Brand/Trade names are shown for reference purposes only. Criteria apply to the generic product when a generic equivalent has been approved by the FDA. Additional criteria apply to brand name requests (when a generic is available), per PHC Policy #MPRP4033.

Aducanumab-avwa (Aduhelm™)	Benralizumab (Fasenra™)	Betibeglogene Autotemcel (Zynteglo™)	Dupilumab (Dupixent™)
Etranacogene dezaparvovec-drlb (Hemgenix™)	Immune Globulin (Asceniv™)	Immune Globulin (Bivigam™)	Immune Globulin (Cutaquig™)
Immune Globulin (Cuvitru™)	Immune Globulin (Flebogamma™)	Immune Globulin (Gamastan S/D™)	Immune Globulin (Gammagard™)
Immune Globulin (Gammaked™)	Immune Globulin (Gammaplex™)	Immune Globulin (Gamunex-C™)	Immune Globulin (Hizentra™)
Immune Globulin (Hyqvia™)	Immune Globulin (Octagam™)	Immune Globulin (Panzyga™)	Immune Globulin (Privigen™)
Immune Globulin (Xembify™)	Lecanemab-irmb (Leqembi™)	Mepolizumab (Nucala™)	Omalizumab (Xolair™)
Pembrolizumab (Keytruda™)		Tezepelumab (Tezspire™)	

Requirements for Benralizumab (Fasenra™ AutoInjector Pen & Fasenra™ Prefilled Syringe)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	Add-on maintenance treatment of severe asthma in adults with an eosinophilic phenotype.
Exclusion Criteria	• Monotherapy use (benralizumab is add on therapy to the current asthma treatment regimen) • Benralizumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, reslizumab or tezepelumab
Required Medical Information	Must submit clinical documentation to substantiate the following: 1) Must be used for FDA approved indications and dosages 2) Patient has a diagnosis of severe asthma with an eosinophilic phenotype and has a blood eosinophil counts equal to or greater than 150 cells/μL 3) Patient has persistent uncontrolled asthma as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ6) score of 1.5 or more, or an Asthma b. Control Test (ACT) score less than 20 at baseline c. At least two exacerbations while on high-dosage inhaled corticosteroids and long acting β2-agonists (LABA) (ICS plus LABA) in the previous year d. A history of Emergency Department (ED) visits requiring use of oral/systemic corticosteroids and/or hospitalization in the past year e. Reduced lung function at baseline [pre-bronchodilator FEV1 below 80% in adults, and below 90% in adolescents] despite regular treatment with high dose inhaled corticosteroid (ICS) or with medium or high dose ICS plus a LABA with or without oral corticosteroids (OCS) and additional asthma controller medications such as antileukotriene agent, tiotropium, or sustained-release theophylline. 4) State the specific dosage form that will be administered during the medical office visit: a. Fasenra™ Autoinjector pen (may be administered by patient or caregiver with proper training) OR b. Fasenra™ Prefilled syringe (administered by health care provider)
Age Restriction	Must be 12 years of age or older.
Prescriber Restriction	None
Coverage Duration	Prefilled syringes: 3 doses (3 months) to allow administration of loading doses and for self-administration training with the goal of transitioning to the autoinjector pen for maintenance treatment at home (provided by the pharmacy). Autoinjector pens: 1 time dose for training & observation of self-administration technique.

Requirements for Benralizumab (Fasenra™ AutoInjector Pen & Fasenra™ Prefilled Syringe)

Other Requirements & Information	Benralizumab (Fasenra™) is available for self-administration in the form of an auto-injector and is typically administered by the member or a caregiver at home. As soon as the maintenance dose is established and member or caregiver can be trained for self-administration, Fasenra™ autoinjector should be provided to the member by a pharmacy for administration at home whenever possible. Prefilled syringes: Requests will be approved for up to 3 months, if the healthcare provider prefers to administer the loading dose for new start requests, by obtaining it though the practice until maintenance dose and safety of self-administration is determined. Autoinjector pens: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J0517	Injection, benralizumab, per 1 mg (Fasenra™ auto-injector pen & Fasenra™ prefilled syringe)	30 mg subcutaneously every 4 weeks x 3 doses, and then once every 8 weeks thereafter. Maximum Dose: 30 mg (30 HCPCS units)

Requirements for Dupilumab (Dupixent™)

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) Moderate to severe atopic dermatitis (AD) 2) Add on maintenance treatment for moderate to severe eosinophilic asthma or oral glucocorticoid dependent asthma 3) Chronic rhinosinusitis in adults with nasal polyposis (CRSwNP) 4) Eosinophilic esophagitis (EoE)
Exclusion Criteria	Combination with another monoclonal antibody/biologic therapy.
Required Medical Information	Moderate to severe Atopic Dermatitis: 1) Patient meets ONE of the following (a or b): a) Greater than or equal to 10% BSA affected with documented trial and failure of at least two medium to super-high potency topical corticosteroids (TCS) applied daily for at least one month (up to 14 days consecutive use is within prescribing recommendations in TCS package labeling) AND trial and failure of topical tacrolimus or pimecrolimus or crisaborole applied daily for at least one month OR b) Less than 10% BSA involving sensitive areas that significantly affect quality of life (face, eyes, skin folds, genitalia) with documented trial and failure of topical tacrolimus or pimecrolimus or crisaborole applied daily for at least one month. AND 2) Patient (≥ 18 years of age) has tried and failed at least one of the following systemic agents within the previous 6 months: oral cyclosporine, azathioprine, methotrexate, mycophenolate. Moderate to severe Asthma: 1) Diagnosis of moderate to severe asthma with: a) Documentation of history with 2 or more exacerbations (hospitalization, ED visit, exacerbations requiring systemic corticosteroids burst) within the previous 12 months despite compliant use of high dose inhaled corticosteroids and a secondary asthma controller (e.g. LA Beta Agonist) for at least 3 months. i. Include which inhaler(s) is/are being used for asthma control along with strength of the inhaler(s) used *Note: Compliance to be confirmed per patient claims or fill history submitted.* AND b) Absolute eosinophil counts greater than or equal to 300/microL 2) Baseline FEV1 <80% predicted, to indicate airflow limitation. 3) Baseline Asthma Control Questionnaire (ACQ) or Asthma Control Test (ACT) with final score indicating inadequate control with the current treatment regimen. Chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) Documentation of chronic rhinosinusitis with nasal polyposis with all of the following: a) Minimum of least 2 failed prior trials of short course oral corticosteroid (7- 21 days), followed by b) A treatment course of nasal corticosteroid use at doses for the treatment of nasal polyps for a minimum of 3 months, AND c) Adjunctive therapy with a leukotriene antagonist. Eosinophilic esophagitis (EoE): 1) Clinical documentation confirming: a) Diagnosis by upper endoscopy with esophageal biopsies showing

Requirements for Dupilumab (Dupixent™)

