PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **April 28, 2022**

Subject: **Pharmacy Policy Renewals**

Summary: Pharmacy policy renewals approved by the Louisiana Department of Health.

AmeriHealth Caritas Louisiana would like to make you aware of the attached policies that have been renewed by the Louisiana Department of Health in accordance with La. R.S. 46:460.54 and **will become effective May 29, 2022.**

Safety Edit Exception Criteria
Insulin Pumps

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert? You can find a complete listing of provider alerts on the Provider Newsletters and Updates page of our website.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com.

Where can I find more information on COVID-19?
AmeriHealth Caritas Louisiana has updated its website to streamline communications and important notifications about COVID-19. Please visit http://amerihealthcaritasla.com/covid-19 for up-to-date information for both providers and members, including frequently asked questions, and important provider alerts from AmeriHealth Caritas Louisiana and the Louisiana Department of Health.

Field Name	Field Description
Prior Authorization Group Description	**Safety Edit Exception Criteria**
Covered Uses	All medically accepted indications. Medically accepted indications are defined using the following compendia resources: the Food and Drug Administration (FDA) approved indication(s) (Drug Package Insert), American Hospital Formulary Service Drug Information (AHFS-DI), and DRUGDEX Information System. The reviewer may also reference disease state specific standard of care guidelines.
Scope	Requests for formulary drugs and for previously approved non-formulary drugs: • Exceeding the Food and Drug Administration (FDA) or compendia max dose recommendations • Exceeding the FDA dosing or compendia administration frequency recommendations • Exceeding the FDA or compendia duration of therapy recommendations • Duplication of therapy error at Point of Service (POS) • Age Restriction error at POS • **Day Supply Limit error at POS** • Concurrent Use error at POS • **Drug Drug Interaction error at POS**
Criteria	**Exceeding the Food and Drug Administration (FDA) or compendia maximum dose, administration frequency or duration of therapy recommendations.** • The member must have a documented treatment failure with the drug at the maximum tolerated dose or maximum dose (whichever is the lesser dose), administration frequency or duration of therapy. AND • The provider must submit a medical reason why the maximum dose, administration frequency or duration of therapy needs to be exceeded based on the member's condition or treatment history. **Duplication of therapy** Transition from one agent to another • If a provider has outlined a plan to transition a member to a similar drug or provided a dose titration schedule, the requested drug is approved for one month*. Concurrent Therapy with two similar agents

	• The provider must submit a medical reason why treatment with more than one drug in the same class is required based on the member's condition and treatment history. OR • The provider must submit disease state specific standard of care guidelines supporting concurrent therapy. **Age Restriction** • The provider must submit a medical reason why the drug is needed for a member whose age is outside of the plan's minimum or maximum age limit. AND • The indication and dose requested is supported by the Medical Compendia or current treatment guidelines. **Day Supply Limit** • **An additional fill exceeding the day supply limit is needed based on a dose increase or is needed to achieve a total daily dose** **OR** • **The provider must submit a medical reason why an additional fill is needed outside of the plan's day supply limit.** **AND** • **The indication and dose requested is supported by the FDA, Medical Compendia or current treatment guidelines.** **Concurrent Use/Drug Drug Interaction:** • The provider must submit a medical reason why treatment with both drugs is necessary for the member **AND** • **The increased risk for side effects when taking the drugs together has been discussed with the member** **Medical Director/clinical reviewer may override criteria when, in his/her professional judgement, the requested item is medically necessary.**
Coverage Duration	*One month approval for Duplication of therapy when transitioning from one agent to another. All Other Scenarios: 12 months
Revision/Review Date:	~~5~~**10/2021**

Field Name	Field Description
Prior Authorization Group Description	**Insulin Pumps**
Drugs	Omnipod Dash, insulin delivery pods only (Notes: The Omnipod Dash PDM (Personal Diabetes Manager) is provided direct by Insulet and should not be requested by the prescriber/billed to the plan.) **This policy does not apply to pumps reviewed and/or covered by the Medical Benefit including, but not limited to V-Go 24-hour disposable system and t:slim X2, and continuous glucose monitor/insulin pumps such as MiniMed ~~and t:slim X2~~. Requests for these products are referred to the plan's Utilization Management team for review.**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months. If the criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.
Other Criteria	**Initial Authorization** • Diagnosis – diabetes • One of the following o ≤ 18 years with type 1 diabetes or other insulin-deficient forms of diabetes (i.e. cystic-fibrosis related diabetes) o Continuation of therapy for patient new to plan o Treatment with multiple daily doses (≥ 3) of insulin and one of the following ▪ Persistently inadequate glycemic control (i.e. HbA1C ≥ 7% on multiple consecutive readings with one being within the last 3 months, frequent bouts of hypoglycemia, overt microvascular complications)

Revision/Review Date ~~6~~**10**/2021	▪ History of acutely dangerous symptoms (i.e. severe glycemic excursions; brittle diabetes; nocturnal hypoglycemia; hypoglycemia unawareness, ketosis) ▪ Other difficult to manage symptoms/scenarios (i.e. "dawn" phenomenon; extreme insulin sensitivity; very low insulin requirements) ▪ Pregnancy **Reauthorization** • One of the following: o Child or adolescent with type 1 diabetes or other insulin-deficient form of diabetes o Documentation of positive clinical response (i.e. improved HbA1C; reduced frequency of severe hypoglycemia episodes; target time in range [TIR] > 70% or time below range < 4%) with 1st reauthorization o Initial approval was based on continuation of therapy for patient new to plan. • Continuation of therapy based on a diagnosis of pregnancy alone is not eligible for reauthorization **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**