

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)
  - Click on **For Providers**



The screenshot shows the top navigation bar of the IEHP website. The logo is on the left, and navigation links are on the right. The 'For Providers' link is highlighted with a red rectangular box. Below the navigation bar is a large blue banner with a graphic of a hand holding a bandage and the text 'NO MORE FLU! FLU SHOT & VACCINES'. To the right of the banner is a section titled 'Our Plans' with sub-sections for 'IEHP DualChoice Cal MediConnect Plan' and 'Medi-Cal'.

## ○ Pharmaceutical Services

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### Providers

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## Providers

IEHP strives to provide our Provider Network with all the tools necessary to deliver the highest quality of care.

- [Secure Site Login](#)
- [Find a Doctor](#)
- [2018 IEHP Global Quality P4P Program Guide PCP \*\*NEW!\*\*](#)
- [2018 IEHP Global Quality P4P Program Guide IPAs \*\*NEW!\*\*](#)
- [2018 Hospital P4P Program Guide \*\*NEW!\*\*](#)
- [Flu Updates](#)
- [Public Health Advisory](#)
- [REMINDER: Community-Based Adult Services](#)
- [Coordinated Care Initiative \(CCI\) - Monthly Update: August 2017](#)
- [Accessible Clinics Program](#)
- [2017 Model Output Report \(MOR\) Data File Layout](#)
- [Gun Violence: A Public Health Crisis with Solutions](#)
- [Care After Hours](#)
- [Provider Network Expansion Fund Program](#)



## ○ Clinical Information

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### Providers

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#### Pharmaceutical Services

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## Pharmaceutical Services



All IEHP Pharmacy related information for Physician and Pharmacist can be found in this section.

If you are an IEHP Member, please go to the Member Section for Pharmacy Provider and Formulary information.

Here, you will find links to the Pharmacy Program Manual, Communications, DTM Program, Prior Authorization Criteria, Clinical Practice Guidelines, Forms, IEHP Formulary, and Safety Resources with drug recall information.

If you have any questions regarding services provided by the Pharmaceutical Services Department, please feel free to contact the IEHP Pharmacy Department at (909) 890-2049.

○ **PA Drug Treatment Criteria**

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**Pharmaceutical Services**

Clinical Information

- Clinical Practice Guidelines
- Diabetes DME Coverage
- Disease Therapy Management Program
- High Risk Medications
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- Pharmacy Pain Management

Drug MAC

Cal MediConnect

Formulary

PA Submission Tool

Pharmacy Forms

Pharmacy Manuals

Pharmacy Network Lists

Pharmacy P4P Program

Pharmacy Quality Ratings

Pharmacy PA Universal Form

Provider Communications

## Rx PA Drug Treatment Criteria

### Prescription Drug Prior Authorization (Rx PA) Drug Treatment Criteria

**Medicare:**  
 For Medicare Dual Choice Cal MediConnect Plan (Medicare-Medicaid Plan) Formulary and Criteria information, please visit the page here:  
<https://www3.iehp.org/en/members/plans/cal-medicconnect/prescription-drugs/2018-drugs-covered/>

**Non-Medicare:**  
 To provide access to quality and clinically effective medications, IEHP uses a drug formulary. The IEHP Formulary provides information regarding medications covered under the benefit plans.  
 Please note that coverage is not limited only to drugs on the IEHP Formulary. Many drugs not listed on the Formulary are covered through the **Rx Prior Authorization Process**.

- Rx prior authorization encourages the appropriate and rational use of medications by allowing coverage only when certain conditions are met.
- The Rx prior authorization program is based upon current medical findings, FDA-approved manufacturer labeling information, and recommendation by the IEHP Pharmacy and Therapeutics Subcommittee.
- If the medication you prescribe is not on IEHP Formulary, you or the pharmacist may request authorization for the medication by submitting an **IEHP Prescription Drug Prior Authorization Request Form (Rx PA)** to IEHP. If the request is approved, you will be notified and the medication will be covered. If the request is denied, you and your patient will be notified of the decision.

Any medication not on the IEHP Formulary requires Rx Prior Authorization to be covered by IEHP. The medications requiring Rx Prior Authorization are subject to change.  
 First line Formulary medications should be used instead of the Non-Formulary medications. Drugs with specific criteria / guidelines are listed here:  
[Medi-Cal PA Drug Criteria Summary Table - Click Here](#)

To view Drug Criteria Referenced in Summary Table - Click Links Below:  
[Clinical Practice Guidelines - CPGs](#)

- Scroll down until you can view the **Drug Prior Authorization Criteria, Drug Class Prior Authorization Criteria, and Pharmacy Policies.**

