li> <li>• At least two copies of the F508del mutation in the CFTR gene detected using either an FDA-cleared CF mutation test or testing was completed by a CLIA certified laboratory, OR</li> <li>• One of the following mutations known to be responsive to tezacaftor-ivacaftor, ivacaftor in the CFTR gene</li> </ul>						
A1067T	D1270N	E56K	K1060T	R117C	S945L	2789+5G→A
A455E	D110E	E831X	L206W	R347H	S977F	3272-26A→G
D110H	D579G	F1052V	P67L	R352Q		3849+10kbC→T
D1152H	E193K	F1074L	R1070W	R74W		711+3A→G
<b>Continuation of Therapy Criteria:</b>						
<ul style="list-style-type: none"> <li>• Documentation of positive clinical response AND</li> <li>• Specialist follow-up has occurred in the past 12 months, AND</li> <li>• AST, ALT, bilirubin, and ophthalmic changes (patients up to 17 years) are monitored at least annually</li> </ul>						

## Cystic Fibrosis (CFTR) Correctors-Orkambi

Generic	Brand
LUMACAFITOR-IVACAFITOR	ORKAMBI PACK

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 12 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is a specialist in the management of Cystic Fibrosis (CF), AND</li> <li>• Age <math>\geq</math>2 years, AND</li> <li>• Diagnosis of CF confirmed by a clinician in expertise in providing CF care, AND</li> <li>• At least two copies of the F508del mutation in the CFTR gene detected using either an FDA-cleared CF mutation test or testing was completed by a CLIA certified laboratory, AND</li> <li>• If <math>\geq</math>6 years, baseline percent predicted FEV1 is <math>\geq</math>30%</li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response AND</li> <li>• Specialist follow-up has occurred in the past 12 months, AND</li> <li>• AST, ALT, bilirubin, and ophthalmic changes (patients up to 17 years) are monitored at least annually</li> </ul>

## Cystic Fibrosis (CFTR) Potentiators-Kalydeco

<b>Generic</b>	<b>Brand</b>
IVACAFTOR	KALYDECO

<b>Prior Authorization Criteria:</b>							
<b>Length of Authorization:</b>							
<ul style="list-style-type: none"> <li>Initial: 12 months</li> <li>Reauthorization: 12 months</li> </ul>							
<b>Initial Review Criteria:</b>							
<ul style="list-style-type: none"> <li>Age <math>\geq</math>6 months, AND</li> <li>Patient is NOT homozygous for the F508del mutation in the CFTR gene, AND</li> <li>At least one of the following mutations in the CFTR gene:</li> </ul>							
P67L	R117C	R347H	E831X	K1060T	R1070W	S1251N	2789+5G→A
R74W	G178R	R352Q	S945L	A1067T	F1074L	S1255P	3272-26A→G
D110E	E193K	A455E	S977F	G1069R	D1152H	D1270N	3849+10kbC→T
D110H	L206W	S549N	F1052V	R1070Q	G1244E	G1349D	711+3A→G
						E56K	
-OR-							
<ul style="list-style-type: none"> <li>Patients with a R117H mutation in the CFTR gene who have clinically significant disease (patients with R117H and the 5T form of the poly-T tract, but not 7T or 9T)</li> </ul>							
<b>Continuation of Therapy Criteria:</b>							
<ul style="list-style-type: none"> <li>Documentation of positive clinical response AND</li> <li>Specialist follow-up has occurred in the past 12 months, AND</li> <li>AST, ALT, bilirubin, and ophthalmic changes (patients up to 17 years) are monitored at least annually</li> </ul>							

## Enzymes

Generic	Brand
PEGVALIASE-PQPZ	PALYNZIQ

<b>Prior Authorization Criteria:</b>
<b>Length of Authorization:</b> <ul style="list-style-type: none"> <li>• Initial: 6 months</li> <li>• Reauthorization: 12 months</li> </ul>
<b>Initial Review Criteria:</b> <ul style="list-style-type: none"> <li>• Patient is <math>\geq 18</math> years, AND</li> <li>• Documented diagnosis of classical phenylketonuria (PKU) confirmed by metabolic specialist, AND</li> <li>• Pre-treatment baseline phenylalanine (Phe) level <math>&gt;600</math> micromol//L, AND</li> <li>• Dose does not exceed maximum FDA-approved dosing, AND</li> <li>• Not using concurrent Kuvan (sapropterin); sapropterin should be discontinued prior to initiation of pegvaliase-pqpz</li> </ul>
<b>Continuation of Therapy Criteria:</b> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response AND</li> <li>• Office visit or telephone visit with a specialist within the past 12 months</li> </ul>
<b>Notes:</b> <ul style="list-style-type: none"> <li>• <u>Do not approve continuation of therapy if Phe level <math>&gt;600</math> micromol/L after 16 weeks on the maximum 40 mg daily dose</u></li> </ul>

