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| Clinical Policy Title: | colonoscopy preparation products |
| Policy Number: | RxA.074 |
| Drug(s) Applied: | OsmoPrep |
| Original Policy Date: | 05/20/2020 |
| Last Review Date: | 12/11/2025 |
| Line of Business Policy Applies to: | All lines of business (except Medicare) |

Criteria

I. Initial Approval Criteria

A. Colonoscopy Preparation (must meet all):

1. Failure of one (1) of the following:
 - a. Adults: Suprep® or Clenpiq® unless contraindicated or clinically significant adverse effects are experienced;
 - b. Pediatric patients 9 years and older: Clenpiq® unless contraindicated or clinically significant adverse effects are experienced.

Approval duration:

All Lines of Business (except Medicare): 4 weeks (One colonoscopy procedure)

II. Continued Therapy

A. Colonoscopy Preparation (must meet all):

1. Member is currently receiving medication in the past 120 days that has been authorized by RxAdvance or the member has met the initial approval criteria.

Approval duration:

All Lines of Business (except Medicare): 4 weeks (One colonoscopy procedure)

References:

N/A

| Review/Revision History | Review/Revised Date | P&T Approval Date |
|---|---------------------|-------------------|
| Policy was established | 01/2020 | 02/07/2020 |
| Updated Criteria II, A, i to: Currently receiving medication that has been authorized by RxAdvance benefit or member has previously met initial approval criteria. | 05/08/2020 | 05/20/2020 |

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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| <p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Sutab was added to this policy. 1. Approval duration for both initial approval criteria and continued therapy criteria was updated to 4 weeks. | 01/29/2021 | 03/09/2021 |
| <p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". | 11/23/2021 | 1/17/2022 |
| Policy was reviewed. | 07/27/2022 | 10/19/2022 |
| Policy was reviewed. | 10/19/2023 | 10/19/2023 |
| <p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Updated continuation of therapy language. 2. Updated approval duration verbiage. | 03/20/2025 | 04/10/2025 |
| Policy reviewed. | 12/11/2025 | 12/11/2025 |