DUR Board Meeting
December 4, 2019
Capitol Buliding
Brynhild-Haugland Room

North Dakota Medicaid
DUR Board Meeting Agenda
Brynhild Haugland Room
State Capitol
600 East Boulevard Avenue
Bismarck, ND
December 4, 2019
1:00 pm

1. Administrative items
    - DHS announcements

2. Old business
    - Review and approval of September 2019 meeting minutes
    - Budget update
    - Review top 25 drugs for third quarter of 2019
    - Prior authorization/PDL update
    - Second review of antifungal agents for aspergillus and candidiasis infections
    - Second review of eosinophilic asthma agents
    - Annual prior authorization review of prior authorization forms and criteria

3. New business
    - Review of Glucagon agents
    - Retrospective DUR criteria recommendations
    - Upcoming meeting date/agenda.
        - Next meeting is March 4, 2020 in the Brynhild Haugland Room

4. Adjourn

Please remember to silence all cellular phones during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
September 4, 2019

Members Present: Michael Quast, Gabriela Balf, Tanya Schmidt, Andrea Honeyman, Peter Woodrow, Laura Schield, Jennifer Iverson

Members Absent: Michael Booth, Russ Sobotta, Katie Kram, LeNeika Roehrich

Medicaid Pharmacy Department: Brendan Joyce, Alexi Murphy

Old Business

T. Schmidt served as interim chair and the meeting to order at 1:05 p.m. Chair T. Schmidt asked for a motion to approve the minutes of the June meeting. G. Balf moved that the minutes be approved, and A. Honeyman seconded the motion. The chair called for a voice vote to approve the minutes. The motion passed with no audible dissent.

Review Top 15 Therapeutic Categories/Top 25 Drugs

B. Joyce presented the quarterly review of the top 15 therapeutic classes by total cost of claims, top 25 drugs based on number of claims, and top 25 drugs based on claims cost for the 2nd quarter of 2019.

PDL/PA Criteria Updates

A. Murphy shared with the Board all of changes made to the Preferred Drug List since the most recent version of the Preferred Drug List was posted. Notable changes included removing PA requirements for a number of pulmonary hypertension agents and NSAIDs, as well as adding numerous agents to recently DUR Board approved PA class criteria. When a new version of the PDL is published and posted to the website, all updates/changes made since the last version are called out at the top of the document itself.

Second Review of Short-Acting Opioid Analgesic Agents

A motion and second was made at the June meeting to place select short-acting opioid analgesic agents on prior authorization. The topic was brought up for a second review. There was no public comment. Chair T. Schmidt called for a voice vote and the motion passed with no audible dissent.

Second Review of Agents for the Treatment of Thrombocytopenia

A motion and second was previously made to place agents for the treatment of thrombocytopenia on prior authorization. The topic was brought up for a second review. There was no public comment. Chair T. Schmidt called for a voice vote and the motion passed with no audible dissent.

Second Review of Agents for Treatment of Interstitial Cystitis

A motion and second was made at the June meeting to place agents for the treatment of interstitial cystitis on prior authorization. The topic was brought up for a second review. There was no public comment. Chair T. Schmidt called for a voice vote and the motion passed with no audible dissent.

Second Review of Agents for the Treatment of Narcolepsy
A motion and second was made at the June meeting to place agents for the treatment of narcolepsy on prior authorization. The topic was brought up for a second review. There was no public comment. Chair T. Schmidt called for a voice vote and the motion passed with no audible dissent.

Sanford Health Plan Update
Danny Weiss, representing Sanford Health Plan, spoke regarding ND Medicaid Expansion. In mid-year 2019, there were 19,226 average members per month with 78% of members utilizing benefits. The generic fill rate was 86.1%. The cost of specialty medications during that time accounted for 29.2% of total costs. The presentation focused on breakdowns of costs associated with specialty vs. non-specialty medications.

New Business

Review of Antifungal Agents for Aspergillus and Candidiasis Infections
A. Murphy presented a review of short-acting opioid agents to the Board. A motion was made by P. Woodrow to create PA criteria for the use of these agents and manage these medications through prior authorization. The motion was seconded by M. Quast. This topic will be reviewed at the next meeting.

Utilization Review of Rescue Inhalers and ADHD Products
T. DeRuiter presented data on the utilization of rescue inhalers and ADHD Products in the fee-for-service Medicaid population. The data indicated an overall reduction in rescue inhaler use per patient since 2015. Data also indicated that the utilization of Adderall as compared to Vyvanse has decreased drastically over the years with 2019 being the first year where Vyvanse is being used at a higher rate than Adderall. of therapeutic duplication with benzodiazepine and or sedative agents, drilled down to most commonly duplicated agents and regimen.

Retrospective Drug Utilization Review (RDUR) Criteria Recommendations
The recommended RDUR criteria enclosed in the packet were developed from product information provided by the manufacturers and are usually consistent with new indications, new drugs added, and new warnings. These proposed criteria will be added to the current set of criteria and will be used in future DUR cycles. T. Schmidt moved to approve the new criteria and G. Balf seconded the motion. The motion passed with no audible dissent.

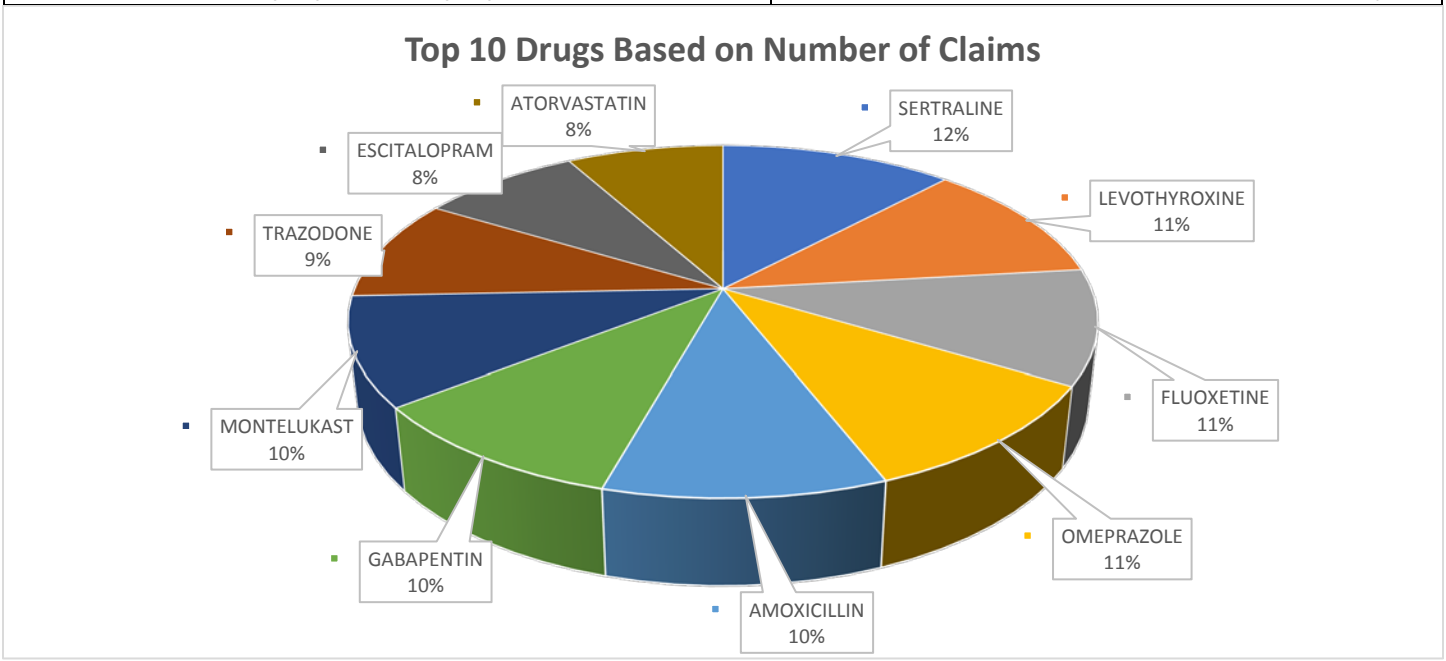
Case Reviews
B. Joyce and A. Murphy presented cases for the DUR Board to review for any potential areas for improvement through targeted interventions, claims processing edits, or other intervention methods.

Adjournment and Upcoming Meeting Date
Chair T. Schmidt adjourned the meeting at 2:45 pm. The next DUR Board meeting will be held December 4, 2019 at 1:00 pm at the State Capitol building in the Brynhild -Haugland room.

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 07/01/2019 – 09/30/2019

Drug	AHFS Class	Claims	Claims Cost	Patients	Cost Per Claim	% Total Claims
SERTRALINE HCL	ANTIDEPRESSANTS	2,436	$49,017.05	1,123	$20.12	1.83%
LEVOTHYROXINE SODIUM	THYROID AGENTS	2,269	$44,395.01	838	$19.57	1.71%
FLUOXETINE HCL	ANTIDEPRESSANTS	2,132	$37,804.45	960	$17.73	1.60%
OMEPRAZOLE	PROTON-PUMP INHIBITORS	2,106	$38,730.94	973	$18.39	1.58%
AMOXICILLIN	PENICILLIN ANTIBIOTICS	2,091	$80,140.35	1,972	$38.33	1.57%
GABAPENTIN	ANTICONVULSANTS, MISC	2,038	$51,176.40	847	$25.11	1.53%
MONTELUKAST SODIUM	LEUKOTRIENE MODIFIERS	2,023	$39,924.42	1,000	$19.74	1.52%
TRAZODONE HCL	ANTIDEPRESSANTS	1,896	$34,113.38	848	$17.99	1.43%
ESCITALOPRAM OXALATE	ANTIDEPRESSANTS	1,673	$38,279.42	803	$22.88	1.26%
ATORVASTATIN CALCIUM	STATINS	1,640	$42,364.91	714	$25.83	1.23%
VYVANSE	AMPHETAMINES	1,613	$368,030.99	632	$228.17	1.21%
LISINOPRIL	ACE INHIBITORS	1,573	$45,390.24	725	$28.86	1.18%
HYDROCODONE-APAP	OPIATE AGONISTS	1,536	$40,913.42	976	$26.64	1.16%
CLONIDINE HCL	CENTRAL ALPHA-AGONISTS	1,505	$26,452.37	638	$17.58	1.13%
PROAIR HFA	BETA AGONISTS	1,433	$112,108.77	1,412	$78.23	1.08%
RISPERIDONE	ANTIPSYCHOTIC AGENTS	1,366	$19,819.70	442	$14.51	1.03%
LAMOTRIGINE	ANTICONVULSANTS, MISC	1,340	$23,106.20	451	$17.24	1.01%
CONCERTA	CNS STIMULANTS	1,335	$433,087.83	538	$324.41	1.00%
DULOXETINE HCL	ANTIDEPRESSANTS	1,292	$27,451.04	496	$21.25	0.97%
METFORMIN HCL	BIGUANIDES	1,286	$22,116.88	570	$17.20	0.97%
ASPIRIN EC	NSAIDS	1,282	$63,023.96	512	$49.16	0.96%
ARIPIPRAZOLE	ANTIPSYCHOTIC AGENTS	1,264	$26,811.63	516	$21.21	0.95%
FLUTICASONE PROPIONATE	CORTICOSTEROIDS (EENT)	1,247	$28,731.56	870	$23.04	0.94%
PANTOPRAZOLE SODIUM	PROTON-PUMP INHIBITORS	1,219	$18,948.79	524	$15.54	0.92%
VITAMIN D3	VITAMIN D	1,214	$19,970.48	517	$16.45	0.91%

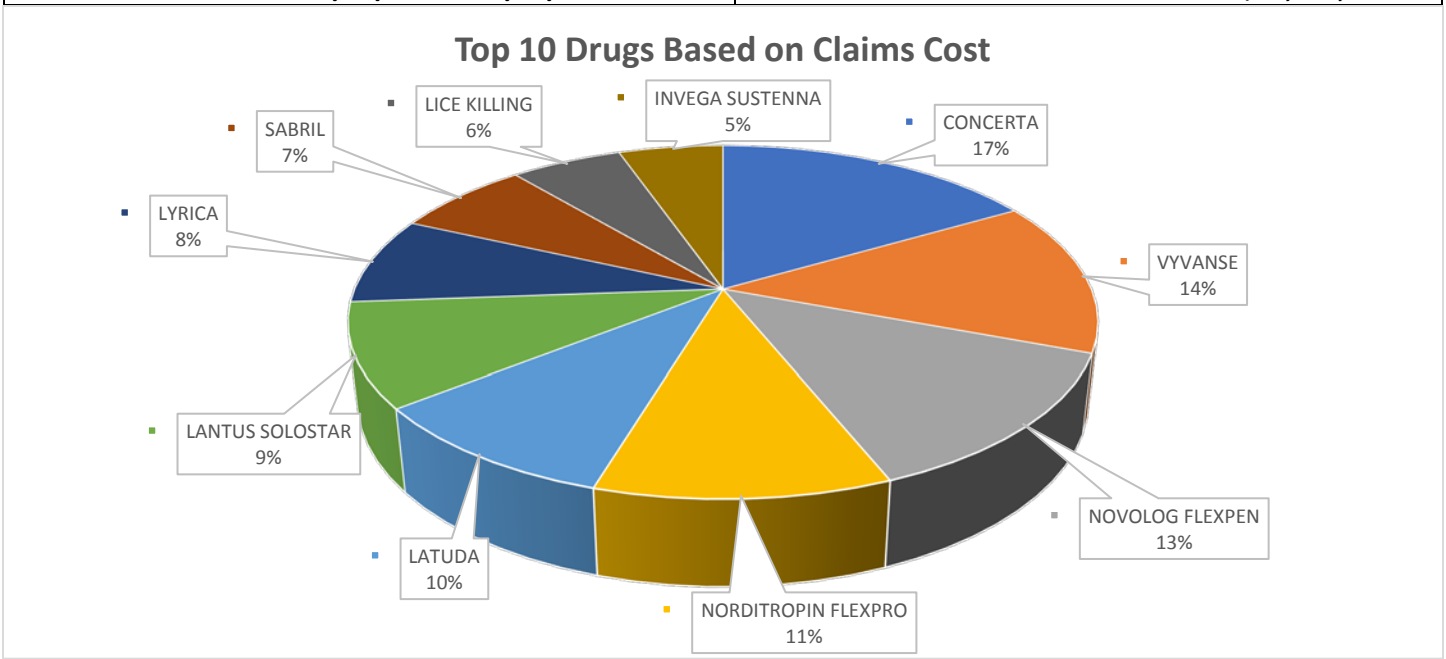
Total Claims From 07/01/2019 – 09/30/2019	132,943



TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 07/01/2019 – 09/30/2019

Drug	AHFS Class	Claims Cost	Claims	Patients	Cost Per Claim	% Total Cost
CONCERTA	CNS STIMULANTS	$433,087.83	1,335	538	$805.00	3.70%
VYVANSE	AMPHETAMINES	$368,030.99	1,613	632	$582.33	3.14%
NOVOLOG FLEXPEN	INSULINS	$342,269.64	583	312	$1,097.02	2.92%
NORDITROPIN FLEXPRO	PITUITARY	$281,234.26	79	33	$8,522.25	2.40%
LATUDA	ANTIPSYCHOTIC AGENTS	$252,157.23	329	117	$2,155.19	2.15%
LANTUS SOLOSTAR	INSULINS	$247,206.50	591	294	$840.84	2.11%
LYRICA	ANTICONVULSANTS, MISC	$208,391.72	456	192	$1,085.37	1.78%
SABRIL	ANTICONVULSANTS, MISC	$183,736.41	9	3	$61,245.47	1.57%
LICE KILLING	SCABICIDES AND LICE	$149,695.00	343	265	$564.89	1.28%
INVEGA SUSTENNA	ANTIPSYCHOTIC AGENTS	$140,220.16	73	30	$4,674.01	1.20%
VIMPAT	ANTICONVULSANTS, MISC	$130,987.99	206	59	$2,220.14	1.12%
GENVOYA	ANTIRETROVIRALS	$123,026.42	105	45	$2,733.92	1.05%
EPCLUSA	HCV ANTIVIRALS	$121,600.25	5	3	$40,533.42	1.04%
NIX	SCABICIDES AND LICE	$120,245.64	274	255	$471.55	1.03%
MAVYRET	HCV ANTIVIRALS	$115,717.14	9	6	$19,286.19	0.99%
HUMIRA PEN	DMARDS	$114,589.01	24	10	$11,458.90	0.98%
PROAIR HFA	BETA-ADRENERGIC AGONISTS	$112,108.77	1,433	1,412	$79.40	0.96%
LEVEMIR FLEXTOUCH	INSULINS	$111,359.58	282	164	$679.02	0.95%
FLOVENT HFA	INHALED CORTICOSTEROIDS	$110,195.46	503	324	$340.11	0.94%
HUMIRA(CF) PEN	DMARDS	$100,938.12	18	7	$14,419.73	0.86%
FOCALIN XR	CNS STIMULANTS	$97,712.49	286	122	$800.92	0.83%
NOVOLOG	INSULINS	$95,186.15	181	90	$1,057.62	0.81%
ZUBSOLV	OPIATE PARTIAL AGONISTS	$90,966.20	357	80	$1,137.08	0.78%
XIFAXAN	ANTIBACTERIALS, MISC	$90,057.88	53	22	$4,093.54	0.77%
SYMBICORT	INHALED CORTICOSTEROIDS	$89,841.83	284	166	$541.22	0.77%

Total Claims Cost From 07/01/2019 – 09/30/2019	$11,705,810.83



PDL Update

ADDED TO PA	
Apokyn	Parkinson's Disease
Aprepitant	Nausea/Vomiting
Asmanex	Corticosteroids – Inhaled
Astagraf XL	Preferred Dosage Forms
Baxdela	Antibiotics - Resistance Prevention
Candesartan-Hydrochlorothiazide	ARBs (Angiotensin Receptor Blockers)
Cutaquig (Human Ig G Solution)	Immune Globulins
Divigel	Estrogens
Duopa	Parkinson's Disease
Emsam	Parkinson's Disease
Femring	Estrogens
Forteo	Osteoporosis
Lokelma	Hyperkalemia
Loprox	Preferred Dosage Forms
Menest	Estrogens
Motegrity	Idiopathic Constipation
Natroba	Lice
Neulasta	Hematopoietic, Colony Stimulating Factors
Nucala	Eosinophilic Asthma
Nuzyra	Antibiotics - Resistance Prevention
Otovel	Otic Anti-infectives/Anti-inflammatories
Oxaprozin	NSAIDS
Pancreaze	Digestive Enzymes
Pennsaid	NSAIDS
Prefest	Estrogens
Qtern	DPP4/SGLT2 Inhibitors Combination
Rasagiline Patch	Parkinson's Disease
Sivextro	Antibiotics - Resistance Prevention
Tazarotene	Antipsoriatics - Topical
Tolcapone	Parkinson's Disease
Tolterodine Tartrate	Urinary Antispasmodics
Tolterodine Tartrate ER	Urinary Antispasmodics
Uloric	Gout
Veltassa	Hyperkalemia
Vivelle-Dot	Estrogens

Removed from PA	
Aliskiren	Renin Inhibitors
Armodafinil	Narcolepsy
Belbuca	Opioid Analgesics – Long Acting
Duaklir Pressair	Anticholinergic/Beta Agonists Combinations
Fasenra	Eosinophilic Asthma
Fiasp	Insulins
Jentadueto XR	DPP4-Inhibitors
Moxifloxacin	Antibiotics - Resistance Prevention
Nourianz	Parkinson's Disease
Orenitram ER	Pulmonary Hypertension
Ozobax	Skeletal Muscle Relaxants
Panzyga	Immune Globulins
Proair Respiclick	Albuterol/Levalbuterol Rescue Inhalers
Retin-A Micro Pump	Acne
Rinvoq	Cytokine Modulators
Rybelsus	GLP-1 Agonists
Sunosi	Narcolepsy
Tolmetin Sodium	NSAIDs
Tosymra	Treatment of Migraine - Triptans - 5HT(1) Agonist
Treprostinil	Pulmonary Hypertension
Tyvaso	Pulmonary Hypertension
Uptravi	Pulmonary Hypertension
Varubi	Nausea/Vomiting
Ventavis	Pulmonary Hypertension
Wakix	Narcolepsy

ANTIFUNGAL AGENTS FOR ASPERGILLUS AND CANDIDA INFECTIONS

Group Criteria: *Approval Duration = 2 weeks*

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have documented history of failure to all preferred agents in last 30-days, as evidenced by paid claims or pharmacy print-outs

Product Specific Criteria

- **Tolsura**:
  - The patient must be intolerant of or refractory to amphotericin B therapy.
- **Cresemba**:
  - For use in prophylaxis of invasive Aspergillus and Candida infections:
    - The patient must be severely immunocompromised (e.g. hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD), patients with hematologic malignancies with prolonged neutropenia from chemotherapy).

PREFERRED AGENTS	NON-PREFERRED AGENTS
Clotrimazole	NOXAFIL (posaconazole)
Fluconazole	TOLSURA (itraconazole)
Itraconazole	CRESEMBA (isavuconazonium)
Nystatin	
ORAVIG (miconazole)	

EOSINOPHILIC ASTHMA

Group Criteria:

- **Initial Criteria:** *Approval Duration = 3 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
    - **Cinqair**: The patient must be 18 years of age or older
    - **All others**: The patient must be 12 years of age or older
  - The patient must have had 2 or more asthma exacerbations in previous year despite continued compliant use of one of the following combination therapies, as evidenced by paid claims or pharmacy print-outs (A or B):
    A. A moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA)
    B. A moderate to high dose inhaled steroid in combination with a long-acting muscarinic antagonist (LAMA)
  - One of the following must be met (A or B):
    A. The patient must have baseline eosinophil level of ≥ 300 cells/mcL within past 12 months
    B. The patient must have oral corticosteroid dependent asthma and has required at least 30 days of oral steroid use in past 120 days, as evidenced by paid claims or pharmacy print-outs
- **Renewal Criteria:** *Approval Duration = 3 months*
  - The prescriber must provide documentation showing that the patient has achieved a significant reduction in asthma exacerbations and utilization of rescue medications since treatment initiation

PREFERRED AGENTS	NON-PREFERRED AGENTS
DUPIXENT (dupilumab)	CINQAIR (reslizumab)
NUCALA (mepolizumab)	
FASENRA (benralizumab)	

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General
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred medications to meet specific diagnosis and step-therapy requirements. Criteria for agents requiring prior authorization can be found at one of the following locations:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf
- Prior Authorization Criteria available at www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

*****Completed Medwatch form(s) must be attached to this request for failed trial(s) in which the active ingredient of the failed product is the same as the requested product*****

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**

Additional Qualifications for Coverage (e.g. medical justification explaining inability to meet required trials)

□ Patient is pregnant: Due Date _____
□ Patient has inability to take or tolerate solid oral dosage forms (please attach swallow study)
□ Patient has feeding tube in place: (please state specific type of feeding tube _____)
□ Other: (please fill out below)

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Non-Preferred Dosage Forms
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for non-preferred dosage form of a preferred agent must meet the following prior authorization criteria:

- The prescriber must submit medical justification explaining why the patient cannot use the preferred product (subject to clinical review)
- Patient must have FDA approved indication for use
- Patient must not have contraindications to requested product
- Patient must have failed a therapeutic course of all preferred agents 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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**

List all failed medications:	**Start Date:**	**End Date:**

• **Does the patient have any contraindications to therapy with the requested agent?**	□ YES □ NO
• **Is medical justification explaining why the patient cannot use the preferred product attached?** *(please attach any relevant documentation to the request)*	□ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Dispense as Written Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

North Dakota Medicaid requires that patients receiving a brand name drug, when there is a generic equivalent available, must first try and fail the generic product for one of the following reasons.

