UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Mytesi

Program	Prior Authorization
Medication	Mytesi (crofelemer)
Markets in Scope	Arizona, California, Florida-CHIP, Hawaii, Maryland, Nevada, New Mexico, New York, New York EPP, Ohio, Rhode Island, Washington, New Jersey, Louisiana
Issue Date	3/2013
Pharmacy and Therapeutics Approval Date	2/2018
Effective Date	4/2018

1. Background:

Mytesi (crofelemer) is an anti-diarrheal indicated for the symptomatic relief of non-infectious diarrhea in adult patients with HIV/AIDS on anti-retroviral therapy.[1]

Members will be required to meet the coverage criteria below.

2. Coverage Criteria:

A. <u>Authorization</u>

1. Mytesi will be approved based on the following criteria:

a. Diagnosis of HIV/AIDS associated diarrhea

Authorization will be issued for 12 months.

3. References:

1. Mytesi [package insert]. San Francisco, CA: Napo Pharmaceuticals, Inc; June 2016.

Program	Prior Authorization –Mytesi (crofelemer)
Change Control	
Date	Change
3/2013	New Guideline
6/2015	Annual review, no changes to clinical criteria

10/2016	Updated clinical criteria to align with Employer and Individual's notification policy and updated policy template
2/2017	Program updated to reflect change in brand name from Fulyzaq to Mytesi. No change in clinical coverage. Updated reference.
3/2017	Changed initial authorization duration to 12 months.
9/2017	Removed requirement that patient be on antiretroviral therapy. Removed reauthorization criteria to allow for Dx to Rx implementation
2/2018	Annual review. No change to criteria.