STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

TOSYMRA – Tosymra is nasal form of sumatriptan.

EXISTING CRITERIA:

Non-preferred agents require three (3) day trials of each preferred unique chemical entity before they will be approved, unless one (1) of the exceptions on the PA form is present.

***In addition to the Class Criteria**: Onzetra Xsail requires three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.

PROPOSED CRITERIA:

Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.

***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.

ANTIMIGRAINE AGENTS, TRIPTANS[AP]		
CLASS PA CRITERIA: Non-preferred medications require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available).		
	TRIPTANS	
naratriptan rizatriptan ODT rizatriptan tablet sumatriptan injection[CL] sumatriptan nasal spray sumatriptan tablets	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX INJECTION (sumatriptan)[CL] IMITREX NASAL SPRAY (sumatriptan) IMITREX tablets (sumatriptan) MAXALT MLT (rizatriptan) MAXALT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) SUMAVEL (sumatriptan) TOSYMRA NASAL SPRAY (sumatriptan)* ZECUITY PATCH (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan zolmitriptan ODT ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.

KATERZIA SUSPENSION – Amlodipine suspension indicated for children greater than 6 years of age.

*Katerzia will be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Katerzia may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.

CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

LONG-ACTING		
amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA (diltiazem) COVERA-HS (verapamil)	*Katerzia will be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Katerzia may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.

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PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
07/01/2020
Version 2020.3a

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	diltiazem LA KATERZIA SUSPENSION (amlodipine)* MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	

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DUAKLIR PRESSAIR

EXISTING CRITERIA:

Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

*In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of Anoro Ellipta.

PROPOSED CRITERIA:

Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

*In addition to the Class PA criteria, Duaklir Pressair requires sixty (60) day trials of each long acting preferred agent, as well as a 60-day trial of Stiolto Respimat.

**In addition to the Class PA Criteria, Stiolto Respimat requires a sixty (60) day trial of a long acting preferred agent.

COPD AGENTS

CLASS PA CRITERIA: Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
ANORO ELLIPTA (umeclidinium/vilanterol) albuterol/ipratropium nebulizer solution BEVESPI (glycopyrrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ipratropium) UTIBRON (indacaterol/glycopyrrolate)	DUAKLIR PRESSAIR (aclidinium/formoterol)* DUONEB (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)**	*In addition to the Class PA criteria, Duaklir Pressair requires sixty (60) day trials of each long acting preferred agent, as well as a 60-day trial of Stiolto Respimat. **In addition to the Class PA Criteria, Stiolto Respimat requires a sixty (60) day trial of a long acting preferred agent.

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***Ezallor Sprinkle*-** Rosuvastatin

Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.

**Ezallor SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.

LIPOTROPICS, STATINS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	STATINS	
atorvastatin lovastatin pravastatin rosuvastatin simvastatin*	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) EZALLOR (rosuvastatin)[NR] EZALLOR SPRINKLE (rosuvastatin)** fluvastatin fluvastatin ER LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)* ZYPITAMAG (pitavastatin)	Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. *Zocor/simvastatin 80mg tablets will require a clinical PA. **Ezallor SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.

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Drizalma Sprinkle - Duloxetine

****Drizalma will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.

NEUROPATHIC PAIN		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
capsaicin OTC	CYMBALTA (duloxetine)	*Gralise will be authorized only if the following criteria are met:

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EFFECTIVE
07/01/2020
Version 2020.3a

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
duloxetine gabapentin lidocaine patch pregabalin capsule	DRIZALMA SPRINKLE (duloxetine)**** GRALISE (gabapentin)* HORIZANT (gabapentin) IRENKA (duloxetine) LIDODERM (lidocaine) LYRICA CR (pregabalin)** LYRICA SOLUTION (pregabalin)** NEURONTIN (gabapentin)[AP] QUTENZA (capsaicin) SAVELLA (milnacipran)*** ZTLIDO PATCH (lidocaine) LYRICA CAPSULE (pregabalin)	1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800 mg maximum daily dosage. **Lyrica CR and Lyrica Solution require medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules. ***Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent ****Drizalma will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.

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Wakix

*Sunosi is approvable only with documentation of treatment failure after 30-day trials of both armodafinil and modafinil.

**Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi.

STIMULANTS AND RELATED AGENTS
CLASS PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Non-preferred agents will NOT be "grandfathered" for adults. Children under the age of 18 may continue their current therapy until the end of the school year after which they will be required to switch to a preferred agent.

