Ohio Medicaid Fee-For-Service

Pharmacy Benefit Management Program

Preferred Drug List

Effective April 1, 2017

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Analgesic Agents: NSAIDs

LENGTH OF AUTHORIZATIONS: Dependent on medication request

NSAID Type	Approval Criteria	Approval Length
Non-Gastroprotective NSAIDs	no less than a one-month trial of at least two non-gastroprotective NSAID medications	1 year
Gastroprotective	no less than a one-month trial of at least two non-gastroprotective NSAID medications.	1 year
Gastroprotective	patient is undergoing surgical or other medical procedures that may predispose them to potential bleeding complications.	2 months
Gastroprotective	patients is being treated for H. pylori.	30 days
Transdermal/Topical	diclofenac solution and gel: no less than a one-month trial of at least two oral NSAID medications within the past 6 months	3 months
Transdermal/Topical	diclofenac patch: no less than a 7-day trial on one oral NSAID	14 days

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval. Acceptable contraindications for GASTROPROTECTIVE NSAIDs include:
  - Concurrent or history of a GI event (perforation, ulcer, bleed)
  - Other risks for treatment with NON-GASTROPROTECTIVE NSAIDs:
    - Coagulation disorders (i.e. hemophilia, chronic liver disease), erosive esophagitis
    - Documented NSAID-induced ulcer
    - Peptic ulcer disease (PUD)
    - Patient on warfarin or heparin
    - Patient on oral corticosteroids
    - Patient on methotrexate
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

1. The medication is prescribed for an approved indication
2. There has been a therapeutic failure as defined as:

- NON-GASTROPROTECTIVE NSAIDS:
  - no less than a one-month trial of at least two non-gastroprotective NSAID medications
- GASTROPROTECTIVE NSAIDS:
  - no less than a one-month trial of at least two non-gastroprotective NSAID medications.

    OR

- patient is undergoing surgical or other medical procedures that may predispose them to potential bleeding complications.
  OR
- patient is being treated for H. pylori.

- TRANSDERMAL/TOPICAL:
  - DICLOFENAC SOLUTION AND GEL: no less than a one-month trial of at least two oral NSAID medications within the past 6 months
    OR
  - DICLOFENAC PATCH: no less than a 7-day trial on one oral NSAID and no more than 2 patches per day

ANALGESIC AGENTS: NON-GASTROPROTECTIVE NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DICLOFENAC SODIUM (generic of Voltaren®) DICLOFENAC POTASSIUM (generic of Cataflam®) ETODOLAC (generic of Lodine, Lodine XL) FENOPROFEN IBUPROFEN (generic of Motrin®) INDOMETHACIN (generic of Indocin®) KETOPROFEN KETOROLAC MECLOFENAMATE SODIUM MEFENAMIC ACID (generic of Ponstel®) MELOXICAM (generic of Mobic®) NABUMETONE NAPROXEN OXAPROZIN (generic of Daypro®) PIROXICAM (generic of Feldene®) SULINDAC TOLMETIN	ZORVOLEX® (diclofenac) TIVORBEX® (indomethacin) VIVLODEX ™ (meloxicam)

ANALGESIC AGENTS: GASTROPROTECTIVE NSAIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CELECOXIB (generic for Celebrex®) (no PA required for age 60 or older)	CELECOXIB (generic for Celebrex®) (PA required for under age 60) DICLOFENAC/MISOPROSTOL (generic of Arthrotec®) DUEXIS® (ibuprofen/famotidine) VIMOVO® (naproxen/esomeprazole)

ANALGESIC AGENTS: NSAIDS TRANSDERMAL/TOPICAL

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
VOLTAREN® gel (diclofenac sodium)	DICLOFENAC 1.5% topical solution (generic of Pennsaid®) FLECTOR® patch (diclofenac epolamine) PENNSAID® 2% solution (diclofenac sodium)

Analgesic Agents: Gout

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to an agent not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- Febuxostat will be approved after adequate trial of allopurinol, or intolerance/contraindication to allopurinol.
- Lesinurad will be approved when target serum uric acid levels (<6mg/dL) are not achieved on appropriate dose of xanthine oxidase inhibitor alone for at least 90 days and the treatment plan includes ongoing use of an appropriate dose of xanthine oxidase inhibitor
    - Appropriate dose of xanthine oxidase inhibitors:
        - Allopurinol: 300mg daily (200mg daily in patients with eCrCl <60mL/min)
        - Febuxostat: 80mg daily
- Colchicine will be approved if any one of the following is true:
    - Diagnosis of Familial Mediterranean Fever (FMF) (6 month approval); OR
    - Trial of one of the following:
        - NSAID (i.e., indomethacin, naproxen, ibuprofen, sulindac, ketoprofen)
        - Oral corticosteroid

ANALGESIC AGENTS: GOUT – Agents to Reduce Hyperuricemia

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALLOPURINOL (generic of Zyloprim®) PROBENECID (generic for Benemid®) PROBENECID-COLCHICINE	ULORIC® (febuxostat) ZURAMPIC® (lesinurad)

ANALGESIC AGENTS: GOUT – Analgesic Agents*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
MITIGARE® capsules (colchicine)	COLCHICINE (generic of Colcrys®)

* Colchicine quantity limit 6 tabs/claim for acute gout, 60 tabs/month for chronic gout after trial on xanthine oxidase inhibitor, 120 tabs/month for FMF

Analgesic Agents: Opioids

LENGTH OF AUTHORIZATIONS: 6 months

STEP THERAPY: Long-acting drugs

1. For a preferred brand, there must have been inadequate clinical response to preferred generic alternatives, including a trial of no less than one week of at least one preferred generic
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one week each of at least two preferred generics or brands

STEP THERAPY: Short-acting drugs

1. Short-acting, single entity, CII tablets/capsules require previous utilization of at least one combination product or tramadol, for no less than one week
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one week each of at least two preferred agents

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to at least two unrelated medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient must have failed the generic product (if covered by the state) before brand is authorized, in addition to the above.

ADDITIONAL CRITERIA FOR TRANSMUCOSAL FENTANYL:

- Diagnosis of cancer pain; and
- Prescription is from oncologist or pain specialist; and
- Concurrently taking a long-acting opioid at therapeutic dose (any of the following for ≥1 week without adequate pain relief):
  - ≥ 60 mg oral morphine/day, or
  - ≥ 25 mcg/hr transdermal fentanyl, or
  - ≥ 30 mg oral oxycodone/day, or
  - ≥ 8 mg oral hydromorphone/day, or
  - ≥ 25 mg oral oxymorphone/day, or
  - Equianalgesic dose of another opioid; and
- Dose is </= 4 units per day

ANALGESIC AGENTS: OPIOIDS – Long-Acting Oral

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
Extended Release Buprenorphine Products		
		BELBUCA™ (Buprenorphine buccal film)
Extended Release Hydrocodone Products		
		ZOHYDRO ER® (hydrocodone)
Extended Release Morphine Products		
MORPHINE SULFATE ER tablet (generic of MS Contin®)		EMBEDA® (morphine sulfate/ naltrexone) MORPHINE SULFATE ER capsule (generic of Avinza®, Kadian®)
Extended Release Oxycodone Products		
		HYSINGLA ER® (hydrocodone) OXYCODONE ER (generic of Oxycontin®) OXYCONTIN® (oxycodone) XARTEMIS XR® (oxycodone/ acetaminophen) XTAMPZA® ER (oxycodone)
Extended Release Tramadol Products		
		CONZIP® (tramadol) TRAMADOL ER (generic of Ryzolt ER®, Ultram ER®)
Extended Release Oxymorphone Products		
		OPANA® ER tablets (oxymorphone abuse-deterrent) OXYMORPHONE HCL ER tablets (generic of Opana® ER non-abuse-deterrent)
Extended Release Hydromorphone Products		
		HYDROMORPHONE ER (generic of Exalgo® ER)
Extended Release Tapentadol Products		
	NUCYNTA® ER (tapentadol)	

ANALGESIC AGENTS: OPIOIDS – Long-Acting Transdermal

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
		BUTRANS® patch (buprenorphine) FENTANYL PATCH (generic of Duragesic®) FENTANYL patch 37.5mg/hr, 62.5mg/hr, 87.5mg/hr

ANALGESIC AGENTS: OPIOIDS – Short-Acting Oral Single-Entity CII *

* Note: Step therapy required for all Short-Acting Oral Single-Entity CII products; patient must have prior therapy with combination products or tramadol

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
Codeine Products	
CODEINE SULFATE tablet	
Hydromorphone Products	
HYDROMORPHONE HCL tablet (generic of Dilaudid®)	
Levorphanol Products	
	LEVORPHANOL TABLETS (generic of Levo-Dromoran®)
Meperidine Products	
	MEPERIDINE tablet (generic of Demerol®)
Methadone Products	
	METHADONE tablet (generic of Dolophine®)
Morphine Products	
MORPHINE SULFATE: immediate-release tablets (generic of MSIR®)	
Oxycodone Products	
ROXICODONE® tablets (oxycodone) OXYCODONE HCL capsules, tablets (generic of M-Oxy®, OxyIR®)	OXECTA® (oxycodone)
Oxymorphone Products	
	OXYMORPHONE HCL tablets (generic of Opana®)
Tapentadol Products	
NUCYNTA® (tapentadol)	

ANALGESIC AGENTS: OPIOIDS – Short-Acting Combination

NO PA REQUIRED "PREFERRED"	PA REQUIRED
Codeine Combinations	
ACETAMINOPHEN w/CODEINE TABLETS (generic of Tylenol® #2, #3, #4)	
Dihydrocodeine Combinations	
	DIHYDROCODEINE/ASPIRIN/CAFFEINE (generic of Synalgos-DC®)
Hydrocodone Combinations	
HYDROCODONE/ACETAMINOPHEN tablets containing 325mg acetaminophen (generic of Lorcet®, Lortab®, Norco®)	HYDROCODONE/ IBUPROFEN (generic of Ibudone®, Vicoprofen®) HYDROCODONE/ACETAMINOPHEN tablets containing 300mg acetaminophen (generic of Vicodin®, Xodol®)
Oxycodone Combinations	
OXYCODONE W/ ACETAMINOPHEN tablets (generic of Percocet®)	OXYCODONE W/ IBUPROFEN (generic of Combunox®) PRIMLEV® (oxycodone/ acetaminophen)
Pentazocine Combinations	
Not advocated for use	PENTAZOCINE/NALOXONE (generic of Talwin NX®)
Tramadol Combinations	
TRAMADOL/ACETAMINOPHEN (generic of Ultracet®)	
Carisoprodol Combinations	
	CARISOPRODOL/ASPIRIN/CODEINE (generic of Soma Compound w/Codeine®)

ANALGESIC AGENTS: CENTRAL, WITH OPIOID ACTIVITY

NO PA REQUIRED "PREFERRED"	PA REQUIRED
TRAMADOL (generic of Ultram®)	

ANALGESIC AGENTS: OPIOIDS –Liquids Immediate-Release (Single Entity)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HYDROMORPHONE 1mg/ml liquid (generic of Dilaudid-5®) MORPHINE SULFATE solution: 10 mg/5ml, 20mg/5ml, 20mg/ml (generic of MSIR Soln®, Roxanol Soln®) OXYCODONE oral solution 5mg/5ml, concentrate 20mg/1ml (generic of Oxydose®, Roxicodone Intensol®)	MEPERIDINE HCL SYRUP 50 mg/5ml (generic of Demerol Oral Syrup®) METHADONE HCL oral concentrate 10mg/ml METHADONE HCL SOLN 5mg/5ml, 10mg/5ml METHADONE INTENSOL® 10mg/ml

ANALGESIC AGENTS: OPIOIDS – Liquids and Oral Syrup Immediate-Release (Combination)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACETAMINOPHEN w/CODEINE ORAL SOLN 120mg-12mg/5ml (generic of Tylenol w/Codeine Elixir®) HYDROCODONE BITARTRATE w/ ACETAMINOPHEN ELIXIR 2.5mg-167mg/5ml, 2.5mg-108mg/5ml (generic of Hycet®, Lortab Elixir®) LORTAB® 10mg-300mg/15ml (hydrocodone/ acetaminophen) ROXICET® ORAL SOLN (5mg Oxycodone-325mg APAP/5ml)	CAPITAL w/CODEINE® suspension 12mg codeine-120mg APAP/5ml ZAMICET® 10mg-325mg/15ml (hydrocodone/ acetaminophen)

ANALGESIC AGENTS: OPIOIDS – Nasal Inhalers

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUTORPHANOL TARTRATE NS (generic of Stadol NS®)	

ANALGESIC AGENTS: OPIOIDS – Transmucosal System *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	ABSTRAL® (fentanyl) FENTANYL CITRATE (generic of Actiq®) FENTORA® (fentanyl) SUBSYS® (fentanyl)

* Note: Clinical criteria must be met for transmucosal systems

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

LENGTH OF AUTHORIZATIONS: Dependent on diagnosis

ALL PRODUCTS IN THIS CLASS REQUIRE CLINICAL PRIOR AUTHORIZATION:

Approval of epoetin alfa or darbepoetin:

Diagnosis	Hemoglobin Level	Approval Length
Anemia due to chronic renal failure, patient on dialysis	<=11	12 months
Anemia due to chronic renal failure, patient not on dialysis	<=10	12 months
Chemotherapy-induced anemia	<=10	3 months
Anemia in myelodysplastic syndrome	<=11	6 months

Approval of epoetin alfa only (not darbepoetin):

Diagnosis	Hemoglobin Level	Approval Length
Autologous blood donation, patient will require blood transfusions	>10, <=13	1 month
Anemia of prematurity, age <=6 months	N/A	6 weeks
Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis)	<=11	6 months
Anemia associated with ribavirin combination therapy in hepatitis C-infected patient	<=11	6 months
Anemia in zidovudine-treated HIV-infected patients	<=11	6 months

PDL CRITERIA:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with preferred medications?

BLOOD AGENTS: HEMATOPOIETIC AGENTS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
ARANESP® (darbepoetin alfa) PROCRIT® (epoetin alfa)	EPOGEN® (epoetin alfa) MIRCERA® (methoxy polyethylene glycol-epoetin beta)

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

LENGTH OF AUTHORIZATIONS: Varies based on criteria below

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with medications not requiring prior approval?

DURATION OF THERAPY LIMIT: 35 days

Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than five weeks. Patients should be transitioned to oral warfarin as soon as possible.

Is there any reason the patient cannot be changed to oral warfarin? Acceptable reasons include:
- patients with cancer (approved up to 6 months),
- pregnant women (approved up to 40 weeks), or
- patients unable to take warfarin (approved up to 6 months).

BLOOD AGENTS: HEPARIN-RELATED PREPARATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FRAGMIN® (dalteparin) ENOXAPARIN (generic of Lovenox®)	FONDAPARINUX (generic of Arixtra®)

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

LENGTH OF AUTHORIZATIONS: 1 year

INDICATIONS:

		Apixaban	Clopidogrel	Dabigatran	Edoxaban	Prasugrel	Rivaroxaban	Ticagrelor	Voraxapar	Warfarin
Reduction of atherosclerotic events:	After cardiac valve replacement									✓
	In established peripheral arterial disease		✓						✓	
	In non-STEMI ACS		✓			✓		✓		✓
	In non-valvular atrial fibrillation	✓		✓	✓		✓ (15 & 20mg)			✓
	In recent MI or stroke		✓						✓ (MI only)	✓
	In STEMI ACS		✓			✓		✓		✓
Thrombosis Risk and Treatment	Treatment of venous thrombosis, pulmonary embolism	✓		✓ (in patients who have been treated with a parenteral anticoagulant for 5-10 days)	✓ (in patients who have been treated with a parenteral anticoagulant for 5-10 days)		✓ (15 & 20mg)			✓
	Prophylaxis of DVT in patients undergoing total hip or knee replacement	✓		✓ (in hip replacement only)			✓ (10mg)			✓
	Reduce risk of recurrence of DVT and PE in patients who have been previously treated	✓		✓			✓ (20mg)			

DVT: deep vein thrombosis; STEMI: ST-elevated myocardial infarction; ACS: acute coronary syndrome; MI: myocardial infarction

APPROVAL CRITERIA:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed a therapeutic trial of two weeks with one medication not requiring prior approval?

BLOOD AGENTS: ORAL ANTICOAGULANTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ELIQUIS® (apixaban) PRADAXA® (dabigatran) WARFARIN (generic of Coumadin®) XARELTO® (rivaroxaban) *	SAVAYSA® (edoxaban)

* Note: Duration limit of 35 days applies to Xarelto 10mg tablets, see Heparin-Related Preparations for details

BLOOD AGENTS: PLATELET AGGREGATION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BRILINTA® (ticagrelor) CLOPIDOGREL (generic of Plavix®) EFFIENT® (prasugrel) WARFARIN (generic of Coumadin®)	DURLAZA® (aspirin ER capsule) ZONTIVITY® (vorapaxar sulfate)

Cardiovascular Agents: Angina, Hypertension & Heart Failure

LENGTH OF AUTHORIZATIONS: 1 year

ANGIOTENSIN II RECEPTOR ANTAGONIST (ARB) AND ARB COMBINATION THERAPY:

1. For a drug requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month of at least one preferred product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month each of at least two preferred or step therapy products
3. For ARB/calcium channel blocker combinations, the preferred drug trial may be a calcium channel blocker or ARB
4. For ARB/beta blocker combinations, the preferred drug trial may be a preferred beta blocker or ARB

CHRONIC STABLE ANGINA STEP THERAPY:

Ranolazine (Ranexa®) may be approved if there has been a therapeutic failure to no less than a one-month trial of at least one beta blocker, calcium channel blocker, or nitrate (excluding sublingual nitroglycerin).

