The focus of this guide is to assist you with accessing the IEHP drug monographs and drug policies. These policies have been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutic Subcommittee.

**Definition of key terms:**

**Drug Classification** – a set of medications that have similar chemical structures and mechanism of action and are used to treat the same disease

**FDA** – Food and Drug Administration

**Medi-Cal** – California’s Medicaid program

**P&T** – Pharmacy and Therapeutic; refers to the IEHP Pharmacy and Therapeutic Subcommittee

**Prior Authorization** – a process in which to determine whether a prescription medication can be covered by IEHP

**Re-Authorization Criteria** – a set of criteria that needs to be met before additional prior authorization can be granted

**Drug Policy** – policy and/or criteria for medical necessity that is developed through review of medical literature

**Accessing the Drug Prior Authorization Criteria, Drug Class Prior Authorization Criteria, and Pharmacy Policies:**

- Navigate to [www.iehp.org](http://www.iehp.org)
  - Hover over For Providers
- Click on **Pharmacy Services**

![Pharmacy Services](image1)

**Academic Detailing**
The IEHP Pharmacy Academic Detailing team is an educational and evidence-based outreach program for our providers and pharmacies. We perform phone and one-on-one outreach with physicians, nurse practitioners, physician assistants, and pharmacy staff. Our goal is to transform the prescriber and pharmacy practice and enhance the provider, pharmacist, and member experience.

- Click on **Clinical Information**

![Clinical Information](image2)

**Clinical Information**
In this section find these resources that include printable reference documents for your convenience and ease of use:
- Clinical Practice Guidelines
- Diabetes DME Coverage
- Disease Therapy Management Program
- High Risk Medications
- Medication Therapy Management
- Pharmacutical Pain Management
- Prior Authorization Drug Treatment Criteria
- Safety Resources

- Click on **Prior Authorization Drug Treatment Criteria**
Drug Prior Authorization Criteria and Pharmacy Policies


**Drug Prior Authorization Criteria**
- HP Acthar (recombinant corticotropin injection) (PDF)
- Nicolid (PDF)
- Spiroton (buspirone) (PDF)
- Synalar (PDF)
- Xolair (omalizumab) (PDF)

**Drug Class Prior Authorization Criteria**
- Adult Externl Nutritional Supplementation (PDF)
- Antihypertensive Agents (PDF)
- Botulinum Toxin (PDF)
- Enzyme Inhibitors-Neurogenic Agents (PDF)
- Growth Hormones (PDF)
- Hepatitis C (PDF)
- Hereditary Angiopathies (PDF)
- Immuno Globulin (PDF)
- Intravenous Antibiotics (PDF)
- Nutritional Supplement Infant Formulas (PDF)
- Oral Antigens (PDF)
- Pediatric Enteral Nutritional Supplementation (PDF)
- Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor (PDF)
- Testosterone Hormone Replacement (PDF)
- Therapeutic Agents in Rhematoid Arthritis and Inflammatory Diseases (PDF)
- Vitamins/Supplementation Products (PDF)

**Pharmacy Policies**
- Adult Vaccines (PDF)
- Ambulatory Surgery (PDF)
- Automatic Blood Pressure Monitor Coverage Policy (PDF)
- Brand Name Drug Policy (PDF)
- Continuous Glucose Monitoring Devices (PDF)
- Drug Trial and Failure (PDF)
- External Insulin Pump Policy (PDF)
- Hepatitis B and C Center of Excellence - CDE (PDF)
- High Dose Mitomycin Equivalents (PDF)
- IEHP Prescription Drug Prior Authorization Drug Treatment Criteria and Policy (PDF)
- Intravenous and Subdermal Contraceptive Devices (PDF)
- Nebulizer Policy (PDF)
- Non-Formulary Drug Policy (PDF)
- Non-Sterile Compound Medication (PDF)
- Off-Label Indications of Non-Formulary Drugs (PDF)
- Pharmacy Drug Management Program for Gen (PDF)
- Quantity Limits (PDF)
- Transgender Hormonal Treatment for Adults (PDF)
- Transgender Hormonal Treatment for Pediatrics (PDF)

**Interpreting the Drug Prior Authorization Criteria and Pharmacy Policies:**
- The Drug Prior Authorization Criteria section contains links to drug criteria for specific medications.
- The Drug Class Prior Authorization Criteria section contains links to drug criteria for a group of medications within the same classification.
- The Pharmacy Policies section contains links to policies that do not fall in the above categories.
- Each monograph/policy is formatted as follows:
  - **Drug/Class/Policy name**: Name of drug, classification of medication, or policy name
  - **Line of Business**: Line of business criteria applies to
  - **P&T Approval Date**: Date P&T approved criteria
  - **Effective Date**: Date criteria became effective
Drug Prior Authorization Criteria and Pharmacy Policies

- **Drugs/Products Requiring Prior Authorization Review**: List of medications policy applies to
- **Formulary Alternative**: list of formulary alternatives if available
- **Criteria**: Criteria to be followed including pertinent diagnosis, specialist, quantity limit, and duration of allowed therapy. Make sure criteria is reviewed for the correct diagnosis.
- **Change Control**: For internal use to track criteria updates.

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### Drug Prior Authorization Criteria
**H.P. Acthar Gel**

**Line of Business**: Medicaid

**P & T Approval Date**: Effective Date:

*This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutics Subcommittee.*

**Drugs Requiring Prior Authorization Review: H.P. Acthar Gel** *(repository corticotropin injection)*

**Formulary Alternative**: None

### CRITERIA:

**H.P. ACTHAR GEL (REPOSITORY CORTICOTROPIN INJECTION)**

**Covered Uses:**

*Infantile Spasms (West Syndrome)

(*Subject to review by Clinical Pharmacist)*

**Exclusion Criteria:**

N/A

**Required Medical Information:**

Must meet the following requirement:

a. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.

**Age Restriction:**

Must be less than 24 months old

**Prescriber Restrictions:**

Neurologist or Pediatrician

**Other Criteria:**

N/A
# Drug Prior Authorization Criteria and Pharmacy Policies

## Covered Uses:
*Multiple Sclerosis with acute exacerbation (*Subject to review by Clinical Pharmacist)*

## Exclusion Criteria:
N/A

## Required Medical Information:
Must meet all of the following requirements:
- Failure or clinically significant adverse effects to corticosteroid therapy (i.e. prednisone, intravenous methylprednisolone, etc.).
- Documentation of concurrent multiple sclerosis agents (i.e. **Avonex**, **Betaseron**, **Glatiramer**, etc.).
- Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.

## Age Restriction:
N/A

## Prescriber Restrictions:
Neurologist

## Other Criteria:
N/A

## Change Control

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For all questions, comments, or concerns regarding the Drug Prior Authorization Criteria, Drug Class Prior Authorization Criteria, and Pharmacy Policies please call (888) 860-1297.