Aetna Better Health® of New Jersey

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met
Medications requiring Prior Authorization	Requests for Medications requiring Prior Authorization (PA) will be reviewed based on the PA Guidelines/Criteria for that medication. Scroll down to view the PA Guidelines for specific medications. Medications that do not have a specific PA guideline will follow the Non-Formulary Medication Guideline. Additional information may be required on a case-by-case basis to allow for adequate review.	As documented in the individual guideline
Step Therapy	Medications requiring Step Therapy first go through trial and failure of formulary agent prior to approval If prerequisite medications have been filled within specified time frame, prescription will automatically process at the pharmacy Prior Authorization will be required for prescriptions that do not process automatically at pharmacy **For NJ, see formulary search tool:** New Jersey Formulary Search Tool	**Initial Approval:** One year **Renewal Approval:** One year ***Requires:*** Member response to treatment
Brand Name Medication Requests	**Aetna Medicaid requires use of generic agents that are considered therapeutically equivalent by the Food and Drug Administration (FDA)** • Provider attestation that member had a trial and failure, or intolerance/adverse effect to the generic formulation that is made by two different manufacturers	**Approval Duration:** One year
Behavioral Health Medications for	• Behavioral Health medication request is prescribed for member that is less than 18 years of age • Behavioral Health medication requests that are submitted with diagnosis of	**Initial Approval:** 12 months

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met

Children Less than 18 Years of Age	seizure will bypass behavioral health authorization requirement
	
	Prescriber attestation to all the following:
	• Prescribing information for requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements
	• All laboratory testing and clinical monitoring recommended in prescribing information have been completed as of date of request and will be repeated as recommended
	• If requested medication is being added to another behavioral health medication, child has been adherent to established medication therapy without adequate resolution of symptoms
	• Member meets <u>one</u> of the following:
	  ○ Recipient has been treated in past, or is currently receiving treatment with requested medication, and has positive response to treatment without evidence of adverse effects
	  ▪ Information is stated on request
	  ○ Recipient has not previously used this medication; however, prescriber is citing references, and supporting use of medication for child's age and diagnosis
	  ▪ For example, peer-reviewed journal article demonstrating safety and efficacy of requested medication for indication
	  ○ All medication options that are appropriate for both age and diagnosis of
		<u>Renewal Approval</u>:
		12 months

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met
	child have met <u>one</u> of the following: ▪ There was a trial, resulting in either treatment failure or intolerable side effects ▪ There was not a trial, due to documented contraindication to remaining medication options that are appropriate for age and condition being treated ▪ Recipient has no inappropriate concomitant drug therapies or disease states	
COVID-19 **Paxlovid**	https://www.aetnabetterhealth.com/newjersey/providers/pharmacy	
CAPS Products **Arcalyst** **Ilaris** **Kineret**	https://www.aetnabetterhealth.com/newjersey/providers/pharmacy-guidelines.html	**<u>Initial Approval</u>:** 6 months **<u>Renewal Approval</u>:** 6 months
Bonjesta **Doxylamine Succinate and Pyridoxine Hydrochloride**	**May be authorized when the following criteria are met:** • Member is at least 18 years of age • Diagnosis of nausea and vomiting in pregnancy • Inadequate response or intolerable side effects to dietary and lifestyle changes ○ For example, avoiding stimuli/triggers, avoiding spicy or fatty foods, eating frequent small meals, or inadequate response to ginger	**<u>Initial Approval:</u>** 3 months **<u>Renewal Approval:</u>** 3 months ***Requires:***

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

Aetna Better Health® of New Jersey

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met

(Diclegis)[i]	• Use of individual products (over-the-counter doxylamine and pyridoxine) as separate dosage forms has not achieved adequate treatment response
	  ○ Pyridoxine is available as a single agent and recommended dose 10-25mg orally every six to eight hours.
	  ○ Doxylamine is available as over-the-counter and as prescription products, with recommended dose as one-half 25mg over-the-counter tablet, or two chewable 5mg prescription tablets
	• For Bonjesta: Use of generic prescription doxylamine succinate and pyridoxine hydrochloride has not achieved adequate treatment response
		• Documentation member is still pregnant and continues to have nausea and vomiting symptoms
		
