UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Rayos

Program	Prior Authorization
Medication	Rayos (prednisone delayed-release tablet)
Markets in Scope	Arizona, California, Colorado, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	9/2019
Pharmacy and Therapeutics Approval Date	9/2020
Effective Date	11/2020

1. Background:

Rayos (prednisone delayed-release tablet) is a corticosteroid indicated:

- as an anti-inflammatory or immunosuppressive agent for certain allergic, dermatologic, gastrointestinal, hematologic, ophthalmologic, nervous system, renal, respiratory, rheumatologic, specific infectious diseases or conditions and organ transplantation
- for the treatment of certain endocrine conditions
- for palliation of certain neoplastic conditions

2. Coverage Criteria:

A. Rayos will be approved based on **all** of the following criteria:

1. One of the following:

(a) The requested drug must be used for an FDA-approved indication

-OR-

(b) The use of this drug is supported by information from the appropriate compendia of current literature.*

-AND-

2. The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.

-AND-

3. Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to generic prednisone tablets which is unable to

be resolved with attempts to minimize the adverse effects where appropriate.

-AND-

4. History of failure, contraindication, or intolerance to **two** of the following:
    - Dexamethasone tablet/oral solution
    - Hydrocortisone tablet
    - Methylprednisolone tablet
    - Prednisolone tablet/oral solution

Authorization will be issued for 12 months.

*****Compendia of current literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical Pharmacology • United States Pharmacopoeia-National Formulary (USP-NF)

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Rayos [package insert]. Lake Forest, IL: Horizon Pharma USA, Inc.; December 2019.

Program	Prior Authorization –Rayos
Change Control	
Date	Change
9/2019	New policy
9/2020	Annual review. Removed prednisolone oral syrup as a step therapy drug. Updated references.