Louisiana Medicaid
Oncology Agents – Oral – Breast

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred oral breast oncology agents.

Additional Point-of-Sale edits may apply.

~~***NOTE:*** *Some medications in this therapeutic class may have* ***Black Box Warnings*** *and/or may be subject to* ***Risk Evaluation and Mitigation Strategy (REMS)*** *under FDA safety regulations. Please refer to individual prescribing information for details.*~~

~~**ALL of the following are required**~~**Approval Criteria for** ~~**both initial**~~ **Initial and** ~~**reauthorization**~~ **Reauthorization** ~~**requests**~~**Requests**~~:~~

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- ~~For Capecitabine (generic for Xeloda®) – there has been a treatment failure or intolerable side effect with or contraindication to brand Xeloda®; **AND**~~
- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
  - The prescriber states that the recipient is currently using the requested medication; **AND**
- By submitting the authorization request, the prescriber attests to the following:
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
  - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
  - The recipient has no inappropriate concomitant drug therapies or disease states.

Duration of Initial and Reauthorization ~~**approval**~~**Approval**~~**, both initial and reauthorization**~~**:**
Up to 12 months based upon patient-specific factors and the condition being treated.

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; Retrieved from https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; Retrieved from https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

~~Xeloda (capecitabine) [package insert]. South San Francisco, CA: Genentech USA, Inc; February 2019. https://www.gene.com/download/pdf/xeloda_prescribing.pdf~~

Revision	Date
Single PDL Implementation	May 2019
Reviewed current criteria and no changes made	September 2019
Added specific wording for use of Xeloda®, separated "Oncology Agents" into individual therapeutic class documents.	~~November 2019~~
Removed wording requiring use of preferred brand Xeloda® and removed reference, formatting changes	~~July 2020~~

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