Aetna Better Health® of Florida

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline	Requirements	Duration of Approval if Requirements Are Met
Medications requiring Prior Authorization	Requests for Medications requiring Prior Authorization (PA) will be reviewed based on the PA Guidelines/Criteria for that medication. Scroll down to view the PA Guidelines for specific medications. Medications that do not have a specific Prior Authorization guideline will follow the Non-Formulary Medication Guideline. Additional information may be required on a case-by-case basis to allow for adequate review.	As documented in the individual guideline
Step Therapy	Medications requiring Step Therapy first go through trial and failure of formulary agent prior to approval If prerequisite medications have been filled within specified time frame, prescription will automatically process at the pharmacy Prior Authorization will be required for prescriptions that do not process automatically at pharmacy	**Initial Approval:** One year **Renewal Approval:** One year ***Requires:*** Member response to treatment
Quantity Level Limits	Requests that exceed established Quantity Level Limits will require prior authorization Drugs subject to additional utilization management requirements (for example, non-formulary, clinical prior authorization, and step therapy) must meet clinical criteria and medical necessity for approval, in addition to any established Quantity Level Limit Approval of Quantity Level Limit exceptions are considered after medication specific prior authorization guideline and medical necessity review	**Initial Approval:** One year **Renewal Approval:** One year

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	Authorization Criteria for Quantity Limit Exceptions: • **Quantities that Exceed Food and Drug Administration (FDA) Maximum Dose:** ○ Member is tolerating medication with no side effect, but had inadequate response at lower dose, and the inadequate response is not due to medication non-adherence	

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	○ Request meets one of the following: ▪ Dose is included in drug compendia or evidence-based clinical practice guidelines for same indication ▪ Published randomized, double blind, controlled trial, demonstrating safety and efficacy of requested dose is submitted with request • **Quantities that do not Exceed Food and Drug Administration (FDA) Maximum Dose (Dose Optimization):** ○ Request meets one of the following: ▪ There was inadequate response or intolerable side effect to optimized dose ▪ There is a manufacturer shortage of higher strengths ▪ Member is unable to swallow tablet/capsule due to size, and dosage form cannot be crushed ▪ Effect of medication is wearing off between doses ▪ Member cannot tolerate entire dose in one administration • **Quantities for Medications that do not have Established Food and Drug Administration (FDA) Maximum Dose:** ○ Member is tolerating medication with no side effects, but had inadequate response at lower dose, and the inadequate response is not due to medication non-adherence ○ Requested dose is considered medically necessary	

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met

Anticoagulants - Oral[i]
 	
Savaysa
	Savaysa may be authorized for members who meet all of the following:
	• Age is 18 years or older
	• Diagnosis is for one of the following:
	  ○ Non-valvular atrial fibrillation
	  ▪ There is no moderate-to-severe mitral stenosis or mechanical heart valve
	  ▪ Documentation of a CHA_2DS_2-VASc score of 1 or more (greater than or equal to 1 in males or greater than or equal to 2 in females)
	  ▪ Creatinine clearance is less than 95 milliliters per minute
	  ○ Treatment of Deep Vein Thrombosis and Pulmonary Embolism
	• There was 5 – 10 days of initial therapy with parenteral anticoagulant
		Initial Approval:
		• Atrial fibrillation: 1 year
		• Treatment of Deep Vein Thrombosis or Pulmonary Embolism:
		  ○ 3 months
		Renewal Approval:
		• Atrial fibrillation:
		  ○ 1 year
		• Treatment of Deep Vein Thrombosis or Pulmonary Embolism:
		  ○ 3 months
		• American College of Chest Physicians (CHEST) recommends 3-month duration for most acute Venous Thromboembolism treatment

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		Quantity Level Limit: Savaysa: 1 tablet per day

Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists[ii]
 	
Aimovig
 	
Emgality 100mg
 	
Emgality 300mg
	May be authorized when member meets the following criteria:
	• Prescribed by, or in consultation with neurologist for preventative treatment of migraines, treatment of acute migraines, or treatment of cluster headaches
	• Age is 18 years or older
	• **Chronic Migraine** (Aimovig):
	  ○ Headache occurring on 15 or more days per month with at least 8 migraine days per month for more than 3 months
	• **Episodic Migraine** (Aimovig):
	  ○ Headache occurring less than 15 days per month with 4 to 14 migraine days per month
	• For Chronic and Episodic migraines, there is documented inadequate response, or intolerable side effects, to at least two medications for migraine prophylaxis from two different classes, for at least 2 months:
	  ○ Beta-Blockers: Propranolol, metoprolol, atenolol, timolol, nadolol
	  ○ Anticonvulsants: Valproic acid, or divalproex, topiramate
	  ○ Antidepressants: Amitriptyline, nortriptyline, venlafaxine, duloxetine
	• **Episodic Cluster Headaches:** (Emgality)
		Initial Approval:
		3 months
		
