Ohio | Department of Medicaid

30 Day Change Notice
Effective Date: July 1, 2021

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Nyvepria
Ophthalmic Agents: Dry Eye Treatments	Eysuvis
Topical Agents: Corticosteroids	Impeklo
Dermatological: Topical Acne Products	Tazorac (labeler 00023)

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Central Nervous System (CNS) Agents: Narcolepsy	Armodafinil Modafinil
Dermatological: Topical Acne products	Adapalene Gel 0.1%

NEW CLINICAL PA REQUIRED PREFERRED	
THERAPEUTIC CLASS	**CLINICAL PA REQUIRED "PREFERRED"**
Chemotherapy	Votrient

NEW THERAPEUTIC CATEGORIES
Central Nervous System (CNS) Agents: Narcolepsy

Central Nervous System (CNS) Agents: Narcolepsy	
PREFERRED	**NON-PREFERRED**
Amphetamine/Dextroamphetamine	Sunosi
Armodafinil	Wakix
Dextroamphetamine ER	Xyrem
Methylphenidate ER	Xywav
Methylphenidate Tab	
Modafinil	

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Legend

AR (Age Restriction) - An age edit allows claims for members within a defined age range to adjudicate without authorization
BvG (Brand Preferred Over the Generic) - The brand name medication is preferred over the generic equivalent
PA (Clinical Prior Authorization) - A prior authorization is required before the medication will adjudicate
QL (Quantity Limit) – A limit on the quantity that can be covered within a given time frame
ST (Step Therapy) - Medications require a trial with one or more preferred products before approval

Central Nervous System (CNS) Agents: Narcolepsy

LENGTH OF AUTHORIZATIONS: 365 Days

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindications to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

NON-PREFERRED MEDICATION:

- ☐ For non-preferred drugs without medication specific criteria, there must have been an inadequate clinical response to preferred alternatives, including a trial of no less than 30 days each of at least two preferred products

PRIOR AUTHORIZATION CRITERIA:

- ☐ Sunosi (soriamfetol)
  - Diagnosis of narcolepsy with excessive daytime sleepiness or obstructive sleep apnea with excessive daytime sleepiness **AND**
  - An inadequate response to or inability to tolerate a 30-day course of treatment with modafinil or armodafinil **AND**
  - An inadequate response to or inability to tolerate a 30-day course of treatment with a preferred methylphenidate or amphetamine product

- ☐ Wakix (pitolisant), Xyrem (sodium oxybate)
  - Diagnosis of narcolepsy with excessive daytime sleepiness **AND**
  - An inadequate response to or inability to tolerate a 30-day course of treatment with modafinil or armodafinil **AND**
  - An inadequate response to or inability to tolerate a 30-day course of treatment with a preferred methylphenidate or amphetamine product **OR**
  - Diagnosis of narcolepsy with cataplexy

- Xywav (calcium, magnesium, potassium & sodium oxybates)
  - Diagnosis of narcolepsy with excessive daytime sleepiness **AND**
  - An inadequate response to or inability to tolerate a 30-day course of treatment with modafinil or armodafinil **AND**
  - An inadequate response to or inability to tolerate a 30-day course of treatment with a preferred methylphenidate or amphetamine product **AND**
  - Sodium restriction with documented adherence to sodium restricted diet **OR**
  - Diagnosis of narcolepsy with cataplexy **AND**
  - Sodium restriction with documented adherence to sodium restricted diet

REAUTHORIZATION CRITERIA:

- Attestation that the patient's condition has improved while taking the requested medication

CHANGES IN CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Ophthalmic Agents: Dry Eye Treatments	**LENGTH OF AUTHORIZATIONS**: 365 Days for Cequa, Restasis Trays, Restasis Multi-Dose and Xiidra 14 Days for Eysuvis All drugs in this class require step therapy: Patient must have a claim for an artificial tear or OTC dry eye drop in the previous 120 days. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include: • Allergy to medications not requiring prior approval • Contraindications to or drug interaction with medications not requiring prior approval • History of unacceptable/toxic side effects to medications not requiring prior approval Patient must have a therapeutic failure to at least 30 days of one of the preferred agents.

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CHANGES IN CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Endocrine Agents: Diabetes-Non-Insulin	**LENGTH OF AUTHORIZATIONS:** 365 Days **STEP THERAPY:** 1. For a drug requiring step therapy, there must have been inadequate clinical response to metformin products (either single-ingredient or in a sulfonylurea/ metformin or TZD/metformin combination), including a trial of no less than 60 days of at least one preferred metformin product 2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including metformin and a trial of no less than 60 days of at least one preferred or step therapy product Note: Inadequate clinical response after at least 60 days of recommended therapeutic dose with documented adherence to the regimen. 3. Farxiga and Trulicity step therapy requirements are waived for members with Type 2 diabetes and established cardiovascular disease or multiple cardiovascular disease risk factors. □ Farxiga step therapy requirements are waived for members without a diagnosis of Type 2 diabetes and with a diagnosis of heart failure with reduced ejection fraction, or chronic kidney disease at risk of progression. 4. Victoza and Jardiance step therapy requirements are waived for members with Type 2 diabetes and established cardiovascular disease. 5. Invokana step therapy requirements are waived for members with Type 2 diabetes and established cardiovascular disease or diabetic nephropathy with albuminuria. **OTHER APPROVAL CRITERIA:** Is there any reason the patient cannot be changed to a medication within the same class not requiring prior approval? Acceptable reasons include: □ Allergy to medications not requiring prior approval □ Contraindication to or drug interaction with medications not requiring prior approval □ History of unacceptable/toxic side effects to medications not requiring prior approval