Prior Authorization Criteria

This is NOT an all-inclusive list of medications that require prior authorization. If you are looking for a medication that requires prior authorization that is not on this list, please see:

- The Preferred Drug List (PDL) and navigate to the most current year and version
- The preferred dosage forms list at the end of this document
- Other documents explaining limitations that may cause a prior authorization denial:
    - Preferred Diabetic Supply List (PDSL)
    - Coverage Rules on Medications
    - Drug Utilization Management List

Contents

ACE-Inhibitors

General Prior Authorization Form

Criteria for non-preferred medication:
EPANED:

- Patient must be less than 9 years of age, or unable to ingest solid dosage form as evidenced by swallow study documentation

QBRELIS:

- Patient must be less than 9 years of age, or unable to ingest solid dosage form as evidenced by swallow study documentation
- The prescriber must submit medical justification explaining why the patient cannot use Epaned (subject to clinical review)

Non-preferred Combination Medications:

- Please prescribe individual medication separately or use a different medication combination

Preferred	Non-Preferred
amlodipine-benazepril	benazepril-hydrochlorothiazide
benazepril	captopril
enalapril	captopril-hydrochlorothiazide
enalapril-hydrochlorothiazide	EPANED (enalapril)
fosinopril	fosinopril-hydrochlorothiazide
lisinopril	PRESTALIA (perindopril/amlodipine)
lisinopril-hydrochlorothiazide	QBRELIS (lisinopril)
moexipril	trandolapril-verapamil ER
moexipril-hydrochlorothiazide	
perindopril	
quinapril	
quinapril-hydrochlorothiazide	
ramipril	
trandolapril	

ARBs (Angiotensin Receptor Blockers)

General Prior Authorization Form

ENTRESTO:

- Please see “Heart Failure-Neprilysin Inhibitor/Angiotensin Receptor Blocker” category on PDL. http://www.hidesigns.com/ndmedicaid/pdl/

Criteria for non-preferred products
Candesartan-hydrochlorothiazide, candesartan, eprosartan:

- Patient must fail three 30-day trials at the highest tolerable therapeutic dose of the following as evidenced by paid claims or pharmacy print outs:
    - Irbesartan
    - Telmisartan
    - Azilsartan
    - Olmesartan
    - Valsartan
    - Losartan

Combination Medications: (telmisartan-hydrochlorothiazide, Exforge, Exforge Hct, amlodipine-olmesartan, Byvalson, Amlodipine-valsartan, Candesartan-hydrochlorothiazide, Telmisartan-amlodipine):

- Please prescribe individual medication separately or use a different medication combination

Preferred	Non-Preferred
EDARBI (azilsartan)	Amlodipine-olmesartan
EDARBYCLOR (azilsartan/chlorothalidone)	Amlodipine-valsartan
ENTRESTO (sacubitril/valsartan)	BYVALSON (nebivolol/valsartan)
Irbesartan	Candesartan-hydrochlorothiazide
Irbesartan-hydrochlorothiazide	Candesartan
Losartan	Eprosartan
Losartan-hydrochlorothiazide	EXFORGE (amlodipine-valsartan)
Olmesartan	EXFORGE HCT (amlodipine-valsartan-hydrochlorothiazide)
Olmesartan-hydrochlorothiazide	Telmisartan-amlodipine
Telmisartan	Telmisartan-hydrochlorothiazide
Valsartan	
Valsartan-hydrochlorothiazide	

Renin Inhibitor

General Prior Authorization Form

Criteria:

- Patient must have failed 30-day trials at the highest tolerable therapeutic dose of two medications in each of the following groups as evidenced by paid claims or pharmacy print outs:

    - ARB: Azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan

    - ACE-Inhibitors: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, perindopril, or fosinopril

Preferred	Non-Preferred

	TEKTURNA (aliskiren)
	TEKTURNA HCT (aliskiren-hydrochlorothiazide)

Acne

General Prior Authorization Form

Criteria:

- Patient must be between 12 and 35 years old
- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)

Preferred	Non-Preferred
clindamycin-benzoyl peroxide	
ACANYA (clindamycin-benzoyl peroxide) 1.2%-2.5%)	BENZACLIN (clindamycin/benzoyl peroxide) 1%-5%
clindamycin-benzyl peroxide 1.2%-5%	clindamycin/benzoyl peroxide 1%-5% with pump - manufacturer 45802
clindamycin/benzoyl peroxide 1%-5% without pump- manufacturers 00378, 00781, 045802, and 68682	clindamycin/benzoyl peroxide 1%-5% without pump - manufacturer 51672
ONEXTON (clindamycin/benzoyl peroxide) 1.2%-3.75%	clindamycin-benzoyl peroxide) 1.2%-2.5%
TRETINOIN MICROSPHERES	
	tretinoin microsphere
	tretinoin microsphere with pump
TRETINOIN	
AVITA (tretinoin) CREAM *(brand preferred)*	ALTRENO (tretinoin) LOTION
RETIN-A (tretinoin) CREAM *(brand preferred)*	AVITA (tretinoin) GEL
tretinoin gel 0.01%, 0.03%	RETIN-A (tretinoin) GEL
	tretinoin cream
	tretinoin gel 0.05%, 0.1%
ADAPALENE	
DIFFERIN (adapalene) CREAM (*brand preferred*)	PLIXDA (adapalene) SWAB
adapalene gel	
DIFFERIN (adapalene) GEL W/ PUMP *(brand preferred)*	
DIFFERIN (adapalene) LOTION	
EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5% *(brand preferred)*	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	

ACZONE (dapsone) GEL WITH PUMP	FABIOR (tazarotene)
AZELEX (azelaic acid)	dapsone gel
ZIANA (clindamycin-tretinoin 1.2%-0.025%) *(brand preferred)*	tazarotene cream
sulfacetamide	
TETRACYCLINES	
Preferred	Non-Preferred
clindamycin capsule	doxycycline hyclate capsule 50 mg
clindamycin cream	doxycycline hyclate tablet DR 50 mg
clindamycin foam	doxycycline monohydrate tablet 50 mg
clindamycin gel	doxycycline hyclate tablet DR 75 mg
clindamycin lotion	doxycycline hyclate tablet 75 mg
doxycycline monohydrate 25 mg/5mL	doxycycline monohydrate capsule 75 mg
doxycycline monohydrate capsule 50 mg	doxycycline hyclate capsule 100 mg
doxycycline monohydrate tablet 75 mg	doxycycline hyclate tablet DR 100 mg
doxycycline monohydrate capsule 100 mg	DORYX MPC (doxycycline hyclate) 120mg
doxycycline monohydrate tablet 100 mg	doxycycline hyclate tablet 150 mg
metronidazole cream	doxycycline monohydrate capsule 150mg
metronidazole gel	doxycycline monohydrate tablet 150 mg
metronidazole lotion	doxycycline hyclate tablet DR 150 mg
minocycline	doxycycline hyclate tablet DR 200mg
VIBRAMYCIN (doxycycline monohydrate) 25 mg/5mL SUSP	MINOLIRA ER (minocycline)
VIBRAMYCIN (doxycycline monohydrate) 50 mg/5mL SYRUP	minocycline ER
	MORGIDOX (doxycycline hyclate) 100mg
	MORGIDOX (doxycycline hyclate) 50mg
	SOLODYN (minocycline)
	tetracycline
	XIMINO (minocycline)
	VIBRAMYCIN (doxycycline hyclate)100 mg

Actinic Keratosis

General Prior Authorization Form

Criteria for non-preferred medication:

- Patient must fail a 6-month trial of imiquimod before receiving a non-preferred product as evidenced by paid claims or pharmacy print outs.

Preferred	Non-Preferred
Imiquimod 5% cream packet	Imiquimod 3.75% cream pump
ZYCLARA (imiquimod) 3.75% CREAM PUMP	PICATO (ingenol mebutate)

ZYCLARA (imiquimod) 3.75% CREAM PACKET	SOLARAZE (diclofenac sodium) GEL
ZYCLARA (imiquimod) 2.5% CREAM PUMP	

Albuterol/Levalbuterol Rescue Inhalers

General Prior Authorization Form
MedWatch Form

Criteria for non-preferred medications:
ProAir RespiClick:

- Patient must fail a 30-day trials of all the following as evidenced by paid claims or pharmacy print outs:
  - Proventil HFA
  - Ventolin HFA
  - Xopenex HFA
- A MedWatch form documenting the experienced treatment failure for each trial must be provided with authorization request

Ventolin HFA:

- A steroid inhaler must be used with Ventolin HFA. See Coverage Rules for Medications for specifics.

