Aetna Better Health® of Michigan

Pharmacy Prior Authorization
Non-Formulary, Step Therapy and Prior Authorization Guidelines

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

PA Guideline	Requirements	Duration of Approval if Requirements Are Met

Anthelmintic[i]
 	
Praziquantel (Biltricide)
 	
Albendazole (Albenza)
	<u>Praziquantel</u> pays at Point of Sale when one of the following infections is present:
	• Flukes
	  ▪ Clonorchiasis
	  ▪ Opisthorchiasis
	  ▪ Paragonimiasis
	  ▪ Fasciolopsis
	• Tapeworms
	  ▪ Schistosomiasis
	  ▪ Taeniasis
	  ▪ Cysticercosis/Neurocysticercosis
	Prescriptions for praziquantel that do not pay at Point of Sale may be approved for members who meet one of the following:
	• Trial and failure with ivermectin or pyrantel
	• Infection falls either under Fluke or Tapeworm:
	  ○ Flukes
	  ▪ Clonorchiasis
	  ▪ Opisthorchiasis
	  ▪ Paragonimiasis
	  ▪ Fasciolopsis
	  ○ Tapeworms
		<u>Initial Approval:</u>
		Roundworm: 21 days
		All others: 3 days
		
		<u>Exceptions to Initial Approval</u>:
		<u>*Praziquantel*</u>:
		• Cysticercosis/Neurocysticercosis: Up to 15 days
		
		<u>*Albendazole*</u>:
		• Cysticercosis/Neurocysticercosis: 120 tablets per month
		• Clonorchiasis and Opisthorchiasis: Up to 7 days
		• Hydatid Disease:

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	▪ Schistosomiasis ▪ Taeniasis ▪ Cysticercosis/Neurocysticercosis **<u>Albendazole</u> pays at Point of Sale when one of the following infections is present:** o Tapeworm ▪ Taeniasis ▪ Cystericerosis/Neurocystercosis ▪ Hydatid disease/Echinococcosis o Roundworm ▪ Capillariasis ▪ Trichinellosis/Trichinosis ▪ Ascariasis ▪ Toxocariasis ▪ Baylisascariasis o Flukes ▪ Clonorchiasias ▪ Opisthorchis **Prescriptions for albendazole that do not pay at Point of Sale may be approved for members who meet one of the following:**	Up to 112 tablets every 42 days for 4 months (112 tablets every 28 days with a 14-day drug-free period. Repeat up to 2 more cycles) • Toxocariasis: 400 mg by mouth twice a day for five days

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	• Trial and failure with ivermectin or pyrantel
	• Infection is with one of the following:
	  ○ Tapeworm
	  ▪ Taeniasis
	  ▪ Cysticercosis/Neurocysticercosis
	  ▪ Hydatid disease/Echinococcosis
	  ○ Roundworm
	  ▪ Capillariasis
	  ▪ Trichinellosis/Trichinosis
	  ▪ Ascariasis
	  ▪ Toxocariasis
	  ▪ Baylisascariasis
	  ○ Flukes
	  ▪ Clonorchiasias
	  ▪ Opisthorchis	

Botulinum Toxins Botox Myobloc Dysport	**See Detailed document:** Aetna Better Health® of Michigan Pharmacy Guidelines	

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
Xeomin		

Corlanor[ii]	**May be authorized for members 18 years of age or older when the following criteria are met:**
	• Diagnosis of stable symptomatic chronic heart failure (New York Heart Association (NYHA) Class II-III)
	• Left ventricular ejection fraction (LVEF) is less than or equal to 35%
	• Member is in sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute
	• Continuation of therapy with maximally tolerated beta-blocker, or there is intolerance or contraindication to beta-blockers
	• Continuation of therapy with angiotensin-converting-enzyme inhibitor (ACEI)/Angiotensin Receptor Blockers (ARB), or Entresto, or there is intolerance, or contraindication to angiotensin-converting-enzyme inhibitor (ACEI)/Angiotensin Receptor Blockers (ARB), or Entresto
	  ○ Note: Entresto requires Prior Authorization
	• Provider attestation that no contraindications to treatment exist:
	  ○ Acute decompensated heart failure
	  ○ Blood pressure less than 90/50 mmHg
	  ○ Pacemaker dependent (for example: heart rate maintained exclusively by
		Initial Approval:
		6 months
		