## Gastrointestinal (GI) Motility Agents

*Last Revised 12.1.2023; Effective 1.1.2024*

Adapted from DMAS Preferred Drug List

Generic	Brand
LUBIPROSTONE	AMITIZA
LINACLOTIDE	LINZESS
NALOXEGOL OXALATE	MOVANTIK
ALOSETRON HCL	LOTRONEX
METHYLNALTREXONE BROMIDE	RELISTOR
NALDEMEDINE TOSYLATE	SYMPROIC
PLECANATIDE	TRULANCE
ELUXADOLINE	VIBERZI
PRUCALOPRIDE	MOTTEGRITY

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Documentation of adequate trial and failure of a preferred medication (Amitiza, Linzess, lubiprostone or Movantik) with clinical evidence of medical necessity is required before authorization will be given for a non-preferred medication (alosetron, Lotronex, Relistor, Trulance, Viberzi, Motegrity, Relistor, Symproic)
- Documented diagnosis of Idiopathic Chronic Constipation (ICC), Constipation Predominant Irritable Bowel Syndrome (IBS-C), Severe Diarrhea Predominant Irritable Bowel Syndrome (IBS-D), or Opioid Induced Constipation in chronic non-cancer pain (OIC)
- Criteria for Amitiza, Linzess, Trulance:
  - Documentation of treatment failure on at least two of the following classes
    - Osmotic Laxatives (i.e. lactulose, polyethylene glycol, sorbitol)
    - Bulk Forming Laxatives (i.e. psyllium, fiber)
    - Stimulant Laxatives (i.e. bisacodyl, senna)
- Criteria for Amitiza, Movantik, Relistor, Symproic (Diagnosis of OIC only):
  - Documentation of treatment failure on both polyethylene glycol and lactulose
- Criteria for Lotronex, Viberzi:
  - Documentation of treatment failure on at least three of the following classes
    - Bulk Forming Laxatives (i.e. psyllium, fiber)
    - Antispasmodic Agents (i.e. dicyclomine, hyoscyamine)
    - Antidiarrheal Agents (i.e. loperamide, diphenoxylate/atropine, codeine)
- Criteria for Motegrity:
  - Documentation and treatment failure on at least two osmotic laxatives (i.e. lactulose, polyethylene glycol, sorbitol) **AND** Amitiza, Linzess, or Trulance

**Continuation of Therapy Criteria:**

- Documentation of continued medical necessity



## Growth Hormones

*Last Revised 12/18/2023; Effective 02/06/2024*

Generic	Brand
SOMATROPIN	GENOTROPIN, HUMATROPE, NORDITROPIN, NORDITROPIN FLEXP RO, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SEROSTIM, ZOMACTON ZORBTIVE
MECASERMIN	INCRELEX
LONAPEGSOMATROPIN-TCGD	SKYTROFA
SOMATROGON-GHLA	NGENLA
SOMAPACITAN-BECO	SOGROYA

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year (Exception: Serostim: 3 months)
- Reauthorization: 1 year

**Initial Review Criteria:**

For Pediatric Patients ( $\leq 18$  years old)

- Requested medication must be prescribed by or in consultation with a specialist:
  - Endocrinology, Nephrology,
- Documentation of diagnosis of one of the following conditions:
  - Turner Syndrome, Prader-Willi Syndrome, Renal Insufficiency, Pediatric Chronic Kidney Disease, Small for Gestational Age, Idiopathic Short Stature, Growth Hormone Deficiency, or Newborn with Hypoglycemia and Diagnosis of Hypopituitarism or Panhypopituitarism, Familial Short Stature, Noonan Syndrome, SHOX Deficiency
- Requirements for Growth Hormone Deficiency:
  - Growth velocity  $< 25^{\text{th}}$  percentile for bone age in a child with no other identifiable cause and in whom hypothyroidism, chronic illness, under nutrition and genetic syndromes have been excluded AND growth hormone response of less than 10 ng/mL to at least 2 provocative stimuli of growth hormone release: insulin, levodopa, arginine, clonidine, or glucagon; priming with sex steroids prior to stimulation test should be considered
- Requirements for Pediatric Chronic Kidney Disease/Chronic Renal Insufficiencies:
  - Creatinine clearance of 75 mL/min/1.73 m<sup>2</sup> or less
  - Serum creatinine greater than 3.0 g/dL
  - Dialysis dependency

For Adult Patients ( $> 18$  years old)

- Requested medication must be prescribed by or in consultation with Endocrinology
- Documentation of diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA)
- Documentation of whether the cause of growth hormone deficiency is a result of Adult Onset Growth Hormone Deficiency (AO-GHD) alone or with multiple hormone deficiencies, such as hypopituitarism, because of hypothalamic or pituitary disease, radiation therapy, surgery, or trauma
- Documentation of rule-out of other hormonal deficiencies such as thyroid, cortisol, or sex steroids
- Documentation of diagnosis of short bowel syndrome
- Documentation of diagnosis of AIDS Wasting or cachexia

Kaiser Permanente Mid-Atlantic States Region  
Virginia (Medicaid) Prior Authorization and Step Therapy Criteria



