Ohio | Department of Medicaid

30 Day Change Notice
Effective Date: April 1, 2023

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Nyvepria Ziextenzo
Cardiovascular Agents: Pulmonary Arterial Hypertension	Tadliq
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	Forteo

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	Fylnetra
Cardiovascular Agents: Angina, Hypertension, and Heart Failure	Clonidine ER (generic of Nexiclon XR) Levamlodipine
Central Nervous System (CNS) Agents: Anticonvulsants	Zonisade Susp Ztalmy
Central Nervous System (CNS) Agents: Antidepressants	Auvelity
Genitourinary Agents: Benign Prostatic Hyperplasia	Entadfi
Immunomodulator Agents: Systemic Inflammatory Disease	Sotyktu
Infectious Disease Agents: Antifungals	Vivjoa
Respiratory Agents: Nasal Preparations	Ryaltris
Topical Agents: Immunomodulators	Zoryve

REMOVED FROM UPDL	
THERAPEUTIC CLASS	
Analgesic Agents: Opioids	Oxaydo

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors
Cardiovascular Agents: Pulmonary Arterial Hypertension
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers
Genitourinary Agents: Benign Prostatic Hyperplasia
Infectious Disease Agents: Antifungals
Infectious Disease Agents: Hepatitis C Agents

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REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	**CLINICAL PA CRITERIA:** • Must provide documentation of diagnosis, patient's weight, and duration of treatment
Cardiovascular Agents: Pulmonary Arterial Hypertension	**AR** - Sildenafil Susp and Tadliq: a PA is required for patients 6 years and older
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	**TERIPARATIDE (FORTEO™) CRITERIA:** • Must have had an inadequate clinical response of at least 365 days with one bisphosphonate • A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog **ADDITIONAL ABALOPARATIDE (TYMLOS™) CRITERIA:** • Must have had an inadequate clinical response of at least 365 days with one bisphosphonate • A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog
Genitourinary Agents: Benign Prostatic Hyperplasia	**ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) & FINASTERIDE/TADALAFIL (ENTADFI) CRITERIA** • Must provide documentation for patient's inability to use the individual drugs
Infectious Disease Agents: Antifungals	**ADDITIONAL OTESECONAZOLE (VIVJOA) CRITERIA:** • Must provide documentation of at least three symptomatic episodes of vulvovaginal candidiasis in the past 12 months • Must provide documentation of non-reproductive potential (i.e., post-menopausal) • Must have had an inadequate clinical response of at least 180 day maintenance course with oral fluconazole shown by documentation of more than one breakthrough infection

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Infectious Disease Agents: Hepatitis C Agents

OHIO DEPARTMENT OF MEDICAID

PRIOR AUTHORIZATION HEPATITIS C TREATMENT

Request Date	Review Requested ☐ STANDARD ☐ URGENT	
Individual's Name	Prescriber's Name	
Individual's Medicaid ID Number	Prescriber's NPI Number	
Individual's Date of Birth	Prescriber's Address	
	Prescriber's Phone Number	Prescriber's Fax Number

Only Hepatitis C treatment PA requests for individuals who meet the following guidelines will be approved. This PA form will cover up to the length authorized by the American Association for the Study of Liver Disease (AASLD) guidelines.

Please refer to the **APPENDIX** which lists the various regimens and the clinical situations for which they will be considered medically necessary according to the Ohio Department of Medicaid (ODM) criteria.

The PA must be approved prior to the 1st dose and include appropriate supporting documentation.

APPENDIX

Treatment naïve

No cirrhosis

☐ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks ~~(for GT5/6 and/or HIV/HCV co-infection, 12 weeks is recommended)~~

☐ sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks

Compensated cirrhosis~~, HIV negative~~

☐ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks (GT4 WITH HIV coinfection, IDSA/AASLD guidelines recommend 12 weeks of therapy)

☐ sofosbuvir/velpatasvir 400/100, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive)

~~**Compensated cirrhosis, HIV positive**~~

~~☐ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks~~

~~☐ sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive)~~

Treatment experienced

Previously failed a Sofosbuvir-based regimen

☐ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks

Previously failed a NS3/4 protease inhibitor inclusive regimen (e.g. Zepatier)

☐ Vosevi 400/100/100 mg, one tablet daily for 12 weeks

Previously failed Mavyret

☐ Vosevi 400/100/100 mg, one tablet daily for 12 weeks (if compensated cirrhosis, add weight-based RBV)

Previously failed Vosevi or sofosbuvir + Mavyret

☐ Vosevi 400/100/100 mg, one tablet daily + weight-based RBV for 24 weeks

Previously failed GT 3 only: sofosbuvir/NS5A (e.g. Harvoni)

☐ Vosevi 400/100/100 mg, one tablet daily + weight-based RBV for 12 weeks

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