- **The generic product(s) are not effective (attach MedWatch form for ALL available different generic manufacturers)**
- **There was an adverse reaction with the generic product(s) (attach MedWatch form for ALL available different generic manufacturers)**
- **Primary insurance requires a ND Medicaid non-preferred brand product.**

****DAW not allowed for drugs with an authorized generic available.**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name		Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name				
Prescriber NPI		Telephone Number	Fax Number	
Address		City	State	Zip Code
Requested Drug:	**DOSAGE:**	**Diagnosis for this request:**		

QUALIFICATIONS FOR COVERAGE: □ FAILED TWO GENERIC EQUIVALENTS	**Start Date**	**End Date**	**Dose**	**Frequency**

ADVERSE REACTION TO GENERIC EQUIVALENT: □ FDA MEDWATCH FORM ATTACHED FOR EACH GENERIC FAILED

PRIMARY INSURANCE REQUIRES: □ BRAND NAME PRODUCT

Primary insurance carrier: _____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Concurrent Medication Required Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a product on the "Concurrent Medications and Step Care" list must also be taking the required concurrent medication listed in the document. Overrides will be considered for patients that are unable to take the required concurrent medication based on medical justification provided by the prescriber (subject to clinical review by ND Medicaid).

For an override to be considered, please complete and fax in this request form to the above number. Please attach any and all documentation (chart notes, pharmacy print-outs, etc.) supporting a medical justification as to why the patient is unable to use the required concurrent medication.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested product(s) and frequency of use:	**Diagnosis for this request:**

Medical justification for inability to use required concurrent medication (please attach any supporting documentation to this request):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Out of State Pharmacy Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

Part I

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number

Requested Drug and Dosage:

Qualifications for coverage:

Start Date	End Date	Dose	Frequency

Reason for out of state pharmacy request:

Recipient is residing out of state? □ YES □ NO
If yes, please provide recipient residence, city, state, zip code:

Requested drug is only available at out of state pharmacies? □ YES □ NO

Third party requires out of state pharmacy for coverage? □ YES □ NO
If yes, contact State Provider Relations at 1-800-755-2604.

Part II

PHARMACY NAME (REQUIRED)			ND MEDICAID PROVIDER NUMBER (REQUIRED)
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC # (REQUIRED)

Pharmacy Signature:	Date:

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Topical Anesthetics
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for topical anesthetic must meet the following criteria:

- The request must be for patient home use of cream, prior to injection pain from a medically necessary procedure

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
Is the requested agent being given used at the patient's residence?		□ YES □ NO	
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Antibiotics – Resistance Prevention Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for select antibiotics to meet the following criteria:

- Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol
- Patient must be of an appropriate age for use per manufacturer label and have a diagnosis of an FDA approved indication for use, proven to be caused by a susceptible microorganism by culture and susceptibility testing
- One of the following must be met:
  - Prescriber must provide evidence-based medical justification for use, explaining why a preferred antibiotic is not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
  - Patient is continuing treatment upon discharge from an acute care facility

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**

Qualifications for coverage:

Has the provider attached documentation showing that the patient's infection is caused by a susceptible microorganism by culture and susceptibility testing?	□ YES □NO
Is the patient continuing treatment upon discharge from an acute care facility?	□ YES □NO
RENEWAL ONLY: Is the patient's condition improving and continued treatment is required after re-evaluation of their condition?	□ YES □NO

Justification for use over preferred agents (provide below or in documentation attached to this request):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Antihemophilic Factors Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for antihemophilic factors must meet the following criteria:

Criteria for all agents:

- The provider must attest that the patient visits an accredited Hemophilia Treatment Center once per year.
  - The date of the patient's last appointment with treatment center must be provided.
  - Contact information for treatment center must be provided.

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the PREFFERED AGENTS (no PA required) (subject to clinical review).
  - The 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)

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this Request:**
TREATMENT CENTER CONTACT INFORMATION:	**Date of last appointment with treatment center:**
	Patient visits an accredited Hemophilia Treatment Center for yearly checkups: □ YES □ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Benzodiazepine + Opioid Concurrent Use Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving both an opioid analgesic and a benzodiazepine must meet the following criteria:

- Patient must have tried all treatment alternatives without achievement of therapeutic goal (please provide details on trial and outcome, or reason alternative cannot be attempted)
- Either a tapering plan must be included, or given the CDC guidelines and FDA black box warnings, clinical justification must be provided to explain:
  - Reason opioid analgesic cannot be avoided in this patient currently receiving a benzodiazepine
  - Reason the patient cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER OF THE OPIOID ANALGESIC

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Pain, Palliative Care, or Oncology/Hematology Specialist involved in therapy (if not treating physician)	
Prescriber NPI	Telephone Number	Fax Number
Requested Opioid Analgesic:	**Diagnosis for use of opioid(s) in this patient:**	
Plan to taper: (dose and length of treatment)	**Clinical justification for concurrent opioid and benzodiazepine treatment and/or reason opioid dose cannot be reduced:**	

Treatment Alternatives:	**Start/End Date:**	**Reason for failure:**
□ NSAIDs □ TCAs □ SNRIs □ Corticosteroids □ Weight Loss □ Physical Therapy □ Cognitive Behavioral Therapy □ Other		

Qualifications for coverage:	
Does provider routinely check the PDMP?	□ YES □ NO
Has the provider established a realistic treatment plan with the patient, addressing expected outcomes and limitations of therapy in totally eliminating pain?	□ YES □ NO
Will opioid therapy be routinely evaluated for effectiveness?	□ YES □ NO
Does the patient undergo routine drug screens?	□ YES □ NO
Has the provider discussed and counseled the patient on the known risks of utilizing opioid analgesics in combination with benzodiazepines and other CNS depressing medications/conditions?	□ YES □ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

□ Patient's treatment/tapering plan including an evaluation of effectiveness and plans for continuation/discontinuation
□ Clinical documentation of previously tried and failed non-opioid therapies.

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

health information designs

Benzodiazepine + Opioid Concurrent Use Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving both an opioid analgesic and a benzodiazepine must meet the following criteria:

- Patient must have tried all treatment alternatives without achievement of therapeutic goal (please provide details on trial and outcome, or reason alternative cannot be attempted)
- Either a tapering plan must be included, or given the CDC guidelines and FDA black box warnings, clinical justification must be provided to explain:
  - Reason opioid analgesic cannot be avoided in this patient currently receiving a benzodiazepine
  - Reason the patient cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER OF THE BENZODIAZEPINE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating physician)	
Prescriber NPI	Telephone Number	Fax Number
Requested Benzodiazepine:	**Diagnosis for use of a benzodiazepine in this patient:**	
Plan to taper: (dose and length of treatment)	**Clinical justification for concurrent opioid and benzodiazepine treatment and/or reason opioid dose cannot be reduced:**	
List all failed treatments: □ SSRIs □ SNRIs □ Buspirone □ Lyrica □ Mirtazapine □ Exercise Therapy □ Cognitive Behavioral Therapy □ Relaxation and Breath Training □ Other	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:	
Does provider routinely check the PDMP?	□ YES □ NO
Has the provider established an appropriate treatment plan with the patient, addressing the delayed onset of effectiveness of their maintenance therapy?	□ YES □ NO
Will the benzodiazepine therapy be routinely evaluated for continued necessity?	□ YES □ NO
Does the patient undergo routine drug screens?	□ YES □ NO
Has the provider discussed and counseled the patient on the known risks of utilizing benzodiazepines in combination with opioid analgesics and other CNS depressing medications/conditions?	□ YES □ NO

Please confirm that all of the following is attached to the request, along with any other relevant documentation:

□ Patient's treatment plan including an evaluation of effectiveness and plans for continuation/discontinuation
□ Clinical documentation of previously tried and failed non-benzodiazepine therapies.

Prescriber (or Staff) / Pharmacy Signature**	Date

health information designs

Brineura
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving Brineura to meet prior authorization criteria. The prior authorization criteria can be found at **http://hidesigns.com/assets/files/ndmedicaid/2019/Criteria/PA_Criteria.pdf**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Billing Facility Name	Billing Facility NPI	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**ICD-10 Diagnosis Code(s) for this request:**

Qualifications for Coverage:

Initial Requests (please answer the questions below):	
Does patient have ventriculoperitoneal shunts?	□ YES □NO
Has the patient's diagnosis been confirmed by a genetic test confirming CLN2 disease?	□ YES □NO
Have results of an enzyme assay confirmed a deficiency of tripeptidyl peptidase 1 (TPP1) in this patient?	□ YES □NO
Have the patient's baseline results of motor and language domains of the Hamburg CLN2 Clinical Rating Scale been attached/faxed in with this request?	□ YES □NO
Renewal Requests (please answer the questions below):	
Does the patient have an acute, unresolved localized infection on or around the device insertion site or suspected or confirmed CNS infection?	□ YES □NO
Have the patient's current results of motor domain of the Hamburg CLN2 Clinical Rating Scale been attached/faxed in with this request?	□ YES □NO
Has the patient responded to therapy compared to pretreatment baseline with stability/lack of decline* in motor function/milestones?	□ YES □NO
**: Decline is defined as having an unreversed (sustained) 2-category decline or an unreversed score of 0 in the Motor domain of the CLN2 Clinical Rating Scale*	

Prescriber (or Staff) / Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

health information designs

Diabetic Testing Supplies Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

In line with current ADA guidelines, ND Medicaid requires that patients receiving a prescription for diabetic testing supplies that are not receiving an insulin or sulfonylurea product, as evidenced by paid pharmacy claims, will require prior authorization to qualify for coverage.
Overrides for a period of 6 months will be considered for patients that are newly diagnosed, acutely ill, or have a significant change in health status for medically necessary purposes. To obtain an override, please complete this form and fax to the number above for clinical review.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested product(s) and frequency of use:	**Diagnosis for this request:**		
Medical justification for use/ qualifications for coverage (please attach any supporting documentation to this request):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Dupixent
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Dupixent must meet criteria for coverage, as stated in the PA Criteria page of the North Dakota Medicaid Prior Authorization website (www.hidesigns.com/ndmedicaid) or directly at the following link: http://www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug:	**Diagnosis for this request:**	**Is the affected area is on the face, groin, axilla, or under occlusion?** □ YES □ NO
List all failed medications:	**Start Date:**	**End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Emflaza
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Emflaza must meet the criteria for use available at www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**	
List all failed medications:	**Start Date:**	**End Date:**

- **Patient's serum creatinine kinase activity prior to initiating treatment:**
- **Patient's current motor milestone score** (provide score and assessment used):
- **Did the patient experience onset of weakness before 5 years of age?** □ YES □ NO
- *INITIAL*: **Patient has experienced the following significant intolerable adverse effects*** (select all that apply)
  - □ Cushingoid appearance
  - □ Central (truncal) obesity
  - □ Severe behavioral adverse effect
  - □ Undesirable weight gain (>10% of body weight gain increase over 6-month period)
  - □ Diabetes and/or hypertension that is difficult to manage
- *RENEWAL*: **Patient has experienced an improvement from adverse effects experienced on prednisone*** □ YES □ NO

Documentation of experienced adverse events or improvement on Emflaza must be provided with this request

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Growth Hormone
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a preferred growth hormone*, Serostim, or Zorbtive must meet the criteria for the specified product listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

**=Patient's receiving a non-preferred growth hormone product must be switched to a preferred agent.*

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dosage:	**Diagnosis for this request:**

Qualifications for coverage:

Does patient have any active malignancy?	□ YES □NO
Has patient attained epiphyseal closure?	□ YES □NO
Does the patient consult with a dietician to maintain a nutritious diet?	□ YES □NO
Is growth hormone needed to maintain proper blood glucose *(endogenous GH deficiency only)*?	□ YES □NO
Does the patient have multiple pituitary hormone deficiencies caused by a known, hypothalamic-pituitary Disease*(endogenous GH deficiency only)*?	□ YES □NO
Has the patient received a renal transplant *(chronic renal insufficiency only)?*	□ YES □NO
Has a diagnosis of sleep apnea been ruled out in this patient *(Prader-Willi syndrome only)*?	□ YES □NO
Are all lab values stated as required in the criteria attached to this request?	□ YES □NO

Patient's current BMI (Prader-Willi syndrome only):

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Hemangeol
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Hemangeol must meet the following criteria:

- The patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy
- The patient must be between 5 weeks and 1 year of age
- The patient must weigh at least 2 kg
- The provider must attest that the patient does not have any of the following contraindications to treatment:
  - 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

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug: □ HEMANGEOL	Diagnosis: Patient's weight:	Does patient have ANY contraindications to Hemangeol?	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Hepatitis C Treatments
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for hepatitis C treatments must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

- Please complete this form in its entirety and provide any and all required documentation (if available)

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug and Dose:	**Duration requested:**	**Patient is drug (illicit use by injection) and alcohol free for past 3 months:** □ YES □ NO
Diagnosis: □ HCV □ OTHER:	**Genotype:**	**Patient's Child-Pugh class:** □ A □ B □ C □ N/A

Please list any previous treatments the patient has failed for chronic HCV: □ N/A	Regimen:	Dates of treatment:	Response:

Will the requested medication be given with ribavirin to a patient of child bearing potential? If yes, has the patient had a negative pregnancy test in the last 30 days? Will the receive pregnancy tests monthly during treatment?	□ YES □ NO □ YES □ NO □ N/A □ YES □ NO □ N/A
Has patient completed or is currently in a treatment program from an enrolled addiction medicine/chemical dependency provider (or buprenorphine waived provider if history of IV drug use)? Approximate Dates of Treatment:	□ YES □ NO Attested by: □ PROVIDER □ PATIENT
Does patient have a diagnosis of alcohol use disorder?	□ YES □ NO
Does patient have a history of illicit use of drugs by injection?	□ YES □ NO
Does the patient have Hepatitis B?	□ YES □ NO
If the patient has Hepatitis B, has it been treated or will it be closely monitored during treatment?	□ YES □ NO
Is the patient post-liver transplant?	□ YES □ NO
Does the patient's life expectancy greater than one year?	□ YES □ NO
Does patient attended scheduled visits with no more than 1 no-show and fill maintenance medications on time?	□ YES □ NO
Does patient have any contraindications to therapy with the requested agent?	□ YES □ NO

Please confirm that all of the following is attached to the request, along with any other documentation required, as stated in the PDL:

- □ Baseline HCV RNA
- □ ≥ 2 drug and alcohol tests dated at least 3 months apart
- □ Patient attestation form
- □ HCV RNA 4 weeks after starting therapy (for renewal)
- □ Chart notes addressing patient's alcohol and drug free status over the past year
- □ Documentation of patient's fibrosis score if available (e.g. APRI, Fibroscan, Fibrotest)

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Hepatitis C Patient Consent Form

I, _____, have been counseled by my healthcare provider on the following:

- ☐ I agree to complete the entire course of treatment and have laboratory tests before starting, during, and after completing treatment as ordered by my healthcare provider.
- ☐ I understand that for the medication to work, it is important that I take my medication each day for the entire course of treatment.
- ☐ I understand the importance to not drink alcohol or use illicit drugs during and after my treatment for Hepatitis C.
- ☐ I understand how to avoid being re-infected with Hepatitis C during and after my treatment.
- ☐ (Females) I understand that these drugs are harmful to babies. I will use two methods to avoid getting pregnant. I understand that this medication may cause serious birth defects to an unborn child for up to 6 months after I have completed my treatment.
- ☐ (Males) I understand that while I am taking the medication, I must avoid getting my partner pregnant. If my partner becomes pregnant, the baby may have serious birth defects. My partner and I will prevent pregnancy using two forms of birth control for up to 6 months after my treatment is complete. If I have a committed partner, I have discussed these risks with her.

Patient Signature _____ Date __/__/____

Pharmacy or Prescriber Representative:

Signature _____ Date __/__/____

By signature, the pharmacy or prescriber representative confirms the contract has been reviewed with the patient.

health information designs

Hyperkalemia
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for select agents for hhyperkalemia to meet the following criteria:

- Patient must be 18 years of age or older
- Medication must be prescribed by, or in consultation with, a nephrologist
- Patient's current serum potassium level must be exceeding the upper limit of normal (shown by 2 labs)
- Patient must not have gastrointestinal motility disorders
- One of the following criteria must be met:
  - Patient must have failed a 30-day trial with at least one preferred product
  - Provider has submitted medical justification explaining why the patient cannot use any preferred agents
- The patient must not be receiving the medications known to cause hyperkalemia, OR medical justification must be provided explaining why discontinuation of these agents would be clinically inappropriate in this patient
- **Renewal**: Patient's current serum potassium level must be within normal limits or significantly reduced from baseline

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	

Additional Qualifications for Coverage

Has the provider attached required lab documentation showing 2 of the patient's current potassium levels?	□ YES □NO
Does the patient have a diagnosis of any gastrointestinal motility disorder?	□ YES □NO
Is the patient to continue to receive a medication known to cause hyperkalemia?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Idiopathic Pulmonary Fibrosis Agents Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for agents used to treat idiopathic pulmonary fibrosis must meet the following criteria:

Category Criteria:

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

Product Specific Criteria

- **Alternative Ofev Products:**
  - The patient must have documented diagnosis of systemic sclerosis-associated interstitial lung disease

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number		
Prescriber Name	Specialist Involved in Therapy (if different than prescriber)			
Prescriber NPI	Telephone Number	Fax Number		
Address	City	State	Zip Code	
Requested Drug:	Diagnosis:	FVC:	Date of FVC Provided:	
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*				
Prescriber (or Staff) / Pharmacy Signature**	Date			
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*				

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Immune Globulins
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for an immune globulin must meet the following criteria:

- **If patient's BMI > 30, adjusted body weight must be provided along with the calculated dose.**
- **For Gammagard S/D:** Patient must be intolerant to IgA.
- **For Cutaquig, Cuvitru, Hizentra, Hyqvia or Xembify:** Patient must be unable to tolerate IV administration and fail a trial of two of the following: Gamunex-C, Gammaked, or Gammagard.
- **For all other agents:** Patient must try and fail two of the following: Gamunex-C, Privigen, or Gammagard.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	

Qualifications for coverage:

Is patient intolerant to IgA? □ YES □NO
Is patient unable to tolerate IV administration? □ YES □NO
Is patient BMI over 30? □ YES □NO
If patient BMI over 30, provide adjusted body weight and calculated dose:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Prior Authorization Vendor for ND Medicaid

Insulins
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a non-preferred insulin must meet the following criteria:

- **For pens/syringes when vials are available:** Prescriber must provide medical justification explaining why the patient cannot use a vial
- **For Fiasp:** Patient must have failed a 30-day trial with Novolog, Humalog, and Apidra
- **For Basaglar:** Prescriber must provide medical justification explaining why the patient cannot use a preferred products
- **For Tresiba and Toujeo:**
  - Initial Criteria
    - Must be prescribed by or in consultation with an endocrinologist or diabetes specialist
    - Patient must have one of the following (A or B):
      A. Recurrent episodes of hypoglycemia on preferred basal insulin product despite adjustments to current regimen (prandial insulin, interacting drugs, meal and exercise timing).
      B. Inconsistent blood sugars with a basal insulin requirement of a minimum of 100 units/day for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
    - **If dose is >200 units of insulin per day**, clinical justification must be provided explaining why the patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin).
  - Renewal Criteria
    - Must provide clinical notes or labs documenting either an improvement in frequency and/or severity of hypoglycemia or documented improved glycemic control (A1C)

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name:			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	Diagnosis for this request:		
Failed Therapy:	Start Date:	End Date:	
Has all required documentation/medical justification supporting use over preferred agents been attached? □ YES □ NO			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Juxtapid
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Juxtapid must meet the following criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have LDL levels of >130 mg/dL after a 90-day trial of the following:
  - A lipid lowering agent other than a statin combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- The patient must meet one of the following (A, B, or C):
  - A. Patient must have genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
  - B. The patient's current untreated LDL and total cholesterol level is > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
  - C. The patient has a current untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

Patient's Current LDL:

Does the patient have genetic confirmation of 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus?
□ YES □ NO

Untreated LDL and total cholesterol level of > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age?
□ YES □ NO

Does the patient have an untreated LDL level consistent with HeFH in both parents?
□ YES □ NO

List all failed medications (drug name, date of trial, reason for failure):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Makena
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Makena to meet criteria confirming the medication is being used according to its FDA-approved indication. Please fill out the following form in its entirety.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Patient's Estimated Date of Delivery or Gestational Age of Current Pregnancy (weeks and days):			
Does the patient have a history of singleton spontaneous preterm birth?	□ YES	□ NO	
Is the patient currently pregnant with singleton?	□ YES	□ NO	
Additional Qualifications for Coverage (*if applicable*)			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Mifeprex
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Mifeprex must meet the following criteria:

- **Patient must have an FDA approved indication for the medication requested.**
- **Prescriber must provide signed written statement as listed in the Mifeprex Prior Authorization Criteria at www.hidesigns.com/assets/files/ndmedicaid/2018/Criteria/PA_Criteria.pdf**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Physician Name			
Physician Medicaid Provider Number	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		

- **Is the patient terminating a pregnancy before 70 days of gestation?**
  □ YES □ NO
- **Is the pregnancy resulting from an act of rape or incest?**
  □ YES □ NO (If yes, please attach written statements as outlined in section 1 below)
- **Does the woman suffer from a physical disorder that would place the woman in danger of death unless abortion is performed?**
  □ YES □ NO (If yes, please attach a written statement as outlined in section 2 below)

Section 1:

- 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.

Section 2:

- 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

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Migraine Prophylaxis (CGRP Inhibitors) Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for a CGRP inhibitor must meet the criteria listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

Initial Request Criteria for All Diagnoses:

- The patient must have had a 3-month trial of each preferred agent*.
- The patient must have had the specified 2-month trial(s) of the required prerequisite therapy (stated in the PDL)*.
- **Additional criteria for migraine prevention:** Patient must experience ≥4 migraine days per-month.
- **Additional criteria for episodic cluster headaches:** Prescriber must submit documentation supporting a diagnosis that meets the International Headache Society 3 – beta (IHS-3b) diagnostic criteria for cluster headache (chronic migraine must be ruled out).