**Continuation of Therapy Criteria:**

Requirements for Pediatrics

- Documentation of improved/normalized growth velocity of at least 2 cm per year

Requirements for Adults

- Documentation of prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass)

## Hepatitis C Agents

Generic	Brand
LEDIPASVIR/SOFOSBUVIR	HARVONI
SOFOSBUVIR	SOVALDI
OMBITASVIR/PARITAPREVIR/ RITONAVIR	TECHNIVIE
OMBITASVIR/PARITAPREVIR/ RITONAVIR/DASABUVIR	VIEKIRA PAK VIEKIRA XR
ELBASVIR/GRAZOPREVIR	ZEPATIER
SOFOSBUVIR/VELPATASVIR	EPCLUSA
SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR	VOSEVI
PEGINTERFERON ALFA-2A	PEGASYS, PEGASYS PROCLICK

\*representative list

### Prior Authorization Criteria:

Adapted from DMAS Preferred Drug List

#### Length of Authorization:

- Initial: based on standard length of treatment course
- Reauthorization: N/A

#### Initial Review Criteria:

- Non-preferred medication must be prescribed by or in consultation with a specialist
  - Gastroenterology, Hepatology, Infectious Disease, Transplant
- Patient may benefit from specialty consultation if meets any of these criteria: coinfecting with hepatitis B or HIV; pregnant, breastfeeding, or planning to breastfeed; taking atazanavir or rifampin; severe kidney problems or is on dialysis; severe decompensated liver cirrhosis or a Child-Pugh score class B or C
- Documentation of diagnosis of Acute or Chronic Hepatitis C, Compensated cirrhosis, Hepatocellular Carcinoma, Decompensated Cirrhosis (Child Pugh Score Class B or C), Status Post Liver Transplant, and severe renal impairment (eGFR < 30 mL/min) or end stage renal disease requiring hemodialysis
- Documentation of HCV Genotype Test Results with corresponding treatment plan
- Selected therapy should be FDA-approved based on indication and specific genotype
- Documentation of any past treatment for Hepatitis C with dates, agents, and outcomes

Kaiser Permanente Mid-Atlantic States Region  
Virginia (Medicaid) Prior Authorization and Step Therapy Criteria



## Hereditary Angioedema (HAE) Agents

Last revised 08/09/2023 (effective 10/03/2023)

Generic	Brand
C1 ESTERASE INHIBITOR	BERINERT; CINRYZE
C1 ESTERASE INHIBITOR	HAEGARDA
ECALLANTIDE	KALBITOR
LANADELUMAB-FLYO	TAKHZYRO 150 MG/ML; 300MG/2ML
ICATIBANT ACETATE	FIRAZYR
BEROTRALSTAT HCL	ORLADEYO

\*representative list

### Prior Authorization Criteria:

Adapted from DMAS Preferred Drug List

#### Length of Authorization:

- Initial: 1 year
- Reauthorization: 1 year

#### Review Criteria:

- Confirmed diagnosis of HAE by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:
  - C1-INh antigenic level below the lower limit of normal, OR
  - C1-INh functional level below the lower limit of normal, AND
- Prescribed by, or in consultation with, a board-certified allergist, immunologist, pulmonologist, hematologist, or medical geneticist
- For prophylactic use, therapy must be with one of the following:
  - Cinryze (C1 esterase inhibitor)
  - Haegarda (C1 esterase inhibitor)
  - Orladeyo (berotralstat)
  - Takhzyro (ianadelumab-flyo)
- For the treatment of acute HAE attacks, monotherapy with one of the following must be used:
  - Berinert (C1 esterase inhibitor)
  - Firazyr (icatibant)
  - Kalbitor (ecallantide)
  - Ruconest (C1 esterase inhibitor)
  - Sajazir (icatibant)
- Documentation prior pharmaceutical agents used as well as treatment outcomes
- Documentation of medical necessity providing clinical evidence that the preferred agent(s) will not provide adequate benefit
  -

Kaiser Permanente Mid-Atlantic States Region  
Virginia (Medicaid) Prior Authorization and Step Therapy Criteria



## Interleukin Inhibitors (Dupixent)

*Last Revised 06/09/2023. Effective 07/01/2023*

Generic	Brand
DUPILUMAB	DUPIXENT

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Review Criteria:**

- Atopic Dermatitis
  - $\geq 6$  months of age, AND
  - Diagnosis of moderate to severe atopic dermatitis, AND
  - Prior documented trial for 30 days and failure (or contraindication) of:
    - One topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone); OR
    - One topical calcineurin inhibitor (tacrolimus or pimecrolimus)
- Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)
  - $\geq 18$  years of age, AND
  - Patient has inadequate response after 3 consistent months' use of intranasal steroids or oral corticosteroids, AND
  - Patient is concurrently treated with intranasal corticosteroids, AND
  - Physician has assessed baseline disease severity utilizing an objective measurement/tool
- Asthma
  - $\geq 6$  years of age, AND
  - Diagnosis of moderate to severe asthma with either:
    - Eosinophil count  $\geq 150$  cells/mcL, OR
    - Oral corticosteroid-dependent asthma with at least one month of daily oral corticosteroid use within the last 3 months
- Diagnosis of eosinophilic esophagitis (EoE)
  - $\geq 12$  years of age, AND
  - Patient weighs  $\geq 40$  kg, AND
  - Prescribed by or consultation with an allergist or gastroenterologist; AND
  - Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor
- Prurigo nodularis (PN)
  - $\geq 18$  years of age, AND
  - Diagnosis of PN, AND
  - Prescribed by or in consultation with a dermatologist, allergist, or immunologist