Preferred	Non-Preferred
PROAIR (albuterol) HFA	PROAIR RESPICLICK (albuterol)
VENTOLIN (albuterol) HFA**	PROVENTIL (albuterol) HFA
XOPENEX (levalbuterol) HFA *(brand preferred)*	

Allergenic Extracts – Oral

General Prior Authorization Form

Criteria

- Patient must have an FDA-approved diagnosis of allergic rhinitis confirmed by a positive skin test or in vitro testing for pollen-specific IgE antibodies contained in the requested product
- Patient must be an FDA-approved age
- Patient must have failed a trial of 2 of the following: oral antihistamines, intranasal antihistamines, intranasal corticosteroids, or leukotriene inhibitors as evidenced by paid claims or pharmacy printouts.
- Patient must have failed a trial of have intolerance to subcutaneous allergen immunotherapy (allergy shots) as evidenced by paid claims or pharmacy printouts.

Preferred	Non-Preferred
	ORALAIR (GR POL-ORC/SW VER/RYE/KENT/TIM)

Ampyra

Prior Authorization Form - Ampyra

Approval:

Initial: 3 months
Renewals: 6 months

Initial Criteria:

- Patient must be 18 years or older
- Patient must have a specialist (neurologist or physiatrist) involved in therapy
- Patient must have confirmed diagnosis of multiple sclerosis
- Patient must not have a history of seizures
- Patient's CrCl (creatinine clearance) must be greater than 50mL/min
- Patient must not have experienced any acute exacerbations within the last 60 days
- Patient must have established a baseline ability of walking 25 feet in 8 to 45 seconds

1st Renewal Request Criteria:

- Renewal PA Requests must include patient's baseline and current T25FW
- Current 25-foot walk time must be 20% faster than baseline 25-foot walk time

Subsequent Renewal Request Criteria:

- Renewal PA Requests must include patient's baseline and current T25FW
- Current 25-foot walk time must be faster than baseline 25-foot walk time

Anesthetics - Topical

Prior Authorization Form - Anesthetics - Topical

Criteria:

- Patients must be 12 years of age or older
- Use must be for placement of peripheral or central line or injections through an implanted port

Anticoagulants - Injectable

General Prior Authorization Form

Criteria for non-preferred medication:

- Patient must have FDA Approved Indication
- Patient must have failed a 30-day trial with enoxaparin, as evidenced by paid claims or pharmacy printouts.
    - Patients with Heparin-induced thrombocytopenia (HIT) requesting fondaparinux can bypass enoxaparin trial

Preferred	Non-Preferred
enoxaparin	fondaparinux
	FRAGMIN (dalteparin)

Antifungals – Topical

Approval:

Onychomycosis: 1 year
Dermatophytosis: 1 month

Criteria:

- Patient must have an FDA approved diagnosis confirmed by potassium hydroxide (KOH) preparation
- Patient must have failed a trial of 3 preferred agents including at least one oral agent (terbinafine, fluconazole, or itraconazole) for the length of recommended treatment time for patient's particular infection.
- Medical Justification must be provided for why a preferred product cannot be used if requested product ingredient is available in a preferred formulation.

Additional Criteria for onychomycosis:

- There must have been enough time since treatment cessation to assess healthy toenail outgrow (at least 6 months)

Preferred	Non-Preferred
Ciclopirox cream	JUBLIA (efinaconazole)
Ciclopirox gel	KERYDIN (tavaborole)
Ciclopirox shampoo	Ketoconazole foam
Ciclopirox solution	luliconazole cream
Clotrimazole cream	MENTAX (butenafine) CREAM
Econazole cream	Naftifine cream
ERTACZO (sertraconazole) CREAM	NAFTIN (naftifine) GEL
EXELDERM CREAM (sulconazole)	Nystatin – triamcinolone cream
EXELDERM SOLUTION (sulconazole)	Nystatin – triamcinolone ointment
Ketoconazole cream	Oxiconazole cream
Ketoconazole shampoo	OXISTAT (oxiconazole) LOTION
LUZU (luliconazole) CREAM	
Miconazole	
Nystatin cream	
Nystatin ointment	
Nystatin powder	
VUSION (miconazole/zinc oxide/white	

petrolatum)	

Antihistamines

General Prior Authorization Form

Criteria for non-preferred medication:

- Patient must have failed the following 14-day trials, as evidenced by paid claims or pharmacy printouts.
    - loratadine
    - cetirizine

Preferred	Non-Preferred
cetirizine chew tablet	desloratadine ODT
cetirizine solution	desloratadine tablet
cetirizine tablet	levocetirizine solution
levocetirizine tablet	
loratadine ODT	
loratadine solution	
loratadine tablet	

Antihemophilic Factor Products

Prior Authorization Form - Antihemophilic Factors

Criteria:

- Patient must visit an accredited Hemophilia Treatment Center once per year
- Date of Last Appointment with treatment center must be provided
- Contact information for treatment center must be provided

Criteria for non-preferred medication:

- Medical justification must be given as to why preferred product won't work
- Patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

Preferred	Non-Preferred
ADVATE	ADYNOVATE
AFSTYLA	ELOCTATE
ALPHANATE	HEMLIBRA
ALPHANINE SD	JIVI
ALPROLIX	KOVALTRY
BEBULIN	
BENEFIX	

FEIBA	
HELIXATE FS	
HEMOFIL M	
HUMATE-P	
IDELVION	
IXINITY	
KOATE-DVI	
KOGENATE FS BIO-SET	
KOGENATE FS	
MONOCLATE-P	
MONONINE	
NOVOEIGHT	
NOVOSEVEN	
OBIZURE	
PROFILNINE SD	
RECOMBINATE	
RIXUBIS	
VONVENDI	
WILATE	
XYNTHA	

Antihyperuricemics

General Prior Authorization Form

Criteria for non-preferred medication:
Colchicine tablets:

- Medical justification must be given as to why preferred product won't work

Duzallo:

- Patient must have failed 30-day trials of Uloric and allopurinol, as evidenced by paid claims or pharmacy printouts.

Uloric

- Patient must have failed a 30-day trial of allopurinol, as evidenced by paid claims or pharmacy printouts.

Zurampic:

- Patient must have failed 30-day trials of Uloric and allopurinol, as evidenced by paid claims or pharmacy printouts.
- Zurampic must be used in combination with allopurinol or Uloric

Preferred	Non-Preferred
allopurinol tablet	colchicine tablet
colchicine capsule	DUZALLO (lesinurad/allopurinol)
probenecid-colchicine	ULORIC (febuxostat) TABLET

	ZURAMPIC (lesinurad) TABLET

Antimalarial Agents

General Prior Authorization Form

Preferred and Non-Preferred Agent Criteria:

- Antimalarials are only covered for treatment, *NOT for prophylaxis*

Additional Criteria for Non-Preferred Agent

- Patient must have tried generic quinine in the last 30 days, as evidenced by paid claims or pharmacy print outs
- Patient must be less than 18 years old to qualify for atovaquone/proguanil 62.5-25 MG

Preferred	Non-Preferred
daraprim	atovaquone/proguanil
hydroxychloroquine	chloroquine
quinine	COARTEM (artemether/lumefantrine)
	MALARONE (atovaquone/proguanil)
	mefloquine
	primaquine

Antipsoriatics – Topical

General Prior Authorization Form

Criteria for non-preferred medication:

- For Foams and Sprays: Patient must have failed a 30-day trial of the preferred solution and shampoo formulations as evidenced by paid claims or pharmacy print outs
- For Ointments: Patient must have failed a 30-day trial of the preferred ointment formulations as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
calcipotriene ointment	calcipotriene/betamethasone ointment
calcipotriene solution	ENSTILAR (calcipotriene/betamethasone) FOAM
calcipotriene cream	SORILUX (calcipotriene) FOAM
TACLONEX (calcipotriene/betamethasone) SUSPENSION	
Preferred	Non-Preferred
Clobetasol Cream	Clobetasol Emollient Cream
Clobetasol Gel	Clobetasol Emollient Foam

CLOBEX (Clobetasol) LOTION *(brand required)*	Clobetasol Foam
Clobetasol Ointment	
CLOBEX (Clobetasol) SHAMPOO *(brand required)*	
Clobetasol Solution	
CLOBEX (Clobetasol) SPRAY *(brand required)*	

Benign Prostatic Hyperplasia

General Prior Authorization Form

Criteria for non-preferred medication:

- Recipient must have diagnosis of benign prostatic hyperplasia (BPH)
- Patient must have failed a 30-day trial of all preferred products, unless contraindicated as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
alfuzosin ER	sildenafil
CARDURA XL (doxazosin)	
doxazosin	
dutasteride	
finasteride	
prazosin	
silodosin	
tamsulosin	
terazosin	

Biosimilar Agents

General Prior Authorization Form

Criteria:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)
- Patient must have FDA indication

Corticosteroids – Inhaled

General Prior Authorization Form

Criteria:

Patient must have failed a 30-day trial of all preferred inhalers will be required before a non-preferred agent will be authorized.

