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| --- | --- | --- | --- |
| **Criteria Title** | H-2 Antagonist | | |
| **Criteria Subtitle** | Nizatidine | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| NIZATIDINE | 011679 | GCNSeqNo |
| NIZATIDINE | 011680 | GCNSeqNo |
| NIZATIDINE | 057867 | 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 | Is the patient’s condition clinically unstable or was nizatidine initiated in hospital to treat a gastrointestinal (GI) bleed or other serious acute condition? | Y | 1002 |
| N | 1000 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response to at least 30 days with one preferred drug in the past 90 days?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Does the patient have a contraindication with one preferred drug?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select | What is the patient’s diagnosis? | Duodenal ulcer | END (Approve x 365 days) |
| Other | END (Approve x 84 days) |
| 7 | 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 |
| 8 | 1234 |  | Select | What is the patient’s diagnosis? | Duodenal ulcer | END (Approve x 365 days) |
| Other | END (Approve x 84 days) |
| 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 AUTHORIZATION: Authorizations will be for 84 days unless diagnosis is duodenal ulcer.

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| **Last Approved** | 4/20/2023 |
| **Other** |  |