Department of Medicaid

30 Day Change Notice
Effective Date: April 1, 2024

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	Dyanavel XR Tab
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	Brixadi
Hyperkalemia Agents: Potassium Binders	Lokelma
Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	Ciprofloxacin/Dexamethasone
Respiratory Agents: Inhaled Agents	Arnuity Ellipta Fluticasone Propionate Qvar

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Immunomodulator Agents: Systemic Inflammatory Disease	Amjevita
Respiratory Agents: Pulmonary Fibrosis	Ofev

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**
Endocrine Agents: Growth Hormone	Ngenla
Hyperkalemia Agents: Potassium Binders	Sodium Polystyrene Sulfonate Veltassa
Immunomodulator Agents: Systemic Inflammatory Disease	Adalimumab-aacf
Ophthalmic Agents: Glaucoma Agents	Iyuzeh
Respiratory Agents: Inhaled Agents	Airsupra Breyna
Respiratory Agents: Pulmonary Fibrosis	Pirfenidone

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction
Central Nervous System (CNS) Agents: Narcolepsy
Infectious Disease Agents: Antivirals – Hepatitis C Agents

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REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	**AR** – Adderall, Dexedrine, & Zenzedi IR: a PA is required for patients younger than 3 years **AR** – Adderall XR, Atomoxetine, ~~Cotempla XR-ODT,~~ ~~Daytrana~~, Dexedrine ER, Dexmethylphenidate, ~~Methylphenidate IR & ER~~, & Xelstrym: a PA is required for patients younger than 6 years **AR** – Dextroamphetamine Solution ~~& Dyanavel XR~~: a PA is required for patients 12 years and older **AR** – Methylphenidate solution/suspension/chewable tab: a PA is required for patients ~~younger than 6 years and~~ 12 years and older
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	**ADDITIONAL INFORMATION** Vivitrol, ~~and~~ Sublocade, and Brixadi may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.
Central Nervous System (CNS) Agents: Narcolepsy	~~**AR** – Methylphenidate: a PA is required for patients younger than 6 years~~
Infectious Disease Agents: Antivirals – Hepatitis C Agents	**The following documentation must be submitted with initial request for consideration of approval:** ☐ Active HCV infection verified by viral load within 180 days HCV RNA: million IU/mL Date ☐ HCV Genotype verified by lab (must also indicate genotype): ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Note: HCV genotype is not required if all of the follow apply: 1. Patient is treatment naïve AND 2. No evidence of cirrhosis AND 3. Requesting simplified treatment regimen (either a. or b.) a. Mavyret 100/40 mg, three (3) tablets daily for 8 weeks b. Sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks Hepatitis fibrosis stage | Date ~~Method(s) used:~~ ☐ Individuals scheduled to receive an HCVNS3 protease inhibitor *(i.e. grazoprevir, voxilaprevir, glecaprevir)* should be assessed for a history of decompensated liver disease and liver disease severity using the Child-Turcotte-Pugh (CTP) score if cirrhosis is determined to be likely present *(as evidenced by clinical findings, radiology, Metavir fibrosis score of F4, pathology findings, or other laboratory markers (FibroTest/FibroSure/FIB-4 index).* ☐ Prescriber has discussed the importance of adherence to treatment plan, office visits, lab monitoring, imaging, procedures, and to taking requested regimen as prescribed. ☐ Individual does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions.

NEW THERAPEUTIC CATEGORIES
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency*
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B*
Hyperkalemia Agents: Potassium Binders
Respiratory Agents: Pulmonary Fibrosis

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NEW THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency*	Split the original class (Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*) into separate categories. No changes to drug placement or changes in clinical criteria.
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B*	Split the original class (Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*) into separate categories. No changes to drug placement or changes in clinical criteria.
Hyperkalemia Agents: Potassium Binders	**LENGTH OF AUTHORIZATIONS:** 365 Days **ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling **NON-PREFERRED CRITERIA:** • Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug ○ For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available) ○ For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available) **SUBSEQUENT AUTHORIZATION CRITERIA:** Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring
Respiratory Agents: Pulmonary Fibrosis	**LENGTH OF AUTHORIZATIONS:** 365 Days **ALL AUTHORIZATIONS:** Must be prescribed in accordance with FDA approved labeling **CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a pulmonologist **NON-PREFERRED CRITERIA:** • Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred

	drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR** ○ For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug ○ For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available) ○ For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available) **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety