Drug Use Research & Management Program
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Orphan Drug Evaluation: Elamipretide

Date of Review: February 2026
Generic Name: Elamipretide

End Date of Literature Search: 10/31/25
Brand Name (Manufacturer): FORZINITY (Stealth BioTherapeutics Inc)
Estimated Yearly Cost: $793,520
Dossier Received: no

Purpose for Review:

- To review evidence of safety and effectiveness of elamipretide in people with Barth Syndrome and
- To establish prior authorization (PA) criteria to support medical appropriateness and necessity.

Plain Language Summary:

- Barth Syndrome is an inherited condition that decreases muscle strength, leads to heart failure, and increases risk of infection. There is no cure; treatment focuses on maintaining muscle function and managing symptoms such as tiredness, shortness of breath, or infections.
- In 2025, the Food and Drug Administration (FDA) approved a new medicine called elamipretide to improve muscle strength in people with Barth Syndrome.
- In 12 people with Barth Syndrome, elamipretide did not improve walking distance or tiredness compared to placebo (or sugar pill) over 12 weeks. Placebo also had similar benefit compared to elamipretide for outcomes of muscle strength, balance, time required to stand, overall disease improvement, and heart imaging at 12 weeks. This study enrolled people over 12 years of age who had mild or moderate motor function impairment. People with more severe disease and rapidly progressing symptoms were not included in the study.
- The Drug Use Research and Management group recommends that Oregon Health Authority only pay for elamipretide when other therapies available for symptoms of Barth Syndrome have been prescribed such as medicines to treat heart failure.

Research Questions:

1. What is the effectiveness and safety of elamipretide in people with Barth Syndrome?
2. Are there subpopulations based on age, symptom severity, type of heart failure, for which elamipretide is more effective or safe?

Conclusions:

- Elamipretide has no impact on motor function, heart failure symptoms, or fatigue in people with Barth Syndrome over 12 weeks (insufficient certainty evidence). A small randomized controlled trial (RCT) in 12 patients demonstrated no benefit in the 6-minute walk test (6MWT) or fatigue severity compared to placebo at 12 weeks.[1] There is no randomized controlled data evaluating elamipretide for longer than 12 weeks in people with Barth Syndrome, and observational data is significantly limited by lack of an adequate control group and high risk of bias.

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- There is insufficient evidence for safety of elamipretide in patients with Barth syndrome. The majority of long-term safety data comes from an open-label, uncontrolled, extension study in 10 patients over 3 years.[2] The most common side effects were injection site reactions (e.g., erythema, pruritus, injection-site pain).
- There is no data on specific populations of patients with Barth Syndrome who may benefit from therapy with elamipretide. There is insufficient evidence for use of elamipretide in other conditions.

Recommendations:

- Implement prior authorization for elamipretide to require documentation of genetic testing and supportive care for heart failure.

Background:

- Barth Syndrome is an X-linked mitochondrial disease caused by mutations in the TAFAZZIN (or TAZ) gene, an enzyme necessary for normal mitochondrial functioning. Common symptoms of Barth Syndrome include cardiomyopathy, skeletal muscle weakness or myopathy, delayed growth and cyclic neutropenia.[3] Other complications can include arrhythmias, prolonged QT intervals, and developmental delay.[3] Cardiomyopathy generally develops before the age of 5 years and is the most common cause of early mortality.[4,5] Risk of early mortality appears to be highest in the first few years of life; patients that survive into their teenage years typically have normal systolic function.[2,3] Advances in heart failure management have been correlated with improved mortality over time.[5]
- Current therapies focus on management of symptoms including heart failure related to cardiomyopathy and infection risk related to neutropenia.[6] Because Barth Syndrome is a rare condition, much of the direct evidence for treatments is based on case series, observational studies, and small trials.[6] There is very limited evidence from small observational studies (enrolling fewer than 20 people) that routine strength training or exercise may improve muscle function in people with Barth Syndrome.[7,8] In 2017, the American Heart Association in 2017 recommended the following treatments for people with neuromuscular disorders and cardiac involvement:[5]
    - Angiotensin converting enzyme (ACE) inhibitor/angiotensin receptor blocker {ARB) and beta adrenergic blockade for people with reduced ejection fraction (Class I; Level of Evidence B).[5] Level B evidence includes data from a single RCT or non-randomized studies.
    - Diuretics to achieve a euvolemic state in patients with fluid retention associated with ventricular dysfunction (Class I; Level of Evidence C).[5] Level C evidence is based on expert opinion, case studies or standard of care.
    - Aspirin or low-dose anticoagulation may be considered for people with Barth Syndrome and noncompaction phenotype (Class IIb; Level of Evidence C).
    - Thrombosis prophylaxis in the setting of normal systolic ventricular function and atrial fibrillation or flutter (Class IIb; Level of Evidence C).[5]
- In 2022, the American College of Cardiology issued the following recommendations for people with heart failure with preserved ejection fraction (HFpEF).[9] No specific recommendations were issued for people with neuromuscular disorders.
    - Sodium-Glucose Cotransporter-2 inhibitors (SGLT2i) can be beneficial in decreasing heart failure hospitalizations and cardiovascular mortality (moderate strength recommendation based on moderate quality evidence from randomized trials).[9]
    - Titrate medications to manage hypertension and prevent morbidity (strong recommendation based on limited data from randomized or nonrandomized studies) and manage atrial fibrillation to improve symptoms (moderate strength recommendation based on expert opinion).[9]
    - Mineralocorticoid receptor antagonist (MRAs), ARB, and angiotensin receptor/neprilysin inhibitor (ARNi) may be considered to decrease hospitalizations, particularly among patients with left ventricular ejection fraction on the lower end of this spectrum (weak strength recommendation based on moderate quality data from randomized trials).[9]

- Estimated frequency of diagnosis:
  - As an X-linked genetic disorder Barth Syndrome is more common in males.
  - Literature estimates vary and this condition may be underdiagnosed.
  - Estimated incidence: 1 in 300,000 to 400,000 births.[10]
  - Estimated prevalence: 1 in 1 million males.[2] Estimates of individuals affected in the United States range from 111 to 150 people.[10,11]
  - In Oregon Medicaid, 30 fee-for-service (FFS) and coordinated care organization (CCO) members had medical claims with a diagnosis of Barth Syndrome (ICD-10 code of E78.71) from 04/01/2024 to 03/31/2025. Claims estimates are likely inaccurate as many of these members also identified as female which is not consistent with an X-linked disease like Barth Syndrome which predominantly affects males.
- Diagnostic criteria:
  - The only definitive method to diagnose Barth Syndrome is genetic testing based on a pathogenic mutation in the TAZ gene.
  - 90% of patients with Barth Syndrome have cardiomyopathy.
- Outcome assessments:
  - The 6MWT measures distance walked over 6 minutes and evaluates both function and endurance. In healthy children and adolescents, the distance patients are able to walk is expected to remain stable or improve over time with estimated mean walk distances ranging from 500-700 meters.[12,13] In natural history studies of children and adolescents with Barth Syndrome, the average distance walked was 62% of the predicted value for matched cohorts with average values between 300 and 400 meters.[8] Distance walked was generally smaller for adults compared to children and adolescents.[8] A minimum clinically important difference for patients with Barth Syndrome has not been established in the literature. In Duchenne Muscular Dystrophy, a neuromuscular disorder that also causes skeletal muscle weakness and heart failure, an improvement of 30 meters has been documented as a clinically meaningful change.[14]
  - Total fatigue score based on the Barth Syndrome Symptom Assessment (BTHS-SA) includes 3 questions that evaluated fatigue at rest, fatigue during activities, and muscle weakness during activities.[11] Each question was scored on a 1 to 5 scale with higher scores indicating more severe symptoms. Total scores ranged from 3 (no symptoms) to 15 (severe symptoms).[11]

Drug Information

See **Appendix 1** for **Highlights of Prescribing Information** from the manufacturer, including Boxed Warnings and Risk Evaluation Mitigation Strategies (if applicable), indications, dosage and administration, formulations, contraindications, warnings and precautions, adverse reactions, drug interactions and use in specific populations.

Elamipretide was approved by the FDA through the accelerated approval pathway based on results from a secondary outcome (muscle strength of the knee extensors) in an uncontrolled phase 2 extension study. Elamipretide is thought to work by improving the function of mitochondria in muscle cells.