	≥15 eosinophils per high power field (HPF) b) Two or more episodes of dysphagia per week c) Evaluation for other conditions that may be associated with esophageal eosinophilia 2) Trial and inadequate response (or intolerance/contraindication) to: a) Proton pump inhibitors (PPI) therapy for 8 weeks, and b) Swallowed topical corticosteroid therapy with either fluticasone or budesonide for 4-8 weeks.
Age Restriction	Moderate-to-severe AD: ≥ 6 months of age Moderate-to-severe asthma: ≥ 6 years of age CRSwNP: ≥18 years of age EoE: ≥12 years of age and weighing ≥ 40kg
Prescriber Restriction	Must be prescribed by or recommended by: AD: Dermatologist, Allergist, or Immunologist Asthma: Allergist or pulmonologist CRSwNP: Otolaryngologist EoE: Allergist or gastroenterologist
Coverage Duration	Case-dependent (medical office single dose requested vs outpatient hospital with multiple doses requested). Limited to the number of doses needed until the member is able to resume self-administration at home.
Other Requirements & Information	This medication is typically self-administered by the member or a caregiver at home. See the additional requirements for medical claim TARs in the PHC criteria document titled *Standard Requirements for Self-Administered Drugs.* Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Requirements for Mepolizumab (Nucala™ Autoinjector Pen, Nucala™ Prefilled Syringe, & Nucala™ vials)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) Add-on maintenance treatment of severe asthma in adults with an eosinophilic phenotype. 2) Eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome or EGPA). 3) Hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause. 4) Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) with inadequate response to nasal corticosteroids.
Exclusion Criteria	• When used as monotherapy (mepolizumab is add on therapy to the current asthma treatment regimen) • When used concurrently with other monoclonal antibodies with similar indications such as benralizumab, dupilumab, omalizumab, reslizumab or tezepelumab
Required Medical Information	TARs must include the NDC &/or the stated dosage form that is being requested for administration during the medical visit (Pens *vs* Syringes *vs* Vials): • Nucala™ Autoinjector pen or prefilled syringes: FDA approved for self or caregiver administration with proper training. • Nucala™ Vials: FDA approved for administration by health care provider. TARs must include clinical documentation that demonstrates all of the following: 1) Asthma: a. Member has asthma with an eosinophilic phenotype defined as blood eosinophils greater than or equal to 300 cells/µL within previous 12 months or greater than or equal to150 cells/µL within six weeks of dosing and b. Member has inadequate asthma control (for example, hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimal dosages i. Inhaled corticosteroid; and ii. Long acting beta2-agonist, leukotriene modifier, or sustained release theophylline) 2) Eosinophilic Granulomatosis with Polyangiitis a. Member has a history or the presence of an eosinophil count of more than 1000 cells/µL or a blood eosinophil level of higher than 10 percent b. Member has two or more of the following disease characteristics of EGPA: i. Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation ii. Neuropathy iii. Pulmonary infiltrates iv. Sinonasal abnormalities v. Cardiomyopathy vi. Glomerulonephritis vii. Alveolar hemorrhage viii. Palpable purpura ix. Antineutrophil Cytoplasmic Antibody (ANCA) positivity c. Member has had at least one relapse (requiring increase in oral corticosteroids dose, initiation/increased dose of immunosuppressive therapy or hospitalization) within 2 years prior to starting treatment with Nucala or has a refractory disease. 3) CRSwNP: a. History of prior nasal poly removal surgery along with date of procedure.

Requirements for Mepolizumab (Nucala™ Autoinjector Pen, Nucala™ Prefilled Syringe, & Nucala™ vials)

	b. Treatment failure with ≥ 8 weeks of a nasal corticosteroid c. Recurrent and symptomatic CRSwNP (e.g. loss of smell/taste, nasal obstruction, rhinorrhea, facial pressure) indicated by: • Visual analogue scale (VAS) score > 5 (access total clinical symptoms) AND • Bilateral nasal polyp score (NPS) ≥ 5 or NSP ≥ 2 for a single nasal cavity (extent/severity of polyps based on endoscopic evaluation). 4) Hypereosinophilic syndrome (HES): a. Clinic notes to confirmation the diagnosis of HES ≥ 6 months b. Clinic notes to indicate that secondary potential causes of non-hematologic eosinophilia have been ruled out, such as but not limited to: • FIP1L1-PDGFRα kinase positive • Parasitic helminth infection • Drug hypersensitivity • HIV infection • Non-hematologic malignancy c. Signs and symptoms of organ involvement d. At least 2 HES flares within the past 12 months e. Current lab report with absolute eosinophil count (AEC) ≥1,500 cells/uL f. Documentation of failure to induce remission with a corticosteroid (first line therapy) g. Documentation of failure to induce remission with hydroxyurea or imatinib (Gleevec™)
Age Restriction	Asthma: 6 yrs and older EGPA: 18 yrs and older HES: 12 yrs and older CRSwNP: 18 yrs and older
Prescriber Restriction	None
Coverage Duration	Vials: 1 dose to allow administration of starting dose with the goal of transitioning to the autoinjector pen or prefilled syringe for maintenance treatment at home (provided by the pharmacy). Autoinjector pens & Prefilled syringes 1 time dose for training & observation of self-administration technique.
Other Requirements & Information	Mepolizumab (Nucala™) is available for self-administration in the form of an autoinjector and a prefilled syringe, which are typically administered by the member or a caregiver at home. When the member or caregiver can be trained for self-administration, Nucala™ autoinjector or prefilled syringes should be provided to the member by a pharmacy for administration at home whenever possible. Vials: Requests will be approved up to 1 month, if the healthcare provider prefers to administer the first dose for new start requests, by obtaining it though the practice until safety is determined. Autoinjector Pen & Prefilled syringes: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide an autoinjector pen or pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Requirements for Mepolizumab (Nucala™ Autoinjector Pen, Nucala™ Prefilled Syringe, & Nucala™ vials)

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J2182	Injection, mepolizumab, per 1 mg (Nucala™ Autoinjector Pen & Prefilled syringe)	Asthma • 12 yrs and older: 100 mg (100 units) subcutaneously (SC) every 4 weeks • 6-11 yrs: 40 mg (40 units) SC every 4 weeks
		EGPA • 18 yrs and older: 300 mg (300 units) SC every 4 weeks
		HES • 18 yrs and older: 300 mg (300 units) SC every 4 weeks
		CRSwNP • 18 yrs and older: 100 mg (100 units) SC every 4 weeks
		Maximum Dose: 300 mg (300 HCPCS units per service date)

Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) Moderate-to-severe persistent asthma in patients who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids 2) Chronic idiopathic urticaria (CIU) in patients 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. 3) Nasal Polyps
Exclusion Criteria	• Asthma treatment other than for moderate-severe persistent asthma with positive test for perennial aeroallergen. • Treatment of acute urticaria (hives that last less than 6 weeks). • Omalizumab will not be used concurrently with other monoclonal antibodies with similar indications such as benralizumab, dupilumab, mepolizumab, reslizumab or tezepelumab • The treatment of other allergic conditions or other forms of urticaria. • The relief of acute bronchospasm or status asthmaticus
Required Medical Information	TARs must include clinical documentation that demonstrates all of the following: <u>Asthma</u>: 1) The service is medically necessary to treat moderate-to-severe persistent asthma. Severe asthma as defined by symptoms that are persistent and uncontrolled despite: a. The use of high dose inhaled corticosteroids combined with a long-acting beta2 agonist, leukotriene receptor agonist, or theophylline for the previous one year or longer OR b. The use of systemic glucocorticoids for 50% or more of the previous year. 2) Persistent uncontrolled asthma as defined by at least one of the following: a. An ACQ score consistently greater than 1.5 (Asthma Control Questionnaire) OR ACT score less than 20 (Asthma Control Test). b. Two or more exacerbations in the previous year, each requiring 3 or more days of treatment with systemic glucocorticoids. c. A history of hospitalization, intensive care unit stay, or mechanical ventilation in the previous year. d. A FEV1 (Forced Expiratory Volume in 1 second) at less than 80% of predicted after bronchodilator administration measured by pulmonary function testing or spirometry and documented by report and interpretation. 3) A positive skin test or in vitro reactivity to a perennial aeroallergen. 4) Symptoms are inadequately controlled with inhaled corticosteroids. 5) Pre-treatment serum IgE level between 30 and 700 IU/ml. <u>Chronic Idiopathic Urticaria (CIU)</u>: 1) The service is medically necessary to treat CIU for patients 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. <u>Nasal polyps</u>: 1) Documentation of chronic rhinosinusitis with nasal polyposis with: a. Pretreatment serum IgE level is required for new starts, or prior to restart of treatment when there has been a break of 1 year or more. b. Current member weight. c. Minimum of least 2 failed prior trials of short course oral corticosteroid (7-21 days), followed by:

Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)

	i. A treatment course of nasal corticosteroid use at doses for the treatment of nasal polyps for a minimum of 3 months, AND ii. Adjunctive therapy with a leukotriene antagonist. 2) Documentation of trial and reason(s) for failure with dupilumab (Dupixent™). For all indication above: 1) State the specific dosage form that will be administered during the medical office visit: a. Xolair™ Prefilled Syringes (may be administered by patient or caregiver with proper training) OR b. Xolair™ Vials (administered by health care provider)
Age Restriction	Asthma: 6 years and older. Chronic Urticaria: 12 years and older. Nasal Polyps: 18 years and older
Prescriber Restriction	None
Coverage Duration	Vials and Prefilled Syringes: Requests will be approved for up to 3 months, for consideration of issuing a prescription for self-administration to allow for dose stabilization and for self-administration training with the goal of transitioning to the prefilled syringes for maintenance treatment at home (provided by the pharmacy).
Other Requirements & Information Needed for Continuation of Care	Omalizumab (Xolair™) is available for self-administration in the form of a prefilled syringe and is typically administered by the member or a caregiver at home. As soon as the maintenance dose is established and member or caregiver can be trained for self-administration, Xolair™ prefilled syringes should be provided to the member by a pharmacy for administration at home whenever possible. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Requirements for Omalizumab (Xolair™ Prefilled Syringe & Xolair™ Vial)

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units

J2357	Injection, Omalizumab, 5 mg (Nucala™ prefilled syringes & Nucala™ vials)	Asthma:
		• ≥ 12 yrs:
		  ○ 150 mg – 375 mg, every 2-4 weeks
		  ○ Dose and frequency determined by initial pretreatment IgE level and body weight (kg)
		• 6-11 yrs:
		  ○ 75 mg -375 mg every 2-4 weeks
		  ○ Dose and frequency determined by initial total IgE level and body weight (kg)
		
		Chronic idiopathic urticaria:
		• ≥ 12 yrs: 150 – 300 mg every 4 weeks
		
		Nasal Polyps:
		• ≥ 18 yrs: 75 mg – 600 mg every 2-4 weeks
		• Dose and frequency determined by initial pretreatment IgE level and wt (kg)

Requirements for Tezepelumab
(Tezspire™ Autoinjector Pen & Prefilled Syringes)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	Add-on maintenance treatment of severe asthma.
Exclusion Criteria	• Monotherapy use (tezepelumab is add on therapy to the current asthma treatment regimen) • Tezepelumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, reslizumab or benralizumab
Required Medical Information	TARs must include clinical documentation to substantiate the following: 1) Patient has a physician-diagnosed asthma for at least 12 months 2) Patient is adherent on medium or high-dose inhaled corticosteroids (ICS) and at least one additional asthma controller (such as long acting beta2 agonist (LABA), with or without oral corticosteroids (OCS) 3) Patient has persistent uncontrolled asthma as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ6) score of 1.5 or more, or an Asthma Control Test (ACT) score less than 20 at baseline b. A history of at least two asthma exacerbation events within prior 12 months c. A history of at least one severe asthma exacerbation resulting in hospitalization within prior 12 months d. Patient has inadequate asthma control (for example, hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimal dosages: i. Inhaled corticosteroid; and ii. Long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). 4) State the specific dosage form that will be administered during the medical office visit: a. Tezspire™ Autoinjector pen (may be administered by patient or caregiver with proper training) OR Tezspire™ Prefilled Syringe (administered by health care provider)
Age Restriction	12 years of age or older
Prescriber Restriction	Must be prescribed by or in consultation with a pulmonologist, allergist or immunologist
Coverage Duration	Prefilled syringes: 1 dose to allow administration of starting dose with the goal of transitioning to the autoinjector or prefilled syringe for maintenance treatment at home (provided by the pharmacy). Autoinjector pens: 1 time dose for training & observation of self-administration technique

Requirements for Tezepelumab
(Tezspire™ Autoinjector Pen & Prefilled Syringes)

Other Requirements	Tezepelumab (Tezspire™) is available for self-administration in the form of an autoinjector pen, which are typically administered by the member or a caregiver at home. The member or caregiver can be trained for self-administration, Tezspire™ autoinjector pen should be provided to the member by a pharmacy for administration at home whenever possible. Prefilled syringes: Requests will be approved for one-time, if the healthcare provider prefers to administer the first dose for new start requests, by obtaining it though the practice. Autoinjector pens: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide auto-injector pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J2356	Injection, tezepelumab-ekko, 1 mg (Tezspire™ auto-injector pen & Tezspire™ prefilled syringe)	• Recommended (& maximum) dose: 210 mg • Administered as 210 mg subcutaneously once every 4 weeks
		1 HCPCS unit = 1 mg, therefore a 210 mg dose is billed as a count of 210 units of service.

General Requirements for Antineoplastic Agents, Not Otherwise Having Specific TAR Criteria

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	1) Case-Specific. 2) FDA approved indications. 3) Off-Label indications: a. The California Department of Health Care Services (DHCS) requires the Managed Care Plans (MCPs) and County Operated Health Systems (COHS) apply the following requirements to Off-Label use of medications: i. Per Title 22 CCR 51313(4), Authorization for unlabeled use of drugs shall not be granted unless the requested unlabeled use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based on: 1. Reference to current medical literature 2. Consultation with provider organizations, academic and professional specialists. ii. Off-label use that is not approved by the FDA for the diagnosis in question is not coverable unless: 1. FDA-approved alternatives have been medically ruled out (cannot be used in a particular situation for medical reasons such as allergy, serious drug interactions, previous adverse effects, or other contraindications). 2. There are no FDA-approved alternatives and the medication requested is the least costly treatment that is demonstrated to be possibly effective in treatment of the diagnosed condition. b. Medically accepted off-label indications are defined using the following standard reference compendia, under the Centers for Medicare and Medicaid Services guidance, such as (but not limited to): i. American Hospital Formulary Service-Drug Information (AHFSDI) ii. Truven Health Analytics iii. Micromedex DrugDeX (DrugDex) iv. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium (as indicated by a category 1, 2A, or 2B) v. Wolters Kluwer Lexi-Drugs (Lexicomp®, Facts & Comparisons®, and UpToDate®) vi. Elsevier/Gold Standard Clinical Pharmacology vii. And/or positive results from two peer-reviewed published medical studies.
Exclusion Criteria	Uses without supporting evidence for the stated indication (experimental).
Required Medical Information	1) TARs must include an accurate diagnosis, as provided by the treating clinician, and include all relevant clinical documentation necessary to support medical justification (e.g. clinic notes, member-specific weight and body surface area, treatment history including prior regimen(s), lab reports, specialist consults, imaging reports, etc). 2) TAR must include the amount of drug in metric weight (g, mg, mcg) &/or metric volume (ml, or # of vials if measured by each) to be administered at each dose and the number of doses necessary to complete treatment. For cyclically administered therapy, include the number of doses needed in a cycle, and the number of cycles necessary to complete treatment.
Age Restriction	Agent-specific

