

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

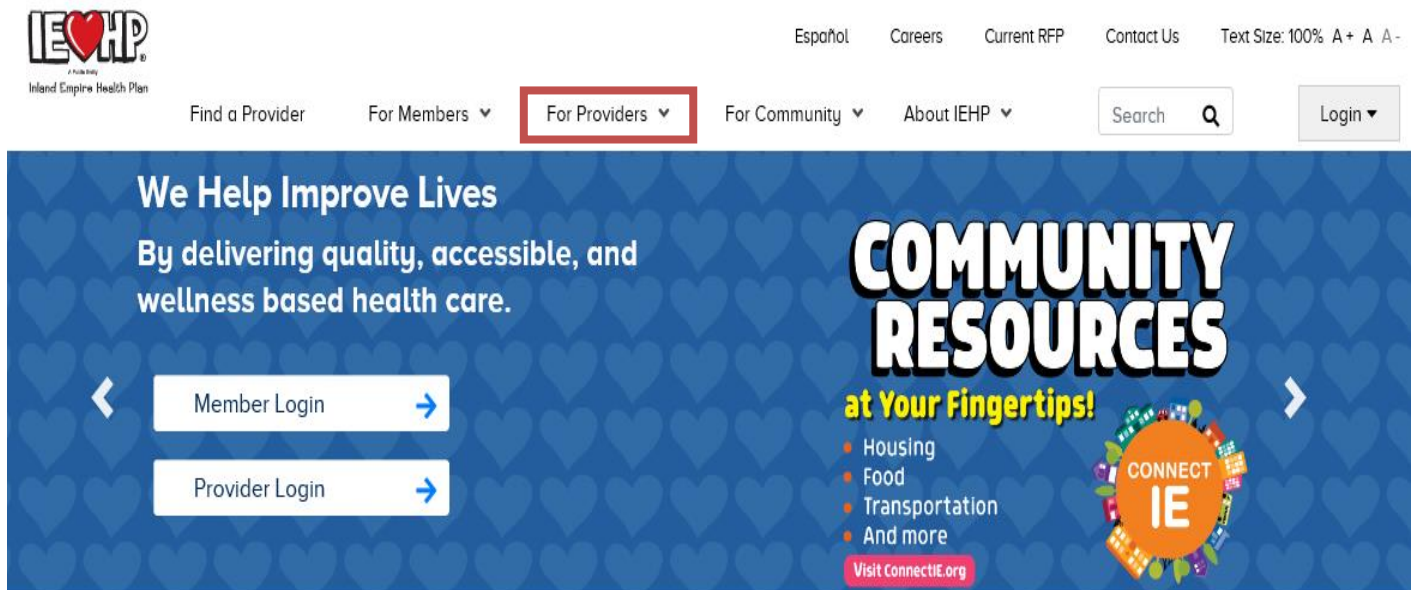
Prior Authorization – a process in which to determine whether a prescription medication can be covered by IEHP

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:

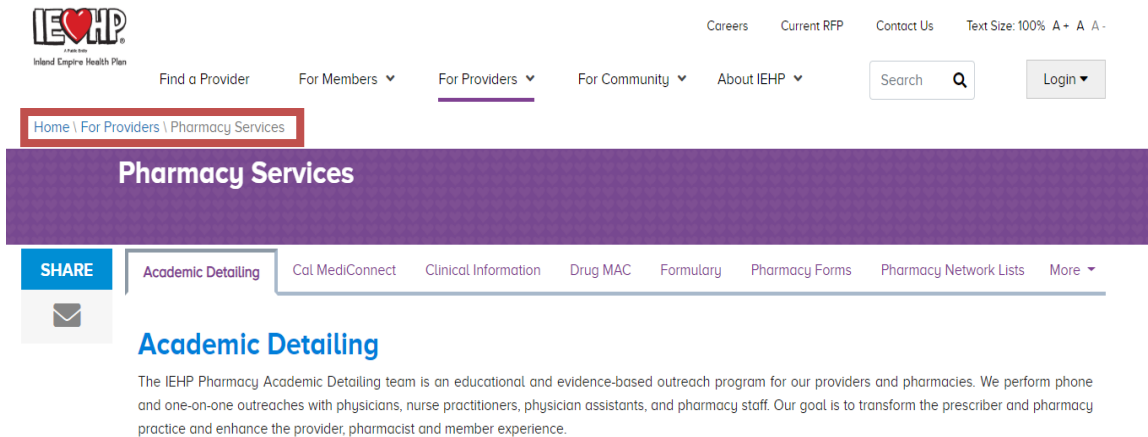
- Navigate to www.iehp.org
 - Hover over **For Providers**