**= The prescriber must submit documentation, including clinical notes regarding failure of prior treatments.*

Renewal Requests: Patient must experience a reduction in migraines/weekly cluster headaches of at least 50%

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**
Additional Qualifications for Coverage (e.g. medical justification explaining inability to meet required trials)			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

NSAIDs
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients using non-preferred NSAIDs must meet the criteria for the specified product listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating physician)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:	**Diagnosis for this request:**	

List all failed medications:	**Start Date:**	**End Date:**	**Reason for Failure:**

Qualifications for coverage:

Is the patient unable to ingest solid dosage forms (please attach swallow study documentation)?	□ YES □NO
Does the patient have a history of gastric or duodenal ulcer or comorbidities of GI bleed, perforation, or obstruction?	□ YES □NO
Does patient have a diagnosis of postoperative nausea and vomiting?	□ YES □NO
All other needed qualifications for coverage/medical justification for use is attached to this request?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Nausea/Vomiting
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for a non-preferred agent for nausea/vomiting treatment must meet the criteria for the specified product listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating physician)	
Prescriber NPI	Telephone Number	Fax Number

Requested Drug and Dosage:	**Diagnosis for this request:**	
List all failed medications:	**Dates:**	**Reason for Failure:**

Estimated last day of treatment (ie. pregnancy due date or final date of chemotherapy):

Additional Qualifications for Coverage:
□ Does the patient have an inability to tolerate oral medications (please attach swallow study)? □ YES □ NO
□ Other, Explain:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Nuedexta
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Nuedexta must meet the following criteria:

Initial Criteria

- Patient must be 18 years of age or older
- Patient must not have a prolonged QT interval, heart failure, or complete atrioventricular block
- Patient's baseline CNS-LS and weekly PBA episode count must be provided
- Patient must have a diagnosis of PBA due to one of the following conditions: ALS, MS, Alzheimer's disease, or stroke
- **For 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 of one medication from BOTH classes listed: SSRIs (sertraline, fluoxetine, citalopram and paroxetine) and Tricyclic Antidepressants (nortriptyline or amitriptyline)
    - A PBA episode count and CNS-LS score must be provided for before and after each trial

Renewal Criteria

- 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
- **For 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% decrease from baseline

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request (include cause of PBA):**		
List all failed medications:	**Start Date (PBA Count at Start):**	**End Date (PBA Count at End):**	
Does the patient have a prolonged QT interval, heart failure, or complete atrioventricular (AV) block? □ YES □ NO Has the neurologic condition been stable for at least 3 months? □ YES □ NO			
Baseline CNS-LS:	Baseline weekly PBA episode count:	Current CNS-LS:	Current weekly PBA episode count:
Prescriber (or Staff) / Pharmacy Signature**		Date	
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Opioid Analgesics
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a long-acting opioid analgesic must meet the following criteria:

- Patient must have required around-the-clock pain relief for the past 90 days
- The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.
- Patient must be in consult with oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if:
  - Cumulative daily dose of narcotics exceed 90 MED/day
  - Patient is using benzodiazepine concurrently with narcotic medication
- Patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)

*** For additional and agent-specific criteria, please see criteria for coverage in the Preferred Drug List at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Pain, Palliative Care, or Oncology/Hematology Specialist involved in therapy (if not treating physician):		
Prescriber NPI	Telephone Number	Fax Number	
Requested Opioid Analgesic:	**Diagnosis for use of opioid(s) in this patient:**		
List All Failed/Current Medications: □ NSAIDs □ TCAs □ SNRIs □ Corticosteroids □ Weight Loss □ Physical Therapy □ Cognitive Behavioral Therapy □ Other:	**Dose and Frequency:**	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:	
Has the past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber?	□ YES □ NO
Has the provider established a realistic treatment plan with the patient, addressing expected outcomes and limitations of therapy in totally eliminating pain?	□ YES □ NO
Does the patient undergo routine drug screens?	□ YES □ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

□ Patient's treatment plan including an evaluation of effectiveness and plans for continuation/discontinuation
□ Clinical documentation of previously tried and failed non-opioid therapies.

Prescriber (or Staff) / Pharmacy Signature**	Date

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health information designs

Prior Authorization Vendor for ND Medicaid

Opioid Dependence Agents Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a new prescription for buprenorphine and buprenorphine/naloxone combinations must meet the following criteria:

- Patient must be 16 years or older.
- Indicated for use in treatment of documented opioid dependence.
- Must not be taking other opioids, tramadol, or carisoprodol concurrently.
- Prescriber must be registered to prescribe buprenorphine and buprenorphine/naloxone combinations under the Substance Abuse and Mental Health Services Administration (SAMHSA).
- For non-preferred agents, the presciber must submit medical justification explaining why preferred agents cannot be used.

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name	**(SAMHSA ID-X DEA Number)**		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA Approved Indication for this request:**		

□ Patient is not taking other opioids, tramadol, or carisoprodol concurrently with requested medication.

Has a contract between the prescriber and patient been signed?	□ YES	□ NO
Does the prescriber perform routine drug screens?	□ YES	□ NO
Does the prescriber routinely check the PDMP system?	□ YES	□ NO
Is the patient pregnant?	□ YES	□ NO
Is the patient currently breastfeeding?	□ YES	□ NO

Patient Due Date (if pregnant):	

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Orilissa
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for Orilissa to meet the following prior authorization criteria:

- Patient must have an FDA-approved indication for use and be of the FDA approved age for use
- Documented pain scores must be attached (updated pain scores must be attached to renewals)
- Patient must not have osteoporosis or severe liver disease (Child-Pugh Class C).
- Patient must have failed trials of the following (A and B):
  - A 3-cycle trial of mefenamic acid (or similar fenamate Non-Steroidal Anti-Inflammatory agent (NSAIDs))
  - A 3-cycle trial of twoan oral estrogen-progestin or progestin contraceptives

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:	**Start Date:**	**End Date:**	

Qualifications for coverage:

Has the patient had a negative pregnancy test and will use a non-combination hormone birth control method must be used throughout treatment? □ YES □NO

Does the patient have osteoporosis or severe liver disease (Child-Pugh Class C)? □ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

Osteoporosis Agents
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for non-preferred osteoporosis agents must meet the following criteria:

- Patient must have a diagnosis of an FDA approved indication for use
- Patient must have a current BMD T-score ≤ -2.5 OR new fracture after 6-month trials of each of the following:
  - Denosumab AND either Alendronate or Risedronate
- Patient must be at high risk of fracture, confirmed by at least one of the following:
  - History of hip or vertebral fracture
  - T-score of BMD measurements at the femoral neck or spine is ≤ -2.5 OR between −1.0 and −2.5 & a 10-year hip fracture risk ≥3% as assessed with the FRAX
  - 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX
- Additional Criteria for Forteo and Miacalcin:
  - Patient must have a current BMD T-score ≤ -2.5 OR new fracture after 6-month trials of each of the following:
    - Evenity (Romosozumab) AND Tymlos (Abaloparatide)

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**

Qualifications for coverage:

Patient's BMD T-Score:	Site of BMD Measurement:
Does the patient have a history of low trauma fracture?	□ YES □NO
Has the patient had a new fracture within the last 6-months?	□ YES □NO
Does the patient have multiple risk factors for fracture?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

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Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

health information designs

PCSK9 Inhibitors
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for PCSK9 inhibitors must meet the following criteria:

Group Criteria:

- Patient's LDL must have remained greater than 70 mg/dL after an 8-week trial of Rosuvastatin 20-40 mg or Atorvastatin 40-80 mg with good compliance, as evidenced by paid claims or pharmacy printouts.
- Clinical documentation of the patient's LDL during prior trials must be provided with the request.

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:**		
	LDL level:		

List all failed medications:	**Start Date:**	**End Date:**
Prescriber (or Staff) / Pharmacy Signature**		Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Phenylketonuria Agents Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a phenylketonuria agent must meet the criteria for the specified product listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	**Recipient Date of Birth**	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code:

Requested Drug and Dosage:	**Diagnosis for use:**	**PHE level:**	**Patient's weight:**

Has the patient been known to have two null mutations in TRANS?	□ YES	□ NO
Are baseline PHE levels attached?	□ YES	□ NO
Is patient of child-bearing potential?	□ YES	□ NO
Is this a renewal request?	□ YES	□ NO
Has the patient been compliant with diet and medications for past 6 months?	□ YES	□ NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Sedative/Hypnotic Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for a non-preferred sedative/hypnotic agent must meet the criteria for the specified product listed in the preferred drug list (PDL). Please see the PDL at http://hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf:

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
Qualifications for coverage:			
List all failed medications:	**Start Date:**	**End Date:**	
Have other conditions causing sleep issues been ruled out? Is the patient's insomnia characterized by difficulty with sleep initiation? Is the patient's insomnia characterized by difficulty with sleep maintenance? Does the patient require dose tapering?		□ YES □ NO □ YES □ NO □ YES □ NO □ YES □ NO	
□ I *confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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Spinraza PA Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a prescription for Spinraza must meet the following criteria:

- **For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2 or 3:**
  - **Patient must not have respiratory insufficiency**
  - **i.e. Need for invasive or noninvasive ventiliation 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**
    - **e.g. falls, trouble climbing stairs, unable to walk independently**

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Prescriber NPI		
Billing Facility NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Billing Facility NPI	ICD-10 Code:		
Requested Drug and Dose:			
Diagnosis for this request: □ **SMA Type 1** □ **SMA Type 2** □ **SMA Type 3**			
Does the patient have respiratory insufficiency? □ **YES** □ **NO** **Does the patient require gastric feeding tubes for the majority of feeds?** □ **YES** □ **NO** **Does the patient have severe contractures or severe scoliosis?** □ **YES** □ **NO** **Does the patient have wasting or cachexia?** □ **YES** □ **NO** **Does the patient experience issues with ambulating (SMA Type 3 only)?** □ **YES** □ **NO**			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

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SYNAGIS WEB BASED FORM

For questions regarding this Prior Authorization Call 701-328-4023

Prior Authorization Vendor for ND Medicaid

Note:

- Synagis season will be October 19th through April 21st
- Providers will choose when to start dosing Synagis based on prevalence of RSV in the community
- Clinicians may administer up to a maximum of 5 monthly doses during the RSV season.
- Qualifying infants born during the RSV season may require fewer doses.

TO BE COMPLETED BY PRESCRIBER

Recipient Medicaid ID Number	Recipient Date of Birth	Prescriber NPI	Prescriber Fax Number
Billing Facility NPI	Billing Facility Name		ICD-10 code

Diagnosis (qualification for Synagis)

___ **Prematurity**

<29 weeks, 0 days gestational age – Synagis allowed if younger than 12 months of age at start of RSV season (max of 5 doses)

Gestational Age (e.g. 28 weeks, 4 days)

Weeks _____ **Days** _____

___ **Chronic Lung Disease of Prematurity (CLD)** – Child ≤12 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth.

___ **Chronic Lung Disease of Prematurity (CLD**) – Child ≤24 months old with gestational age <32 weeks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth and continues to receive medical support within six months before the start of RSV season.

___ Supplemental Oxygen

___ Diuretic

___ Chronic corticosteroid therapy

___ **Congenital Heart Disease (CHD)**

Child ≤12 months old with hemodynamically significant cyanotic or acyanotic CHD

Medical Therapy Required _____

*children less than 24 months who undergo cardiac transplantation during RSV season may be considered for prophylaxis.

___ **Neuromuscular disease** (may be considered for prophylaxis during the first year of life)

___ **Pulmonary abnormalities** (may be considered for prophylaxis during the first year of life)

___ **Profoundly Immunocompromised children** (children <24 months of age may be considered for prophylaxis during the RSV season)

***Accessed online at pediatrics.aappublications.org**

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Prior Authorization Vendor for ND Medicaid

Tardive Dyskinesia Agents Prior Authorization Form

Fax Completed Form to: 855-207-0250
For questions regarding this Prior authorization, call 866-773-0695

ND Medicaid requires that patients receiving a new prescription for Austedo, Ingrezza, or tetrabenazine must meet the following criteria:

- **All Agents**
  - 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
- **Additional Criteria for Austedo/tetrabenazine:**
  - Patient must have chorea associated with Huntington's disease or Tardive Dyskinesia
  - Patient must not have hepatic impairment

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name			
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**FDA approved indication for this request:** Does the patient have hepatic impairment? □ YES □ NO		
List all failed medications (drug name, date of trial, reason for failure):			
□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #

Preferred Drug List (PDL)

& Prior Authorization Criteria

Published By:

Medical Services Division
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck, ND 58505-0250

December 2019

Version 2020.1

Effective: January 1, 2020

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Guiding Rules of the Preferred Drug List (PDL):

THIS LIST REFERS TO MEDICATIONS PROCESSED BY PHARMACY POINT OF SALE SYSTEMS.

For Clinic Administered Drugs - Prior authorization criteria for medication claims processed by physician/clinic billing using 837P codes can be found at the end of this document or by using this link:
Clinic Administered Drugs - Prior Authorization Criteria.
For medications not on this list, FDA or compendia supported indications are required.

- Prior authorization criteria apply in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program
    - Other documents explaining coverage rules
        - Preferred Diabetic Supply List (PDSL)
        - Coverage Rules on Medications
        - Therapeutic Duplication Edits

- Please use the NDC Drug Lookup tool to view coverage status, quantity limits, copay, and prior authorization information for all medications.

- To access PA forms, please use:
    - Prior Authorization Form Lookup Tool
    - PA Forms Link

- Length of prior authorizations is a year unless otherwise specified.

- The use of pharmaceutical samples will not be considered when evaluating the member's medical condition or prior prescription history for drugs that require prior authorization.

- Prior authorization for a non-preferred agent with a preferred brand/generic equivalent in any category will be given only if all other criteria is met, including all DAW criteria, clinical criteria, and step therapy specific to that category.

- A trial will be considered a failure if a product was not effective at maximum tolerated dose with good compliance, as evidenced by paid claims or pharmacy print outs or patient has a documented contraindication, intolerance, or adverse reaction to an ingredient

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- Rational of inability to swallow a solid dosage form must be provided after age 9 for all non-solid oral dosage forms.

- Clinical justification must be provided for combination products that are comprised of components available and more cost effective when prescribed separately

*** - Indicates that additional PA criteria applies as indicated in the Product PA Criteria

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General

Dispense as Written (DAW1)

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

Criteria for ALL DAW requests (must meet one of the following (A or B):

A. Primary insurance requires a ND Medicaid non-preferred branded product
B. All of the following are met (1-3):
   1. The requested brand-name product must not have an authorized generic available

2. The patient must have failed a 30-day trial of each pharmaceutically equivalent generic product from each available manufacturer, as evidenced by paid claims or pharmacy print outs
    a. 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
    b. The patient or prescriber preference is NOT criteria considered for approval
3. A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request

Medications that cost over $3000/month

General Prior Authorization Form

Group Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use in line with label recommendations

PA REQUIRED
GATTEX (teduglutide)
INCRELEX (mecasermin)
OXERVATE (cenegermin-bkbj)

Non-solid dosage preparations

General Prior Authorization Form

Group Criteria:

- The patient must have failed treatment with a more cost-effect dosage form in the last 30 days, as evidenced by paid claims or pharmacy printouts

    OR

- The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

See Preferred Dosage Forms List

Cardiology

Angina:

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred product (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RANEXA (ranolazine)	Ranolazine ER

Blood Modifying Agents

Anticoagulants - Oral:

General Prior Authorization Form

Group Criteria:

- The patient must have a diagnosis of an FDA-approved indication.

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ELIQUIS (Apixaban)	SAVAYSA (edoxaban)
PRADAXA (dabigatran)	
XARELTO (rivaroxaban)	

Anticoagulants - Injectable

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- One of the following must be met (A or B)
    A. The patient must have had a 30-day trial of enoxaparin, as evidenced by paid claims or pharmacy printouts.
    B. The request must be for fondaparinux and the patient must have a diagnostic history of heparin-induced thrombocytopenia (HIT)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
enoxaparin	ARIXTRA (fondaparinux)
	fondaparinux
	FRAGMIN (dalteparin)
	LOVENOX (enoxaparin)

Antihemophilic Factor Products

Prior Authorization Form - Antihemophilic Factors

Group Criteria:

- The provider must attest that the patient visits an accredited Hemophilia Treatment Center once per year
- The date of the patient's last appointment with treatment center must be provided
- Contact information for treatment center must be provided

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the PREFFERED AGENTS (no PA required) (subject to clinical review).
- The 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)

FACTOR VIIa	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
NOVOSEVEN RT (Coagulation Factor VIIa recombinant)	
FACTOR VIII – HEMOPHILIA A	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ADVATE (factor VIII recombinant)	ADYNOVATE (factor VIII recombinant, PEGylated)

HEMOFIL M (factor VIII plasma derived; mAb-purified)	AFSTYLA (factor VIII recombinant, single chain)
KOATE (factor VIII plasma derived, chromatography purified)	ELOCTATE (factor VIII recombinant, Fc fusion protein)
KOGENATE FS (factor VIII recombinant)	JIVI (factor VIII recombinant, pegylated-aucl)
NOVOEIGHT (factor VIII recombinant)	KOVALTRY (factor VIII recombinant)
NUWIQ (factor VIII recombinant)	OBIZUR (recombinant, B domain-deleted porcine factor VIII)
RECOMBINATE (factor VIII recombinant)	
XYNTHA (factor VIII recombinant)	
XYNTHA SOLOFUSE (factor VIII recombinant)	
FACTOR VIII:C – HEMOPHILIA A	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
MONOCLATE-P (Antihemophilic Factor VIII:C (human))	
FACTOR VIII – HEMOPHILIA A/vWF	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALPHANATE (Antihemophilic Factor/Von Willebrand Factor Complex (Human))	
HUMATE-P (Factor VIII/von Willebrand Factor (human))	
WILATE (Factor VIII/von Willebrand Factor (human))	
FACTOR VIII – VON WILLEBRAND FACTOR - RECOMBINANT	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
	VONVENDI (Recombinant human vWF)
FACTOR IX – HEMOPHILIA B	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALPHANINE SD (factor IX, plasma-derived)	ALPROLIX (factor IX recombinant, Fc fusion)
BENEFIX (factor IX recombinant)	IDELVION (factor IX recombinant, albumin fusion)
IXINITY (factor IX recombinant)	REBINYN (factor IX recombinant, glycol-PEGylated)
MONONINE (factor IX, plasma-derived mAb purified)	
PROFILNINE (factor IX complex)	
RIXUBIS (factor IX recombinant)	
FACTOR IXa/IX	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HEMLIBRA (Emicizumab-kxwh)	
FACTOR X	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COAGADEX (Coagulation Factor X (Human))	
FACTOR X	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
CORIFACT (Factor XIII Concentrate (Human))	
FACTOR XIII A – SUBUNIT, RECOMBINANT	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
TRETTEN (Factor XIII A-Subunit, recombinant)	
ANTI-INHIBITOR COAGULANT COMPLEX	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
FEIBA NF (Anti-Inhibitor Coagulant Complex)	

Hematopoietic, Colony Stimulating Factors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred product (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FULPHILA (Pegfilgrastrim-JMDB)	GRANIX (TBO-Filgrastim)
LEUKINE (Sargramostim)	NEULASTA (Pegfilgrastim)
NEUPOGEN (Filgrastim)	NIVESTYM (Figrastim-AAFI)
UDENYCA (pegfligrastim-CBQV)	ZARXIO (Filgrastim-SNDZ)

Platelet Aggregation Inhibitors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Yosprala DR/Durlaza**: Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AGGRENOX (aspirin/dipyridamole)	Aspirin/Dipyridamole ER
Aspirin	Aspirin/Omeprazole DR
BRILINTA (ticagrelor)	Clopidogrel 300mg
Clopidogrel 75 mg	DURLAZA (aspirin ER)***
Dipyridamole	EFFIENT (prasugrel)
Prasugrel	PLAVIX (clopidogrel)
	YOSPRALA DR (aspirin/omeprazole)***
	ZONTIVITY (vorapaxar)

Thrombocytopenia

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Documentation of the patient's current platelet count must be attached to the request

Non-Preferred Agents Criteria:

- The patient must have had trials with each preferred agent (at the recommended dose and duration) with each preferred agent, as evidenced by paid claims or pharmacy Printouts.

Diagnosis Specific Criteria: Chronic immune thrombocytopenia (ITP):

- Criteria for coverage of **Promacta, Doptelet, Nplate, Tavalisse**:
    - **Initial Criteria:**
        - The provider must attest that the patient's degree of thrombocytopenia and clinical condition increase the risk for bleeding
            - The patient must have experienced an inadequate response after one of the following (A or B):
                A. The patient must have failed a trial of appropriate duration of a corticosteroid or immunoglobulins as evidenced by paid claims or pharmacy print outs

B. The patient must have undergone a splenectomy

- **Renewal Criteria:**
  - The patient must be experiencing a significant increase in platelet count and bleeding reduction risk on therapy (supported by documentation)
  - If on maximum dose: The patient's platelet count must have increased to a level sufficient to avoid clinically important bleeding after the recommended duration for the product*
    *Promacta, Nplate, Doptelet: 4 weeks
    *Tavalisse: 12 weeks

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
PROMACTA (Eltrombopag)	DOPTELET (Avatrombopag)
TAVALISSE (Fostamatinib)	NPLATE (Romiplostim)

Diagnosis Specific Criteria: Chronic liver disease-associated thrombocytopenia

- Criteria for coverage of **Doptelet** and **Mulpleta**
  - The patient must have a diagnosis of chronic liver disease
  - The patient must be scheduled to undergo a procedure that puts the patient at risk of bleeding
    - The prescriber must include documentation of the name and scheduled date of the procedure
  - The provider must indicate the date therapy will be initiated and discontinued*
    *Doptelet: given from 10-13 to 5-8 days prior to procedure
    *Mulpleta: given from 8-14 to 2-8 days prior to procedure

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DOPTELET (Avatrombopag)	MULPLETA (Lusutrombopag)

Diagnosis Specific Criteria: Chronic hepatitis C infection-associated thrombocytopenia

- Criteria for coverage of **Promacta**
  - The patient must have a diagnosis of hepatitis C and be currently receiving or planning to initiate interferon-based treatment
    - Prescriber must attest that the patient's degree of thrombocytopenia prevents continuation or initiation of interferon

Diagnosis Specific Criteria: Aplastic Anemia

- Criteria for coverage of **Promacta**
  - One of the following must be met (A or B):
    A. The patient must be receiving Promacta as first-line treatment in combination with standard immunosuppressive therapy (e.e. corticosteroid, Atgam, cyclosporin)
    B. The patient must have had an insufficient response to treatment with prior immunosuppressive therapy

Hypertension

ARBs (Angiotensin Receptor Blockers)

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of 3 preferred agents at their highest tolerable therapeutic dose, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Combination agents:**
  - Clinical justification must be provided explaining why the patient is unable to use a preferred combination product or the individual agents separately (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)

Amlodipine-olmesartan	Amlodipine-Valsartan-Hydrochlorothiazide
Amlodipine-valsartan	ATACAND (Candesartan)
Candesartan 4mg, 32mg	ATACAND HCT (Candesartan-Hydrochlorothiazide)
EDARBI (azilsartan)	AVALIDE (Irbesartan-Hydrochlorothiazide)
EDARBYCLOR (azilsartan/chlorothalidone)	AVAPRO (irbesartan)
Irbesartan	AZOR (Amlodipine/Olmesartan)
Irbesartan-hydrochlorothiazide	BYVALSON (Nebivolol/Valsartan)
Losartan	Candesartan 8mg, 16mg
Losartan-hydrochlorothiazide	Candesartan-hydrochlorothiazide
Olmesartan	COZAAR (Losartan)
Olmesartan-hydrochlorothiazide	DIOVAN HCT (Valsartan-Hydrochlorothiazide)
Telmisartan	Eprosartan
Valsartan	EXFORGE (Amlodipine-Valsartan)
Valsartan-hydrochlorothiazide	EXFORGE HCT (Amlodipine-Valsartan-Hydrochlorothiazide)
	HYZAAR (Losartan-Hydrochlorothiazide)
	Telmisartan-Amlodipine
	Telmisartan-Hydrochlorothiazide
	TRIBENZOR (Olmesartan-Amlodipine-Hydrochlorothiazide)

Renin Inhibitors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of 2 different ACE-inhibitors and 2 different ARBs, each at the highest tolerable therapeutic dose, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS	NON-PREFERRED AGENTS
TEKTURNA (aliskiren)	aliskirin
	TEKTURNA HCT (aliskiren-hydrochlorothiazide)

Vecamyl

General Prior Authorization Form

Group Criteria:

- The 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.