## Immunomodulators (Atopic Dermatitis)

*Last revised: 12.18.2023*

Generic	Brand
PIMECROLIMUS	ELIDEL
CRISABOROLE	EUCRISA
TACROLIMUS	PROTOPIC
RUXOLITINIB	OPZELURA
TRALOKINUMAB-LDRM	ADBRY

\*representative list

Kaiser Permanente Mid-Atlantic States Region  
Virginia (Medicaid) Prior Authorization and Step Therapy Criteria





**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Clinical Criteria for Elidel, Protopic, and tacrolimus
  - Patient must have an FDA age approved diagnosis of atopic dermatitis
    - Elidel mild to moderate for ages  $\geq 2$  years old Protopic 0.03%: moderate to severe for ages  $\geq 2$  years old
    - Protopic 0.1%: moderate to severe for ages  $\geq 16$  years
  - Failure of 8 weeks therapy to topical corticosteroids (i.e. desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
- Clinical Criteria for Eucrisa and Opzelura
  - Patient must have an FDA age approved diagnosis of atopic dermatitis
    - Eucrisa: mild to moderate for ages equal or  $> 3$  months old
    - Opzelura: mild to moderate for ages equal or  $\geq 12$  years of age
    - **Topical Opzelura is not covered for nonsegmental vitiligo in adult and pediatric patients  $\geq 12$  years old**
  - Eucrisa-prior trial & failure for 30 days (or contraindication) of:
    - Topical corticosteroids (i.e. desonide, fluticasone propionate, hydrocortisone butyrate, etc.); AND
    - Topical calcineurin inhibitors (tacrolimus or pimecrolimus)
  - Opzelura prior trial & failure for 8 weeks (or contraindication)
    - Topical corticosteroids (i.e. desonide, fluticasone propionate, hydrocortisone butyrate, etc.); AND
    - Topical calcineurin inhibitors (tacrolimus or pimecrolimus)
    - Dupixent
    - Eucrisa
- Clinical Criteria for Adbry
  - Patient must have an FDA age approved diagnosis of atopic dermatitis
    - Adbry: moderate to severe for ages  $\geq 18$  years
  - Prior documented trial and failure of 8 weeks of each:
    - One topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone), AND
    - One topical calcineurin inhibitor (tacrolimus or pimecrolimus), AND

**Continuation of Therapy Criteria:**

- Documentation that the initial review criteria are still met

## Leptins

Generic	Brand
METRELEPTIN	MYALEPT

<p><b>Prior Authorization Criteria:</b></p> <p><b>Length of Authorization:</b></p> <ul style="list-style-type: none"> <li>• Initial: 4 months</li> <li>• Reauthorization: 12 months</li> </ul>
<p><b>Initial Review Criteria:</b></p> <ul style="list-style-type: none"> <li>• Prescriber is an Endocrinologist, AND</li> <li>• Diagnosis of congenial or acquired generalized lipodystrophy associated with leptin deficiency (less than 12.0 ng/mL in females and less than 8.0 mg/mL in males), AND</li> <li>• Is being used as an adjunct to diet modification, AND</li> <li>• Documentation demonstrates that patient has at least <u>ONE</u> of the following:             <ul style="list-style-type: none"> <li>○ Diabetes mellitus or insulin resistance with persistent hyperglycemia (HgbA1C &gt;7) despite <u>BOTH</u> of the following:                 <ul style="list-style-type: none"> <li>▪ Dietary intervention</li> <li>▪ Optimized insulin therapy at maximum tolerated doses</li> </ul> </li> <li>○ Persistent hypertriglyceridemia (TG &gt;200) despite <u>BOTH</u> of the following:                 <ul style="list-style-type: none"> <li>▪ Dietary intervention</li> <li>▪ Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses</li> </ul> </li> </ul> </li> </ul>
<p><b>Continuation of Therapy Criteria:</b></p> <ul style="list-style-type: none"> <li>• Documentation of positive clinical response and/or stabilization of laboratory parameters provided in initial authorization (i.e. fasting triglyceride concentrations, and/or HbA1C), AND</li> <li>• Is being used as an adjunct to diet modification, AND</li> <li>• Continues to be prescribed by an Endocrinologist</li> </ul>

## Movement Disorder Agents

Generic	Brand
TETRABENAZINE	XENAZINE
DEUTRABENAZINE	AUSTEDO
VALBENAZINE	INGREZZA and INGREZZA CPPK

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Diagnosis of Tardive Dyskinesia or Huntington's disease
- Prescribed by or in consult with a neurologist or psychiatrist

