PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **September 5, 2025**

Subject: **LDH Approved Medical Drug Policies**

Summary: LDH Approved Medical Drug Policies

AmeriHealth Caritas Louisiana would like to make you aware of four policies that the Louisiana Department of Health has approved in accordance with La. R.S. 46:460.54. The guidelines will be located at the following link on our website under Pharmacy Prior Authorization Criteria: https://www.amerihealthcaritasla.com/pdf/pharmacy/acla-non-pdl-prior-auth-criteria.pdf.

1. Myasthenia Gravis Agents
2. Radicava
3. Somatostatin Analogs
4. Specialty Drugs

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions:
Thank you for your continued support and commitment to our patients' care. If you have questions about this communication, please get in touch with AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert?
You can always find a complete list of provider alerts on our website's Newsletters and Updates page.

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

Field Name	Field Description
Prior Authorization Group Description	**Myasthenia Gravis Agents**
Drugs	Rystiggo (rozanolixizumab), Soliris (eculizumab), Ultomiris (ravulizumab)**,Vyvgart** (efgartigimod), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase), Zilbrysq (zilucoplan)**), BVEMV (eculizumab-aeeb), Epysqli (eculizumab-aagh)**
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	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	**According to package insert**~~≥ 18 years~~
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or rheumatologist
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.

Other Criteria
 	
Revision/Review Date: 4/202**5**
	****Drug is being requested through the member's medical benefit****
	
	Initial Authorization:
	• Diagnosis of generalized myasthenia gravis (gMG)
	• Patient has a positive serological test for one of the following:
	  o Anti-AChR antibodies
	  o Anti-muscle-specific tyrosine kinase (MuSK) antibodies (Rystiggo only)
	• Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of class II, III or IV
	• **For adults: p**~~P~~atient has tried and failed, or has contraindication, to one of the following:
	  o Two (2) or more conventional therapies (i.e. acetylcholinesterase inhibitors, corticosteroids, non-steroidal immunosuppressive therapies)
	  o Failed at least 1 conventional therapy and required chronic plasmapheresis or plasma exchange or intravenous immunoglobulin
	• **For eculizumab in patients 6-17 years: one of the following:**
	  o **Trial and failure of at least 1 conventional therapy (i.e. acetylcholinesterase inhibitors, corticosteroids, non-steroidal immunosuppressive therapies)**
	  o **Patient requires maintenance plasma exchange or intravenous immunoglobulin to control symptoms**
	• Medication is prescribed at an FDA approved dose
	• Patient is not using agents covered by this policy concurrently (i.e. no concurrent use of Vyvgart, Vyvgart Hytrulo, Rystiggo, Soliris, Ultomiris, **BKEMV, Epysqli** or Zilbrysq)
	• For Vyvgart Hytrulo, patient has tried and failed, or has contraindication, to Vyvgart
	• Requests for Soliris (eculizumab)**, BKEMV (eculizimab-aeeb), Epysqli (eculizumab-aagh),** Ultomiris (ravulizumab), and Zilbrysq (zilucoplan) will also require all of the following:
	  o **For adults: p**~~P~~atient has tried and failed, or has contraindication, to

	Vyvgart, Vyvgart Hytrulo, or Rystiggo. ▪ **Additionally, if the request is for Soliris or BKEMV, member must also have a documented trial and failure or intolerance to Epysqli or a medical reason why Epysqli cannot be used.** o **All ages: dD**ocumentation patient complies with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal infections in patients receiving a complement inhibitor**.** **Re-Authorization:** • Provider has submitted documentation of clinical response to therapy (e.g., reduction in disease severity, improvement in quality-of-life scores, MG-ADL scores, etc). • Medication is prescribed at an FDA approved dose. **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**

Field Name	Field Description
Prior Authorization Group Description	**Radicava**
Drugs	Edaravone (Radicava), Radivaca ORS (edaravone) and any other newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	N/A
Required Medical Information	See "other criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist
Coverage Duration	If the criteria are met, requests will be approved for up to 6 month duration
Other Criteria Revision/Review Date 4/2025	****Drug is being requested through the member's medical benefit**** **Initial Authorization:** • Member must have a diagnosis of ALS • Member must have a documented baseline evaluation of functionality using the revised ALS functional rating scale (ALSFRS-R) score ≥ 2 • Member's disease duration is 2 years or less • Member has a baseline forced vital capacity (FVC) of ≥ 80% • Member has been on riluzole (Rilutek), is beginning therapy as an adjunct to treatment with Radicava, or provider has provided a medical reason why patient is unable to use riluzole • Dose is within FDA approved limits **<u>Reauthorization:</u>** • Member is not ventilator-dependent • Provider documents clinical stabilization in symptoms (e.g. stabilization of ALSFRS-R score) • Dose is within FDA approved limits **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

