**Endocrine Agents: Endometriosis**

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| Criteria 1 | NP Criteria- Synarel |
| Criteria 2 | Danazol (P, ST), Depo-Subq Provera 104 (P, ST), Lupaneta Pack (P, ST), Orilissa (P, ST), Zoladex (P, ST) |
| Criteria 3 | Lupron Depot 3.75, 11.25mg (P, QL, ST) |
| Criteria 4 | Myfembree (P, QL, ST) |

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| **Criteria Title** | Endocrine Agents: Endometriosis | | |
| **Criteria Subtitle** | Synarel | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| SYNAREL | 044984 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred NSAID?  If yes, please submit the medication trials and dates. | Y | 1000 |
| N | 1002 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred oral contraceptive?  If yes, please submit the medication trials and dates. | Y | 1001 |
| N | 1002 |
| 5 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred step-therapy drug?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 6 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 7 | 1003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1004 |
| N | END (Pending Manual Review) |
| 8 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

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| **Last Approved** | 5/5/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Endometriosis | | |
| **Criteria Subtitle** | Danazol, Depo-Subq Provera 104, Lupaneta Pack, Orilissa, Zoladex | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| DANAZOL | 006600 | GCNSeqNo |
| DANAZOL | 006601 | GCNSeqNo |
| DANAZOL | 006602 | GCNSeqNo |
| DEPO-SUBQ PROVERA 104 | 058938 | GCNSeqNo |
| LUPANETA PACK | 003274 | GCNSeqNo |
| ORILISSA | 078657 | GCNSeqNo |
| ORILISSA | 078659 | GCNSeqNo |
| ZOLADEX | 044961 | GCNSeqNo |
| ZOLADEX | 044962 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred NSAID?  If yes, please submit the medication trials and dates. | Y | 1000 |
| N | 1002 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred oral contraceptive?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1002 |
| 5 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 7 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 5/5/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Endometriosis and Uterine Fibroids | | |
| **Criteria Subtitle** | Lupron Depot 3.75, 11.25mg | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| LUPRON DEPOT | 044980 | GCNSeqNo |
| LUPRON DEPOT | 045017 | GCNSeqNo |
| LUPRON DEPOT | 047665 | GCNSeqNo |
| LUPRON DEPOT | 067738 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0999 |  | Select | What is the patient’s diagnosis? | Endometriosis | 1000 |
| Uterine Fibroids | 2000 |
| Other | 1235 |
| 2 | 1000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1001 |
| Continuation (re-authorization request) | 1232 |
| 3 | 1001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1002 |
| N | 1235 |
| 4 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred NSAID?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1004 |
| 5 | 1003 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred oral contraceptive?  If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 1004 |
| 6 | 1004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | END (Pending Manual Review) |
| N | 1236 |
| 7 | 2000 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 2001 |
| Continuation (re-authorization request) | 1233 |
| 8 | 2001 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 2002 |
| N | 1235 |
| 9 | 2002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with at least one preferred oral contraceptive?  If yes, please submit the medication trials and dates. | Y | 2004 |
| N | 2003 |
| 10 | 2003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2004 |
| N | 1236 |
| 11 | 2004 |  | Select | Ohio Medicaid covers a total lifetime duration of therapy of 180 days for Lupron Depot.  Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 12 | 1232 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 14 | 1234 |  | Select and Free Text | Ohio Medicaid covers a total lifetime duration of therapy of 180 days for Lupron Depot.  Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1237 |
| 15 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 16 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |
| 17 | 1237 |  | Free Text | Please provide the rationale for the dose and frequency requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Endometriosis- 365 Days; Uterine Fibroids- Up to 180 days

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| **Last Approved** | 5/5/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Endometriosis and Uterine Fibroids | | |
| **Criteria Subtitle** | Myfembree | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| MYFEMBREE | 082317 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1233 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | What is the patient’s diagnosis? | Endometriosis | 1000 |
| Uterine Fibroids | 2000 |
| Other | 1235 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred NSAID?  If yes, please submit the medication trials and dates. | Y | 1001 |
| N | 1002 |
| 5 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 84 days with at least one preferred oral contraceptive?  If yes, please submit the medication trials and dates. | Y | 1003 |
| N | 1002 |
| 6 | 1002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1003 |
| N | 1236 |
| 7 | 1003 |  | Select | Ohio Medicaid covers a total lifetime duration of therapy of 730 days between Oriahnn and Myfembree (if applicable).  Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 2000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with at least one preferred oral contraceptive?  If yes, please submit the medication trials and dates. | Y | 2002 |
| N | 2001 |
| 9 | 2001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2002 |
| N | 1236 |
| 10 | 2002 |  | Select | Ohio Medicaid covers a total lifetime duration of therapy of 730 days between Oriahnn and Myfembree.  Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 12 | 1234 |  | Select | Ohio Medicaid covers a total lifetime duration of therapy of 730 days between Oriahnn and Myfembree (if applicable).  Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 14 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: Endometriosis- 365 Days; Uterine Fibroids- Up to 180 days

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| **Last Approved** | 5/5/2023 |
| **Other** |  |