**Continuation of Therapy Criteria:**

- Documentation of continued medical necessity

## Multiple Sclerosis (Kesimpta) – Step Therapy (ST)

Generic	Brand
OFATUMUMAB	Kesimpta

\*representative list

**Prior Authorization Criteria:**  
*Adapted from DMAS Preferred Drug List*

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Authorization required for:
  - Kesimpta - Step therapy – Trial and failure of preferred Tecfidera

**Continuation of Therapy Criteria:**

- Documentation of continued medical necessity

## Opioid Agents

*Last reviewed 06/09/2023 (effective 07/01/2023)*

Short-Acting Opioids
Long-Acting Opioids
Methadone

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Up to 1 month for severe post-surgical pain.
- Up to 3 months for pain associated with HIV/AIDS, chronic back pain, arthritis, fibromyalgia, diabetic neuropathy, postherpetic neuralgia.
- Up to 6 months for cancer pain, sickle cell disease, palliative care, end-of life care, hospice.

**Review Criteria:**

- Authorization required for:
  - All Long-Acting Opioids
  - Any Short-Acting Opioid prescribed for > 7 days or two (2) 7-day supplies per 60 days
  - Any cumulative opioid prescription > 90 morphine milligram equivalents (MME)
- Authorization Exclusion Criteria:
  - Intractable pain from active cancer, end-of-life, palliative care, hospice care
  - Remission from cancer and prescriber is safely weaning patient off opioids
  - Patient is living in a long-term care facility
- Documentation of Cumulative Total Daily MME dose calculated from PMP
  - If patient's Active Daily MME  $\geq$  90, the prescriber must attest that he/she will be managing the patient's opioid therapy long term, has reviewed the Virginia BOM Regulations for Opioid Prescribing, has prescribed naloxone, and acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this patient
- Criteria for methadone pain management:
  - Documentation of treatment failure with at least 2 or more preferred long-acting opioids
  - Documentation of signed chronic pain agreement with patient
- Documentation of type of pain being treated as well as a list of opioid and non-opioid treatments trialed with outcomes
- If the patient is female between 18 and 45 years old, documentation of discussion of risk of neonatal abstinence syndrome and counseling on contraceptive options
- Documentation that prescriber has checked the PMP and provide the last fill date of the patient's most recent opioid and benzodiazepine prescription
  - If benzodiazepine filled in past 30 days, the prescriber must attest that he/she has counseled the patient on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines

- Documentation that naloxone has been prescribed for patients with risk factors of substance use disorder, doses in excess of 50 MME/day, antihistamines, antipsychotics, benzodiazepines, gabapentin, pregabalin, tricyclic antidepressants, or the “Z” drugs (zopiclone, zolpidem, or zaleplon).
- Documentation of a treatment plan with goals that addresses benefits and harm established with patient.

## Opioid-Benzodiazepine Concurrent Use

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Opioids
Benzodiazepines

### Prior Authorization Criteria:

Adapted from DMAS Preferred Drug List

#### Length of Authorization:

- Initial: 1 year
- Reauthorization: 1 year

#### Initial Review Criteria:

- Authorization required when a benzodiazepine is prescribed while a patient is taking an opioid medication to ensure patient safety according to CDC Guidelines and FDA Black Box Warning when these agents are concurrently used
- Documentation of the patient's diagnosis for taking a benzodiazepine:
  - Acute alcohol withdrawal
  - Adjunct for relief of skeletal muscle spasms
  - Anxiety
  - Convulsive disorders
- Documentation of the patient's diagnosis for taking an opioid:
  - Active Cancer Pain
  - Hospice care/Palliative care
  - Chronic, non-cancer pain
  - Acute Pain
- Documentation that prescriber has checked the PMP and provide the last fill date of the patient's most recent opioid and benzodiazepine prescription
- Prescriber attestation that he/she will be managing the patient's therapy long term and that they have read the FDA Black Box Warning on prescribing opioids and benzodiazepines and the dangers involved and that therapy is medically necessary for this patient

#### Continuation of Therapy Criteria:

- Documentation that initial review criteria are still met



## Opioid Dependency Oral Agents

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Buprenorphine-Naloxone SL film
Zubsolv SL tablet

### **Prior Authorization Criteria:**

Adapted from DMAS Preferred Drug List

#### **Length of Authorization:**

- Initial: 3 months
- Reauthorization: 6 months

#### **Review Criteria:**

The following criteria applies to non-preferred products only.

- Patient must be  $\geq$  16 years old
- Patient must meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5)
- If the patient is pregnant, include expected date of delivery as well as positive pregnancy test
- Buprenorphine monotherapy will only be covered during the following:
  - Pregnant women for a maximum of 10 months
  - Patients when being converted to buprenorphine/naloxone combination therapy for 7 days
- If the requested product is non-preferred, provide documentation indicating medical necessity and reasoning for why a non-preferred product is required
- Daily doses of buprenorphine greater than 24 mg will deny.

