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| --- | --- | --- | --- |
| **Criteria Title** | Topical Agents: Treatment of Anal Fissure | | |
| **Criteria Subtitle** | Rectiv (nitroglycerin) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| RECTIV | 059201 | GCNSeqNo |

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| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 2 | 1001 |  | Select and Free Text | Has the patient had an inadequate clinical response to 14 days of a combination with 3 of the following alternatives: stool softeners, fiber, topical steroid containing product, or topical calcium channel blocker containing product in the past 60 days?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select | Ohio Medicaid covers one fill of less than or equal to a 30-gram tube every 60 days.  Does this request meet this requirement? | Y | END (Pending Manual Review) |
| N | 1236 |
| 4 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 5 | 1236 |  | Free Text | Please provide the rationale for the dose and frequency being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATION: 60 days

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| --- | --- |
| **Last Approved** | 5/1/2023 |
| **Other** |  |