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

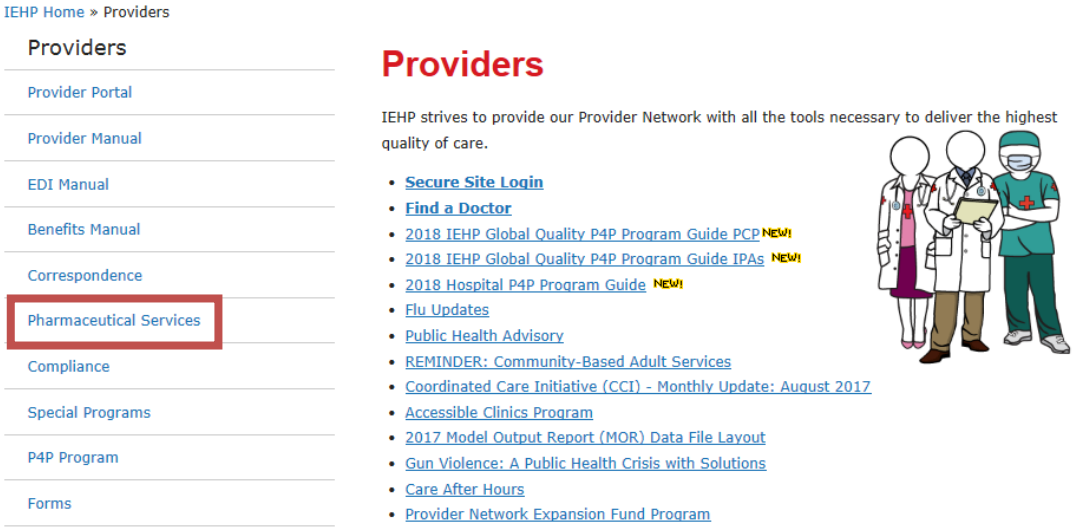
Re-Authorization Criteria – a set of criteria that needs to be met before additional prior authorization can be granted

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

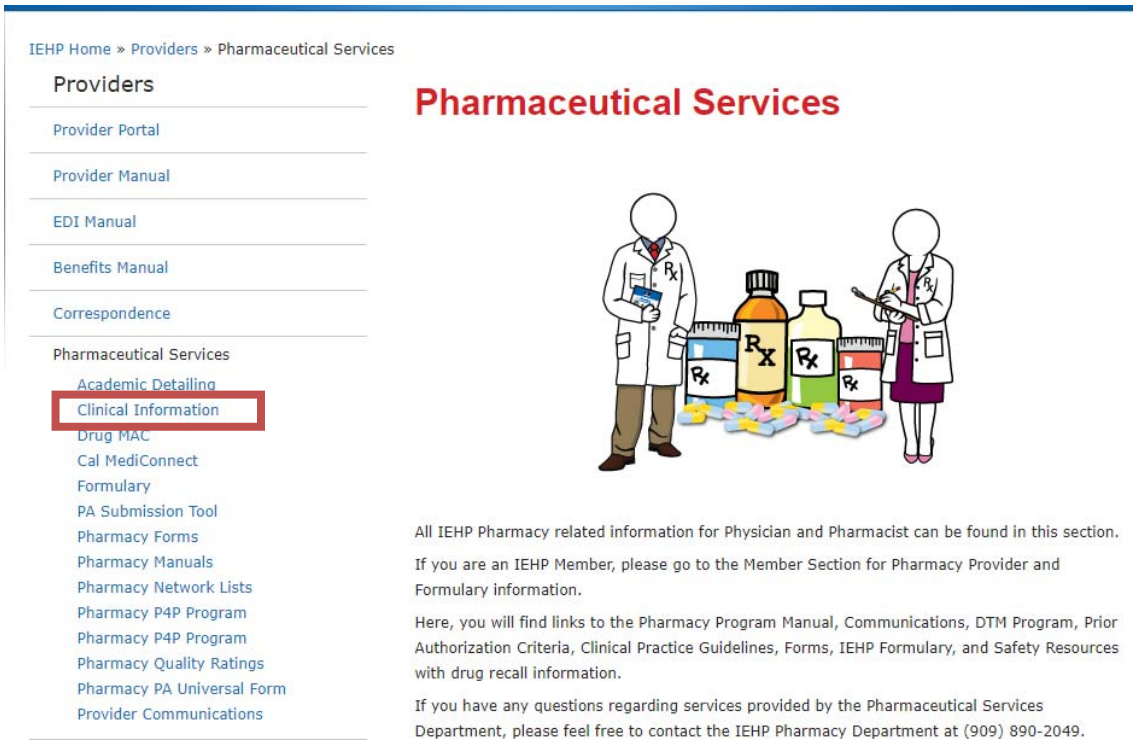
Accessing the Drug Prior Authorization Criteria, Drug Class Prior Authorization Criteria, and Pharmacy Policies:

- Navigate to www.iehp.org
  - Click on **For Providers**

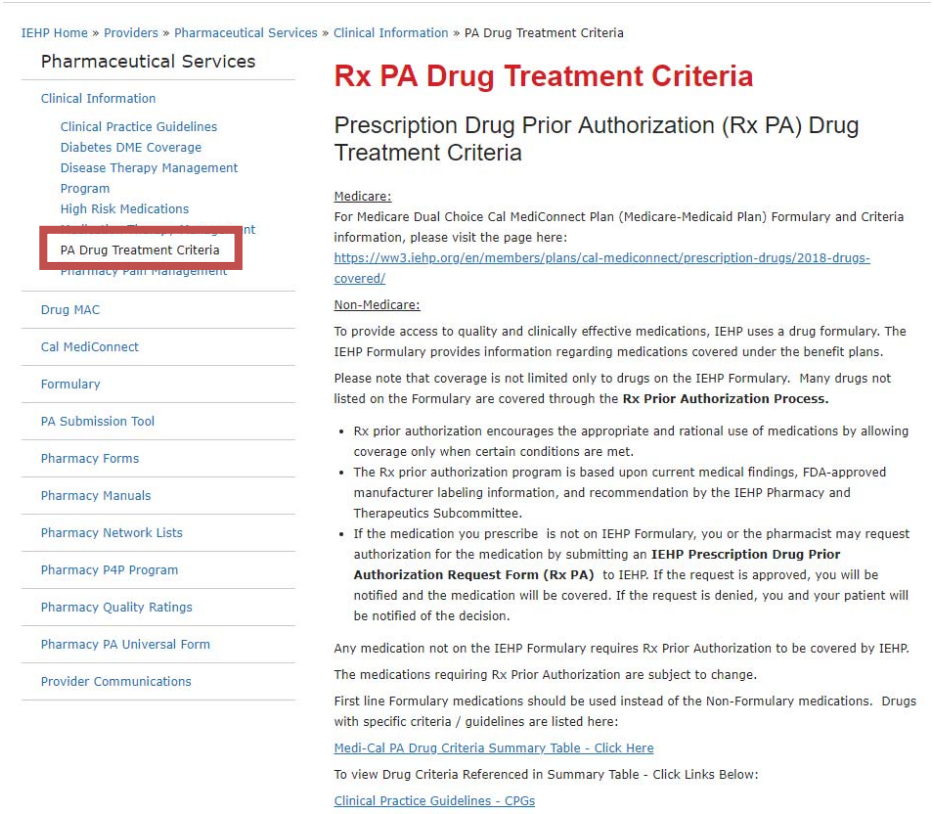
- **Pharmaceutical Services**



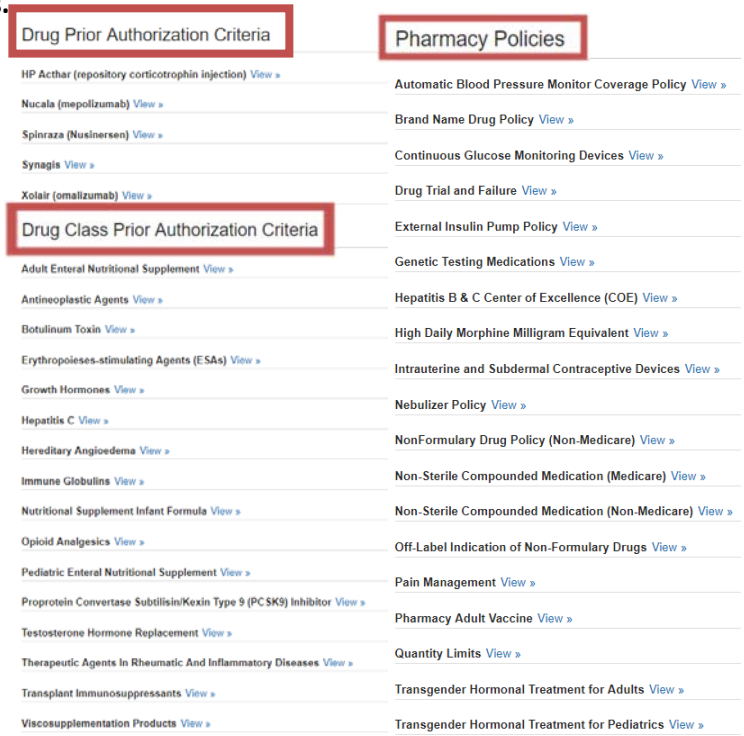
- **Clinical Information**



- **PA Drug Treatment Criteria**

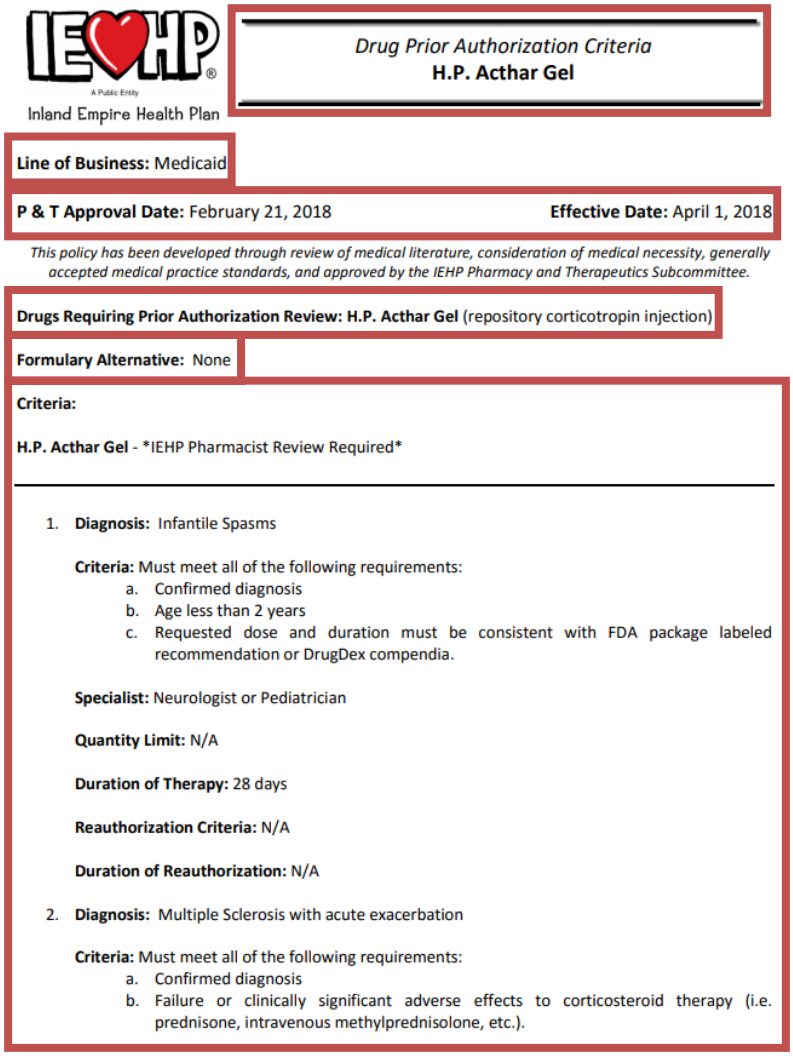


- Scroll down until you can view the **Drug Prior Authorization Criteria, Drug Class Prior Authorization Criteria, and Pharmacy Policies.**



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 no 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



Inland Empire Health Plan

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*

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.