		Quantity Level Limit:
		Diclegis or generic Doxylamine Succinate and Pyridoxine Hydrochloride:
		4 tablets per day
		
		Bonjesta:
		2 tablets per day

Exondys[ii]	**May be authorized when documentation is presented to meet all the following criteria:** • Genetic testing to confirm member diagnosis of Duchenne Muscular Dystrophy and to identify the specific type of DMD gene mutation • Prescribed by or in consultation with a physician who specializes in treatment of Duchenne Muscular Dystrophy • Lab results showing a DMD gene mutation is amenable to exon 51 skipping • Treatment is initiated prior to the age of 14 years • Member is able to achieve an average distance of at least 180 meters while walking independently over 6 minutes	**Initial Approval:** 6 months **Renewal Approval:** 12 months ***Requires:*** • Documentation of response to therapy as evidenced by remaining ambulatory ○ For example, member is able

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met
		to walk with or without assistance, and is not wheelchair dependent
Human Immunodeficiency Virus (HIV) Medications[iii] **Preferred Medications/Regimens for Treatment Naïve:** • Biktarvy • Triumeq • Truvada + Tivicay • Descovy + Tivicay • Truvada + Isentress • Descovy + Isentress • Odefsey	**Non-Preferred Human Immunodeficiency Virus (HIV) Medications will pay at the point of sale without requiring a prior authorization when all the following are met:** • Member has a prior claims or prior authorization history of medications for human immunodeficiency virus (HIV) • Member has a previous diagnosis of human immunodeficiency virus (HIV) **Non-Preferred Human Immunodeficiency Virus (HIV) Medications, and Non-Preferred Human Immunodeficiency Virus (HIV) Medications for Pre- and Post-Exposure Prophylaxis may be authorized when the following criteria are met:** • Medication is being used for the treatment of Human Immunodeficiency Virus (HIV), Pre-exposure Prophylaxis (PrEP), or Post-exposure Prophylaxis (PEP) • Member has had an inadequate response, intolerable side effects, or contraindication to a preferred regimen for the diagnosis	**Approval Duration:** One Year

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

Aetna Better Health® of New Jersey

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met
Pre-exposure Prophylaxis (PrEP): • Truvada • Descovy **Post-exposure Prophylaxis (PEP):** • Truvada + Tivicay • Truvada + Isentress		
Rectiv	**Rectiv may be authorized when the following criteria are met:** • Member has a diagnosis of pain associated with anal fissures.	**Initial Approval:** 6 months **Renewal Approval:** 1 year
Tranexamic Acid Tablets[iv]	• Member is 12 years of age or older • Treatment is for cyclic heavy menstrual bleeding • Prescriber attestation that member has no fibroids, or fibroids are less than 3 cm in size • There was inadequate response, intolerable side effect, or contraindication to one oral Non-Steroidal Anti-inflammatory Drug (NSAID)	**Initial Approval:** 90 days **Renewal Approval:** 6 months ***Requires:***

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

Pharmacy Prior Authorization
Non-Formulary and Prior Authorization Guidelines

Scroll down to see PA Criteria by drug class, or Ctrl+F to search document by drug name

PA Guideline Name	Requirements	Duration of Approval if Requirements Are Met

	• Member had inadequate response, intolerable side effect, or contraindication to one of the following:
	  ○ Oral hormonal cycle control combinations
	  ○ Oral progesterone
	  ○ Progesterone-containing intrauterine device (IUD)
	  ○ Medroxyprogesterone depot
	• Member does not have history of thrombosis or thromboembolism (including retinal vein or artery occlusion)
	• Approved for treatment and prevention of acute bleeding episodes, such as dental surgery, in members with hemophilia.
		Reduction in menstrual blood loss
		
		Quantity Level Limit:
		• Menstrual bleeding: 30 tablets per 30 days
		• Hemophilia: 84 tablets per 30 days