## Other Miscellaneous Therapeutic Agents

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<b>Generic</b>	<b>Brand</b>
BUROSUMAB-TWZA	CRYSVITA

<b>Prior Authorization Criteria:</b>
<b>Length of Authorization:</b> <ul style="list-style-type: none"> <li>Initial: 12 months</li> <li>Reauthorization: 12 months</li> </ul>
<b>Initial Review Criteria:</b>
<b>X-Linked Hypophosphatemia</b> <ul style="list-style-type: none"> <li>Prescribed by, or in consultation with, a specialist experienced in the treatment of metabolic bone disorders, AND</li> <li>Patient is <math>\geq 1</math> year, AND</li> <li>Patient has a diagnosis of X-linked hypophosphatemia (XLH) supported by at least one of the following: genetic testing (PHEX mutation) OR family member with X-linked inheritance OR serum fibroblast growth factor 23 (FGF23) level <math>&gt;30</math> pg/mL, AND</li> <li>Fasting serum phosphorus below the reference range for age, AND</li> <li>Patient meets either of the following based on age group: pediatric patients (epiphyseal growth plates are open), at least one of the following: <ul style="list-style-type: none"> <li>radiographic evidence of active bone disease (rickets in wrists and/or knees and/or femoral/tibial bowing), OR</li> <li>documented abnormal growth velocity, OR</li> <li>1 to 2 years of age without radiographic evidence or abnormal growth velocity; but with confirmed genetic testing or family history, and low fasting serum phosphorus; consider treatment per clinical judgement</li> </ul> </li> </ul> <p><b>-OR-</b></p> <ul style="list-style-type: none"> <li>Adults and adolescents at final adult height (epiphyseal growth plates are closed) have presence of non-healing fractures (e.g., visible fracture lines), AND</li> <li>Patient does NOT have any of the following: chronic kidney disease (CKD) stage 2 or greater, evidence of tertiary hyperparathyroidism</li> </ul>
<b>Tumor-Induced Osteomalacia (TIO)</b> <ul style="list-style-type: none"> <li>Prescribed by, or in consultation with, a specialist experienced in the treatment of metabolic bone disorders and/or oncologist, AND</li> <li>Patient is <math>\geq 2</math> years, AND</li> <li>Patient has a diagnosis of TIO not amenable to surgical excision of the offending tumor/lesion, AND</li> <li>Serum phosphorus is within or above the normal range for age prior to treatment initiative, AND,</li> <li>Patient has no evidence of tertiary hyperparathyroidism</li> </ul>
<b>Continuation of Therapy Criteria:</b> <ul style="list-style-type: none"> <li>Documentation of positive clinical response (defined below), AND</li> <li>Office visit or telephone visit with a specialist within the past 12 months</li> </ul>
<b>Notes:</b> <ul style="list-style-type: none"> <li><u>Discontinuation only recommended if:</u> intolerance to medication OR non-adherence to medication, lab-monitoring or follow-up assessments with a specialist OR lack of normalization of serum phosphorus OR lack of positive clinical response (a positive response is defined as an improvement in growth velocity, deformities, fractures, or bone pain) OR if initiating chemotherapy or planned surgical excision of tumor/lesion</li> </ul>

## Pancreatic Enzymes

Generic	Brand
PANCRELIPASE	CREON, ZENPEP, PANCREAZE, VIOKACE , PERTZYE

\*representative list

### **Prior Authorization Criteria:** Adapted from DMAS Preferred Drug List

#### **Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

#### **Initial Review Criteria:**

- Documentation of diagnosis of pancreatic insufficiency due to one of the following conditions:
  - Cystic fibrosis
  - Chronic pancreatitis
  - Pancreatectomy

#### **Continuation of Therapy Criteria:**

- Documentation of continued medical necessity

## Potassium Sparing Diuretics

Generic	Brand	HICL	GSN	Representative NDC
FINERENONE	KERENDIA TABS 10 MG	47487	082499	50419054001
FINERENONE	KERENDIA TABS 20 MG	47487	082500	50419054101

**Prior Authorization Criteria:**

**Length of Authorization:**

- Initial: 6 months
- Reauthorization: 12 months

**Initial Review Criteria:**

- Prescriber is a Nephrologist or Endocrinologist,
- AND documented diagnosis of type 2 diabetes mellitus in patients at least 18 years of age,
- AND documented diagnosis of CKD (defined as eGFR 25-74 mL/min/1.73 m<sup>2</sup> and/or urinary albumin-to-creatinine ratio of >300),
- AND patient is on ACEI or ARB therapy, or if not prescribed, provider has documented rationale,
- AND documented baseline eGFR and serum potassium ≤4.8 mEq/L within past 3 months,
- AND documented adequate therapeutic trial (≥3 months) and failure, contraindication, or intolerance to Jardiance AND at least 1 anti-mineralocorticoid (i.e. spironolactone/eplerenone)

**Continuation of Therapy Criteria:**

- Documented beneficial response to therapy (i.e. no documentation of initiation of dialysis, kidney transplant, or decrease in eGFR of 40% or greater)
- AND patient continues to be under the care of a specialist

