

POLICY AND PROCEDURE

POLICY NUMBER: *RX.PA.241.E*

REVISION DATE: *N/A*

PAGE NUMBER: 1 of 3

POLICY TITLE: *Cuvposa (glycopyrrolate oral solution)*
DEPARTMENT: *Clinical Pharmacy Services- Utilization Management*
ORIGINAL DATE: *November 2014 (as adopted from UPMC Health Plan)*

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

Product Applicability: *mark all applicable products below:*

COMMERCIAL	<input type="checkbox"/> HMO <input type="checkbox"/> PPO Products: <input type="checkbox"/> Small Exchange: <input type="checkbox"/> Shop <input checked="" type="checkbox"/> All <input type="checkbox"/> Indiv. <input type="checkbox"/> Indiv. <input type="checkbox"/> Large
OTHER	<input checked="" type="checkbox"/> Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Cuvposa (glycopyrrolate oral solution).

Cuvposa (glycopyrrolate oral solution) is indicated to reduce chronic severe drooling in patients aged 3-16 years with neurologic conditions associated with problem drooling (e.g., cerebral palsy).

DEFINITIONS

N/A

POLICY

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 drug, Cuvposa (glycopyrrolate oral solution), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be age 3 to 16 years
- Must have a diagnosis of chronic severe drooling
- Must have a diagnosis of a neurologic condition that is associated with problem drooling (e.g. cerebral palsy)

Reauthorization Criteria:

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon chart documentation from the prescriber that the member's condition has improved based upon the prescriber's assessment while on therapy.

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial

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

REFERENCES

1. Cuvposa [prescribing information]. Atlanta, GA: Mikart; 2011

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.



Cuvposa (glycopyrrolate oral solution)

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REVIEW HISTORY

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

