Mountain Health Trust/WV Health Bridge

Preferred Drug List (PDL)
The West Virginia Preferred Drug List (PDL) is a list of medications recommended to BMS by the West Virginia Medicaid Pharmaceutical and Therapeutics (P&T) Committee and approved by the Secretary of the Department of Health and Human Resources. The P&T Committee is composed of actively practicing physicians, pharmacists, a nurse practitioner, and a physician’s assistant. Meetings of the P&Y Committee are held three times per year and are open to the public.

The drugs that are designated as “preferred” have been selected for their clinical significance and overall cost efficiencies. All Medicaid-covered drugs noted as “non-preferred” continue to be available through the prior authorization process.

The PDL only addresses certain drug classes. Some classes of drugs will not be reviewed for preferential agents because there are no limited cost savings associated with these classes.

The PDL can be found at [http://www.dhhr.wv.gov/bms](http://www.dhhr.wv.gov/bms).

Prior Authorization
Prior authorization can be obtained by calling Pharmacy Services at 1.800.624.6961, ext. 7914. Authorization for Coverage consists of rules-based programs for determining whether members qualify for coverage of a requested drug based upon the plan’s pre-defined benefit criteria. Additionally, a prior authorization may be started via the Internet at [https://www.healthplan.org/eform/submit/formulary-exception-request](https://www.healthplan.org/eform/submit/formulary-exception-request).

Pharmacist Deems Dispensing Emergency Situation
In cases of an emergency, when the prescribing physician and/or The Health Plan cannot be reached, a 72-hour supply of the non-formulary medication can be filled if necessary. The non-formulary prescription must be converted to a formulary prescription unless medical necessity is proven for the use of the non-formulary prescription.

Mountain Health Trust/WVHB members have zero copay at the pharmacy and do not have mail order pharmacy benefits. Coverage is limited to participating retail pharmacies.

Changes to the PDL
Changes to the PDL are made at least annually. Any changes approved by the P&T Committee will be published in the next version of the PDL and can be found at the website listed above.

Contact Information for Prescriber Inquiries About WV Medicaid Pharmacy Benefits
Contact Pharmacy Services at 1.800.624.6961, ext. 7914 or email at pharmacy@healthplan.org.
GLP-1 Agonists

Covered Medications
• Exenatide (Byetta®, Bydureon®)
• Dulaglutide (Trulicity®)
• Liraglutide (Victoza®)

What it does and how it is used?
• Exenatide is an injectable form of an incretin mimetic. It increases insulin secretion, decreases post-prandial glucose, and decreases glucagon secretion during hyperglycemia. It is used for treatment of NIDDM (Type 2 Diabetes).

Rationale for Coverage Authorization
• To limit coverage to situations where exenatide is indicated as adjunct therapy.

Coverage Authorization Criteria
Coverage for Byetta® is provided in accord with the following:
• For the treatment of Type 2 Diabetes in patients who have failed to achieve desired glucose control despite prior use of combination therapy with at least two oral hypoglycemic agents, one of which should be either metformin.
• Recent HbA1c value of 6.5% – 9.0%.
• Member is not on any type of insulin.

Continued coverage is provided for 12 months. Renewals require an improvement in the patient's HbA1c.
Erythropoietin Stimulus Agents/Darbepoetin

Covered Medications
- Epoetin Alfa (Epogen®, Procrit®)
- Darbepoetin Alfa (Aranesp®)