General Requirements for Antineoplastic Agents, Not Otherwise Having Specific TAR Criteria

Prescriber Restriction	Prescribed by oncologist, hematologist, hematologist-oncologist, or other relevant specialist with oncology scope of practice), or with specialist consult/recommendation.
Coverage Duration	Case-dependent, based on patient-specific needs, package labeling &/or Compendia or specialty professional treatment guidelines.
Other Requirements & Information	1) **Case-by-case reviews** for anti-neoplastic agents will include consideration of: a. Availability of more cost-effective therapeutic alternatives b. Member-specific co-morbidities, intolerances, allergies, or other risk factors, which may be relative or absolute contraindications to preferred therapies. d. Previous treatments tried and failed. e. The manufacturer's FDA approved package labeling &/or published clinical guidelines in regards to indications, administration, place in therapy (eg, 1st, 2nd, 3rd line), typical and maximum doses, study populations, pediatric use, recommended laboratory studies (either pretreatment screening or post-treatment monitoring). f. Drug-specific State Medi-Cal billing policies (Medi-Cal TAR requirements) may be used in lieu of PHC drug-specific criteria to guide the reviewer in establishing that medical necessity has been fully documented in the TAR submission. 2) **Renewals:** a. TAR renewals require clinical documentation that the patient is demonstrating a positive response to the requested therapy, as evidenced by: i. An improvement in the condition being treated without adverse effects causing treatment interruption, or ii. The member has progressed more slowly than anticipated in the original prognosis b. Renewal submissions must include most recent clinic visit notes, which show the current evaluation/assessment of the member's disease and any treatment plan updates. 3) **Biosimilars:** When a biosimilar product is available in the marketplace, the biosimilar product is generally preferred by PHC. TARs for the reference drug (ie, original patented brand product) must include: a. Documentation of trial and failure with the biosimilar product, including the nature of the failure and how the use of the reference drug product would avoid likelihood of the same failure. OR b. The biosimilar has not been FDA approved for the same indication that the original brand is indicated for. OR c. The facility providing the infusion has operational access limitations, such as limited by facility formulary or contracts and is unable to obtain the preferred biosimilar. i. Whenever possible, the TAR should include an estimate as to when biosimilars might be available to the provider, understanding that the reference drug will be authorized as an interim until the biosimilar is available.

Requirements for Immunoglobulin (Human) Products (IVIG, IMIG, SCIG)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) FDA approved indications: • Antiviral Prophylaxis • Chronic Inflammatory Demyelinating Polyneuropathy • Dermatomyositis/Polymyositis, Severe, Life Threatening or Refectory • Hypogammaglobinemia, prophylaxis against bacterial infection with hypogammaglobinemia and/or recurrent bacterial infections with malignancy or primary humoral immunodeficiency disorder or Common variable immunodeficiency, CVID • Acute and Chronic Immune Thrombocytopenia (ITP) • Kawasaki Syndrome • Multifocal Motor Neuropathy 2) Medically accepted off-label indications as evidenced in compendia or treatment guidelines, such as but not limited to: • Pemphigus foliaceus and vulgaris, refractory • Toxic shock syndrome, streptococcal • Antibody mediated rejection, treatment • Guillain-Barre syndrome • Acute exacerbation of myasthenia gravis
Exclusion Criteria	None
Required Medical Information	<u>Requirements for ALL indications</u>: (1) Clinic notes to confirm the diagnosis submitted (see specific requirements below). (2) Treatment plan from appropriate specialist, including: • Weight (kg, lb) • Dosing schedule • Previous treatments with other indicated therapies (if any), with evaluation of response. (3) If requesting use of Asceniv™, please submit additional information regarding reason(s) why alternative products cannot be used. <u>Additional Diagnosis-Dependent Requirements:</u> 1) <u>Antiviral prophylaxis:</u> a. Hepatitis A –pre or post-exposure within 2 weeks for patients who are: • Immunocompromised • Chronic liver disease • Ages ≥ 12 months who are unvaccinated • High-risk exposure situations within a facility (e.g. school, hospital), international travel, or during pregnancy. b. Measles – post exposure within 6 days of exposure and unable to receive a MMR vaccine within 72 hours for patients who are: • Infants < 12 months • Pregnant women or persons without evidence of immunity (rapid IgG antibody test is acceptable). • Severely Immunocompromised (e.g. bone marrow transplant procedure <12 months after finishing immunosuppressive therapy,

graft vs host disease, HIV/AIDs with so CD4 <15% or CD4 <200 lymphocytes/mm3 for ages >5 yrs).

c. Varicella – post exposure, if varicella-zoster immune globulin, such as Varizig™ is unavailable for:
   - Persons without evidence of immunity

2) Chronic inflammatory demyelinating polyneuropathy:
   a. Confirmation of diagnosis based on the European Academy of Neurology (EAN/PNS) guidelines
   b. Electro diagnostic findings of peripheral nerve demyelination
   c. Exclusion of other similar disease states that overlap with similar symptoms, such as but not limited to:
      - Neuropathy probably caused by B. burgdorferi infection (Lyme disease), diphtheria, drug or toxin exposure
      - Hereditary demyelinating neuropathy
      - Prominent sphincter disturbance
      - Diagnosis of multifocal motor neuropathy (MMN)
      - IgM monoclonal gammopathy with high titer antibodies to myelin-associated glycoprotein (MAG)
      - Other causes for a demyelinating neuropathy including POEMS syndrome, osteosclerotic myeloma, and diabetic and nondiabetic lumbosacral radiculoplexus neuropathy; peripheral nervous system lymphoma and amyloidosis may occasionally have demyelinating features
   d. Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment
   e. Documentation of failure to respond to glucocorticoids (oral or injectable) or reason(s) why glucocorticoids cannot be used such as but not limited to:
      - Contraindication
      - Severe disability
      - Pure motor phenotype
      - Fast progressive disease