Preferred	Non-Preferred

ALVESCO (ciclesonide)	ARMONAIR RESPICLICK (fluticasone)
ASMANEX (mometasone) TWISTHALER	ARNUITY ELLIPTA (fluticasone)
budesonide suspension	ASMANEX HFA (mometasone)
FLOVENT DISKUS (fluticasone)	PULMICORT RESPULES (budesonide)
FLOVENT HFA (fluticasone)	QVAR REDIHALER (beclomethasone)
PULMICORT FLEXHALER (budesonide)	

Corticosteroids - Topical

General Prior Authorization Form

Criteria:

For non-preferred agents not labeled as "STEP 2" (Step 1):

- Patient must have failed a 2-week trial of all preferred drug entities within the same potency category and dosage form group within the last 3 months.

For non-preferred agents labeled as "STEP 2":

- Patient must have failed a 2-week trial of all preferred and non-preferred drug entities within the same potency category and dosage form group within the last 3 months.

See Topical Corticosteroids Preferred Medication List

Dispense as Written (DAW1)

Prior Authorization Form - Dispense As Written (DAW1)
MedWatch Form

Criteria:

- Patient must have failed a 30-day trial of all accessible generic product (s), as evidenced by paid claims or pharmacy print outs
    - A failure is defined as product was not effective at maximum tolerated dose or caused adverse reaction where the branded product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient
    - Patient or prescriber preference is NOT criteria considered for approval
- A MedWatch form for each manufacturer must be filled out and attached to request
- Product must not have an authorized generic

OR

- Primary insurance requires a ND Medicaid non-preferred branded product

Dificid

General Prior Authorization Form

Approval: 5 days

Criteria:

- Patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- Patient must be ≥ 18 years of age
- Patient must have failed 10-day trial with Firvanq

Additional Renewal Criteria:

- Must be first recurrence for a patient whose initial episode was treated with Dificid

Preferred	Non-Preferred
FIRVANQ (vancomycin)	DIFICID (fidaxomicin)
	VANCOCIN (vancomycin)

Dupixent

Prior Authorization Form - Dupixent

Approval: 3 months

Atopic Dermatitis

Initial Criteria:

- Patient must have a diagnosis of an FDA-approved indication for use
- Patient must be 18 years of age or older
- Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy print-outs:
    - Tacrolimus or Pimecrolimus
- One of the following must be met (A or B):
    A. Patient must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy print-outs.
    B. Patient must meet both of the following (1 and 2):
        1. Affected area is on face, groin, axilla, or under occlusion
        2. Patient must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy print-outs.

Renewal Criteria:

- Documentation from the prescriber must be provided showing that the patient has achieved a significant reduction in severity of atopic dermatitis.

Asthma

Initial Criteria:

- Patient must have a diagnosis of an FDA-approved indication for use
- Patient must be 12 years of age or older
- Patient must have had 2 or more exacerbations in previous year despite continued compliant use of moderate to high dose inhaled steroid plus long-acting beta agonist (LABA) or long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy print-outs.

- One of the following must be met (A or B):
    A. Patient must have baseline eosinophil level of ≥ 300 cells/mcL within past 12 months
    B. Patient must have oral corticosteroid dependent asthma with at least 30 days of oral steroid use in past 120 days

Renewal Criteria:

- Documentation from the prescriber must be provided showing that the patient has achieved a significant reduction in exacerbations and utilization of rescue medications.

Dihydroergotamine

General Prior Authorization Form

Criteria for non-preferred medications:

- Patient must have a diagnosis of migraine or cluster headache
- Patient must have had two 30 day trials (within the past 2 years) of 'Preferred Agents' and two 30 day trials (within the past 2 years) of 'Non-Preferred Step 1 Agents'

Preferred	Non-Preferred Step 1	Non-Preferred Step 2
RELPAX (eletriptan)	ONZETRA XSAIL (sumatriptan) NASAL SPRAY	CAFERGOT (ergotamine/caffeine) TABLET
rizatriptan	ZOMIG (zolmitriptan) NASAL SPRAY	D.H.E.45 (dihydroergotamine) INJECTION
Rizatriptan ODT	zolmitriptan ODT	dihydroergotamine injection
sumatriptan		ERGOMAR (ergotamine) SL TABLET
		MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
		MIGRANAL (dihydroergotamine) SPRAY

Edecrin

General Prior Authorization Form

Criteria:

- Patient must have sulfa allergy

OR

- Patient must have failed a 30-day trial of all preferred agents, as evidenced by paid claims or pharmacy print outs

Preferred	Non-Preferred
furosemide	ethacrynic acid
bumetanide	
torsemide	

Emflaza

Prior Authorization Form - Emflaza

Criteria:

- Patient must be 5 years of age or older
- Patient must have diagnosis of Duchenne muscular dystrophy (DMD) confirmed by the documented presence of abnormal dystrophin or a confirmed mutation of the dystrophin gene

Additional Initial Criteria: Approval 6 months

- Onset of weakness before 5 years of age
- Must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- Serum creatinine kinase activity at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- Inadequate treatment response, intolerance, or contraindication to a 6-month trial of prednisone
- Obtain a baseline motor milestone score from ONE the following assessments:
    i. 6-minute walk test (6MWT)
    ii. North Star Ambulatory Assessment (NSAA)
    iii. Motor Function Measure (MFM)
    iv. Hammersmith Functional Motor Scale (HFMS)
- Patient must have ONE of the following significant intolerable adverse effects supported by documentation:
    i. Cushingoid appearance
    ii. Central (truncal) obesity
    iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
    iv. Diabetes and/or hypertension that is difficult to manage
    v. Severe behavioral adverse effect

Additional Renewal Criteria: Approval 1 year

- Patient must have ONE of the following:
    - Improvement in motor milestone score from baseline from ONE the following assessments:
        i. 6MWT – improvement of 20 meters from baseline
        ii. NSAA – improvement of 2 points from baseline
        iii. MFM – improvement of 2 points from baseline
        iv. HFMS – improvement of 2 points from baseline
    - Patient must have had improvement of adverse effects experienced on prednisone supported by documentation:
        i. Cushingoid appearance
        ii. Central (truncal) obesity
        iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
        iv. Diabetes and/or hypertension that is difficult to manage
        v. Severe behavioral adverse effect

Hemangeol

Prior Authorization Form - Hemangeol

Criteria:

- Patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy
- Patient must be between 5 weeks and 1 year of age
- Patient must weigh 2 kg or greater
- Patient must have not have contraindications:
    - Asthma or history of bronchospasm
    - Bradycardia (<80 beats per minute)
    - Greater than first-degree heart block
    - Decompensated heart failure
    - Blood pressure <50/30 mmHg
    - Pheochromocytoma

Hereditary Angioedema

Prior Authorization - Hereditary Angioedema

Criteria:

- Patient must have diagnosis of hereditary angioedema
- Diagnosis must be confirmed by a specialist

Idiopathic Pulmonary Fibrosis

Prior Authorization Form - Idiopathic Pulmonary Fibrosis

Criteria:

- Patient must be 18 years of age or older
- Patient must have documented diagnosis of idiopathic pulmonary fibrosis
- Patient must have a specialist involved in therapy
- Patient must have forced vital capacity (FVC) ≥ 50% of predicted within prior 60 days

Immune Globulins

Prior Authorization Form - Immune Globulins

Criteria for all products:

- If patient's BMI > 30, adjusted body weight must be provided along with the calculated dose
- The indication has been provided
- Patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

Product specific criteria:

Gammagard S/D:

- Patient must be intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of igA)

Cuvitru, Hizentra, or Hyqvia:

- Patient must be unable to tolerate IV administration
- Patient failed a trial of two of the following:
    - Gamunex-C
    - Gammaked
    - Gammagard

Other Products:

- Patient failed a trial of two of the following:
    - Gammagard
    - Gamunex-C
    - Privigen

Preferred	Non-Preferred
BIVIGAM (human immunoglobulin gamma)	CUVITRU (human immunoglobulin gamma)
CARIMUNE NF (human immunoglobulin gamma)	GAMMAGARD S-D (human immunoglobulin gamma)
FLEBOFAMMA DIF (human immunoglobulin gamma)	HIZENTRA (human immunoglobulin gamma)
GAMANEX-C (human immunoglobulin gamma)	HYQVIA (human immune globulin G and hyaluronidase
GAMASTAN S-D	PANZYGA (Immune Globulin- IFAS)
GAMMAGARD LIQUID (human immunoglobulin gamma)	
GAMMAKED (human immunoglobulin gamma)	
GAMMAPLEX (human immunoglobulin gamma)	
OCTAGAM (human immunoglobulin gamma)	
PRIVIGEN (human immunoglobulin gamma)	

Juxtapid

Prior Authorization Form - Juxtapid

Criteria:

- Patient must have a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH)
- Patient must be 18 years of age or older

- Patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy print-outs:
    - A lipid lowering agent other than a statin combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- Patient meets one of the following:
    - genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
    - an untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
    - an untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

Ketek

Prior Authorization Form - Ketek

Approval: 5 days

Criteria:

- Patient must have a diagnosis of community-acquired pneumonia (of mild to moderate severity) due to Streptococcus pneumoniae
- Patient must be 18 years and older
  OR
  Patient must have an allergy to fluoroquinolones or tetracyclines
- Patient must not have myasthenia gravis
- Patient must have tried another antibiotic in the last 3 months

Medications that cost over $3000/month

General Prior Authorization Form

Criteria:

- Patient must have FDA approved diagnosis

DOPTELET (avatrombopag)
INCRELEX (mecasermin)
LUCEMYRA (lofexidine)
MULPLETA (lusutrombopag)
TAVALISSE (fostamatinib)

Miacalcin:

Prior Authorization Form – Miacalcin and Tymlos

Criteria:
Patient must have one of the following diagnoses and meet additional criteria for their diagnosis:

- Paget's Disease of the bone
  Additional Criteria:
  - Patient must have failed a 6-month trial of a preferred product (a bisphosphonate)
- Postmenopausal Osteoporosis
  Additional Criteria:
  - Patient must be postmenopausal for ≥ 5 years
  - Patient must have failed a 6-month trial of a preferred product (a bisphosphonate)
- Hypercalcemia

Preferred	Non-Preferred
Alendronate	MIACALCIN (calcitonin)
Ibandronate	TYMLOS (abaloparatide)
Risedronate	

Mifeprex

Prior Authorization Form - Mifeprex

Approval: 1 month

Criteria:

- Patient must not be over 70 days in gestation
- One of the following criteria must be met along with additional criteria:
  - Pregnancy must have resulted from an act of rape or incest
    Additional Criteria: One of the following criteria must be met
    - The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
    - The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.
  - The woman must suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a provider, place the woman in danger of death unless an abortion is performed
    Additional Criteria:
    - The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Naloxone Rescue Medications

Prior Authorization Form - Naloxone Rescue Medications

Initial Criteria:
Narcan Nasal Spray does NOT require prior authorization for the initial dose

Evzio:

- Provider has provided medical justification explaining why the patient cannot use Narcan Nasal Spray or injectable naloxone
- Patient must have one of the following diagnosis and must meet additional criteria for their diagnosis
    - Diagnosis of opioid use disorder:
      Additional Criteria:
        - Patient has been referred to addiction counseling services
    - Diagnosis of overdose with opioid pain treatment:
      Additional Criteria:
        - Patient must have chronic pain issue where benefit outweighs risk of continuing treatment
        - Patient must have had paid opioid claim in the last 30 days

Additional Renewal Criteria:

- The provider has answered if it is known that the previous dose was taken by the patient (and not diverted or given to another patient)
- One of the following criteria must be met:
    - The previous dose has expired
    - The dose was used by patient for illicit drug use
    - The patient is currently taking opioids and meets one of the following criteria:
        - The opioid dose must have been decreased
        - The provider has provided medical justification why the opioid dose as not been decreased

Preferred	Non-Preferred
Naloxone injection	EVZIO (naloxone) AUTO-INJECTOR
NARCAN (naloxone) NASAL SPRAY	

Nausea/Vomiting

Prior Authorization Form - Nausea/Vomiting

Chemo Induced

Approval: 6 months OR until the last day of chemotherapy
Criteria:

- Patient must have diagnosis of nausea and/or vomiting
- Prescriber must be an oncologist

- Patient must be receiving a moderately or highly emetogenic chemotherapy
- The final date of chemotherapy treatment must be indicated
- Patient must have failed a 3 day trial of the preferred oral product(s) in the same class within the last 30 days as evidenced by paid claims or pharmacy print outs.

SANCUSO (Additional Criteria):

- Patient must be less than 7 years of age, or unable to ingest solid dosage form as evidenced by swallow study documentation
- The granisetron tablet failure must not be due to side effects.

ZUPLENZ (Additional Criteria):

- The patient must fail a trial of both the ondansetron ODT and solution.
- The ondansetron failures must not be due to side effects.

SYNDROS (Additional Criteria)

- Patient must be less than 7 years of age, or unable to ingest solid dosage form as evidenced by swallow study documentation
- Patient must have one of the following diagnoses and meet required trial for their diagnosis:
    - Loss of appetite due to HIV/AIDS:
        - Patient must have tried and failed a 3-month trial with Megace, as evidenced by paid claims or pharmacy printouts
    - Chemotherapy-induced nausea and vomiting:
        - Patient must have tried and failed a 3-day trial of ondansetron ODT in combination with aprepitant suspension and a glucocorticoid if, as evidenced by paid claims or pharmacy printouts

Preferred	Non-Preferred
Aprepitant	AKYNZEO (netupitant/palonosetron)
	VARUBI (rolapitant) TABLET
Preferred	**Non-Preferred**
Granisetron tablet	ANZEMET (dolasetron)
Ondansetron ODT	SANCUSO (granisetron) PATCH
Ondansetron solution	ZUPLENZ (ondansetron) FILM
Ondansetron tablet	
Palonestron	
Preferred	**Non-Preferred**
Dronabinol	Cesamet (nabilone) Syndros (Dronabinol) SOLUTION

Pregnancy

Approval: Until two weeks past provided due date

Criteria:

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient must have failed a 3-day trial of all preferred products
- Patient's due date must be provided
- Diclegis/Bonjesta has not been studied in women with hyperemesis gravidarum
- Bonjesta: The prescriber must submit medical justification explaining why the patient cannot use a preferred product or Diclegis (subject to clinical review)

Preferred	Non-Preferred
meclizine	BONJESTA (doxylamine/vitamin B6)
metoclopramide	DICLEGIS (doxylamine/vitamin B6)
ondansetron	

Nasal Steroids

General Prior Authorization Form

Non-Preferred Agent Criteria:

- Patient must have had 30 day trials (within the past 2 years) of 3 preferred agents

Preferred	Non-Preferred
BECONASE AQ (beclomethasone)	flunisolide
Fluticasone	mometasone
OMNARIS (ciclesonide)	QNASL CHILDREN'S (beclomethasone)
QNASL (beclomethasone)	XHANCE (fluticasone)
ZETONNA (ciclesonide)	

Noxafil

General Prior Authorization Form

Approval: 2 weeks

Criteria:

- Medication indication must be prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- Patient must have documented history of failure to all preferred agents in last 30 days

Preferred	Non-Preferred
itraconazole	NOXAFIL (posaconazole)
fluconazole	

NSAIDS

Prior Authorization Form - NSAIDs

Oral solid dosage forms

Mefanemic acid:

- Patient must have diagnosis of dysmenorrhea
- Patient must have failed a 30-day trial of 3 different oral generic NSAIDs, as evidenced by paid claims or pharmacy print outs