What it does and how it is used?
- Epoetin alfa is a recombinant version of human erythropoietin. Erythropoietin stimulates the bone marrow to produce red blood cells.
- Hemoglobin (Hg) levels represent a rough estimate of the oxygen-carrying capacity of the blood. Normal levels are 13.8-17.2 gm/dl for men and 12.1-15.1 gm/dl for women.
- Hematocrit (HCT) levels represent the actual volume of red blood cells in a unit volume of blood. Normal levels are 41-50 gm/dl for men and 35-46 gm/dl for women.
- Anemia is characterized by a decrease in either hemoglobin or red blood cells, which results in decreased oxygen carrying capacity of blood.
- Epoetin alfa therapy stimulates red blood cell production, thereby increasing both the Hg and HCT levels in patients.
- The hematocrit level measures the severity of the anemia. The rate of hematocrit increase in response to epoetin alfa therapy varies among patients and is dependent upon the dose of erythropoietin.
- Epoetin alfa has been shown to be effective in the treatment of anemia secondary to chronic renal failure, myelodysplasia, human immunodeficiency virus (HIV) infection and chemotherapy.
- Pre-surgical epoetin alfa therapy potentially reduces the need for allogenic transfusions (i.e., self-donated blood).

Rationale for Prior Authorization
- To limit coverage to situations for which erythropoietin is effective.

Prior Authorization Criteria
*Prior to Initializing Therapy, Evaluate the Patient’s Iron Stores:*

- Transferrin saturation is at least 20%.
- Ferritin is at least 100ng/ml.

Ferritin could be falsely elevated in iron deficient dialysis patients – if suspected, the best measure is an iron saturation level > 20%.

*** Prior to initializing therapy, review the two recommendation protocols below ***
*to determine if erythropoietin therapy is indicated for the specified patient.*
Patients for Whom Epoetin Alfa Treatment is recommended:

- Chronic renal failure with or without dialysis with HCT < 36%, serum creatinine ≥ 2 mg/dl. HCT should be maintained between 33 – 36%.
- Anemia related to zidovudine therapy in HIV – patients with HCT < 36% or Hgb < 10 g/dl when dose of AZT is ≤ 4200 mg/week.
- Non-myeloid malignancies where anemia (HCT < 36% or Hgb < 10 g/dl) is directly due to effects of chemotherapy.
- Anemia of prematurity with low birth weight (< 1500 grams) or premature infants with gestational age < 33 weeks (duration of therapy should be limited to six weeks).
- Anemic patients (Hgb 10 %– 13%) scheduled to undergo elective, noncardiac, nonvascular surgery or patients at high risk for preoperative transfusions with significant, anticipated blood loss.
- Baseline hemoglobin concentrations < 8.0 g/dl (women) and < 9.0 g/dl (men).
- Baseline hematocrit ≤ 24% - 30%.
- Rapid decline in Hb (> 1.0 g/dl) after first cycle of chemotherapy.
- Special circumstance patients who cannot (due to disease or religious beliefs) receive whole blood or components as replacement for traumatic or surgical loss.

Patients for Whom Epoetin Alfa Treatment is NOT recommended:

- Patients who require immediate correction of severe anemia.
- Patients with uncontrolled hypertension.
- Patients with a known history of seizure disorders.
- Anemia due to iron deficiency, folate deficiency, hemolysis or GI bleed-correct underlying cause.
- Anemia in rheumatoid arthritis.
- Pruritis associated with renal failure.
- Anemia in Gaucher’s disease.
- Anemia in Castleman’s disease.
- Anemia in paroxysmal nocturnal hemoglobinuria (PNH).
- Sickle cell anemia.
- Autologous blood transfusion.
- Baseline hemoglobin concentration > 10.0 g/dl.

Important Predictors of a Successful Response to Epoetin Alfa:

- Reticulocyte count ≥ 40,000 cells/uL after two to four weeks of therapy.
- Hemoglobin increase > 0.5 g/dl after two weeks of therapy or 1 g/dl after four weeks of therapy.
- Decrease dose if hematocrit increases by > 4 g/dl in any two week period during therapy.
- EPO concentration < 100 mU/mL after two to four weeks of therapy.
- Hematocrit has not increased within eight weeks of treatment.
- Iron deficiency unrecognized either shortly before or shortly after the start of treatment.
- Ferritin level > 400 ng/mL after two weeks of therapy.
- Benefit is approved for the following durations:
  - Anemia secondary to chronic renal failure or chronic renal insufficiency – six months and renewable.
  - Anemia secondary to HIV infection or HIV drug therapy – four months and renewable.
  - Chemotherapy induced anemia – four months and renewable.
  - Anemia due to myelodysplasia – two months and renewable if in the presence of therapeutic benefit (e.g., improvement of symptoms), or if hematocrit has increased or stabilized, or if the need for transfusions has decreased.
- Reduce the need for **allogenic blood transfusions in surgery patients** – one month.
**Forteo® (Teriparatide)**

**Covered Medications**
- Teriparatide (Forteo®)

**What it does and how it is used?**
- Recombinant human parathyroid hormone. Regulates bone metabolism, intestinal calcium absorption and renal tubular calcium and phosphate reabsorption.

