

MSQ4.2 - Utilization Management Criteria Structure

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Utilization Management Algorithm Examples

The examples below demonstrate different types of question flow logic, or algorithms that are utilized in our current State clients.

Algorithm Example #1

Ubrelvy

1. Is the medication being prescribed by or in consultation with a neurologist, headache specialist or pain specialist?
If YES = Go to next question. If NO = DENY and refer to RPH.
2. Is this an initial or reauthorization request?
If initial = Go to next question. If reauthorization = Go to question 8.
3. What is the member's diagnosis?
If acute treatment of migraine = Go to next question. If preventive (prophylaxis) treatment of migraine or other diagnosis = DENY and refer to RPH.
4. What is the member's age?
If 18 years or older = Go to next question. If less than 18 = DENY and refer to RPH.
5. Has the member tried and failed to achieve an adequate response with at least 2 triptans?
<i>Triptans may include but not limited to rizatriptan, sumatriptan, almotriptan, eletriptan, frovatriptan, naratriptan and zolmitriptan.</i>
If YES = Go to question 7. If NO = Go to next question.
6. Does the member have allergies, contraindications, drug-drug interactions or intolerable side effects to triptans?
If YES = Go to next question.

If NO = DENY and refer to RPH.

7. Will the requested medication be taken in combination with a strong CYP3A4 inhibitor or strong CYP3A4 inducer?

Strong CYP 3A4 inhibitors may include but not limited to ketoconazole, itraconazole, clarithromycin. Strong CYP 3A4 inducers may include but not limited to phenytoin, barbiturates, rifampin, St. John's Wort.

If YES = DENY and refer to RPH.

If NO = APPROVE for 6 months.

8. Is the member experiencing clinical improvement in acute migraine (such as ability to function normally within 2 hours of dose, headache pain disappears within 2 hours of dose or therapy works consistently in majority of migraine attacks)?

If YES = APPROVE for 1 year.

If NO = DENY and refer to RPH.

1 . Criteria

Product Name: Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming diagnosis of progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3 confirmed by one of the following: Diagnostic test (e.g., liver function test, liver ultrasound and biopsy, bile analysis)	

- Genetic Testing

AND

2 - Patient is experiencing both of the following:

- Moderate to severe pruritus
- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

3 - Patient is 3 months of age or older

AND

4 - Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

5 - Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg

AND

6 - Prescribed by or in consultation with a hepatologist or gastroenterologist

Product Name: Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	12 Months

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., reduced serum bile acids, improved pruritus) AND 2 - Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg	

Product Name: Bylvay	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Submission of medical records (e.g., chart notes) confirming both of the following: 1.1 Diagnosis of Alagille Syndrome (ALGS) AND 1.2 Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene AND 2 - Patient is experiencing both of the following: Moderate to severe pruritus	

- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

3 - Patient is 12 months of age or older

AND

4 - Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

5 - Prescribed by or in consultation with a hepatologist or gastroenterologist

Product Name: Bylvay	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 Months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria 1 - Documentation of positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score)	