Heart Failure

Edecrin

General Prior Authorization Form

Product Specific Criteria:

- **Ethacrynic acid**: One of the following must be met (A or B)
  - A. The patient must have a documented sulfa allergy
  - B. The patient must have failed a 30-day trial of all preferred agents, as evidenced by paid claims or pharmacy print outs.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
furosemide	ethacrynic acid
bumetanide	
torsemide	

Entresto

Product Specific Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ENTRESTO (sacubitril/valsartan)	

Lipid-Lowering Agents

Juxtapid

Prior Authorization Form - Juxtapid

Product Specific Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy printouts:
    - A lipid lowering agent other than a statin combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
- The patient must meet one of the following (A, B, or C):
    - A. The patient must have genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus
    - B. The patient's current untreated LDL and total cholesterol level is > 500 mg/dl or >300 mg/dl with cutaneous or tendon xanthoma before 10 years of age
    - C. The patient has a current untreated LDL level consistent with Heterozygous Familial Hypercholesterolemia (HeFH) in both parents

PCSK9 Inhibitors

PCSK9 Inhibitors Prior Authorization Form

Group Criteria:

- Patient's LDL must have remained greater than 70 mg/dL after an 8-week trial of Rosuvastatin 20-40 mg or Atorvastatin 40-80 mg with good compliance, as evidenced by paid claims or pharmacy printouts.
- Clinical documentation of the patient's LDL during prior trials must be provided with the request.

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
PRALUENT PEN (Alirocumab)	REPATHA SURECLICK (Evolocumab)
REPATHA PUSHTRONEX (Evolocumab)	REPATHA SYRINGE (Evolocumab)

Statins

General Prior Authorization Form

Product Specific Criteria:

- **Livalo**:
    - Statin intensity treatment goal must be "moderate" or "low"
    - The patient must have failed 3-month trials of one of the below drug regimens (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
- **Altoprev (lovastatin) ER/Fluvastatin/Fluvastatin ER/Zypitamag:**
    - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
atorvastatin	ALTOPREV (lovastatin)
lovastatin	ALTOPREV (lovastatin) ER
pravastatin	Amlodipine-atorvastatin
rosuvastatin	CRESTOR (rosuvastatin)
simvastatin	EZALLOR SPRINKLE (rosuvastatin)
	Ezetimibe-simvastatin
	fluvastatin
	fluvastatin ER
	LESCOL XL (fluvastatin)
	LIPITOR (atorvastatin)
	LIVALO (pitavastatin)
	PRAVACHOL (pravastatin)
	ZOCOR (simvastatin)
	ZYPITAMAG (pitavastatin)

Pulmonary Hypertension

General Prior Authorization Form

PDE-5 Inhibitors

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Sildenafil/Tadalafil:**
    - One of the following must be met (A or B):
        A. The patient must be less than 12 years of age
        B. The provider must submit clinical documentation to support patient's diagnosis
- **Revatio Suspension:**
    - The provider must submit clinical documentation to support patient's diagnosis
    - One of the following must be met (A or B):
        A. The patient must be less than 9 years of age.

B. The provider must submit clinical documentation of the patient's inability to ingest a solid dosage form.

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ALYQ (Tadalafil)	ADCIRCA (Tadalafil) TABLET
REVATIO (Sildenafil) SUSPENSION*** - *Brand Required*	REVATIO (Sildenafil) TABLET
Sildenafil tablet***	Sildenafil Suspension
Tadalafil tablet***	

Soluble Guanylate Cyclase Stimulators

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ADEMPAS (riociguat)	

Endothelin Receptor Antagonists

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Tracleer Suspension**
  - One of the following must be met (A or B):
    A. The patient must be less than 9 years of age
    B. The provider must submit clinical documentation of the patient's inability to ingest a solid dosage form

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Ambrisentan	Bosentan
TRACLEER (bosentan) SUSPENSION***	LETAIRIS (ambrisentan)
TRACLEER (bosentan) TABLETS - *Brand Preferred*	OPSUMIT (macitentan)

Prostacyclins

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ORENITRAM ER (Treprostinil) TABLET	REMODULIN (Treprostinil) INJECTION
UPTRAVI (Selexipag) TABLET	
Treprostinil injection	
TYVASO (Treprostinil) INHALATION	
VENTAVIS (Iloprost) INHALATION	

Dermatology

Acne

General Prior Authorization Form

Group Criteria:

- The patient must be between 12 and 35 years of age

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

CLINDAMYCIN-BENZOYL PEROXIDE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Clindamycin-benzyl peroxide 1.2%-5%	ACANYA (Clindamycin-benzoyl peroxide) 1.2%-2.5%
Clindamycin/benzoyl peroxide 1%-5% without pump	BENZACLIN (Clindamycin/benzoyl peroxide without pump) 1%-5%
ONEXTON (Clindamycin/benzoyl peroxide) 1.2%-3.75%	BENZACLIN (Clindamycin/benzoyl peroxide with pump) 1%-5%
	Clindamycin/benzoyl peroxide 1%-5% with pump
	Clindamycin-benzoyl peroxide 1.2%-2.5%
	DUAC (lindamycin/benzoyl peroxide) 1.2%-5%
	NEUAC (Clindamycin/benzoyl peroxide) 1.2%-5%
TRETINOIN MICROSPHERES	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.06%	RETIN-A MICRO (Tretinoin Microsphere) GEL WITHOUT PUMP
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.08%	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.04%
	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.10%
	tretinoin microsphere without pump
	tretinoin microsphere with pump
TRETINOIN	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALTRENO (tretinoin) LOTION	ATRALIN (Tretinoin) 0.05% GEL
AVITA (tretinoin) CREAM *(brand preferred)*	Clindamycin-tretinoin 1.2%-0.025%
RETIN-A (tretinoin) CREAM *(brand preferred)*	FABIOR (tazarotene) 0.1% FOAM
Tretinoin gel 0.01%, 0.03%	Tretinoin cream
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) *(brand preferred)*	Tretinoin gel 0.05%
ADAPALENE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
DIFFERIN (adapalene) CREAM (*brand preferred*)	Adapalene 0.1% cream
Adapalene gel	Adapalene 0.3% gel with pump
DIFFERIN (adapalene) GEL W/ PUMP *(brand preferred)*	Adapalene/Benzoyl Peroxide 0.1%-2.5%
DIFFERIN (adapalene) LOTION	
EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5% *(brand preferred)*	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ACZONE (Dapsone) GEL WITH PUMP 7.5%	ACZONE (Dapsone) GEL WITHOUT PUMP 5%
AZELEX (Azelaic Acid)	AKLIEF (Trifarotene) CREAM 0.005%
Clindamycin capsule	CLEOCIN T (Clindamycin) GEL
Clindamycin gel	CLEOCIN T (Clindamycin) LOTION
Clindamycin lotion	CLEOCIN T (Clindamycin) MED SWAB
Clindamycin solution	CLINDACIN P (Clindamycin) MED SWAB
Clindamycin med. swab	CLINDACIN ETZ (Clindamycin) MED SWAB
Sulfacetamide suspension	CLINDAGEL (Clindamycin) GEL DAILY
	Clindamycin Gel Daily
	Clindamycin foam
	Dapsone gel without pump 5%
	EVOCLIN (Clindamycin) FOAM
TETRACYCLINES	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Doxycycline hyclate capsule	Demeclocycline
Doxycycline hyclate tablet 20mg, 100mg	DORYX (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate 25 mg/5mL suspension	DORYX MPC (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate tablet 50 mg, 75mg, 100mg	Doxycycline monohydrate capsule 75mg, 150mg
Doxycycline monohydrate capsule 50 mg, 100mg	Doxycycline hyclate tablet 75mg, 150 mg
Minocycline capsule	Doxycycline monohydrate tablet 75mg, 150 mg
Minocycline tablet	Doxycycline hyclate tablet DR
VIBRAMYCIN (Doxycycline) 25mg/5mL SUSPENSION	MINOCIN (Minocycline) CAPSULE
VIBRAMYCIN (Doxycycline calcium) 50 mg/5mL SYRUP	Minocycline Tablet ER
	MINOLIRA ER (Minocycline) TABLET
	MORGIDOX (Doxycycline hyclate) CAPSULE
	SEYSARA (Sarecycline)
	SOLODYN ER (Minocycline) TABLET
	Tetracycline
	XIMINO (Minocycline) CAPSULE ER

Actinic Keratosis

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 6-month trial of each preferred agent of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CARAC (Fluorouracil) 0.5% CREAM	Fluorouracil 0.5% cream
Diclofenac 3% sodium gel	Imiquimod 3.75% cream pump
Imiquimod 5% cream packet	PICATO (ingenol mebutate)
Fluorouracil 5% cream	ZYCLARA (imiquimod) 3.75% CREAM PUMP
TOLAK (Fluorouracil) 4% CREAM	ZYCLARA (imiquimod) 3.75% CREAM PACKET
	ZYCLARA (imiquimod) 2.5% CREAM PUMP

Antifungals – Topical

General Prior Authorization Form

Diagnosis Specific Criteria:

- **Onychomycosis:** *Approval Duration = 12 months*
  - The patient must have a diagnosis of an FDA approved indication for use
    - Diagnosis must be confirmed by potassium hydroxide (KOH) preparation
  - The patient must have had a trial of one oral agent (terbinafine, fluconazole, or itraconazole), for the length of recommended treatment time for patient's particular infection, as evidenced by paid claims or pharmacy printouts
  - Adequate time must have passed since treatment cessation to accurately assess healthy toenail outgrow (at least 6 months)
  - One of the following must be met (A or B):
    A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
    B. The active ingredient of the requested product is not available in a preferred formulation
- **Other diagnoses:** *Approval Duration = 12 months*
  - The patient must have had a trial of 3 preferred agents, for the length of recommended treatment time for patient's particular infection, as evidenced by paid claims or pharmacy printouts
  - One of the following must be met (A or B):
    A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
    B. The active ingredient of the requested product is not available in a preferred formulation

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Ciclopirox cream	CICLODAN (Ciclopirox) CREAM
Ciclopirox gel	CICLODAN (Ciclopirox) SOLUTION
Ciclopirox shampoo	EXTINA (Ketoconazole) FOAM
Ciclopirox solution	JUBLIA (efinaconazole) SOLUTION
Clotrimazole cream	KERYDIN (tavaborole) SOLUTION
Clotrimazole solution	Ketoconazole foam
Econazole cream	LOPROX (Ciclopirox) CREAM
ERTACZO (sertraconazole) CREAM	LOPROX (Ciclopirox) SHAMPOO
EXELDERM CREAM (sulconazole)	LOPROX (Ciclopirox/Skin Cleanser) KIT
EXELDERM SOLUTION (sulconazole)	LOPROX (Ciclopirox) SUSPENSION
Ketoconazole cream	LUZU (Luliconazole) Cream
Ketoconazole shampoo	Naftifine Cream
Luliconazole cream	Natfifine Gel
MENTAX (butenafine) CREAM	NAFTIN (Naftifine) CREAM
Miconazole	NAFTIN (Naftifine) GEL
Miconazole/zinc oxide/white petrolatum ointment	NIZORAL (Ketoconazole) SHAMPOO
Nystatin cream	NYAMYC (Nystatin) POWDER
Nystatin ointment	NYSTOP (Nystatin) POWDER
Nystatin powder	Oxiconazole cream
Nystatin – triamcinolone cream	OXYSTAT (Oxiconazole) CREAM
Nystatin – triamcinolone ointment	OXISTAT (oxiconazole) LOTION
	PENLAC (Ciclopirox) SOLUTION

	VUSION (Miconazole/Zinc/White Petrolatum) OINTMENT

Antipsoriatics – Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
calcipotriene ointment	calcipotriene/betamethasone ointment
calcipotriene solution	Calcitriol ointment
calcipotriene cream	DOVONEX (Calcipotriene) CREAM
SORILUX (calcipotriene) FOAM	DUOBRII (halobetasol/tazarotene) LOTION
TACLONEX (calcipotriene/betamethasone) SUSPENSION	ENSTILAR (calcipotriene/betamethasone) FOAM
TAZORAC (Tazarotene) CREAM 0.05%	TACLONEX (calcipotriene/betamethasone) OINTMENT
TAZORAC (Tazarotene) GEL	Tazarotene cream
VECTICAL (Calcitriol) OINTMENT	TAZORAC (Tazarotene) CREAM 0.1%

Eczema / Atopic Dermatitis

Prior Authorization Form - Eczema

Topical Corticosteroids: Please see the Preferred Drug List of Topical Corticosteroids at the end of this document

Category PA Criteria:

- Patient must meet FDA label recommendations for indication and age

Product Specific Criteria (Initial): *Approval Duration = 3 months*

- **Eucrisa**:
  - Patient must have had a 30-day trial of at least one of the following within the past 180 days, as evidenced by paid claims or pharmacy printouts:
    - A topical calcineurin inhibitor (tacrolimus or pimecrolimus) OR a topical corticosteroid
- **Dupixent**
  - Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy printouts:
    - 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 printouts.
    - 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 printouts.

Product Specific Criteria (Renewal): *Approval Duration = 3 months*

- **Eucrisa and Dupixent:**
    - The prescriber must submit documentation showing that the patient has achieved a significant reduction in severity of atopic dermatitis since treatment initiation

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)***	Tacrolimus 0.03%
EUCRISA (crisaborole) OINTMENT***	Tacrolimus 0.1%
Pimecrolimus – Labeler 68682	ELIDEL (pimecrolimus) CREAM
PROTOPIC (tacrolimus) OINTMENT 0.03%	Pimecrolimus – Labeler 00591
PROTOPIC (tacrolimus) OINTMENT 0.1%***	

Hemangeol

Prior Authorization Form - Hemangeol

Product Specific Criteria:

- The patient must have a diagnosis of proliferating infantile hemangioma requiring systemic therapy
- The patient must be between 5 weeks and 1 year of age
- The patient must weigh at least 2 kg
- The provider must attest that the patient does not have any of the following contraindications to treatment:
    - 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

Lice

General Prior Authorization Form

Category Criteria:

- The patient must have had a 28-day/2-application trial of each preferred agent, as evidenced by paid claims or pharmacy printouts (not required *in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent).*

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
LICE KILLING SHAMPOO (piperonyl butoxide/pyrethrins)	CROTAN (Crotamiton)
NATROBA (spinosad)	ELIMITE (permethrin) CREAM
NIX 1% (Permethrin) CRÈME RINSE LIQUID	EURAX (crotamiton)
Permethrin 5% cream	Malathion
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID	OVIDE (malathion)
	SKLICE (ivermectin)
	Spinosad

Steroids - Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Non-preferred Step 1 agents (not labeled as "STEP 2"):**
  - The 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, as evidenced by paid claims or pharmacy printouts
- **Non-preferred agents labeled as "STEP 2":**
  - The 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

Endocrinology

Diabetes

DPP4-Inhibitors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- One of the following must be met (A OR B):
  A. The requested agent is a combination product containing metformin
  B. The patient is currently stable on a metformin-containing agent, with good compliance in the past 3 months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial with EACH of the following agents, as evidenced by paid claims or pharmacy printouts:
  - A preferred sitagliptin product (Janumet, Janumet XR, or Januvia)
  - A preferred linagliptin preferred product (Jentadueto or Tradjenta)
  - Victoza

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
JANUMET (sitagliptin/metformin)	alogliptan/pioglitizone
JANUMET XR (sitagliptin/metformin)	alogliptin
JANUVIA (sitagliptin)	alogliptin/metformin
JENTADUETO (linagliptin/metformin)	JUVISYNC (sitagliptin/simvastatin)
JENTADUETO XR (linagliptin/metformin)	KAZANO (alogliptin/metformin)
TRADJENTA (linagliptin)	KOMBIGLYZE XR (saxagliptin/metformin)
	NESINA (alogliptin)
	ONGLYZA (saxagliptin)
	OSENI (alogliptin/pioglitazone)

DPP4-Inhibitors/SGLT2 Inhibitors Combination

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
	GLYXAMBI (Empagliflozin/linagliptin)
	STEGLUJAN (Ertugliflozin/Sitagliptin)
	QTERN (Dapagliflozin/Saxagliptin)

GLP-1 Agonists

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient is currently stable on a metformin-containing agent, with good compliance in the past 3 months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of each GLP-1 agonist of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
VICTOZA (liraglutide)	ADLYXIN (lixisenatide)
BYDUREON (exenatide microspheres)	BYDUREON BCISE (exenatide microspheres)
BYETTA (exenatide)	OZEMPIC (semaglutide)
	RYBELSUS (semaglutide)
	TRULICITY (dulaglutide)

Insulin/GLP-1 Agonist Combination

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
	SOLIQUA (Insulin glargine/lixisenatide)
	XULTOPHY (insulin degludec/liraglutide)

Insulin

Insulin Prior Authorization Form

Group Criteria:

- **Non-preferred insulins:**
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- **Syringe/Pens:**
  - Clinical justification must be provided explaining why the patient is unable to use the preferred insulin vial/pen products (subject to clinical review).

Product Specific Criteria:

- ***Fiasp:** The patient must have had a 3-month trial of one of the following agents, as evidenced by paid claims or pharmacy printouts:
    - Novolog, Humalog, or Apidra
- ***Basaglar:** Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- ***Toujeo/Tresiba:**
    - **Initial Criteria:** Approval 6 months
        - The requested agent must be prescribed by or in consultation with an endocrinologist or diabetes specialist.
        - One of the following must be met (medical documentation of reported events must be provided):
            - The patient experiences recurrent episodes of hypoglycemia on Insulin glargine U100, insulin detemir U100, or U-500R despite adjustments to current regimen (prandial insulin, interacting drugs, meal and exercise timing).
            - The patient currently experiences inconsistent blood sugars with a basal insulin requirement of a minimum of 100 units/day for a minimum of 3 months with good compliance, as evidenced by paid claims or pharmacy print outs.
            - Clinical justification must be provided explaining why the patient needs for a smaller volume of insulin (max is 80 units/injection for both Insulin glargine 300 units/mL and 100 units/mL. Patients using Insulin glargine 300 unit/mL may require more basal insulin than those receiving 100 units/mL).
        - **If dose is >200 units of insulin per day**, clinical justification must be provided explaining why the patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin).
    - **Renewal Criteria:** Approval 12 months
        - The patient must have experienced at least one of the following, as evidenced by provided clinical notes or labs:
            - Reduction in frequency and/or severity of hypoglycemia
            - Improved glycemic control (A1C)
            -

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG (insulin lispro) VIAL	AFREZZA (insulin regular, human)
HUMALOG (insulin lispro) CARTRIDGE	BASAGLAR KWIKPEN U-100 (insulin glargine)***
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) FLEXTOUCH***
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL***
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	Insulin lispro vial
HUMULIN R (insulin regular, human) VIAL	Insulin lispro syringe
HUMULIN R U-500 (insulin regular, human) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)
LANTUS (insulin glargine) SOLOSTAR	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN
LANTUS (insulin glargine) VIAL	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

LEVEMIR (insulin detemir) VIAL	HUMALOG U-100 (insulin lispro) KWIKPEN
LEVEMIR (insulin detemir) FLEXTOUCH	HUMALOG U-200 (insulin lispro) KWIKPEN
NOVOLIN R (insulin regular, human) VIAL	HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN
NOVOLOG (insulin aspart) CARTRIDGE	HUMULIN N (insulin NPH human isophane) VIAL
NOVOLOG (insulin aspart) FLEXPEN	HUMULIN N (insulin NPH human isophane) KWIKPEN
NOVOLOG (insulin aspart) VIAL	HUMULIN R (Insulin regular, human) U-500 KWIKPEN
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN – Labeler 00002	NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN – Labeler 00169
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
	NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
	NOVOLIN N (insulin NPH human isophane) VIAL
	TOUJEO MAX SOLOSTAR (insulin glargine)***
	TOUJEO SOLOSTAR (insulin glargine)***
	TRESIBA (insulin degludec) FLEXTOUCH U-100***
	TRESIBA (insulin degludec) FLEXTOUCH U-200***
	TRESIBA (insulin degludec) VIAL***

Rosiglitazone

General Prior Authorization Form

Product Specific Criteria:

- The patient must have failed a 30-day trial of pioglitazone, as evidenced by paid claims or pharmacy printouts
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents and other classes of medication (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Pioglitazone	Rosiglitazone

SGLT2 Inhibitors

General Prior Authorization Form

Group PA Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient is currently stable on a metformin-containing agent, with good compliance in the past 3 months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of an empagliflozin agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Steglatro/Steglatromet:** The patient must have had a 30-day trial of each of the following, as evidenced by paid claims or pharmacy printouts: a dapagliflozin agent AND a canagliflozin agent.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
JARDIANCE (empagliflozin)	FARXIGA (dapagliflozin)
SYNJARDY (empagliflozin/metformin)	INVOKANA (canagliflozin)
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET (canagliflozin)

	INVOKAMET XR (canagliflozin/metformin)
	STEGLATRO (ertugliflozin)***
	STEGLATROMET (ertugliflozin/metformin)***
	XIGDUO XR (dapagliflozin/metformin)

Sulfonylureas

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial of glipizide, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents and other classes of medication (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Glimepiride	Glyburide
Glipizide	Glyburide/Metformin
Glipizide/Metformin	
Glipizide ER	

Growth Hormone

Prior Authorization Form - Growth Hormone

Group Criteria:

- Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone.
    - Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone.
- **For Initial or Renewal Requests:**
    - Patient must have a diagnosis of a **covered indication** (listed below):
        - Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
        - Turner's syndrome
        - SHOX syndrome
        - Noonan syndrome
        - Chronic renal insufficiency
        - Prader–Willi syndrome
        - Endogenous growth hormone deficiency
    - For all covered indications:
        - Patient must not have active malignancy
        - Prescriber must be an endocrinologist or nephrologist, or prescriber must have at least one annual consultation about the patient with the pediatric specialty.
        - Patient must not have epiphyseal closure and must still be growing, unless one of the below exceptions is present:
            - Exceptions:
                - Patient has a diagnosis of Prader-Willi syndrome
                - Patient has a diagnosis of endogenous growth hormone deficiency - and is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose.
    - Diagnosis of chronic renal insufficiency (additional criteria):
        - Patient must not have received a renal transplant.