**Rationale for Prior Authorization**
- To limit Forteo® to use in appropriate situations.

**Coverage Authorization Criteria**
Coverage is provided for the treatment of osteoporosis in postmenopausal women or men ≥ 35 years of age in the following situations:
- The patient has previously failed treatment with a bisphosphonate or is unable to receive treatment with a bisphosphonate.
- Coverage is not provided in the presence of concurrent treatment with a bisphosphonate.
- Coverage is not provided in the presence of any of the following conditions:
  - Hypercalcemia
  - Paget’s disease
  - Pediatric patients or young adults with open epiphyses
  - Prior radiation therapy involving the skeleton
  - Bone metastases or history of skeletal malignancies
  - Metabolic bone disease other than osteoporosis

Continued duration: 12 months or when the plan year ends whichever occurs sooner.
Growth Hormone

Covered Medications
• Biosynthetic Human Growth Hormone: somatropin (Norditropin®, Genotropin®)

What do they do and how they are used?
• Growth hormone (GH) stimulates linear and skeletal growth, increases the number of skeletal muscle cells, influences organ size, and increases red cell mass.
• GH is used in children who have growth failure due to lack of adequate endogenous growth hormone and in the treatment of children who have growth failure associated with chronic renal insufficiency. It also is used to accelerate growth in patients with Turner Syndrome (gonadal dysgenesis), a chromosomal abnormality seen in females. GH is also used in children with Prader-Willi syndrome, a rare genetic disorder that is characterized by short stature, an involuntary continuous urge to eat, low muscle tone, obesity, and cognitive disabilities. GH treatment of children with Prader-Willi syndrome improves growth, increases muscle mass, and reduces body fat.
• GH therapy is used for adults with childhood onset growth hormone deficiency, pituitary or hypothalamic disease, or growth hormone deficiency due to surgery, radiation therapy, or previous trauma. Adult growth hormone deficiency is characterized by increased weight and body fat mass, decreased lean body mass, decreased exercise capacity, decreased muscle mass and strength, reduced cardiac performance, reduced bone density, and impaired sense of well-being. In adults, goals of GH therapy are to restore normal body composition, improve muscle and cardiac function, normalize serum lipid concentrations, and improve the quality of life.
• Serostim® is used in the treatment of AIDS-related cachexia or wasting. GH has been shown to increase lean body mass and decrease fat mass in patients with AIDS.
• Other conditions for which there is insufficient information to support the use of GH and coverage is not provided for include:
  • Idiopathic short stature in children (i.e., short children with normal growth hormone secretion)
  • Constitutional delay of growth, which is characterized by normal prenatal growth followed by growth deceleration during infancy and childhood. In general, these patients can achieve normal adult height if no treatment is given.
  • To delay or reverse the aging process in older adults.
  • Adjunct to infertility treatment
  • Treatment of burn injuries
  • Treatment of obesity
• GH is administered subcutaneously or intramuscularly one to six times weekly dependent on what is being treated

Rationale for Prior Authorization
• To reduce exposure to cost associated with use of growth hormone for conditions for which its effectiveness is not known (e.g., treatment of familial short stature or constitutional delayed growth or infertility). Growth hormone therapy is not covered for use in reversing or delaying the aging process.
Coverage Authorization Criteria

Pediatric Growth Hormone Deficiency:

- Benefit approval is limited to pediatric patients with documented human growth hormone deficiency, Turner syndrome (chromosomal abnormality), Prader-Willi syndrome, and pediatric growth failure secondary to chronic renal failure (prior to renal transplantation). Benefit is not covered for familial short stature or constitutional delayed growth. Benefit is not covered in the presence of active neoplasia.
- Patients ten years of age or older must have confirmed open epiphyses.
- Pediatric patients must be below the third percentile (below the fifth percentile for Turner syndrome patients) of their age and gender specific height requirements.
- Patient’s growth velocity must be equal to or greater than two standard deviations below the age-related mean or have a delayed skeletal maturation equal to or greater than two standard deviations below the age/gender mean.
- Patients must have a hand X-ray that indicates more than two or more years less than chronological age.
- Pediatric growth hormone deficiency (< 10ng/ml) must be confirmed by two provocative tests or through the measurement of growth hormone related levels (e.g., insulin growth factor-1 (IGF-1), somatomedin C, or IGF binding protein-3 (IGFBP-3) levels).
  - Arginine Infusion
  - Clonidine
  - Insulin Tolerance Test
- Provocative stimulation tests are not required in the treatment of Turner or Prader-Willi syndrome.
- In patients with pediatric growth hormone deficiency, Turner syndrome, or pediatric growth failure due to chronic renal failure, benefit coverage is provided for 12 months after which a growth response of ≥ 4.5 cm/yr (pre-pubertal growth) or 2.5 cm/yr (post-pubertal growth) must occur for continuation of coverage.
- Benefit coverage is provided for three month intervals for Prader-Willi syndrome and is renewable in the presence of clinical benefit from therapy as evidenced by an increase in lean body mass or decrease in fat mass.

Adult Growth Hormone Deficiency:

- Benefit coverage is provided for adult growth hormone deficiency due to childhood onset deficiency, pituitary or hypothalamic disease, or growth hormone deficiency due to surgery, radiation therapy, or previous trauma.
- At least one standard growth hormone stimulation test must be performed before benefit coverage for adult growth hormone therapy.
- Benefit coverage is provided for three month intervals for adult growth hormone deficiency and benefit is renewable in the presence of clinical benefit from therapy as evidenced by an increase in total lean body mass, an increase in IGF-1 or IGFBP-3 levels, or an increase in exercise capacity.
Serostim® Coverage Authorization Criteria

- Benefit approval is limited to patients ≥ 18 years of age,
- Benefit approval is limited to patients who have AIDS wasting syndrome not attributable to other causes such as depression, chronic infectious diarrhea, or mycobacterium avium complex (MAC infection), or malignancy (Kaposi sarcoma limited to skin or mucous membranes is covered).
- Patients must have unintentionally lost ≥ 10% of body weight.
- Patients must be on highly active combination anti-HIV viral therapy with viral load reduced to 10,000 copies/ml or less or be no longer receiving anti-HIV viral therapy due to therapeutic failure or resistance to anti-HIV viral drugs.
- Patients must be undergoing concurrent nutritional counseling.
- Benefit is approved for one month and is renewable for one month intervals based on confirmation that the patient’s weight has stabilized (e.g., no further weight loss) or increased.
Nuvigil® (Armodafinil)

Covered Medications
- Armodafinil (Nuvigil®)

What it does and how it is used?
- Armodafinil is a wakefulness-promoting agent for oral administration. The precise mechanism of action is unknown. Armodafinil has wake-promoting actions like sympathomimetic agents with a different side effect profile.

Rationale for Prior Authorization
- To limit use to appropriate indications.

Coverage Authorization Criteria
Coverage for Provigil® is determined through prior authorization in accord with the following criteria:
- Coverage provided for the treatment of:
  - Narcolepsy
  - Idiopathic Hypersomnia (confirmed by sleep study)
  - Obstructive Sleep Apnea
  - Shift Work Sleep Disorder
  - Fatigue Associated with Multiple Sclerosis
- Nuvigil® must not be used in combination with other CNS stimulants such as amphetamines, pemoline, or methylphenidate.