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Field Name	Field Description
Prior Authorization Group Description	**Somatostatin Analogs and Growth Hormone Receptor Antagonists**
Drugs	Octreotide (Sandostatin) Sandostatin LAR (octreotide) Lanreotide 120 mg/0.5 mL **Lanreotide (**Somatuline Depot**)** ~~(lanreotide)~~ 60 mg/0.2 mL, 90 mg/0.3 mL, 120 mg/0.5mL Mycapssa (octreotide) Signifor (pasireotide) Signifor LAR (pasireotide) Somavert (pegvisomant)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA) Drug Package Insert (PPI). ** Non-FDA approved (i.e. off-label) uses; refer to the "Oncology Drugs" policy for off-label oncology uses**
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per FDA approved package insert
Prescriber Restrictions	Prescriber must be a specialist with appropriate expertise in treating the condition in question (such as an endocrinologist, neurologist/neurosurgeon, oncologist, etc.). Consultation with appropriate specialist for the condition in question is also acceptable.
Coverage Duration	If all of the criteria are met, the initial request will be approved for 6 months. For continuation of therapy, the request will be approved for 12 months.
Other Criteria	****Drug is being requested through the member's medical benefit**** **Initial Authorization** For all FDA approved indications (including FDA-approved oncology related uses) • Medication requested is for an FDA approved indication and dose • If the provider is requesting therapy with more than one somatostatin analog or a somatostatin analog and a growth hormone receptor antagonist, then documentation must be submitted as to why patient is unable to be treated with monotherapy, or a medical reason was provided why monotherapy is not appropriate. For Acromegaly • Patient has had an inadequate response to, or medical reason why, surgical treatment cannot be used. • If the patient mild disease (e.g. mild signs and symptoms of growth hormone excess, modest elevations in IGF-1) there is a documented trial of a dopamine agonist (e.g. bromocriptine mesylate, cabergoline)

Revision/Review Date 4/2025**4**	at a therapeutically appropriate dose or a documented medical reason why a dopamine agonist cannot be used • **Additionally for Mycapssa:** o Patient has showed clinical response to and tolerates treatment with octreotide or lanreotide therapy o Clinical justification is provided as to why patient cannot continue use of injectable somatostatin analog therapy • **Additionally for Somavert:** o Patient has had an inadequate response to therapy with a somatostatin analog, or has a documented medical reason why a somatostatin analog cannot be used • **Additionally for Signifor LAR:** o Patient has had an inadequate response to therapy with either lanreotide (Somatuline Depot) or octreotide (Sandostain, Sandostatin LAR), or has a documented medical reason why these somatostatin analogs cannot be used. For Cushing's Disease (pasireotide products only) • Patient must have had inadequate response, or medical reason why surgical treatment cannot be used **Reauthorization** • Medication requested is for an FDA approved indication and dose • Documentation has been provided that demonstrates a clinical benefit (e.g. improvement in laboratory values, improvement or stabilization of clinical signs/symptoms, etc.) **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

Field Name	Field Description
Prior Authorization Group Description	**Specialty Drugs**
Drugs	Oral and injectable specialty drugs without drug or class specific prior authorization criteria *** The Oncology Drugs prior authorization criteria will be applied to oncology drugs without drug or class specific criteria***
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	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	According to package insert
Prescriber Restrictions	N/A
Coverage Duration	If all of the conditions are met, requests will be approved for up to **12~~6~~** months. If the conditions are not met, the request will be sent to a Medical Director/clinical reviewer for medical necessity review.
Other Criteria Revision/Review Date 4/202**5~~4~~**	****Drug is being requested through the member's medical benefit**** **All of the following criteria must be met:** • The drug is requested for an appropriate use (per the references outlined in "Covered Uses" • The dose requested is appropriate for the requested use (per the references outlined in "Covered Uses") • Documentation has been provided of a trial and failure of an appropriate alternative first line therapy, if one exists, for the requested use (per the references outlined in "Covered Uses"**)** or has a medical reason why these drug(s) cannot be used (e.g. intolerance, contraindication) • If the request is for a reference biologic drug with either a biosimilar or interchangeable biologic drug currently available**, documentation of one of the following:** o The provider has either verbally or in writing submitted a member specific reason why the reference biologic is required based on the member's condition or treatment history **OR** o The currently available biosimilar product does not have the same appropriate use (per the references outlined in "Covered Uses") as the reference biologic drug being requested **Physician/clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**