Clinical Efficacy and Safety:

Clinical trials used to support FDA approval are described and evaluated below in **Table 2**.

Noteworthy trial design and patient characteristics include:

- Key inclusion criteria:
  - Pathogenic genetic variant in the TAZ gene (genetically confirmed Barth syndrome)
  - Ambulatory with impairment in the 6MWT as assessed by the provider. A specific definition of impairment was not documented.
  - At least 12 years of age and weighing more than 30 kg.

- Key exclusion criteria:
    - Hospitalization within 30 days or likely to need hospitalization during the trial.
    - Uncontrolled hypertension >160/100 mmHg, history of heart transplant or on the waiting list for transplant, or implantation of cardioverter defibrillator within previous 3 months.
- Baseline disease severity and population characteristics: Patients had generally mild to moderate symptoms with mean baseline 6MWT of 395 meters with BTHS-SA fatigue score of 8 (on a 3 to 15 scale with higher scores indicating greater severity) and preserved ejection fraction (EF 60%). Baseline treatments for heart failure symptoms and muscle strength were not reported.
- Number of participants: 12
- Trial outcomes evaluated at 12 weeks with subsequent long-term extension trial.

Efficacy:

- Primary outcomes: No difference from placebo in the 6MWT or total fatigue score on the BTHS-SA scale.[1] The study was powered to detect differences in these endpoints.
- Secondary outcomes: While not powered to detect differences in the secondary endpoints, none of the more than 10 secondary clinical outcomes (including knee extensor muscle strength) were different from placebo at 12 weeks.[1]
- Exploratory outcomes in the long-term uncontrolled extension study: Ten patients (83%) were subsequently enrolled in a long-term extension study for an additional 168 weeks which provided the basis of FDA approval. In the long-term extension study, muscle strength of the knee extensors improved by a median of 34 Newtons after 12 weeks with subsequent increases of 35 to 68 Newtons over 3 years.[11] Outcomes are presented in **Table 1.** There is no established minimum clinically important difference for muscle strength in people with Barth Syndrome, and strength from a single muscle group has not been correlated with clinical functional outcomes.

Table 1. Exploratory outcomes of knee extensor muscle strength from the elamipretide trial[11]

Visit timepoint	N	Elamipretide Median Newtons (range)	Placebo Median Newtons (range)
Screening	12	131 (77-210)	
Week 12 (controlled study)	12	124 (72-176)	126 (66-195)
Week 12 (open label extension)	10	166 (93-228)	NA
Week 168 (open label extension)	8	193 (155-235)	NA

Safety:

- Common adverse events included injection site reactions including erythema (100%), pain (75%), induration (67%), pruritus (67%), bruising (25%), and urticaria (25%).[15] Similar adverse events have been reported in larger studies of elamipretide in other conditions.
- Four patients (33%) had discontinued treatment by week 36; in 2 cases discontinuation was related to hypersensitivity reactions.[11]
- Elamipretide was associated with increased eosinophil counts which were highest 90 days after treatment initiation and had returned to baseline levels after 6-12 months.[15]
- Elamipretide has not been studied in people weighing less than 30 kg, and it is not approved for neonates because of risk for benzyl alcohol toxicity.[15]

Subgroup analyses and other populations:

- This study enrolled too few patients to determine if there are certain populations who may benefit from therapy.
- There is insufficient evidence that elamipretide has benefit in other conditions. Elamipretide has been studied in other types of mitochondrial diseases including a phase 3 study in patients with primary mitochondrial myopathy with no improvement in the 6MWT or total fatigue scores,[16,17] in a phase 2 study of people with heart failure with reduced ejection fraction without improvement in left ventricular ejection fraction,[18] and in people with myocardial infarction without improvement in short-term cardiac outcomes.[19]

Major evidence limitations (see **Table 2** for details):

- Unclear risk of selection, performance, and reporting bias during the 12-week randomized, crossover period.
- Risk of performance, detection, and attrition bias during the open-label, non-controlled extension period related to lack of blinding, lack of a control group, attrition, and effort-dependent outcome measures.
- Applicability concerns related to the population studied. Data is primarily applicable to adolescents and adults with mild to moderate functional impairment and fatigue.

Table 2. Comparative Evidence Table.