NARCOLEPTIC AGENTS		
armodafinil[CL] modafinil[CL]	NUVIGIL (armodafinil) PROVIGIL (modafinil) SUNOSI (solriamfetol)*	*Sunosi is approvable only with documentation of treatment failure after 30-day trials of both armodafinil

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	WAKIX (pitolisant)**	and modafinil. **Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi.

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Office of Pharmacy Service

Prior Authorization Criteria

Ruconest®
Effective 06/01/2020

Prior Authorization Request Form

RUCONEST *is a C1 esterase inhibitor (recombinant) indicated for the treatment of acute attacks in adult and adolescent patients with hereditary angioedema (HAE).*

CRITERIA FOR APPROVAL:

1) Diagnosis of hereditary angioedema (HAE) must be clinically established by, or in consultation with, an allergist, immunologist, hematologist or dermatologist; **AND**

2) Patient must be 13 years of age or older; **AND**

3) Diagnosis of HAE is documented based on laboratory evidence of one of the following:

a. Low C4 level and a low C1 inhibitor (C1-INH) antigenic level; or
b. Low C4 level, normal C1-INH antigenic level and low C1-INH functional level; or
c. Normal C4, normal C1-INH antigenic level, normal C1-INH AND documentation of family history of hereditary angioedema or HAE causing mutation**; AND**

4) Patient must be experiencing at least one symptom of a moderate or severe attack (non-laryngeal) (i.e. swelling of the face or abdomen); **AND**

5) Baseline frequency of HAE attacks must be documented; **AND**

6) Patient is not concurrently taking an angiotensin converting enzyme (ACE) inhibitor, estrogen replacement therapy or any other medication known to potentially cause angioedema; **AND**

7) Patient is NOT concurrently on, or using in combination with, other approved treatments for acute HAE attacks (e.g. Firazyr, Berinert, and Kalbitor); **AND**

8) Patient does not have known or suspected allergies to rabbits or rabbit derived products.

Initial prior authorization approval will be for 6 months.

Continuation of therapy Criteria:

Medical records documenting improvement (reduction in the number, duration and/or severity of attacks prior to treatment) are provided.

Continuation of therapy approval will be for 12 months.

References:

1.) Ruconest package insert 7/2014
2.) Lexi-Comp Clinical Application 4/21/2020
3.) US Hereditary Angioedema Association Medical Advisory Board 2013 Recommendations for the Management of Hereditary Angioedema Due to C1 Inhibitor Deficiency; J ALLERGY CLIN IMMUNOL: IN PRACTICE VOLUME 1, NUMBER 5

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HYPOGLYCEMICS, GLP-1 AGONISTS[CL]

EXISTING CRITERIA:

CLASS PA CRITERIA: Agents in this class will not be approved for patients with a starting A1C < 7%. Non-preferred agents are available only on appeal. Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met:

- Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient's current and stabilized regimen.
- No agent in this class shall be approved except as add on therapy to a regimen consisting of at least one (1) other agent prescribed at the maximum tolerable dose for at least 90 days.
- Re-authorizations require continued maintenance on a regimen consisting of at least one (1) other agent at the maximum tolerable dose AND an A1C of ≤8%.

PROPOSED CRITERIA:

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:

1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.
2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).

NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.

HYPOGLYCEMICS, GLP-1 AGONISTS[CL]

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6 month intervals) if ALL of the following criteria has been met:

1) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
2) Medical records indicated treatment failure with all unique preferred agents in the same class.
3) Baseline A1C must be submitted.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, an A1C of ≤8%, or show continued improvement.

NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.

OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON (exenatide) BYETTA (exenatide) BYDUREON BCISE (exenatide) RYBELSUS (semaglutide) TANZEUM (albiglutide)	

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS

CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

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HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]

EXISTING CRITERIA:

CLASS PA CRITERIA: Agents in this class will not be approved for patients with a starting A1C < 7%. Non-preferred agents are available only on appeal. Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met.

- Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient's current and stabilized regimen.
- No agent in this class shall be approved except as add on therapy to a regimen consisting of at least one (1) other agent prescribed at the maximum tolerable dose for at least 90 days.
- Re-authorizations require continued maintenance on a regimen consisting of at least one (1) other agent at the maximum tolerable dose AND an A1C of ≤8%.

PROPOSED CRITERIA: - motioned, seconded, Approved with change

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:

1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.
2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).

HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6 month intervals) if ALL of the following criteria has been met:

1) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
2) Medical records indicated treatment failure with all unique preferred agents in the same class.
3) Baseline A1C must be submitted.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, an A1C of ≤8%, or show continued improvement.

SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	

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New Therapeutic Class

MABS, ANTI-IL/IgE

Drugs in this class already have approved criteria posted on BMS's website:

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/PA-Criteria.aspx