**Gastrointestinal Agents: Unspecified GI**

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| Criteria 1 | NP Agents  - Ibsrela, Linzess 72mcg, Motegrity, Mytesi  \*- Preferred product has BvG designation |
| Criteria 2 | NP with additional criteria- Relistor and Symproic |
| Criteria 3 | NP with additional criteria- Aemcolo |
| Criteria 4 | NP with additional criteria- Zorbtive and Gattex |
| Criteria 5 | ST Preferred Drugs (Amitiza, Lubiprostone, Linzess 145, 290 mcg, Movantik, Trulance) |
| Criteria 6 | Xifaxan |

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| **Criteria Title** | Gastrointestinal Agents: Unspecified GI | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| IBSRELA | 080204 | GCNSeqNo |
| LINZESS 72 mcg | 077085 | GCNSeqNo |
| MOTEGRITY | 066215 | GCNSeqNo |
| MOTEGRITY | 066216 | GCNSeqNo |
| MYTESI | 070418 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least three preferred drugs, if indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | 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 | 1002 |
| N | 1236 |
| 5 | 1002 |  | 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 | 1003 |
| N | END (Pending Manual Review) |
| 6 | 1003 |  | 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 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 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** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Gastrointestinal Agents: Unspecified GI | | |
| **Criteria Subtitle** | Relistor and Symproic | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| RELISTOR | 064011 | GCNSeqNo |
| RELISTOR | 068482 | GCNSeqNo |
| RELISTOR | 068483 | GCNSeqNo |
| RELISTOR | 076398 | GCNSeqNo |
| SYMPROIC | 077258 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least three preferred drugs, if indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | 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 | 1002 |
| N | 1236 |
| 5 | 1002 |  | 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 | 1003 |
| N | 1004 |
| 6 | 1003 |  | 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 | 1004 |
| N | 1235 |
| 7 | 1004 |  | Select | Does the patient have a history of chronic pain requiring continuous opioid therapy for at least 84 days? | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 10 | 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** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Gastrointestinal Agents: Unspecified GI | | |
| **Criteria Subtitle** | Aemcolo | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AEMCOLO | 079335 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least three preferred drugs, if indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | 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 | 1002 |
| N | 1236 |
| 5 | 1002 |  | 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 | 1003 |
| N | 1004 |
| 6 | 1003 |  | 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 | 1004 |
| N | 1235 |
| 7 | 1004 |  | Select and Free Text | Is the patient unable to take, or has the patient failed, ALL of the following: azithromycin, ciprofloxacin, levofloxacin, ofloxacin, or rifaximin?  If yes, please submit the medication trials and dates or medication names and reasons for inability to use. | Y | END (Pending Manual Review) |
| N | 1235 |
| 8 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 10 | 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: 3 Days

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| **Last Approved** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Gastrointestinal Agents: Unspecified GI | | |
| **Criteria Subtitle** | Zorbtive, Gattex | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ZORBTIVE | 44087338807 | NDC |
| GATTEX | 070407 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least three preferred drugs, if indicated for diagnosis?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | 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 | 1002 |
| N | 1236 |
| 5 | 1002 |  | 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 | 1003 |
| N | 1004 |
| 6 | 1003 |  | 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 | 1004 |
| N | 1235 |
| 7 | 1004 |  | Select and Free Text | Has the provider submitted documentation of specialized parenteral nutritional support?    If yes, please submit documentation. | Y | 1005 |
| N | 1235 |
| 8 | 1005 |  | Select and Free Text | Has the provider submitted documentation of appropriate lab assessment (bilirubin, alkaline phosphatase, lipase, and amylase) at least 180 days prior to initiation?    If yes, please submit documentation. | Y | END (Pending Manual Review) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)? | 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** | 6/2/2023 |
| **Other** |  |

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| **Criteria Title** | Gastrointestinal Agents: Unspecified GI | | |
| **Criteria Subtitle** | Step Therapy Agents | | |
| **Approval Level** | NDC-9 | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| AMTIZA | 060341 | GCNSeqNo |
| AMITZA | 063946 | GCNSeqNo |
| LINZESS 145, 290 mcg | 069922 | GCNSeqNo |
| LINZESS 145, 290 mcg | 069923 | GCNSeqNo |
| MOVANTIK | 073335 | GCNSeqNo |
| MOVANTIK | 073336 | GCNSeqNo |
| TRULANCE | 077047 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 3999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 4000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 4000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 4001 |
| N | 1235 |
| 3 | 4001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least two preferred drugs?    If yes, please submit the medication trials and dates. | Y | END (Pending Manual Review) |
| N | 4002 |
| 4 | 4002 |  | 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 |
| 5 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 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** | 6/2/2023 |
| **Other** |  |