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

Corlanor[i]	**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
	• 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
		<u>Initial Approval</u>:
		6 months
		
		<u>Renewals</u>:
		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 dose adjusted

Previous Version Effective: 1/7/2018, 2/1/2018, 6/1/2018, 6/15/2018, 7/1/2018, 8/1/2018, 10/1/2018, 12/1/2018, 12/17/2018, 2/4/2019, 4/1/2019, 6/3/2019, 10/1/2019, 12/2/2019, 1/1/2020, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 10/1/2020, 2/1/2021, 3/1/2021, 5/1/2021, 6/28/2021, 1/9/2022, 6/7/2022, 8/1/2022, 9/1/2022, 2/10/2023, 3/2/2023, 3/20/2023, 4/6/2023, 4/15/2023, 5/25/2023, 8/10/2023
Current Version Effective: 8/17/2023

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
	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)	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 SV[ii]	• Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy • Prescribed by or in consultation with an infectious disease specialist	**Initial Approval:** 6 months

Previous Version Effective: 1/7/2018, 2/1/2018, 6/1/2018, 6/15/2018, 7/1/2018, 8/1/2018, 10/1/2018, 12/1/2018, 12/17/2018, 2/4/2019, 4/1/2019, 6/3/2019, 10/1/2019, 12/2/2019, 1/1/2020, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 10/1/2020, 2/1/2021, 3/1/2021, 5/1/2021, 6/28/2021, 1/9/2022, 6/7/2022, 8/1/2022, 9/1/2022, 2/10/2023, 3/2/2023, 3/20/2023, 4/6/2023, 4/15/2023, 5/25/2023, 8/10/2023
Current Version Effective: 8/17/2023

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
	• 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 and stable on anti-retroviral therapy for at least 8 weeks • Member does not have an active malignancy • Member does not have disruption of the hypothalamic-pituitary gland axis, or head trauma • Women of childbearing potential are not pregnant and are using appropriate contraception • Egrifta will not be approved for weight loss management	**Renewal Approval:** 6 months ***Requires*:** • Documentation of a positive clinical response to treatment: A decrease in waist circumference

[i] **Corlanor References**

1. Yancy CW et al. 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure Circulation: 2017. http://www.onlinejacc.org/content/accj/70/6/776.full.pdf?_ga=2.179733604.1964533065.1574204551-936785029.1560984365. Accessed November 19, 2019.
2. Corlanor (ivabradine) [package insert]. Thousand Oaks, CA; Amgen Inc.; Revised April, 2019. Retrieved from https://www.pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/corlanor/corlanor_pi.pdf. Accessed November 19, 2019.
3. Corlanor. Clinical Pharmacology [Internet]. Tampa (FL): Elsevier.c2018 [cited 2018 October 29] Available from: http://www.clinicalpharmacology.com

Previous Version Effective: 1/7/2018, 2/1/2018, 6/1/2018, 6/15/2018, 7/1/2018, 8/1/2018, 10/1/2018, 12/1/2018, 12/17/2018, 2/4/2019, 4/1/2019, 6/3/2019, 10/1/2019, 12/2/2019, 1/1/2020, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 10/1/2020, 2/1/2021, 3/1/2021, 5/1/2021, 6/28/2021, 1/9/2022, 6/7/2022, 8/1/2022, 9/1/2022, 2/10/2023, 3/2/2023, 3/20/2023, 4/6/2023, 4/15/2023, 5/25/2023, 8/10/2023
Current Version Effective: 8/17/2023

[ii] **Egrifta SV References:**

1. Egrifta SV® [package insert]. Theratechnologies, Inc., Montreal, Quebec, Canada; October 2019. https://www.egriftasv.com/pdf/Prescribing_Info_en.pdf. Accessed March 21, 2022.
2. Clinical Pharmacology. http://www.clinicalpharmacology-ip.com/Default.aspx. Accessed September 6, 2019.
3. Treatment of HIV-associated lipodystrophy. (2020). UpToDate. https://www.uptodate.com/contents/treatment-of-hiv-associated-lipodystrophy?search=egrifta&source=search_result&selectedTitle=2~3&usage_type=default&display_rank=1. Accessed March 21, 2022.
4. Stanley T, Falutz J, Marsolais C, et al. Reduction in visceral adiposity is associated with an improved metabolic profile in HIV-infected patients receiving tesamorelin. Clin Infect Dis. 2012 Jun;54(11):1642-51. Accessed September 12,2019
5. Clinical Review Report: Tesamorelin (Egrifta) [Internet]. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2016 Aug. https://www.ncbi.nlm.nih.gov/books/NBK539131/ Accessed September 6, 2019