The screenshot shows the top navigation bar of the IEHP website. The IEHP logo is on the left. To the right are links for 'Español', 'Careers', 'Current RFP', 'Contact Us', and 'Text Size: 100% A+ A A-'. Below these are dropdown menus for 'Find a Provider', 'For Members', 'For Providers' (highlighted with a red box), 'For Community', and 'About IEHP'. A search bar and a 'Login' button are also present.

The banner below the navigation bar has a blue background with a heart pattern. On the left, it says 'We Help Improve Lives By delivering quality, accessible, and wellness based health care.' Below this are two buttons: 'Member Login' and 'Provider Login', both with right-pointing arrows. On the right, it says 'COMMUNITY RESOURCES at Your Fingertips!' followed by a list: 'Housing', 'Food', 'Transportation', and 'And more'. At the bottom right is a 'CONNECT IE' logo and a button that says 'Visit ConnectIE.org'.

- Click on **Pharmacy Services**



The screenshot shows the IEHP website navigation for Pharmacy Services. The breadcrumb trail is "Home \ For Providers \ Pharmacy Services". The "Pharmacy Services" menu is highlighted, and the "Academic Detailing" sub-menu item is selected. Below the menu, the "Academic Detailing" section is visible, with a description of the program.

Home \ For Providers \ Pharmacy Services

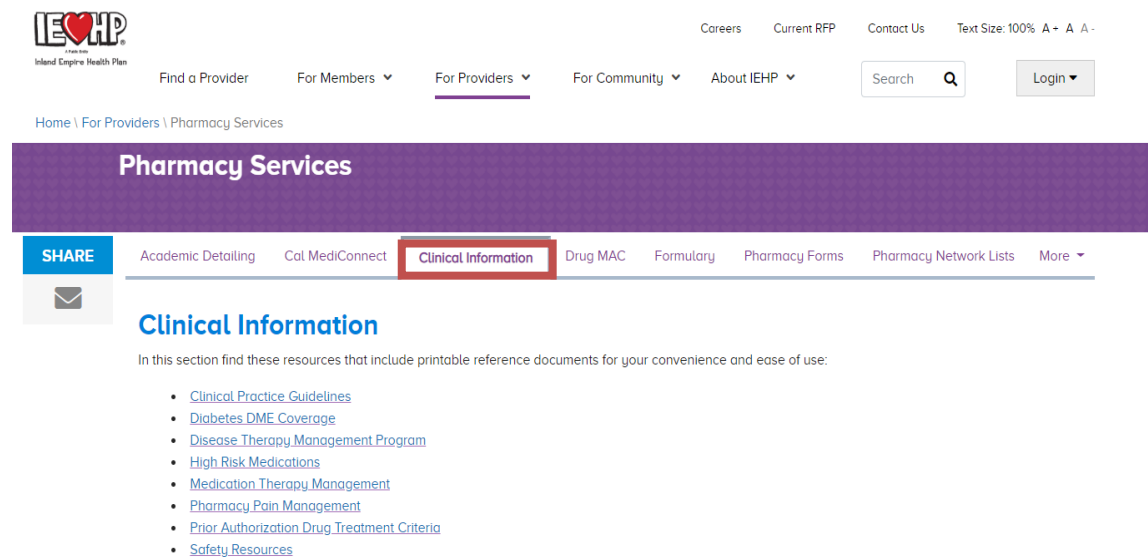
Pharmacy Services

SHARE Academic Detailing Cal MediConnect Clinical Information Drug MAC Formulary Pharmacy Forms Pharmacy Network Lists More ▾

