MEDICATION COVERAGE POLICY

PHARMACY AND THERAPEUTICS ADVISORY COMMITTEE

POLICY	Chronic Bowel Disease	**P&T DATE**	5/14/2019
THERAPEUTIC CLASS	Gastrointestinal Disorders	**REVIEW HISTORY** (MONTH/YEAR)	2/18, 2/17, 2/16, 2/15, 2/13
LOB AFFECTED	Medi-Cal		

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the HPSJ Pharmacy and Therapeutic Advisory Committee.

❖ PART 1 INFLAMMATORY BOWEL DISEASE OVERVIEW

Inflammatory bowel disease (IBD) is the chronic inflammation of a part (Ulcerative Colitis) or of an entire (Crohn's Disease) digestive tract. Although the exact etiology of IBD is unknown, effective management of IBD and its symptoms help in improving a patient's quality of life. Health Plan of San Joaquin has adopted the treatment goals and recommendations of the most recent practice guidelines from the American College of Gastroenterology (ACG) and National Institute for Health and Care Excellence (NICE) in the management of Ulcerative Colitis and Crohn's Disease.[1,2] The below criteria, limits, and requirements for certain agents are in place to ensure appropriate use of those agents and to help members towards induction and maintenance of remission of symptoms.

IBD Non-Biologic Agents Formulary Positioning: *(Current as of 4/2019)*

Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Formulary Limits	Average Cost/Rx*	Notes
Oral Amino-salicylates	**Sulfasalazine (Azulfidine)** *Tablets*	IR: 500 mg	--	$20.94	
		DR: 500 mg		$30.47	
	Balsalazide (Colazol) *Capsules*	750 mg	--	$99.62	
	Mesalamine:				
	Apriso *Capsules*	ER: 0.375 mg	**PA; QL; FL**	$493.15	Treatment failure or intolerance to Balsalazide, Sulfasalazine, or Mesalamine enema for 3 months for induction or maintenance. Max 120 capsules per 30 days, 6 fills per 180 days.
	Delzicol *Capsules*	DR: 400 mg	**PA**	$678.26	Treatment failure or intolerance to Balsalazide, Sulfasalazine, or Mesalamine enema for 3 months for induction or maintenance.
	Pentasa *Capsules*	CR: 250 mg	**PA**	$557.45	Reserve for treatment failure or intolerance to Delzicol,or Apriso, for 3 months.
		CR: 500 mg		$1,017.29	
	Mesalamine (Lialda) *Tablets*	DR: 1.2 mg	**PA, QL**	$509.97	Reserve for treatment failure or intolerance to Delzicol,or Apriso, for 3 months. Max 120 tabs per 30 Days
	Mesalamine (Asacol HD) *Tablets*	DR: 800 mg	**PA; QL**	$575.18	Reserve for treatment failure or intolerance to Delzicol,or Apriso, for 3 months. Max 120 tabs per 30 Days
	Olsalazine (Dipentum) *Capsules*	250 mg	**NF**	--	Alternatives: sulfasalazine, balsalazide
Topical Amino-salicylates (Rowasa, Canasa)	**Mesalamine** *Enema Solution*	4 GM/60 ml	--	$250.78	
	Mesalamine *Suppository*	1000 mg	**PA**	--	Reserved for patients unable to administer mesalamine enema.
Cortico-steroids	**Prednisone (Deltasone)** *Tablets, Solution*	1 mg, 2.5 mg, 5 mg, 10 mg, 20 mg, 50 mg, 5mg/5ml	--	$6.76	

		5mg/ml	**NF**		Alternatives: Prednisone 5mg/5mL solution
	Budesonide:				
	Budesonide (Entocort)	Delayed release 3 mg capsules	**PA, QL, FL**	$402.68	Reserved for induction of remission in those intolerant to conventional glucocorticoids. Maximum of 3 months of induction therapy plus additional 1 month to taper off. 3 capsules of 3 mg per day dosing therefore update criteria for quantity to 90 capsules per month, 360 capsules per 365 days.
	Budesonide (Uceris)	Extended release 24-hour 9 mg tablets	**NF**	--	
	Budesonide (Uceris)	2 mg Rectal Foam	**NF**	--	
Immuno-modulators	**6-Mercaptopurine**	50 mg	--	$79.85	
	Azathioprine (Azasan, Imuran)	50 mg	--	$20.06	
		75 mg	NF	$484.07	Alternatives: Azathioprine 50 mg tablet
		100 mg	NF	--	

PA = Prior Authorization; ST = Step Therapy; NF = Non-Formulary; SP = Specialty Pharmacy; IR = Immediate Release; DR = Delayed Release; CR = Controlled Release; SR = Sustained Release * Based on pharmacy claims from 3/2018-2/2019 ^No claims, based on AWP price

Anti-inflammatory Biologic Agents in Crohn's Disease Formulary Positioning: *(Current as of 4/2019)*

Therapeutic Class	Generic Name (Brand Name)	Available Strengths	Form. Limits	Estimated Cost per Month*	Notes
Tumor Necrosis Factor-α Blockers	**Infliximab-dyyb (Inflectra), Infliximab-abda (Renflexis)**	100 mg	**PA, SP**	--	Reserved for treatment failure to adequate trial or oral immunosuppressive agents. Must be initiated by a gastroenterologist. Restricted to specialty pharmacy.
	Adalimumab (Humira) *SQ injection*	40 mg/0.8 ml pen	**PA, SP**	$5,557.02	
		40 mg/0.8 ml syringe		$4,467.54	
		40 mg/0.4 ml (CF)pen		--	
	Certolizumab (Cimzia) *SQ injection* **(For Crohn's Disease only)**	400 mg	**PA, SP**	$4,897.94^	
	Golimumab (Simponi) *SQ injection* **(For Ulcerative Colitis only)**	100mg	**PA, SP**	$5,350.17	
	Infliximab (Remicade) *IV infusion*	100 mg	**NF**	$3,573.53	Alternatives: Inflectra and Renflexis
Janus Associated Kinase Inhibitor	**Tolfacitinib (Xeljanz)** *Tablets*	5 mg	**PA, SP**	$4,603.14	**(For Ulcerative Colitis only)** Reserved for treatment failure or intolerance to TNF inhibitors Must be initiated by a gastroenterologist.
		10 mg	**PA, SP**	$4,177.55	
		XR 11 mg	**NA**	--	

					Restricted to specialty pharmacy
IL-12, IL-23 Inhibitor	**Ustekinumab (Stelara)** *SQ Syringe*	45 mg/0.5 ml	**PA, SP**	$10,576.30	**(For Crohn's Disease only)** Reserved for treatment failure to Corticosteroids, Thiopurines, Methotrexate, and TNF inhibitors Must be initiated by a gastroenterologist. Restricted to specialty pharmacy
		90 mg/ml	**PA, SP**	$20,995.99	
Selective Adhesion Molecule Inhibitor	**Natalizumab (Tysabri)** *IV infusion*	300 mg	**PA, SP**	--	**(For Crohn's Disease only)** Reserved for patients with contraindication to **ALL** other agents. Restricted to specialty pharmacy. Must be initiated by a gastroenterologist.
	Vedolizumab (Entyvio) *IV infusion*	300 mg	**PA, SP**	$6,406.10	Reserved for patients with contraindication to **ALL** other agents. Restricted to specialty pharmacy. Must be initiated by a gastroenterologist.

**Based on pharmacy claims from 3/2018-2/2019*

❖ EVALUATION CRITERIA FOR APPROVAL/EXCEPTION CONSIDERATION

Below are the coverage criteria and required information for each agent. These coverage criteria have been reviewed approved by the HPSJ Pharmacy & Therapeutics (P&T) Advisory Committee. For conditions not covered under this Coverage Policy, HPSJ will make the determination based on Medical Necessity as described in HPSJ Medical Review Guidelines (UM06).

Oral Aminosalicylates
Sulfasalazine (Azulfidine); Balsalazide (Colazol)

Sulfasalazine (Azulfidine); Balsalazide (Colazol):

- **Coverage Criteria:** NONE
- **Limits:** NONE
- **Required Information for Approval:** NONE

Mesalamine (Pentasa, Delzicol, Apriso, Asacol HD, Lialda), Olsalazine (Dipentum)

Mesalamine (Apriso, Delzicol):

- **Coverage Criteria:**
  - Reserved Treatment failure or intolerance to Balsalazide, Sulfasalazine, or Mesalamine enema for 3 months for induction or maintenance.
- **Limits:**
  - **Apriso:**
    - Quantity Limit: 120 capsules per 30 days
    - Fill Limit: 6 fills per 180 days
- **Required Information for Approval:**
  - History of fills for Balsalazide, Sulfasalazine, or Mesalamine enema for 3 months.

Mesalamine (Pentasa, Asacol HD, Lialda):

- **Coverage Criteria:**
  - Reserve for treatment failure or intolerance to Delzicol, or Apriso, for 3 months.
- **Limits:**
  - 120 capsules/tablets per 30 days
- **Required Information for Approval:**
  - History of fills for Delzicol, or Apriso, for 3 months..

- **Not on Formulary:** Dipentum (Olsalazine)

Topical Aminosalicylates
Mesalamine Enema (Rowasa)

Mesalamine Enema (Rowasa):
- **Coverage Criteria:** NONE
- **Limits:** NONE
- **Required Information for Approval:** NONE

Mesalamine (Canasa)

Mesalamine (Canasa):
- **Coverage Criteria:** Canasa is reserved for patients unable to administer mesalamine enema.
- **Limits:** NONE
- **Required Information for Approval:** Documented inability to administer Mesalamine enema

Corticosteroids
Prednisone (Deltasone)

Prednisone (Deltasone):
- **Coverage Criteria:** NONE
- **Limits:** NONE
- **Required Information for Approval:** NONE
- **Not on Formulary:** Prednisone 5 mg/mL solution

Budesonide (Entocort EC, Uceris)

Budesonide (Entocort EC):
- **Coverage Criteria:**
  - **Entocort EC** is reserved for induction of remission in those intolerant to conventional glucocorticoids.
- **Limits:** 90 capsules per month, 360 capsules per 365 days, maximum of 4 months.
- **Required Information for Approval:**
  - Documented intolerance to conventional glucocorticoids
- **Not on Formulary:** Uceris Tablets and rectal foam

Immunomodulators
6-Mercaptopurine, Azathioprine (Azasan, Imuran)

6-Mercaptopurine, Azathioprine (Imuran):
- **Coverage Criteria:** NONE
- **Limits:** NONE
- **Required Information for Approval:** NONE
- **Not on Formulary:** Azasan 75mg and 100mg tablets

Tumor Necrosis Factor α Blockers
Infliximab-abda (Renflexis),Infliximab-dyyb (Inflectra), Adalimumab (Humira), Adalimumab (Cyltezo), Certolizumab Pegol (Cimzia), Golimumab (Simponi)

Infliximab-abda (Renflexis),Infliximab-dyyb (Inflectra), Adalimumab (Humira), Certolizumab Pegol (Cimzia), Golimumab (Simponi):
- **Coverage Criteria:**
  - **Inflectra/Renflexis/Humira:** Reserved for treatment failure to adequate trial of oral immunosuppressive agents (Azathiopurine, Mercaptopurine, Mesalamine, and Sulfasalazine) OR intolerance to corticosteroids.
    - Must be initiated by a gastroenterologist.
  - **Cimzia:** *(for the treatment of Crohn's disease)*
  - **Simponi:** *(for the treatment of Ulcerative colitis)*
- **Limits:** Restrict to Specialty Pharmacy.
- **Required Information for Approval:**
  - Documented intolerance to conventional glucocorticoids OR treatment failure to IBD non-biologic agents OR have fistulizing disease.

- Therapy initiation by a gastroenterologist.

- **Other Notes:** Medication is to be dispensed by HPSJ's designated specialty pharmacy. Biologics exceeding labeled standard maintenance doses may be approved 1 month at a time. Subsequent fills of the increased maintenance dose will require documentation of symptom improvement.
- **Not on Formulary:** Remicade, Adalimumab (Cyltezo)

Selective Adhesion Molecule Inhibitor
Natalizumab (Tysabri), Vedolizumab (Entyvio)

Natalizumab (Tysabri):

- **Coverage Criteria:** *(for the treatment of Crohn's disease)* Reserved for patients with contraindication to ALL other agents.
- **Limits:** NONE
- **Required Information for Approval:** Documentation showing contraindication to ALL other agents and a negative anti-JCV antibody detection test result.
    - Must be initiated by a gastroenterologist.
- **Notes:** Not restricted to Specialty Pharmacy because Natalizumab is a limited distribution drug. Biologics exceeding labeled standard maintenance doses may be approved 1 month at a time. Subsequent fills of the increased maintenance dose will require documentation of symptom improvement.

Vedolizumab (Entyvio):

- **Coverage Criteria:** Reserved for patients with contraindication to ALL other agents.
- **Limits:** NONE
- **Required Information for Approval:** Documentation showing contraindication to ALL other agents. Must be initiated by a gastroenterologist.

Janus Associated Kinase Inhibitor
Tofacitinib (Xeljanz)

Tofacitinib (Xeljanz):

- **Coverage Criteria:***(for the treatment of Ulcerative Colitis)* Reserved for treatment failure or intolerance to TNF inhibitors.
- **Limits:** NONE
- **Required Information for Approval:** Fill history or documentation of treatment failure or intolerance to TNF inhibitors.
- **Notes:** Restricted to specialty pharmacy

IL-12, IL-23 Inhibitor
Ustekinumab (Stelara)

Ustekinumab (Stelara):

- **Coverage Criteria:***(for the treatment of Crohn's Disease)* Reserved for treatment failure to Corticosteroids, Thiopurines, Methotrexate, and TNF inhibitors.
- **Limits:** NONE
- **Required Information for Approval:** Fill history or documentation of treatment failure to Corticosteroids, Thiopurines, Methotrexate, and TNF inhibitors.
- **Notes:** Restricted to specialty pharmacy

❖ CLINICAL JUSTIFICATION

American College of Gastroenterology (ACG) and NICE guidelines states 5-ASA effectiveness in irritable bowel disease. Both oral and rectal 5-ASA have are used in mild to moderately active disease states, with combination of oral and rectal therapy resulting in better outcome than with monotherapy. Oral corticosteroids should be used in short term induction therapy due to systemic effects associated with long term use. Although Budesonide is formulated to target ileal area of the colon, given its low bioavailability and efficacy, budesonide is reserved for patients with disease involving ilea area who are intolerant to conventional oral corticosteroid therapy. Immunomodulators and biologics are reserved for moderate to severe disease states due to systemic effects on immune system.

❖ PART 2 IBS-C AND IBS-D OVERVIEW

Inflammatory bowel syndrome (IBS) is a common disorder of bowel function that causes change in bowel habits resulting in either constipation (IBS-C) or diarrhea (IBS-D), along with symptoms such as abdominal pain, bloating, and other non-intestinal symptoms. Although the exact etiology of IBS is unknown, effective management of IBS and its symptoms help in improving a patient's quality of life. Health Plan of San Joaquin has adopted the treatment goals and recommendations of the most recent practice guidelines from the American

Gastroenterological Association (AGA) and The National Institute for Health Care and Excellence Guidelines (NICE) in the management of IBS-C and IBS-D.[1,2,12] The below criteria, limits, and requirements for certain agents are in place to ensure appropriate use of those agents.

IBS-C and IBS-D Agents Formulary Positioning: *(Current as of 4/2019)*

Drug	Available Strengths	Formulary Limit	Average Cost/Rx*	Notes
Bulk Forming				
Psyllium Husk with Sugar (Metamucil, Natural Fiber, Konsyl)	3.4 gram/7 gram powder	--	$5.64	
	3.4 gram oral powder packet	NF	--	
Psyllium Husk with Aspartame (Metamucil Fiber)	3.4 gram/5.8 gram powder	--	$5.71	
	3.4 gram oral powder packet	NF	--	
Psyllium Seed (Reguloid, Hydrocil Instant)	Reguloid Laxative Powder	--	$6.14	
	Hydrocil Instant Packet	NF-	--	
Psyllium Seed with Dextrose (Natural Fiber Lax, Fiber Smooth, Konsyl-D, Natural Vegetable Laxative Powder)	Fiber oral powder	--	--	
	Metamucil Fiber Wafer 2.5 gram oral Wafer	--	$5.54	
Osmotic				
Polyethylene Glycol 3350 (Miralax, Clearlax, Purelak, Gavilax, Smoothlax)	17gram/dose oral powder jar	QL	$21.93	Limited to 1054 grams per 30 days.
	17g/dose oral powder packet	NF	$60.08	
Peg 3350/Na Sulf/ Bicarb/Cl/KCl (Gavilyte, Golytely, Colyte)	Gavilyte-C 240 gram-22.72 gram-6.72 gram-5.84 gram oral solution	--	$10.19	
	Gavilyte-G 236 gram-22.74 gram-6.74 gram-5.86 gram oral solution	--	$12.01	
	PEG 3350 and ELS	--	$22.58	
	Golytely 236 gram-22.74 gram-6.74 gram-5.86 gram oral solution	NF	--	
	Golytely 227.1 gram-21.5 gram-6.36 gram oral packet	NF	--	
Sodium chloride/ NaHCO3/KCl/Peg (Trilyte, Gavilyte-N, Nulytely)	Trilyte With Flavor Packets 420 gram oral solution	--	$15.67	
	PEG 3350 and ELS	--	--	
	Gavilyte-N 420 gram solution	NF	--	
	Nulytely With Flavor Packets	NF	--	
Antimotility				
Loperamide (Imodium)	2 mg capsule	--	$5.57	
	2 mg tablet		$0.44	
	1 mg/5 ml oral solution		$3.78	
	1 mg/7.5 ml oral solution		$2.48	
Antispasmodics				
Dicyclomine (Bentyl)	10 mg capsule	--	$5.83	
	10 mg /5 mL solution		$21.19	
	20 mg tablet		$2.74	
Hyoscyamine (Anaspaz, Cystospaz, Levsin)	0.125 mg ODT	--	$15.84	
	0.125 mg tablet SL		$9.73	
	0.375 mg ER tablet		$40.87	
	0.125 mg tablet		$17.70	
	125 mcg/5 mL elixir		$6.62	

	0.125 mg/mL drop	AL	--	Restrict use to children and infants < 2 years old only.
Tricyclic Antidepressants				
Amitriptyline (Elavil)	10 mg tablet	--	$4.10	Avoid use in members over 65 years old.
	25 mg tablet		$6.53	
	50 mg tablet		$8.27	
	75 mg tablet		$21.40	
	100 mg tablet		$18.97	
	150 mg tablet		$43.40	
Clomipramine (Anafranil)	25 mg capsule	NF	$128.33	
	50 mg capsule		$76.29	
	75 mg capsule		$500.78	
Desipramine (Norpramin)	10 mg tablet	--	$33.82	
	25 mg tablet		$41.95	
	50 mg tablet		$59.68	
	75 mg tablet		--	
	100 mg tablet		$90.02	
	150 mg tablet		--	
Doxepin (Sinquan)	Silenor 3 mg tablet	NF	--	
	Silenor 6 mg tablet		--	
	10 mg/5 ml solution	--	$2.23	
	10 mg capsule		$14.14	
	25 mg capsule		$18.65	
	50 mg capsule		$27.98	
	75 mg capsule		$34.71	
	100 mg capsule		$55.99	
	150 mg capsule		$20.50	
Imipramine (Tofranil)	10 mg tablet	--	$5.11	
	25 mg tablet		$6.43	
	50 mg tablet		$8.54	
Nortriptyline (Pamelor)	10 mg/5 ml oral concentrate	--	--	
	10 mg capsule		$5.26	
	25 mg capsule		$6.66	
	50 mg capsule		$6.20	
	75 mg capsule		$8.41	
Trimipramine	25 mg capsule	NF	--	
	50 mg capsule			
	100 mg capsule			
Prosecretory Agnets				
Lubiprostone (Amitiza)	8 mcg capsule	PA;QL	$378.52	Reserved for women 18 year and older who have failed treatment with linaclotide (Linzess) or naloxegol (Movantik). Patient must have also failed regularly scheduled, dose optimized polyethylene glycol (Miralax), AND two of the following: bisacodyl, Senna, psyllium, magnesium citrate or hydroxide. Restricted to 60 capsules per 30 days.
	24 mcg capsule	PA; QL	$361.77	
Linaclotide (Linzess)	72 mcg capsule	PA; QL	$396.68	Linzess is reserved for patients with treatment failure of properly titrated and regularly scheduled dosing of polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the following: bisacodyl, Senna, psyllium, magnesium citrate or hydroxide. Restricted to 30 capsules per 30 days.
	145mcg capsule	PA; QL	$379.06	
	290 mcg capsule	PA;QL	$398.75	
Plecanatide (Trulance)	3 mg tablets	NF	--	

