MEDICAL MUTUAL®

Drug Policy

Policy:	**Inflammatory Bowel Agents Preferred Step Therapy**	**Annual Review Date:** **04/20/2023**
Impacted Drugs:	**Apriso** **Azulfidine** **Azulfidine Entab** **Colazal** **Delzicol** **Giazo** **mesalamine 800 mg delayed-release** **Pentasa**	**Last Revised Date:** **04/20/2023**

OVERVIEW

The mechanism of action of mesalamine (5-ASA) is unknown but appears to be local to the colon mucosa and not systemic. Mesalamine may act by decreasing inflammation by blocking production of arachidonic acid in the colon. Oral 5-ASA is absorbed in the small intestine; so many formulations have been developed to deliver the active agent to the site of inflammation in the colon. Some are pH-dependent systems and others are pH-independent. Sulfasalazine combines sulfapyridine (an antibiotic) with mesalamine in the same molecule. About 15% of sulfasalazine is absorbed and metabolized in the liver. Sulfasalazine is cleaved by bacteria in the lower intestine and colon to sulfapyridine, which is absorbed from the colon (and metabolized), and mesalamine, which mostly remains in the colon. Mesalamine is the active component of sulfasalazine in IBD. The sulfapyridine component is thought to be responsible for many of the adverse events (AEs) of sulfasalazine. Metabolism of sulfapyridine is via acetylation, and the rate of metabolism depends on acetylator phenotype. Slow acetylators of sulfapyridine may have a higher incidence of AEs. The absorption of mesalamine from Asacol/Delzicol, Asacol HD, Pentasa, Lialda, and Apriso is about 28%, 20%, 20% to 30%, 21% to 22%, and 32% ± 11% (mean ± standard deviation [SD]), respectively. Balsalazide is a prodrug of mesalamine. Following administration, balsalazide disodium is enzymatically cleaved in the colon to produce mesalamine, an active component, and 4-aminobenzoyl-β-alanine, a moiety that is only minimally absorbed and largely inert. A daily dose of 6.75 g of balsalazide delivers 2.4 g of free 5-ASA to the colon.

POLICY STATEMENT

A preferred step therapy program has been developed to encourage the use of a preferred product prior to the use of a non-preferred product. If the preferred step therapy rule is not met for a non-preferred agent at the point of service, coverage will be determined by the preferred step therapy criteria below. All approvals are provided for 1 year in duration.

Automation: A patient with a history of one Step 1 Product within the 130-day look-back period is excluded from Step Therapy.

*Note: Apriso (with DAW9) will also count as a Preferred drug.

Preferred Medication

- balsalazide disodium 750 mg
- sulfasalazine and sulfasalazine delayed release 500 mg
- mesalamine 1.2 g delayed release tablets (generic)
- mesalamine 0.375 g extended release capsules (generic)
- mesalamine 400 mg delayed release capsules (generic)
- mesalamine 500 mg controlled-release capsules (generic)
- Pentasa (mesalamine controlled-release) 250 mg and 500 mg

Non-Preferred Medication

- Apriso (meslamine extended-release) 0.375 g
- Azulfidine (sulfasalazine) 500 mg
- Azulfidine Entab (sulfasalazine enteric-coated, delayed release) 500 mg
- Colazal (balsalazide) 750 mg
- Dipentum (olsalazine) 250 mg
- Giazo (balsalazide) 1.1 g
- mesalamine delayed release 800 mg

PREFERRED STEP THERAPY CRITERIA

1. If the patient has tried a preferred medication, then authorization for a non-preferred medication may be given.

2. Approval for Delzicol may be granted if the patient meets BOTH of the following:
    a. The patient is between the ages of 5 and 17 years; AND
    b. According to the prescriber, the patient has inflammation of the terminal ileum

Approval Duration: 365 days (1 year)

Preferred Step Therapy Exception Criteria

In certain situations, the patient is not required to trial preferred agents. Approve for 1 year if the patient meets the following (A, B, or C):

A. The patient has an atypical diagnosis and/or unique patient characteristics which prevent use of all preferred agents. If so, please list diagnosis and/or patient characteristics [documentation required]; **OR**
B. The patient has a contraindication to all preferred agents. If so, please list the contraindications to each preferred agent [documentation required]; **OR**
C. The patient is continuing therapy with the requested non-preferred agent after being stable for at least 90 days [verification in prescription claims history required] or, if not available, [verification by prescribing physician required] AND meets ONE of the following:

1. The patient has at least 130 days of prescription claims history on file and claims history supports that the patient has received the requested non-preferred agent for 90 days within a 130-day look-back period AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product); OR
2. When 130 days of the patient's prescription claims history file is unavailable for verification, the prescriber must verify that the patient has been receiving the requested non-preferred agent for 90 days AND that the patient has been receiving the requested non-preferred agent via paid claims (i.e. the patient has NOT been receiving samples or coupons or other types of waivers in order to obtain access to the requested non-preferred agent) AND there is no generic equivalent available for the requested nonpreferred product (i.e. AA-rated or AB-rated to the requested nonpreferred product).

Documentation Required: When documentation is required, the prescriber must provide written documentation supporting the trials of these other agents, noted in the criteria as [documentation required]. Documentation should include chart notes, prescription claims records, and/or prescription receipts.

Approval Duration: All approvals for continuation of therapy are provided for 1 year unless noted otherwise below. In cases where the initial approval is authorized in months, 1 month is equal to 30 days.

Approval Duration: 365 days (1 year)

Documentation Requirements:
The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Kornbluth A, Sachar DB and The Practice Parameters Committee of the American College of Gastroenterology. Ulcerative colitis practice guidelines in adults: American College of Gastroenterology, Practice Parameters Committee. *Am J Gastroenterol.* 2010;105:501-523.
2. Dipentum® capsules [prescribing information]. Smyrna, GA: Meda; December 2022.
3. Pentasa® capsules [prescribing information]. Wayne, PA: Takeda; November 2022.
4. Colazal® capsules [prescribing information]. Morrisville, NC: Salix; November 2022.
5. Lialda® delayed release tablets [prescribing information]. Wayne, PA: Takeda; November 2022.
6. Apriso® capsules [prescribing information]. Morrisville, NC: Salix; November 2022.
7. Giazo® tablets [prescribing information]. Morrisville, NC: Salix; November 2021.
8. Delzicol® capsules [prescribing information]. Madison, NJ: Allergan; March 2016.
9. Asacol® HD tablets [prescribing information]. Madison, NJ: Allergan; November 2022.
10. Azulfidine En-tabs® [prescribing information]. New York, NY: Pfizer; October 2022.

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11. Azulfidine® tablets [prescribing information]. New York, NY: Pfizer; October 2022.