		Renewals:
		1 year
		
		Requires:
		• Member is responding to treatment
		• Heart rate is within recommended range for continuation of maintenance dose
		  • For example, 50-60 beats per minute, or

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	pacemaker) ○ Sick sinus syndrome, sinoatrial block of third-degree AV block (unless functioning demand pacemaker is present) ○ Severe hepatic impairment (Child-Pugh class C) **May be authorized for pediatric members 6 months of age or older when the following criteria are met:** • Diagnosis of heart failure due to dilated cardiomyopathy • Member is in sinus rhythm with a resting heart rate of greater than or equal to 70 beats per minute • Provider attestation that no contraindications to treatment exist: ○ Acute decompensated heart failure ○ Blood pressure less than 90/50 mmHg ○ Pacemaker dependent (for example, heart rate maintained exclusively by pacemaker) ○ Sick sinus syndrome, sinoatrial block of third-degree AV block (unless functioning demand pacemaker is present) ○ Severe hepatic impairment (Child-Pugh class C)	dose adjusted accordingly to achieve goal **Quantity Level Limit**: Adults and Pediatrics: 60 tablets per 30 days Oral solution for pediatrics: 120 ampules per 30 days
Egrifta[iii]	• Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy	**Initial Approval:**

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	• Documentation of waist circumference greater than or equal to 95 cm for males, or greater than or equal to 94 cm for females at start of therapy
	• Member is currently receiving anti-retroviral therapy
	• Baseline evaluation within the past 3 months of the following:
	  ○ Hemoglobin A1c (HbA1c)
	  ○ Insulin-like growth factor 1 (IGF-1)
	• Attestation Hemoglobin A1c (HbA1c) will be monitored every 3 to 4 months
	• Member is at risk for medical complications due to excess abdominal fat
	• Member does not have active malignancy
	• Member does not have disruption of the hypothalamic-pituitary gland axis or head trauma
	• Women of childbearing age are not pregnant and are using appropriate contraception
		6 months
		
		<u>Renewal Approval:</u>
		6 months
		
		***Requires*:**
		Documentation of a positive clinical response:
		• Hemoglobin A1c (HbA1c) within normal range (for the lab)
		• Insulin-like growth factor 1 (IGF-1) within normal range (for the lab)
		• Decrease in waist circumference

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Emflaza[iv]	**Authorization criteria for members 2 years of age and older when all the following are met:**
	• Prescribed by or in consultation with a neurologist
	• Documentation indicating member has diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by one of the following:
	  ○ Genetic testing demonstrating a mutation in the dystrophin gene,
	  ○ Muscle biopsy evidence of total absence of dystrophin or abnormal dystrophin
	• Serum creatine kinase (CK) at least 10 times the upper limit of normal
	• Documentation member had a trial of prednisone for at least 6 months with unmanageable and clinically significant weight gain/obesity or psychiatric/behavioral issues (for example abnormal behavior, aggression, or irritability)
	• Documentation of baseline motor milestone scores by one of the following assessments:
	  ○ 6-minute walk test (6MWT)
	  ○ North Star Ambulatory Assessment (NSAA)
	  ○ Motor Function Measure (MFM)
	  ○ Hammersmith Functional Motor Scale (HFMS)
	• Attestation of all the following:
	  ○ Emflaza will not be given concurrently with live vaccinations
	  ○ Member does not currently have an active infection (including Hepatitis B Virus (HBV))
		Initial Approval:
		6 months
		
		Renewal Approval:
		12 months
		
		***Requires*:**
		• Clinical benefit from therapy documented as an improvement in baseline motor milestone scores
		• Attestation to the following:
		  ○ Not given concurrently with live vaccinations
		  ○ Absence of an

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	○ For members with history of Hepatitis B Virus (HBV) infection, prescriber agrees to monitor for Hepatitis B Virus (HBV) reinfection	active infection (including Hepatitis B Virus (HBV)). ○ If member has history of Hepatitis B Virus (HBV) infection, prescriber agrees to monitor for Hepatitis B Virus (HBV) reinfection
Idiopathic Pulmonary Fibrosis Agents[v]	**Documentation is required to support approval, when all the following criteria are met:** • Member is 18 years of age or older	**Initial Approval:** **3 months**

