

PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

DIPENTUM
(olsalazine)

Status: CVS Caremark Criteria

Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS

Dipentum is indicated for the maintenance of remission of ulcerative colitis in patients who are intolerant of sulfasalazine.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the maintenance of remission of ulcerative colitis in patients who are intolerant of sulfasalazine

REFERENCES

1. Dipentum [package insert]. Somerset, New Jersey: Mylan Specialty L.P.; October 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Hudson, OH: Wolters Kluwer Clinical Drug Information, Inc. <http://online.lexi.com/>. June 2020.
3. Micromedex (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. <http://www.micromedexsolutions.com/>. June 2020.