



## Commercial/Healthcare Exchange PA Criteria Effective: February 2, 2021

**Prior Authorization:** Alkindi

**Products Affected:** Alkindi Sprinkle (hydrocortisone granule)

**Medication Description:** Short-acting corticosteroid with minimal sodium-retaining potential that causes varied metabolic effects.

**Covered Uses:** Replacement therapy in pediatric patients with adrenocortical insufficiency.

**Exclusion Criteria:**

1. Hypersensitivity to hydrocortisone

**Required Medical Information:**

1. Diagnosis
2. Previous medications tried

**Age Restrictions:** N/A

**Prescriber Restrictions:** N/A

**Coverage Duration:** 12 months

**Other Criteria:**

1. Patient has a diagnosis of adrenocortical insufficiency; **AND**
2. Patient has had treatment failure, intolerance, or a contraindication to ONE oral generic corticosteroid (e.g. hydrocortisone, dexamethasone, prednisone, prednisolone)

**References:**

1. Alkindi Sprinkle [Prescribing Information] Deer Park, IL: Eton Pharmaceuticals, Inc; October 2020. Accessed December 14, 2020.

**Policy Revision History:**

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	1/1/2021

January 2021



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