Continued duration: 12 months or when the plan year ends whichever occurs sooner.
Multiple Sclerosis Drugs

Covered Medications

- Ampyra® (dalfampridine) – PO
- Aubagio (teriflumonide) - PO
- Avonex® (interferon beta 1a) – IM
- Betaseon® (interferon beta 1b) – SC
- Copaxone® (glatiramer) – SC
- Extavia® (interferon beta 1b) – SC
- Gilenya® (fingolimod) –IM
- Mitoxantrone - IV
- Plegridy® (peginterferon beta 1a) – SC
- Rebif® (interferon beta 1a) – SC
- Tecfidera® (dimethyl fumarate) – PO
- Tysabri® (natalizumab) – IV

What do they do and how are they used?
- All act as immunomodulators for reducing the frequency of relapses in MS patients.

Rationale for Coverage Authorization
- To limit coverage to appropriate patients.

Coverage Authorization Criteria
Coverage for the above drugs is provided in accord with the following:

- For patients with a diagnosis of relapsed-remitted, secondary progressive or progressive-relapsing multiple sclerosis (MS) confirmed by MRI.
- The treating physician is a neurologist.
- The patient is ambulatory or has some arm/hand use consistent with performing activities of daily living.

Coverage is provided for 12 months or end of plan year.
Injectable Drugs for Psoriasis/Psoriatic Arthritis

Covered Medications
- Humira® (adalimumab)
- Enbrel® (etanercept)
- Cimzia® (certolizumab pegol)
- Cosentyx (secukinumab)
- Gengraf® (cyclosporine modified)
  - Otezla (apremilast)
  - Remicade® (infliximab)
- Simponi® (golimumab)
- Soriatane® (acitretin)
  - Stelara (ustekinumab)

What do they do and how are they used?
- All are immunomodulators.

Rationale for Prior Authorization
- To limit use for treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy.

Coverage Authorization Criteria
Coverage is determined through prior authorization in accord with the following criteria:
- Coverage is provided for the treatment of moderate to severe plaque psoriasis in patients ≥ 18 years of age.
- Coverage is provided when prescribed under the care or referral of a dermatologist.
- Coverage is provided in situations where the patient has already been treated with phototherapy (i.e., PUVA or broadband or narrowband UVB) unless phototherapy is not available or contraindicated for the patient.

AND
- Coverage is provided in situations where the patient has already been treated with or is not a candidate for any other systemic treatments such as methotrexate (oral or IM), cyclosporine, and acitretin (Soriatane®).
- Coverage is not provided for the use of more than one biologic drug simultaneously. Coverage duration: 12 months (or recommended treatment duration) or when the plan year ends whichever occurs sooner.
Treatment of Crohn’s Disease

Covered Medications
- Cimzia® (certolizumab pegol)
- Entyvio (vedolizumab)
  - Humira® (adalimumab)
- Remicade® (Infliximab)
- Tysabri® (natalizumab)

What it does and how it is used?
- Remicade® and Humira® are monoclonal antibodies that neutralize the biological activity of TNF by binding with high affinity to the soluble and transmembrane forms of TNF and inhibits binding of TNF with its receptors.
- Elevated concentrations of TNF have been found in the stools of patients with Crohn’s disease and correlate with disease activity.
- Remicade® and Humira® are used for the treatment of moderately to severely active Crohn’s disease for the reduction of signs and symptoms in patients who have not had an adequate response to conventional therapy.
- Remicade® is used for the treatment of patients with fistulizing Crohn’s disease for the reduction in the number of draining enterocutaneous fistula(s).
  - Tysabri is monoclonal antibody which binds integrins on leukocyte cell walls, preventing migration into inflamed parenchymal tissue.
  - Entyvio is a monoclonal antibody which binds alpha 4 beta 7 integrin, leading to inhibition of memory T-lymphocyte migration into inflamed GI parenchymal tissue.
  - Cimzia binds and inhibits tumor necrosis factor alpha.

Rationale for Prior Authorization
- To limit exposure to cost associated with the use of these medications for conditions other than Crohn’s disease.