5-HT3 Antagonist				
Alosetron (Lotronex)	0.5 mg tablet 1 mg tablet	NF	--	
5-HT4 Receptor Agonist				
Tegaserod (Zelnorm)	2 mg tablet 6 mg tablet	NF	--	
Mixed Mu-Opioid Receptor Agonist, Delta Opioid Receptor Antagonist, And Kappa Opioid Receptor Agonist				
Eluxadoline (Viberzi)	75 mg tablets	NF	--	
	100 mg tablets		$1,184.58	
Antibiotics				
Rifaximin (Xifaxan)	550 mg tablet	PA;QL;FL	$2,075.31	For IBS-D: Restricted to 42 tablets per 14 days. Restricted to 3 fills per 365 days. Xifaxan is reserved for patients who have failed treatment with at least one antispasmodic, one TCA, and loperamide; or failed treatment with at least one antispasmodic and one TCA for use in abdominal pain relief. For HE: Xifaxan is reserved for treatment failure of compliant use of lactulose evidenced by consistent lactulose fills.

**Cost per Rx based on HPSJ utilization historical data from March 2018 through February 2019*

❖ EVALUATION CRITERIA FOR APPROVAL/EXCEPTION CONSIDERATION

Below are the coverage criteria and required information for each agent. These coverage criteria have been reviewed approved by the HPSJ Pharmacy & Therapeutics (P&T) Advisory Committee. For conditions not covered under this Coverage Policy, HPSJ will make the determination based on Medical Necessity as described in HPSJ Medical Review Guidelines (UM06).

Bulk Forming Laxative
Psyllium Husk with Sugar (powder), Psyllium Husk with Aspartame (powder), Psyllium Seed (powder), Psyllium Seed with Dextrose (powder, wafer)

- ❒ **Coverage Criteria:** None
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** N/A
- ❒ **Other Notes:** None
- ❒ **Non-Formulary:** Psyllium Husk with Aspartame (packet), Psyllium Husk with Sugar (packet), Psyllium Seed (packet)

Osmotic Laxative
Polyethylene Glycol 3350 (powder jar), Peg 3350/Na Sulf/ Bicarb/Cl/KCl (Gavilyte-C, Gavilyte-G, Sodium chloride/ NaHCO3/KCl/Peg (Trilyte), Lactulose, Magnesium oxide (400 mg tablet), Magnesium hydroxide, Magnesium citrate, Glycerin (Adult and Child suppository)

Polyethylene Glycol 3350 (powder jar)

- ❒ **Coverage Criteria:** None
- ❒ **Limits:** 1054g per 30 days
- ❒ **Required Information for Approval:** N/A
- ❒ **Other Notes:** None
- ❒ **Non-Formulary:** Polyethylene Glycol 3350 (powder packet)

Peg 3350/Na Sulf/ Bicarb/Cl/KCl (Gavilyte-C, Gavilyte-G, Sodium chloride/ NaHCO3/KCl/Peg (Trilyte), Lactulose (solution), Magnesium oxide (400 mg tablet), Magnesium hydroxide, Magnesium citrate, Glycerin (Adult and Child suppository)

- ❒ **Coverage Criteria:** None
- ❒ **Limits:** None
- ❒ **Required Information for Approval:** N/A
- ❒ **Other Notes:** None

- ❐ **Non-Formulary:** Polyethylene Glycol 3350 (oral solution), Golytely (solution, powder packet), Gavilyte-N, Nulytely, Suprep Bowel Prep Kit, Prepopik Powder Packet, Moviprep

Chloride Channel Activators
Linaclotide, Lubiprostone

Linaclotide (Linzess)

- ❐ **Coverage Criteria:** Linzess is reserved for patients with treatment failure of properly titrated and regularly scheduled dosing of polyethylene glycol for 2 months (as evidenced by prescription history fills) AND two of the following: bisacodyl, Senna, psyllium, magnesium citrate or hydroxide.
- ❐ **Limits:** Limited to 30 capsules per 30 days.
- ❐ **Required Information for Approval:** Proper chart note documentation and pharmacy fill history of at least 2 months of regularly scheduled Miralax, and of two other formulary alternatives.