Academic Detailing

The IEHP Pharmacy Academic Detailing team is an educational and evidence-based outreach program for our providers and pharmacies. We perform phone and one-on-one outreaches with physicians, nurse practitioners, physician assistants, and pharmacy staff. Our goal is to transform the prescriber and pharmacy practice and enhance the provider, pharmacist and member experience.

- Click on **Clinical Information**



The screenshot shows the IEHP website navigation for Clinical Information. The breadcrumb trail is "Home \ For Providers \ Pharmacy Services". The "Pharmacy Services" menu is highlighted, and the "Clinical Information" sub-menu item is selected. Below the menu, the "Clinical Information" section is visible, with a list of resources.

Home \ For Providers \ Pharmacy Services

Pharmacy Services

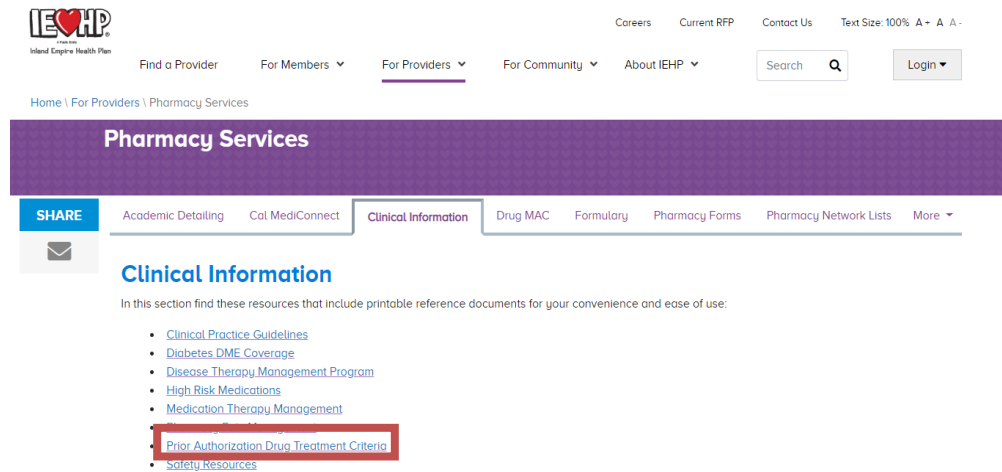
SHARE Academic Detailing Cal MediConnect Clinical Information Drug MAC Formulary Pharmacy Forms Pharmacy Network Lists More ▾

Clinical Information

In this section find these resources that include printable reference documents for your convenience and ease of use:

- [Clinical Practice Guidelines](#)
- [Diabetes DME Coverage](#)
- [Disease Therapy Management Program](#)
- [High Risk Medications](#)
- [Medication Therapy Management](#)
- [Pharmacy Pain Management](#)
- [Prior Authorization Drug Treatment Criteria](#)
- [Safety Resources](#)

- Click on **Prior Authorization Drug Treatment Criteria**



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

Drug Prior Authorization Criteria

- [HP Acthar \(repository corticotropin injection\)](#) (PDF)
- [Nucala](#) (PDF)
- [Spinraza \(nusinersen\)](#) (PDF)
- [Synagis](#) (PDF)
- [Xolair \(omalizumab\)](#) (PDF)