3) Dermatomyositis/Polymyositis, severe, life-threatening or refractory:
   a. Confirmation of diagnosis with at least one of the following:
      i. Cutaneous manifestations (e.g. Heliotrope, Gottron's sign, erythema on extremity joints)
      ii. Muscle biopsy
      iii. Skin biopsy
      iv. Electrocardiogram
      v. European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) criteria or Bohan and Peter criteria AND
   b. Confirmation of diagnosis with at least 4 of the following:
      i. Symmetrical muscle weakness in the shoulders/upper arms or hips/upper legs and trunk
      ii. Elevation of serum levels of skeletal muscle-associated enzymes: CK, aldolase, lactate dehydrogenase (LD or LDH), transaminases (ALT/SGPT and AST/SGOT)
      iii. Muscle pain on grasping or spontaneous pain
      iv. The triad of muscle-related changes on EMG:
         - Short, small, low-amplitude poly-phasic motor unit potentials
         - Fibrillation potentials, even at rest
         - Bizarre high-frequency repetitive discharges
      v. Positive for any of the myositis-specific autoantibodies

vi. Nondestructive arthritis or arthralgia
vii. Signs of systemic inflammation
viii. Muscle biopsy findings compatible with inflammatory myositis

c. Documentation of failure to respond to or contraindicated to:
i. Glucocorticoids after an appropriate trial (≥ 3 months)
ii. Glucocorticoids plus methotrexate or azathioprine after an appropriate trial AND
iii. Rituximab (Rituxan™)

4) Hypogammaglobulinemia, prophylaxis against bacterial infection:
a. Documentation to confirm:
i. Decrease of IgG (at least 2 SD below the mean for age)
ii. Decrease in at least one of the isotypes IgM or IgA
iii. Onset of immunodeficiency ≥ 4 years of age
iv. Absent isohemagglutinins (A and B blood group antigens) and/or poor response to vaccines
v. History of recurrent bacterial and/or viral infections
vi. Other causes of hypogammaglobulinemia have been excluded
b. Treatment plan with anticipated:
i. Dose
ii. Frequency
iii. Transition to subcutaneous treatment, if started treatment with intravenous administration

5) Acute Immune thrombocytopenic purpura (ITP):
a. Clinic notes must confirm low platelet count is due to ITP vs other causes such as malignancy or bone marrow failure, AND
b. One or more of the following:
i. Documentation of inadequate response to treatment course with an oral glucocorticoid (dexamethasone, or prednisone), contraindication or intolerance OR
ii. Severe bleeding symptoms OR
iii. Planned surgery or invasive procedure OR
iv. Platelets count between 30,000/microL-50,000/microL in patients ≥18 yrs with one additional high risk factor for bleeding (i.e. peptic ulcer, use of anticoagulants, high risk of falling or chronic Hep. C associated thrombocytopenia OR
v. Current lab report showing platelet count <30,000/microL, for ages <18 yrs OR <20,000/microL, for ages ≥18 yrs:
- With at least one risk factor, such as but not limited to:
  - Use of antiplatelet medication or anticoagulation medication
  - Bleeding disorder (e.g. von Willebrand disease)
  - Active lifestyle subject to frequent trauma
  - Close monitoring or medical care is limited
  - Urgent surgery
  - Head trauma

6) Kawasaki syndrome:
a. Age ≤5 years
b. Fever of unknown origin or cause ≥ 5 days
c. Lab report with:
i. C-reactive protein (CRP)test < 3 mg/dL AND Erythrocyte sedimentation rate (ESR) <40 mm/hr OR
ii. CRP ≥3 mg/dL AND/OR ESR ≥40 mm/hr
d. Positive echocardiogram:
i. Z-score of the left anterior descending coronary artery or right coronary artery is ≥2.5, a coronary artery aneurysm is observed

Requirements for Immunoglobulin (Human) Products (IVIG, IMIG, SCIG)

OR

ii. ≥3 other suggestive features exist including decreased left ventricular function, mitral regurgitation, pericardial effusion

OR

iii. Z-scores in the left anterior descending coronary artery or right coronary artery of 2 to 2.5.

7) Multifocal motor neuropathy (MMN):
   a. Confirmation of diagnosis based on the European Academy of Neurology (EAN/PNS) guidelines
   b. Exclusion criteria are the following:
      - Upper motor neuron signs
      - Marked bulbar involvement
      - Sensory impairment more marked than minor vibration loss in the lower limbs
      - Diffuse symmetric weakness during the initial weeks
   c. Rasch disability scale for MMN (MMN-RODS(C)) prior to treatment.

Accepted Off-Label use with high level of evidence and/or used in current standards and practices:

8) Guillain-Barre syndrome (GBS):
   a. Clinic notes documenting confirmation of diagnosis, such as but not limited to:
      - Loss of deep tendon reflexes
      - Symmetrical weakness
      - Pain, numbness, tingling in feet
      - Cerebrospinal fluid analysis (more protein observed and few WBC)
      - Electrodiagnostic studies to indicate abnormalities consistent with GBS
      - Dysautonomia
   b. GBS disability score between 3-5 or rapid progression

9) Antibody mediated rejection (AMR), heart, kidney or lung transplant treatment:
   a. See criteria above, listed in the section ”Requirements for all indications”

10) Pemphigus foliaceus and vulgaris, refractory:
   a. Documentation of failure to both (i and ii):
      i. Glucocorticoids with an immunosuppressant (i.e. azithromycin, mycophenolate, cyclophosphamide, dapsone, methotrexate).
      ii. Glucocorticoids with rituximab

11) Toxic Shock Syndrome, streptococcal:
   a. Documentation indicating complications associated with toxic shock syndrome due to invasive group A streptococcus pyogenes (GAS) streptococcal toxic shock syndrome.

12) Myasthenia gravis (acute exacerbation):
   a. Documentation indicating treatment required for:
      i. Myasthenia gravis crisis
      ii. Preoperatively
      iii. Bridge therapy while transitioning to slower onset corticosteroid sparing immunotherapy

Age Restriction	Per FDA package labeling for each product

Requirements for Immunoglobulin (Human) Products (IVIG, IMIG, SCIG)

Prescriber Restriction	Prescribed by an appropriate specialist (disease state under treatment is within the standard scope of the specialty), or by a PCP with appropriate specialist's consultations & recommendation.
Coverage Duration	Dependent upon the indication submitted
Other Requirements & Information Needed for Continuation of Care	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.* 1) CDIP: a. Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment. i. If symptoms do not improve or continue to progress after an initial two-to-three-month treatment trial, the patient should be reevaluated to verify the diagnosis of CIDP. 2) Hypogammaglobulinemia, prophylaxis against bacterial infection: a. Treatment plan, including expected timeframe for transition from intravenous (IV) to subcutaneous (SC). b. If IV route is to be ongoing without transition to SC, please provide the reason(s) why SC formulations cannot be used. 3) MMN: a. Current Rasch disability scale for MMN (MMN-RODS(C)) prior to renewal request. <u>ITP Renewals</u>: Standard is usually 1-2 treatments, and if no response, alternatives should be considered. Documentation of ongoing moderate or severe bleeding symptoms with persistent platelet count <20,000/microL is required for consideration of additional treatment with IgG. <u>Guillain-Barré Renewals</u>: Limited to a single treatment (standard of care) except when extenuating circumstances are submitted which indicate an additional treatment is medically necessary. Requesting a second treatment for treatment-related fluctuation: clinical documentation must be submitted to indicate very severely affected patient with no improvement or further deterioration at 2 weeks since initial treatment.