Ref./ Study Design	Drug Regimens/ Duration	Patient Population	N	Efficacy Endpoints	ARR/ NNT	Safety Outcomes	ARR/ NNH	Risk of Bias/ Applicability
Reid Thompson, et al. 2020.[1] FDA Integrated review[11] NCT03098797 DB, PC, phase 2, single-site, crossover RCT	1. Elamipretide 40 mg SC daily 2. Placebo SC daily 12 week treatment period with 4 week washout before crossover to the alternative group. Patients could enroll in an open-label, non-controlled, extension study for up to 168 weeks.	Demographics: - Mean age 19.5 years - Race: White: 92% - 6MWT 395.5 m - BTHS-SA total fatigue: 8 - Mean EF: 60.6% - Median muscle strength (knee extensor): 131 (range 77-210) Newtons[11] Key Inclusion Criteria: - Genetically-confirmed Barth syndrome - Age ≥ 12 years - Ambulatory with impairment in the 6MWT - Stable medication regimen for ≥ 30 days - Body weight >30 kg with eGFR ≥90 mL/min/1.73 m^2 OR weight >40 kg with eGFR ≥60 mL/min/1.73 m^2	ITT: 12 Attrition during 12 week RCT: 0 Attrition during 36 week extension: 4 (33%)	Primary Endpoint from baseline to 12 weeks: Change in 6MWT 1. 43.0 m 2. 31.3 m Mean difference: 11.7m (95% CI -25.8 to 49.1); p=0.50 Median difference: -0.8 m (95% CI NR); p=0.97 Change in BTHS-SA total fatigue score 1. -1.4 2. -1.2 Mean difference -0.2 (95% CI -1.2 to 0.8); p=0.70 Median difference 0.06 (95% CI NR); p=0.89	NA	DC due to adverse events: 2 (17%) at week 12 related to injection site reactions	NA	**Risk of Bias (low/high/unclear)**: Selection Bias: UNCLEAR. Method of randomization was not reported. Baseline differences in mean age and BMI for people who received treatment-placebo (15.7 years and 18.23 kg/m^2) versus placebo-treatment (23 years and 16.88 kg/m^2). Performance Bias: UNCLEAR. Patient and study team were blinded with matching placebo; presence of injection site reactions may have resulted in unblinding. The extension period has high risk of bias related to lack of a control group or blinding particularly for effort-dependent outcomes like muscle strength and motor function tests. Detection Bias: LOW. Data management team and sponsor blinded to treatment with matching placebo. The open-label extension period has high risk of bias particularly for effort-dependent motor function and muscle strength. Attrition Bias: LOW. No attrition during the 12-week crossover period. High risk of bias for the extension period (33% discontinued treatment). Reporting Bias: HIGH. Data related to primary and secondary outcomes during the randomized crossover period was not reported. Outcomes during the non-controlled, extension period were emphasized. Study sponsor was involved with data analysis and writing the manuscript. Other Bias: UNCLEAR. Study funded by manufacturer. Cross-over design with adequate wash-out period between treatment periods based on expected drug duration.