Prior Authorization Criteria
- Benefit approved for patients with nonfistulizing Crohn’s disease that have had an inadequate response to conventional therapy. Patient must have had one or more trial(s) with the following:
  - Mesalamine (Asacol®, Pentasa®, Rowasa®)
  - Azathioprine (Imuran®)
  - Sulfasalazine (Azulfidine®)
  - 6-mercaptopurine (Purinethol®)
  - Corticosteroids:
    - Betamethasone (Celestone®)
    - Hydrocortisone (Cortef®, Hydrocortrone®, Cortenema®, Cortifoam®)
    - Cortisone (Cortone®)
    - Dexamethasone (Decadron®, Dexone®, Dexameth®, Hexadrol®)
    - Methylprednisolone (Medrol®)
    - Prednisolone (Delta-Cortef®)
      - Prednisone (Meticorten®, Orasone®, Panasol-S®, Deltasone®)
- Triamcinolone (Aristocort®, Atolone®, Kenacort®)
- For Cimzia, Entyvio, Tysabri, patient must have a trial of Humira

- Benefit approved for Remicade® for patients with fistulizing Crohn's disease. Benefit is approved for three doses. These three doses consist of an initial 5 mg/kg dose followed with additional 5 mg/kg doses at two and six weeks after the first infusion.
Osteoporosis

Covered Medications

- Reclast® (zoleodronic acid)
- Boniva® (ibandronate)
- Forteo® (teriparatide)
- Prolia® (denosumab)

What it does and how it is used?

- Zoledronic Acid is an intravenous bisphosphonate. It inhibits osteoclast activity, reducing bone resorption and turnover. It is given as a 15-minute infusion once a year. It is used to treat osteoporosis and also symptomatic Paget’s disease.
- Boniva® is an IV bisphosphonate. It inhibits osteoclast activity, reducing bone resorption and turnover. It is given as an infusion every three months. It is also available generically in tablet form taken once monthly.
- Prolia is an injectable bisphosphonate. It inhibits osteoclast activity reducing bone resorption and turnover. It is given as an SC injection every six months.

Rationale for Prior Authorization

- To limit coverage to appropriate patients.

Coverage Authorization Criteria

- Coverage for Reclast® is provided in accord with the following:
  - For the treatment of osteoporosis in patients who are unable to take medication by mouth or have serious upper GI disease.
  - For patients who have had a recent fracture (in the past 90 days)
  - For patients who have symptomatic Paget’s disease
  - Patient is not hypocalcemic
  - Patient does not have renal impairment (CrCl < 35)

Coverage is provided for one treatment per year.
Drugs Used for Rheumatoid Arthritis After DMARD Failure

Covered Medications

- Actemra (tocilizumab)
  - Cimzia® (certolizumab pegol)
  - Enbrel® (etanercept) – self administered
- Humira® (adalimumab) – self administered
  - Kineret™ (anakinra) – self administered
- Orencia (abatacept)
- Remicade® (infliximab recombinant)
  - Rituxan (rituximab)
- Simponi® (golimumab)
- Xeljanz

Humira and Enbrel are preferred. For all other medications, the patient must have trial of Humira and Enbrel.

What they do and how they are used?

**Biologic Response Modifier - Tumor Necrosis Factor Inhibitors**
- Humira, Enbrel, Cimzia, Remicade, Simponi,

**Biological Response Modifier – Interleukin Inhibitors**
- Actemra, Kineret

**Biological Response Modifier – Fusion Protein**
- Orencia

**Miscellaneous – Monoclonal Antibody**
- Rituxan

**DMARD – Janus Kinase Inhibitor**
- Xeljanz

Rationale for Prior Authorization

- To reduce exposure to cost associated with these medications for the treatment of conditions other than rheumatoid arthritis and to warrant its use only after treatment failure with other DMARDs.
Coverage Authorization Criteria

