

Non-preferred Pancreatic Enzyme Replacement Drug Step

POLICY NUMBER: RX.PA.240.E

REVISION DATE: N/A

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Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The non-preferred Pancreatic Enzyme Replacement Drugs 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 Creon

2. Members without a documented claims history:

- Must have documentation indicating that the member has failed or has an intolerance or contraindication to Creon

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. Creon [prescribing information]. Marietta, GA: Solvay Pharmaceuticals, Inc.; April 2009.
2. Pancreaze® [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; November 2013.
3. Pertzye® [prescribing information]. Bethlehem, PA: Digestive Care, Inc.; May 2012.
4. Ultresa® [prescribing information]. Bridgewater, NJ: Aptalis Pharma US, Inc.; September 2014.
5. Viokace® [prescribing information]. Mont-St-Hilaire, PQ, Canada: Aptalis Pharma Canada, Inc. February 2012.
6. Zenpep® [prescribing information]. Bridgewater, NJ: Aptalis Pharma US, Inc.; September 2014.

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.



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REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
<i>Annual review</i>	<i>02/17, 02/18</i>

