GEORGIA MEDICAID FEE-FOR-SERVICE
BILE ACID SEQUESTRANTS PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholestyramine powder generic</td>
<td>Cholestyramine powder packets generic</td>
</tr>
<tr>
<td>Cholestyramine light powder generic</td>
<td>Cholestyramine light powder packets generic</td>
</tr>
<tr>
<td>Colestipol tablets generic</td>
<td>Colestid granules and packets (colestipol)</td>
</tr>
<tr>
<td>Prevalite powder (cholestyramine light)</td>
<td>Colestipol granules and packets generic</td>
</tr>
<tr>
<td></td>
<td>Prevalite powder packets (cholestyramine light)</td>
</tr>
<tr>
<td></td>
<td>Welchol (colesevelam)</td>
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</tbody>
</table>

LENGTH OF AUTHORIZATION: 1 Year

NOTE:
- If brand Colestid granules or packets is approved, the PA will be issued for generic colestipol granules or packets.

PA CRITERIA:

Cholestyramine, Cholestyramine Light and Prevalite Powder Packets
- Physician must submit a written letter of medical necessity stating the reason(s) the preferred products, generic cholestyramine powder (in a can) and cholestyramine light powder/Prevalite powder (in a can), are not appropriate for the member.

Colestid Granules and Packets, Colestipol Granules and Packets
- Member must be unable to swallow solid oral dosage forms of medication
  AND
- Member must have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects to cholestyramine.

OR
- Physician must submit a written letter of medical necessity stating the reason(s) the preferred product, generic colespol tablets, is not appropriate for the member.

Welchol
- For hyperlipidemia, approvable for members ages 10-17 who experience ineffectiveness, allergies, contraindications, drug-to-drug interactions, or history of intolerable side effects to cholestyramine.
- For hyperlipidemia, approvable for members 18 years or older who experience ineffectiveness, allergies, contraindications, drug-to-drug interactions, or a history of intolerable side effects to two preferred products.
- For Type 2 diabetes, approvable for members 18 years or older who experience ineffectiveness, allergies, contraindications, drug-to-drug interactions, or a history of intolerable side effects to metformin.

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EXCEPTIONS:

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

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to [http://dch.georgia.gov/preferred-drug-lists](http://dch.georgia.gov/preferred-drug-lists).

PA and APPEAL PROCESS:

- For online access to the PA process, please go to [www.dch.georgia.gov/prior-authorization-process-and-criteria](http://www.dch.georgia.gov/prior-authorization-process-and-criteria) and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), 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 and select that manual.