

Field Name	Field Description
Prior Authorization Group Description	Specialty Drugs for Ulcerative Colitis
Drugs	<p><u>Preferred Agents:</u> Infliximab</p> <p><u>Non-Preferred Agents:</u> Avsola (infliximab-axxq) Remicade (infliximab) Renflexis (infliximab-abda) Inflectra (infliximab-dyyb) Entyvio (vedolizumab) Stelara IV (ustekinumab) Or any newly marketed agent</p>
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist
Coverage Duration	If all of the conditions are met, the request will be approved for 12 month duration.
Other Criteria	<p>Initial Authorization:</p> <ol style="list-style-type: none"> 1. The member has a diagnosis of moderate to severely active ulcerative colitis 2. The medication is being prescribed at an appropriate FDA approved dose (for age and weight) 3. The member has had a an adequate trial of, or a documented medical reason (e.g. allergy, intolerance, contraindication) for not using, at least one conventional therapy (e.g. sulfasalazine, azathioprine, mesalamine, 6-mercaptopurine, budesonide MMX (Uceris), or oral corticosteroids) 4. If the request is for a non-preferred agent, documented adequate trial of the preferred agent. <p>Reauthorization:</p>

<p>Revision/Review Date 8/2023</p>	<ol style="list-style-type: none">1. The medication is being recommended or prescribed by a gastroenterologist for an FDA-approved indication at an FDA-approved dosage.2. The member has been receiving the medication and documentation was provided that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit). <p>Continuation of Therapy:</p> <ul style="list-style-type: none">• Members with history (within the past 90 days) of a non-preferred agent are not required to try a preferred agent or the above mentioned conventional therapies prior to receiving the non-preferred agent.• Members with history (within the past 90 days) of a preferred agent are not required to try the above mentioned conventional therapies prior to receiving the preferred agent <p>Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.</p>
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