<div style="border: 2px solid #c00000; padding: 2px; margin-bottom: 10px; text-align: center;"><b>Drug Prior Authorization Criteria</b></div> <ul style="list-style-type: none"> <li><a href="#">HP Acthar (repository corticotrophin injection) View »</a></li> <li><a href="#">Nucala (mepolizumab) View »</a></li> <li><a href="#">Spinraza (Nusinersen) View »</a></li> <li><a href="#">Synagis View »</a></li> <li><a href="#">Xolair (omalizumab) View »</a></li> </ul> <div style="border: 2px solid #c00000; padding: 2px; margin-bottom: 10px; text-align: center;"><b>Drug Class Prior Authorization Criteria</b></div> <ul style="list-style-type: none"> <li><a href="#">Adult Enteral Nutritional Supplement View »</a></li> <li><a href="#">Antineoplastic Agents View »</a></li> <li><a href="#">Botulinum Toxin View »</a></li> <li><a href="#">Erythropoiesis-stimulating Agents (ESAs) View »</a></li> <li><a href="#">Growth Hormones View »</a></li> <li><a href="#">Hepatitis C View »</a></li> <li><a href="#">Hereditary Angioedema View »</a></li> <li><a href="#">Immune Globulins View »</a></li> <li><a href="#">Nutritional Supplement Infant Formula View »</a></li> <li><a href="#">Opioid Analgesics View »</a></li> <li><a href="#">Pediatric Enteral Nutritional Supplement View »</a></li> <li><a href="#">Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitor View »</a></li> <li><a href="#">Testosterone Hormone Replacement View »</a></li> <li><a href="#">Therapeutic Agents In Rheumatic And Inflammatory Diseases View »</a></li> <li><a href="#">Transplant Immunosuppressants View »</a></li> <li><a href="#">Viscosupplementation Products View »</a></li> </ul>	<div style="border: 2px solid #c00000; padding: 2px; margin-bottom: 10px; text-align: center;"><b>Pharmacy Policies</b></div> <ul style="list-style-type: none"> <li><a href="#">Automatic Blood Pressure Monitor Coverage Policy View »</a></li> <li><a href="#">Brand Name Drug Policy View »</a></li> <li><a href="#">Continuous Glucose Monitoring Devices View »</a></li> <li><a href="#">Drug Trial and Failure View »</a></li> <li><a href="#">External Insulin Pump Policy View »</a></li> <li><a href="#">Genetic Testing Medications View »</a></li> <li><a href="#">Hepatitis B &amp; C Center of Excellence (COE) View »</a></li> <li><a href="#">High Daily Morphine Milligram Equivalent View »</a></li> <li><a href="#">Intrauterine and Subdermal Contraceptive Devices View »</a></li> <li><a href="#">Nebulizer Policy View »</a></li> <li><a href="#">Non-Formulary Drug Policy (Non-Medicare) View »</a></li> <li><a href="#">Non-Sterile Compounded Medication (Medicare) View »</a></li> <li><a href="#">Non-Sterile Compounded Medication (Non-Medicare) View »</a></li> <li><a href="#">Off-Label Indication of Non-Formulary Drugs View »</a></li> <li><a href="#">Pain Management View »</a></li> <li><a href="#">Pharmacy Adult Vaccine View »</a></li> <li><a href="#">Quantity Limits View »</a></li> <li><a href="#">Transgender Hormonal Treatment for Adults View »</a></li> <li><a href="#">Transgender Hormonal Treatment for Pediatrics View »</a></li> </ul>
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## 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
  - **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.
  - **Reauthorization Criteria:** Criteria to be followed for reauthorization of drug

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

**Line of Business:** Medicaid

**P & T Approval Date:** February 21, 2018      **Effective Date:** April 1, 2018

*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 - \*IEHP Pharmacist Review Required\***

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1. **Diagnosis:** Infantile Spasms

**Criteria:** Must meet all of the following requirements:

- a. Confirmed diagnosis
- b. Age less than 2 years
- c. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.

**Specialist:** Neurologist or Pediatrician

**Quantity Limit:** N/A

**Duration of Therapy:** 28 days

**Reauthorization Criteria:** N/A

**Duration of Reauthorization:** N/A

2. **Diagnosis:** Multiple Sclerosis with acute exacerbation

**Criteria:** Must meet all of the following requirements:

- a. Confirmed diagnosis
- b. Failure or clinically significant adverse effects to corticosteroid therapy (i.e. prednisone, intravenous methylprednisolone, etc.).

**Reauthorization Criteria:** Must meet "1" of the following requirements:

- a. Recent pharmacy claim within 6 months (180 days) of request.
- b. Confirmed stability or no disease progression.

**Duration of Reauthorization:** 6 months (180 days)

- **Clinical Justification (if applicable):** Clinical justification for approved criteria

**Clinical Justification:**

1. Pharmaceutically equivalent products consist of the same active ingredient(s), strength or concentration, dosage form, and route of administration. According to the FDA, therapeutically equivalent products are pharmaceutically equivalent and expected to produce the same clinical effect and safety profile. Drug products that are considered therapeutically equivalent to other pharmaceutical equivalents are listed as A-rated in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book). AB-rated drug products in the Orange Book meet necessary bioequivalence requirements that are supported by adequate in vivo and/or in vitro studies.

- **References (if applicable):** References used for criteria and Clinical Justification

**References:**

1. Smith, Liz. "Practice Guidelines: New AHA Recommendations For Blood Pressure Measurement - American Family Physician". *Aafp.org*. N.p., 2016. Web. 5 May 2016.
2. "Decision Memo For Ambulatory Blood Pressure Monitoring (CAG-00067N)". *Cms.gov*. N.p., 2016. Web. 5 May 2016.

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.