Requirements for Immunoglobulin (Human) Products (IVIG, IMIG, SCIG)

Medical Billing:

A) Accepted HCPCS codes (with an approved TAR):

Product	HCPCS	HCPCS Description
Intravenous Infusion		
Asceniv	J1554	Injection, immune globulin (asceniv), 500 mg
Bivigam	J1556	Injection, immune globulin (bivigam), 500 mg
Flebogamma; Flebogamma DIF	J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg
Gammagard S/D; Carimune NF	J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
Gammaplex	J1557	Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
Octagam	J1568	Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg
Panzyga	J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
Privigen	J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
Either Intravenous or Subcutaneous Infusion, depending on diagnosis for use		
Gammagard	J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg • IV or SC: Primary Immunodeficiency • IV only: All other indications
Gammaked; Gamunex-C	J1561	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg • IV or SC: Primary Immunodeficiency • IV only: All other indications
Intramuscular Injection		
GamaSTAN S/D	J1460	Injection, gamma globulin, intramuscular, per 1 cc
	J1560	Injection, gamma globulin, intramuscular, per 10 cc
Subcutaneous Infusion		
Cutaquig	J1551	Injection, immune globulin (cutaquig), 100 mg
Cuvitru	J1555	Injection, immune globulin (cuvitru), 100 mg
Hizentra	J1559	Injection, immune globulin (hizentra), 100 mg
Hyqvia	J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin
Xembify	J1558	Injection, immune globulin (xembify), 100 mg

B) General dosing information, by indication – a compilation from the drug monographs available through Wolters Kluwer Facts & Comparisons®

Indication	Dosing
FDA Approved Indications	
Antiviral prophylaxis	Dosing and frequency determined by wt (kg), type (Hepatitis A, measles, varicella) and time of potential exposure, current IVIG products used to treat the patient.
Chronic inflammatory demyelinating polyneuropathy	Initial: 2 g/kg IV divided in doses over 2-5 days or 400 mg/kg IV once a day for 5 days (max daily dose of 1 g/kg). Maintenance: 1 g/kg IV divided over 1-2 days every 3 weeks. Transitioning to SC: Start 1 week after last IVIG infusion, at 200 mg/kg – 400 mg/kg per week, over 1-2 sessions over 1 to 2 days.

Requirements for Immunoglobulin (Human) Products (IVIG, IMIG, SCIG)

Indication	Dosing
FDA Approved Indications, continued	
Dermatomyositis/polymyositis, severe, life threatening or refractory	1 g/kg per day IV x 2 days every 4 weeks or 1 g/kg per day once every 2 weeks
Hypogammaglobulinemia prophylaxis against bacterial infection	Acquired secondary to malignancy: 200 mg/kg – 400 mg/kg IV once every 3-4 weeks Primary humoral immunodeficiency disorder: 200 mg/kg – 800 mg/kg IV once every 3-4 weeks
Immune thrombocytopenia	≥ 18 yrs: 1 g/kg IV once a day for 1 -2 days, may hold second dose with adequate platelet response (eg, plt > 50,000 mm^3) after 24 hrs or 400 mg/kg IV daily x 5 days 2-17 yrs: Dose is dependent on product used for treatment, age, wt (kg) and dosing frequency chosen for acute or chronic treatment.
Kawasaki Syndrome	Infants and children (specific age range in not referenced): 2000 mg/kg IV over 8-12 hr, given within 10 days of disease onset. If signs and symptoms persist ≥ 36 hrs, 1000 mg/kg – 2000 mg/kg may be considered.
Multifocal motor neuropathy	Initial dosing: 2 g/kg IV divided over 2-5 consecutive days or 400 mg/kg IV once a day x 5 days (max daily dose: 1 g/kg) and maintenance dose of 1 g/kg – 2 g/kg every 2-6 weeks or if high dose was tolerated dosing 1 g/kg IV once daily x 2 days can be considered.
Off-Label Indications	
Pemphigus foliaceus and vulgaris, refractory	2 g/kg IV given in divided doses over 2-5 days or 400 mg/kg IV once a day x 5 days. May repeat every 4-6 weeks based on clinical response.
Guillain-Barré syndrome	Start treatment within 4 weeks of symptoms. 400 mg/kg IV x 5 days only. Retreatment is not recommended.
Myasthenia gravis, acute exacerbation	2 g/kg IV administered in divided doses given over 2-5 consecutive days or 400 mg/kg IV once a day x 5 days or 1 g/kg IV once a day for 2 days.
Toxic shock syndrome, streptococcal (adjunctive agent)	1 g/kg IV on day 1, followed by 500 mg/kg IV once daily on days 2 and 3
	Heart transplantation: 2 g/kg IV divided in 2-4 doses, given on consecutive days. If plasmapheresis is utilized, give 100 mg/kg IV after each session. This regimen may be repeated monthly if needed. Kidney transplantation: <1 year after transplant: 1 g/kg – 2.4 g/kg IV in divided doses over 1-3 consecutive days (max daily dose of 1 g/kg). If plasmapheresis is utilized, give 100 mg/kg IV after each session and remaining total dose after final session over 1-2 days. >1 year after transplant: 200 mg/kg IV every 2 weeks for 3 doses Lung transplant: 500 mg.kg – 2 g/kg IV (doses >1 g/kg are usually divided into 2 doses given over 2 days) and may be repeated monthly if needed.

Eureka | Fairfield | Redding | Santa Rosa
(707) 863-4100 www.partnershiphp.org

Requirements for Aducanumab-avwa (Aduhelm™)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care on the TAR request, if member is not new to treatment.

<table>
<tr><th>PA Criteria</th><th>Criteria Details</th></tr>
<tr><td>Covered Uses</td><td>For the treatment of confirmed Alzheimer's disease (AD) with mild cognitive impairment or mild dementia stage of disease.</td></tr>
<tr><td>Exclusion Criteria</td><td>Members with AD having advanced beyond mild stage.</td></tr>
<tr><td>Required Medical Information</td><td>See next page</td></tr>
<tr><td>Age Restriction</td><td>50 years and older.
Members under 50 years old with early onset Alzheimer’s disease (AD) and have met all criteria will be reviewed on a case-by-case basis.</td></tr>
<tr><td>Prescriber Restriction</td><td>Neurologist, geriatrician, psychiatrist</td></tr>
<tr><td>Coverage Duration</td><td><u>Initial titration, 1st 4 doses:</u> 4 months’ duration
<u>First renewal (continued titration, doses 5 & 6:</u> 2 months’ duration w/MRI results prior to dose 5 included.
<u>Additional renewals, 7th dose and beyond:</u> 6 months’ duration, with MRI prior to dose 7 and 12 included with renewals.</td></tr>
<tr><td>Other Criteria</td><td><u>Medical billing information:</u> An approved TAR is required.
<table>
<tr><th>HCPCS</th><th>Description</th><th>Billed as</th></tr>
<tr><td>J0172</td><td>Injection, Aducanumab-avwa, 2 mg</td><td>1 HCPCS unit for every 2 MG administered.
Example: 80 kg patient weight, initial dose of 1 mg/kg is an 80 mg dose.
80 mg/dose x 1 unit/2 mg=40 units billed for this dose.</td></tr>
</table>
<table>
<tr><th>Indication</th><th>Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td>Alzheimer’s disease, mild</td><td>Treatment should be titrated upward as shown below:
<table>
<tr><td>IV infusion, every 4 weeks</td><td>Dosage</td></tr>
<tr><td>Infusion 1 & 2</td><td>1 mg/kg</td></tr>
<tr><td>Infusion 3 & 4</td><td>3 mg/kg</td></tr>
<tr><td>Infusion 5 & 6</td><td>6 mg/kg</td></tr>
<tr><td>Infusion 7 & beyond</td><td>10mg mg/kg</td></tr>
</table></td><td>10 mg/kg every 21 days</td></tr>
</table>
DHCS statement:
Under the terms of the NCD, since Aduhelm is not covered by Medicare Part B, CMS considers it a Medicare Part D drug. Since Medicaid does not pay for Part D drugs for full-benefit dually eligible enrollees, regardless of Medicare Part D enrollment status, Medi-Cal will not cover Aduhelm for patients with Medicare-Medicaid coverage (dually eligible enrollees). Medicare-Medi-Cal dual-eligible enrollees are required to obtain the medication via their Medicare benefit by enrolling in clinical trials.
https://files.medi-cal.ca.gov/pubsdoco/aduhelm_faq.aspx</td></tr>
</table>

