Pharmacy Medical Necessity Guidelines:
Mytesi™ (crofelemer)

Effective: March 10, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	Rx	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Mytesi (crofelemer) is indicated for symptomatic relief of non-infectious diarrhea in adult patients with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) on anti-retroviral therapy.

Several studies have found that patients with HIV experience diarrhea at a higher rate than other populations. The management of idiopathic, noninfectious diarrhea, associated with HIV or protease inhibitor use has generally been nonspecific. Commonly used therapies include anti-motility agents (e.g., loperamide, diphenoxylate/atropine), adsorbents (e.g., bismuth subsalicylate), bulk-forming fiber supplements, calcium supplements, and at times, pancrelipase or octreotide.

COVERAGE GUIDELINES

The plan may authorize coverage of **Mytesi (crofelemer)** for Members, when the **ALL** the following criteria are met:

1. Documented diagnosis of noninfectious diarrhea associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)

AND

2. The Member has had an inadequate response or adverse reaction to at least two other commonly used generic therapies for non-infectious diarrhea, including but not limited to:
   a) Anti-motility agents (e.g. loperamide, diphenoxylate/atropine)
   b) Adsorbents (e.g. bismuth subsalicylate)
   c) Bulk-forming fiber supplements
   d) Calcium supplements

LIMITATIONS

Note: Mytesi™ has been previously marketed under name Fulyzaq. Product strength and formulation remains the same.

CODES

None

REFERENCES

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2. Cello JP, Day LW. Idiopathic AIDS enteropathy and treatment of gastrointestinal opportunistic pathogens. *Gastroenterology.* 2009;136(6):1952-65.
3. Department of Health and Human Services (DHHS) Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1 infected adults and adolescents. 2016 July 16. URL: aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf Available from Internet. Accessed 2016 July 21.
4. Framptom JE. Crofelemer: a review of its use in the management of non-infectious diarrhoea in adult patients with HIV/AIDS on antiretroviral therapy. Drugs. 2013 Jul;73(10):1121-9.
5. MacArthur RD, DuPont HL. Etiology and pharmacologic management of noninfectious diarrhea in HIV-infected individuals in the highly active antiretroviral therapy era. *Clin Infect Dis.* 2012b;55(6):860-7.

6. MacArthur R, Hawkins T, Brown S, et al. Efficacy and safety of crofelemer for noninfectious diarrhea in HIV-seropositive individuals (ADVENT trial): a randomized, double-blind, placebo-controlled, two-stage study. *HIV Clin Trials*. 2013 Nov-Dec;14(6):261-73.
7. Mytesi (crofelemer) [prescribing information]. San Francisco, CA: Napo Pharmaceuticals, Inc.; February 2024.
8. Sherman DS, Fish DN. Management of protease inhibitor-associated diarrhea. *Clin Infect Dis.* 2000;30(6):908-14.

APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. June 13, 2023: No changes.
2. March 12, 2024: Effective April 1, 2024, updated wording for previous trial language. Updated RxUM fax number.
3. March 11, 2025: No changes
4. March 10, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services