		Key Exclusion Criteria: - Hospitalization within 30 days or likely to need hospitalization - Hypertension > 160/100 mmHg - History of heart transplant or on the waiting list for transplant - History of substance abuse - Implantation of cardioverter defibrillator within 3 months - Recent pubertal growth spurt - Current immuno-suppressive or chemotherapeutic drugs		Secondary Endpoint at 12 weeks: Change from baseline in muscle strength of knee extensors 1. 4 N 2. -5 N MD 6.7 Newtons; p=0.65 No difference from placebo in other secondary endpoints including: - 5-times sit-to-stand test - echocardiographic measurements - accelerometry counts - balance assessments - clinician, caregiver and patient global impression scales - other patient-reported fatigue and quality of life scales Specific outcome data was not reported.				**Applicability**: Patient: Exclusion criteria related to age, recent hospitalization, need for transplant, and ambulation would exclude patients with more severe or progressive disease. Barth Syndrome has primarily been associated with left ventricular dilation and reduced ejection fraction, but eligibility criteria based on age may select for people with preserved systolic function (mean EF 60%). Of enrolled patients 11 of 12 were White although Barth syndrome affects all ethnic groups. Intervention: The 40 mg dose was selected based on dosing in early studies of people with mitochondrial myopathy. However, subsequent trials in in mitochondrial myopathy have failed to demonstrate clinical benefit in the 6MWT. Standard of care interventions for heart failure, fatigue, or motor function were not described. Comparator: Placebo appropriate to determine efficacy. Data from the extension period lacks a comparator and does not control for potential confounding factors including patient growth or adjunct therapy. Outcomes: 6MWT, fatigue, and motor scales are appropriate to evaluate symptoms in a disease that commonly causes heart failure. 12 weeks is a relatively short period for a chronic, progressive disease. Cardiomyopathy is the leading cause of death in Barth syndrome and elamipretide does not appear to impact symptoms of heart failure. Setting: Single site (Johns Hopkins Hospital) beginning July 2017. The open-label extension was ongoing as of September 2020
Abbreviations: 6MWT = 6-minute walk test; ARR = absolute risk reduction; BTHS-SA = Barth Syndrome Symptom Assessment; CI = confidence interval; DB = double blind; DC = discontinue; EF = ejection fraction; eGFR = estimated glomerular filtration rate; ITT = intention to treat; kg = kilogram; MD = mean difference; m = meters; mITT = modified intention to treat; mmHg = millimeters mercury; N = number of subjects; NA = not applicable; NNH = number needed to harm; NNT = number needed to treat; NR = not reported; PC = placebo controlled; PP = per protocol; RCT = randomized controlled trial; SC = subcutaneous;								

References:

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Appendix 1: Prescribing Information Highlights

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use FORZINITY™ safely and effectively. See full prescribing information for FORZINITY.

FORZINITY (elamipretide) injection, for subcutaneous use
Initial U.S. Approval: 2025

----------INDICATIONS AND USAGE----------
FORZINITY™ is a mitochondrial cardiolipin binder indicated to improve muscle strength in adult and pediatric patients with Barth syndrome weighing at least 30 kg. (1)

This indication is approved under accelerated approval based on an improvement in knee extensor muscle strength, an intermediate clinical endpoint. (14) Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

----------DOSAGE AND ADMINISTRATION----------
For patients weighing 30 kg and greater, the recommended dosage is 40 mg subcutaneously once daily. (2.1)

Reduce the dose in adults with severe renal impairment. (2.2, 8.6).

----------DOSAGE FORMS AND STRENGTHS----------
Injection: 280 mg/3.5 mL (80 mg/mL) solution for injection in single-patient-use vials. (3)

----------CONTRAINDICATIONS----------
Serious hypersensitivity to any of the ingredients (4, 5.2)

----------WARNINGS AND PRECAUTIONS----------
- Benzyl alcohol toxicity: Do not use in neonates. (5.1)

----------ADVERSE REACTIONS----------
Most common adverse reactions are injection site reactions. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Stealth BioTherapeutics Inc. at 1-844-444-6486 or FDA at 1-800-FDA-1088 or *www.fda.gov/medwatch.*

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

Revised: 9/2025

Elamipretide

Goal(s):

- Promote evidence-based standard of care in patients diagnosed with Barth Syndrome and with symptoms of cardiomyopathy and heart-related conditions.
- Limit to populations in which elamipretide has been studied and approved by the Food and Drug Administration.

Length of Authorization:

- Up to 12 months

Requires PA:

- Elamipretide

Covered Populations: FFS and CCO populations beginning 1/1/26 (pharmacy or provider administered claims)

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Table 1. Recommended adjunct treatments for heart-related conditions

Population	Adjunct treatment
Ejection fraction ≤ 40%	ACE inhibitor, ARB or angiotensin receptor/neprolysin inhibitor (ARNI) AND Beta blocker
Arrhythmias (atrial fibrillation or flutter) or non-compaction cardiomyopathy	Aspirin or anticoagulation
Current edema related to heart failure	Diuretics to achieve a euvolemic state (chronic or as needed)

Table 2. Target doses for Common HFrEF therapies

ACE inhibitor/ARB/ARNI	**Target Dose**	**Beta Blockers**	**Target Dose**
Candesartan	32 mg once daily	Bisoprolol	10 mg once daily
Captopril	50 mg three times daily	Carvedilol	25 mg twice daily
Enalapril	10 mg twice daily	Carvedilol CR	80 mg once daily
Fosinopril	40 mg once daily	Metoprolol	200 mg once daily
Lisinopril	20 mg once daily		

