MEDICATION POLICY

Generic Name: Pegademase Bovine

Therapeutic Class or Brand Name: Adagen®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 11/16/17

GPI Code: 2000005000

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

I. Documented diagnosis of enzyme replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) who are not suitable candidates for or who have failed bone marrow transplantation.

II. Patient is less than 18 years old.

III. Copy of prescription from physician.

IV. Dose must be delivered in a pre-filled syringe for exact dosing.

V. Plan must be notified of changes in dosage with a copy of a new prescription.

Exclusion Criteria:

- For use as preparatory or support therapy for bone marrow transplantation.
- In patients with severe thrombocytopenia.

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Up to 4 pre-filled syringes per 28 days.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current prior authorization criteria are met and that the medication is effective.

MEDICATION POLICY

Appendix:

N/A

References:

1. https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Adagen.pdf.
2. Drugs.com.
3. Medi-Span.
4. http://www.adagen.com/pdf/AdagenPI_Jun2014.pdf.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
11/16/2017	1. Policy reviewed: no changes made.
9/23/2016	1. Policy reviewed: no changes made.
3/17/2015	1. **Added** "Patient is less than 18 years old" **under Prior Authorization Criteria**. 2. **Changed** "An updated letter of medical necessity" **to** "An updated letter of medical necessity or progress notes showing current prior authorization criteria are met and that the medication is effective" **for Re-Authorization under Approval Length**. 3. **Updated** "http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/pdf/Adagen.pdf" **to** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Adagen.pdf" **and** "http://adagen.com/pdf/AdagenPI_May2010.pdf" **to** "http://www.adagen.com/pdf/AdagenPI_Jun2014.pdf"**under References**.
11/12/2013	1. **Adapted policy to new format.** 2. **Changed GPI Code from** "20000050002025" **to** "2000005000". 3. **Combined and changed** "DOCUMENTED diagnosis of Adenosine Deaminase (ADA) Deficiency" **under Prior Authorization criteria and** "Severe combined immunodeficiency disease (SCID) in patients with adenosine deaminase (ADA) deficiency" **under Covered Uses to** "Documented diagnosis of enzyme replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) who are not suitable candidates for or who have failed bone marrow transplantation" **under Prior Authorization Criteria**. 4. **Changed** "Medicaid must be notified of changes in dosage with a copy of a new prescription" **to** "Plan must be notified of changes in dosage with a copy of a new prescription" **under Prior Authorization Criteria**. 5. **Added** "For use as preparatory or support therapy for bone marrow transplantation; In patients with severe thrombocytopenia" **under Exclusion Criteria**. 6. **Added** "Up to 4 pre-filled syringes per 28 days" **under Quantity/Days Supply Restrictions**. 7. **Updated references** to include specific Utah Medicaid policy referred to, Medi-Span, and website address for Adagen package insert.