Celecoxib 400mg/Naproxen 275 mg:

- Patient must use another tablet strength

Other oral generic NSAIDs:

- Patient must have failed a 30-day trial of 3 oral generic NSAID, as evidenced by paid claims or pharmacy print outs

Branded NSAIDs

- Provider has provided medical justification explaining why the patient cannot use another NSAID

Generic Solid Oral Dosage Forms	
Preferred	Non-Preferred
celecoxib 50mg, 100mg, 200mg	celecoxib 400mg
flurbiprofen	diclofenac
ibuprofen	diclofenac ER
indomethacin	etodolac
Indomethacin ER	etodolac ER
ketoprofen	fenoprofen
ketorolac	ketoprofen ER
meloxicam	meclofenamate
nabumatone	mefenamic acid
naproxen	Naproxen ER 375 mg
sulindac	Naproxen 275mg
	oxaprozin
	piroxicam
	TIVORBEX (indomethacin, submicronized)
	tolmetin
	VIVLODEX (meloxicam, submicronized)
	ZIPSOR (diclofenac)
	ZORVOLEX (diclofenac, submicronized)

Oral Solutions

Indomethacin and meloxicam oral solution:

- Patient must be unable to ingest solid dosage form and include swallow study documentation
- Patient must have failed a 30-day trial of naproxen oral solution, as evidenced by paid claims or pharmacy print outs

Oral Combination Products:

Arthotec:

- The prescriber must provide medical justification explaining why the patient cannot use individual products (diclofenac + misoprostol)

Duexis:

- The prescriber must provide medical justification explaining why the patient cannot use individual products (famotidine + ibuprofen)

Vimovo:

- The prescriber must provide medical justification explaining why the patient cannot use individual products (naproxen + esomeprazole)

Nasal

Sprix:

- Patient must be 18 years of age or older
- Patient must have a diagnosis of postoperative nausea and vomiting
-
- Patient must not have a history of gastric or duodenal ulcer or comorbidities of GI bleed, perforation, or obstruction

Non-solid dosage preparations

General Prior Authorization Form

Criteria:

- Patient must have tried a more cost-effect dosage form in the last 30 days
  OR
- Patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Nuedexta

Prior Authorization Form - Nuedexta

Approval: for 3 months

Initial Criteria:

- Patient must be 18 years of age or older
- Patient must not have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block
- The following information must be provided:
  - Baseline Center for Neurological Studies lability (CNS-LS)
  - Baseline weekly PBA episode count

- Patient must have diagnosis of pseudobulbar affect (PBA) due to one of the following neurologic conditions and meet additional criteria for diagnosis:
    - Amytrophic Lateral Sclerosis (ALS)
    - Multiple Sclerosis (MS)
    - Alzheimer's Disease
    - Stroke

Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:

- Neurologic condition must have been stable for at least 3 months
- Patient must have failed** a 3-month trial, as evidenced by paid claims or pharmacy print outs, of one medication from BOTH classes listed:
    - SSRIs: sertraline, fluoxetine, citalopram and paroxetine
    - Tricyclic Antidepressants: nortriptyline and amitriptyline
- A PBA episode count and CNS-LS score must be provided for before and after each trial

**A failure is defined as one of the following:

- ❖ PBA count decreased less than 75 percent, stayed the same, or increased from baseline in each trial
- ❖ CHS-LS score decreased less than 7 points, stayed the same, or increased from baseline in each trial

Renewal Criteria: Approval for 6 months

- Benefit of renewal must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode count must be a 75 percent decrease from baseline

Additional renewal criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:

- Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
- Current CNS-LS score must be a 30 percent decrease from baseline

Nuvigil

General Prior Authorization Form

Criteria:

- Patient must have FDA approved diagnosis
- Patient must have failed a 30-day trial of modafinil, as evidenced by paid claims or pharmacy print outs

Opioid Analgesic – Short Acting

Prior Authorization Form - Short Acting Opioids

Subsys, Fentora, Lazanda, Actiq, and Abstral:

- Patient must be an FDA approved age
- Patient must have cancer pain
- Patient must currently be on around the clock opioid therapy for at least a week, as evidenced by paid claims or pharmacy print-outs
    - The around the clock opioid therapy must be equivalent to 60mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily, or equianalgesic dose of another opioid daily

Oxycodone IR:

- The patient must have chronic pain
- The patient must currently be on a long-acting narcotic, as evidenced by paid claims or pharmacy print-outs
- The prescriber must confirm that they have reviewed the North Dakota PDMP reports for the patient
- The Morphine Equivalent Dose (MED) of the requested oxycodone strength must be less than 15% of the total daily Morphine Equivalent Dose (MED) provided by the long acting narcotic as calculated below (Please use an Opioid Dose Calculator to find the MED for specific products):
    - Oxycodone 15mg tablet: long acting narcotic must provide at least 150mg MED per day
    - Oxycodone 20mg tablet: long acting narcotic must provide at least 200mg MED per day
    - Oxycodone 30mg tablet: long acting narcotic must provide at least 300mg MED per day

Oravig

General Prior Authorization Form

Approval: 1 week
Criteria:

- Patient must have failed a 30-day trial of one of the preferred agents, as evidenced by paid claims or pharmacy print-outs

Preferred	Non-Preferred
Clotrimazole	ORAVIG (miconazole)
Fluconazole	
Itraconazole	
Nystatin	

PCSK9 Inhibitors

Prior Authorization Form - PCSK9 Inhibitors

Criteria:

- Patient must have one of the following diagnosis:
  - Heterozygous familial hypercholesterolemia
  - Clinical atherosclerotic cardiovascular disease
  - *Diagnosis for Repatha only*: Homozygous familial hypercholesterolemia
- Patient must have failed** all the following 3-month trials:
  - Crestor 20-40mg
  - Atorvastatin 40-80mg
  - A statin combined with another lipid lowering agent

**A failure is defined as an LDL level that remained 130 mg/DL or greater

Additional initial criteria:

- Patient's LDL level must be 130 mg/DL or greater

Preferred	Non-Preferred
Praluent Pen	Repatha Sureclick
Repatha Pushtronex	Repatha Syringe

Phenylketonuria

Prior Authorization Form - Phenylketonuria

Criteria:

- Patient must have a diagnosis of hyperphenylalaninemia
- Patient must be following a PHE restricted diet

Kuvan:

Approval:

Initial: 2 months
Renewal: 12 months

- Additional Criteria for initial requests:
  - Patient's weight must be provided
  - Patient must be 4 years of age or older
  - Patient must not have been known to have two null mutations in TRANS
  - Baseline PHE levels must be attached
    - For females of child bearing potential: PHE levels must be above 360 micromoles/liter
    - For males or females unable to bear children: PHE levels must be above 600 micromoles/liter
  - Requested initial dose must be 10 mg/kg or less

- Additional Criteria for renewal requests:
    - Patient's weight must be provided
    - If dose is the same or less than previous trial:
        - PHE level must be between 60 and 360 micromoles per liter
    - For a dose increase from previous trial:
        - PHE levels must be attached that were taken after 1 month of previous trial
        - Patient's PHE level must be greater than 360 micromoles per liter
        - For increase > 10 mg/kg - patient must have failed a trial of 1 month of 10 mg/kg

Palynziq:

Approval:

Initial: 6 months
Renewal: 12 months

- Additional Criteria for initial requests:
    - Patient must be 18 years of age or older
    - PHE levels must be above 600 micromoles/liter
    - Patient must have been compliant with diet and medication management for past 6 months.
- Additional Criteria for renewal requests:
    - If dose is the same or less than previous trial:
        - PHE level must be between 60 and 360 micromoles per liter
    - For a dose increase to 40mg:
        - PHE levels must be attached that were taken after 24 weeks of 20mg
        - Patient's PHE level must be greater than 360 micromoles per liter

Proton Pump Inhibitor

General Prior Authorization Form

Approval: 6 months

Criteria:
Esomeprazole:

- Patient must meet one of the following criteria:
    - Patient has had a 30-day trial of all the preferred Solid Dosage Forms (lansoprazole, omeprazole, pantoprazole, and rabeprazole) in the past 2 years

Lansoprazole ODT:

- Patient must have feeding tube
- Patient must have had a 30-day trial of all Preferred Non-Solid Dosage forms (Nexium Packet and Protonix Packet) in the past 2 years