        - Patient must consult with a dietitian to maintain a nutritious diet.
    - Diagnosis of Prader–Willi syndrome (additional criteria):
        - Sleep apnea must be ruled out by sleep study in obese patients.
        - Patient must consult with a dietitian to maintain a nutritious diet.
- **Additional Criteria for Initial Authorization Requests:**
    - Diagnosis of endogenous growth hormone deficiency:
        - Must meet ONE of below criteria (A OR B)
            A. Patients with multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation) must have an IGF-1 or IGFBP-3 level of less than SDS 1.3.
            B. Patient must have had two GH stimulation tests by insulin, levodopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart

- **Additional Criteria for Subsequent Authorization**
    - For all covered indications:
        - Patient must have been compliant with growth hormone (last 6 fills must have been on time).
    - Diagnosis of Prader–Willi syndrome (additional criteria):
        - If patient is obese, BMI must have decreased. If patient is not obese, BMI must have maintained or decreased.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
GENOTROPIN (somatropin)	HUMATROPE (somatropin)
GENOTROPIN MINIQUICK (somatropin)	NUTROPIN AQ (somatropin)
NORDITROPIN FLEXPRO (somatropin)	OMNITROPE (somatropin)
	SAIZEN (somatropin)
	ZOMACTON (somatropin)

Serostim

Prior Authorization Form - Growth Hormone

Product Specific Criteria (Initial):

- Patient must have a diagnosis of treatment of HIV with wasting cachexia
- Patient must not have an active malignancy
- 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, as evidenced by paid claims or pharmacy Printouts

Product Specific Criteria (Renewal):

- 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

Zorbtive

Prior Authorization Form - Growth Hormone

Product Specific Criteria:

- Patient must not have active malignancy

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

Pituitary Suppressants

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ELIGARD (leuprolide)	
LUPRON DEPOT (leuprolide)	
SUPPRELIN LA (histrelin)	
SYNAREL (nafarelin)	
TRESTAR (triptorelin)	
TRIPTODUR (triptorelin)	
VANTAS (histrelin)	
ZOLADEX (goserelin)	

Gastrology

Constipation – Irritable Bowel Syndrome/Opioid Induced

Category PA Criteria:

- The patient must be 18 years of age or older.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Idiopathic Constipation

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Amitiza and Linzess

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone)	LINZESS (linaclotide) 72 mcg
LINZESS (linaclotide) 145 mcg, 290 mcg	MOTEGRITY (prucalopride)
	TRULANCE (plecanatide)
	ZELNORM (Tegaserod)

Opioid-Induced Constipation:

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must be currently receiving an opioid agent, as evidenced by paid claims or pharmacy printouts.
- The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Amitiza and Movantik

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone)	RELISTOR (methylnaltrexone) TABLET
MOVANTIK (naloxegol)	SYMPROIC (naldemedine)
RELISTOR (methylnaltrexone) SYRINGE	
RELISTOR (methylnaltrexone) VIAL	

Diarrhea – Irritable Bowel Syndrome

General Prior Authorization Form

Non-Preferred Agents Criteria:

- Patient must be 18 years of age or older.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Alosetron**: The patient must be a female.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Dicyclomine Capsule	Alosetron***
Dicyclomine Tablet	Dicyclomine Oral Syrup
LOTRONEX (alosetron)***	
VIBERZI (eluxadoline)	
XIFAXIN (rifaximin) 550 mg tablet	

Digestive Enzymes

General Prior Authorization Form

Non-Preferred Agents Criteria:

- A 30-day trial of all PREFFERED AGENTS (no PA required) will be required before a non-preferred agent will be authorized unless patient stable on a pancreatic enzyme written by a gastroenterologist or pancreas disease specialist

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)
ZENPEP (lipase/protease/amylase)	PANCRELIPASE (lipase/protease/amylase)
	PERTZYE (lipase/protease/amylase)
	VIOKACE (lipase/protease/amylase)

Nausea/Vomiting

Chemo Induced

Prior Authorization Form - Nausea/Vomiting

Non-Preferred Agents Criteria: *Approval Duration = 6 months or until last day of chemotherapy*

- The patient must have diagnosis of nausea and/or vomiting
- Prescriber must be an oncologist
- The patient must be receiving a moderately or highly emetogenic chemotherapy
- The final date of chemotherapy treatment must be provided with the request
- Patient must have failed a 3-day trial of each preferred product(s) in the same class within the last 6 months as evidenced by paid claims or pharmacy print outs
- Patient must not have failed preferred chemical entity with same active ingredient as requested product due to side effects

Product Specific Criteria:

- **Syndros**

- The patient must have one of the following diagnoses and meet required trial for their diagnosis:
  - Loss of appetite due to HIV/AIDS:
    - The 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:
    - The patient must have tried and failed a 3-day trial of ondansetron ODT in combination with aprepitant suspension and a glucocorticoid, as evidenced by paid claims or pharmacy printouts

NK1 RECEPTOR ANTAGONISTS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
VARUBI (Rolapitant) TABLET	AKYNZEO (Netupitant/Palonosetron)
	Aprepitant Capsule
	EMEND (Aprepitant) CAPSULE
	EMEND (Aprepitant) SUSPENSION
5-HT3 RECEPTOR ANTAGONISTS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Granisetron tablet	AKYNZEO (Netupitant/Palonosetron)
Ondansetron ODT	SANCUSO (Granisetron) PATCH
Ondansetron solution	ZOFRAN (Ondansetron) TABLET
Ondansetron tablet	ZUPLENZ (Ondansetron) FILM
CANNABINOIDS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Dronabinol Capsule	CESAMET (Nabilone) CAPSULE
	MARINOL (Dronabinol) CAPSULE
	SYNDROS (Dronabinol) SOLUTION

Pregnancy

Prior Authorization Form - Nausea/Vomiting

Non-Preferred Agents Criteria: *Approval Duration = 3 months or until due date*

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DICLEGIS (doxylamine/vitamin B6) – *Brand Required*	BONJESTA (doxylamine/vitamin B6)
meclizine	Doxylamine/Vitamin B6
metoclopramide	
ondansetron	

Proton Pump Inhibitor

Solid Dosage Forms

General Prior Authorization Form

Group Criteria: *Approval Duration = 6 months*

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Non-Preferred Agents Criteria: Step 1 Agents (Esomeprazole Magnesium, Lansoprazole 15mg, rabeprazole):

- Patient must have failed a 25-day trial of at least one of the preferred or Step 1 Solid Dosage Form agents in the past 90 days, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria: Step 2 Agents (Esomeprazole strontium, Esomeprazole magnesium/glycerin, Omeprazole-sodium bicarbonate):

- Clinical justification must be provided explaining why the patient is unable to use the other agents (subject to clinical review).

SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
DEXILANT (dexlansoprazole)	Esomeprazole magnesium	Esomeprazole magnesium/glycerin
Lansoprazole 30mg	Lansoprazole 15mg	Esomeprazole strontium
omeprazole	Rabeprazole	NEXIUM (esomeprazole)
pantoprazole		Omeprazole-Sodium bicarbonate
		PREVACID (Lansoprazole)
		PRILOSEC (Omeprazole)
		PROTONIX (Pantoprazole)

Non-Solid Dosage Forms

General Prior Authorization Form

Group Criteria: *Approval Duration = 6 months*

Non-Preferred Agents Criteria:

- The patient must have feeding tube in place
- The patient must have failed a 30-day trial of all Preferred Non-Solid Dosage form agents (Nexium Packet and Protonix Packet) in the past 2 years, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- **Prilosec Packet:**
  - The patient must have had a 30-day trial of lansoprazole ODT in the past 2 years, as evidenced by paid claims or pharmacy printouts
- **Omeprazole-sodium bicarbonate packet/Aciphex Sprinkle:**
  - Clinical justification must be provided explaining why the patient is unable to use the other proton-pump inhibitor agents (subject to clinical review)

NON-SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
NEXIUM (esomeprazole) PACKET	Lansoprazole 15mg ODT	ACIPHEX SPRINKLE (rabeprazole)
PROTONIX (pantoprazole) PACKET	PRILOSEC PACKET (omeprazole)	Lansoprazole 30mg ODT
		Omeprazole-sodium bicarbonate packet
		PREVACID (Lansoprazole) SOLUTAB

Vancomycin - Oral

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 5 days*

- The patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- The patient must be 18 years of age or older
- The patient must have failed a 10-day trial with vancomycin, as evidenced by paid claims or pharmacy printouts
- Request must be for treatment of the first recurrence for a patient whose initial episode was treated with Dificid

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FIRVANQ (vancomycin) SOLUTION	DIFICID (fidaxomicin) TABLET
Vancomycin capsule	VANCOCIN (vancomycin) CAPSULE

Genetic and Rare Disease

Cystic Fibrosis Inhaled Antibiotics

General Prior Authorization Form

Product Specific Criteria:

- ***Tobramycin:
  - The patient must be stable on tobramycin, as evidenced by a paid claim or pharmacy printouts in the past 75 days
- ***Tobi Podhaler:
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
  - The patient must have had a 28-day trial of a preferred nebulized product, as evidenced by paid claims or pharmacy printouts.
- ***Cayston:
  - The patient must be colonized with *Pseudomonas aeruginosa.*
  - The patient must have had a 28-day trial of TOBI Podhaler, as evidenced by paid claims or pharmacy printouts.
- ***Arikayce:
  - The patient must be colonized with *Mycrobacterium avium* complex (MAC).
  - The patient must have not achieved negative sputum cultures after a minimum duration of 6 consecutive months of background treatment with a macrolide, a rifamycin, and ethambutol.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BETHKIS (Tobramycin)	ARIKAYCE (Amikacin/Nebulizer) ***
KITABIS PAK (Tobramycin/Nebulizer) (*Brand Preferred)*	CAYSTON (Aztreonam)***
TOBI PODHALER (Tobramycin) ***	TOBI (Tobramycin)
	Tobramycin***
	Tobramycin/Nebulizer

Hereditary Angioedema

General Prior Authorization Form

Category Criteria:

- The patient must have diagnosis of hereditary angioedema, confirmed by a specialist.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BERINERT (C1 Esterase Inhibitor)	
CINRYZE (C1 Esterase Inhibitor)	
FIRAZR (Icatibant)	
HAEGARDA (C1 Esterase Inhibitor)	
KALBRITOR (Ecallantide)	
RUCONEST (C1 Esterase Inhibitor)	
TAKHZYRO (Lanadelumab-FLYO)	

Idiopathic Pulmonary Fibrosis

Prior Authorization Form - Idiopathic Pulmonary Fibrosis

Category Criteria:

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

Product Specific Criteria

- **Alternative Ofev Products:**
  - The patient must have documented diagnosis of systemic sclerosis-associated interstitial lung disease

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ESBRIET (Pirfenidone)	
OFEV (Nintedanib)	

Phenylketonuria

Kuvan:

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 2 months*

- The patient must have a diagnosis of hyperphenylalaninemia
- The patient must be following a PHE restricted diet
- The patient's weight must be provided
- The patient must be 4 years of age or older
- The 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

Criteria for renewal requests: *Approval Duration = 12 months*

- The 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
  - The 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:

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 6 months*

- The patient must have a diagnosis of hyperphenylalaninemia
- The patient must be following a PHE restricted diet
- The patient must be 18 years of age or older

- PHE levels must be above 600 micromoles/liter
- The patient must have been compliant with diet and medication management for past 6 months.

Criteria for renewal requests: *Approval Duration = 12 months*

- **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 40 mg:**
  - PHE levels must be attached that were taken after 24 weeks of 20 mg
  - The patient's PHE level must be greater than 360 micromoles per liter

Immunology

Biosimilar Agents

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

Cytokine Modulators

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 3-month trial of 2 preferred cytokine modulator agents, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Stelara, Skyrizi:**
  - The patient must have had a 3-month trial of 1 non-preferred agent, as evidenced by paid claims or pharmacy printouts.

ANKYLOSING SPONDYLITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	SIMPONI (golimumab)
HUMIRA (adalimumab)	TALTZ (ixekizumab)
BEHCET'S SYNDROME	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	OTEZLA (apremilast)
CHRONIC INFANTILE NEUROLOGICAL, CUTANEOUS AND ARTICULAR SYNDROME	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
KINERET (anakinra)	
CROHN'S DISEASE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	CIMZIA (certolizumab)
	STELARA (ustekinumab)***
CYTOKINE RELEASE SYNDROME	

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ACTEMRA (tocilizumab)	
GIANT CELL ARTERITIS	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
HIDRADENITIS SUPPURATIVA	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	
NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	CIMZIA (certolizumab)
PLAQUE PSORIASIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	OTEZLA (apremilast)
HUMIRA (adalimumab)	SILIQ (brodalumab)***
	SKYRIZI (risankizumab-rzaa)***
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	TREMFYA (guselkumab)***
PSORIATIC ARTHRITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	ORENCIA (abatacept)
HUMIRA (adalimumab)	OTEZLA (apremilast)
	SIMPONI (golimumab)
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
RHEUMATOID ARTHRITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
COSENTYX (secukinumab)	ACTEMRA (tocilizumab)
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	RINVOQ (upadacitinib)
	SIMPONI (golimumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
SCHNITZLER SYNDROME	
PREFFERED AGENTS (PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
KINERET (anakinra)	
ULCERATIVE COLITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	SIMPONI (golimumab)

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

	STELARA (ustekinumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
UVEITIS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	

Dupixent

Prior Authorization Form - Dupixent

Asthma

Click to Jump to Criteria

Eczema

Click to Jump to Criteria

Chronic Rhinosinusitis

General Prior Authorization Form

Initial Criteria: *Approval Duration = 3 months*

- The patient must meet label recommendations for indication and age.
- Diagnosis has been confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)
- The patient must still be experiencing inflammation of paranasal sinuses after 12 weeks of treatment with intranasal or oral corticosteroids and nasal saline irrigations, as evidenced by paid claims or pharmacy printouts.

Renewal Criteria: *Approval Duration = 9 months*

- The prescriber must provide documentation showing that the patient has achieved a significant reduction in systemic or intranasal corticosteroids and reduction in inflammation.

Eosinophilic Asthma

Prior Authorization Form – Eosinophilic Asthma

Category Criteria (Initial): *Approval Duration = 3 months*

- The patient must meet label recommendations for indication and age.
- The patient must have had 2 or more asthma exacerbations in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) or long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts
- One of the following must be met (A or B):
    A. The patient must have baseline eosinophil level of ≥ 300 cells/mcL within past 12 months
    B. The patient must have oral corticosteroid dependent asthma and has required at least 30 days of oral steroid use in past 120 days, as evidenced by paid claims or pharmacy printouts

Category Criteria (Renewal): *Approval Duration = 3 months*

- The prescriber must provide documentation showing that the patient has achieved a significant reduction in asthma exacerbations and utilization of rescue medications since treatment initiation

PREFERRED AGENTS	NON-PREFERRED AGENTS
DUPIXENT (Dupilumab)	
FASENRA (Benralizumab)	

NUCALA (Mepolizumab)	

Epinephrine

General Prior Authorization Form

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Epinephrine – Labeler 49502	Epinephrine – Labeler 00935
SYMJEPI (Epinephrine)	Epinephrine – Labeler 11516
	EPIPEN (Epinephrine)
	EPIPEN (Epinephrine) JUNIOR

Gout

General Prior Authorization Form

Category Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Uloric:**
  - The patient must have had a 30-day trial of allopurinol, as evidenced by paid claims or pharmacy printouts

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Allopurinol Tablet	COLCRYS (Colchicine) TABLETS
Colchicine Capsules	Febuxostat
Colchicine Tablets	MITIGARE (Colchicine) CAPSULE
Probenecid-Colchicine Tablets	ULORIC (Febuxostat) TABLET
Probenecid Tablets	ZYLOPRIM (Allopurinol) TABLET

Immune Globulins

Prior Authorization Form - Immune Globulins

Non-Preferred Agents Criteria:

- If the patient's BMI > 30, adjusted body weight must be provided along with the calculated dose
- The patient must have a diagnosis of an FDA-approved indication for use
- The 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:**
  - The patient must be intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA)
- **Cutaquig, Cuvitru, Hizentra, Hyqvia or Xembify:**
  - The patient must be unable to tolerate IV administration
  - The patient must have failed a trial of at least two of the following, as evidenced by paid claims or pharmacy printouts:
    - Gamunex-C
    - Gammaked
    - Gammagard
- **Other Products:**

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

- The patient must have failed a trial of at least two of the following, as evidenced by paid claims or pharmacy printouts:
    - Gammagard
    - Gamunex-C
    - Privigen

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BIVIGAM (human immunoglobulin gamma)	CUTAQUIG (human immune globulin G solution)
FLEBOFAMMA DIF (human immunoglobulin gamma)	CUVITRU (human immunoglobulin gamma)
GAMANEX-C (human immunoglobulin gamma)	GAMMAGARD S-D (human immunoglobulin gamma)
GAMASTAN S-D	HIZENTRA (human immunoglobulin gamma)
GAMMAGARD LIQUID (human immunoglobulin gamma)	HYQVIA (human immune globulin G and hyaluronidase)
GAMMAKED (human immunoglobulin gamma)	XEMBIFY (human immune globulin-klhw)
GAMMAPLEX (human immunoglobulin gamma)	
OCTAGAM (human immunoglobulin gamma)	
PANZYGA (Immune Globulin- IFAS)	
PRIVIGEN (human immunoglobulin gamma)	

Steroids - Nasal

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial (within the past 2 years) of 1 preferred agent, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- ***Xhance (fluticasone) and Zetonna (ciclesonide):**
    - Clinical justification must be provided explaining why the patient is unable to use another product with the same active ingredient (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BECONASE AQ (beclomethasone)	flunisolide
Fluticasone	mometasone
QNASL (beclomethasone)	OMNARIS (ciclesonide)
	QNASL CHILDREN'S (beclomethasone)
	XHANCE (fluticasone)***
	ZETONNA (ciclesonide)***

Ulcerative Colitis Agents

General Prior Authorization Form

Category PA Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Oral

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
APRISO (mesalamine) CAPSULE	AZULFIDINE (sulfasalazine)
ASACOL HD (mesalamine)	AZULFIDINE DR (sulfasalazine)

Balsalazide capsule	COLAZAL (balsalazide)
DELZICOL (mesalamine) CAPSULE	Mesalamine DR
DIPENTUM (olsalazine)	Mesalamine HD
LIALDA (mesalamine) TABLET	SULFAZINE (sulfasalazine)
PENTASA (mesalamine)	
Sulfasalazine DR tablet	
Sulfasalazine tablet	

Rectal

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Mesalamine enema	CANASA (mesalamine) RECTAL SUPPOSITORY
Mesalamine rectal suppository	Mesalamine enema kit
	ROWASA (mesalamine) ENEMA KIT
	SF ROWASA (mesalamine) ENEMA
	UCERIS (budesonide) RECTAL FOAM

Infectious Disease

Antimalarial Agents

General Prior Authorization Form

Group Criteria:

- The request must be for TREATMENT of malaria (*NOT covered for prophylaxis)*

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
daraprim	ARAKODA (tafenoquine)
hydroxychloroquine	atovaquone/proguanil
quinine	chloroquine
	COARTEM (artemether/lumefantrine)
	KRINTAFEL (tafenoquine)
	MALARONE (atovaquone/proguanil)
	mefloquine
	primaquine
	QUALAQUIN (Quinine)

Human Immunodeficiency Virus (HIV)

Serostim - Wasting Cachexia

Dronabinol/Syndros - Loss of Appetitie

Antiretrovirals

Category Criteria:

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Integrase Strand Transfer Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	
DOVATO (Dolutegravir/Lamivudine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
ISENTRESS (raltegravir)	
JULUCA (dolutegravir/rilpivirine)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
TIVICAY (dolutegravir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	

Non-Nucleoside Reverse Transcriptase Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ATRIPLA (Efavirenz/Emtricitabine/Tenofovir)	SUSTIVA (Efavirenz)
COMPLERA (Emtricitabine/Rilpivirine/tenofovir)	VIRAMUNE (Nevirapine)
EDURANT (Rilpivirine)	VIRAMUNE XR (Nevirapine)
Efavirenz	
Etravirine	
INTELENCE (Etravirine)	
JULUCA (dolutegravir/rilpivirine)	
Nevirapine	
Nevirapine ER	
ODEFSEY (Emtricitabine/Rilpivirine/Tenofovir)	
PIFELTRO (Doravirine)	
Rilpivirine	
SYMFI (efavirenz/lamivudine/tenofovir)	
SYMFI LO (efavirenz/lamivudine/tenofovir)	

Nucleoside Reverse Transcriptase Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Abacavir	COMBIVIR (lamivudine/zidovudine)
Abacavir/lamivudine	EPIVIR (lamivudine)
Abacavir/lamivudine/zidovudine	EPZICOM (abacavir)
ATRIPLA (efavirenz/emtricitabine/tenofovir)	RETROVIR (zidovudine)
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	TRIZIVIR (abacavir/lamivudine)
CIMDUO (lamivudine/tenofovir)	VIDEX EC (didanosine)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	VIREAD (tenofovir)
DELSTRIGO (doravirine/lamivudine/tenofovir)	ZERIT (stavudine) CAPSULE
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)
Didanosine	
EMTRIVA (emtricitabine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
Lamivudine	
Lamivudine/zidovudine	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
SYMFI (efavirenz/lamivudine/tenofovir)	
SYMFI LO (efavirenz/lamivudine/tenofovir)	
Stavudine	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
Tenofovir	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

TRUVADA (emtricitabine/tenofovir)	
VIDEX (didanosine)	
Zidovudine	

Post-Attachment Inhibitor

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
TROGARZO (Ibalizumab-uiyk)	

Protease Inhibitor

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir) SOLUTION
Atazanavir	LEXIVA (Fosamprenavir)
CRIXIVAN (indinavir)	REYATAZ (atazanavir) CAPSULE
EVOTAZ (atazanavir/cobicistat)	Ritonavir
Fosamprenavir	
INVIRASE (saquinavir)	
KALETRA (lopinavir/ritonavir) TABLET	
Lopinavir/ritonavir solution	
NORVIR (ritonavir)	
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
REYATAZ (atazanavir) POWDER PACK	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
VIRACEPT (nelfinavir)	

Lipodystrophy – Growth Hormone-Releasing Hormone Analogue

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
EGRIFTA (Tesamorelin)	

Hepatitis C Treatments

Prior Authorization From – Hepatitis C

Category Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Chronic Hepatitis C must be documented by one of the following:
  - **Liver fibrosis F1 and below**: 2 positive HCV RNA levels at least 6 months apart.
  - **Liver fibrosis F2 and above**: 1 positive HCV RNA test within the last 12 months.
- The patient must be drug (illicit use of drugs by injection) and alcohol free as documented by 2 drug and alcohol tests dated at least 3 months apart and meet criteria as outlined below:
  - **If the patient has a history of alcohol use disorder**, the patient must have abstained from alcohol for at least 12 months OR patient must:
    - have abstained from alcohol for at least 3 months AND
    - be receiving treatment from an enrolled provider and agree to abstain from alcohol during treatment AND
    - be under the care of an addiction medicine/chemical dependency treatment provider and the provider attests the patient has abstained from alcohol use for at least 3 months
  - **If the patient has a history of illicit use of drugs by injection**, the patient must have abstained from drug use for at least 12 months OR patient must:
    - have abstained from drug use for at least 3 months AND
    - be receiving treatment from an enrolled provider and agree to abstain from said drug use during treatment AND
    - be under the care of an addiction medicine/chemical dependency treatment (or buprenorphine waived provider) provider and the provider attests the patient agrees to abstain from drug use for at least 3 months

- The patient must not be receiving a known recreationally used high risk combination of drugs (e.g. "the holy trinity") for the past 6 months.
- Patient must attest that they will continue treatment without interruption for the duration of therapy.
- Prescriber must be, or consult with, a hepatology, gastroenterology, or infectious disease specialist.
- Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.
- Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling maintenance medications on time as shown in the prescription medication history for the past 6 months.
- Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment.
- Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
- HCV RNA level must be taken on week 4 and sent with a renewal request for any duration of treatment 12 weeks or longer.
- PA approval duration will be based on label recommendation.