		Renewal Approval:
		6 months
		
		Requires:
		• Documentation of reduction in migraine headache days from baseline
		• Aimovig 140mg monthly injection requires trial and failure with the 70mg injection
		• Medication will not be used in combination

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	○ Headaches occurring at maximum 8 attacks per day, or minimum one attack every other day ○ Trial and failure with verapamil for preventive treatment or sumatriptan (nasal or subcutaneous) for acute treatment • Aimovig 140mg monthly injection, requires trial and failure with the 70mg injection • Medication will not be used in combination with another Calcitonin Gene-Related Peptide Receptor (CGRP) antagonist, or with Botulinum toxin (Botox)	with another Calcitonin Gene-Related Peptide Receptor (CGRP) antagonist, or with Botulinum toxin (Botox) **Quantity Level Limits:** **Aimovig**: • 1mL per 30 days **Emgality for Cluster Headaches:** • 3mL for 1st 30 days then 1mL per 30 days
Epidiolex[iii]	**May be authorized when the following criteria are met:** • Member is at least 1 years of age • Prescribed by, or in consultation with a neurologist • Medication will be taken as adjunctive therapy to at least one other antiepileptic drug	**Initial Approval:** 6 months **Renewal Approval:** 1 year

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	• Attestation that serum transaminases and total bilirubin levels have been obtained prior to initiation and will be taken periodically as appropriate (per Food and Drug Administration (FDA) approved labeling)
	• Dose must be appropriate for member's liver function and should not exceed 20mg/kg/day
	• **For Lennox-Gastaut syndrome:**
	  ○ Documentation member has tried and failed or has intolerance or contraindication to Onfi® (clobazam) and two of the following:
	  ▪ Valproic acid, topiramate, lamotrigine, and/or felbamate
	• **For Dravet syndrome:**
	  ○ Documentation member has tried and failed or has intolerance or contraindication to Onfi® (clobazam), valproic acid, and one of the following:
	  ▪ Topiramate, levetiracetam, zonisamide, lamotrigine, or felbamate
	• **For seizures associated with tuberous sclerosis complex:**
	  ○ Documentation member has tried and failed or has intolerance or contraindication any two antiepileptic agents
	
	*Note zonisamide and lamotrigine are not generally recommended in Dravet Syndrome treatment but will be recognized as previous therapy trials should they have been previously used.
		***Requires*:**
		• Member has had decrease in seizure frequency from baseline
		• Serum transaminase level has not been greater than 3 times the upper limit of normal (ULN) while accompanied by bilirubin greater than 2 times the ULN
		• Serum transaminase level has not been sustained at greater than 5 times the upper limit of normal (ULN)
		
		Quantity Level Limit:

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		• Lennox-Gastaut Syndrome and Dravet Syndrome: 20 mg/kg/day • Tuberous Sclerosis Complex: 25 mg/kg/day **All requests require current weight** to confirm correct dose not being exceeded

Griseofulvin[iv]	Griseofulvin is approved when ONE of the following criteria is met:
	• Member had inadequate response, intolerable side effect, or contraindication to ONE of the following agents:
	  ○ fluconazole
	  ○ itraconazole
	  ○ ketoconazole
	  ○ terbinafine
	  OR
	• Member has a diagnosis of tinea capitis
		Initial Approval: 6 months
		
		Renewal Approval: 6 months

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Oxervate[v]	**May be authorized when member meets the following criteria:** • Diagnosis is for treatment of stage 2 or Stage 3 neurotrophic keratitis • Member is 2 years of age or older • Member experienced persistent epithelial defects (PED), or corneal ulceration for at least 2 weeks • There was trial and failure with one or more conventional non-surgical treatments ○ For example: preservative free artificial tears • Documentation of decreased corneal sensitivity (less than or equal to 4 cm using the Cochet-Bonnet aesthesiometer) within the area of epithelial defects (PED) or corneal ulcer, and outside the area of the defect in at least one corneal quadrant • The member has not received a previous 8-week course of Oxervate in the affected eye • All other indications are considered experimental/investigational and not medically necessary	**Approval Duration:** 8 weeks total per eye **Recommended Dosing:** One drop in the affected eye(s), 6 times per day at 2-hour intervals, for 8 weeks