HYPERPOLARIZATION-ACTIVATED CYCLE NUCLEOTIDE-GATED CHANNEL INHIBITOR CLINICAL PRIOR AUTHORIZATION CRITERIA:

Ivabradine (Corlanor®) may be approved if all of the following are met:

1. Diagnosis of stable, symptomatic heart failure, and
2. Left ventricular ejection fraction less than or equal to 35%, and
3. Resting heart rate 70 bpm or higher, and
4. Patient in sinus rhythm, and
5. Heart failure symptoms persisting with maximally tolerated doses of beta blockers, or patient has a contraindication to beta blocker therapy.

ARB/ NEPRILYSIN INHIBITOR COMBINATION CLINICAL PRIOR AUTHORIZATION CRITERIA:

Valsartan/sacubitril (Entresto™) may be approved if all of the following are met:

1. Diagnosis of chronic heart failure (NYHA Class II-IV), and
2. Age greater than or equal to 18 years, and
3. Left ventricular ejection fraction less than or equal to 35%, and
4. No history of angioedema or unacceptable side effects with ACE inhibitor or ARB, and
5. If patient has diabetes, not concomitantly taking aliskiren, and
6. Not concomitantly taking an ACE inhibitor or other ARB, and
7. Patient does not have severe hepatic impairment (Child-Pugh C).

OTHER APPROVAL CRITERIA:

1. Is there any reason the patient cannot be changed to a preferred medication? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with preferred medications
   - History of unacceptable/toxic side effects to preferred medications
2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval
   - The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated
3. If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication. This medication should be reviewed for need at each request for reauthorization.

CHRONIC STABLE ANGINA

NO PA REQUIRED "PREFERRED"	PA REQUIRED
Generic beta blockers Generic calcium channel blockers Generic nitrates	RANEXA® (ranolazine)

ACE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENAZEPRIL (generic of Lotensin®) CAPTOPRIL (generic of Capoten®) ENALAPRIL (generic of Vasotec®) EPANED® (enalapril oral solution) FOSINOPRIL (generic of Monopril®) LISINOPRIL (generic of Zestril®, Prinivil®) MOEXIPRIL (generic of Univasc®) PERINDOPRIL ERBUMINE (generic of Aceon®) QUINAPRIL (generic of Accupril®) RAMIPRIL (generic of Altace®) TRANDOLAPRIL (generic of Mavik®)	QBRELIS™ (lisinopril oral solution)

ACE INHIBITORS/CCB COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMLODIPINE/BENAZEPRIL (generic of Lotrel®) TARKA® (verapamil/trandolapril)	PRESTALIA® (perindopril-amlodipine tablet) VERAPAMIL/TRANDOLAPRIL (generic of Tarka®)

ACE INHIBITORS/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BENAZEPRIL/HCTZ (generic of Lotensin HCT®) CAPTOPRIL/HCTZ (generic of Capozide®) ENALAPRIL/HCTZ (generic of Vaseretic®) FOSINOPRIL/HCTZ (generic of Monopril HCT®) LISINOPRIL/HCTZ (generic of Zestoretic®, Prinzide®) MOEXIPRIL/HCTZ (generic of Uniretic®) QUINAPRIL/HCTZ (generic of Accuretic®)	

ALPHA-BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARVEDILOL (generic of Coreg®) LABETALOL (generic of Trandate®)	COREG CR™ (carvedilol)

ANGIOTENSIN II RECEPTOR ANTAGONISTS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
IRBESARTAN (generic of Avapro®) LOSARTAN (generic of Cozaar®) VALSARTAN (generic of Diovan®)	BENICAR® (olmesartan)	CANDESARTAN (generic of Atacand®) EDARBI® (azilsartan) EPROSARTAN (generic of Teveten®) OLMESARTAN (generic of Benicar®) TELMISARTAN (generic of Micardis®)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ DIURETIC COMBINATION

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
IRBESARTAN-HCTZ (generic of Avalide®) LOSARTAN-HCTZ (generic of Hyzaar®) VALSARTAN/HCTZ (generic of Diovan HCT®)	BENICAR HCT® (olmesartan/HCTZ)	CANDESARTAN/HCTZ (generic of Atacand HCT®) EDARBYCLOR™ (azilsartan/ chlorthalidone) OLMESARTAN/HCTZ (generic of Benicar HCT®) TELMISARTAN/HCTZ (generic of Micardis HCT®) TEVETEN HCT® (eprosartan/HCTZ)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ BETA BLOCKERS COMBINATION

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
		BYVALSON™ (nebivolol/valsartan)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ CALCIUM CHANNEL BLOCKER COMBINATION

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
	AZOR® (amlodipine/olmesartan) AMLODIPINE/VALSARTAN (generic of Exforge®)	AMLODIPINE/ TELMISARTAN (generic of Twynsta®) AMLODIPINE/OLMESARTAN (generic of Azor®)

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ CALCIUM CHANNEL BLOCKER/DIURETIC COMBINATION

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
	AMLODIPINE/ VALSARTAN /HCTZ (generic of Exforge® HCT) TRIBENZOR® (olmesartan/ amlodipine/hctz)	OLMESARAN/AMLODIPINE/ HCTZ (generic of Tribenzor®)

ANGIOTENSIN II RECEPTOR ANTAGONIST/ NEPRILYSIN INHIBITOR/ COMBINATION

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
		ENTRESTO™ (valsartan/sacubitril)

BETA BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACEBUTOLOL (generic of Sectral®) ATENOLOL (generic of Tenormin®) BETAXOLOL (generic of Kerlone®) BISOPROLOL FUMARATE (generic of Zebeta®) METOPROLOL SUCCINATE (generic of Toprol XL®) METOPROLOL TARTRATE (generic of Lopressor®) NADOLOL (generic of Corgard®) PINDOLOL (generic of Visken®) PROPRANOLOL (generic of Inderal®) PROPRANOLOL ER (generic of Inderal LA®) SOTALOL (generic of Betapace®) SOTALOL AF (generic of Betapace AF®) TIMOLOL (generic of Blocadren®)	BYSTOLIC® (nebivolol) INNOPRAN XL® (propranolol) LEVATOL® (penbutolol) SOTYLIZE® oral solution (sotalol)

BETA-BLOCKERS/DIURETIC COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ATENOLOL/CHLORTHALIDONE (generic of Tenoretic®) BISOPROLOL/HCTZ (generic of Ziac®) DUTOPROL® (metoprolol succinate/HCTZ) METOPROLOL/HCTZ (generic of Lopressor HCT®) NADOLOL/BENDROFLUMETHIAZIDE (generic of Corzide®) PROPRANOLOL/HCTZ (generic of Inderide®)	

CALCIUM CHANNEL BLOCKERS- DIHYDROPYRIDINE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMLODIPINE (generic of Norvasc®) FELODIPINE (generic of Plendil®) NICARDIPINE (generic of Cardene®) NIFEDIPINE ER (generic of Procardia XL®, Adalat CC®) NIFEDIPINE IMMEDIATE RELEASE (generic of Procardia®)	ISRADIPINE (generic of Dynacirc®) NIMODIPINE (generic of Nimotop®)* NYMALIZE oral solution (nimodipine) * NISOLDIPINE (generic of Sular®)

* Note: Clinical criteria required for nimodipine, only approvable for 21 days after subarachnoid hemorrhage.

CALCIUM CHANNEL BLOCKERS- NON-DIHYDROPYRIDINE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DILTIAZEM (generic of Cardizem®) DILTIAZEM ER (generic of Cardizem CD® q24h, Tiazac®) DILTIAZEM SR (generic of Cardizem SR® q12h) VERAPAMIL (Generic of Calan®) VERAPAMIL SR/ER (Generic of Calan SR®, Isoptin SR®, Verelan®)	DILTIAZEM 24H ER tablet (generic of Cardizem LA®) VERAPAMIL ER PM (generic of Verelan PM®)

DIRECT RENIN INHIBITORS*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKTURNA® (aliskiren)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

DIRECT RENIN INHIBITOR/DIURETIC Combination*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKTURNA HCT® (aliskiren/HCTZ)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
TEKAMLO ® (aliskiren/amlodipine)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

DIRECT RENIN INHIBITOR/CALCIUM CHANNEL BLOCKER/DIURETIC Combination*

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
AMTURNIDE ® (aliskiren/amlodipine/HCTZ)	

* Note: Step therapy required for direct renin inhibitors – patient must have a claim for an alternative anti-hypertensive agent within the last 120 days.

HYPERPOLARIZATION-ACTIVATED CYCLE NUCLEOTIDE-GATED CHANNEL INBITOR

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
	CORLANOR® (ivabradine)

Cardiovascular Agents: Antiarrhythmics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Has the patient failed a therapeutic trial of one month with one medication not requiring prior approval?

CARDIOVASCULAR AGENTS: ANTIARRHYTHMICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMIODARONE (generic of Cordarone®) 200mg DISOPYRAMIDE PHOSPHATE IR (generic of Norpace®) DISOPYRAMIDE PHOSPHATE ER (generic of Norpace® CR) FLECAINIDE (generic of Tambocor®) MEXILITINE PROPAFENONE (generic of Rythmol®) PROPAFENONE ER (generic of Rythmol SR®) QUINIDINE GLUCONATE ER QUINIDINE SULFATE QUINIDINE SULFATE ER TIKOSYN® (dofetilide)	AMIODARONE 100mg, 400mg MULTAQ® (dronedarone)

Cardiovascular Agents: Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year all Lipotropics except Omega-3 Fatty Acid
2 months for Omega-3 Polyunsaturated Fatty Acid

Trial period	1 month (30 days) for HMG-CoA Reductase Inhibitors, Niacin derivatives, 3 months for Fibrates
Number of non-PA agents	1 medication – The assumption is that the medication must be in the same class of the medication requested, if available, except for HMG-CoA reductase inhibitors- see specific criteria

GENERAL GUIDELINES:

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to medications not requiring prior approval
  - Contraindication to or drug-to-drug interaction with medications not requiring prior approval (pravastatin is the only HMG-CoA not metabolized by the cytochrome P450 liver enzyme system)
  - History of unacceptable/toxic side effects to medications not requiring prior approval
- If there has been a therapeutic failure to no less than two of the HMG-CoA preferred products for a one-month trial, then a non-preferred HMG-CoA agent will be authorized.

ADDITIONAL CRITERIA FOR OMEGA-3 POLYUNSATURATED FATTY ACID AND ICOSAPENT ETHYL (LOVAZA®, VASCEPA®):

- Prescription-only omega-3 polyunsaturated fatty acid and icosapent ethyl are approvable only for adult patients with triglyceride levels equal to or greater than 500 mg/dL who have been unable to lower triglyceride levels with lifestyle changes including diet and exercise.
- Medications known to increase triglycerides (beta blockers, thiazides, and estrogens) must be discontinued or changed, if clinically appropriate, before the drug is approved. Initial approval will be for 2 months, with evidence of reduced triglycerides required for re-approval.

ADDITIONAL CRITERIA FOR COLESEVELAM (WELCHOL®):

- Colesevelam may be approved as first-line therapy if there is a diagnosis of diabetes
- Will be approved through systematic PA if there is a history of an oral hypoglycemic or insulin in the previous 120 days

ADDITIONAL CRITERIA FOR EZETIMIBE (ZETIA®) TABLETS:

- Ezetimibe tablets may be approved after a therapeutic trial of one month on one HMG-CoA Reductase Inhibitor

ADDITIONAL CRITERIA FOR PCSK9 INHIBITORS:

- All products in this class require clinical prior authorization:
  - Age ≥18 years or Age ≥ 13 years and Homozygous Familial Hypercholesterolemia (HoFH)
  - Documented adherence to prescribed lipid lowering medications for previous 90 days

- Baseline lab results are required and approvals will be limited to 12 weeks initially and then annually thereafter. Subsequent approvals will require additional levels being done to assess changes.
    - Lipid profile required at week 8 for HeFH or ASCVD
    - Lipid profile required after 3rd dose for HoFH

Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH): must meet both:

1. Total Cholesterol > 290 mg/dL or LDL-C > 190 mg/dL and one of the following:
    - Presence of tendon xanthomas or 1st or 2nd degree relative with documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL **OR**
    - Confirmation of diagnosis by gene or receptor testing
2. Unable to reach goal LDL-C with maximally tolerated dose of statin plus ezetimibe (Zetia®) 10 mg daily plus concurrently administered lipid lowering agent
    - A trial of 2 or more statins, at least one must be atorvastatin

Diagnosis of Clinical Atherosclerotic Cardiovascular Disease: must meet both:

1. History of MI, angina, coronary or other arterial revascularization, stroke, TIA or PVD of atherosclerotic origin and
2. Unable to reach goal LDL-C with maximally tolerated dose of statin plus ezetimibe (Zetia®) 10 mg daily
    - A trial of 2 or more statins, at least one must be atorvastatin

Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH): must meet all:

1. Total cholesterol and LDL-C >600 mg/dL and TG within reference range or confirmation of diagnosis by gene or receptor testing
2. Unable to reach goal LDL-C with maximally tolerated dose of statin plus ezetimibe (Zetia®) 10 mg daily with at least 1 other concurrently administered lipid lowering agent
3. Age ≥ 13 years old

CARDIOVASCULAR AGENTS: LIPOTROPICS – BILE ACID SEQUESTRANTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CHOLESTYRAMINE LIGHT POWDER (generic of Questran Light®) CHOLESTYRAMINE POWDER (generic of Questran®) COLESTIPOL tablets (generic of Colestid® tablets) PREVALITE® POWDER (cholestyramine)	COLESTIPOL granules (generic of Colestid® granules) WELCHOL® packets (colesevelam) WELCHOL® tablets (colesevelam)

CARDIOVASCULAR AGENTS: LIPOTROPICS - STATINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ATORVASTATIN (generic of Lipitor®) LOVASTATIN (generic of Mevacor®) PRAVASTATIN (generic of Pravachol®) SIMVASTATIN (generic of Zocor®)	ALTOPREV® (lovastatin) FLUVASTATIN (generic of Lescol®) LESCOL XL® (fluvastatin) LIVALO® (pitavastatin) ROSUVASTATIN (generic of Crestor®)

CARDIOVASCULAR AGENTS: LIPOTROPICS – STATIN/NIACIN COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
SIMCOR® (Simvastatin/Niacin)	ADVICOR® (Lovastatin/Niacin)

CARDIOVASCULAR AGENTS: LIPOTROPICS - FIBRIC ACID DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GEMFIBROZIL (generic of Lopid®) FENOFIBRATE TABLETS (generic of Tricor®)	ANTARA® (fenofibrate) FENOFIBRATE CAPSULES (generic of Lipofen®) FENOFIBRIC ACID (generic of Trilipix®) LOFIBRA® (fenofibrate) TRIGLIDE® (fenofibrate)

CARDIOVASCULAR AGENTS: LIPOTROPICS - NICOTINIC ACID DERIVATIVES

NO PA REQUIRED PREFERRED"	PA REQUIRED
NIACIN NIASPAN® (niacin)	NIACIN ER (generic of Niaspan®)

CARDIOVASCULAR AGENTS: LIPOTROPICS - OMEGA-3 POLYUNSATURATED FATTY ACIDS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
OTC FISH OIL 340-1000, 360-1200, 435-880, 500-1000	OMEGA 3-ACID ETHYL ESTERS (generic of Lovaza®) VASCEPA® (icosapent ethyl)

CARDIOVASCULAR AGENTS: LIPOTROPICS - SELECTIVE CHOLESTEROL ABSORPTION INHIBITORS *

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
ZETIA® (ezetimibe)	EZETIMIBE (generic of Zetia®)

* Note: Step therapy required – must have therapeutic trial of one preferred statin.

CARDIOVASCULAR AGENTS: LIPOTROPICS – STATIN / SELECTIVE CHOLESTEROL ABSORPTION INHIBITOR COMBINATIONS *

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
	LIPTRUZET® (atorvastatin/ezitimibe) VYTORIN® (simvastatin/ezetimibe)

* Note: Step therapy required – must have therapeutic trial of two preferred statins.

CARDIOVASCULAR AGENTS: LIPOTROPIC/HYPERTENSION COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	AMLODIPINE/ATORVASTATIN (generic of Caduet®)

CARDIOVASCULAR AGENTS: LIPOTROPICS PCSK9 INHIBITORS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	PRALUENT® (alirocumab) REPATHA™ (evolocumab)

Cardiovascular Agents: Pulmonary Arterial Hypertension

LENGTH OF AUTHORIZATIONS: 1 year

All products in this class require clinical prior authorization: Diagnosis of pulmonary arterial hypertension

GRANDFATHERING:

Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

1. Patients diagnosed as World Health Organization Group 3 or more severe may be approved for inhalation or intravenous agents
2. Riociguat (Adempas®) may be approved for patients with persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) who have had surgical treatment or have inoperable CTEPH.
3. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
4. Has the patient failed a therapeutic trial of at least one month with at least two medications, one of which is a Phosphodiesterase-5 Inhibitor, not requiring prior approval?

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Phosphodiesterase-5 Inhibitor, Oral*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
ADCIRCA® (tadalafil) REVATIO® oral solution (sildenafil) (no PA for age under 6) SILDENAFIL (generic of Revatio®)	REVATIO® oral solution (sildenafil) (PA required for age over 6)

*Patients on current regimens will be grandfathered.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Endothelin Receptor Antagonist, Oral*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
LETAIRIS® (ambrisentan) TRACLEER® (bosentan)	OPSUMIT® (macitentan)

*Patients on current regimens will be grandfathered.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Analog, Oral*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	ORENITRAM® (treprostinil diolamine)

*Patients on current regimens will be grandfathered.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Receptor Agonist, Oral*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	UPTRAVI® (selexipag)

*Patients on current regimens will be grandfathered.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Guanylate Cyclase Stimulators, Oral*

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	ADEMPAS® (riociguat)

*Patients on current regimens will be grandfathered.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Analog, Inhaled *

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	TYVASO® (treprostinil) VENTAVIS® (iloprost)

*Patients on current regimens will be grandfathered.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION Prostacyclin Analog, Intravenous *

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	EPOPROSTENOL (generic of Flolan®) REMODULIN® (treprostinil sodium) VELETRI® (epoprostenol)

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Alzheimer's Agents

LENGTH OF AUTHORIZATIONS: 1 year

GRANDFATHERING:
Patients who have a claim for a drug requiring step therapy or a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

STEP THERAPY:
1. For a drug requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month of at least one preferred product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:
Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL CRITERIA FOR RIVASTIGMINE PATCH (EXELON®):
May be approved first-line for a patient who is unable to swallow.

CNS AGENTS: ALZHEIMER'S AGENTS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
DONEPEZIL 5mg, 10mg (generic of Aricept®) DONEPEZIL ODT (generic of Aricept® ODT) GALANTAMINE (generic of Razadyne™) GALANTAMINE ER (generic of Razadyne™ ER) RIVASTIGMINE capsules (generic of Exelon®)	EXELON® patch (rivastigmine) MEMANTINE (generic of Namenda®) NAMENDA® 10mg/5ml solution (memantine)	DONEPEZIL 23mg (generic of Aricept® 23mg) GALANTAMINE 4mg/ml solution (generic of Razadyne™) NAMENDA XR® NAMZARIC® (memantine ER/donepezil) RIVASTIGMINE patch (generic of Exelon® patch)

Central Nervous System (CNS) Agents: Anti-Migraine Agents

LENGTH OF AUTHORIZATIONS: 6 months

STEP THERAPY: All anti-migraine agents listed

1. For a preferred brand, there must have been inadequate clinical response to preferred generic alternatives, including a trial of no less than two weeks of at least one preferred product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than two weeks each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:

- Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
  - Allergy to preferred medications
  - Contraindication to all preferred medications
  - History of unacceptable/toxic side effects to at least two preferred medications

CLINICAL CONSIDERATIONS:

Prior Authorization will not be given for prophylaxis unless the patient has exhausted or has contraindications to all other "controller" migraine medications (i.e., beta-blockers, neuroleptics, calcium channel blockers, etc.)

ADDITIONAL INFORMATION

In addition to utilizing a preferred agent when applicable, the number of tablets/doses allowed per month is restricted based on the manufacturer's package insert.

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS – "Fast" Onset

NO PA REQUIRED "PREFERRED"	PA REQUIRED
RIZATRIPTAN tablets (generic of Maxalt®) RIZATRIPTAN ODT (generic of Maxalt-MLT®) SUMATRIPTAN tablets, nasal spray, injection (generic of Imitrex®)	ALMOTRIPTAN (generic of Axert®) ONZETRA™ XSAIL™ (sumatriptan) RELPAX® (eletriptan) SUMAVEL DOSEPRO® (sumatriptan) ZOLMITRIPTAN (generic of Zomig®) ZOLMITRIPTAN ODT (generic of Zomig ZMT®) ZOMIG® NASAL SPRAY (zolmitriptan) ZECUITY® (sumatriptan)

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONISTS - "Slow" Onset

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
NARATRIPTAN (generic of Amerge®)	FROVA® (frovatriptan)	

CNS AGENTS: ANTI-MIGRAINE AGENTS – SEROTONIN 5-HT1 RECEPTOR AGONIST/NSAID COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	TREXIMET® (sumatriptan/naproxen)

Central Nervous System (CNS) Agents: Anticonvulsants

LENGTH OF AUTHORIZATIONS: 1 year

GRANDFATHERING:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

OTHER APPROVAL CRITERIA:
1. Is there any reason the patient cannot be changed to a preferred medication? Acceptable reasons include:
   - Allergy to two preferred medications
   - Contraindication to or drug interaction with two preferred medications
   - History of unacceptable/toxic side effects to two preferred medications
   - The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.
2. If there has been a therapeutic failure to no less than two preferred products for a one-month trial each. Prescriptions submitted with the prescriber NPI of a physician who has registered a neurology specialty with Ohio Medicaid, for products that are used only for seizures, require a trial of one preferred product for one month. This provision applies only to the standard tablet/capsule dosage form, and does not apply to brand products with available generic alternatives.

ANTICONVULSANTS: CARBAMAZEPINE DERIVATIVES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARBAMAZEPINE IR tablet, chewable, oral suspension (generic of Tegretol®) CARBAMAZEPINE 12-hour ER capsule, tablet (generic of Carbatrol®, Tegretol XR®) OXCARBAZEPINE tablet, suspension (generic of Trileptal®) TEGRETOL® SUSP (carbazepine) TRILEPTAL® suspension	CARBAMAZEPINE SUSP (generic of Tegretol® Susp) OXTELLAR XR™ (oxcarbazepine)

ANTICONVULSANTS: FIRST GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CLONAZEPAM tablet (generic of Klonopin®) DIASTAT® rectal gel (diazepam) DIVALPROEX (generic of Depakote®) DIVALPROEX ER (generic of Depakote® ER) ETHOSUXAMIDE (generic of Zarontin®) PHENOBARBITAL PHENYTOIN (generic of Dilantin®) PRIMIDONE (generic of Mysoline®) VALPROIC ACID (generic of Depakene®)	CELONTIN® (methsuximide) CLONAZEPAM ODT (generic of Klonopin® wafer) DIAZEPAM rectal gel (generic of Diastat®) ONFI® (clobazam) PEGANONE® (ethotoin) STAVZOR® (valproic acid delayed-release)

ANTICONVULSANTS: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GABAPENTIN (generic of Neurontin®) LAMOTRIGINE IR tablet, chewable tablet (generic of Lamictal®) LEVETIRACETAM IR tablet, solution (generic of Keppra®) SABRIL® powder (no PA for age < 2) TOPIRAMATE tablet (generic of Topamax®) ZONISAMIDE (generic of Zonegran®)	BANZEL® (rufinamide) BRIVIACT® (brivaracetam) FELBAMATE (generic of Felbatol®) FYCOMPA® (perampanel) LAMICTAL®ODT LAMOTRIGINE ER tablet(generic of Lamictal® XR) LEVETIRACETAM ER tablet (generic of Keppra® XR) LYRICA® (pregabalin) QUDEXY XR® (topiramate ER) SABRIL® powder (PA required for age > 2) SABRIL® tablet (vigabatrin) SPRITAM® (levetiracetam tablet for suspension) TIAGABINE (generic of Gabitril®) TOPIRAMATE ER TOPIRAMATE sprinkle cap (generic of Topamax® sprinkle cap) TROKENDI XR® (topiramate)

ANTICONVULSANTS: THIRD GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
VIMPAT® (lacosamide)	APTIOM® (esliscarbazepine acetate) POTIGA® (ezogabine)

Central Nervous System (CNS) Agents: Antidepressants

GRANDFATHERING:
Patients who have a claim for a non-preferred drug, or drug requiring step therapy, in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

PSYCHIATRIST EXEMPTION:
Physicians who are registered with Ohio Medicaid as having a specialty in psychiatry are exempt from prior authorization of any non-preferred antidepressant, or step therapy of any preferred brand, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization by a psychiatrist. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the psychiatrist.

LENGTH OF AUTHORIZATIONS: 1 year

1. If there has been a therapeutic failure to no less than two preferred products for a one-month trial each.
2. Is there any reason the patient cannot be changed to a preferred medication? Acceptable reasons include:
   - Allergy to preferred medications
   - Contraindication to or drug interaction with preferred medications
   - History of unacceptable/toxic side effects to preferred medications
   - For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.
   - The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

ANTIDEPRESSANTS: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CITALOPRAM solution (generic of Celexa®)	BRISDELLE® (paroxetine mesylate)
CITALOPRAM tablets (generic of Celexa®)	FLUOXETINE ER (generic of Prozac Weekly®)
ESCITALOPRAM (generic of Lexapro®)	FLUVOXAMINE ER (generic of Luvox CR®)
FLUOXETINE HCL capsules, tablets (generic of Prozac®)	PAROXETINE ER (generic of Paxil CR®)
FLUOXETINE HCL solution (generic of Prozac®)	PEXEVA® (paroxetine mesylate)
FLUVOXAMINE MALEATE (generic of Luvox®)	
PAROXETINE HCL (generic of Paxil®)	
SERTRALINE (generic of Zoloft®)	
SERTRALINE oral concentrate (generic of Zoloft®)	

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DULOXETINE 20mg, 30mg, 60mg (generic of Cymbalta®) VENLAFAXINE (generic of Effexor®) VENLAFAXINE ER capsule (generic of Effexor XR®)	DESVENLAFAXINE ER (generic of Khedezla ER®) DESVENLAFAXINE ER tablet DESVENLAFAXINE FUMARATE DULOXETINE 40mg (generic of Irenka®) FETZIMA® (levomilnacipran) PRISTIQ® (desvenlafaxine) VENLAFAXINE ER tablet

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUPROPION HCL (generic of Wellbutrin®) BUPROPION SR (generic of Wellbutrin SR®) BUPROPION XL (generic of Wellbutrin XL®)	APLENZIN™ (bupropion) FORFIVO XL® (bupropion)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: ALPHA-2 RECEPTOR ANTAGONISTS*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MIRTAZAPINE (generic of Remeron®) MIRTAZAPINE rapid dissolve (generic of Remeron® Sol-Tab)	

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: MONOAMINE OXIDASE INHIBITORS (MAOI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	EMSAM® patches (selegiline) MARPLAN® (isocarboxazid) NARDIL® (phenelzine) TRANYLCYPROMINE (generic of Parnate®)

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: Serotonin-2 Antagonist/Reuptake Inhibitors (SARI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
NEFAZODONE TRAZODONE 50mg, 100mg, 150mg	OLEPTRO ER® (trazodone) TRAZODONE 300mg

*Patients on current regimens will be grandfathered.

ANTIDEPRESSANTS: SSRI - SEROTONIN PARTIAL AGONIST*

NO PA REQUIRED "PREFERRED GENERIC"	PA REQUIRED
	TRINTELLIX® (vortioxetine) VIIBRYD® (vilazodone)

*Patients on current regimens will be grandfathered.

Central Nervous System (CNS) Agents: Antipsychotics, Second Generation

GRANDFATHERING:
Patients who have a claim for a non-preferred drug, or drug requiring step therapy, in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

PSYCHIATRIST EXEMPTION:
Physicians who are registered with Ohio Medicaid as having a specialty in psychiatry are exempt from prior authorization of any non-preferred second generation antipsychotic, or step therapy of any preferred brand, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization by a psychiatrist. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual identifier for the psychiatrist.

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY: all agents listed
1. For a drug requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than fourteen days of at least one preferred product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than fourteen days each of at least two preferred or step therapy products

ADDITIONAL CRITERIA FOR AGENTS FOR PARKINSON'S DISEASE PSYCHOSIS (NUPLAZID™):
Pimavanserin (Nuplazid™) may be approved if all of the following are met:
1. Patient is diagnosed with Parkinson's disease and has psychotic symptoms (hallucinations and/or delusions) that started after Parkinson's diagnosis
2. These psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic AND are not related to dementia or delirium
3. The patient's other medications for Parkinson's Disease have been reduce or adjusted and psychotic symptoms remain OR patient is unable to tolerate adjustment of these other medications
4. There has been inadequate clinical response to a trial of no less than fourteen days of either quetiapine or clozapine OR these therapies cannot be utilized
5. An exemption to the criteria will be granted for prescribing doctors with a neurology specialty to a patient with a history of an anti-Parkinson's agent

OTHER APPROVAL CRITERIA:
Is there any reason the patient cannot be changed to a preferred medication? Acceptable reasons include:
- Allergy to preferred medications
- Contraindication to or drug interaction with preferred medications
- History of unacceptable/toxic side effects to preferred medications

- For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.
- Clozapine or lurasidone (pregnancy category B) may be approved if a patient is pregnant. Additionally, clozapine may be approved if the diagnosis is for psychosis related to Parkinson's Disease.

ANTIPSYCHOTICS, SECOND GENERATION, ORAL *

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
QUETIAPINE (generic of Seroquel®) RISPERIDONE (generic of Risperdal®) ZIPRASIDONE (generic of Geodon®)	ARIPIPRAZOLE tablet and solution (generic of Abilify®) LATUDA® (lurasidone) SEROQUEL XR® (quetiapine)	ABILIFY DISCMELT® (aripiprazole) CLOZAPINE (generic of Clozaril®) FANAPT® (iloperidone) FAZACLO® (clozapine) INVEGA® (paliperidone) OLANZAPINE (generic of Zyprexa®) OLANZAPINE ODT (generic of Zyprexa® Zydis) QUETIAPINE ER (generic of Seroquel XR®) REXULTI® (brexpiprazole) SAPHRIS® (asenapine) VERSACLOZ® (clozapine oral suspension) VRAYLAR™ (cariprazine capsule)

*Patients on current regimens will be grandfathered.

ANTIPSYCHOTICS, SECOND GENERATION, AGENTS FOR PARKISON'S PSYCHOSIS*

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
		NUPLAZID™ (pimavanserin)

*Patients on current regimens will be grandfathered.

ANTIPSYCHOTICS, SECOND GENERATION and SSRI COMBINATION *

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
		FLUOXETINE/OLANZAPINE (generic of Symbyax®)

*Patients on current regimens will be grandfathered.

ANTIPSYCHOTICS, SECOND GENERATION, LONG-ACTING INJECTABLES * +

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ABILIFY MAINTENA® (aripiprazole) ARISTADA™ (aripiprazole lauroxil) INVEGA SUSTENNA® (paliperidone) INVEGA TRINZA® (paliperidone) RISPERDAL CONSTA® (risperidone) ZYPREXA RELPREVV® (olanzapine)	

*Patients on current regimens will be grandfathered.

+ Long-Acting Injectable Antipsychotics may be billed by the pharmacy if they are not dispensed directly to the patient. The drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

LENGTH OF AUTHORIZATIONS: 1 year

Short Acting considered separately from Long Acting products

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to at least two medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
   - Preferred long-acting non-solid dosage forms may be approved for a patient over age 12 if the patient is unable to swallow pills.

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – Short Acting

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMPHETAMINE SALTS (generic of Adderall®) DEXMETHYLPHENIDATE (generic of Focalin®) DEXTROAMPHETAMINE (generic of Dexedrine®) DEXTROSTAT® (dextroamphetamine) FOCALIN® (dexmethylphenidate) METHYLPHENIDATE tablets (generic of Ritalin®)	DEXTROAMPHETAMINE solution (generic of Procentra®) EVEKEO® (amphetamine sulfate) METHAMPHETAMINE (generic of Desoxyn®) METHYLPHENIDATE solution, chewable tablets (generic of Methylin®) ZENZEDI® (dextroamphetamine)

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – Long Acting, SOLID DOSAGE FORMS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ADDERALL XR® (amphetamine/dextroamphetamine) DEXTROAMPHETAMINE SA (generic of Dexedrine® spansule) FOCALIN® XR (dexmethylphenidate) GUANFACINE ER (generic of Intuniv®) METADATE® CD (methylphenidate) METADATE® ER (methylphenidate) STRATTERA® (atomexetine) VYVANSE™ (lisdexamfetamine)	APTENSIO XR™ (methylphenidate) CLONIDINE ER (generic of Kapvay®) DEXMETHYLPHENIDATE ER (generic of Focalin XR®) DEXTROAMPHETAMINE-AMPHETAMINE (generic of Adderall XR®) METHYLPHENIDATE ER (generic of Concerta®) METHYLPHENIDATE ER (generic of Ritalin SR®) METHYLPHENIDATE LA (generic of Metadate® CD, Ritalin® LA)

CNS AGENTS: ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS – Long Acting, NON-SOLID DOSAGE FORMS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
ADZENYS™ XR-ODT (amphetamine tablet, ODT) (no PA for age 12 or under) QUILLICHEW™ ER (methylphenidate tablet, chewable, extended release) (no PA for age 12 or under) QUILLIVANT XR® suspension (methylphenidate) (no PA for age 12 or under)	ADZENYS™ XR-ODT (amphetamine tablet, ODT) (PA required for age over 12) DAYTRANA® patch (methylphenidate) DYANAVEL™ XR (amphetamine ER oral suspension) QUILLICHEW™ ER (methylphenidate tablet, chewable, extended release) (PA required for age over 12) QUILLIVANT XR® suspension (methylphenidate) (PA required for age over 12)

Central Nervous System (CNS) Agents: Fibromyalgia Agents

LENGTH OF AUTHORIZATIONS: 1 year

Non-preferred medications will be approved for fibromyalgia after trial of agents from no less than 2 of the following drug classes in the past 90 days (guidelines suggest use of multiple agents concurrently to manage the signs of fibromyalgia):

- Gabapentin
- Pregabalin
- Short- and/or long-acting opioids**
- Skeletal muscle relaxants
- SNRIs
- SSRIs
- Trazodone
- Tricyclic antidepressants

**** The P&T Committee does not recommend the use of opioids for treatment of fibromyalgia**

CNS AGENTS: FIBROMYALGIA AGENTS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
LYRICA® (pregabalin) *	SAVELLA® (milnacipran)

* Clinical PA required for Lyrica®, may be approved for diagnosis of fibromyalgia.

Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

LENGTH OF AUTHORIZATIONS: 30 days for initial authorization
6 months for subsequent authorizations

Prescribing for buprenorphine products must follow the requirements of Ohio Administrative Code rule 4731-11-12, *Office based opioid treatment*.

BUPRENORPHINE INITIAL AUTHORIZATION CRITERIA:

1. Patient has diagnosis of opioid addiction (NOT approvable for pain).
2. Prescribing physician has a DATA 2000 waiver ID ("X-DEA" number)
3. Patient has been referred to counseling for addiction treatment
4. Maximum dose 16mg Suboxone equivalent (11.4mg Zubsolv or 8.4mg Bunavail) per day, unless:
   - The higher dose was started prior to January 31, 2015, or
   - The physician is a board certified addictionologist or addiction psychiatrist and has determined that a dosage greater than 16 milligrams is required for the patient, and has documented patient-specific reasons for the need for a dosage greater than 16 milligrams in the patient's record, or
   - The physician has consulted with a board certified addictionologist or addiction psychiatrist who has recommended a dosage greater than 16 milligrams and that fact is documented in the patient's medical record.
5. Prescriber has reviewed Ohio Automated Rx Reporting System (OARRS) for opioid prescription use, within 7 days prior to requesting the PA.

BUPRENORPHINE SUBSEQUENT AUTHORIZATION CRITERIA:

1. Patient has been personally seen by the physician:
   - For the first year of therapy, at least monthly
   - In subsequent years, at least every 3 months
2. Patient is actively participating in counseling, at minimum attending 12-step program meetings three times per week. Prescriber should retain documentation of meeting attendance. If the patient is in professional counseling by another practitioner, the prescriber should communicate with the counselor about the patient's progress on a regular, frequent basis.
3. The physician has reviewed OARRS within 7 days prior to the PA request. If the patient has received controlled substances since the previous authorization:
   - The physician has coordinated with all other prescribers of controlled substances and has determined that the patient should continue treatment; and
   - If the patient has received other controlled substances for 12 or more continuous weeks, the physician has consulted with a board-certified addictionologist or addiction psychiatrist who has recommended the patient receive substance abuse treatment (consultation not necessary if the prescriber is a board-certified additionologist or addiction psychiatrist).
4. The dose is no more than 16mg/day Suboxone-equivalent, unless:
   - The higher dose was started prior to January 31, 2015, or

- The physician is a board certified addictionologist or addiction psychiatrist and has determined that a dosage greater than 16 milligrams is required for the patient, and has documented patient-specific reasons for the need for a dosage greater than 16 milligrams in the patient's record, or
- The physician has consulted with a board certified addictionologist or addiction psychiatrist who has recommended a dosage greater than 16 milligrams and that fact is documented in the patient's medical record.

5. The dose has been reduced in the previous 6 months, or the patient has been evaluated for a dose reduction and the prescriber and patient agree that a dose reduction would not be beneficial/may be harmful.
6. The prescriber has provided toxicology results showing the presence of buprenorphine and its metabolites, and the absence of other opioids, at least twice in the previous 6 months. If the toxicology report is not as expected, the physician must document actions taken.

For buprenorphine only (without naloxone):
1. Patient is pregnant or breast-feeding a methadone-dependent baby
2. Patient has documented allergy to naloxone (very rare)

ADDITIONAL INFORMATION

A non-preferred medication may be approved if the following is true:
- The patient experiences a relapse that the physician suspects may be due to non-adherence with treatment
- The patient is allergic to ingredients other than buprenorphine
- The patient experiences adverse events that are attributable to ingredients other than buprenorphine

CENTRAL NERVOUS SYSTEM AGENTS: MEDICATION ASSISTED TREATMENT OF OPIOID ADDICTION

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
SUBOXONE® SL film (buprenorphine/naloxone) ZUBSOLV® SL tablets (buprenorphine/naloxone)	BUNAVAIL® buccal film (buprenorphine/naloxone) BUPRENORPHINE SL tablets (generic of Subutex®) BUPRENORPHINE/NALOXONE SL tablets

CENTRAL NERVOUS SYSTEM AGENTS: MEDICATION ASSISTED TREATMENT OF OPIOID ADDICTION LONG-ACTING INJECTABLES +

NO PA REQUIRED "PREFERRED"	PA REQUIRED
VIVITROL® (naltrexone)	

+ Vivitrol may be billed by the pharmacy if it is not dispensed directly to the patient. The drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

Central Nervous System (CNS) Agents: Multiple Sclerosis

DISEASE MODIFYING AGENTS

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

CNS AGENTS: MULTIPLE SCLEROSIS DISEASE MODIFYING AGENTS, INJECTABLE *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AVONEX® (interferon beta-1a)	COPAXONE® (glatiramer) 40MG
BETASERON® (interferon beta-1b)	EXTAVIA® (interferon beta-1b)
COPAXONE® (glatiramer) 20MG	GLATOPA™ (glatiramer)
REBIF® (interferon beta-1a)	PLEGRIDY® (peginterferon beta-1a)

*Patients on current regimens will be grandfathered.

CNS AGENTS: MULTIPLE SCLEROSIS DISEASE MODIFYING AGENTS, ORAL *

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GILENYA® (fingolimod)	AUBAGIO® (teriflunomide)
	TECFIDERA® (dimethyl fumarate)

*Patients on current regimens will be grandfathered.

POTASSIUM CHANNEL BLOCKERS

LENGTH OF AUTHORIZATIONS: Initial authorization 180 days,
Subsequent authorizations 1 year

1. Clinical criteria for initial authorization:
   - Diagnosis of multiple sclerosis; and
   - Prescription written by physician specializing in neurology
2. Criteria for subsequent authorizations
   - Improvement in function

CNS AGENTS: MULTIPLE SCLEROSIS POTASSIUM CHANNEL BLOCKERS

NO PA REQUIRED "PREFERRED"	CLINICAL PA REQUIRED
	AMPYRA® (dalfampridine)

INTERLEUKIN RECEPTOR BLOCKERS

LENGTH OF AUTHORIZATIONS: 1 year

1. Clinical criteria authorization:
    - Diagnosis of multiple sclerosis
    - Patient does not have pre-existing hepatic disease or impairment (AST or ALT is not above 2 times the upper limit of normal; confirmed prior to initiation of treatment)
    - Patient does not have a history of autoimmune hepatitis or other autoimmune condition involving the liver
    - Patient does not have an existing infection and has demonstrated a negative tuberculin test
    - The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial on at least two medications in the Multiple Sclerosis drug category

CNS AGENTS: MULTIPLE SCLEROSIS INTERLEUKIN RECEPTOR BLOCKERS

NO PA REQUIRED "PREFERRED"	CLINICAL PA REQUIRED
	ZINBRYTA® (daclizumab)

Central Nervous System (CNS) Agents: Neuropathic Pain

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior authorization

Lidocaine patch (Lidoderm®) will only be approved for treatment of neuropathic pain (e.g., diabetic peripheral neuropathy, post-herpetic neuralgia).

CNS AGENTS: NEUROPATHIC PAIN

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMITRIPTYLINE (generic of Elavil®)	GRALISE® (gabapentin)
CARBAMAZEPINE (generic of Tegretol®)	HORIZANT® (gabapentin enacarbil)
CLOMIPRAMINE (generic of Anafranil®)	LIDOCAINE patch (generic of Lidoderm®)
DESIPRAMINE (generic of Norpramin®)	LYRICA® (pregabalin)
DOXEPIN (generic of Sinequan®)	
DULOXETINE (generic of Cymbalta®)	
GABAPENTIN (generic of Neurontin®)	
IMIPRAMINE (generic of Tofranil®)	
NORTRIPTYLINE (generic of Pamelor®)	
OXCARBAZEPINE (generic of Trileptal®)	

Central Nervous System (CNS) Agents: Parkinson's Agents

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

1. If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval
2. The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.
3. Neupro® may be approved if the patient is unable to swallow.

PARKINSON'S AGENTS – COMT INHIBITOR

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ENTACAPONE (generic of Comtan®)	TASMAR® (tolcapone) TOLCAPONE (generic of Tasmar®)

PARKINSON'S AGENTS – DOPAMINE RECEPTOR AGONISTS, NON-ERGOT, INJECTABLE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	APOKYN® (apomorphine)

PARKINSON'S AGENTS – DOPAMINE RECEPTOR AGONISTS, NON-ERGOT, ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PRAMIPEXOLE (generic of Mirapex®) ROPINIROLE (generic of Requip®)	PRAMIPEXOLE ER (generic of Mirapex ER®) ROPINIROLE ER (generic of Requip XL®)

PARKINSON'S AGENTS – DOPAMINERGIC AGENTS, ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CARBIDOPA/LEVODOPA (generic of Sinemet®) CARBIDOPA/LEVODOPA CR (generic of Sinemet® CR) SELEGILINE (generic of Eldepryl®)	CARBIDOPA/LEVODOPA dispersible tablets (generic of Parcopa®) CARBIDOPA/LEVODOPA/ENTACAPONE (generic of Stalevo®) NEUPRO® patch (rotigotine) RASAGILINE (generic of Azilect®) RYTARY® (carbidopa/levodopa ER) ZELAPAR® ODT (selegiline)

Central Nervous System (CNS) Agents: Restless Legs Syndrome

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval

CNS AGENTS: RESTLESS LEGS SYNDROME AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PRAMIPEXOLE (generic of Mirapex®)	HORIZANT® (gabapentin enacarbil)
ROPINIROLE (generic of Requip®)	NEUPRO® patch (rotigotine)

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

LENGTH OF AUTHORIZATIONS: 6 months

1. The requested medication may be approved if there has been a therapeutic failure to no less than a ten-day trial of at least two medications not requiring prior approval
2. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
3. If the prescriber indicates the patient has a history of addiction, then may approve a requested non-controlled medication.
4. The P&T Committee does not recommend use of flurazepam (Dalmane®) or triazolam (Halcion®)

CNS AGENTS: SEDATIVE-HYPNOTICS, NON-BARBITURATE

NO PA REQUIRED "PREFERRED GENERIC"	PA REQUIRED
ESTAZOLAM (generic of Prosom®) TEMAZEPAM 15mg, 30mg (generic of Restoril®) ZALEPLON (generic of Sonata®) ZOLPIDEM (generic of Ambien®)	BELSOMRA® (suvorexant) ESZOPICLONE (generic of Lunesta®) INTERMEZZO® SL (zolpidem) ROZEREM® (ramelteon) SILENOR® (doxepin) TEMAZEPAM 7.5mg, 22.5mg (generic of Restoril®) ZOLPIDEM ER (generic of Ambien® CR) ZOLPIDEM SL (generic of Edluar®) ZOLPIMIST® (zolpidem)

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

CNS AGENTS: SKELETAL MUSCLE RELAXANTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BACLOFEN (generic of Lioresal®) CHLORZOXAZONE (generic of Parafon Forte®) CYCLOBENZAPRINE (generic of Flexeril®) DANTROLENE (generic of Dantrium®) METHOCARBAMOL (generic of Robaxin®) TIZANIDINE tablets (generic of Zanaflex®)	CARISOPRODOL (generic of Soma®) * CARISOPRODOL COMPOUND (generic of Soma Compound®) * CARISOPRODOL COMPOUND W/CODEINE (generic of Soma Compound w/Codeine®) * CYCLOBENZAPRINE ER (generic of Amrix®) FEXMID® (cyclobenzaprine) LORZONE® (chlorzoxazone) METAXALONE (generic of Skelaxin®) ORPHENADRINE (generic of Norflex®) ORPHENADRINE COMPOUND (generic of Norgesic®) ORPHENADRINE COMPOUND FORTE (generic of Norgesic Forte®) TIZANIDINE capsules (generic of Zanaflex®)

* Note: Clinical criteria must be met for Soma®/Carisoprodol products– approvable only if no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition, would serve the clinical needs of the patient.

Central Nervous System (CNS) Agents: Smoking Deterrents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to an agent not requiring prior approval, then may approve the requested medication.

CNS AGENTS: SMOKING DETERRENTS – NICOTINE REPLACEMENT

NO PA REQUIRED "PREFERRED"	PA REQUIRED
COMMIT™ lozenge (nicotine) NICODERM®CQ patch (nicotine) NICORETTE® gum (nicotine) NICOTINE gum (generic of Nicorette®) NICOTINE lozenge (generic of Commit™) NICOTINE patch (generics) NICOTROL® inhaler (nicotine) NICOTROL® nasal spray(nicotine)	

CNS AGENTS: SMOKING DETERRENTS – NON-NICOTINE PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUPROPION (generic of Zyban®) CHANTIX®(varenicline)	

Endocrine Agents: Androgens

LENGTH OF AUTHORIZATIONS: 1 year

The requested medication may be approved if there has been a therapeutic failure to no less than a three-month trial of all medications not requiring prior approval.

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to all medications not requiring prior approval
- Contraindication to or drug interaction with all medications not requiring prior approval
- History of unacceptable/toxic side effects to all medications not requiring prior approval

ADDITIONAL INFORMATION

Limited to males >/= 18 years

ORAL AGENTS: ANDROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ANDROXY™ (fluoxymesterone) METHITEST™ (methyltestosterone)	ANDROID® (methyltestosterone) METHYLTESTOSTERONE (generic of Methitest™) STRIANT® (testosterone) TESTRED® (methyltestosterone)

TOPICAL AGENTS: ANDROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ANDRODERM® patch (testosterone) ANDROGEL® (testosterone)	AXIRON® gel (testosterone) NATESTO™ nasal gel (testosterone) TESTOSTERONE gel (generic of Androgel® 1%, Fortesta®, Testim®) VOGELXO™ gel (testeosterone)

Endocrine Agents: Diabetes Adjunctive Therapy

LENGTH OF AUTHORIZATIONS: 6 months

All drugs in this class require step therapy: Patient must have a claim for an oral hypoglycemic or insulin in the previous 120 days. Refills require continued use of oral hypoglycemics and/or insulin.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)
2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization.

ENDOCRINE AGENTS: DIABETES – AMYLIN ANALOGS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
SYMLIN® (pramlintide)	

ENDOCRINE AGENTS: DIABETES – INCRETIN MIMETICS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
BYDUREON® (exenatide) BYETTA™ (exenatide) VICTOZA® (liraglutide)	TANZEUM™ (albiglutide) TRULICITY® (dulaglutide)

Endocrine Agents: Diabetes – Insulin

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Condition is difficult to control (i.e. prone to ketoacidosis, hypoglycemia)
2. The requested medication may be approved if there has been a therapeutic failure to at least one medication within the same class not requiring prior authorization.

ADDITIONAL CLINICAL CRITERIA FOR INHALED INSULIN:

- Patient has a claim for a long-acting insulin in the previous 120 days, or patient has type 2 diabetes; and
- Patient has not been diagnosed with asthma or COPD; and
- Spirometry shows FEV1 > / = 70% predicted; and
- Patient has not smoked for at least 6 months

ENDOCRINE AGENTS: DIABETES - INSULINS - Rapid and Short Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMALOG® vial and pen (insulin lispro) HUMULIN R® (insulin regular human) HUMULIN R 500-U® vial and pen(insulin regular human) NOVOLIN R® (insulin regular human) NOVOLOG® vial and pen (insulin aspart)	AFREZZA® inhalation powder (insulin human) APIDRA® vial and pen (insulin glulisine)

* Patients on current insulin regimens will be grandfathered.

ENDOCRINE AGENTS: DIABETES - INSULINS - Intermediate Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
HUMALOG MIX 50/50, 75/25® vial and pen (insulin lispro protamine/insulin lispro) HUMULIN 70/30® vial and pen (insulin NPH/regular) HUMULIN N® vial and pen (insulin NPH) NOVOLIN 70/30® (insulin NPH/regular) NOVOLIN N® (insulin NPH) NOVOLOG MIX 70/30® vial and pen (insulin aspart protamine/ insulin aspart)	

* Patients on current insulin regimens will be grandfathered.

ENDOCRINE AGENTS: DIABETES - INSULINS - Long Acting*

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LANTUS® vial and pen (insulin glargine) LEVEMIR® vial and pen (insulin detemir)	BASAGLAR® (insulin glargine) TOUJEO® (insulin glargine) TRESIBA FLEXTOUCH® (insulin degludec)

* Patients on current insulin regimens will be grandfathered.

Endocrine Agents: Diabetes – Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY: All oral hypoglycemics

1. For a drug requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month of at least one preferred product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication within the same class not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

DIABETES – ORAL HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
ACARBOSE (generic of Precose®)	GLYSET® (miglitol)	

DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDES

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
METFORMIN (generic of Glucophage®) METFORMIN ER (generic of Glucophage XR®)		METFORMIN ER (generic of Fortamet®) RIOMET® 500mg/5ml (Metformin)

DIABETES – ORAL HYPOGLYCEMICS, BIGUANIDE/SULFONYLUREA COMBO

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
GLIPIZIDE/METFORMIN (generic of Metaglip®) GLYBURIDE/METFORMIN (generic of Glucovance®)		

DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
	JANUVIA® (sitagliptin) TRADJENTA™(linagliptin)	NESINA® (alogliptin) ONGLYZA® (saxagliptin)

DIABETES – DIPEPTIDYL PEPTIDASE-4 INHIBITOR COMBINATIONS

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
	JANUMET™ (sitagliptin/metformin) JANUMET XR™ (sitagliptin/ metformin) JENTADUETO™ (linagliptin/ metformin)	JENTADUETO® XR (linagliptin/ metformin) KAZANO® (alogliptin/ metformin) KOMBIGLYZE XR® (saxagliptin/metformin)

DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDES

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
NATEGLINIDE (generic of Starlix®)		REPAGLINIDE (generic of Prandin®)

DIABETES – ORAL HYPOGLYCEMICS, MEGLITINIDE/BIGUANIDE COMBO

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
		PRANDIMET® (repaglinide/ metformin)

DIABETES – ORAL HYPOGLYCEMICS, SULFONYLUREAS SECOND GENERATION

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
GLIMEPIRIDE (generic of Amaryl®) GLIPIZIDE (generic of Glucotrol®) GLIPIZIDE ER (generic of Glucotrol XL®) GLYBURIDE (generic of Diabeta®, Micronase®) GLYBURIDE MICRONIZED (generic of Glynase PressTabs®)		

DIABETES – ORAL HYPOGLYCEMICS, THIAZOLIDINEDIONES

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
PIOGLITAZONE (generic of Actos®)		AVANDIA® (rosiglitazone)

DIABETES – ORAL HYPOGLYCEMICS, TZD/SULFONYLUREAS COMBO

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
		AVANDARYL® (glimepiride/ rosiglitazone) GLIMEPIRIDE/PIOGLITAZONE (generic of Duetact®)

DIABETES – ORAL HYPOGLYCEMICS, TZD / DPP-4 COMBINATION

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
		OSENI® (pioglitazone/alogliptin)

DIABETES – ORAL HYPOGLYCEMICS, TZD / BIGUANIDE COMBO

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
PIOGLITAZONE/METFORMIN (generic of ActoPlus Met®)	ACTOPLUS MET XR® (pioglitazone/metformin)	AVANDAMET® (rosiglitazone/ metformin)

DIABETES – ORAL HYPOGLYCEMICS, SODIUM-GLUCOSE COTRANSPORTER 2 (SGLT2) INHIBITOR AND COMBINATIONS

NO PA REQUIRED	STEP THERAPY REQUIRED	PA REQUIRED
		FARXIGA® (dapagliflozin) GLYXAMBI® (empagliflozin/ linagliptin) INVOKAMET® (canagliflozin/ metformin) INVOKAMET® XR (canagliflozin/ metformin) INVOKANA® (canagliflozin) JARDIANCE® (empagliflozin) SYNJARDY® (empagliflozin and metformin) XIGDUO XR® (dapagliflozin/ metformin)

Endocrine Agents: Estrogenic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to at least two trials of thirty days each with medications not requiring prior approval

ESTROGENS – ORAL ESTROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CENESTIN® (synthetic conjugated estrogens) ENJUVIA® (synthetic conjugated estrogens) ESTRADIOL (generic of Estrace®) ESTROPIPATE MENEST® (esterified estrogens) PREMARIN® (conjugated estrogens)	FEMTRACE® (estradiol)

ESTROGENS – ORAL ESTROGEN/PROGESTERONE COMB

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ETHINYL ESTRADIOL/NORETHINDRONE ACETATE (generic of FemHRT®) FEMHRT® (norethindrone/ethinylestradiol) PREMPHASE® (medroxyprogesterone/estrogens conj) PREMPRO® (medroxyprogesterone/estrogens conj)	ANGELIQ® (drospirenone/estradiol) ESTRADIOL/NORETHINDRONE ACETATE tablets (generic of Activella®) PREFEST® (estradiol/norgestimate)

ESTROGENS & ESTROGEN AGONIST/ANTAGONIST COMB

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	DUAVEE™ (conjugated estrogens/bazedoxifene)

ENDOCRINE AGENTS: ESTROGENS – TRANSDERMAL ESTROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALORA® patch (estradiol) ESTRADIOL patch (generic of Climara®, Vivelle-Dot®)	DIVIGEL® transdermal gel (estradiol) ELESTRIN® transdermal gel (estradiol) ESTRASORB® transdermal emulsion (estradiol) EVAMIST® transdermal solution (estradiol) MENOSTAR® patch (estradiol) MINIVELLE® patch (estradiol)

ESTROGENS – TRANSDERMAL ESTROGEN/ PROGESTERONE COMB

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CLIMARA PRO® (estradiol/levonorgestrel oral) COMBIPATCH® (estradiol/norethindrone)	

ESTROGENS – VAGINAL ESTROGENS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ESTRING® vaginal ring (estradiol) PREMARIN® vaginal cream (estrogens conjugated)	ESTRACE® vaginal cream (estradiol) FEMRING® vaginal ring (estradiol) VAGIFEM® vaginal tablet (estradiol)

Endocrine Agents: Progestin Agents

LENGTH OF AUTHORIZATIONS: 1 year

3. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
    - Allergy to medications not requiring prior approval
    - Contraindication to or drug interaction with medications not requiring prior approval
    - History of unacceptable/toxic side effects to medications not requiring prior approval
4. The requested medication may be approved if there has been a therapeutic failure to at least two trials of thirty days each with medications not requiring prior approval

PROGESTIN – ORAL PROGESTINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MEDROXYPROGESTERONE ACETATE TABLET NORETHINDRONE ACETATE PROGESTERONE MEGACE ES® SUSP (megestrol acetate)	MEGESTROL ACETATE SUSP (generic of Megace®)

PROGESTIN – INJECTABLE PROGESTINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MAKENA® (hydroxyprogesterone caproate) HYDROXYPROGESTERONE CAPROATE	PROGESTERONE IN OIL

Endocrine Agents: Growth Hormone

LENGTH OF AUTHORIZATIONS: varies as listed below.

- All products in this class require clinical prior authorization
- Must be treated and followed by a pediatric endocrinologist, pediatric nephrologist, clinical geneticist, endocrinologist or gastroenterologist (as appropriate for diagnosis)

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a three-month trial of at least one preferred medication

CLINICAL CRITERIA

Children - initial approval for the following diagnoses:

1. Growth Hormone Deficiency (GHD) – 6 month approval:
    a. Acquired GHD due to cranial irradiation, panhypopituitarism, central nervous system tumors, trauma, radiation, or pituitary damage; OR
    b. GHD with all the following:
        i. Must be evaluated, therapy prescribed and monitored by a pediatric endocrinologist; and
        ii. Must not have attained epiphyseal closure (documented by X-ray); and
        iii. Must have failed to respond to TWO standard GH stimulation tests (with insulin, levodopa, arginine, propranolol, clonidine, or glucagon; may be done in the same session) defined as a peak measure GH level of less than 10ng/ml after stimulation; and
        iv. Height at initiation of therapy must be > 2 standard deviations below population normal mean height for age and sex; and
        v. Bone age is ≥ 2 years behind chronological age
2. Genetic diagnosis – 1 year approval:
    a. Krause-Kivlin Syndrome; or
    b. Turner Syndrome; or
    c. Prader-Willi Syndrome; or
    d. Noonan Syndrome
3. Short stature associated with Chronic Renal Insufficiency PRIOR to kidney transplant – 6 month approval (AACE does not recommend GH for post-transplantation).
4. SHOX – Short Stature Homeobox Gene deficiency
    a. Diagnosis documented by chromosome analysis; and
    b. Must not have attained epiphyseal closure (documented by X-ray); and
    c. Height at initiation of therapy must be > 2 standard deviations below population normal mean height for age and sex; and
    d. Bone age is ≥ 2 years behind chronological age

5. Small for gestational age (intrauterine growth restriction) – 1 year approval:
    a. Birth weight or length is ≥ 2 SD below the mean for gestational age; and
    b. Child fails to manifest catch-up growth by age of 2 years, defined as a height ≥ 2 SD below the mean for age and sex; and
    c. Age is no less than 24 months and no more than 48 months
6. Reauthorization– 1 year approval:
    a. Acquired GHD or genetic syndrome diagnosis; or
    b. Growth Hormone Deficiency, Small for Gestational Age and SHOX
        i. Must not have attained epiphyseal closure (documented by X-ray)
        ii. Increase in growth double the annualized pre-treatment growth rate within first six months, then at least 3cm per year thereafter

Adults - initial approval for the following diagnoses:

1. AIDS-related wasting or cachexia – 6 month approval
    a. Diagnosis; and
    b. Involuntary weight loss of >10% from baseline or BMI < 20; and
    c. Patient has not responded to high-calorie diet; and
    d. Patient is being treated with antiretroviral drugs
2. Short bowel syndrome – 6 month approval
    a. Diagnosis by gastroenterologist; and
    b. Patient receiving intravenous nutritional support
3. Pituitary damage – 1 year approval
    a. Acquired GHD due to cranial irradiation, panhypopituitarism, central nervous system tumors, trauma, radiation, or pituitary damage; OR
    b. Must have failed to respond to TWO standard GH stimulation tests (with insulin, levodopa, arginine, propranolol, clonidine, or glucagon; may be done in the same session) defined as a peak measure GH level of less than 5 ng/ml after stimulation
4. Reauthorization: The patient health status has improved since last approval (weight gain, improved body composition)
    a. AIDS-related wasting or cachexia or short bowel syndrome – 6 months
    b. Pituitary damage or genetic syndrome – 1 year

GROWTH HORMONES

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
GENOTROPIN® cartridge, miniquick (somatropin) NORDITROPIN® cartridge, FlexPro, NordiFlex, vial (somatropin)	HUMATROPE® cartridge, vial (somatropin) NUTROPIN AQ® cartridge, Nuspin, vial (somatropin) NUTROPIN® vial (somatropin) OMNITROPE® cartridge, vial (somatropin) SAIZEN® cartridge, vial (somatropin) SEROSTIM® vial (somatropin) ZOMACTON® vial (somatropin)

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

CRITICAL INFORMATION

Patients should only be on ONE of the therapeutic classes (bisphosphonates, calcitonin-salmon).

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - ORAL BISPHOSPHONATES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALENDRONATE tablets (generic of Fosamax®)	ALENDRONATE ORAL SOLN 70mg/75ml (generic of Fosamax®) ATELVIA® (risedronate) BINOSTO® (alendronate sodium effervescent tablet) ETIDRONATE (generic of Didronel®) FOSAMAX PLUS D™ (alendronate/cholecalciferol) FOSAMAX® ORAL SOLN 70mg/75ml (alendronate) IBANDRONATE (generic of Boniva®) RISEDRONATE (generic of Actonel®)

ENDOCRINE AGENTS: OSTEOPOROSIS - BONE OSSIFICATION ENHANCERS - CALCITONIN-SALMON

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	CALCITONIN-SALMON (generic of Miacalcin®) FORTICAL® (calcitonin salmon)

Gastrointestinal Agents: Anti-Emetics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a seven-day trial on at least one medication not requiring prior approval.

GASTROINTESTINAL AGENTS: ANTI-EMETIC AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
EMEND® tablets, trifold (aprepitant) ONDANSETRON tablets, solution, ODT (generic of Zofran®)	ANZEMET® (dolasetron) APREPITANT (generic of Emend®) GRANISETRON tablet, solution (generic of Kytril®) SANCUSO® patch (granisetron) VARUBI™ (rolapitant) ZUPLENZ® film (ondansetron)

GASTROINTESTINAL AGENTS: ANTI-EMETIC AGENTS: non-5-HT3 receptor antagonists

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DIMENHYDRINATE tablets DIPHENHYDRAMINE tablets, capsules, solution MECLIZINE tablets (generic of Antivert®) METOCLOPRAMIDE tablets (generic of Reglan®) PHOSPHORATED CARBOHYDRATE SOLUTION (generic of Emetrol®) PROCHLORPERAZINE tablets, suppositories (generic of Compazine®) PROMETHAZINE tablets, suppositories (generic of Phenergan®) TRANSDERM-SCOP® patch (scopolamine) TRIMETHOBENZAMIDE capsules (generic of Tigan®)	DICLEGIS® (doxylamine and pyridoxine) METOCLOPRAMIDE ODT (generic of Metozolv® ODT)

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) / Selected GI

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least two medications not requiring prior approval

ADDITIONAL INFORMATION:

1. Patient must be 18 years or older
2. NUTRESTORE ™, ZORBTIVE ®, and GATTEX ® require a diagnosis of short bowel syndrome (SBS) and evidence of specialize nutritional support
   a. NUTRESTORE ™ requires evidence of concurrent use of recombinant growth hormone
   b. GATTEX ® requires evidence of parenteral nutrition support at least three times per week and appropriate colonoscopy and lab assessment (bilirubin, alkaline phosphatase, lipase, and amylase) 6 months prior to initiation
   c. Re-authorization of these therapies requires evidence of improved condition (i.e. as measured by total volume, total calories, or decreased frequency of specialized nutrion support)
3. MYTESI ™ requires a diagnosis of non-infectious diarrhea and evidence of concurrent HIV antiviral therapy
   a. MYTESI ™ will be limited to no more than 2 tablets per day

IBS WITH CONSTIPATION & CHRONIC IDIOPATHIC CONSTIPATION AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BISACODYL(generic of Dulcolax®) CASANTHRANOL/DOCUSATE SODIUM (generic of Peri-Colace®) LACTULOSE (generic of Chronulac®) POLYETHYLENE GLYCOL (generic of Miralax®) PSYLLIUM FIBER (e.g. Konsyl®) SENNA (generic of Senokot®)	AMITIZA® capsule (lubiprostone) LINZESS™ capsule (linaclotide)

IBS WITH DIARRHEA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DICYCLOMINE (generic of Bentyl®) DIPHENOXYLATE/ATROPINE (generic of Lomotil®) LOPERAMIDE (maximum of 16mg per day)	ALOSETRON (generic of Lotronex®) VIBERZI™ (eluxadoline tablet) XIFAXAN® (rifaximin)

SHORT BOWEL SYNDROME AGENTS

NO PA REQUIRED	PA REQUIRED
	NUTRESTORE™ (l-glutamine) ZORBTIVE® (somatropin) GATTEX® (teduglutide)

NON-INFECTIOUS DIARRHEA AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DIPHENOXYLATE/ATROPINE (generic of Lomotil®) LOPERAMIDE (Maximum of 16mg per day)	MYTESI™ (crofelemer)

Gastrointestinal Agents: Opioid-Induced Constipation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least two medications not requiring prior approval

ADDITIONAL INFORMATION:

1. Patient must be 18 years or older
2. Approval requires a history of chronic pain requiring continuous opioid therapy for 12 weeks or longer. Electronic PA will approve with a history of 90 days of opioid therapy in the previous 90 days, in addition to trials of preferred products.

GASTROINTESTINAL AGENTS: OPIOID-INDUCED CONSTIPATION AGENTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BISACODYL(generic of Dulcolax®) CASANTHRANOL/DOCUSATE SODIUM (generic of Peri-Colace®) POLYETHYLENE GLYCOL (generic of Miralax®) SENNA (generic of Senokot®)	AMITIZA® capsules (lubiprostone) MOVANTIK® tablets (naloxegol) RELISTOR® tablets and subcutaneous injection (methylnaltrexone bromide)

Gastrointestinal Agents: Pancreatic Enzymes

LENGTH OF AUTHORIZATIONS: 1 year

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval

GASTROINTESTINAL AGENTS: PANCREATIC ENZYMES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CREON® (pancrelipase) ZENPEP® (pancrelipase)	PANCREAZE® (pancrelipase) PERTZYE® (pancrelipase) ULTRESA® (pancrelipase) VIOKACE® (pancrelipase)

Gastrointestinal Agents: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: 6 months, except as listed under clinical criteria

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval, then may approve the requested medication.
3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, may approve the requested medication.

ADDITIONAL INFORMATION

- No PA needed for preferred PPI at once-daily dosing
- No PA needed for preferred PPI at any dose for age under 21
- Must have therapeutic failure on preferred agent before PA of non-preferred

CLINICAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY

1. For diagnosis of H. Pylori, BID dosing may be authorized for 1 month
2. For diagnosis of COPD, Dyspepsia, Gastritis, Gastroparesis, Symptomatic Uncomplicated Barrett's Esophagus, Carcinoma of GI tract, Crest Syndrome, Esophageal Varices, Scleroderma, Systemic Mastocytosis, Zollinger Ellison Syndrome:
   - Length of authorization: 1 year
   - Criteria for approval: Must have failed QD dosing

GASTROINTESTINAL AGENTS: PPIs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LANSOPRAZOLE capsules (generic of Prevacid®)	ACIPHEX® sprinkle capsule (rabeprazole)
OMEPRAZOLE capsules (generic of Prilosec®)	DEXILANT® (dexlansoprazole)
OMEPRAZOLE tablets (generic of Prilosec OTC®)	ESOMEPRAZOLE STRONTIUM
PANTOPRAZOLE (generic of Protonix®)	ESOMEPRAZOLE capsules (generic of NEXIUM®)
PREVACID 24 HR® (lansoprazole)	NEXIUM® packets (esomeprazole)
PREVACID SOLUTAB® (lansoprazole ODT) (No PA required for age 6 or under)	OMEPRAZOLE/SODIUM BICARBONATE
	PREVACID SOLUTAB® (lansoprazole ODT) (PA required for age over 6)
	PRILOSEC® suspension (omeprazole)
	PROTONIX® suspension
	RABEPRAZOLE (generic of Aciphex®)

Gastrointestinal Agents: Ulcerative Colitis Agents

LENGTH OF AUTHORIZATIONS: 6 months

For a non-preferred agent, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month each of at least two preferred products.

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

1. Ulcerative Colitis Agents are available in both oral (IR, ER) and rectal (enema, suppository) formulations. Patients with mild or moderate disease may be treated with either rectal or oral agents.
2. The efficacy among the different 5-ASA derivatives appears to be comparable.