Product Specific Criteria:

- ***Epclusa:**
  - Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B C).
- ***Mavyret/Vosevi:**
  - Patient must not have decompensated cirrhosis (Child-Pugh B or Child-Pugh C).

Non-Preferred Agents Criteria:

- The patient must have had a trial of each preferred treatment options indicated for the patient's genotype, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
EPCLUSA (sofosbuvir/velpatasvir) *Brand Preferred****	HARVONI (ledipasvir/sofosbuvir)
MAVYRET (glecaprevir/pibrentasvir)***	Ledipasvir/sofosbuvir
	Sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir)
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)***
	ZEPATIER (elbasvir/grazoprevir)

Antibiotics - Resistance Prevention

Prior Authorization Form – Antibiotics – Resistance Prevention

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 5 days*
  - Patient must have an FDA-approved indication for use (meets label recommendations for diagnosis & age)
    - Diagnosis must be proven to be caused by a susceptible microorganism by culture and susceptibility testing
  - Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol.
  - One of the following criteria must be met (A or B)
    - A. Prescriber must provide evidence-based medical justification for use, explaining why a preferred antibiotic is not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
    - B. The patient is continuing treatment upon discharge from an acute care facility

- **Renewal Criteria:** *Approval Duration = 5 days*
    - Prescriber must attest that the patient's condition is improving and that it is medically necessary to continue treatment course after re-evaluation of the patient's condition.
    - The total requested duration of use must not be greater than manufacturer labeling or treatment guideline recommendations (whichever is greater).

Community-Acquired Pneumonia

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amoxicillin	BAXDELA (Delafloxacin)
Amoxicillin-Clavulanate	FACTIVE (Gemifloxacin)
Azithromycin	XENLETA (Lefamulin)
Cefpodoxime	
Cefuroxime	
Clarithromycin	
Doxycycline	
Levofloxacin	
Linezolid	
Moxifloxacin	

Methicillin-Resistant *Staphylococcus aureus* (MRSA):

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Clindamycin	BAXDELA (Delafloxacin)
Doxycycline	NUZYRA (Omadacycline)
Linezolid	SIVEXTRO (Tedizolid)
Minocycline	
Trimethoprim-Sulfamethoxazole	

Antifungals - Aspergillius and Candidiasis Infections

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 2 weeks*

- The request must be for use as prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- The patient must have documented history of failure to all preferred agents in last 30-days, as evidenced by paid claims or pharmacy printouts

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Clotrimazole	DIFLUCAN (Fluconazole)
CRESEMBA (Isavuconazonium)	NOXAFIL (posaconazole)
Fluconazole	SPORANOX (Itraconazole)
Itraconazole	TOLSURA (itraconazole)
Nystatin	VFEND (Voriconazole)
ORAVIG (miconazole)	
Voriconazole	

Men's Health

Androgens

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

Injectable/Implantable

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Testosterone Cypionate injection	AVEED (Testosterone Undecanoate)
Testosterone Enanthate injection	DEPO-TESTOSTERONE (Testosterone Cypionate)
	TESTOPEL (Testosterone)
	XYOSTED (Testosterone Enanthate)

Oral

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
	ANDROID (Methyltestosterone)
	Methyltestosterone
	METHITEST (Methyltestosterone)
	STRIANT (Testosterone)
	TESTRED (Methyltestosterone)

Topical

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ANDRODERM (testosterone) PATCH	ANDROGEL (testosterone)
Testosterone 1% gel packet	AXIRON (testosterone) TOPICAL SOLUTION
Testosterone 1% gel tube	FORTESTA (testosterone) 2% Gel MD PMP CANISTER
Testosterone 12.5/1.25G gel MD PMP Bottle	TESTIM (testosterone) GEL TUBE
	Testosterone 2% Gel MD PMP Canister
	Testosterone 20.25/1.25G Gel MD PMP Bottle
	Testosterone 1.25G-1.62% Gel Packet
	Testosterone 2.5G-1.62% Gel Packet
	VOGELXO (Testosterone)

Benign Prostatic Hyperplasia

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have diagnosis of benign prostatic hyperplasia (BPH)
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
alfuzosin ER	AVODART (Dutasteride)
CARDURA XL (doxazosin)	CARDURA (Doxazosin)
doxazosin	FLOMAX (Tamsulosin)

dutasteride	MINIPRESS (Prazosin)
finasteride	PROSCAR (Finasteride)
prazosin	sildenafil
RAPAFLO (silodosin) – *brand required*	tadalafil
tamsulosin	
terazosin	

Nephrology/Urology

Hematopoietic, Erythropoiesis Stimulating Agents

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 4-week trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ARANESP (darbepoetin alfa)	EPOGEN (epoetin alfa)
PROCRIT (epoetin alfa)	MIRCERA (methoxy polyethylene glycol-epoetin beta)
	RETACRIT (epoetin alfa - epbx)

Hyperkalemia

Prior Authorization Form - Hyperkalemia

Group Criteria:

- **Initial criteria**: *Approval Duration = 3 months*
  - The patient must be 18 years of age or older.
  - Medication must be prescribed by, or in consultation with, a nephrologist
  - The patient's current serum potassium level must be exceeding the upper limit of normal, as evidenced by documentation from at least two separate lab values, submitted with the request
  - The patient must not have gastrointestinal motility disorders (e.g. severe constipation, bowel obstruction or impaction, abnormal postoperative bowel motility disorders)
  - One of the following criteria must be met:
    - The patient must have failed 30-day trials with at least two of the following products
      - Bumetanide, Chlorothiazide, Fludrocortisone, Furosemide, Hydrochlorothiazide, Indapamide, Metolazone, Torsemide
  - The patient must not be receiving the medications known to cause hyperkalemia listed below, OR medical justification must be provided explaining why discontinuation of these agents would be clinically inappropriate in this patient:
    - angiotensin-converting enzyme inhibitor
    - angiotensin II receptor blocker
    - aldosterone antagonist
    - nonsteroidal anti-inflammatory drugs (NSAIDs)
- **Renewal Criteria:** *Approval Duration = 6 months*

- The patient's current serum potassium level is within normal limits or has been significantly reduced from baseline, as evidenced by lab documentation submitted with the request

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
LOKELMA (Sodium Zirconium Cyclosilicate)	VELTASSA (Patiromer)

Interstitial Cystitis

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Duration of Approval = 3 Months*
  - The prescriber must attest that all other potential causes for bladder pain/discomfort have been ruled out.
  - The patient must have a diagnosis of pain or discomfort due to interstitial cystitis.
  - The patient must be 16 years of age or older.
  - The patient must have not experienced adequate symptom relief after implementing self-care practices and behavior modification (e.g. avoiding food/beverages and activities that exacerbate symptoms, fluid management, etc).
  - The patient must have failed a 30-day trial of amitriptyline, as evidenced by paid claims or pharmacy printouts.
- **Renewal Criteria:** *Duration of Approval = 12 months*
  - The patient must have experienced a significant reduction in bladder pain/discomfort since initiating therapy (supported by clinical documentation).

PREFFERED AGENTS (PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amitriptyline	ELMIRON (Pentosan Polysulfate Sodium)

Phosphate Binders

General Prior Authorization Form

Category Criteria:

- The patient must have had 30-day trials of at least 3 preferred agents of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.
- The patient must have a diagnosis of end-stage renal disease or chronic kidney disease.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Calcium acetate	AURYXIA (ferric citrate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET *– brand preferred*	FOSRENOL (lanthanum) POWDER PACK
PHOSLYRA (calcium acetate) ORAL solution	Lanthanum chew tab
RENVELA (sevelamer) POWDER PACK	RENAGEL (Sevelamer HCl) TABLET
Sevelamer Carbonate Tablet	RENVELA (sevelamer carbonate) TABLET
Sevelamer Powder Pack - Labeler 00955	Sevelamer HCl 400mg Tablet
	Sevelamer HCl 800mg Tablet
	Sevelamer Powder Pack - Labeler 65862, 43598
	VELPHORO (Sucroferric oxyhydroxide)

Urinary Antispasmodics

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

- The patient must have had a 30-day trial of 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***** Trospium ER:** The patient must have had a 30-day trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Trospium and tolterodine ER

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Darifenacin ER – Labeler 10370	Darifenacin ER
ENABLEX (darifenacin ER)	DETROL (tolterodine)
Flavoxate	DETROL LA (tolterodine)
GELNIQUE (oxybutynin)	DITROPAN XL (oxybutynin)
Oxybutynin ER	MYRBETRIQ (mirabegron)
Oxybutynin syrup	SANCTURA (trospium)
Oxybutynin tablet	SANCTURA ER (trospium)***
OXYTROL (oxybutynin) PATCH	Tolterodine
Solifenacin	Tolterodine ER
TOVIAZ (fesoterodine)	Trospium ER***
Trospium	VESICARE (solifenacin)

Neurology

Anticonvulsants

Group Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of 2 pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
APTIOM (Eslicarbazepine)	CARBATROL (Carbamazepine)
BANZEL (Rufinamide) ORAL SUSPENSION	DEPAKENE (Valproic acid) CAPSULE
BANZEL (Rufinamide) TABLET	DEPAKENE (Valproic acid) ORAL SOLUTION
BRIVIACT (Brivaracetam)	DEPAKOTE (Divalproex sodium) TABLET
Carbamazepine chewable tablet	DEPAKOTE ER (Divalproex sodium)
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (Divalproex sodium)
Carbamazepine oral suspension	DILANTIN (Phenytoin) CHEWABLE TABLET
Carbamazepine tablet	DILANTIN (Phenytoin) ORAL SUSPENSION
Carbamazepine XR tablet	DILANTIN ER (Phenytoin)
CELONTIN (Methsuximide)	EPITOL (Carbamazepine)
Divalproex ER	Felbamate Tablet
Divalproex sprinkle	Felbamate Oral Suspension
Divalproex tablet	KEPPRA (Levetiracetam)
Ethosuximide capsule	KEPPRA (Levetiracetam) ORAL SOLUTION
Ethosuximide oral solution	KEPPRA XR (Levetiracetam)
FELBATOL (Felbamate) (*Brand Preferred)*	LAMICTAL (Lamotrigine)
FELBATOL (Felbamate) ORAL SUSPENSION (*Brand Preferred)*	LAMICTAL (Lamotrigine) CHEWABLE TABLET
FYCOMPA (Perampanel)	LAMICTAL (Lamotrigine) DOSE PACK
FYCOMPA (Perampanel) ORAL SUSPENSION	MYSOLINE (Primidone)
Gabapentin capsule	NEURONTIN (Gabapentin) CAPSULE
Gabapentin oral solution	NEURONTIN (Gabapentin) ORAL SOLUTION
Gabapentin tablet	NEURONTIN (Gabapentin) TABLET

GABITRIL (Tiagabine) (*Brand Preferred)*	Pregabalin
LAMICTAL ER (Lamotrigine) DOSE PACK	Pregabalin oral solution
LAMICTAL ODT (Lamotrigine)	QUDEXY XR (Topiramate)
LAMICTAL ODT (Lamotrigine) DOSE PACK	TEGRETOL XR (Carbamazepine)
LAMICTAL XR (Lamotrigine)	TEGRETROL (Carbamazepine oral suspension)
Lamotrigine chewable tablet	Tiagabine
Lamotrigine dose pack	TOPAMAX (Topiramate)
Lamotrigine ER	TOPAMAX (Topiramate) SPRINKLE CAPSULE
Lamotrigine ODT	TRILEPTAL (Oxcarbazepine)
Lamotrigine tablet	TRILEPTAL (Oxcarbazepine) ORAL SUSPENSION
Levetiracetam ER	Vigabatrin
Levetiracetam oral solution	Vigabatrin powder pack
Levetiracetam tablet	VIGADRONE (Vigabatrin)
LYRICA (Pregabalin) *(Brand Preferred)*	ZARONTIN (Ethosuximide)
LYRICA (Pregabalin) ORAL SOLUTION (*Brand Preferred)*	ZARONTIN (Ethosuximide) ORAL SOLUTION
Oxcarbazepine oral solution	ZONEGRAN (Zonisamide)
Oxcarbazepine tablet	
OXTELLAR XR (Oxcarbazepine)	
PEGANONE (Ethotoin)	
Phenobarbital elixir	
Phenobarbital tablet	
PHENYTEK (phenytoin)	
Phenytoin chewable tablet	
Phenytoin ER capsule	
Phenytoin suspension	
Primidone	
SABRIL (Vigabatrin) (*Brand Preferred)*	
SABRIL (Vigabatrin) POWDER PACK (*Brand Preferred)*	
SPRITAM (Levetiracetam)	
TEGRETOL (Carbamazepine)	
Topiramate ER	
Topiramate sprinkle capsule	
Topiramate tablet	
TROKENDI XR (Topiramate)	
Valproic acid capsule	
Valproic acid oral solution	
VIMPAT (lacosamide)	
VIMPAT (lacosamide) ORAL SOLUTION	
Zonisamide	

Dementia

General Prior Authorization Form

Category PA Criteria:

- One of the following (A OR B) must be met:
  A. The patient must have a diagnosis of an FDA-approved indication for use
  B. The patient is greater than 30 years of age.
- **Non-Preferred Agents Criteria:**
  - **Branded Non-Preferred Agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
  - **Generic Non-Preferred Agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
  - **Non-Solid Dosage Forms:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Product Specific Criteria:

- ***Memantine ER**:

- The patient must have had a 30-day trial of memantine IR, as evidenced by paid claims or pharmacy printouts.
- The patient must not reside in facility with skilled nursing care.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Donepezil 5mg, 10mg Tablet	ARICEPT (donepezil)
Galantamine Tablet	Donepezil ODT
Galantamine ER	Donepezil 23mg Tablet
Memantine	EXELON (rivastigmine) PATCH
Rivastigmine Capsule	Galantamine oral solution
	Memantine oral solution
	Memantine ER
	NAMENDA (memantine)
	NAMENDA XR (memantine)
	NAMZARIC (memantine/donepezil)
	RAZADYNE (galantamine)
	RAZADYNE ER (galantamine)
	Rivastigmine patch

Emflaza

Prior Authorization Form - Emflaza

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 2 years of age or older
- The 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
- Onset of weakness must have occurred before 2 years of age
- The medication must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- The patient must have serum creatinine kinase activity of at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- The patient must have failed a 6-month trial of prednisone due to inadequate treatment response, intolerance, or contraindication, as evidenced by paid claims or pharmacy printouts
- The provider must submit baseline motor milestone score results from at least 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)
- The 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

Renewal Criteria: *Approval Duration = 12 months*

- The patient must have ONE of the following (A or B)
    A. 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

B. The 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

Headache/Migraine

Prophylaxis of Migraine – CGRP Inhibitors

Prior Authorization Form – CGRP Inhibitors

Group Criteria:

- **Initial (approval duration: 3 months):**
  - Patient must experience 4 or more migraine days per month.
  - The patient must have had 2-month trials of at least two of the following agents from different therapeutic classes, as evidenced by paid claims or pharmacy printouts:
    - amitriptyline, atenolol, divalproex sodium, metoprolol, nadolol, propranolol, timolol, topiramate, venlafaxine
  - Prescriber must submit documentation, including clinical notes regarding failure of prior treatments to reduce migraine frequency after 2-month trial.
- **Renewal:**
  - The patient must have experienced at least a 50% reduction in migraines from baseline, since starting treatment with a CGRP inhibitor.

Non-Preferred Agents Criteria:

- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AIMOVIG (Erenumab-aooe)	AJOVY (Fremanezumab-vfrm)
EMGALITY (Galcanazumab-gnlm)	

Cluster Headache – Emgality

Prior Authorization Form – CGRP Inhibitors

Initial PA Criteria: *Approval Duration: 3 months*

- Patient must meet ICHD-3 criteria for diagnosis of cluster headache
- Patient must use medication as preventative treatment during episodic cluster headache episodes, as medication is not indicated for chronic use

Renewal PA Criteria: *Approval Duration: 9 months*

- Prescriber must submit documentation indicating that the members' cluster headaches have been reduced in frequency and/or severity as a result of therapy per patient headache journal

Treatment of Migraine - Triptans - 5HT(1) Agonist

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Patients able to take oral medications:**
  - Patients 18 years old or older: The patient must have had a 30-day trial of each preferred agent within the past 24 months, as evidenced by paid claims or pharmacy printouts.

- Patients 6 to 17 years of age: The patient must have had a 30-day trial of rizatriptan within the past 24 months, as evidenced by paid claims or pharmacy printouts.

- **Patients not able to take oral medications (as evidenced by swallow study documentation):**
  - The patient must have had a 30-day trial of rizatriptan within the past 24 months, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

Cambia Powder Pack -Migraine Treatment

- ***Sumatriptan/Tosymra Nasal Spray:**
  - The patient must have had a 30-day trial of each of the following agents within the past 24 months, as evidenced by paid claims or pharmacy printouts:
    - Zomig Nasal Spray 5mg
    - Onzetra Xsail 22mg
- ***Zolmitriptan tablet:**
  - The patient must have had a 30-day trial of naratriptan 2.5 mg within the past 24 months, as evidenced by paid claims or pharmacy printouts.
- ***Sumatriptan pen/syringe/cartridge, Frovatriptan, Almotriptan, Sumatriptan/Naproxen:**
  - The patient must have had a 30-day trial of each available triptan agent within the past 24 months, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RELPAX (eletriptan) – *Brand Preferred*	Almotriptan Tablet***
Rizatriptan	ALSUMA (sumatriptan) PEN INJCTR***
Rizatriptan ODT	AMERGE (naratriptan) TABLET
Sumatriptan tablet	Eletriptan Tablet
	FROVA (frovatriptan) TABLET***
	Frovatriptan Tablet***
	IMITREX (sumatriptan) CARTRIDGE***
	IMITREX (sumatriptan) PEN INJCTR***
	IMITREX (sumatriptan) SPRAY***
	IMITREX (sumatriptan) TABLET
	IMITREX (sumatriptan) VIAL***
	MAXALT (rizatriptan) TABLET
	MAXALT MLT (rizatriptan)
	Naratriptan Tablet
	ONZETRA XSAIL (sumatriptan)
	Sumatriptan Cartridge***
	Sumatriptan Pen Injctr***
	Sumatriptan Spray***
	Sumatriptan Syringe***
	Sumatriptan Vial
	Sumatriptan/Naproxen Tablet***
	TOSYMRA (Sumatriptan) NASAL SPRAY***
	TREXIMET (Sumatriptan/Naproxen) TABLET
	ZEMBRANCE SYMTOUCH (Sumatriptan)***
	Zolmitriptan Tablet***
	Zolmitriptan ODT
	ZOMIG (zolmitriptan) TABLET***
	ZOMIG (zolmitriptan) SPRAY

	ZOMIG ODT (zolmitriptan)

Dihydroergotamine

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Non-preferred step 1 agents:**
  - The patient must have a diagnosis of migraine or cluster headache
  - Within the past 2 years, the patient must have had 30-day trials of at least two 'Preferred Agents', as evidenced by paid claims or pharmacy printouts
- **Non-preferred step 2 agents:**
  - The patient must meet criteria for Step 1 agents
  - Within the past 2 years, the patient must have had 30-day trials of at least two 'Non-Preferred Step 1 Agents', as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
RELPAX (eletriptan)	ONZETRA XSAIL (sumatriptan) NASAL SPRAY	CAFERGOT (ergotamine/caffeine) TABLET
Rizatriptan Tablets	ZOMIG (zolmitriptan) NASAL SPRAY	D.H.E.45 (dihydroergotamine) INJECTION
Rizatriptan ODT	zolmitriptan ODT	Dihydroergotamine Injection
Sumatriptan Tablets		Dihydroergotamine Nasal Spray
		ERGOMAR (ergotamine) SL TABLET
		MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
		MIGRANAL (dihydroergotamine) SPRAY

Multiple Sclerosis

General Prior Authorization Form

Interferons

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of at least 1 preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AVONEX (interferon beta-1A) PEN	EXTAVIA (interferon beta-1B)
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE
BETASERON (interferon beta-1B)	REBIF (interferon beta-1A)
	REBIF REBIDOSE (interferon beta-1A)

Injectable Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of each of the following, as evidenced by paid claims or pharmacy printouts.
  - Copaxone 20mg/mL, Aubagio, Gilenya, and Tecfidera

- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
COPAXONE (glatiramer) 20 MG/ML – *Brand Preferred*	COPAXONE (glatiramer) 40 MG/ML
	glatiramer 20mg/ml
	glatiramer 40mg/ml
	Glatopa (glatiramer)

