

Prior Authorization Criteria
Obrexza (glycopyrronium)

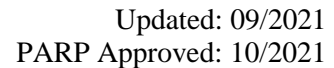
All requests for Obrexza (glycopyrronium) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of primary axillary hyperhidrosis and the following criteria is met:

- The member must be 9 years of age or older
- There is documentation that the axillary hyperhidrosis is severe, intractable and disabling in nature as documented by at least one of the following:
 - Significant disruption of professional and/or social life as a result of excessive sweating
 - The condition is causing persistent or chronic cutaneous conditions (e.g., skin maceration, dermatitis, fungal infections, secondary microbial infections)
- Potential causes of secondary hyperhidrosis have been ruled out (e.g., hyperthyroidism)
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to at least 2 months of topical aluminum chloride 20%
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
 - Documentation of improvement from baseline
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



Prescribing Provider Signature	Date