Requirements for Aducanumab-avwa (Aduhelm™)

PA Criteria	Criteria Details – Required Medical Information (continued from first page)

Required Medical Information	Initial Approval Criteria (Must meet all):
	• Specialist's clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness)
	• Documentation supporting and/or medical justification why Aduhelm is preferred over Leqembi.
	• Documentation of diagnostic workup which demonstrates other causes of cognitive impairment have been excluded such as::
	  ○ Parkinson's disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD).
	  ○ Specific alternative neurodegenerative disease or causative factors (e.g., cerebrovascular disease, cobalamin [Vitamin B12] deficiency, syphilis, thyroid disease, head trauma, normal pressure hydrocephalus)
	• The patient must have a diagnosis of mild cognitive impairment (MCI) due to AD or mild AD demonstrated by all of the following validated scales
	  ○ Clinical Dementia Rating (CDR-GS)-Global Score of 0.5
	  ○ Mini-Mental Examination Status (MMSE) score of 24-30
	  ○ Montreal Cognitive Assessment (MoCA) score of ≥16
	• Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following:
	  ○ Amyloid PET
	  ○ Lumbar puncture: CSF assessment positive for amyloid beta plaque
	• ALL of the following MUST be documented:
	  ○ Member is NOT currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less for prophylactic)
	  ○ Member must NOT have brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities
	  ○ Member must NOT have history of transient ischemic attack (TIA), stroke or unexplained loss of consciousness within the previous year
	  ○ Member must NOT have history of depression and/or clinically unstable psychiatric illness in the past 12 months
	  ○ Member must NOT have history of alcohol or substance abuse in the past 12 months
	• Member must NOT have history of unstable angina, myocardial infarction, advanced chronic heart failure or clinically significant conduction abnormalities within the past year
	• Member must NOT have contraindications to MRI or PET scans
	• If member is receiving an approved AD treatment such as an acetylcholinesterase inhibitor (AChEI) or memantine or both, must be on a stable dose for at least 12 weeks prior to Leqembi treatment initiation
	• TAR must include baseline brain magnetic resonance imaging (MRI) dated within 12 months prior to request and MRI must documents all of the following:
	  ○ No localized superficial siderosis
	  ○ Less than 10 brain micro-hemorrhages
	  ○ No brain hemorrhage greater than 1 cm within the past year
	• Member's weight must be included
	• The requested dose and frequency must be in accordance with FDA-approved labeling and must not exceed dosing guidelines

Requirements for Aducanumab-avwa (Aduhelm™)

	Renewal during the 1st six months', treatment titration phase: • Must meet ALL: o Member continues to meet the above criteria o Include all MRI reports from scans completed after treatment initiation. o Member has not had adverse effects/toxicity from the drug such as amyloid related imaging abnormalities ARIA: ARIA-edema (ARIA-E), ARIA-hemosiderin deposition (ARIA-H), ARIA-H superficial siderosis. o Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤0.5, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score ≥24. Additional Renewals (dose 7 and onward): • Must meet ALL: o Provider's attestation that the potential benefit outweighs known risks o Prior to the 7th and 12th infusions, documentation of recent brain MRI showing one of the following: i) Less than 10 new incident micro-hemorrhages ii) ≤ 2 focal areas of superficial siderosis iii) Radiographic stabilization since baseline (i.e., no increase in size or number of ARIA-H) o If radiographic severe ARIA-H is observed, treatment may be continued with caution only after a clinical evaluation and a follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H) o Doses may not exceed the recommended dosage per product labeling

Requirements for Lecanemab-irmb (Leqembi™)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	For the treatment of Alzheimer's Disease (AD) in patients with mild cognitive impairment or mild dementia stage of disease.
Exclusion Criteria	Members with AD having advanced beyond mild stage.

Required Medical Information	<u>Initial Approval Criteria (Must meet all):</u>
	• Specialist's clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness)
	• Documentation of diagnostic workup which demonstrates other causes of dementia have been ruled out, such as:
	  ○ Parkinson's disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD)
	  ○ Specific alternative neurodegenerative disease or causative factors such as cobalamin (Vitamin B12) deficiency, Niacin (Vitamin B3) deficiency, meningitis and encephalitis infections, thyroid disease, head trauma, normal-pressure hydrocephalus.
	• Confirmed diagnosis of Mild Cognitive Impairment (MCI) due to Alzheimer's Disease (AD) or mild AD dementia and must have:
	  ○ Clinical Dementia Rating (CDR)-Global Score of 0.5
	  ○ Mini-Mental Examination Status (MMSE) score of 24–30
	  ○ Montreal Cognitive Assessment (MoCA) score of ≥16
	• Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following:
	  ○ Amyloid PET
	  ○ Lumbar puncture: CSF assessment positive for amyloid beta plaque.
	• Must provide baseline brain magnetic resonance imaging (MRI) dated within 12 months prior to request and MRI must document all of the following:
	  ○ Less than 4 brain micro-hemorrhages
	  ○ No prior brain hemorrhage greater than 1cm within the past year
	  ○ No localized superficial siderosis
	  ○ No evidence of acute/subacute cerebral contusion, aneurysms, vascular malformations, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory.
	  ○ No evidence of vasogenic edema or brain tumors
	  ○ No severe small vessel, or white matter disease
	• ALL of the following MUST be documented:
	  ○ Member does NOT have a history of cerebrovascular abnormalities or bleeding disorder that would present a risk for ARIA-related bleeding
	  ○ Member does NOT have history of transient ischemic attack (TIA), stroke or seizures within the previous year of screening.
	  ○ Member does NOT have untreated bleeding disorder (platelet count <50,000 or INR>1.5)
	  ○ Member must NOT have contraindications to MRI or PET scans
	  ○ Member does NOT have history of depression and/or clinically unstable psychiatric illness in the past 12 months
	  ○ Member does NOT have a history of alcohol or substance abuse in the past 12 months

Requirements for Lecanemab-irmb (Leqembi™)

	• If member is receiving an approved AD treatment such as an acetylcholinesterase inhibitor (AChEI) or memantine or both, must be on a stable dose for at least 12 weeks prior to Leqembi treatment initiation • Member weight must be included. • The requested dose and frequency must be in accordance with FDA-approved labeling and must not exceed dosing guidelines
Age Restriction	50 to 85 years old. Member under 50 years old with early onset Alzheimer's disease (AD) and met all criteria will be reviewed on a case-by-case basis.
Prescriber Restriction	Neurologist, geriatrician, psychiatrist.
Coverage Duration	Initial, doses 1-4: 2 months' duration (up to 4 doses of infusion) First Renewals, doses 5-12: 4 months' duration (up to 8 doses of infusion) Additional Renewals, dose 13 and later: 6 months' duration (up to 2 doses/month). Treatment duration beyond 18 months will be reviewed on a case-by-case basis.