Oral Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- One of the following must be met (A OR B):
  - **A.** The patient must have had a 3-month trial of Copaxone, as evidenced by paid claims or pharmacy printouts.
  - **B.** If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, the patient must have had a 3-month trial interferon beta-1, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AUBAGIO (teriflunomide)	MAVENCLAD (Cladribine)
GILENYA (fingolimod)	MAYZENT (Siponimod)
	TECFIDERA (dimethyl fumarate)

Narcolepsy

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)

Diagnosis Specific Criteria:

- **Narcolepsy:**
  - The patient must have failed 30-day trials of each preferred agent and at least 1 additional CNS stimulant indicated for treatment of narcolepsy, as evidenced by paid claims or pharmacy printouts
  - Provider must submit documentation of prior treatment failure, as evidenced by documentation of one of the following, while on prior treatments:
    - Multiple Sleep Latency Test (MSLT) <8 minutes
    - EPWORTH sleepiness scale score ≥10
- **Obstructive Sleep Apnea:**
  - The requested agent must be Sunosi
  - The patient must have failed 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts
  - Provider must submit documentation of prior treatment failure, as evidenced by documentation of one of the following, while on prior treatments:
    - Multiple Sleep Latency Test (MSLT) <8 minutes
    - EPWORTH sleepiness scale score ≥10

Renewal Criteria:

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

- Provider must submit documentation of symptom improvement, as evidenced by documentation of one of the following, while on prior treatments:
  - Multiple Sleep Latency Test (MSLT) <8 minutes
  - EPWORTH sleepiness scale score ≥10

PREFERRED AGENTS	NON-PREFERRED AGENTS
Modafinil	Armodafinil
NUVIGIL (Armodafinil) – *Brand Preferred*	PROVIGIL (Modafinil)
	SUNOSI (Solriamfetol)
	WAKIX (Pitolisant)
	XYREM (Sodium Oxybate)

Nuedexta

Prior Authorization Form - Nuedexta

Group Criteria (Initial): *Approval Duration = 3 months*

- The patient must be 18 years of age or older
- The patient must not have a diagnosis of any of the following: prolonged QT interval, heart failure, or complete atrioventricular (AV) block
- The prescriber must provide the following information:
  - Baseline Center for Neurological Studies lability (CNS-LS) score
  - Baseline weekly PBA episode count
- The 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 of at least one medication from each of the classes listed below (A and B), as evidenced by paid claims or pharmacy print outs:
    A. **SSRIs**: sertraline, fluoxetine, citalopram and paroxetine
    B. **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*

Group Criteria (Renewal): *Approval Duration = 6 months*

- Benefit of continued therapy must be assessed
- Baseline and current PBA episode count must be included with request
- Current PBA episode must be reduced by at least 75% from baseline
- **Additional initial 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 reduced by at least 30% from baseline

Parkinson's disease

General Prior Authorization Form

Product Specific Criteria:

- **Gocovri, Osmolex ER, Rytary, and Pramipexole ER:**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - The patient is must not currently be residing in a facility with skilled nursing care
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).
- **Inbrija, Apokyn, Duopa:**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - Documentation of intermittent hypomobility or "off" episodes (number and frequency) must be provided
  - The patient must have had inadequate response to medications in two of the following classes to reduce number and frequency of OFF episodes, as evidenced by paid claims or pharmacy printouts
    - A monoamine oxidase-B (MAO-B) inhibitor (e.g. rasagiline and selegiline)
    - A dopamine agonist (e.g. pramipexole IR, ropinirole IR)
    - A catechol-O-methyltransferase (COMT) inhibitor (e.g. entacapone)
- **Xadago and Nourianz:**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The patient must be currently experiencing intermittent hypomobility or "off" episodes
  - The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - The patient must be exhibiting deterioration in quality of response to during levodopa/carbidopa therapy for intermittent hypomobility, or "off" episodes
  - The patient must have had inadequate response to rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts
- **Nuplazid**:
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The patient must be experiencing recurrent or continuous hallucinations and/or delusions for the past 30 days
  - The patient must have experienced an inadequate response to a 30-day trial of quetiapine or clozapine, as evidenced by paid claims or pharmacy printouts
  - The patient must not have experienced a reduction in symptoms of psychosis, despite documented medication dosage reduction and discontinuation trials (with a goal of levodopa monotherapy)
- **Tolcapone**
  - The patient must have failed a 30-day trial of entacapone, as evidenced by paid claims or pharmacy printouts

- **Rasagiline and Emsam**
    - The patient must have failed a 30-day trial of selegiline, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria (Renewal):

- Documentation of disease stabilization or improvement in disease since initiation of treatment must be provided

PREFERRED AGENTS	NON-PREFERRED AGENTS
Amantadine IR	APOKYN (Apomorphine)
AZILECT (Rasagiline)	Carbidopa-Levodopa ODT
Benztropine	DUOPA (Levodopa/Carbidopa)
Bromocriptine	EMSAM (Selegiline) PATCH
Carbidopa-levodopa-entacapone	GOCOVRI (Amantadine ER)
Carbidopa-Levodopa Capsules	INBRIJA (Levodopa)
Carbidopa-Levodopa ER	NOURIANZ (Istradefylline)
Entacapone	NUPLAZID (Pimavanserin)
Levodopa	OSMOLEX ER (Amantadine ER)
NEUPRO (Rotigotine) PATCH	Pramipexole ER
Pramipexole IR	Rasagiline
Ropinirole	RYTARY (Levodopa/Carbidopa)
Ropinirole ER	Tolcapone
Selegiline	XADAGO (Safinamide)
Trihexyphenidyl	

Tardive Dyskinesia

Prior Authorization Form – Tardive Dyskinesia

Category Criteria

- The patient must be 18 years of age or older.
- The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).
- The patient must have a diagnosis of tardive dyskinesia, including the following:
    - Involuntary athetoid or choreiform movements
    - History of treatment with dopamine receptor blocking agent (DRBA)
    - Symptom duration lasting longer than 4-8 weeks
- The patient must not be taking monoamine oxidase inhibitor (MAOI)
- The patient is not pregnant or breastfeeding

Product Specific Criteria:

- ***** Austedo/tetrabenazine:**
    - The patient must have a diagnosis of Huntington's disease or Tardive Dyskinesia.
    - The patient must not have hepatic impairment

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AUSTEDO (deutetrabenazine)***	
INGREZZA (valbenazine)	
tetrabenazine***	

Ophthalmic

Antihistamines

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ALOMIDE (lodoxamide)	ALOCRIL (nedocromil)
Azelastine	ELESTAT (epinastine)
BEPREVE (bepotastine)	Epinastine
Cromolyn	Olopatadine 0.2% - Labeler 17478, 00093, 60505
LASTACAFT (alcaftadine)	PATANOL 0.1% (olopatadine)
Olopatadine 0.1%	PATADAY 0.2% (olopatadine)
Olopatadine 0.2% - Labeler 61314	
PAZEO (olopatadine)	

Anti-infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 3-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Bacitracin/polymyxin B ointment	AZASITE (azithromycin)
BESIVANCE (besifloxacin) DROPS	Bacitracin ointment
CILOXAN (ciprofloxacin) OINTMENT	BLEPH-10 (sulfacetamide) DROPS
Ciprofloxacin drops	CILOXAN (ciprofloxacin) DROPS
Erythromycin ointment	Gatifloxacin drops
GENTAK (gentamicin sulfate) OINTMENT	Levofloxacin drops
Gentamicin sulfate drops	Neomycin SU/bacitracin/polymyxin B ointment
Gentamicin sulfate ointment	Neomycin SU/polymyxin B/gramicidin drops
Moxifloxacin drops	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT
MOXEZA (moxifloxacin) DROPS	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS
Ofloxacin drop	OCUFLOX (ofloxacin) DROPS
Polymyxin B/trimethoprim drops	POLYCIN (bacitracin/polymyxin) OINTMENT
Sulfacetamide drops	POLYTRIM (polymyxin B/trimethoprim) DROPS
Tobramycin drops	Sulfacetamide ointment
TOBREX (tobramycin) OINTMENT	TOBREX (tobramycin) DROPS
	VIGAMOX (moxifloxacin) DROPS
	ZYMAXID (gatifloxacin) DROPS

Anti-infectives/Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 7-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)

Neomycin/bacitracin/polymyxin b/hydrocortisone ointment	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT
Neomycin/polymyxin b/dexamethasone ointment	Neomycin/polymyxin b/hydrocortisone drops
Neomycin/polymyxin b/hydrocortisone ointment	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT
PRED-G (gentamicin/prednisol ac) DROPS	TOBRADEX ST (tobramycin/dexamethasone) DROPS
PRED-G (gentamicin/prednisol ac) OINTMENT	Tobramycin/dexamethasone
Sulfacetamide/prednisolone drops	
TOBRADEX (tobramycin/dexamethasone) DROPS	
TOBRADEX (tobramycin/dexamethasone) OINTMENT	
ZYLET (tobramycin/lotepred etab) DROPS	

Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 5-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ACUVAIL (ketorolac)	ACULAR (ketorolac)
ALREX (loteprednol)	ACULAR LS (ketorolac)
Diclofenac sodium	Bromfenac sodium
DUREZOL (Difluprednate)	BROMSITE (bromfenac sodium)
FLAREX (fluorometholone)	Dexamethasone sodium phosphate
Fluorometholone	INVELTYS (Loteprednol)
Flurbiprofen sodium	FML (fluorometholone)
FML FORTE (fluorometholone)	ILEVRO (nepafenac)
FML S.O.P. (fluorometholone)	LOTEMAX SM (Loteprednol)
ketorolac tromethamine 0.4%	Loteprednol eye drops
Ketorolac tromethamine 0.5%	OCUFEN (flurbiprofen)
LOTEMAX (loteprednol) GEL DROPS	OMNIPRED 1% (prednisolone acetate)
LOTEMAX (loteprednol) OINTMENT	PRED FORTE 1% (prednisolone acetate)
MAXIDEX (dexamethasone)	PROLENSA (bromfenac)
NEVANAC (nepafenac)	
PRED MILD 0.12% (prednisolone acetate)	
Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	

Dry Eye Syndrome

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Cequa, Restasis Multidose**
  - The patient must have had a 30-day trials of Xiidra, as evidenced by paid claims or pharmacy printouts.

- Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RESTASIS (Cyclosporine)	CEQUA (Cyclosporine)***
	RESTASIS MULTIDOSE (Cyclosporine)***
	XIIDRA (Lifitegrast)

Glaucoma

Alpha Adrenergics

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ALPHAGAN P 0.1% (brimonidine)	Apraclonidine 0.5%
ALPHAGAN P 0.15% (brimonidine)	Brimonidine 0.15%
IOPIDINE (apraclonidine) 1%	
IOPIDINE (apraclonidine) 0.5%	
Brimonidine 0.2%	
COMBIGAN (brimonidine/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	

Beta Blockers

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred ophthalmic beta blocker products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BETOPTIC S (Betaxolol) 0.25%	Betaxolol 0.5%
Carteolol	COSOPT (Dorzolamide/Timolol)
COMBIGAN (brimonidine/timolol)	ISTALOL (Timolol) Daily
Dorzolamide/Timolol	Timolol Daily
Levobunolol	Timolol gel forming solution
Timolol Maleate	TIMOPTIC (Timolol Maleate)
TIMOPTIC OCUDOSE (timolol)	TIMOPTIC-XE (Timolol gel forming solution)

Prostaglandins

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred ophthalmic prostaglandin products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Latanoprost	Bimatoprost 0.03%
LUMIGAN (Bimatoprost) 0.01%	VYZULTA (latanoprostene)

TRAVATAN Z (Travoprost)	XALATAN (Latanoprost)
ZIOPTAN (Tafluprost)	XELPROS (Latanoprost)

Other

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AZOPT (Brinzolamide)	ISOPTO CARPINE (Pilocarbine)
Dorzolamide	TRUSOPT (Dorzolamide)
PHOSPHOLINE (Echothiophate Iodide)	
Pilocarpine	
RHOPRESSA (Netarsudil)	
ROCKLATAN (Netarsudil/Latanoprost)	

Otic

Anti-infectives/Anti-inflammatories – Fluoroquinolones

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 7-day trial of one preferred product in the past 3 months, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CIPRO HC (ciprofloxacin/hydrocortisone)	OTOVEL (ciprofloxacin/fluocinolone)
CIPRODEX (ciprofloxacin/dexamethasone)	

Pain

Lidocaine topical cream

Prior Authorization Form - Anesthetics - Topical

Group Criteria:

- The request must be for patient home use of cream, prior to injection pain from a medically necessary procedure

NSAIDS

Prior Authorization Form - NSAIDs

Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial of 3 different oral generic NSAIDs including a COX-2 inhibitor with GI intolerances, as evidenced by paid claims or pharmacy print outs

Product Specific Criteria:

- **Mefanemic acid:**
  - The patient must have diagnosis of dysmenorrhea
- **Branded NSAIDs and non-preferred strengths**:
  - Clinical justification must be provided explaining why the patient is unable to use other NSAID agents (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Celecoxib 50mg, 100mg, 200mg	ARTHROTEC (Diclofenac/Misoprostol)
Diclofenac potassium	Celecoxib 400mg
Diclofenac sodium 50mg, 75mg	CELEBREX (Celecoxib)
Etodolac	DAYPRO (Oxaprozin)
Fenoprofen 600mg	Diclofenac sodium ER 100mg
Flurbiprofen	Diclofenac sodium 25mg
Ibuprofen	Diclofenac/Misoprostol
Indomethacin	DUEXIS (Famotidine/Ibuprofen)
Indomethacin ER	Etodolac ER
Ketoprofen 50mg, 75mg	FELDENE (Piroxicam)
Ketorolac	Fenoprofen 400mg
Meloxicam	INDOCIN (Indomethacin)
Nabumetone	Ketoprofen 25mg
Naproxen 220mg, 250mg, 500mg	Ketoprofen ER 200mg
Piroxicam	Meclofenamate
Sulindac	Mefenamic acid
Tolmetin 200mg, 400mg	MOBIC (Meloxicam)
ZIPSOR (diclofenac)	NALFON (Fenoprofen)
	NAPRELAN (Naproxen)
	Naproxen ER 375 mg
	Naproxen 275mg, 550mg
	Oxaprozin
	TIVORBEX (indomethacin, submicronized)
	Tolmetin 600mg
	VIMOVO (Naproxen/Esomeprazole)
	VIVLODEX (meloxicam, submicronized)
	ZORVOLEX (diclofenac, submicronized)

Non-Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Product Specific Criteria:

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
Ibuprofen	CAMBIA (Diclofenac Potassium) POWDER PACK
Naproxen	Indomethacin
	QMIIZ ODT (meloxicam)

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Nasal

Prior Authorization Form - NSAIDs

Product Specific Criteria:

- **Sprix**:
  - The patient must be 18 years of age or older
  - The patient must have a diagnosis of postoperative nausea and vomiting
  - The patient must not have a documented history of gastric or duodenal ulcer or comorbidities of GI bleed, perforation, or obstruction

Topical:

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Diclofenac 1.5% Topical Solution	Diclofenac Patch
Diclofenac Gel	PENNSAID (Diclofenac) 2% PUMP
FLECTOR (diclofenac) PATCH *(Brand Preferred)*	VOLTAREN (diclofenac) GEL

Opioid Analgesics – Long Acting

Category Criteria (initial):

- The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports.
- The patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.).
- The prescription must be written by or in consultation with an oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if one of the following:
  - Cumulative daily dose of narcotics exceeds 90 MED/day
  - Patient is using benzodiazepine concurrently with narcotic medication
- **Non-Preferred Agents Criteria:**
  - Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic agents (subject to clinical review).

Category Criteria (renewal):

- Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

Partial Agonist/Antagonist Opioids

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BELBUCA (Buprenorphine)	buprenorphine patches
Butorphanol	
BUTRANS (buprenorphine) PATCHES	

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

Prior Authorization Form – Opioid Analgesics

Additional Group Criteria:

- The patient must have 30-day trials of both an NSAID and an immediate release opioid, as evidenced by paid claims or pharmacy printouts

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
NUCYNTA ER (tapentadol)	ARYMO ER (morphine)***
OXYCONTIN (oxycodone)	CONZIP (tramadol ER) CAPSULES
Tramadol ER Tablets	HYSINGLA ER (hydrocodone)
	Levorphanol
	Methadone***
	MORPHABOND ER (morphine)***
	Tramadol ER Capsules
	ULTRAM ER (tramadol ER) TABLETS
	XTAMPZA ER (oxycodone)

Full Agonist Opioids Without Abuse Deterrent Formulations

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Fentanyl Patch:**
  - Patient must meet one of the following criteria:
    - The patient has an indication of cancer pain or palliative care pain
    - The patient requires a long acting narcotic and cannot tolerate an oral dosage form
  - Patient must have a BMI ≥17
  - **Fentanyl Patch 12 mcg/hr**:
    - Patient must meet one of the following (A or B):
    A. The patient must be receiving a total daily opioid dose less than or equal to 60 Morphine Equivalent Dose (MED), as evidenced by paid claims or pharmacy printouts
    B. The patient must be continuously tapering off opioids from a higher strength Fentanyl patch
- **Morphine ER Tablets:**
  - Patients have reached the max dose of Oxycontin and are switching to Morphine ER Tablets for an Opioid Rotation strategy

Full Agonist Opioids Without Abuse Deterrent Formulations	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Fentanyl 12 mcg/hr***	DURAGESIC (Fentanyl) Patch
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr	EXALGO (hydromorphone)
	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr
	Hydromorphone ER tablets
	KADIAN (morphine)
	Morphine ER capsules
	Morphine ER tablets
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets
	ZOHYDRO ER (hydrocodone)

Opioid Analgesic – Short Acting

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Subsys, Fentanyl Citrate Buccal Tablet, Lazanda, Actiq, and Abstral:**
  - The patient's age must be within label recommendations
  - The patient must have a diagnosis of cancer pain
  - The patient must currently be on around the clock opioid therapy for at least a week, as evidenced by paid claims or pharmacy printouts

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

        - The around the clock opioid therapy must be equivalent to 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily, or equianalgesic dose of another opioid daily
- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Initial):**
    - The patient must have required around-the-clock pain relief for the past 90 days, as evidenced by paid claims or pharmacy printouts
    - The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports
    - The patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)
    - The prescription must be written by or in consultation with an oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens)
- **Oxycodone IR**
    - The above Initial Criteria must be met
    - The patient must currently be on a long-acting opioid analgesic that provides a daily Morphine Equivalent Dose (MED) which meets requirements below (based on requested strength), as evidenced by paid claims or pharmacy printouts (Please use an Opioid Dose Calculator to find the MED for specific products):
        - **Oxycodone 15 mg tablet:** long-acting opioid must provide ≥150 mg MED per day
        - **Oxycodone 20 mg tablet:** long-acting opioid must provide ≥200 mg MED per day
        - **Oxycodone 30 mg tablet:** long-acting opioid must provide ≥300 mg MED per day
- **Meperidine, butalbital-codeine products:**
    - The above Initial Criteria must be met
    - Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic products (subject to clinical review).
- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Renewal):**
    - Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Acetaminophen/Codeine Solution	ABSTRAL (Fentanyl) SUBLINGUAL TABLET
Acetaminophen/Codeine Tablets	ACTIQ (Fentanyl) LOZENGE
Benzhydrocodone/Acetaminophen	Butalbital-Codeine
Codeine Tablets	CONZIP (Tramadol)
Hydrocodone/Acetaminophen 7.5-325/15ml Solution	DEMEROL (Meperidine)
hydrocodone-acetaminophen 5-325 MG	DILAUDID (Hydromorphone)
hydrocodone-acetaminophen 7.5-325 MG	ENDOCET (Oxycodone/Acetaminophen)
hydrocodone-acetaminophen 10-325 MG	FENTORA (Fentanyl) EFFERVESCENT TABLET
Hydrocodone/Ibuprofen	Fentanyl Citrate Buccal Tablet
Hydromorphone Liquid	Fentanyl Lozenge
Hydromorphone Tablet	Hydrocodone/Acetaminophen 5-163mg/7.5mL Solution
Morphine Tablets	hydrocodone-acetaminophen 2.5-325 MG
Morphine Solution	hydrocodone-acetaminophen 10MG-300MG
NUCYNTA (Tapentadol) TABLETS	hydrocodone-acetaminophen 5 MG-300MG
Oxycodone 5mg, 10mg Tablets	hydrocodone-acetaminophen 7.5-300 MG
Oxycodone Solution	LAZANDA (Fentanyl) SPRAY
oxycodone-acetaminophen 5-325 MG	LORCET (Hydrocodone/Acetaminophen)
oxycodone-acetaminophen 10 -325 MG	LORTAB (Hydrocodone/Acetaminophen) SOLUTION
Oxymorphone Tablets	Meperidine

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Tramadol Tablets	NALOCET (Oxycodone/Acetaminophen)
Tramadol/Acetaminophen Tablets	NORCO (Hydrocodone/Acetaminophen)
	OPANA (Oxymorphone)
	OXAYDO (Oxycodone)
	Oxycodone 15mg, 20mg, 30mg
	oxycodone-acetaminophen 2.5-325 MG
	oxycodone-acetaminophen 7.5-325 MG
	PERCOCET (Oxycodone/Acetaminophen)
	PRIMLEV (Oxycodone/Acetaminophen)
	ROXICODONE (Oxycodone)
	ROXYBOND (Oxycodone)
	SUBSYS (Fentanyl) SPRAY
	ULTRACET (Tramadol/Acetaminophen)
	ULTRAM (Tramadol)
	VICODIN (Hydrocodone/Acetaminophen)

Skeletal Muscle Relaxants

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 3 months*

- The patient must have failed two 30-day trials of other skeletal muscle relaxants, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria

- **Metaxalone:** *Approval Duration = 3 months*
  - One of the required 30-day trials must be methocarbamol, as evidenced by paid claims or pharmacy printouts.
- **Carisoprodol:** *Approval Duration = 1 week*
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Baclofen	AMRIX (Cyclobenzaprine)
Chlorzoxazone 500mg	Chlorzoxazone 375mg and 750mg
Cyclobenzaprine 5mg and 10mg	Cyclobenzaprine 7.5mg
Dantrolene	Cyclobenzaprine ER
Methocarbamol	Carisoprodol
Orphenadrine ER	Carisoprodol-aspirin
Tizanidine tablets	Carisoprodol-aspirin-codeine
	DANTRIUM (Dantrolene)
	FEXMID (Cyclobenzaprine)
	LORZONE (Chlorzoxazone)
	METAXALL (Metaxalone)
	Metaxalone
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)
	OZOBAX (Baclofen) SOLUTION
	ROBAXIN (Methocarbamol)
	SKELAXIN (Metaxalone)
	SOMA (Carisoprodol)
	Tizanidine capsules

	ZANAFLEX (Tizanidine)

Psychiatry

ADHD Agents

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 10-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 10-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- *** **Clonidine ER**: Patient must have had a 30-day trial of immediate release clonidine, as evidenced by pharmacy claims or pharmacy printouts.