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Esbriet
Ofev
	• Prescribed by, or in consultation with, a pulmonologist
	• Diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by one of the following:
	  ○ High resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP)
	  ○ Surgical lung biopsy with usual interstitial pneumonia (UIP)
	• Forced vital capacity (FVC) greater than or equal to 50% predicted
	• Carbon Monoxide Diffusion Capacity (DLCO) greater than or equal to 30%
	• Baseline liver function tests (LFTs) prior to initiating treatment
	• Member is not a current smoker
	• Other known causes of interstitial lung disease have been ruled out (for example, domestic and occupational environmental exposures, connective tissue disease, or drug toxicity)
		Renewal:
		6 months
		
		Requires:
		Documentation of all the following:
		• Stable Forced Vital Capacity (FVC) (recommend discontinuing if there is greater than 10% decline in Forced Vital Capacity (FVC) over 12-month period)
		• Liver function tests

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
		(LFTs) are being monitored • Member is not a current smoker • Compliance and adherence to treatment **Quantity Level Limit:** Ofev: 2 caps per day Esbriet: 9 caps per day or 3 tabs per day
Janus Associated Kinase Inhibitors[vi]	**General Authorization Guideline for All Indications:** • Prescribed by, or in consultation with hematologist/oncologist • Member has been screened for tuberculosis ○ If screening was positive for latent tuberculosis, member has received treatment for	**Initial Approval:** 6 months **Renewal:** 1 year

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Jakafi	latent tuberculosis prior to initiating therapy
	• There is no evidence showing member has a serious current active infection
	
	<u>Additional Criteria Based on Indication:</u>
	
	Myelofibrosis:
	• Member is at least 18 years of age
	• Baseline platelet count is at least 50 X 10^9/L
	• Diagnosis is primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis
	• Intermediate or high-risk disease is defined as having two or more of the following risk factors:
	  ○ Age greater than 65 years
	  ○ Constitutional symptoms (weight loss greater than 10% from baseline and/or unexplained fever, or excessive sweats persisting for more than 1 month)
	  ○ Hemoglobin less than 10g/dL
	  ○ White Blood Cell count greater than or equal to 25 x 10^9/L
	  ○ Peripheral Blood blasts greater than 1%
	  ○ Platelet count less than 100 X 10^9/L
	  ○ Red Cell Transfusion
	  ○ Unfavorable karyotype [for example, complex karyotype, or sole, or two abnormalities
		Requires:
		
		For Myelofibrosis:
		• Spleen size reduction of greater than or equal to 35% OR
		• Symptom improvement (greater than or equal to 50% reduction in total symptom score from baseline) OR
		• Absence of disease progression
		
		For Polycythemia Vera:

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	that include trisomy 8, 7/7q-, i(17q), inv(3), 5/5q-, 12p- or 11q23 rearrangement] **Polycythemia Vera** • Member is at least 18 years of age • Inadequate response or intolerance to hydroxyurea • Diagnosis of Polycythemia vera required by meeting all 3 major criterions, or the first 2 major criterions plus minor criterion below: Major Criteria ○ Hemoglobin greater than 16.5 g/dL in men, greater than 16.0 g/dL in women OR Hematocrit greater than 49% in men, greater than 48% in women OR Increased red cell mass ○ Bone marrow biopsy showing hypercellularity for age with trilineage growth (panmyelosis), including prominent erythroid, granulocytic, and megakaryocytic proliferation with pleomorphic, mature megakaryocytes (differences in size) ○ Presence of Janus Kinase 2 (JAK2) V617F mutation, or Janus Kinase 2 (JAK2) exon 12 mutation Minor criterion ○ Subnormal serum erythropoietin level	• Hematologic improvement (decreased hematocrit, platelet count or white blood cell count) OR • Reduction in palpable spleen length OR • Improvement in symptoms (for example, pruritus, night sweats, bone pain) **For Acute Graft-Versus-Host Disease:** • Response to treatment OR