Prilosec Packet:

- Patient must have feeding tube
- Patient must have had a 30-day trial of all Preferred Non-Solid Dosage forms (Nexium Packet and Protonix Packet) and lansoprazole ODT in the past 2 years

Omeprazole-sodium bicarbonate packet/Aciphex Sprinkle:

- Patient must have feeding tube
- Patient must have had a 30-day trial of all the Preferred Solid Dosage forms (lansoprazole, omeprazole, and pantoprazole), Dexilant, esomeprazole, and rabeprazole in the past 2 years

Esomeprazole strontium/Omeprazole-sodium bicarbonate:

- The prescriber must provide medical justification explaining why the patient cannot use another proton pump inhibitor

Solid Dosage Forms	
Preferred	Non-Preferred
DEXILANT (dexlansoprazole)	esomeprazole
lansoprazole	esomeprazole strontium
omeprazole	omeprazole-sodium bicarbonate
pantoprazole	
rabeprazole	

Non-Solid Dosage Forms	
Preferred	Non-Preferred
NEXIUM (esomeprazole) PACKET	ACIPHEX SPRINKLE (rabeprazole)
PROTONIX (pantoprazole) PACKET	Lansoprazole ODT
	Omeprazole-sodium bicarbonate packet
	PRILOSEC PACKET (omeprazole)

Sedatives/Hypnotics

Prior Authorization Form - Sedative/Hypnotics

Approval:

Initial: 1 month

Renewal:

- Benzodiazepines (temazepam, triazolam, flurazepam, estazolam): 2 weeks
- Others: 6 months

Initial Criteria:

Zolpidem 10mg (prior authorization required for females only):

- Patient must have failed a 25-day trial of zolpidem 5mg within the last 30 days, as evidenced by paid claims or pharmacy print outs

Rozerem:

- Patient's insomnia must be characterized by difficulty with sleep initiation
- Patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
    - Mirtazapine OR Trazodone
    - Silenor

Zolpidem ER:

- Patient's insomnia must be characterized by difficulty with sleep maintenance
- Patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
    - Eszopiclone
    - Silenor
    - Zolpidem IR

Zolpidem SL tab, Edluar:

- Patient's insomnia must be characterized by difficulty with middle of the night awakening with more than 4 hours left to sleep
- Patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
    - Eszopiclone
    - Silenor
    - Zolpidem IR
    - Zolpidem ER

Temazepam, triazolam, flurazepam, estazolam, Seconal sodium, Belsomra, and Zolpimist:

- Patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy print-outs
    - Edluar
    - Eszopiclone
    - Silenor
    - Zaleplon
    - Zolpidem IR
    - Zolpidem ER

<u>Renewal Criteria</u>:

- Confirmation that other conditions causing sleep issues have been ruled out must be provided

Additional renewal criteria for benzodiazepines (temazepam, triazolam, flurazepam, estazolam):

- Patient must require dose tapering

Non-scheduled (non-addictive) options	
Preferred	Non-Preferred
mirtazapine	ROZEREM (ramelteon)

SILENOR (doxepin)	
trazodone	

Preferred	Non-Preferred
eszopiclone	BELSOMRA (suvorexant)
zaleplon	EDLUAR (zolpidem)
zolpidem 5mg	flurazepam
zolpidem 10mg (for males)	SECONAL SODIUM (secobarbital)
	temazepam
	triazolam
	zolpidem CR
	zolpidem 10mg (for females)
	ZOLPIMIST (zolpidem)
	Zolpidem SL tab

Serostim

Prior Authorization Form - Growth Hormone

Criteria:

- Patient must not have an active malignancy
- Patient must have a diagnosis of treatment of HIV with wasting cachexia
- Prescriber must be experienced in the diagnosis and management of HIV infection
- Patient must be on concomitant antiretroviral therapy
- Patient must have failed a 3-month trial with Megace

Additional Renewal Criteria:

- Lean body mass and body weight must have increased in the past 12 weeks
- Physical endurance must have increased in past 12 weeks
- Patient must not have completed 48 weeks of continuous treatments

Skeletal Muscle Relaxants

General Prior Authorization Form

Carisoprodol

Approval: 1 week
Criteria for non-preferred medication:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)

Metaxalone

Approval: 3 months
Criteria:

- Patient must have had two 30-day trials of other skeletal muscle relaxants, one of which must be methocarbamol, as evidenced by paid claims or pharmacy print-outs.

Preferred	Non-Preferred
orphenadrine	AMRIX (cyclobenzaprine)
baclofen	carisoprodol-aspirin
chlorzoxazone	carisoprodol-aspirin-codeine
cyclobenzaprine	DANTRIUM (dantrolene)
dantrolene	FEXMID (cyclobenzaprine)
methocarbamol	LORZONE (chlorzoxazone)
tizanidine	metaxalone
	METAXALL (metaxalone)
	ROBAXIN (methocarbamol)
	SOMA (carisoprodol)
	ZANAFLEX (tizanidine)

Spinraza

Must be billed on medical/physician side via 837P transactions
Prior Authorization Form - Spinraza

Approval: 1 year
Criteria:

- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2, or 3:
    - Patient must not have respiratory insufficiency (need for invasive or noninvasive ventilation for more than 6 hours per 24-hour period)
    - Patient must not require gastric feeding tubes for the majority of feeds
    - Patient must not have severe contractures or severe scoliosis
    - Patient must not have wasting or cachexia
- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 3:
    - Patient must be less than 2 years of age
    - The patient must be experiencing issues with ambulating (falls, trouble climbing stairs, unable to walk independently)

Spiriva Respimat 1.25 mcg

General Prior Authorization Form

Criteria:

- Patient must have a diagnosis of asthma

- Patient must have failed a 30-day trial of a steroid inhaler

Statins

General Prior Authorization Form

Criteria:
Livalo/Zypitamag:

- Statin intensity treatment goal must be "moderate" or "low"
- Patients must have failed the following 3-month trials based on their intensity treatment goal, as evidenced by paid claims or pharmacy print outs:
    - "Moderate" treatment goal
        - atorvastatin 10-20mg, rosuvastatin 5-10mg, and one of the following:
            - Simvastatin 20 - 40mg a day
            - Pravastatin 40 - 80mg a day
            - Lovastatin 40mg a day
            - Fluvastatin XL 80mg a day
            - Fluvastatin 40mg twice a day
    - "Low" treatment goal
        - Two of the following:
            - Simvastatin 10mg a day
            - Pravastatin 10 - 20mg a day
            - Lovastatin 20mg a day
            - Fluvastatin 20 - 40mg a day

Ezetimibe/simvastatin

- Please prescribe individual medication separately or use a different medication combination

Altoprev (lovastatin) ER/Fluvastatin/Fluvastatin ER:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)

Preferred	Non-Preferred
atorvastatin	ALTOPREV (lovastatin) ER
lovastatin	Ezetimibe/simvastatin
pravastatin	fluvastatin
rosuvastatin	fluvastatin ER
simvastatin	LIVALO (pitavastatin)
	ZYPITAMAG (pitavastatin)

Synagis

Must be billed on medical/physician side using 837p transactions

Prior Authorization Form - Synagis

Approval: 5 monthly doses between October 19th through April 21st
Criteria:

- Patient must have one of the following and additional criteria outlined for diagnosis:
    - Prematurity:
        - < 29 weeks, 0 days gestational age
        - ≤12 months of age at start of RSV season
    - Chronic Lung Disease of Prematurity (CLD)
        - ≤12 months of age at start of RSV season
            - < 32 weeks, 0 days gestational age
            - Requires supplemental oxygen > 21% for at least the first 28 days after birth
        - 13-24 months of age at start of RSV season
            - < 32 weeks, 0 days gestational age
            - Requires supplemental oxygen > 21% for at least the first 28 days after birth
            - Continues to receive medical support within six months before the start of RSV season with supplemental oxygen, diuretic, or chronic corticosteroid therapy
    - Congenital Heart Disease
        - ≤12 months of age at start of RSV season
            - Hemodynamically significant cyanotic or acyanotic congenital heart disease with medical therapy required
        - 13-24 months of age at start of RSV season
            - Has undergone cardiac transplantation during the RSV season
    - Neuromuscular disease
        - ≤12 months of age at start of RSV season
    - Pulmonary abnormalities
        - ≤12 months of age at start of RSV season
    - Profoundly Immunocompromised
        - ≤24 months of age at start of RSV season