- Benefit coverage is provided under the following conditions:
  - Patient must have a diagnosis of rheumatoid arthritis
  - Patient must be under the care of a practicing rheumatologist
  - Patient must have a claims history of use and failure* of 1 or more DMARDs (individually, or in combination) [i.e., the patient has previously received a prescription for one or more of the following: methotrexate, hydroxychloroquine (Plaquinil®), oral/injectable gold compounds (e.g., auranofin (Ridaura®), aurothioglucone (Solganal®), gold sodium thiomalate (Myochrisine®), azathioprine (Imuran®), cyclosporine (Neoral®), penicillamine (Cuprimine®), sulfasalazine (Azulfidine® EN-tabs), or leflunomide (Arava®)]
  - If methotrexate is not one of the above failed treatments, an adequate methotrexate regimen trial is required (unless contraindicated) before adding or switching to Enbrel®, Humira® or Kineret™. An adequate methotrexate regimen is defined as 20 mg per week for a period of at least three months. Remicade® is only covered for use in conjunction with methotrexate therapy
  - Enbrel®, Kineret™, Remicade®, or Humira® should not be used in combination with one another
  - Before using Enbrel®, Remicade®, or Humira® the patient should be assessed for infection or risk factors for infection
  - Due to the risk of neutropenia, neutrophil counts should be taken before initiating Kineret™ therapy, monthly for the first three months, and quarterly thereafter for a period of up to one year
  - Benefit coverage subject to three month review, then annually.

Failure is defined as intolerance, lack of satisfactory efficacy with optimal maintenance doses (with appropriate time to benefit), or the presence of a contraindication to the medication. Adequate doses of DMARDs must be tried before treatment is considered a failure. Adequate doses and times to observed benefit for the common DMARDs are listed in the table below:

<table>
<thead>
<tr>
<th>DRUG</th>
<th>TIME TO BENEFIT</th>
<th>USUAL MAINTENANCE DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azathioprine</td>
<td>2 – 3 months</td>
<td>50 – 150 mg/day</td>
</tr>
<tr>
<td>Cyclosporine</td>
<td>2 – 4 months</td>
<td>2.5 – 4 mg/kg/day</td>
</tr>
<tr>
<td>D-Penicillamine</td>
<td>3 – 6 months</td>
<td>250 – 750 mg/day</td>
</tr>
<tr>
<td>Gold, Intramuscular</td>
<td>3 – 6 months</td>
<td>25 -50 mg q2 weeks cumulative dose of 1000 mg</td>
</tr>
<tr>
<td>Gold, Oral</td>
<td>4 – 6 months</td>
<td>3 mg twice a day</td>
</tr>
<tr>
<td>Hydroxychloroquine</td>
<td>2 – 6 months</td>
<td>200 mg. twice a day</td>
</tr>
<tr>
<td>Leflunomide^</td>
<td>4 – 12 weeks</td>
<td>20 mg/day (single dose), if tolerated; otherwise 10 mg/day</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>1 – 2 months</td>
<td>7.5 – 20 mg/week (oral or injectable)</td>
</tr>
<tr>
<td>Sulfasalazine</td>
<td>1 – 3 months</td>
<td>1000 mg 2 – 3 times/day</td>
</tr>
</tbody>
</table>

^Recommended loading dose of leflunomide is 100 mg/day for three days.
Symlin® (Pramlintide Acetate Injection)

Covered Medications
- Pramlintide (Symlin®)

What it does and how it is used?
- Pramlintide is an amylin mimetic which decreases post-prandial glucose rise, suppresses glucagon secretion, slows gastric emptying, and promotes satiety.

Rationale for Prior Authorization
- To limit exposure to uses where Pramlintide is appropriate.

Coverage Authorization Criteria
Coverage for Symlin® is provided in accord with the following:
- For the treatment of Type 1 or Type 2 diabetes in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite good compliance with optimal insulin therapy.
- The member patient must be ≥ 18 years of age and
- The member must have proven ability to self-monitor blood glucose and ability to detect and prevent hypoglycemic episodes and
- The member must not have gastroparesis.
Coverage is provided initially for six months. Continued coverage is provided for 12 months in situations where there has been an improvement in the patient’s HbA1c.