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	Acute Graft-Versus-Host Disease: • Member is at least 12 years of age • There was Inadequate response to steroids after an allogenic hematopoietic stem cell transplant • Diagnosis of grade 2 to 4 disease, based on Mount Sinai Acute GVHD International Consortium (MAGIC) criteria	• Symptoms are recurring during or after taper, and retreatment is needed
Juxtapid[vii]	**Medical Records Required with Requests** **May be authorized when all the following criteria are met:** • Member is 18 years of age or older • Prescribed by, or in consultation with Cardiologist, Endocrinologist, or Lipid Specialist • Females of reproductive potential have a negative pregnancy test prior to starting treatment • Used as an adjunct to a low-fat diet and exercise • Diagnosis of homozygous familial hypercholesterolemia (HoFH) as evidenced by one of the following: ○ Genetic confirmation of 2 mutant alleles at the Low-Density Lipoprotein Receptor (LDLR), Apolipoprotein B100 (APO-B100), or Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9)	**Initial Approval: 3 months** **Renewal Approval: 6 months** ***Requires:*** • Member is continuing a low-fat diet and exercise regimen • Current lipid Panel within the past 90

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	○ History of untreated Low-Density Lipoprotein (LDL) greater than 500 mg/dL, or treated Low-Density Lipoprotein (LDL) greater than 300 mg/dL on maximum dosed statin and evidence of one of the following: ▪ Presence of cutaneous xanthoma before the age of 10 years ▪ Heterozygous familial hypercholesterolemia (HeFH) in both parents • Current lipid panel/Low-Density Lipoprotein (LDL) from past 90 days • Member had a failure or contraindication to a 90-day trial of a Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor (for example, Repatha or Praluent) • Attestation to the following: ○ Member does not have significant hepatic impairment (Child-Pugh B or C) ○ Will be used in conjunction with other lipid lowering therapies such as statins, ezetimibe, bile acid sequestrants, or Low-Density Lipoprotein (LDL) apheresis	days showing **Low-Density Lipoprotein (LDL)** reduction from baseline • Claims history to support compliance or adherence to Juxtapid and adjunctive lipid lowering therapies • Prescriber attestation of monitoring liver related tests, and dosing adjusted according to prescribing information

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		• Females of reproductive potential are currently using contraception **Quantity Level Limits:** • Juxtapid: 1 tablet per day

Korlym[viii]	• Member is 18 years of age or older
	• Documentation (submit chart notes) that diagnosis is of endogenous Cushing syndrome with all the following:
	  ○ Uncontrolled hyperglycemia due to glucose intolerance or type 2 diabetes mellitus
	  ○ Member failed surgery or is not a candidate for surgery
	  ○ There was failure to achieve adequate glycemic control despite individualized diabetic management
	• Prescribed by or in consultation with endocrinologist
	• Baseline labs for hemoglobin A1c (HbA1c)
		Initial Approval:
		6 months
		
		Renewal Approval:
		12 months
		
		Requires:
		• Documentation of improved

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	• Prescriber attestation to all the following:
	  ○ Female members of childbearing potential are not pregnant
	  ○ Female members do not have history of unexplained vaginal bleeding, endometrial hyperplasia with atypia, or endometrial carcinoma
	  ○ Member does not require concurrent long-term corticosteroid use for serious medical conditions or illnesses (for example immunosuppression after organ transplant)
	• Other accepted and approved indications for mifepristone are not covered using the Korlym product
		glycemic control as evidenced by Hemoglobin A1c (HbA1c) labs lower than baseline
		• Female members of childbearing potential are currently using non-hormonal contraception
		
		Quantity Level Limit:
		Maximum dose 1200 mg per day

Lidocaine Topical Patch Lidocaine 5% Patch[ix]	**Lidocaine 5% Patch or ZTLido 1.8% Patch may be authorized for:** • Member that is 18 years of age or older • Diagnosis is for post herpetic neuralgia • Documentation or Pharmacy claims history supporting trial and failure with topical lidocaine 4% patch	**Initial Approval:** 3 months **Renewal Approval:** 12 months