Tardive Dyskinesia

Prior Authorization Form - Tardive Dyskinesia

Criteria:

- Patient is 18 years of age or older
- Patient must have a specialist (neurologist or physiatrist) involved in therapy
- Patient has been diagnosed with tardive dyskinesia
    - Involuntary athetoid or choreiform movements
    - History of treatment with dopamine receptor blocking agent (DRBA)
    - Symptom duration lasting longer than 4-8 weeks

- Patient must not be taking monoamine oxidase inhibitor (MAOI)
- Patient is not pregnant or breastfeeding

Austedo/tetrabenazine:

- Patient must have chorea associated with Huntington's disease or Tardive Dyskinesia
- Patient must not have hepatic impairment

Preferred	Non-Preferred
INGREZZA (valbenazine)	AUSTEDO (deutetrabenazine)
tetrabenazine	

Tobacco Cessation

North Dakota Medicaid has joined forces with the Department of Health to provide free, confidential, telephone-based cessation coaching to recipients interested in quitting tobacco. Beginning November 15, 2008, to receive smoking cessation products (patches, gum, lozenges, bupropion, or Chantix®), Medicaid recipients must be signed up with NDQuits (1-800-QUIT-NOW or 1-800-784-8669). Once a recipient is enrolled in coaching, they will work with their coach to determine which medications they wish to use. The complete process is described below:

1. Patient calls NDQuits and enrolls in coaching.
2. Coaches guide patient through quitting process.
3. Individualized treatment plan (including medications if used) is developed.
4. The patient will receive an NDQuit's Enrollment Letter which will include the NDQuit's recommendation for specific medication(s)
5. The HID Prior Authorization form will be included with the NDQuit's Enrollment Letter.
6. The client must bring the HID Prior Authorization form and enrollment letter to their physician or pharmacy
7. The client must contact their physician and obtain the prescription.
8. The physician or pharmacy must complete and fax the HID Prior Authorization form and NDQuit's Enrollment Letter to HID.
9. If prior authorization is approved, prior authorization letter is faxed to physician and/or pharmacy
10. Pharmacy fills prescription and the claim is paid.

Patients will be limited to a 90 consecutive days supply of therapy for patches, gum, lozenges, and bupropion, every two years.

Chantix is limited to the initial 12 weeks of therapy with an additional 12 weeks (24 consecutive weeks) allowed if the patient has continuously quit for a minimum of one month (since day 56 of therapy). The Chantix regimen will be allowed once every two years.

Nicotrol inhaler requires a smoking cessation trial with nicotine gum, lozenges, or nasal spray.

Prior authorizations will be entered based upon the recipient's Quit Date. This means that the approval date range will be sufficient to allow recipients to pick up medications at least one week prior to their Quit Date. Compliance will be an important aspect of the patient's success.

Please contact Health Information Designs, Inc. at (334) 502-3262 or toll free at 1-800-225-6998, with questions regarding the smoking cessation prior authorization process.

Tymlos

Prior Authorization Form - Miacalcin/Tymlos

Criteria:

- Patient must have a history of osteoporotic fractures
- Patient must have multiple risk factors for fracture
- Patient has not been taking Tymlos for ≥ 2 years
- Patient must have failed a 6-month trial of a preferred product (a bisphosphonate)

Preferred	Non-Preferred
Alendronate	MIACALCIN (calcitonin)
Ibandronate	TYMLOS (abaloparatide)
Risedronate	

Uceris Rectal Foam

General Prior Authorization Form

Criteria:

- Patient has a diagnosis of ulcerative colitis
- Patient must have failed a 1-month trial of one of the preferred agents

Preferred	Non-Preferred
CANASA (mesalamine) RECTAL SUPPOSITORY	Mesalamine enema kit
Mesalamine enema	UCERIS (budesonide) RECTAL FOAM

Vecamyl

General Prior Authorization Form

Criteria:

- Patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses of all first and second line agents) as defined by the most recent JNC report.

Xyrem

General Prior Authorization Form

Criteria:

- Patient must be 7 years of age or older
- Patient must have one of the following diagnoses and additional criteria for diagnosis:
    - Cataplexy in Patient's with Narcolepsy
    - Excessive Daytime Sleepiness
      Additional Criteria:
        - Patient must have failed a 2-month trial of modafinil

Zorbtive

Prior Authorization Form - Growth Hormone

Criteria:

- Patient must not have active malignancy
- Patient must have diagnosis of short bowel syndrome
- Patient must be receiving specialized nutritional support
- Treatment must not be longer than 4 weeks

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

Criteria:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)
- Patient must have FDA indication
- Patient must not have contraindications to requested product
- Patient must have failed a therapeutic course of all preferred agents
    - Trial must have been within the last 2 years
    - Trials must have been at least 30 days in duration unless otherwise indicated
    - A failure is defined as product was not effective at maximum tolerated dose or patient has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient

Altoprev (lovastatin) ER

Trial: 3 months

Preferred	Non-Preferred
lovastatin	ALTOPREV (lovastatin) ER

Amrix (cyclobenzaprine)

Preferred	Non-Preferred
Cyclobenzaprine	AMRIX (cyclobenzaprine)
	Cyclobenzaprine 7.5mg

Bowel Prep Agents

Trial: 1 complete dose

Preferred	Non-Preferred
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE
GOLYTELY 236-22.74G	GAVILYTE-C
MOVIPREP	GAVILYTE-N
OSMOPREP	NULYTELY
PEG-3350 AND ELECTROLYTES 236-22.74G	PEG 3350-ELECTROLYTE 240-22.72G
	PEG 3350-ELECTROLYTE 420 G
	PLENVU
	PREPOPIK
	SUPREP
	TRILYTE

Brisdelle (paroxetine)

Preferred	Non-Preferred
Paroxetine tablets	BRISDELLE (paroxetine) CAPSULES

Colchicine

Preferred	Non-Preferred
Colchicine capsules	Colchicine tablets
	COLCRYS (colchicine) TABLETS
	MITIGARE (colchicine) CAPSULES

Daxbia (Cephalexin)

Preferred	Non-Preferred
Cephalexin	Daxbia (Cephalexin)

Durlaza (aspirin ER)

- Please see “Platelet Aggregation Inhibitor” category on PDL. http://www.hidesigns.com/ndmedicaid/pdl/

Fortamet (metformin)
Glumetza (metformin)

Preferred	Non-Preferred
Metformin ER	FORTAMET (metformin)
	GLUMETZA (metformin)

Gocovri (amantadine ER)
Osmolex ER (amantadine ER)

Preferred	Non-Preferred
Amantadine IR	Gocovri (amantadine ER)
	Osmolex ER (amantadine ER)

Gralise (gabapentin)

Preferred	Non-Preferred
gabapentin	GRALISE (gabapentin)

Horizant (gabapentin)

Preferred	Non-Preferred
gabapentin	HORIZANT (gabapentin)
pramipexole	
ropinirole	

Jadenu (deferasirox)

Preferred	Non-Preferred
EXJADE (deferasirox)	JADENU (deferasirox)

Ketoconazole foam

Preferred	Non-Preferred
ketoconazole cream	ketoconazole foam
ketoconazole shampoo	

Kits

Preferred	Non-Preferred
FDA approved products prescribed separately	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX CINLONE-I CPI (triamcinolone/lidocaine/prilocaine)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	TRIXYLITRAL (diclofenac/lidocaine/tape)

	ELLZIA PAK (triamcinolone/dimethicone)
	INFAMMACIN (diclofenac/capsicum)
	LOPROX (ciclopirox/skin cleanser No. 40)
	MIGRANOW (sumatriptan/menthol/camphor)
	MORGIDOX (doxycycline/skin cleanser No. 19)
	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SILAZONE-II (triamcinolone/silicones)
	TICANSE (fluticasone/sodium chloride/sodium bicarbonate)
	XRYLIX (diclofenac/kinesiology tape)

Lorzone (chlorzoxazone)

Preferred	Non-Preferred
chlorzoxazone	LORZONE (chlorzoxazone)

methotrexate

Trial: 6 weeks

Preferred	Non-Preferred
methotrexate	OTREXUP (methotrexate)
	RASUVO (methotrexate)
	TREXALL (methotrexate)

Moxatag (amoxicillin)