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Duration of Therapy Limits for Proton Pump Inhibitors (PPIs)[vi] Preferred: • Esomeprazole 20 mg capsule OTC (over the counter) • Lansoprazole 15 mg capsule Rx and OTC (prescription and over the counter) • Lansoprazole 30 mg capsule Rx (prescription) • First-Lansoprazole	All Proton Pump Inhibitors (PPIs) (preferred and non-preferred) are subject to a duration of therapy limit. This limit is 180 days in a rolling 365-day period. Requests for a duration of therapy limit override for a non-preferred Proton Pump Inhibitor requires use of preferred Proton Pump Inhibitor (PPI) products. A maximum duration of therapy override request for a Proton Pump Inhibitor will be authorized when one of the following criteria is met: • Member has a documented upper gastrointestinal (GI) testing in the previous 2-year period • Member is dependent on a feeding tube for nutritional intake • Member resides in a long-term care facility • Member is unable to taper off a Proton Pump Inhibitor (PPI) without return of symptoms • Member is unable to transition to a histamine H2-receptor antagonist (H2 Blocker) • Member uses a Proton Pump Inhibitor (PPI) alone or in combination with a histamine H2-receptor antagonist (H2 Blocker) only as needed, but this is still more than 180 days in a year **Duration of Therapy Limit Exemptions for Proton Pump Inhibitors (PPIs)** A maximum duration of therapy override request for a Proton Pump Inhibitor will pay at the point of sale (without requiring a prior authorization) and will be authorized when one of the following are met:	Duration of override approval, both initial and reauthorization, to exceed the 180-day duration of therapy limit: One year

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Suspension 3mg/mL (for members 12 years and younger) • Omeprazole delayed release 20 mg tablet OTC (over the counter) • Omeprazole 10 mg, 20 mg, 40 mg capsule Rx (prescription) • Omeprazole magnesium 20.6 mg capsule OTC (over the counter)	• Member is under 6 years of age • Member is receiving pancreatic enzymes • Member receives a concomitant medication that increases the risk of upper gastrointestinal (GI) bleed (for example, anticoagulants, antiplatelets, Nonsteroidal Anti-inflammatory Drugs (NSAIDs)) • Member with one of the following diagnosis codes: ○ Angiodysplasia of Stomach and Duodenum (with OR without Mention of Hemorrhage) (K31.81*) ○ Atrophic Gastritis with Hemorrhage (K29.41) ○ Barrett's Esophagus (K22.7*) ○ Cerebral Palsy (G80*) ○ Chronic Pancreatitis (K86.0, K86.1) ○ Congenital Tracheoesophageal Fistula (Q39.1, Q39.2) ○ Cystic Fibrosis (E84.*) ○ Eosinophilic Esophagitis (K20.0) ○ Eosinophilic Gastritis (K52.81) ○ Gastrointestinal Hemorrhage (K92.2) ○ Gastrointestinal Mucositis (Ulcerative) (K92.81) ○ Malignant Mast Cell Tumors (C96.2*) ○ Multiple Endocrine Adenomas (D44.0, D44.2, D44.9) ○ Tracheoesophageal Fistula (J86.0) ○ Ulcer of Esophagus with OR without Bleeding (K22.1*) ○ Zollinger-Ellison Syndrome (E16.4)	

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
• First-Omeprazole Suspension 2 mg/mL (for members 12 years and younger) • Pantoprazole 20 mg and 40 mg tablets Rx (prescription) • Rabeprazole 20 mg tablet	* Any number or letter or combination of UP TO FOUR numbers and letters of an assigned ICD-10-CM diagnosis code	

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High Dose Proton Pump Inhibitors (PPIs)[vii] **Preferred agents:** • Esomeprazole 20 mg capsule OTC (over the counter) • Lansoprazole 15 mg capsule Rx and OTC (prescription and over the counter) • Lansoprazole 30 mg capsule Rx (prescription) • First-Lansoprazole	**High Dose Proton Pump Inhibitors (PPIs) will be authorized when the following criteria are met:** • Provider submits rationale for high dose (for example, member has unsatisfactory or partial response to once daily dosing, night-time symptoms, severe erosive esophagitis, stricture, Zollinger-Ellison) • Requests for high dose non-preferred Proton Pump Inhibitors (PPIs) require use of a preferred Proton Pump Inhibitor (PPI) at high dose	**Initial Approval:** One year **Renewal Approval:** One year ***Requires:*** • Response to therapy • Rationale for continuing high dose and failure to once daily dosing after completion of high dose course

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Suspension 3mg/mL (for members 12 years and younger) • Omeprazole delayed release 20 mg tablet OTC (over the counter) • Omeprazole 10 mg, 20 mg, 40 mg capsule Rx (prescription) • Omeprazole magnesium 20.6 mg capsule OTC (over the counter)		