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ZTLido 1.8% Patch	• Documentation or Pharmacy claims history supporting trial and failure, or intolerance, to two oral formulary alternatives
	  ○ For example, gabapentin, tricyclic antidepressants
	• For ZTLido:
	  • Documentation or Pharmacy claims history to support trial and intolerance, or contraindication to Lidocaine 5% patch
	Lidocaine 5% Patch may be authorized for:
	• Member that is 18 years of age or older
	• Diagnosis of diabetic peripheral neuropathy
	• Documentation of Pharmacy claims history supporting trial and failure with topical lidocaine 4% patch
	• Documentation or Pharmacy claims history supporting trial and failure, or intolerance to two oral formulary alternatives
	  ○ For example, duloxetine, venlafaxine, gabapentin, tricyclic antidepressants
	• Documentation or Pharmacy claims history supporting therapy with a diabetic medication
		Quantity Level Limit: 90 patches per 30 days

Multaq[x]	**Multaq may be authorized when the following criteria are met:** • Member is 18 years of age or older • Diagnosis of paroxysmal or persistent atrial fibrillation and	**Initial Approval:** 3 months

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	○ Member is currently in normal sinus rhythm, or ○ Member plans to undergo cardioversion to normal sinus rhythm • Prescribed by, or in consultation with a cardiologist • Attestation member does not have any contraindications as outlined per the prescribing information including, but not limited to the following: ○ Symptomatic heart failure with recent decompensation requiring hospitalization ○ New York Heart Association (NYHA) Class IV chronic heart failure • Member had inadequate response, intolerable side effect, or contraindication to one of the following formulary alternatives: ○ amiodarone ○ propafenone ○ flecainide ○ sotalol	**Renewal Approval:** 6 months ***Requires:*** • Attestation that member has positive response to treatment • Monitoring of electrocardiogram (ECG) every 3 months to make sure atrial fibrillation (AF) has not become permanent **Quantity Level Limits:** 60/30 days

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

PA Guideline	Requirements	Duration of Approval if Requirements Are Met
Nuedexta[xi]	**May be authorized when all of the following criteria are met:** • Member is 18 years of age or older • Medication is prescribed by, or in consultation with, a specialist (for example, a psychiatrist, psychologist, neuropsychologist, or neurologist) • Diagnosis of pseudobulbar affect (PBA) • Documentation that member has at least one underlying neurologic condition associated with pseudobulbar affect (PBA) • Member has had a cognitive assessment to evaluate for the presence of pseudobulbar affect (PBA) (for example, Center for Neurologic Study-Lability Scale (CNS-LS) greater than or equal to 13 or The Pathological Laughter and Crying Scale (PLACS) greater than or equal to 13) • Member does not have any contraindications to therapy (for example, QT prolongation, Atrioventricular (AV) block, or monoamine oxidase inhibitor (MAOI) therapy in the previous 14 days) • Member has tried and failed selective serotonin reuptake inhibitors (SSRIs) or tricyclic antidepressants (TCAs) • Dose adjustments to desipramine, paroxetine, and digoxin will be made if co-administered with Nuedexta	**Initial Approval:** 3 months **Renewal:** 1 year ***Requires***: Decreased frequency of pseudobulbar affect (PBA) episodes **Quantity Level Limit:** 2 capsules per day

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met

Promacta[xii]	**For all indications:**
	• Attestation that Provider to monitor the following labs at baseline and regularly throughout therapy, per frequency outlined in package insert:
	  ○ Ocular examination
	  ○ Complete blood count with differentials
	  ○ Platelet count
	  ○ Liver function tests
	
	Chronic immune thrombocytopenia (ITP) - Relapsed or Refractory:
	• Member is at least 1 year of age
	• Medication is prescribed by or in consultation with a hematologist
	• Member had insufficient response to corticosteroids or immunoglobulins
	• Documentation that Promacta is being used to prevent major bleeding in member with platelet count less than 30,000/mm^3 and NOT to achieve platelet counts in normal range (150,000-450,000/mm^3)
	
	Hepatitis C-associated Thrombocytopenia:
	• Member is at least 18 years of age
	• Medication is prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
	• Member has chronic hepatitis C with baseline thrombocytopenia (documentation of
		Initial Approval:
		4 weeks
		
		Dosing Restrictions by Indication:
		• Chronic ITP:
		  ○ 75mg/day
		• Hepatitis C-associated Thrombocytopenia:
		  ○ 100mg/day
		• Aplastic Anemia:
		  ○ 150mg/day
		
