



STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

DEXMEDETOMIDINE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
DEXMEDETOMIDINE HCL	IGALMI	20971		GPI-10 (6020603010)	ROUTE = SUBLINGUAL

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Is the request for treatment of acute agitation associated with schizophrenia or bipolar I or II disorder and does the patient meet **ALL** of the following criteria?
 - The patient is 18 years of age or older
 - Therapy is prescribed by or in consultation with a psychiatrist
 - The patient had a trial and failure of or contraindication to **THREE** antipsychotics (e.g., olanzapine, ziprasidone, haloperidol)

If yes, **approve for 1 month by GPID or GPI-14 for the requested strength with a quantity limit of #3 per day.**

If no, do not approve.

INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **DEXMEDETOMIDINE (Igalmi)** requires the following rule(s) be met for approval:

- A. You have acute (short-term) agitation associated with schizophrenia (a type of mental health disorder) or bipolar I or II disorder (a type of mood disorder)
- B. You are 18 years of age or older
- C. Therapy is prescribed by or in consultation with a psychiatrist (a type of mental health doctor)
- D. You had a trial and failure of or contraindication (harmful for) to **THREE** antipsychotics (such as olanzapine, ziprasidone, haloperidol)

Your doctor told us **[INSERT PT SPECIFIC INFO PROVIDED]**. We do not have information showing you **[INSERT UNMET CRITERIA]**. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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DEXMEDETOMIDINE

GUIDELINES FOR USE (CONTINUED)

RENEWAL CRITERIA

1. Is the request for treatment of acute agitation associated with schizophrenia or bipolar I or II disorder?

If yes, continue to #2.

If no, do not approve.

DENIAL TEXT: See the renewal denial text at the end of the guideline.

2. Is the patient's maintenance therapy for the underlying psychiatric disorder currently being adjusted/optimized to reduce or eliminate the need for continued PRN medications for acute agitation?

If yes, **approve for 3 months by GPID or GPI-14 for the requested strength with a quantity limit of #3 per day.**

If no, continue to #3.

3. Have attempts to adjust medications been exhausted **AND** the physician has determined that chronic PRN medications are required for the continued safety of the patient or caregivers?

If yes, **approve for 6 months by GPID or GPI-14 for the requested strength with a quantity limit of #3 per day.**

If no, do not approve.

RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **DEXMEDETOMIDINE (Igalmi)** requires the following rule(s) be met for renewal:

- A. You have acute (short-term) agitation associated with schizophrenia (a type of mental health disorder) or bipolar I or II disorder (a type of mood disorder)
- B. You meet ONE of the following:
 1. Your maintenance therapy for the underlying psychiatric (mental) disorder is currently being adjusted/optimized to reduce or eliminate the need for continued PRN medications (as needed drugs) for acute agitation
 2. Attempts to adjust medications have been exhausted AND your physician (doctor) has determined that chronic PRN medications (long-term as needed drugs) are required for the continued safety of you or your caregivers

(Renewal denial text continued on next page)

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DEXMEDETOMIDINE

RENEWAL CRITERIA (CONTINUED)

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Igalmi.

REFERENCES

- Igalmi [Prescribing Information]. New Haven, CT: BioXcel Therapeutics, Inc.; April 2022.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

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