



Hyftor (sirolimus) Quantity Limit Program Summary

This program applies to Medicaid.

POLICY REVIEW CYCLE

Effective Date
2/1/2024

Date of Origin
3/1/2023

FDA APPROVED INDICATIONS AND DOSAGE

See package insert for FDA prescribing information: <https://dailymed.nlm.nih.gov/dailymed/index.cfm>

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Hyftor	Sirolimus Gel	0.2 %	7	Tubes	84	DAYS			

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Hyftor	Sirolimus Gel	0.2 %	Medicaid

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. ALL of the following: <ol style="list-style-type: none"> A. The requested quantity (dose) exceeds the program quantity limit AND B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit <p>Length of Approval: 12 months</p>