GASTROINTESTINAL AGENTS: ULCERATIVE COLITIS AGENTS - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
APRISO® (mesalamine)	ASACOL HD® (mesalamine)
DELZICOL® (mesalamine)	BALSALAZIDE DISODIUM (generic of Colazal®)
PENTASA® (mesalamine)	DIPENTUM® (olsalazine)
SULFASALAZINE (generic of Azulfidine®)	GIAZO® (balsalazide disodium)
SULFASALAZINE EC (generic of Azulfidine Entab®)	LIALDA® (mesalamine)

GASTROINTESTINAL AGENTS: ULCERATIVE COLITIS AGENTS - RECTAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CANASA® suppositories (mesalamine)	MESALAMINE enema kit (generic for Rowasa® kit)
MESALAMINE enema (generic of Rowasa® and SFRowasa®)	UCERIS® foam (budesonide)

Genitourinary Agents: Benign Prostatic Hyperplasia

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindications to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to no less than a one-month trial on at least one medication not requiring prior approval.

ADDITIONAL CRITERIA FOR APPROVAL OF TADALAFIL (CIALIS®):
Patient must have diagnosis of benign prostatic hyperplasia

BENIGN PROSTATIC HYPERPLASIA AGENTS – ALPHA-1 ADRENERGIC BLOCKERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DOXAZOSIN (generic of Cardura®) PRAZOSIN (generic of Minipress®) TAMSULOSIN (generic of Flomax®) TERAZOSIN (generic of Hytrin®)	ALFUZOSIN (generic of Uroxatral®) CARDURA® XL (doxazosin) RAPAFLO® (silodosin)

BENIGN PROSTATIC HYPERPLASIA AGENTS – 5-ALPHA REDUCTASE INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FINASTERIDE (generic of Proscar®)	DUTASTERIDE (generic of Avodart®)

BENIGN PROSTATIC HYPERPLASIA AGENTS – COMBINATION 5-ALPHA REDUCTASE INHIBITOR/ALPHA-1 ADRENERGIC BLOCKER

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	DUTASTERIDE/TAMSULOSIN (generic of Jalyn®)

BENIGN PROSTATIC HYPERPLASIA AGENTS – PHOSPHODIESTERASE TYPE 5 INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	CIALIS® (tadalafil) 2.5mg, 5mg only *

* Note: Clinical PA required for Cialis®. Patient must have diagnosis of benign prostatic hyperplasia.

Genitourinary Agents: Electrolyte Depleter Agents

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY:

1. For a step therapy required agent, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one week of at least one preferred product
2. For a non-preferred agent, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one week each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

CLINICAL INFORMATION

Calcium acetate products may lead to hypercalcemia. This agent is recommended in patients with normal serum calcium levels.

ELECTROLYTE DEPLETERS FOR HYPERPHOSPHATEMIA

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
CALCIUM ACETATE (generic of PhosLo® gelcap) CALCIUM CARBONATE PHOSLYRA® solution (calcium acetate)	MAGNEBIND® (calcium carbonate/ magnesium carbonate/folic acid) RENAGEL® (sevelamer)	AURYXIA® (ferric citrate) tablets ELIPHOS® (calcium acetate) FOSRENOL® (lanthanum carbonate) PHOSLO® (calcium acetate) RENVELA® (sevelamer) VELPHORO® (sucroferric oxyhydroxide)

Genitourinary Agents: Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

1. Patients under age 18 may be approved for tolterodine SR or Gelnique® if there was inadequate clinical response to a trial of no less than one month of oxybutynin (IR or ER).
2. The requested medication may be approved if there has been a therapeutic failure to a trial of no less than two weeks of at least two medications not requiring prior approval
3. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindications to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

GENITOURINARY AGENTS: URINARY ANTISPASMODICS

NO PA REQUIRED "PREFERRED GENERIC"	PA REQUIRED
OXYBUTYNIN ER (generic of Ditropan® XL) OXYBUTYNIN syrup (generic of Ditropan®) OXYBUTYNIN tablets (generic of Ditropan®) OXYTROL® FOR WOMEN OTC patch (oxybutynin) VESICARE® (solifenacin)	ENABLEX® (darifenacin) GELNIQUE® (oxybutynin) MYRBETRIQ® (mirabegron) TOLTERODINE (generic of Detrol®) TOLTERODINE SR (generic of Detrol® LA) TOVIAZ® (fesoterodine) TROSPIUM (generic of Sanctura®) TROSPIUM ER (generic of Sanctura® XR)

Immunomodulator Agents for Systemic Inflammatory Disease

LENGTH OF AUTHORIZATIONS: Dependent on indication

All products in this class require clinical prior authorization:

- No current infection; and
- Prior first-generation therapy appropriate for diagnosis; and
- Diagnosis of one of the following: 1-year approval
  - Rheumatoid Arthritis
  - Psoriatic Arthritis
  - Polyarticular Juvenile Idiopathic Arthritis
  - Crohn's Disease
  - Ankylosing Spondylitis
  - Psoriasis
- Diagnosis of Moderate to Severe Ulcerative Colitis (UC) (Humira and Simponi only): initial approval 8 weeks, reapprovals 1 year
  Humira may be approved if there is an inadequate clinical response to at least three months of therapy with both 5-ASA and immunosuppresants.
  Initial approval for Humira will be for 8 weeks. If clinical response is not seen in 8 weeks, further therapy with TNF inhibitors will not be approved. If there is an initial clinical response to Humira after 8 weeks of therapy, but no improvement in the progression of ulcerative colitis symptoms after 6 months, Simponi may be approved.
  - Quantity limits for UC diagnosis:
    Humira – 7 pens/syringes during month one, then 2 pens/syringes per month
    Simponi – 3 pens/syringes during month one, then 1 pen/syringe per month

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a three-month trial of at least one preferred medication

ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
ENBREL® kit, SureClik, syringe (etanercept) HUMIRA® pen, starter packs, syringe (adalimumab)	CIMZIA® syringe (certolizumab pegol) ORENCIA® syringe (abatacept) SIMPONI™ pen, syringe (golimumab)

ANTI-INFLAMMATORY INTERLEUKIN RECEPTOR ANTAGONIST

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	ACTEMRA® syringe (tocilizumab) COSENTYX™ (secukinumab) KINERET® syringe (anakinra) TALTZ™ (ixekizumab injection)

JANUS KINASE INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	XELJANZ® tablet (tofacitinib citrate) XELJANZ® XR (tofacitinib tablet, extended release)

PHOSPHODIESTERASE-4 INHIBITOR

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	OTEZLA® tablet (apremilast)

Infectious Disease Agents: Antibiotics – Cephalosporins

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
   - Note diagnosis and any culture and sensitivity reports
3. If there have been therapeutic failures to no less than a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

CEPHALOSPORINS, FIRST GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CEFADROXIL capsules, suspension (generic of Duricef®) CEPHALEXIN 250mg, 500 mg capsules, suspension (generic of Keflex®)	CEPHALEXIN 750mg (generic of Keflex®)

CEPHALOSPORINS, SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CEFACLOR (generic of Ceclor®) CEFACLOR ER (generic of Ceclor CD®) CEFACLOR suspension (no PA required for age 12 or under) (generic of Ceclor®) CEFPROZIL (generic of Cefzil®) CEFPROZIL suspension (generic of Cefzil®) (no PA required for age 12 or under) CEFTIN® suspension (no PA required for age 12 or under) (cefuroxime) CEFUROXIME (generic of Ceftin®)	CEFACLOR suspension (PA required for age over 12) (generic of Ceclor®) CEFTIN® suspension (PA required for age over 12) (cefuroxime) CEFPROZIL suspension (generic of Cefzil®) (PA required for age over 12)

CEPHALOSPORINS, THIRD GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CEFDINIR capsules, suspension (generic of Omnicef®)	CEFTIBUTEN capsules, suspension (generic of Cedax®) CEFPODOXIME tablets, suspension (generic of Vantin®) CEFIXIME SUSP (generic for SUPRAX®) SUPRAX® (cefixime)

Infectious Disease Agents: Antibiotics – Macrolides

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
   - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

INFECTIOUS DISEASE AGENTS: MACROLIDES - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AZITHROMYCIN tablets and suspension (generic of Zithromax®) CLARITHROMYCIN ER (generic of Biaxin XL®) CLARITHROMYCIN tablets and suspension (generic of Biaxin®)	ERYPED® (erythromycin ethylsuccinate) ERY-TAB® (erythromycin base) ERYTHROCIN STEARATE® (erythromycin stearate) ERYTHROMYCIN BASE ERYTHROMYCIN ETHYLSUCCINATE ZMAX™ (azithromycin ER) for oral suspension

Infectious Disease Agents: Antibiotics – Quinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
   - Note diagnosis and any culture and sensitivity reports
3. If there has been a therapeutic failure to at least a three-day trial of at least one medication not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.
2. If the prescriber expresses concern over safety issues of a preferred agent, a non-preferred agent may be approved.

INFECTIOUS DISEASE AGENTS: QUINOLONES, SECOND GENERATION - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPROFLOXACIN (generic of Cipro®) CIPRO® suspension (no PA required for age 12 or under) (ciprofloxacin)	CIPROFLOXACIN suspension (PA required for age over 12) (generic of Cipro®) CIPROFLOXACIN ER (generic of Cipro®XR)

INFECTIOUS DISEASE AGENTS: QUINOLONES, THIRD GENERATION - ORAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LEVOFLOXACIN (generic of Levaquin®)	MOXIFLOXACIN (generic of Avelox®)

Infectious Disease Agents: Antibiotics – Inhaled

LENGTH OF AUTHORIZATIONS: 28 days, reauthorized through electronic PA if history of product in previous 120 days

All products in this class require clinical prior authorization:

- Diagnosis of cystic fibrosis with pseudomonas-related infection
- Age limit of 6 and older for tobramycin products
- Age limit of 7 and older for aztreonam
- "Pulse" dosing cycles of 28 days on drug, followed by 28 days off drug

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a 28-day trial of at least one preferred medication

INFECTIOUS DISEASE AGENTS: ANTIBIOTICS - INHALED

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
BETHKIS® inhalation solution (tobramycin) KITABIS® PAK (tobramycin inhalation solution with nebulizer) TOBI™ Podhaler™ (tobramycin inhalation powder)	CAYSTON® inhalation solution (aztreonam) TOBRAMYCIN inhalation solution (generic of TOBI™)

Infectious Disease Agents: Antifungals for Onychomycosis & Systemic Infections

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval:
     Drug interactions (inhibition of CYP450 system)
     Ketoconazole > Itraconazole> Voriconazole >Fluconazole
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the patient has a serious illness that causes them to be immunocompromised [i.e. AIDS, cancer, organ (solid or non-solid) transplant] then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.
2. If the request is for a diagnosis other than fungal infection, please refer the case to a pharmacist. An off label use may be approvable for a medication such as Nizoral® for advanced prostate cancer or for Cushing's Syndrome when standard treatments have failed.

INFECTIOUS DISEASE AGENTS: AGENTS FOR ONYCHOMYCOSIS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GRIFULVIN®V tablets (griseofulvin, microsize) GRISEOFULVIN suspension (generic of Grifulvin®V) GRIS-PEG® (griseofulvin, ultramicrosize) TERBINAFINE (generic of Lamisil®)	ITRACONAZOLE (generic of Sporanox®) LAMISIL® granules (terbinafine) ONMEL™ (itraconazole) SPORANOX® 100mg/10ml oral solution (itraconazole)

INFECTIOUS DISEASE AGENTS: AGENTS FOR SYSTEMIC INFECTIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLUCONAZOLE (generic of Diflucan®) FLUCONAZOLE suspension (generic of Diflucan®) FLUCYTOSINE (generic of Ancobon®) KETOCONAZOLE (generic of Nizoral®)	CRESEMBA® (isavuconazonium) ITRACONAZOLE capsules (generic of Sporanox®) NOXAFIL® (posaconazole) ORAVIG® (miconazole) SPORANOX® 100mg/10ml oral solution (itraconazole) VORICONAZOLE (generif of Vfend®)

Infectious Disease Agents: Antivirals – Hepatitis C Agents

LENGTH OF AUTHORIZATIONS: 1 year except simeprevir and direct acting antivirals (DAAs), see below

Is there any reason the patient cannot be changed to a medication within the same class which does not require prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL CRITERIA FOR DAAs:

All HCV DAAs require clinical prior authorization. Only regimens recommended by the American Association for the Study of Liver Diseases (AASLD) will be approved. Patients must meet all criteria below.

Step 1: Patient Readiness Evaluated

- Patient must be 18 years or older.
- Female patient must have a negative pregnancy test within the last 30 days and must not be lactating.
- Patient must be free for 6 months from alcohol use, controlled drug abuse, and illicit drug use before consideration of therapy.
- If patient is a recovering substance abuser/alcoholic and in a prescribed medication assisted therapy program, must continue counseling during HCV treatment and maintain sobriety.
- Patient's psychiatric status has been stable for 6 months documented in medical record. If patient has mental health conditions that are not currently being treated, then a mental health professional must be consulted to assess for patient readiness before HCV treatment can begin.
- Patient Tested for HIV and, if positive, treated appropriately
- Patient vaccinated against Hepatitis A and Hepatitis B.
- Patient must not have severe renal impairment (eGFR < 30 mL/min/1.73m^2) or end stage renal disease requiring hemodialysis.
- Patient must not be concomitantly taking drugs that have significant clinical interaction as described in the prescribing information for each agent.
- Patient must agree in writing to being adherent with office visits, lab testing, imaging, procedures and, if deemed a candidate, the HCV medication regimen. Prescribers may use the form below or a similar form that covers all four points. Patient signature is required. This statement and patient signature must be included as part of the prior authorization request.

Hepatitis C Patient Readiness:

_____ (print name) agrees to the following:

1. I have not abused alcohol, injectable drugs, or other controlled substances for at least 6 months prior to starting Hepatitis C treatment, and I will not use these substances while being treated for Hepatitis C. If I am involved in a support group or counseling for addiction, I will continue therapy to encourage successful abstinence.

2. I have been reasonably adherent with all my current medications for all conditions and will take my Hepati- tis C treatment daily as prescribed.

3. I have a history of showing up for scheduled appointments and labs, and will continue to show up for all appointments and lab tests while taking Hepatitis C treatment.

4. If I have mental health conditions, I have been and will continue to adhere to my prescribed mental health medications and/or psychotherapy.

Patient signature: _____ Date: _____

Step 2: Clinical Assessment of Disease

- Confirmation of chronic hepatitis C (CHC):
  - Hepatitis C Virus (HCV) antibody test reactive
  - Provide HCV RNA load measured within 90 days prior to starting DAA therapy
  - Specify the Genotype
- Document progression of disease:
  - Document the degree of liver fibrosis:
    - Metavir score (scale of 1-4) must be F3 (bridging fibrosis) or F4 (cirrhosis); or
    - Ishak score (scale of 1-6) is F4-F5 (bridging cirrhosis) or F6 (cirrhosis)
    - If cirrhosis is present, indicate whether cirrhosis is compensated or decompensated and provide the Child-Turcotte-Pugh (CTP) score. Patients with decompensated cirrhosis (CTP score 7 or higher) will be approved for therapy only after consultation with a physician in a liver transplant center.
  - Document any HCV-related extra hepatic manifestations: e.g., lymphoma, symptomatic cryoglobulinemia, membranoproliferative glomerulonephritis
- Indicate any relevant co-infection, e.g., HIV or Hepatitis B
- Document that patient does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions
- Document any previously tried Hepatitis C treatments, dates treated, and response/outcome (patient will not be approved if any other HCV treatments have been used in the last 6 months)

Step 3: Direct Acting Antivirals (DAA) conditions for coverage

- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist
- Initial approval: 8 week period
- HCV RNA testing is required every 4 weeks; treatment beyond the initial 8 weeks of therapy require confirmation of lowered viral load; refills will NOT be granted unless a greater than or equal to a 2 log reduction in the HCV RNA or the HCV RNA is less than 25 IU/mL
- HIV/HCV-coinfected persons should be treated and retreated the same as persons without HIV infection, after recognizing and managing interactions with antiretroviral medications
- No lost or stolen medication will be replaced
- Only regimens listed as recommended or alternative in the current AASLD guidance (http://hcvguidelines.org) will be approved. Regimens listed as not recommended will not be approved.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

- Pegylated Interferons have a Black Box Warning which indicates that a patient should be monitored closely with periodic clinical and laboratory evaluations.
- Ribavirins are contraindicated in women who are pregnant and in their male partner(s). At least two reliable forms of contraception must be used during therapy.

ADDITIONAL CRITERIA FOR PROTEASE INHIBITORS:

- Patient is receiving prior/concurrent interferon and ribavirin as recommended in the FDA-approved package labeling
- Simeprevir: Patient has genotype 1 disease, and if genotype 1a does not have the Q80k polymorphism. Initial approval for 4 weeks, then must report viral load and follow response-guided therapy outlined in the prescribing information. Simeprevir should not be used in patients who have previously failed therapy with boceprevir or telepravir.