[i] **Diclegis & Bonjesta References**

1. Nausea and vomiting of pregnancy. Practice Bulletin No. 189. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018; 131(1):e15-e30. https://journals.lww.com/greenjournal/Fulltext/2018/01000/ACOG_Practice_Bulletin_No__189___Nausea_And.39.aspx
2. Diclegis® (doxylamine succinate and pyridoxine hydrochloride). [Prescribing Information]. Bryn Mawr, PA. Duchesnay Inc; Revised September 2018.
3. Bonjesta® (doxylamine succinate and pyridoxine hydrochloride). [Prescribing Information]. Bryn Mawr, PA. Duchesnay Inc; Revised June 2018.
4. Gold Standard, Inc. Diclegis. Clinical Pharmacology [database online]. Available at: http://www.clinicalpharmacology.com. Accessed October 15, 2019.
5. Gold Standard, Inc. Bonjesta. Clinical Pharmacology [database online]. Available at: http://www.clinicalpharmacology.com. Accessed October 15,[t], 2019.
6. Facts & Comparisons eAnswers. Drug Facts and Comparisons. Indianapolis, IN: Wolters Kluwer Health; 2013. http://online.factsandcomparisons.com/. Accessed October 15, 2019

[ii] **Exondys References:**

1. Exondys 51 [package insert]. Cambridge, MA: Sarepta Therapeutics, Inc.; October 2018.
2. Mendell JR, Rodino-Klapac LR, Sahenk Z, et al. Eteplirsen for the treatment of Duchenne muscular dystrophy. Ann Neurol. 2013;74(5):637-47.
3. Cirak S, Arechavala-Gomeza V, Guglieri M, et al. Exon skipping and dystrophin restoration in patients with Duchenne muscular dystrophy after systemic phosphorodiamidate morpholino oligomer treatment: an open-label, phase 2, dose-escalation study. Lancet. 2011;378(9791):595-605.

Previous Version Effective: 2/4/2019, 3/1/2019, 4/1/2019, 6/3/2019, 8/1/2019, 10/1/2019, 12/2/2019, 4/1/2020, 6/8/2020, 8/3/2020, 8/18/2020, 9/1/2020, 11/4/2020, 03/01/2021, 6/28/2021, 8/1/2021, 8/15/2021, 9/13/2021, 11/2/2021, 1/9/2022, 1/24/2022, 2/10/2022, 3/16/2022, 6/7/2022, 7/9/2022, 8/1/2022, 12/16/2022, 2/1/2023, 2/10/2023, 2/23/2023, 3/2/2023, 3/20/2023, 3/24/2023, 3/30/2023, 4/6/2023, 4/15/2023, 4/20/2023, 5/1/2023, 5/25/2023, 6/1/2023, 6/22/2023, 7/6/2023, 7/20/2023, 8/10/2023, 8/17/2023, 8/31/2023, 9/14/2023
Current Version Effective: 9/28/2023

4. Mendell JR, Goemans N, Lowes LP, et al; Eteplirsen Study Group and Telethon Foundation DMD Italian Network. Longitudinal effect of eteplirsen versus historical control on ambulation in Duchenne muscular dystrophy. Ann Neurol. 2016;79(2):257-271.
5. Randeree L, Eslick GD. Eteplirsen for paediatric patients with Duchenne muscular dystrophy: A pooled-analysis. J Clin Neurosci. 2018;49:1

[iii] **HIV Medications References**

1. CDC Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2016. https://stacks.cdc.gov/view/cdc/38856. Accessed May 25, 2021.
2. CDC PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES – 2017 UPDATE https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf. Accessed May 25, 2021.
3. HHS website AIDS guidelines; https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0. Accessed May 25, 2021.

[iv] **Tranexamic acid References**

1. National institute for health and care excellence, Heavy menstrual bleeding: assessment and management, https://www.nice.org.uk/guidance/ng88/resources/heavy-menstrual-bleeding-assessment-and-management-pdf-1837701412549. Accessed November 26th, 2019
2. Hemostatic agents, World Federation of Hemophilia. (2012). http://www1.wfh.org/publications/files/pdf-1497.pdf. Accessed November 26th, 2019
3. Lysteda® [package insert] March 2016. Parsippany, NJ. Ferring Pharmaceuticals, Inc. Retrieved from http://www.ferringusa.com/wp-content/uploads/2016/07/LystedaPI_3.2016.pdf. Accessed December 24, 2019.
4. Clinical pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; Retrieved from http://clinicalpharmacology-ip.com/Forms/Monograph/monograph.aspx?cpnum=1591&sec=monindi&t=0. Accessed November 28th, 2019