Losartan	50 mg once daily		
Quinapril	20 mg twice daily		
Ramipril	10 mg once daily		
Sacubitril-valsartan	97-103 mg twice daily		
Valsartan	160 mg twice daily		

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the request for a patient with a prior FFS approval for the requested drug?	**Yes**: Go to **Renewal Criteria**	**No:** Go to #3
3. Is there documentation of genetically-confirmed Barth Syndrome (e.g., pathogenic mutation in the TAZ gene)?	**Yes**: Go to #4	**No:** Pass to RPh. Deny; medical appropriateness
4. Is the request for a patient who weighs at least 30 kg?	**Yes**: Go to #5	**No:** Pass to RPh. Deny; medical appropriateness
5. Is the drug prescribed by a pediatric cardiologist or other specialist with experience in mitochondrial disorders?	**Yes**: Go to #6	**No:** Pass to RPh. Deny; medical appropriateness
6. Are there documented baseline assessments for all the following within the past year: • Cardiac function (e.g., ejection fraction) • Ambulatory motor function (e.g., 6MWT) • Muscle strength (e.g., physical therapy assessment)?	**Yes**: Go to #7	**No:** Pass to RPh. Deny; medical appropriateness
7. Is there documentation or provider attestation that the patient has impaired ambulatory function but is still able to complete a 6-minute walk test?	**Yes**: Go to #8	**No:** Pass to RPh. Deny; medical appropriateness
8. Is there documentation or provider attestation that medication therapy for heart failure has been optimized when appropriate (Table 1 and 2)?	**Yes:** Go to #9	**No:** Pass to RPh. Deny; medical appropriateness

Approval Criteria		
9. Is there documentation or provider attestation that a follow-up visit is scheduled with 4 weeks of initiation to assess tolerability and adherence?	**Yes**: Go to #10	**No:** Pass to RPh. Deny; medical appropriateness
10. Has the provider documented patient-specific goals for this therapy over the next 6 months? Note: Goals of therapy can vary from improvement in fatigue, motor function, quality of life disease, burden reduction, or disease stabilization.	**Yes**: Go to #11	**No:** Pass to RPh. Deny; medical appropriateness
11. Has the provider defined objective criteria to evaluate unsuccessful treatment or lack of response based on individual patient goals and current symptoms (i.e., when would the provider consider discontinuing therapy)? To qualify for treatment coverage, the patient and provider must have a documented discussion about when risks of the therapy outweigh the benefits and a knowledge of the realistic expectations of treatment efficacy. Care must always take place in the context of the patient's support systems, overall heath, and core values.	**Yes:** Pass to RPh; Pend. Refer to DMAP for secondary review. Initial approval duration: 12 weeks	**No:** Pass to RPh. Deny; medical appropriateness

Renewal Criteria		
1. Is there documented evidence of adherence and tolerance to therapy based on claims history and provider assessment?	**Yes:** Go to #2	**No:** Pass to RPh. Deny; medical appropriateness
2. Has the provider re-evaluated the following baseline assessments within the past 2 months? • Motor function (e.g., 6MWT) • Muscle strength (e.g., physical therapy assessment)	**Yes:** Go to #3	**No:** Pass to RPh. Deny; medical appropriateness

Renewal Criteria		
3. Is there documentation that muscle strength has improved from baseline? Note: FDA-approval was based on improvements in knee extensor muscle strength after treatment over 12 weeks which continued to improve with over 3 years of follow-up.	**Yes**: Go to #4	**No:** Pass to RPh. Deny; medical appropriateness
4. Is there documentation that the patient's goals of therapy established prior to treatment have been met?	**Yes:** Pass to RPh; Pend. Refer to DMAP for secondary review. Approval duration: 12 months	**No:** Go to #5
5. Is there documentation that pre-established criteria for unsuccessful treatment or lack of response have been met?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #6
6. Have the patient and provider had a documented discussion about when benefits of the therapy outweigh the potential risks?	**Yes:** Pass to RPh; Pend. Refer to DMAP for secondary review. Approval duration: 12 months	**No:** Pass to RPh. Deny; medical appropriateness

P&T/DUR Review: 2/26 (SS)
Implementation: TBD