INFECTIOUS DISEASE AGENTS: HEPATITIS C – DIRECT-ACTING ANTIVIRAL

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
EPCLUSA® (sofosbuvir/velpatasvir) HARVONI® (ledipasvir/sofosbuvir) tablets TECHNIVIE™ (ombitasvir/paritaprevir and ritonavir) VIEKIRA PAK™ (ombitasvir/paritaprevir and ritonavir tablets/dasabuvir tablets) VIEKIRA XR™ (ombitasvir/paritaprevir and ritonavir tablets/dasabuvir tablets) ZEPATIER™ (elbasvir and grazoprevir tablet)	DAKLINZA™ (daclatasvir) SOVALDI® (sofosbuvir)

INFECTIOUS DISEASE AGENTS: HEPATITIS C - PEGYLATED INTERFERONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PEGASYS® (peginterferon alfa-2a) PEG-INTRON® (peginterferon alfa-2b)	

INFECTIOUS DISEASE AGENTS: HEPATITIS C - RIBAVIRINS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
RIBAVIRIN (generic of Rebetol®)	COPEGUS® (ribavirin) MODERIBA PAK® (ribavirin) REBETOL® (ribavirin) RIBAPAK® (ribavirin) RIBASPHERE® (ribavirin) 400mg, 600mg

INFECTIOUS DISEASE AGENTS: HEPATITIS C – PROTEASE INHIBITORS

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
	OLYSIO® (simeprevir)

Infectious Disease Agents: Antivirals – Herpes

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

INFECTIOUS DISEASE AGENTS: ANTIVIRALS - HERPES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ACYCLOVIR (generic of Zovirax®) VALACYCLOVIR (generic of Valtrex®)	FAMCICLOVIR (generic of Famvir®) SITAVIG® buccal tablets (acyclovir)

Infectious Disease Agents: Antivirals – HIV

LENGTH OF AUTHORIZATIONS: 1 year

GRANDFATHERING:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Patients who have taken the drug in the previous 120 days, but do not have claims history (new to Medicaid, samples, etc.), will be approved for PA after prescriber contact.

OTHER APPROVAL CRITERIA:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
2. Allergy to medications not requiring prior approval
3. Contraindication to all medications not requiring prior approval
4. History of unacceptable/toxic side effects to medications not requiring prior approval
5. Has the patient failed a therapeutic trial of at least one month with at least one medication not requiring prior approval?
6. Approval will be given for products containing tenofovir alafenamide (TAF) if the patient has had renal or bone mineral density issues.

HIV PROTEASE INHIBITORS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CRIXIVAN® (indinavir sulfate) EVOTAZ® (atazanavir/cobicistat) INVIRASE® (saquinavir mesylate) KALETRA® (lopinavir/ritonavir) LEXIVA® (fosamprenavir calcium) REYATAZ® capsules, oral powder (atazanavir sulfate) VIRACEPT® (nelfinavir mesylate)	LOPINAVIR/RITONAVIR (generic of Kaletra®)

HIV NON-PEPTIDIC PROTEASE INHIBITORS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PREZISTA® (darunavir ethanolate)	APTIVUS® (tipranavir; tipranavir/vitamin E) PREZCOBIX® (darunavir/cobicistat)

HIV REVERSE TRANSCRIPTASE INHIBITORS, NUCLEOSIDE ANALOGS AND COMBINATIONS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ABACAVIR SULFATE tablet (generic of Ziagen®) DIDANOSINE capsule (generic of Videx®) EMTRIVA® (emtricitabine) EPIVIR® solution EPZICOM® (abacavir/lamivudine) LAMIVUDINE solution, tablet (generic of Epivir®) LAMIVUDINE/ZIDOVUDINE (generic of Combivir®) STAVUDINE (generic of Zerit®) TRIZIVIR® (abacavir/lamivudine/zidovudine) VIDEX® solution (didanosine) ZIAGEN® solution (abacavir sulfate) ZIDOVUDINE (generic of Retrovir®)	ABACAVIR/LAMIVUDINE (generic of Epzicom®)

HIV REVERSE TRANSCRIPTASE INHIBITORS, NUCLEOTIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
VIREAD® (tenofovir disoproxil fumarate)	

HIV REVERSE TRANSCRIPTASE INHIBITORS, NON-NUCLEOSIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
NEVIRAPINE ER (generic of Viramune® XR) NEVIRAPINE IR (generic of Viramune®) SUSTIVA® (efavirenz) VIRAMUNE® XR (nevirapine)	EDURANT® (rilpivirine) INTELENCE® (etravirine) RESCRIPTOR® (delavirdine mesylate)

HIV INTEGRASE STRAND TRANSFER INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ISENTRESS® tablets, chewable tablet, powder packets (raltegravir potassium) TIVICAY® (dolutegravir sodium)	VITECTA® (elvitegravir)

HIV CCR5 CO-RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	SELZENTRY® (maraviroc)

HIV FUSION INHIBITORS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	FUZEON® (enfuvirtide)

HIV RTI, NUCLEOSIDE-NUCLEOTIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
TRUVADA® (emtricitabine/tenofovir)	DESCOVY® (emtricitabine/ tenofovir alafenamide)

HIV RTI, NUCLEOSIDE, NUCLEOTIDE, & NON-NUCLEOSIDE ANALOGS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ATRIPLA® (emtricitabine/efavirenz/tenofovir) COMPLERA® (emtricitabine/rilpivirine/tenofovir)	ODEFSEY® (emtricitabine/rilpivirine/tenofovir alafenamide)

HIV INTEGRASE INHIBITOR & RTI COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
GENVOYA® (elvitegravir, cobicistat, emtricitabine, and tenofovir alafenamide) TRIUMEQ® (dolutegravir/abacavir/lamivudine)	STRIBILD® (elvitegravir/cobicistat/emtricitabine/ tenofovir)

HIV PHARMACOKINETIC ENHANCERS (CYP3A INHIBITORS)

NO PA REQUIRED "PREFERRED"	PA REQUIRED
NORVIR® (ritonavir)	TYBOST® (cobicistat)

Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills for acute infection. Refills for up to 14 days may be authorized for quinolones only for patients undergoing surgery.

STEP THERAPY:

1. For a product requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than three days of at least one preferred product
2. For a non-preferred agent, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than three days each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
   - Note diagnosis and any culture and sensitivity reports

OPHTHALMIC AGENTS: ANTIBACTERIAL - QUINOLONES

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
CIPROFLOXACIN drops (generic of Ciloxan®) OFLOXACIN drops (generic of Ocuflox®)	CILOXAN® ointment (ciprofloxacin) VIGAMOX® drops (moxifloxacin)	BESIVANCE® drops (besifloxacin) LEVOFLOXACIN drops (generic of Quixin®) MOXEZA® drops (moxifloxacin) GATIFLOXACIN drops (generic of Zymaxid®)

OPHTHALMIC AGENTS: ANTIBACTERIAL – NON-QUINOLONE

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
BACITRACIN ointment BACITRACIN-POLYMYXIN ointment ERYTHROMYCIN ointment (generic of Ilotycin®) GENTAMICIN drops GENTAMICIN ointment NEOMYCIN/POLYMYXIN/ BACITRACIN ointment (generic of Neosporin®) NEOMYCIN/POLYMYXIN/ GRAMICIDIN drops (generic of Neosporin®) POLYMYXIN/TRIMETHOPRIM drops (generic of Polytrim®) SULFACETAMIDE drops TOBRAMYCIN drops (generic of Tobrex®)	TOBREX® ointment (tobramycin)	AZASITE® drops (azithromycin) SULFACETAMIDE ointment

OPHTHALMIC AGENTS: ANTIBACTERIAL – STEROID COMBINATIONS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
NEOMYCIN/POLYMYXIN/ BACITRACIN/ HYDROCORTISONE ointment NEOMYCIN/POLYMYXIN/ DEXAMETHASONE drops (generic of Maxitrol®) NEOMYCIN/POLYMYXIN/ DEXAMETHASONE ointment (generic of Maxitrol®) SULFACETAMIDE/ PREDNISOLONE drops (generic of Vasocidin®) TOBRADEX® drops (dexamethasone/tobramycin)	BLEPHAMIDE® drops (prednisolone/sulfacetamide) BLEPHAMIDE® ointment (prednisolone/ sulfacetamide) PRED-G® drops (prednisolone/ gentamicin) PRED-G® ointment (prednisolone/ gentamicin) TOBRADEX® ointment (dexamethasone/tobramycin)	NEOMYCIN/POLYMYXIN/ HYDROCORTISONE drops (generic of Cortisporin®) TOBRADEX ST® (dexamethasone/ tobramycin) TOBRAMYCIN/ DEXAMETHASONE drops (generic of TobraDex®) ZYLET® drops (tobramycin/ loteprednol)

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindications to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to at least one of the preferred agents.

OPHTHALMIC AGENTS: MAST CELL STABILIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CROMOLYN (generic of Crolom®)	ALOCRIL® (nedocromil) ALOMIDE® (lodoxamide)

OPHTHALMIC AGENTS: ANTIHISTAMINE/MAST CELL STABILIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ALAWAY® (ketotifen) BEPREVE® (bepotastine) KETOTIFEN (generic of Alaway®, Zaditor®) PAZEO® (olopatadine) ZADITOR® OTC (ketotifen)	AZELASTINE (generic of Optivar®) EPINASTINE (generic of Elestat®) EMADINE® (emedastine) LASTACAFT® (alcaftadine) OLOPATADINE (generic of Patanol®) PATADAY™ (olopatadine)

Ophthalmic Agents: Dry Eye Treatments

LENGTH OF AUTHORIZATIONS: 1 year

All drugs in this class require step therapy: Patient must have a claim for an artificial tear or OTC dry eye drop in the previous 120 days.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindications to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. Patient must have a therapeutic failure to at least one of the preferred agents.

OPHTHALMIC AGENTS: Dry Eye Treatments

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
RESTASIS® trays (cyclosporine)	RESTASIS® multi-dose (cyclosporine) XIIDRA™ (lifitegrast)

Ophthalmic Agents: Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY: ACROSS ALL AGENTS

1. For a product requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month of at least one preferred product
2. For a non-preferred agent, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindications to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

GLAUCOMA AGENTS – BETA BLOCKERS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
BETAXOLOL CARTEOLOL LEVOBUNOLOL (generic of Betagan®) METIPRANOLOL (generic of Optipranolol®) TIMOLOL gel solution (generic of Timoptic-XE®) TIMOLOL solution (generic of Timoptic®)	BETIMOL® (timolol)	BETOPTIC®S (betaxolol) ISTALOL™ (timolol)

GLAUCOMA AGENTS – PROSTAGLANDIN INHIBITORS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
LATANAPROST (generic of Xalatan®)	TRAVATAN®Z (travoprost)	BIMATOPROST 0.03% LUMIGAN™ 0.01% (bimatoprost) TRAVAPROST ZIOPTAN® (tafluprost)

GLAUCOMA AGENTS – ALPHA ADRENERGIC AGONISTS/SYMPATHOMIMETICS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
BRIMONIDINE 0.2% ALPHAGAN®P (brimonidine 0.15%)	ALPHAGAN®P (brimonidine 0.1%)	APRACLONIDINE 0.5% (generic of Iopidine®) BRIMONIDINE 0.15% (generic of Alphagan® P) IOPIDINE® 1% (apraclonidine)

GLAUCOMA AGENTS – CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
DORZOLAMIDE (generic of Trusopt®)	AZOPT® (brinzolamide)	

GLAUCOMA AGENTS – COMBO BETA BLOCKER & ALPHA ADRENERGIC AGONIST

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
	COMBIGAN® (brimonidine/ timolol)	

GLAUCOMA AGENTS – COMBO BETA BLOCKER & CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
DORZOLAMIDE/TIMOLOL (generic of Cosopt®)		COSOPT® PF (dorzolamide/timolol)

COMBO ALPHA-ADRENERGIC AGONIST AND CARBONIC ANHYDRASE INHIBITORS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
	SIMBRINZA™ (brinzolamide/ brimonidine)	

Ophthalmic Agents: NSAIDs

LENGTH OF AUTHORIZATIONS: For the date of service only; no refills for acute use. Refills for up to 14 days may be authorized for patients undergoing surgery.

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if both of the following are true:

1. If there has been a therapeutic failure to no less than a three-day trial of at least one medication not requiring prior approval
2. The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

OPHTHALMIC NSAIDs

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DICLOFENAC (generic of Voltaren®) FLURBIPROFEN (generic of Ocufen®) KETOROLAC (generic of Acular®, Acular LS®)	ACUVAIL® (ketorolac) BROMFENAC (generic of Bromday®, Xibrom®) BROMSITE™ (bromfenac) ILEVRO® (nepafenac) NEVANAC® (nepafenac) PROLENSA® (bromfenac)

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

LENGTH OF AUTHORIZATIONS: For the date of service only; no refills for acute infection.

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication.
   - Note diagnosis and any culture and sensitivity reports

The requested medication may be approved if both of the following are true:

- If there has been a therapeutic failure to no less than a one-week trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

OTIC AGENTS: ANTIBACTERIAL – STERIOD COMBINATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CIPRODEX® suspension (ciprofloxacin with dexamethasone)	CIPRO HC® suspension (ciprofloxacin with hydrocortisone)
NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE solution (generic of Cortisporin® solution)	COLY-MYCIN-S® suspension (neomycin and colistin with hydrocortisone)
NEOMYCIN-POLYMYXIN B WITH HYDROCORTISONE suspension (generic of Cortisporin® suspension)	CORTISPORIN-TC® suspension (neomycin and colistin with hydrocortisone)
	OTOVEL® (ciprofloxacin with fluocinolone)

OTIC AGENTS: ANTIBACTERIAL

NO PA REQUIRED "PREFERRED"	PA REQUIRED
OFLOXACIN drops (generic of Floxin Otic®)	CIPROFLOXACIN (generic of Cetraxal®)

Respiratory Agents: Antihistamines – Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there have been therapeutic failures after courses of treatment (e.g., one month for allergic rhinitis) with medication not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION

- Fexofenadine is indicated for patients 6 years of age and older
- Loratadine is indicated for patients 2 years of age and older
- Cetirizine and desloratadine are indicated for patients 6 months of age and older

RESPIRATORY AGENTS: ANTIHISTAMINES: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CETIRIZINE chewable (generic of Zyrtec®) (no PA required for age 6 or under) CETIRIZINE syrup (generic of Zyrtec®) (no PA required for age 6 or under) CETIRIZINE tablets (generic of Zyrtec®) CLARITIN® chewable (loratadine) LORATADINE rapid dissolve (generic of Claritin® Redi-tabs) LORATADINE syrup (generic of Claritin® Syrup) LORATADINE tablets (generic of Claritin®)	ALAVERT® rapid dissolve (loratadine) ALAVERT® tablets (loratadine) ALLEGRA® ODT (fexofenadrine) ALLEGRA® suspension (fexofenadrine) CETIRIZINE chewable (generic of Zyrtec®) (PA required for over age 6) CETIRIZINE syrup (generic of Zyrtec®) (PA required for over age 6) CLARINEX REDI-TABS® (desloratadine) CLARINEX® syrup (desloratadine) CLARITIN REDITABS® 5mg (loratadine) DESLORATADINE ODT (generic of Clarinex®) DESLORATADINE tablets (generic of Clarinex®) FEXOFENADINE tablets, suspension (generic of Allegra®) LEVOCETIRIZINE (generic of Xyzal®)

RESPIRATORY AGENTS: ANTIHISTAMINE/DECONGESTANT COMBO: SECOND GENERATION

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CETIRIZINE/PSEUDOEPHEDRINE (generic of Zyrtec- D®) LORATADINE-D (generic of Claritin-D®)	ALAVERT D-12HR® (loratadine/pseudoephedrine) ALLEGRA-D 24 HOUR® (fexofenadrine/ pseudoephedrine) CLARINEX-D 12, 24 HOUR® (desloratadine/ pseudoephedrine) FEXOFENADINE/PSEUDOEPHEDRINE (generic of Allegra-D 12 Hour®)

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Short Acting

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING

Metered Dose Inhalers or Other Devices

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PROAIR® HFA (albuterol) PROVENTIL HFA® (albuterol) VENTOLIN HFA® (albuterol)	PROAIR RESPICLICK® (albuterol) XOPENEX HFA® (levalbuterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC, SHORT-ACTING NEBULIZERS

NO PA REQUIRED " PREFERRED"	PA REQUIRED
ALBUTEROL (generic of Proventil®, Ventolin®) 0.083% Premixed nebulizers, 0.5% Concentrated Solution) ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb®) (no PA required for ages 12 and under)	ALBUTEROL 0.42mg/ml, 0.63mg/ml (generic of Accuneb®) (PA required for over age 12) LEVALBUTEROL (generic of Xopenex®)

Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Long Acting

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval within the same class and formulation. (i.e., nebulizers for nebulizers).

STEP THERAPY REQUIRED for all long-acting beta agonists and combinations:

Criteria	Approval Length
>= 3 claims for LABA (formoterol or salmeterol alone or in combination with steroid) in previous 6 months	6 months
>= 1 claim for anticholinergic (ipratropium, tiotropium, ipratropium/albuterol) in previous 6 months	12 months
>= 3 claims for inhaled corticosteroid (beclomethasone, budesonide, flunisolide, fluticasone, mometasone, triamcinolone) in previous 12 months	6 months
>= 3 claims for leukotriene modifier (montelukast, zafirlukast, zileuton) in previous 12 months	6 months
>= 3 claims for theophylline in previous 12 months	6 months
>= 3 claims for oral corticosteroid in previous 4 months	6 months
Diagnosis is COPD or exercise-induced bronchospasm	12 months
Diagnosis is moderate persistent or severe persistent asthma, or partly controlled or uncontrolled asthma	6 months
Patient scored <= 19 on Asthma Control Test™	6 months

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING INHALERS

STEP THERAPY REQUIRED " PREFERRED"	PA REQUIRED
FORADIL® (formoterol) SEREVENT DISKUS®(salmeterol)	ARCAPTA NEOHALER® (indacaterol) STRIVERDI RESPIMAT® (olodaterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING NEBULIZER SOLUTION

STEP THERAPY REQUIRED " PREFERRED"	PA REQUIRED
	BROVANA™ (arformoterol) PERFOROMIST® (formoterol)

RESPIRATORY AGENTS: BETA-ADRENERGIC COMBINATIONS

STEP THERAPY REQUIRED " PREFERRED"	PA REQUIRED
ADVAIR DISKUS® (salmeterol/fluticasone) ADVAIR® HFA (salmeterol/fluticasone) DULERA® (formoterol/mometasone) STIOLTO™ (tiotropium/olodaterol) SYMBICORT® (formoterol/budesonide)	ANORO™ ELLIPTA (umeclidinium/vilanterol) BEVESPI AEROSPHERE™ (glycopyrrolate/formoterol) BREO® ELLIPTA® (fluticasone/vilanterol)

Respiratory Agents: Chronic Obstructive Pulmonary Disease

LENGTH OF AUTHORIZATIONS: 1 year for inhaled therapy
Daliresp evaluated with each refill

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. The requested medication may be approved if there has been a therapeutic failure to no less than a two-week trial of at least one medication not requiring prior approval.