## Proprotein Convertase Subtilisin Kexin Type-9 (PCSK-9) Inhibitors and Antihyperlipidemic – Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors

*Last revised 12.1.2023; Effective 1.1.2024*  
Adapted from DMAS Preferred Drug List

Generic	Brand
ALIROCUMAB	PRALUENT
EVOLOCUMAB	REPATHA
BEMPEDOIC ACID	NEXLETOL
BEMPEDOIC ACID-EZETIMIBE	NEXLIZET

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Must be prescribed by or in consultation with either a Cardiologist or Endocrinologist
- Documentation of age group for appropriate indication:
  - 13-75 years old being considered for treatment of homozygous familial hypercholesterolemia (HoFH)
  - 18-75 years old being considered for treatment of heterozygous familial hypercholesterolemia (HeFH)
  - 18-75 years old being considered for treatment of suspected familial hypercholesterolemia (LDL  $\geq$ 220 mg/dL)
  - 40-75 years old being considered for treatment of very high-risk ASCVD
    - Very high-risk ASCVD is defined as history of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions.
      - Major ASCVD events include:
        - Recent ACS (within 12 months)
        - History of MI
        - History of ischemic stroke
        - Symptomatic PAD (history of claudication with ABI  $<$ 0.85, or previous revascularization or amputation)
      - High-risk conditions include:
        - Age  $\geq$ 65 years
        - Heterozygous familial hypercholesterolemia
        - History of prior CABG or PCI outside of the major ASCVD events
        - Diabetes mellitus
        - Hypertension
        - CKD (eGFR 15-59 ml/min/1.73 m<sup>2</sup>)
        - Current smoking
        - Persistently elevated LDL-C (LDL-C  $\geq$ 100 mg/dL despite maximally tolerated statin therapy and ezetimibe)
        - History of congestive HF
- For HeFH/HoFH: Documentation of LDL-C  $>$  100 mg/dL in the last 90 days
- For patients with suspected familial hypercholesterolemia: Documentation of LDL-C  $>$  130 mg/dL in the last 90 days
- For patient with very high-risk ASCVD: Documentation of LDL-C  $\geq$  70 mg/dL in the last 90 days
- Patient had an adequate trial (8+ weeks) of high-dose, high-potency statin (atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily) plus ezetimibe

- If statin intolerant:
  - Inability to tolerate at least 2 statins, with at least one started at the lowest starting daily dose AND
    - Statin dose reduction attempted for resolution of muscle symptoms, abnormal biomarkers OR
    - Muscle symptoms, abnormal biomarkers recur with low intensity/lowest possible statin dose re-challenge OR
    - Muscle symptoms, abnormal biomarkers recur with an adequate trial of hydrophilic statins – Pravastatin, Rosuvastatin
- Repatha 140 mg will only be approved for very high-risk ASCVD, suspected familial hypercholesterolemia, heterozygous familial hypercholesterolemia (HeFH).
- Repatha 420 mg will only be approved for diagnosis of homozygous familial hypercholesterolemia (HoFH).
- Praluent should only be prescribed if the patient has a documented failure to or adverse drug reaction to Repatha.
  - Praluent 150 mg will only be approved if there has been a trial of Praluent 75 mg for a minimum of 8 weeks with an LDL-C change of less than 30%: including lab results demonstrating LDL-C reduction pre and post therapy

**Continuation of Therapy Criteria:**

- Repatha should only be continued beyond 8 weeks in presence of LDL-C decrease of greater than 30%
- Praluent should only be continued beyond 8 weeks in presence of LDL-C decrease of greater than 30%
- Leqvio should only be continued beyond 8 weeks in presence of LDL-C decrease of greater than 30%

**ACL Inhibitors**

**Initial Approval Criteria**

- Patient is  $\geq 18$  years of age; AND
- Patient has diagnosis of heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD); AND
- Patient has failed to achieve a target LDL-C despite physician attestation that the patient is adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction; AND
- Patient can be classified into ONE of the following risk factor groups:
  - Extremely high risk ASCVD: (defined as extensive or active burden of ASCVD, or ASCVD with extremely high burden of adverse or poorly controlled risk cardio-metabolic risk factors including HeFH or severe hypercholesterolemia [SH] LDL-C  $> 220$  mg/dl) with an LDL-C  $\geq 70$  mg/dL; OR
  - Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C  $\geq 100$  mg/dL; OR
  - High risk ASCVD: (defined as either less extensive ASCVD and well-controlled risk factors or primary prevention HeFH or SH  $>220$  mg/dl with poorly controlled risk factors) with LDL-C  $\geq 130$  mg/dL; AND

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Virginia (Medicaid) Prior Authorization and Step Therapy Criteria





- Therapy will be used in conjunction with the maximum tolerated doses of a statin; AND
- Therapy will not be used with concurrent doses of simvastatin > 20 mg or pravastatin > 40 mg.