Amoxicillin IR	MOXATAG (amoxicillin) ER

Narcotic/APAP Criteria

Preferred	Non-Preferred
hydrocodone-acetaminophen	2.5-325 MG
hydrocodone-acetaminophen	7.5-325 MG
hydrocodone-acetaminophen	10MG-300MG
hydrocodone-acetaminophen	5 MG-300MG
hydrocodone-acetaminophen	7.5-300 MG
oxycodone-acetaminophen	2.5-325 MG
oxycodone-acetaminophen	7.5-325 MG
PRIMLEV (oxycodone-acetaminophen)	5 MG-300MG
PRIMLEV (oxycodone-acetaminophen)	7.5-300 MG
PRIMLEV (oxycodone-acetaminophen)	10MG-300MG

Nitroglycerin Spray

Trial: 1 dose while on preventative medication

Preferred	Non-Preferred
Nitroglycerin sublingual tablets	Nitroglycerin Spray

Nuvessa (metronidazole)

Preferred	Non-Preferred
Clindamycin vaginal 2% cream	NUVESSA (metronidazole) 1.3% GEL
Metronidazole 0.75% vaginal gel	

Onmel (itraconazole)

Trial: 12 weeks with 6 months outgrow following treatment for onychomycosis

Preferred	Non-Preferred
Itraconazole capsule	ONMEL (itraconazole) tablet
Terbinafine	

Oxaydo (oxycodone)

Preferred	Non-Preferred
Oxycodone	Oxaydo (oxycodone) Roxybond (oxycodone)

Procysbi (cysteamine)

Preferred	Non-Preferred
CYSTAGON (cysteamine)	PROCYSBI (cysteamine)

Ribavirin

Preferred	Non-Preferred
RIBASPHERE (ribavirin)	COPEGUS (ribavirin)
Ribavirin	MODERIBA (ribavirin)
	RIBASPHERE RIBAPAK (ribavirin)

Rytary (Carbidopa/Levodopa)

Additional Criteria: Patient is not in a long term care facility

Preferred	Non-Preferred
Carbidopa/Levodopa	RYTARY (carbidopa/levodopa)
Carbidopa/Levodopa ER	
Carbidopa/Levodopa/Entacapone	

Steroids - Oral

Additional Criteria:

Emflaza: See Emflaza Criteria on this document
Rayos: Trial of 12 weeks with 2AM dosing of prednisone

Preferred	Non-Preferred
Budesonide 3mg EC	Budesonide 9 mg ER
Cortisone	DEXPAK (dexamethasone)
Dexamethasone	EMFLAZA (deflazacort)
Hydrocortisone	MILLIPRED (Prednisolone)
Methylprednisone	Prednisolone sodium phosphate ODT
Prednisolone sodium phosphate 5mg/5ml, 15mg/5ml, 25mg/5ml	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
Prednisone	RAYOS (prednisone)
	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

Tirosint (levothyroxine)

Preferred	Non-Preferred
levothyroxine	TIROSINT (levothyroxine)

Tizanidine Capsules

Preferred	Non-Preferred
Tizanidine tablets	Tizanidine capsules

Tussicaps

Preferred Non-Preferred	Preferred Non-Preferred
Hydrocodone/chlorpheniramine ER suspension	TUSSICAPS (hydrocodone/chlorpheniramine)
Promethazine/codeine	
ZODRYL AC (chlorpheniramine/codeine)	

Topical Corticosteroids Preferred Medication List - Page 1 of 2

Potency	Dosage Form	Preferred		Non-Preferred	
Class 1 - Very High Potency	**Class 1 - Very High Potency**				
	Cream	Clobetasol Propionate	0.05%	Clobetasol Emollient	0.05%
				Halobetasol Propionate	0.05%
				STEP2* Fluocinonide	0.10%
	Ointment	Betamethasone, augmented	0.05%	Halobetasol Propionate	0.05%
		Clobetasol Propionate	0.05%		
	Foam, Gel, Lotion, Shampoo, Solution, Spray, Tape	Clobetasol Propionate Solution	0.05%	Betamethasone, augmented lotion	0.05%
		Clobex (*Brand Required*) Lotion	0.05%	Clobetasol emulsion foam	0.05%
		Clobex (*Brand Required*) Shampoo	0.05%	Clobetasol propionate foam	0.05%
		Clobex (*Brand Required*) Spray	0.05%	Topicort spray	0.25%
		Clobetasol Propionate Gel	0.05%	STEP2* Cordran Tape	4MCG/SQ CM
				STEP 2* Ultravate lotion	0.05%
Class 2 & 3 - High Potency	**Class 2 & 3 - High Potency**				
	Cream	Betamethasone, augmented	0.05%	Apexicon E	0.05%
		Desoximetasone	0.25%	Betamethasone Dipropionate	0.05%
		Diflorasone Diacetate	0.05%	Halog	0.10%
		Fluocinonide	0.05%	Fluocinonide-E	0.05%
		Triamcinolone Acetonide	0.50%	STEP2* Amcinonide	0.10%
	Ointment	Betamethasone Dipropionate	0.05%	Amcinonide	0.10%
		Betamethasone Valerate	0.10%	Diflorasone Diacetate	0.05%
		Desoximetasone	0.25%		
		Fluocinonide	0.05%		
		Fluticasone Propionate	0.01%		
		Halog	0.10%		
		Mometasone Furoate	0.10%		
		Triamcinolone Acetonide	0.50%		
	Gel, Lotion Solution	Fluocinonide gel	0.05%	Betamethasone dipropionate gel	0.05%
		Fluocinonide solution	0.05%	Desoximetasone gel	0.05%
				STEP2* Amcinonide Lotion	0.10%

Topical Corticosteroids Preferred Medication List - Page 2 of 2

Class 4 & 5 - Medium Potency	**Class 4 & 5 - Medium Potency**				
	Cream	Betamethasone Valerate	0.10%	Clocortolone Pivalate	0.10%
		Fluticasone Propionate	0.05%	Fluocinolone Acetonide	0.025%
		Mometasone Furoate	0.10%	Pandel	0.10%
		Synalar	0.025%	Prednicarbate	0.10%
		Triamcinolone Acetonide	0.10%	STEP2* Desoximetasone	0.05%
				STEP2* Flurandrenolide	0.05%
				STEP2* Hydrocortisone Butyrate	0.10%
				STEP2* Hydrocortisone Butyrate Emollient	0.10%
				STEP2* Hydrocortisone Valerate	0.20%
	Ointment	Fluocinolone Acetonide	0.025%	Desoximetasone	0.05%
		Desonide	0.05%	Hydrocortisone Valerate	0.20%
		Hydrocortisone Butyrate	0.10%	Trianex	0.05%
		Prednicarbate	0.10%	STEP2* Flurandrenolide	0.05%
		Triamcinolone Acetonide	0.10%		
		Triamcinolone Acetonide	0.025%		
	Aerosol, Foam, Lotion, Solution, Spray	Mometasone Furoate Solution	0.10%	Betamethasone Valerate Foam	0.12%
		Betamethasone Dipropionate Lotion	0.05%	Triamcinolone Acetonide Aerosol	0.147MG/G
		Hydrocortisone Butyrate Solution	0.10%	STEP2* Flurandrenolide Lotion	0.05%
		Triamcinolone Acetonide Lotion	0.10%	STEP2* Fluticasone Propionate Lotion	0.05%
				STEP2* Sernivo spray	0.05%
Class 6 & 7 - Low Potency	**Class 6 & 7 - Low Potency**				
	Cream	Alclometasone Dipropionate	0.05%		
		Desonide	0.05%		
		Fluocinolone Acetonide	0.01%		
		Hydrocortisone	2.50%		
		Hydrocortisone	1.00%		
		Triamcinolone Acetonide	0.025%		
	Ointment	Alclometasone Dipropionate	0.05%		
		Hydrocortisone	1.00%		
		Hydrocortisone	2.50%		
	Oil, Lotion, Shampoo, Solution	Capex Shampoo	0.01%	Betamethasone Valerate Lotion	0.10%
		Desonide Lotion	0.05%		
		Fluocinolone Acetonide Oil	0.01%		
		Fluocinolone Acetonide Solution	0.01%		
		Hydrocortisone Lotion	2.50%		
		Texacort Solution	2.50%		
		Triamcinolone Acetonide Lotion	0.025%		