Other Requirements & Information Needed for Continuation of Care	First Renewal, must meet ALL:
	• Member continues to meet the indication-specific criteria identified in Required Medical Information initial criteria section AND
	• Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤0.5, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score ≥24.
	• Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 5th and 7th infusion.
	• Absence of amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 5th and 7th infusions as determined by brain MRI.
	• Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, anticoagulants).
	Additional Renewals (dose 13 and later), must meet ALL:
	• Provider's attestation that the potential benefit outweighs known risks as evidence by one of the following:
	  ○ A reduction in amyloid beta plaque buildup compared from baseline in PET imaging of brain.
	  ○ A slowing/reducing cognitive decline from baseline in CDR-SB score or MMSE score.
	• Member has not progressed to moderate or severe AD with continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤0.5, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score ≥24
	• Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 14th infusion.
	• Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, or anticoagulants).
	• Member must continue maintenance therapy at the recommended dosage per product labeling

Requirements for Lecanemab-irmb (Leqembi™)

Medical Billing:
Dose limits & billing requirements (approved TAR is required)

HCPCS	Description	Billed as
J3490 (NOC) or J3590 (NOC)	Unclassified drugs or Unclassified biologics	Injection: NDC 62856-0215-01: 500 mg/5 mL (100 mg/mL) in a single-dose vial NDC 62856-0212-01: 200 mg/2 mL (100 mg/mL) in a single-dose vial PHC reimbursement is the contracted rate (such as AWP +/-) *per vial* (1 vial = 1 unit of service, 2 vials = 2 units of service), until CMS issues a specific code for Leqembi™.

Dosing
10 mg/kg (up to 1,200 mg) once every 2 weeks, administered as an intravenous infusion over approximately one hour, once every two weeks. Maximum dose: 1,200 mg every 14 days

DHCS statement:

Under the terms of the NCD, since Aduhelm is not covered by Medicare Part B, CMS considers it a Medicare Part D drug. Since Medicaid does not pay for Part D drugs for full-benefit dually eligible enrollees, regardless of Medicare Part D enrollment status, Medi-Cal will not cover Aduhelm for patients with Medicare-Medicaid coverage (dually eligible enrollees). Medicare-Medi-Cal dual-eligible enrollees are required to obtain the medication via their Medicare benefit by enrolling in clinical trials.

https://files.medi-cal.ca.gov/pubsdoco/aduhelm_faq.aspx

Requirements for Etranacogene Dezaparvovec-drlb (Hemgenix™)

PA Criteria	Criteria Details
Covered Uses	Treatment of adults with hemophilia B (congenital FIX deficiency) who: • Currently use FIX prophylaxis therapy, or • Have current or historical life-threatening hemorrhage, or • Have repeated, serious spontaneous bleeding episodes
Exclusion Criteria	1) Treatment or use for anything other than hemophilia B 2) Positive Factor IX inhibitor titer test 3) Previous gene therapy treatment with etranacogene dezaparvovec-drlb (Hemgenix™)
Required Medical Information	Clinic notes to confirm moderately severe or severe congenital hemophilia B along with baseline Factor IX level of ≤ 2% of normal: 1) One of the following: a. Current need for routine FIX prophylaxis therapy for ≥ 2 months with >150 previous exposure days of treatment with factor IX protein b. Historical life-threatening hemorrhage with required need for Factor IX therapy c. Have repeated, serious spontaneous bleeding episodes with required need for Factor IX therapy 2) Factor IX inhibitor titer test to confirm a negative results in the past 30 days 3) Current (within the past 30 days) labs to confirm adequate hepatic function 4) Current Hepatitis B AND Hepatitis C status 5) If HIV positive, current (within the past 30 days) CD4 cell level lab results (≥ 500 cell/microL) with anti-viral therapy.
Age Restriction	18 years and older
Prescriber Restriction	Hematologist
Coverage Duration	Once per lifetime
Other Requirements & Information	Allowed for once in a lifetime treatment. There will be no renewals or retreatment requests approved. *Note: Awareness of potential for hepatotoxicity and hepatocellular carcinoma is important when considering this treatment. Screening for hepatic impairment prior to starting treatment and continued monitoring of liver function for a minimum of 3 months is recommended after administration of etranacogene dezaparvovec-drlb (Hemgenix™).*

Medical Billing:

Dose limits & billing requirements (approved TAR is required)

HCPCS	Description	Dosing, Units
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	2 x 1013 genome copies per kg (equivalent to 2 ml/kg) IV as a single one-time dose.

Requirements for Betibeglogene Autotemcel (Zynteglo™)

PA Criteria	Criteria Details
Covered Uses	Treatment of beta thalassemia in adult and pediatric patients who require regular red blood cell transfusions and for whom hematopoietic stem cell (HSC) transplantation is appropriate but a human leukocyte antigen (HLA)-matched related HSC donor is not available
Exclusion Criteria	• Requests for treatment of indications other than beta thalassemia • Prior therapy with betibeglogene autotemcel (Zynteglo™) • HIV positive
Required Medical Information	Documentation that all conditions have been meet: 1) Genetic testing to confirm beta thalassemia with: a. History of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs) OR b. 8 or more transfusions of pRBCs per year in the past 2 years 2) Confirmation that allogeneic hematopoietic stem cell transplantation is appropriate but a human leukocyte antigen (HLA) matched donor or HSC donor (related or non-related) is not available. 3) Confirmation that hematopoietic stem cell (HSC) transplantation is appropriate for the patient with no evidence of: a. Liver impairment severe hepatic fibrosis or cirrhosis b. Renal impairment with CrCl ≤ 70 ml/min/1.73m^2 c. Cardiomyopathy or severe congestive heart failure (NYHA class III or IV) d. Hypersplenism e. Screening to confirm negative results for: i. Human immunodeficiency virus HIV-1 and HIV-2 ii. Hepatitis B virus (HBV) and hepatitis C virus (HCV) or negative viral load, if previously exposed iii. Human T-lymphotrophic virus 1 & 2 (HTLV-1/HTLV-2) iv. Severely elevated iron in the heart (i.e., patients with cardiac T2* value less than 10 msec by magnetic resonance imaging [MRI]) v. Lupus anticoagulant 4) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Granulocyte-colony stimulating factor (G-CSF, TAR required) b. Plerixafor (Mozobil™, TAR required), for mobilization c. Busulfan (TAR required), for myeloablative conditioning
Age Restriction	4 years and older
Prescriber Restriction	Hematologist
Coverage Duration	Once per lifetime
Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

Requirements for Betibeglogene Autotemcel (Zynteglo™)

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J3590 (although PHC inpatient hospital billing does not generally utilize HCPCS codes)	Intravenous injection, betibeglogene, per dose (Zynteglo™)	Minimum recommended dose: 5 × 106 CD34+ cells/kg

Currently in California, there is only one designated treatment center – UCSF Benioff Children's Hospital Oakland.