Drug Class Prior Authorization Criteria

- [Adult Enteral Nutritional Supplement](#) (PDF)
- [Antineoplastic Agents](#) (PDF)
- [Botulinum Toxin](#) (PDF)
- [Erythropoiesis-Stimulating Agents](#) (PDF)
- [Growth Hormones](#) (PDF)
- [Hepatitis C](#) (PDF)
- [Hereditary Angioedema](#) (PDF)
- [Immuno Globulins](#) (PDF)
- [Intravenous Antibiotics](#) (PDF)
- [Nutritional Supplement Infant Formula](#) (PDF)
- [Opioid Analgesics](#) (PDF)
- [Pediatric Enteral Nutritional Supplement](#) (PDF)
- [Proprotein Convertase Subtilisin/Kexin Type 9 \(PCSK9\) Inhibitor](#) (PDF)
- [Testosterone Hormone Replacement](#) (PDF)
- [Therapeutic Agents in Rheumatic And Inflammatory Diseases](#) (PDF)
- [Viscosupplementation Products](#) (PDF)

Pharmacy Policies

- [Adult Vaccine](#) (PDF)
- [Antibiotic Stewardship](#) (PDF)
- [Automatic Blood Pressure Monitor Coverage Policy](#) (PDF)
- [Brand Name Drug Policy](#) (PDF)
- [Continuous Glucose Monitoring Devices](#) (PDF)
- [Drug Trial and Failure](#) (PDF)
- [External Insulin Pump Policy](#) (PDF)
- [Hepatitis B and C Center of Excellence - COE](#) (PDF)
- [High Daily Morphine Milligram Equivalent](#) (PDF)
- [IEHP Prescription Drug Prior Authorization Drug Treatment Criteria and Policy](#) (PDF)
- [Intrauterine and Subdermal Contraceptive Devices](#) (PDF)
- [Nebulizer Policy](#) (PDF)
- [Non-Formulary Drug Policy](#) (PDF)
- [Non-Sterile Compounded Medication](#) (PDF)
- [Off-Label Indications of Non-Formulary Drugs](#) (PDF)
- [Pharmacy Drug Management Program for Pain](#) (PDF)
- [Quantity Limits](#) (PDF)
- [Transgender Hormonal Treatment for Adults](#) (PDF)
- [Transgender Hormonal Treatment for Pediatrics](#) (PDF)

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.
- **Change Control:** For internal use to track criteria updates.



Inland Empire Health Plan

Drug Prior Authorization Criteria
H.P. Acthar Gel

Line of Business: Medicaid
P & T Approval Date:

Effective Date:

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 (REPOSITORY CORTICOTROPIN INJECTION)

Covered Uses:	*Infantile Spasms (West Syndrome) (*Subject to review by Clinical Pharmacist)
Exclusion Criteria:	N/A
Required Medical Information:	Must meet the following requirement: a. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.
Age Restriction:	Must be less than 24 months old
Prescriber Restrictions:	Neurologist or Pediatrician
Other Criteria:	N/A

Covered Uses:	*Multiple Sclerosis with acute exacerbation (*Subject to review by Clinical Pharmacist)
Exclusion Criteria:	N/A
Required Medical Information:	Must meet all of the following requirements: <ul style="list-style-type: none"> a. Failure or clinically significant adverse effects to corticosteroid therapy (i.e. prednisone, intravenous methylprednisolone, etc.). b. Documentation of concurrent multiple sclerosis agents (i.e. Avonex, Betaseron, Glatiramer, etc.). c. Requested dose and duration must be consistent with FDA package labeled recommendation or DrugDex compendia.
Age Restriction:	N/A
Prescriber Restrictions:	Neurologist
Other Criteria:	N/A

Change Control		
Date	Change	RPH
02/20/2019	<ul style="list-style-type: none"> • Changed Format 	ND
06/29/2018	<ul style="list-style-type: none"> • Changed Format 	IK
02/21/2018	<ul style="list-style-type: none"> • Renewed with no new updates/changes. 	CT

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.