Premier Health Plan

POLICY AND PROCEDURE

POLICY NUMBER: *RX.PA.173.E*
REVISION DATE: *05/13*

POLICY TITLE: ***5-Aminosalicylic Acid Derivative Step***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***September 2011 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: *February 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO	[ ] PPO	*Products*: [ ] Small [ ] Indiv. [ ] Large	*Exchange*: [ ] Shop [ ] Indiv.	[x] All
OTHER	[x] Self-funded/ASO				

PURPOSE

The purpose of this policy is to define the prior authorization process for Lialda (mesalamine) and Dipentum (olsalazine).

Lialda (Mesalamine) is a locally-acting 5-aminosalicylic acid medication indicated for induction of remission in patients with active, mild to moderate ulcerative colitis and for the maintenance of remission of ulcerative colitis.

Dipentum (Olsalazine) is a 5-aminosalicylic acid derivative indicated for the maintenance of remission of ulcerative colitis in patients who are intolerant of sulfasalazine.

DEFINITIONS

N/A

POLICY

evolent HEALTH

Proprietary and Confidential Information of Evolent Health LLC
© 2016 Evolent Health LLC All Rights Reserved

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drugs, Lialda (mesalamine) and Dipentum (olsalazine), are subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed under the respective header:

1. **Automatic coverage:**
   - Must have a documented pharmacy claim history of prior therapy with balsalazide (generic Colazal), Apriso, Asacol, Asacol HD, or Delzico

2. **Member without claims history:**
   - Must have documentation indicating that the member has failed or had intolerance to balsalazide, Apriso, Asacol, Asacol HD, or Delzicol

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to duration of member's membership with plan
Reauthorization	N/A

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Apriso [package insert]. Morrisville, NC: Salix Pharmaceuticals, Inc; July 2009.
2. Asacol [package insert]. Rockaway, NJ: Warner Chilcott (US), LLC; January 2011.
3. Colazal [package insert]. Morrisville, NC: Salix Pharmaceuticals, Inc; 2000.
4. Lialda [package insert]. Wayne, PA: Shire US, Inc; July2011.
5. Delzicol [package insert]. Rockaway , NG: Warner Chilcott (US), LLC; February 2013.
6. Dipentum [package insert]. Stockholm, Sweden: Pharmacia AB; November 2011.

Proprietary and Confidential Information of Evolent Health LLC
© 2016 Evolent Health LLC All Rights Reserved

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/17, 02/18*

Proprietary and Confidential Information of Evolent Health LLC
© 2016 Evolent Health LLC All Rights Reserved