ADDITIONAL CRITERIA FOR ROFLUMILAST (DALIRESP®):
Patient must be adherent to concurrent therapy with long-acting beta agonist

RESPIRATORY AGENTS: COPD ANTICHOLINERGICS

NO PA REQUIRED " PREFERRED"	PA REQUIRED
ATROVENT HFA® (ipratropium) IPRATROPIUM nebulizer solution IPRATROPIUM/ALBUTEROL nebulizer solution (generic of Duoneb®) SPIRIVA® Handihaler® (tiotropium)	COMBIVENT Respimat® (ipratropium/albuterol) INCRUSE ELLIPTA® (umeclidinium) SPIRIVA® Respimat® (tiotropium) TUDORZA® (aclidinium bromide)

RESPIRATORY AGENTS: PHOSPHODISTERASE-4 INHIBITORS *

NO PA REQUIRED " PREFERRED"	PA REQUIRED
	DALIRESP® (roflumilast)

* Note: Concurrent therapy with long-acting beta agonist required

Respiratory Agents: Epinephrine Auto-Injectors

LENGTH OF AUTHORIZATIONS: 1 year

The requested medication may be approved if there has been therapeutic failure using the product(s) not requiring prior approval.

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medication(s) not requiring prior approval
- Contraindication to or drug interaction with medication(s) not requiring prior approval
- History of unacceptable/toxic side effects to medication(s) not requiring prior approval

RESPIRATORY AGENTS: EPINEPHRINE AUTO-INJECTORS

NO PA REQUIRED " PREFERRED"	PA REQUIRED
EPINEPHRINE (generic of Adrenaclick®) EPIPEN JR® (epinephrine) EPIPEN® (epinephrine)	EPINEPHRINE (generic of EpiPen®)

Respiratory Agents: Glucocorticoid Agents – Inhaled

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
   - Patient's condition is clinically unstable--patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days--changing to a medication not requiring prior approval might cause deterioration of the patient's condition.
2. If there have been therapeutic failures to no less than one-month trials of at least two medications not requiring prior approval, then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is a child under 13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.

RESPIRATORY AGENTS: GLUCOCORTICOIDS – INHALED

NO PA REQUIRED "PREFERRED"	PA REQUIRED
FLOVENT DISKUS® and HFA (fluticasone) PULMICORT FLEXHALER® (budesonide) QVAR® (beclomethasone)	AEROSPAN® HFA (flunisolide) ALVESCO® (ciclesonide) ARNUITY ELLIPTA® (fluticasone furoate) ASMANEX® HFA, Twisthaler (mometasone)

RESPIRATORY AGENTS: GLUCOCORTICOIDS – NEBULIZERS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BUDESONIDE nebulizer solution (generic of Pulmicort®) (no PA required for age 4 or under) PULMICORT® nebulizer solution (budesonide) (no PA required for age 4 or under)	BUDESONIDE nebulizer solution (generic of Pulmicort®) (PA required for over age 4) PULMICORT® nebulizer solution (budesonide) (PA required for over age 4)

Respiratory Agents: Hereditary Angioedema

LENGTH OF AUTHORIZATIONS: 6 months

All products in this class require clinical prior authorization:

- Diagnosis of hereditary angioedema
- History of recurrent angioedema (without urticaria) within the past 6 months
- History of recurrent episodes of abdominal pain and vomiting within the past 6 months
- History of laryngeal edema within the past 6 months
- Positive family history of angioedema

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been one episode of angioedema during use of a preferred medication

RESPIRATORY AGENTS: HEREDITARY ANGIOEDEMA

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED
CINRYZE® (C1 esterase inhibitor) RUCONEST® (C1 esterase inhibitor, recombinant)	BERINERT® (C1 esterase inhibitor) FIRAZYR® (icatibant acetate) KALBITOR® (ecallantide)

Respiratory Agents: Leukotriene Receptor Modifiers and Inhibitors

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.

RESPIRATORY AGENTS: LEUKOTRIENE RECEPTOR ANTAGONISTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
MONTELUKAST tablets, chewable tablets, granules (generic of Singulair®) ZAFIRLUKAST (generic of Accolate®)	ZYFLO® (zileuton) ZYFLO CR® (zileuton)

Respiratory Agents: Nasal Preparations

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY: GLUCOCORTICOIDS ONLY

1. For a product requiring step therapy, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month of at least one preferred product
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month each of at least two preferred or step therapy products

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

RESPIRATORY AGENTS: NASAL PREPARATIONS - GLUCOCORTICOIDS

NO PA REQUIRED	STEP THERAPY REQUIRED	NON-PREFERRED
FLUNISOLIDE FLONASE OTC® (fluticasone) FLUTICASONE (generic of Flonase®)	NASONEX® (mometasone)	BECONASE®AQ (beclomethasone) BUDESONIDE (generic of Rhinocort Aqua®) DYMISTA® (fluticasone/azelastine) OMNARIS® (ciclesonide) QNASL® (beclomethasone) VERAMYST™ (fluticasone furoate) ZETONNA® (ciclesonide)

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTIHISTAMINES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
ASTEPRO® (azelastine) PATANASE® (olopatadine)	AZELASTINE (generic of Astelin®, Astepro®) OLOPATADINE (generic of Patanase®)

RESPIRATORY AGENTS: NASAL PREPARATIONS - ANTICHOLINERGICS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
IPRATROPIUM (generic of Atrovent®)	

Topical Agents: Acne Preparations

LENGTH OF AUTHORIZATIONS: 1 year

CLINICAL CRITERIA:

All topical retinoids require prior authorization for patients over age 23:

- Patient diagnosis psoriasis – may approve tazarotene (Tazorac®)
- Patient diagnosis acne vulgaris – may approve retinoid if the patient has a history of at least 30 days of therapy with alternative therapy (benzoyl peroxide, sodium sulfacetamide or antibiotic) in the previous 90 days
- Patient diagnosis skin cancer – may approve retinoid

PDL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication in the same class not requiring prior approval

ANTIBIOTIC PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CLINDAMYCIN gel (generic of Cleocin T®, Clindamax®) CLINDAMYCIN lotion (generic of Cleocin T®, Clindamax®) CLINDAMYCIN solution (generic of Cleocin T®) ERYTHROMYCIN gel ERYTHROMYCIN solution (generic of A/T/S®, Akne-Mycin®)	CLINDACIN® Pak (clindamycin/skin cleanser kit) CLINDAMYCIN foam (generic of Evoclin®) CLINDAMYCIN pledgets (generic of Cleocin T®) ERYTHROMYCIN pads (generic of Ery Pads®)

ACNE PREPARATIONS – OTHER PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AZELEX® cream (azelaic acid)	ACZONE® gel (dapsone) FINACEA® gel (azelaic acid)

BENZOYL PEROXIDE AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CLINDAMYCIN-BENZOYL PEROXIDE gel (generic of Benzaclin®, Duac®) BENZOYL PEROXIDE cleanser (generic of Oscion®, Triaz®) BENZOYL PEROXIDE gel (generic of Benzac AC®, Brevoxyl®, Desquam-X®, Panoxyl®) BENZOYL PEROXIDE wash (generic of Benzac AC ®, Benzac W®, Brevoxyl®, Desquam-X®, Pacnex®) ERYTHROMYCIN-BENZOYL PEROXIDE gel (generic of Benzamycin®) NEUAC® gel (clindamycin-benzoyl peroxide) PANOXYL® 10% foam, wash (benzoyl peroxide)	ACANYA® (clindamycin-benzoyl peroxide) BENZOYL PEROXIDE foam (generic of Benzefoam®) ONEXTON™ gel (clindamycin-benzoyl peroxide)

RETINOID AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DIFFERIN® cream, gel, lotion (adapalene) TAZORAC® cream, gel (tazarotene) TRETINOIN cream, gel (generic of Retin-A®) TRETINOIN micro gel (generic of Retin-A® micro)	ADAPALENE cream, gel (generic of Differin®) ATRALIN® gel (tretinoin) EPIDUO® gel (adapalene/benzoyl peroxide) FABIOR® foam (adapalene) RETIN-A MICRO® gel (tretinoin) VELTIN® gel (clindamycin/tretinoin) ZIANA® gel (clindamycin/tretinoin)

SODIUM SULFACETAMIDE AND COMBINATION PRODUCTS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
KLARON® lotion (sulfacetamide) SODIUM SULFACETAMIDE-SULFUR wash (generic of Avar® cleanser, Clenia® foaming wash, Plexion® cleanser, Rosac® wash)	OVACE PLUS® (sodium sulfaetamide) ROSULA® pad (sulfacetamine sodium-sulfur) SODIUM SULFACETAMIDE lotion (generic of Klaron®) SODIUM SULFACETAMIDE-SULFUR pads (generic of Plexion® cleansing cloths) SODIUM SULFACETAMIDE-SULFUR cream (generic of Plexion® SCT cream) SULFACETAMIDE SODIUM-SULFUR topical suspension (generic of Sumaxin TS®)

Topical Agents: Anti-Fungals

LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 6 months)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to at least two medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Is the infection caused or presumed to be caused by an organism resistant to medications not requiring prior approval?
3. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval?

TOPICAL AGENTS: ANTI-FUNGALS

NO PA REQUIRED "PREFERRED"	PA REQUIRED
CICLOPIROX cream, gel, topical suspension, shampoo (generic of Loprox®)	CICLOPIROX kit (generic of CNL® Nail lacquer kit)
CICLOPIROX solution (generic of Penlac®)	ERTACZO® (sertaconazole)
CLOTRIMAZOLE (generic of Lotrimin®)	EXELDERM® (sulconazole)
CLOTRIMAZOLE/BETAMETHASONE (generic of Lotrisone®)	JUBLIA® solution (efinaconazole)
ECONAZOLE (generic of Spectazole®)	KERYDIN® solution (tavaborole)
KETOCONAZOLE Cream & Shampoo (generic of Kuric®, Nizoral®)	KETOCONAZOLE foam(generic of Extina®)
MICONAZOLE	LUZU® (luliconazole)
NYSTATIN	MENTAX® (butenafine)
NYSTATIN/TRIAMCINOLONE	NAFTIN® (naftifine)
TERBINAFINE (generic of Lamisil®)	OXISTAT® (oxiconazole)
TOLNAFTATE (generic of Tinactin®)	PEDIADERM AF® cream (nystatin)
	VUSION® ointment (miconazole/zinc)

Topical Agents: Anti-Parasitics

LENGTH OF AUTHORIZATIONS: 2 weeks

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

ADDITIONAL INFORMATION

The requested medication may be approved if the following is true:

- If there has been a therapeutic failure to no less than a one-month trial of at least one medication not requiring prior approval
- The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.

INDICATIONS AS APPROVED BY FDA

- Benzyl alcohol lotion is indicated for patients 6 months of age and older
- Crotamiton is indicated for adults
- Ivermectin is indicated for age 6 months and older
- Lindane lotion and shampoo are indicated only in patients who cannot tolerate or who have failed other treatments. **The P&T Committee does not recommend use of lindane.**
- Malathion is indicated for patients 6 years of age and older
- Permethrin cream and lotion are indicated for patients 2 months of age and older
- Spinosad is indicated for patients 6 months of age and older
- Package labeling does not list age for permethrin or piperonyl butoxode-pyrethrins

ANTI-PARASITICS, TREATMENT OF SCABIES

NO PA REQUIRED "PREFERRED"	PA REQUIRED
PERMETHRIN cream (generic of Elimite®)	EURAX® cream, lotion (crotamiton)

ANTI-PARASITICS, TREATMENT OF LICE

NO PA REQUIRED "PREFERRED"	PA REQUIRED
LICE kit [piperonyl butoxide-pyrethrins shampoo, comb, permethrin home spray] (generic of Rid® complete kit) NATROBA® (spinosad) PERMETHRIN lotion (generic of Nix® cream rinse) PIPERONYL BUTOXIDE-PYRETHRINS lotion PIPERONYL BUTOXIDE-PYRETHRINS shampoo (generic of Rid® shampoo) SKLICE® lotion (ivermectin)	MALATHION lotion (generic of Ovide®) SPINOSAD (generic of Natroba®) ULESFIA® lotion (benzyl alcohol)

Topical Agents: Corticosteroids

LENGTH OF AUTHORIZATIONS: 1 year for low and medium potency
3 months for high and very high potency

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:
   - Allergy to at least two medications not requiring prior approval
   - Contraindication to all medications not requiring prior approval
   - History of unacceptable/toxic side effects to at least two medications not requiring prior approval
2. Has the patient failed therapeutic trials of two weeks with two medications not requiring prior approval?

TOPICAL AGENTS: CORTICOSTEROIDS – LOW POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED
DESONIDE cream, ointment (generic of Desowen®) FLUOCINOLONE ACETONIDE 0.01% cream, solution (generic of Synalar®) FLUOCINOLONE body oil, scalp oil (generic of Derma-Smoothe/ FS®) HYDROCORTISONE cream, lotion, ointment	ALCLOMETASONE cream, ointment (generic of Aclovate®) CAPEX® shampoo (fluocinolone acetonide) DESONATE®gel (desonide) DESONIDE lotion (generic of Desowen®) HYDROCORTISONE ACETATE WITH ALOE gel HYDROCORTISONE WITH UREA cream (generic of Carmol HC®) PANDEL® cream (hydrocortisone probutate) PEDIADERM HC® kit VERDESO® foam (desonide)

TOPICAL AGENTS: CORTICOSTEROIDS – MEDIUM POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED
BETAMETHASONE VALERATE cream, lotion (generic of Valisone®) FLUOCINOLONE ACETONIDE 0.025% cream, ointment (generic of Synalar®) FLUTICASONE PROPIONATE cream, ointment (generic of Cutivate®) HYDROCORTISONE BUTYRATE solution (generic of Locoid®) MOMETASONE FUROATE cream, lotion, ointment (generic of Elocon®) TRIAMCINOLONE ACETONIDE cream, ointment (generic of Aristocort®, Kenalog®)	BETAMETHASONE DIPROPIONATE lotion (generic of Diprolene®) CLOCORTOLONE PIVALATE (generic of Cloderm®) CORDRAN® tape (flurandrenolide) DESOXIMETASONE cream, gel, ointment (generic of Topicort®) FLUTICASONE PROPIONATE lotion (generic of Cutivate®) HYDROCORTISONE BUTYRATE cream, ointment (generic of Locoid®) HYDROCORTISONE VALERATE cream, ointment (generic of Westcort®) LUXIQ® (betamethasone valerate foam) PREDNICARBATE cream, ointment (generic of Dermatop®) TRIAMCINOLONE ACETONIDE lotion (generic of Kenalog®)

TOPICAL AGENTS: CORTICOSTEROIDS – HIGH POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED
AMCINONIDE ointment, cream, lotion BETAMETHASONE VALERATE ointment (generic of Valisone®) DIFLORASONE DIACETATE cream, ointment (generic of Florone®) FLUOCINONIDE cream, gel, ointment, solution (generic of Lidex®, Lidex-E®)	APEXICON-E® (diflorasone diacetate emollient base) cream BETAMETHASONE DIPROPIONATE cream, ointment (generic of Diprolene®) FLUOCINONIDE (generic of Vanos® cream) HALOG® cream, ointment (halcinonide) KENALOG® aerosol spray (triamcinolone acetonide) SERNIVO™ (betamethasone dipropionate spray)

TOPICAL AGENTS: CORTICOSTEROIDS – VERY HIGH POTENCY

NO PA REQUIRED "PREFERRED"	PA REQUIRED
	BETAMETHASONE DIPROPIONATE AUGMENTED cream, ointment, lotion, gel (generic of Diprolene AF®) CLOBETASOL PROPIONATE cream, emollient base cream, foam, gel, lotion, ointment, shampoo, solution, spray (generic of Clobex®, Olux®, Temovate®) CLOBEX® lotion, shampoo,(clobetasol propionate) CLODAN® shampoo, kit (clobetasol propionate) HALOBETASOL PROPIONATE cream, ointment (generic of Ultravate®) OLUX-E® foam (clobetasol propionate)

Topical Agents: Immunomodulators

LENGTH OF AUTHORIZATIONS: 1 year

STEP THERAPY:

1. For a preferred brand, there must have been inadequate clinical response to no less than two one-month trials of topical corticosteroids
2. For a non-preferred drug, there must have been inadequate clinical response to preferred alternatives, including a trial of no less than one month of the preferred brand

OTHER APPROVAL CRITERIA:

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

CLINICAL INFORMATION

- Indicated for short-term and intermittent long-term treatment of atopic dermatitis if:
  - Alternative, conventional therapies (such as topical corticosteroids) are deemed inadvisable because of potential risks, or
  - There has been inadequate response or intolerance to alternative, conventional therapies (such as topical corticosteroids)
- Elidel® and Protopic® 0.03% are indicated in patients 2 years old or older. Protopic® 0.1% is indicated in adults only

TOPICAL IMMUNOMODULATORS

STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED
ELIDEL® * (pimecrolimus)	TACROLIMUS (generic of Protopic®) *

* Pimecrolimus and tacrolimus have age restriction of 2 years or older