Lubiprostone (Amitiza)

- ❐ **Coverage Criteria:** Lubiprostone (Amitiza) is reserved for women 18 year and older who have failed treatment with linaclotide (Linzess) or naloxegol (Movantik). Patient must have also failed regularly scheduled, dose optimized polyethylene glycol (Miralax), AND two of the following: bisacodyl, Senna, psyllium, magnesium citrate or hydroxide
- ❐ **Limits:** Limited to 60 capsules per fill
- ❐ **Required Information for Approval:** Proper chart note documentation and pharmacy fill history of at least 2 months of regularly scheduled Miralax AND Linzess or Movantik, in addition to two other formulary alternatives described in the coverage criteria.

Antimotility

Loperamide

- ❐ **Coverage Criteria:** None
- ❐ **Limits:** None
- ❐ **Required Information for Approval:** N/A

Antispasmodics
Dicyclomine, Hyoscyamine

Dicyclomine

- ❐ **Coverage Criteria:** None
- ❐ **Limits:** None
- ❐ **Required Information for Approval:** N/A

Hyoscyamine

- ❐ **Coverage Criteria:** None
- ❐ **Limits:** Hyoscyamine 0.125 mg/mL drop: Restrict use to children and infants < 2 years old only.
- ❐ **Required Information for Approval:** N/A

Tricyclic Antidepressants

Amitriptyline (Elavil); Nortriptyline (Pamelor); Imipramine (Tofranil); Desipramine (Norpramine); Doxepin (Sinquan) capsules, solution

- ❐ **Coverage Criteria:** None
- ❐ **Limits:** None
- ❐ **Required Information for Approval:** N/A
- ❐ **Other Notes:** None
- ❐ **Non-Formulary:** Clomipramine, Doxepin (Silenor) tablets, Trimipramine

Antibiotic

Xifaxan

- **Coverage Criteria:**
  - For use in Hepatic encephalopathy, Xifaxan is reserved for treatment failure of compliant use of lactulose evidenced by consistent lactulose fills.
  - For use in IBS-D, Xifaxan is reserved for patients who have failed treatment with at least one antispasmodic, one TCA, and loperamide; or failed treatment with at least one antispasmodic and one TCA for use in abdominal pain relief.
- **Limits:**
  - Quantity limit: Restricted to 42 tablets per 14 days.
  - Fill limit: Restricted to 3 fills per 365 days.
- **Required Information for Approval:** Proper chart note documentation and pharmacy fill history of at least one antispasmodic and one TCA for use in antispasmodic relief and at least one antispasmodic, one TCA, and loperamide for use in IBS-D.

CLINICAL JUSTIFICATION

HPSJ policy is based on current and updated clinical and practice guidelines. According to ACG 2018 IBS treatment monograph recommends exercise, diet and dietary manipulation to improve overall symptoms of IBS. Updated systemic review and meta-analysis on fiber showed statistically significant improvement in fiber compare to placebo. Polyethylene glycol, Tricyclic antidepressants and loperamide improve overall symptoms as well. SSRIs are now recommended to improve constipation in IBS-D. Tegaserod (Zelnorm) has been reintroduced for emergency treatment of IBS-C and chronic idiopathic constipation (CIC) in women (<55 years of age) in which no alternative therapy exists. Tegaserod (Zelnorm) is only available through emergency- investigational new drug (IND) process. Due to pancreatic related health concerns, Eluxadoline (Viberzi)is not on HPSJ formulary.

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13. FDA approved labeling for Zelnorm.

❖ Review & Edit History

Document Changes	Reference	Date	P&T Chairman
Creation of Policy	Biologics Class Review for Crohns 2013-2-19.docx	2/2013	Allen Shek, PharmD
Update to Policy	IBD Class Review 2-17-15.docx	2/2015	Jonathan Szkotak, PharmD

Update to Policy	Class Review- Biologics, Apremilast, and Tofacitinib in Inflammatory Joint, Skin, and Bowel Diseases.docx	2/2016	Johnathan Yeh, PharmD
Update to Policy	HPSJ Coverage Policy – Gastrointestinal – Chronic Bowel Disease 2017-02.docx	2/2017	Johnathan Yeh, PharmD
Update to Policy	HPSJ Coverage Policy – Gastrointestinal – Chronic Bowel Disease 2018-02.docx	2/2018	Johnathan Yeh, PharmD
Update to Policy	HPSJ Coverage Policy – Gastrointestinal – Chronic Bowel Disease 2019-05.docx	5/2019	Matthew Garrett, PharmD

Note: All changes are approved by the HPSJ P&T Committee before incorporation into the utilization policy