

30 Day Change Notice Effective Date: April 1, 2023

NEW CLINICAL PA REQUIRED PREFERRED DRUGS		
THERAPEUTIC CLASS	CLINICAL CRITERIA REQUIRED PREFERRED	
Blood Formation, Coagulation, and Thrombosis	Nyvepria	
Agents: Colony Stimulating Factors	Ziextenzo	
Cardiovascular Agents: Pulmonary Arterial	Tadliq	
Hypertension		
Endocrine Agents: Osteoporosis – Bone	Forteo	
Ossification Enhancers		

NEW NON PREFERRED DRUGS		
THERAPEUTIC CLASS	PA REQUIRED NON PREFERRED	
Blood Formation, Coagulation, and Thrombosis	Fylnetra	
Agents: Colony Stimulating Factors		
Cardiovascular Agents: Angina, Hypertension, and	Clonidine ER (generic of Nexiclon XR)	
Heart Failure	Levamlodipine	
Central Nervous System (CNS) Agents:	Zonisade Susp	
Anticonvulsants	Ztalmy	
Central Nervous System (CNS) Agents:	Auvelity	
Antidepressants		
Genitourinary Agents: Benign Prostatic	Entadfi	
Hyperplasia		
Immunomodulator Agents: Systemic	Sotyktu	
Inflammatory Disease		
Infectious Disease Agents: Antifungals	Vivjoa	
Respiratory Agents: Nasal Preparations	Ryaltris	
Topical Agents: Immunomodulators	Zoryve	

REMOVED I	FROM UPDL
THERAPEUTIC CLASS	
Analgesic Agents: Opioids	Oxaydo

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors
Cardiovascular Agents: Pulmonary Arterial Hypertension
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers
Genitourinary Agents: Benign Prostatic Hyperplasia
Infectious Disease Agents: Antifungals
Infectious Disease Agents: Hepatitis C Agents

Date of Notice: 3/1/2023



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REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	SUMMARY OF CHANGE
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	 CLINICAL PA CRITERIA: Must provide documentation of diagnosis, patient's weight, and duration of treatment
Cardiovascular Agents: Pulmonary Arterial Hypertension	AR - Sildenafil Susp and Tadliq: a PA is required for patients 6 years and older
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	 TERIPARATIDE (FORTEO™) CRITERIA: Must have had an inadequate clinical response of at least 365 days with one bisphosphonate A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog ADDITIONAL ABALOPARATIDE (TYMLOS™) CRITERIA: Must have had an inadequate clinical response of at least 365 days with one bisphosphonate A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog
Genitourinary Agents: Benign Prostatic Hyperplasia Infectious Disease Agents: Antifungals	ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) & FINASTERIDE/TADALAFIL (ENTADFI) CRITERIA • Must provide documentation for patient's inability to use the individual drugs ADDITIONAL OTESECONAZOLE (VIVJOA) CRITERIA: • Must provide documentation of at least three symptomatic episodes of vulvovaginal candidiasis in the past 12 months • Must provide documentation of non-reproductive potential (i.e., postmenopausal) • Must have had an inadequate clinical response of at least 180 day maintenance course with oral fluconazole shown by documentation of more than one breakthrough infection

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Infectious Disease Agents: Hepatitis C Agents

OHIO DEPARTMENT OF MEDICAID PRIOR AUTHORIZATION HEPATITIS C TREATMENT

Individual's Medicaid ID Number Prescriber's NPI Number Prescriber's NPI Number Prescriber's Phone Number Prescriber's Fax Number Prescriber's Phone Number Prescrib		Review Requested STANDARD URGENT
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Inly Hepatitis C treatment PA requests for individuals who meet the following guidelines will be approved. In this PA form will cover up to the length authorized by the American Association for the Study of Liver Disease (AASLE pidelines). In the PA form will cover up to the length authorized by the American Association for the Study of Liver Disease (AASLE pidelines). In the PA form will cover up to the length authorized by the American Association for the Study of Liver Disease (AASLE pidelines). In the PA form will cover up to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved prior to the 1st dose and include appropriate supporting documentation. In the PA must be approved for 1st weeks (for GT3, add weight based RBV if Y93H positive) and the paper appropriate supporting documentation.	Individual's Date of Birth	Prescriber's Address
is PA form will cover up to the length authorized by the American Association for the Study of Liver Disease (AASLE idelines. ease refer to the APPENDIX which lists the various regimens and the clinical situations for which they will be onsidered medically necessary according to the Ohio Department of Medicaid (ODM) criteria. The PA must be approved prior to the 1st dose and include appropriate supporting documentation. PPENDIX Treatment naïve No cirrhosis Mayvret 100/40 mg, three (3) tablets daily for 8 weeks (for GTS/6-and/or HiV/HCV co-infection, 12-weeks is recommended) sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks Compensated cirrhosis, HIV negative Mayvret 100/40 mg, three (3) tablets daily for 8 weeks (GT4 WITH HIV coinfection, IDSA/AASLD guidelines recommend 12 weeks of therapy) sofosbuvir/velpatasvir 400/100, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive Mayvret 100/40 mg, three (3) tablets daily for 12 weeks sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive) Treatment experienced Previously failed a Sofosbuvir-based regimen Mayvret 100/40 mg, three (3) tablets daily for 16 weeks Previously failed a NS3/4 protease inhibitor inclusive regimen (e.g. Zepatier) Vosevi 400/100/100 mg, one tablet daily for 12 weeks (if compensated cirrhosis, add weight-based RBV) Previously failed Nosevi or sofosbuvir + Mayvret Vosevi 400/100/100 mg, one tablet daily for 12 weeks (if compensated cirrhosis, add weight-based RBV) Previously failed Or 3 only: sofosbuvir/NS5A (e.g. Harvoni)		Prescriber's Phone Number Prescriber's Fax Number
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