PRIOR AUTHORIZATION CRITERIA

BRAND NAME*
(generic)

MULTAQ
(dronedarone)

Status: CVS Caremark® Criteria
Type: Initial Prior Authorization ***Ref # 532-A***

**Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

FDA-APPROVED INDICATIONS

Multaq is indicated to reduce the risk of hospitalization for atrial fibrillation in patients in sinus rhythm with a history of paroxysmal or persistent atrial fibrillation (AF).

COVERAGE CRITERIA

Atrial Fibrillation (AF)
Authorization may be granted when the requested drug is being prescribed to reduce the risk of hospitalization for atrial fibrillation (AF) in a patient with a history of paroxysmal or persistent AF, i.e., non-permanent AF

DURATION OF APPROVAL (DOA)

- 532-A: DOA: 12 months

REFERENCES

1. Multaq [package insert]. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; October 2023.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed April 3, 2024.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: *04/03/2024*).

Written by:	UM Development (NB)
Date Written:	08/2010
Revised:	(TM) 08/2011, 12/2011, 08/2012, 09/2012 (updated PI, question 1), 09/2013, 05/2014 (SF) 04/2015; (KM) 04/2016 (removed sinus rhythm and monitoring question), 09/2016 (updated wording of criteria for approval to not discriminate for TGC patients); (CT) 04/2017; (KM) 04/2018 (no clinical changes); (DFW) 04/2019 (removed MDC designation from title/document), 04/2020 (no clinical changes), 04/2021 (no clinical changes); (RZ) 04/2022 (no clinical changes); (DRS) 04/2023 (no clinical changes); (MRS) 04/2024 (no clinical changes)
Reviewed:	Medical Affairs 08/2010, (KP) 08/2011, (KP) 01/2012; (LS) 08/2012, (LS) 09/2012, 10/2012; (DC) 09/2013; (LS) 05/2014; (LCB) 04/2015; (ME) 08/2016; (AN) 04/2017; (GAD) 04/2019, CHART 04/30/20, (CHART) 04/22/2021, (CHART) 04/28/2022, 04/27/2023, 04/25/2024 External Review: 12/2010, 01/2012, 02/2012, 12/2012, 12/2013, 08/2014, 08/2015, 08/2016, 10/2016, 08/2017, 08/2018, 08/2019, 08/2020, 08/2021, 08/2022, 08/2023, 09/2024

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed to reduce the risk of hospitalization for atrial fibrillation (AF) in a patient with a history of paroxysmal or persistent AF, i.e., non-	Yes	No

permanent AF?
[No further questions]

Mapping Instructions			
	Yes	**No**	**DENIAL REASONS**
1.	Approve, 12 Months	Deny	Your plan only covers this drug when it is used for certain health conditions. Covered use is for a history of paroxysmal or persistent atrial fibrillation (AF). Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review. [Short Description: Diagnosis]