



## PANCREATIC ENZYMES PA SUMMARY

<b>PREFERRED</b>	Creon, Pancrelipase, Zenpep
<b>NON-PREFERRED</b>	Pancreaze, Pertzye, Ultresa, Viokace

**LENGTH OF AUTHORIZATION:** 1 Year

### PA CRITERIA:

- ❖ Approvable for members with pancreatic insufficiency
- ❖ Member must have tried and failed two preferred products, unless there is a concomitant diagnosis of cystic fibrosis or the member has already been started and stabilized on the requested medication.
- ❖ In addition, Viokace must be given in combination with a proton pump inhibitor.

### EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827**.

### PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

### QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.