**Renewal Criteria**

- Laboratory analyses demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe); AND
  - Patient has shown continued adherence to maximally tolerated statin dosage
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## Pulmonary Arterial Hypertension (PAH) Agents

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Generic	Brand
SILDENAFIL CITRATE (PULMONARY HYPERTENSION)	REVATIO
TADALAFIL (PULMONARY HYPERTENSION)	ADCIRCA ALYQ

\*representative list

### **Prior Authorization Criteria:**

Adapted from DMAS Preferred Drug List

#### **Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

#### **Initial Review Criteria:**

- Patient must have diagnosis of pulmonary hypertension if  $\geq 18$  years old
- Prescriber must be a pulmonologist or cardiologist or in consultation with a specialty provider
- Documentation of clinical rationale for not taking sildenafil tablet to receive authorization for injectable Revatio

#### **Continuation of Therapy Criteria:**

- Documentation of continued medical necessity
-

## Sotyktu (deucravacitinib)

Adapted from DMAS Preferred Drug List

Last reviewed 06/09/2023 (Effective 07/01/2023)

### Prior Authorization Criteria:

#### Length of Authorization:

- Initial: 1 year
- Reauthorization: 1 year

#### Initial Review Criteria:

- Patient must be 18 years of age or older
- Diagnosis of moderate to severe plaque psoriasis
- Prescribed by, or in consultation with, a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis
- Symptoms persistent for  $\geq 6$  months with at least one of the following:
  - Involvement of at least 3% of body surface area (BSA), OR
  - Psoriasis Area and Severity Index (PASI) score of 10 or greater, OR
  - Incapacitation due to plaque location (i.e., head and neck, palms, soles, or genitalia), AND
- Trial and failure ( $\geq 3$  months) of at least one of the following conventional therapy:
  - DMARD (e.g., methotrexate), OR
  - Immunosuppressant (e.g., cyclosporine), OR
  - Oral retinoid (e.g., acitretin), AND
- Patient is not using Sotyktu (deucravacitinib) in combination with any other biologic agent
- Trial and failure ( $\geq 3$  months) unless contraindication or intolerance to, at least one preferred cytokine or CAM antagonist indicated for the treatment of this condition

#### Continuation of Therapy Criteria:

- Patient has a documented response to therapy compared to baseline (e.g., redness, thickness, scaliness, amount of surface area involvement, and/or PASI score)

## Stimulants (ADHD)

*Last revised 07/01/2023*

Generic	Brand
DEXMETHYLPHENIDATE HCL	FOCALIN, FOCALIN XR
METHYLPHENIDATE HCL	QUILLICHEW ER, QUILLIVANT XR, CONCERTA, APTENSIO XR, METADATE ER, METHYLIN, RELEXXII, RITALIN, RITALIN LA, METADATE CD
METHYLPHENIDATE	DAYTRANA, COTEMPLA XR
DEXTROAMPHETAMINE/AMPHETAMINE	ADDERALL, ADDERALL XR, MYDAVIS
DEXTROAMPHETAMINE SULFATE	DEXEDRINE, DEXEDRINE SPANSULE, ZENZEDI, PROCENTRA
LISDEXAMFETAMINE DIMESYLATE	VYVANSE
METHAMPHETAMINE HCL	DESOXYN
AMPHETAMINE SULFATE	EVEKEO
AMPHETAMINE	ADZENYS ER, ADZENYS XR-ODT, DYANAVEL XR
SERDEXMETHYLPHENIDATE CHLORIDE-DEXMETHYLPHENIDATE HCL45	AZSTARYS

\*representative list

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- Required for patients  $\leq 4$  years old OR  $\geq 18$  years old
- For patients  $\leq 4$  years old, prescriber must be a pediatric psychiatrist, pediatric neurologist, developmental/behavioral pediatrician, or in consultation with one of these specialists.
- For patients  $\geq 18$  years old:
  - Documentation of diagnosis of ADHD by Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (including documentation of impairment in more than one major setting), determined by the primary care clinician
- If the requested product is non-preferred, provide documentation of the following:
  - Pharmaceutical agents attempted with outcome
  - Indicating medical necessity and reasoning for why a non-preferred product is required

**Continuation of Therapy Criteria:**

- Documentation that the prescriber has regularly evaluated the patient for stimulant and/or other substance use disorder, and, if present, initiated specific treatment, consulted with an appropriate healthcare provider, or referred the patient for evaluation for treatment if indicated

## Topical Retinoids

Generic	Brand
TRETINOIN	RETIN-A GEL, TRETIN-X, ATRALIN, ALTRENO, AVITA
ADAPALENE	DIFFERIN, PLIXDA
AZELAIC ACID	AZELEX
ADAPALENE-BENZOYL PEROXIDE	EPIDUO
TRETINOIN MICROSPHERE	RETIN-A MICRO

**Prior Authorization Criteria:**  
Adapted from DMAS Preferred Drug List

**Length of Authorization:**

- Initial: 1 year
- Reauthorization: 1 year

**Initial Review Criteria:**

- All patients must have a diagnosis of acne
- Patients ≥ 18 years old will require evaluation of treatment diagnosis

**Continuation of Therapy Criteria:**

- Documentation of continued medical necessity