GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
GLUCOCORTICOIDS, ORAL PA SUMMARY

Preferred	Non-Preferred
Budesonide delayed-release capsules generic Dexamethasone tablets, oral liquid generic Hydrocortisone tablets generic Medrol 2 mg (methylprednisolone) Methylprednisolone generic Prednisolone oral solution 5/5, 15/5, 25/5 mg/mL generic Prednisone generic	Alkindi Sprinkle (hydrocortisone oral granules) Eohilia (budesonide oral suspension) Hemady (dexamethasone tablets) Prednisolone ODT, tablets generic Prednisolone oral solution 10/5, 20 mg/5 mL generic Rayos (prednisone delayed-release) Taperdex (dexamethasone tablets) Tarpeyo (budesonide delayed-release capsules)

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Alkindi Sprinkles

- Approvable for members 17 years of age or younger with a diagnosis of adrenocortical insufficiency (AI) who are unable to swallow solid dosage formulations; otherwise, prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic hydrocortisone tablets, is not appropriate for the member.
- Must be prescribed by or in consultation with an endocrinologist.

Eohilia

- Approvable for members 11 years of age or older with a diagnosis of eosinophilic esophagitis (EoE) with intraepithelial eosinophils per high-power field (eos/hpf) ≥15 and when secondary cause of eosinophilic esophagitis been ruled out
- Member must have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to proton pump inhibitors (PPI).
- Must be prescribed by or in consultation with a gastroenterologist or other specialist in treating eosinophilic esophagitis.

Hemady and Taperdex

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic dexamethasone tablets, is not appropriate for the member.

Prednisolone ODT and Tablets Generic, Prednisolone Oral Solution 10 mg/5mL and 20 mg/5mL Generic

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, generic prednisolone oral products, are not appropriate for the member.

Rayos

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic prednisone tablets, is not appropriate for the member.

Tarpeyo

- ❖ Approvable for members 18 years of age or older with a diagnosis of primary immunoglobulin A nephropathy (IgAN) who are at risk for rapid disease progression; have a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g; have proteinuria ≥ 1 g/day; have an estimated glomerular filtration rate (eGFR) ≥ 35 mL/min/1.73 m^2; have been on a stable and maximally tolerated dose of an angiotensin converting enzyme [ACE] inhibitor or angiotensin receptor blocker [ARB] for at least 3 months or have allergies, contraindications, drug-drug interactions or intolerable side effects to ACE inhibitors and ARBs; and have tried the preferred glucocorticosteroids, methylprednisolone and prednisone, and failed to achieve an adequate response.
- ❖ Must be prescribed by or in consultation with an immunologist or nephrologist.

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.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to 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, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.