		Renewal Approval:
		• Chronic ITP (idiopathic thrombocytopenic purpura) with

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	platelet count less than 75,000/mm^3) that prevents initiation of interferon-based therapy when interferon is required NOTE: If member is not receiving interferon-based therapy for treatment of Hepatitis C, Promacta should NOT be approved **Severe Aplastic Anemia:** • Member meets one of the following: ○ Age is at least 17 years old for treatment of refractory aplastic anemia ○ Age is at least 2 years old for first-line treatment of severe aplastic anemia in combination with standard immunosuppressive therapy • Medication is prescribed by or in consultation with a hematologist • Diagnosis of severe aplastic anemia is confirmed by documentation of both the following: ○ Bone marrow cellularity less than 25% (or 25 to 50% if less than 30 percent of residual cells are hematopoietic) ○ At least two of the following: ▪ Absolute Neutrophil Count (ANC) less than 500/mm^3 ▪ Platelet count less than 20,000/mm^3 ▪ Absolute Reticulocyte Count (ARC) less than 20,000/mm^3 OR • Anemia is refractory to previous first line treatment, including hematopoietic cell	documented platelet increase to greater than 50,000/mm^3 to less than 200,000/mm^3: ○ 6 months at current dose • Chronic ITP (idiopathic thrombocytopenic purpura) without documented platelet increase to greater than 50,000/mm^3: ○ 4 additional weeks with dose increase to 75mg/day

PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	transplantation or immunosuppressive therapy with combination of cyclosporine A and antithymocyte globulin (ATG) ○ Documentation member has a platelet count less than 30,000/mm^3 **Limitations of Use:** Promacta is not indicated for treatment of myelodysplastic syndrome and is not a covered benefit	• Hepatitis C-associated Thrombocytopenia with documented platelet increase to greater than 50,000/mm^3: ○ Duration of antiviral treatment • Hepatitis C-associated Thrombocytopenia without documented platelet increase to greater than 50,000/mm^3: ○ 4 additional

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
		weeks with dose increase up to a maximum of 100mg/day • Aplastic anemia with documented platelet increase to greater than or equal to 50,000/mm^3: ○ 6 months at current dose • Aplastic Anemia without documented platelet increase to greater than or equal to 50,000/mm^3:

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
		• 4 additional weeks with dose increase up to maximum of 150mg/day

Tavalisse[xiii]	**May be authorized when the following criteria are met:**
	• Member is 18 years of age or older
	• Diagnosis of chronic immune thrombocytopenia (ITP)
	• Medication is prescribed by or in consultation with a hematologist
	• Insufficient response to a previous treatment (such as corticosteroid, splenectomy, intravenous immunoglobulin [IVIG], anti-D immunoglobulin, Thrombopoietin (TPO) Receptor Agonists (Promacta®, Nplate®), or Rituxan®)
	• Documentation of a baseline platelet count: less than 30 x 10^9/L
	• After obtaining baseline assessments, provider agrees to:
	  ○ Monitor complete blood counts (CBCs), including platelet counts, monthly until a stable platelet count (at least 50 x 10^9/L) is achieved. Thereafter, continue to monitor complete blood counts (CBCs), including neutrophils, regularly
	  ○ Monitor liver function tests (LFTs) (for example, alanine aminotransferase [ALT], aspartate aminotransferase [AST] and bilirubin) monthly
	  ○ Monitor blood pressure every 2 weeks until establishment of a stable dose, then monthly thereafter
		Initial approval:
		4 months
		
		Renewals:
		6 months
		
		Requires:
		• After 12 weeks, platelet count increases to a level sufficient to avoid clinically important bleeding.
		• Provider continues to monitor complete blood

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PA Guideline	Requirements	Duration of Approval if Requirements Are Met
	• No concomitant use with a strong CYP3A4 inducer (for example, phenobarbital, carbamazepine)	counts (CBCs), including neutrophils, blood pressure, liver function tests (LFTs) **Quantity Level Limit**: 2 tablets/day

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Pharmacy Prior Authorization
Non-Formulary, Step Therapy and Prior Authorization Guidelines

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