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• First-Omeprazole Suspension 2 mg/mL (for members 12 years and younger) • Pantoprazole 20 mg and 40 mg tablets Rx (prescription) • Rabeprazole 20 mg tablet		
Reyvow[viii]	**May be authorized when the following criteria is met:** • Prescribed by, or in consultation with a neurologist, or headache specialist • Member is 18 years of age or older • Diagnosis of migraine with or without aura according to the International Classification of Headache Disorders (ICHD-III) diagnostic criteria • Headache pain is moderate to severe intensity • Documented inadequate response or intolerable side effects with at least two triptans for at least one month each, or member has a contraindication to triptan use	**Initial Approval:** 3 months **Renewal Approval:** 6 months ***Requires:*** • Response to therapy

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	• Prescriber attestation that member acknowledges and agrees to not drive or operate machinery until at least 8 hours after taking each dose	○ for example, decrease in pain severity; decreased symptoms of photophobia, phonophobia, or nausea and or vomiting • Prescriber attestation that member acknowledges and agrees to not drive or operate machinery until at least 8 hours after taking each dose **Quantity Level Limit:** 4 tablets per 30 days
Somatostatin Analogs[ix]	**General Authorization Criteria for ALL Indications:** • Member is 18 year of age or older (unless prescribed for pediatric chemotherapy-	**Initial Approval:** 6 months

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Sandostatin LAR
Signifor
Signifor LAR
Somavert
Somatuline depot
	induced diarrhea)
	• <u>Sandostatin LAR and Somatuline Depot:</u>
	  ○ Baseline testing for the following:
	  ▪ A1c or fasting glucose
	  ▪ Thyroid-stimulating hormone
	  ▪ Electrocardiography
	• <u>Somavert</u>:
	  ○ Baseline testing shows member's liver function tests (LFTs) are less than 3x the upper limit of normal (ULN)
	• <u>Signifor and Signifor Long-Acting Release</u>:
	  ○ Baseline testing for the following:
	  ▪ A1c, or fasting plasma glucose
	  ▪ Electrocardiography
	  ▪ Potassium
	  ▪ Magnesium
	  ▪ Thyroid-stimulating hormone
	  ▪ Liver function tests
	  ▪ Attestation that gallbladder ultrasound has been completed
	Additional Criteria Based on Indication:
	• **Acromegaly**
	<u>Somatuline Depot, Signifor, Signifor Long-Acting Release, Somavert, Sandostatin</u>
		<u>Renewal Approval:</u>
		• Acromegaly, Cushing's, Carcinoid and VIPomas: One year
		• All other indications: 6 months
		Requires:
		Documentation of the following for all indications for somatostatin analogs:
		• A1c or fasting glucose
		• Electrocardiography
		• Monitor for cholelithiasis and discontinue if complications of

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	Long-Acting Release: ○ Prescribed by, or in consultation with, an endocrinologist ○ Member has one of the following: ▪ Persistent disease following radiotherapy and/or pituitary surgery ▪ Surgical resection is not an option as evidenced by one of the following: ➢ Majority of tumor cannot be resected ➢ Member is a poor surgical candidate based on comorbidities ➢ Member prefers medical treatment over surgery, or refuses surgery ○ Baseline insulin-like growth factor-1 (IGF-1) meets one of the following criteria: ▪ Greater than or equal to 2.5 times the upper limit of normal for age ▪ Remains elevated despite a 6-month trial of maximally tolerated dose of cabergoline (unless member cannot tolerate, or has contraindication to cabergoline) • **Carcinoid Tumor or Vasoactive Intestinal Polypeptide Secreting Tumor (VIPomas)** Somatuline Depot, Sandostatin Long-Acting Release - To reduce frequency of short-acting somatostatin analog rescue therapy: ○ Prescribed by, or in consultation with, an oncologist or endocrinologist • **Cushing's Syndrome** Signifor, Signifor Long-Acting Release: ○ Member has persistent disease after pituitary surgery, or surgery is not an option ○ Member had inadequate response, intolerable side effects, or contraindication to	cholelithiasis are suspected • Thyroid-stimulating hormone • Response to therapy **Documentation of additional requirements per indication or drug:** • Acromegaly: ○ Decreased or normalized insulin-like growth factor-1 (IGF-1) levels • Cushing's: ○ Decreased or normalized cortisol levels • Somavert:

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	cabergoline • **Gastro-entero-pancreatic neuroendocrine tumor** Somatuline Depot, Sandostatin Long-Acting Release: o Prescribed by, or in consultation with, an oncologist or endocrinologist o Member has persistent disease after surgical resection, or is not a candidate for surgery	o Liver function tests o A1c or fasting glucose o Response to therapy • Signifor: o Liver function tests **Quantity Level Limits:** • Signifor: 2 vials per day • Signifor (LAR): 1 vial per 28 days • Somavert: Maximum dose 30mg per day after loading dose • Somatuline Depot:

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
		1 syringe per 28 days

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