



**GEORGIA MEDICAID FEE-FOR-SERVICE
TOPICAL ANTINEOPLASTIC AND GENITAL WARTS THERAPY PA
SUMMARY**

Preferred	Non-Preferred
Condylox (podofilox gel 0.5%) Fluorouracil solution 2%, 5% generic Imiquimod cream 5% generic Valchlor (mechlorethamine gel)*	Bexarotene gel generic Diclofenac gel 3% generic Imiquimod cream 3.75% generic Podocon-25 (podophyllum resin solution 25%) Podofilox solution 0.5% generic Veregen (sinecatechins ointment)

*preferred but requires PA

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Valchlor

- ❖ Approvable for members with a diagnosis of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma who have experienced inadequate response to at least one other previous skin-directed therapy.

Bexarotene Gel Generic

- ❖ Approvable for members with a diagnosis of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least two other previous skin-directed therapies.

Diclofenac 3% Gel Generic

- ❖ Approvable for members with a diagnosis of actinic keratosis (AK) who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to the preferred products, fluorouracil (Carac, Efudex) and imiquimod 5% (Aldara).

Imiquimod Cream 3.75% Generic

- ❖ Approvable for immunocompetent members 18 years of age or older with a diagnosis of actinic keratosis (AK) when being used to treat a large area of skin or prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic imiquimod 5%, is not appropriate for the member.
- ❖ For immunocompetent members 12 years of age or older with a diagnosis of external genital and perianal warts (EGW, condyloma acuminata), prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic imiquimod 5%, is not appropriate for the member.



Podocin-25 and Podofilox 0.5% Solution Generic

- ❖ For members with a diagnosis of external genital and perianal warts (EGW, condyloma acuminata), prescriber must submit a written letter of medical necessity stating the reasons the preferred product, brand Condylox Gel (podofilox 0.5%), is not appropriate for the member.

Veregen

- ❖ Approvable for immunocompetent members 18 years or older with a diagnosis of external genital and perianal warts (EGW, condyloma acuminata) who have experienced inadequate response, allergies, contraindications, drug-to-drug interactions or intolerable side effects to podofilox (Condylox) and imiquimod 5% (Aldara).

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 Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.