Non-Stimulants	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Atomoxetine	Clonidine ER***
Clonidine	INTUNIV (guanfacine ER)
Guanfacine	STRATTERA (atomoxetine)
Guanfacine ER	
Stimulants - Methylphenidates	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ADHANSIA XR (methylphenidate)	Dexmethylphenidate ER
APTENSIO XR (methylphenidate)	FOCALIN (dexmethylphenidate)
CONCERTA (methylphenidate) – *Brand Preferred*	METADATE ER (methylphenidate)
COTEMPLA XR - ODT (methylphenidate)	METHYLIN (methylphenidate) chew tablets
DAYTRANA (methylphenidate)	Methylphenidate ER 72 mg
Dexmethylphenidate	Methylphenidate ER tablet
FOCALIN XR (dexmethylphenidate) – *Brand Preferred*	Methylphenidate LA capsules - 50-50 – 20mg, 30mg, 40mg, 60mg
Methylphenidate solution	METHYLIN (methylphenidate) solution
Methylphenidate CD 30-70	RELEXXII (methylphenidate)
Methylphenidate chew tablet	RITALIN (methylphenidate)
Methylphenidate ER capsules 50-50	RITALIN LA (methylphenidate LA capsules - 50-50) 10mg
Methylphenidate LA capsules - 50-50 – 10mg	
Methylphenidate tablet	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
RITALIN LA (methylphenidate LA capsules - 50-50) 20mg, 30mg, 40mg – *Brand Preferred*	
Stimulants - Amphetamines	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ADZENYS ER (Amphetamine) SOLUTION	ADDERALL (Dextroamphetamine/amphetamine)
ADZENYS XR - ODT (Amphetamine)	ADDERALL XR (Dextroamphetamine/amphetamine)
DESOXYN (Methamphetamine) – *Brand Preferred*	Amphetamine
Dextroamphetamine	DEXEDRINE (Dextroamphetamine)
Dextroamphetamine ER	Dextroamphetamine 5 mg/5 ml
Dextroamphetamine/amphetamine	Methamphetamine
Dextroamphetamine/amphetamine ER	ZENZEDI (Dextroamphetamine)
DYANAVEL XR (Amphetamine)	
EVEKEO (Amphetamine) – *Brand Preferred*	

Non-Stimulants	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
EVEKEO ODT (Amphetamine)	
MYDAYIS (Dextroamphetamine/dextroamphetamine)	
PROCENTRA (Dextroamphetamine) – *Brand Preferred*	
VYVANSE (Lisdexamfetamine)	
VYVANSE (lLsdexamfetamine) CHEW TABLET	

Atypical Antipsychotics

Oral

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Olanzapine/fluoxetine**: Clinical justification must be provided explaining why the patient is unable to use the preferred, individual products separately (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Aripiprazole solution	ABILIFY (aripiprazole)
Aripiprazole	ABILIFY DISCMELT (aripiprazole)
Aripiprazole ODT	CLOZARIL (clozapine)
Clozapine	FAZACLO (clozapine) RAPDIS
Clozapine ODT	GEODON (ziprasidone)
FANAPT (iloperidone)	INVEGA ER (paliperidone)
LATUDA (lurasidone)	Olanzapine/Fluoxetine***
Olanzapine	RISPERDAL (risperidone)
Olanzapine ODT	RISPERDAL (risperidone) ORAL SOLUTION
Paliperidone ER	RISPERDAL M-TAB (risperidone)
Quetiapine	SEROQUEL (quetiapine)
Quetiapine ER	SEROQUEL XR (quetiapine)
REXULTI (brexpiprazole)	SYMBYAX (olanzapine/fluoxetine) ***
Risperidone	ZYPREXA (olanzapine)
Risperidone ODT	ZYPREXA ZYDIS (olanzapine)
Risperidone oral solution	
SAPHRIS (asenapine)	
VRAYLAR (cariprazine)	
Ziprasidone	

Long Acting Injectable

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
ZYPREXA RELPREVV (olanzapine)	

Sedatives/Hypnotics

Prior Authorization Form - Sedative/Hypnotics

Product Specific Criteria (Initial): *Approval Duration = 1 month*

- **Zolpidem 10mg** (prior authorization required for females only):
  - The patient must have failed a 25-day trial of zolpidem 5 mg within the last 30 days, as evidenced by paid claims or pharmacy print outs
- **Zolpidem ER:**
  - The patient's insomnia must be characterized by difficulty with sleep maintenance
  - The patient must have failed a 25-day trial of eszopiclone within the last 30 days, as evidenced by paid claims or pharmacy printouts
- **Belsomra:**
  - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The 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 printouts
    - Silenor (doxepin)
    - Eszopiclone
    - Zolpidem ER
- **Temazepam, zolpidem SL:**
  - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The 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 printouts
    - Zolpidem ER
    - Eszopiclone
    - Silenor (doxepin)
    - Belsomra
- **Edluar (Zolpidem):**
  - The patient's insomnia must be characterized by difficulty with sleep onset
  - The 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 printouts
    - Zolpidem IR
    - Zaleplon
    - Eszopiclone
- **Triazolam, fluazepam, estazolam, Seconal sodium, Zolpimist:**
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

Product Specific Criteria (Renewal): *Approval Duration = 6 months (2 weeks for b*enzodiazepines)

- **ALL Agents:**
  - The prescriber has provided confirmation that other conditions causing sleep issues have been ruled out
- **benzodiazepines (temazepam, triazolam, flurazepam, estazolam):**
  - The patient must be undergoing dose tapering

NON - DEA SCHEDULED (NON-ADDICTIVE) MEDICATION:	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Mirtazapine	Ramelteon
ROZEREM (ramelteon)	

SILENOR (doxepin)	
Trazodone	
DEA SCHEDULED MEDICATIONS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Eszopiclone	AMBIEN (Zolpidem)
Zaleplon	AMBIEN CR (Zolpidem)
Zolpidem 5mg	BELSOMRA (Suvorexant)
Zolpidem 10mg (for males)	EDLUAR (Zolpidem)
	Estazolam
	Flurazepam
	LUNESTA (Eszopiclone)
	SECONAL SODIUM (Secobarbital)
	Temazepam
	Triazolam
	Zolpidem ER
	Zolpidem 10mg (for females)
	ZOLPIMIST (Zolpidem)
	Zolpidem SL tab

Respiratory

Albuterol/Levalbuterol Rescue Inhalers

General Prior Authorization Form
MedWatch Form

Product Specific Criteria

- **Albuterol HFA, ProAir Respiclick:**
  - The patient must currently be receiving an inhaled corticosteroid product, as evidenced by paid claims or pharmacy printouts (see Coverage Rules for Medications).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Albuterol HFA – Labeler 66993***	Albuterol HFA – Labeler 00933 and 00254
PROAIR (albuterol) HFA – *Brand Preferred*	PROVENTIL (albuterol) HFA
PROAIR RESPICLICK (albuterol)***	VENTOLIN (albuterol) HFA***
XOPENEX (levalbuterol) HFA - *Brand Preferred*	

Anticholinergics/Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of 2 preferred, combination anticholinergic/long-acting beta agonist products, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Albuterol/ipratropium	DUAKLIR PRESSAIR (Aclidinium/Formoterol)
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)
COMBIVENT RESPIMAT (albuterol/ipratropium)	
UTIBRON NEOHALER (glycopyrrolate/indacaterol)	

Corticosteroids – Inhaled

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of each preferred inhaler of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- *** **Asmanex Twisthaler, Alvesco**: Patient must have had a 30-day trial of Asmanex HFA, as evidenced by pharmacy claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Budesonide Suspension	ALVESCO (ciclesonide)***
FLOVENT DISKUS (fluticasone)	ARMONAIR RESPICLICK (fluticasone)
FLOVENT HFA (fluticasone)	ARNUITY ELLIPTA (fluticasone)
PULMICORT FLEXHALER (budesonide)	ASMANEX HFA (mometasone)
	ASMANEX (mometasone) TWISTHALER***
	PULMICORT RESPULES (budesonide)
	QVAR REDIHALER (beclomethasone)

Long Acting Anticholinergics

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred long-acting anticholinergic agents, as evidenced by paid claims or pharmacy printouts.
    - Either single ingredient or combination products will count toward trials.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Product Specific Criteria:

- ***Lonhala Magnair**:
    - The patient must have had a 30-day trial of Yupelri, as evidenced by paid claims or pharmacy printouts.
    - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
SPIRIVA HANDIHALER (tiotropium)	INCRUSE ELLIPTA (umeclidinium)
SPIRIVA RESPIMAT 2.5 MG (tiotropium)	LONHALA MAGNAIR (glycopyrrolate)***
TUDORZA PRESSAIR (aclidinium)	SEEBRI NEOHALER (glycopyrrolate)
	YUPELRI (revefenacin)

Spiriva Respimat 1.25 mcg

General Prior Authorization Form

Criteria for coverage:

- The patient must have a diagnosis of asthma
- The patient must have failed a 30-day trial of a steroid inhaler and a long acting beta agonist

Long Acting Beta Agonists

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Product Specific Criteria:

- ***Brovana**: The patient must have had a 30-day trial of Perforomist, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ARCAPTA NEOHALER (indacaterol)	BROVANA (arformoterol)***
PERFOROMIST (formoterol)	
SEREVENT DISKUS (salmeterol)	
STRIVERDI RESPIMAT (olodaterol)	

Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers

General Prior Authorization Form

Criteria for coverage:

- The patient must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts
- The patient must have a diagnosis of an FDA-approved indication for use and meet the criteria for that diagnosis
    - **For COPD diagnosis: one of the following must be met (A or B):**
        - A. The patient must have failed 30-day trials of at least 1 agent from each of the below lists (I and II)
            - I. Tudorza Pressair, Spiriva, Spiriva Respimat, Incruse Ellipta, or Seebri Neohaler
            - II. Brovana, Arcapta Neohaler, Striverdi Respimat, Perforomist, or Serevent.
        - B. The patient must have failed 30-day trials of at least 1 of the following agents below:
            - Anoro Ellipta, Stiolto Respimat, Utibron NeoHaler, Bevespi Aerosphere, or Trelegy Ellipta
    - **For asthma diagnosis:**
        - The patient must have been reviewed for step down therapy for all renewal requests.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ADVAIR HFA (Fluticasone/Salmeterol)	ADVAIR DISKUS (Fluticasone/Salmeterol)
DULERA (Mometasone/Formoterol)	AIRDUO RESPICLICK (Fluticasone/Salmeterol)
Fluticasone/Salmeterol – Labeler 66993	BREO ELLIPTA (Fluticasone/Vilanterol)
SYMBICORT (Budesonide/Formoterol)	Fluticasone/Salmeterol – Labeler - 00093
	WIXELA INHUB (Fluticasone/Salmeterol)

Steroid/Anticholinergics/Long Acting Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of the following combinations (both 1 AND 2), as evidenced by paid claims or pharmacy printouts:
    1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics
    2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steroid

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
	TRELEGY ELLIPTA (Fluticasone Furoate/Umeclidinium/Vilanterol)

Substance Use

Nicotine / Tobacco Dependence Treatment

General Prior Authorization Form

A total of 24 consecutive weeks of Chantix will be covered, every 2 years.

A total of 12 consecutive weeks will be covered for all other products, every 2 years.

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Bupropion SR	NICODERM CQ (Nicotine) PATCH
CHANTIX (Varenicline)	NICORETTE (Nicotine Polacrilex) GUM
Nicotine Lozenge	ZYBAN (Bupropion SR)
Nicotine Patch	
Nicotine Polarcrilex Gum	
NICOTROL (Nicotine Polacrilex) INHALER	
NICOTROL (Nicotine Polacrilex) SPRAY	

Opioid Dependence Treatment

Lucemyra

General Prior Authorization Form

Group Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Clonidine	LUCEMYRA (Lofexidine)
Guanfacine	

Naloxone Rescue Medications

General Prior Authorization Form

Group Criteria (Initial):

- Narcan Nasal Spray does NOT require prior authorization for the initial dose

Group Criteria (Renewal):

- The provider must attest that 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 (A, B, or C)
    A. The previous dose has expired
    B. The dose was used by patient for illicit drug use
    C. 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

Opioid Antagonist

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
VIVITROL (Naltrexone Microspheres)	

Opioid Partial Antagonist

General Prior Authorization Form

Product Specific Criteria:

- *** **Buprenorphine tablets**: The patient must be pregnant or breastfeeding, and estimated delivery date/duration of need for breastfeeding must be provided.

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Antagonist Group PA Criteria.
- For all non-preferred agents OTHER than Zubsolv (buprenorphine/naloxone):
    - The patient must have failed a 30-day trial of Zubsolv (buprenorphine/naloxone)
    - Clinical justification must be provided explaining why the patient is unable to use Zubsolv (subject to clinical review).
    - DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Antagonist Group PA Criteria.

ORAL AGENTS	
PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Buprenorphine-naloxone tablets	BUNAVAIL FILM (buprenorphine/naloxone)
Buprenorphine tablets***	buprenorphine/naloxone film
	SUBOXONE FILM (buprenorphine/naloxone)
	ZUBSOLV (buprenorphine/naloxone)
NON-ORAL AGENTS	
PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
SUBLOCADE (buprenorphine)	
PROBUPHENE (buprenorphine)	

Women's Health

Estrogens

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed 30-day trials of at least two preferred products, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CLIMARA PRO (estradiol-levonorgestrel) PATCH	ALORA (Estradiol) PATCH TWICE WEEKLY
COMBIPATCH (Estradiol- Norethindrone)	CLIMARA (Estradiol) PATCH WEEKLY
ELESTRIN (estradiol) GEL	DELESTROGEN (Estradiol Valerate) INJECTION
Estradiol Tablet	DEPO-ESTRADIOL (Estradiol Cypionate) INJECTION
ESTRING (estradiol)	DIVIGEL (estradiol) GEL
EVAMIST (estradiol) SPRAY	Estradiol Valerate Injection
MENOSTAR (estradiol) PATCH	Estradiol- Norethindrone Tablet

Norethindrone-Ethinyl Estradiol tablet	Estradiol Patch Twice Weekly
PREMARIN (estrogens, conjugated) INJECTION	Estradiol Patch Weekly
PREMARIN (estrogens, conjugated) TABLET	Estradiol Vaginal Cream
PREMARIN (estrogens, conjugated) VAGINAL CREAM	Estradiol Vaginal Tablet
PREMPHASE (estrogen, conj.,m-progest) TABLET	FEMRING (estradiol)
PREMPRO (estrogen, conj.,m-progest) TABLET	MENEST (estrogens, esterified) TABLET
VAGIFEM (estradiol) VAGINAL TABLET	MINIVELLE (Estradiol) PATCH TWICE WEEKLY
YUVAFEM (estradiol) VAGINAL TABLET	PREFEST (estradiol-norgestimate) TABLET
	VIVELLE-DOT (Estradiol) PATCH

Mifepristone

Prior Authorization Form - Mifeprex

Criteria for coverage: *Approval Duration = 1 month*

- Gestational age must be less than or equal to 70 days
- One of the following criteria must be met (A or B):
    A. **Pregnancy must have resulted from an act of rape or incest, and one of the following (I or II)**
        I. 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.
        II. 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.
    B. **Both of the following must be met (I and II)**
        I. 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
        II. 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

Orilissa

Prior Authorization Form - Orilissa

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 18 years of age or older
- The patient must have a diagnosis of moderate to severe pain associated with endometriosis
- The patient must not have osteoporosis or severe liver disease (Child-Pugh Class C).
- The patient must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts:
    A. A 3-cycle trial of mefenamic acid (or similar fenamate Non-Steroidal Anti-Inflammatory agent (NSAIDs))
    B. A 3-cycle trial of an oral estrogen-progestin or progestin contraceptives

Renewal Criteria: *Approval Duration = 18 months*

- Prescriber must submit documentation of improvement in pain score from baseline
- Request must be for maintenance dosing (150 mg strength).

Osteoporosis

Prior Authorization Form - Osteoporosis

Non-Preferred Agents Criteria (Initial): *Approval Duration = 2 years*

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
  - Alendronate or Risedronate
  - Denosumab
- Patient must be at high risk of fracture, confirmed by at least one of the following:
  - The patient with a history of hip or vertebral fracture
  - The patient with a T-score of −2.5 or lower at the femoral neck or spine
  - The patient who have a T-score of between −1.0 and −2.5 at the femoral neck or spine and a ten-year hip fracture risk of ≥3% as assessed with the FRAX
  - 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX

Product Specific Criteria:

- ***Forteo and Miacalcin:**
  - The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of Tymlos (Abaloparatide), as evidenced by paid claims or pharmacy printouts
- ***Binosto and alendronate oral solution:**
  - The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Alendronate	Alendronate oral solution
Calcitonin, Salmon Nasal Spray	BINOSTO (Alendronate) EFFERVESCENT TAB
Ibandronate	FORTEO (Teriparatide)***
PROLIA (Denosumab)	MIACALCIN (Calcitonin, Salmon)***
Risedronate	TYMLOS (Abaloparatide)

Progesterone

Prior Authorization Form - Makena

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
MAKENA (hydroxyprogesterone caproate)	hydroxyprogesterone caproate

Vaginal Anti-Infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 30-day trials of 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)

AVC (sulfanilamide)	Clindamycin cream
CLEOCIN (Clindamycin) SUPPOSITORY	CLEOCIN (Clindamycin) CREAM
CLINDESSE (Clindamycin) CREAM	METROGEL-VAGINAL (Metronidazole)
GYNAZOLE 1 (butoconazole) CREAM	MICONAZOLE 3 (miconazole) suppository
Metronidazole gel	terconazole suppository
NUVESSA (Metronidazole) GEL	
terconazole cream	
VANDAZOLE (Metronidazole) GEL	

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

Criteria for coverage:

- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).
- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must not have any contraindication to the requested product
- The patient must have failed* a therapeutic course** of each preferred agent (listed in boxes below) within the past 2 years, as evidenced by paid claims or pharmacy printouts.

**: 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*

***: Trials must have been at least 30 days in duration unless otherwise indicated*

Amoxicillin ER

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Amoxicillin IR	Amoxicillin ER

Antihistamines

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Cetirizine Chew Tablet	Desloratadine ODT
Cetirizine Solution	Levocetirizine solution
Cetirizine Tablet	
Desloratadine Tablet	
Levocetirizine Tablet	
Loratadine Solution	
Loratadine Tablet	

Bactroban

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Bactroban ointment	Bactroban cream

Belladonna Alkaloids/Phenobarbital

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Belladonna Alkaloids/Phenobarbital Tablets	Belladonna Alkaloids/Phenobarbital Elixir

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Bowel Prep Agents

Required trial duration: 1 complete dose

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
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)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Paroxetine tablets	Paroxetine Mesylate 7.5mg capsules

Butalbital-Acetaminophen-Caffeine

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Butalbital-Acetaminophen-Caffeine Tablets	Butalbital-Acetaminophen-Caffeine Capsules
	ESGIC (Butalbital-Acetaminophen-Caffeine) CAPSULES
	VANATOL LQ (Butalbital-Acetaminophen-Caffeine) SOLUTION
	VANATOL S (Butalbital-Acetaminophen-Caffeine) SOLUTION
	ZEBUTAL (Butalbital-Acetaminophen-Caffeine) CAPSULES

Daxbia (Cephalexin)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Cephalexin	Daxbia (Cephalexin)

Gabapentin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Gabapentin	GRALISE (gabapentin)
Gabapentin	HORIZANT (gabapentin)
Pramipexole	
Ropinirole	

Jadenu (Deferasirox)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Deferasirox tablet for suspension	JADENU (deferasirox)

Kits

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FDA approved products prescribed separately	DERMACINRX ARM PAK (lidocaine/dimethacone)

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

	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)

Metformin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Metformin ER	FORTAMET (Metformin)
	GLUMETZA (Metformin)
	RIOMET (Metformin) ORAL SOLUTION

Methotrexate

Required trial duration: 6 weeks

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
methotrexate	OTREXUP (methotrexate)
	RASUVO (methotrexate)
	TREXALL (methotrexate)

Mupirocin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Mupirocin Ointment	Mupirocin Calcium Cream

Nascobal (Cyanocobalamin) Nasal Spray

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Cyanocobalamin Injection	NASCOBAL (Cyanocobalamin) NASAL SPRAY

Nitroglycerin Spray

Required trial duration: 1 dose while on preventative medication

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Nitroglycerin sublingual tablets	GONITRO (Nitroglycerin) SUBLINGUAL PACKET
	Nitroglycerin Spray
	NITROLINGUAL (Nitroglycerin) SPRAY

Nocdurna (desmopressin)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Desmopressin	Nocdurna (desmopressin)

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

Onmel (itraconazole)

Required trial duration: 12 weeks with 6 months outgrow following treatment for onychomycosis

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Itraconazole capsule	ONMEL (itraconazole) tablet
Terbinafine	

Potassium

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Potassium tablets	Potassium Solution
	Potassium Powder for Solution

Procysbi (cysteamine)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CYSTAGON (cysteamine)	PROCYSBI (cysteamine)

Ribavirin

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
RIBASPHERE (ribavirin)	RIBASPHERE RIBAPAK (ribavirin)
Ribavirin	

Siklos (Hydroxyurea)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DROXIA (Hydroxyurea capsule)	SIKLOS (Hydroxyurea tablet)
Hydroxyurea capsule	

Steroids - Oral

Additional Criteria for coverage of Emflaza: See Emflaza Criteria on this document

Rayos required trial duration: 12 weeks with 2AM dosing of prednisone

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Budesonide 3mg EC Capsules	Budesonide 9 mg ER Tablet
Cortisone	DEXPAK (dexamethasone)
Dexamethasone	DXEVO (dexamethasone)
Hydrocortisone	EMFLAZA (deflazacort)
Methylprednisone	MILLIPRED (Prednisolone)
Prednisolone sodium phosphate 5mg/5ml, 15mg/5ml, 25mg/5ml	Prednisone Intensol
Prednisone Solution	Prednisolone sodium phosphate ODT
Prednisone Tablets	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
	RAYOS (prednisone)
	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

Tacrolimus

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Tacrolimus	ASTAGRAF XL (Tacrolimus)

	ENVARSUS ER (Tacrolimus)

Tirosint (levothyroxine)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
levothyroxine	TIROSINT (levothyroxine)

Tussicaps

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Hydrocodone/chlorpheniramine ER suspension	TUSSICAPS (hydrocodone/chlorpheniramine)
Promethazine/codeine	
ZODRYL AC (chlorpheniramine/codeine)	

Topical Corticosteroids Preferred Medication List

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%
		Clobetasol Propionate Lotion	0.05%	Betamethasone, augmented gel	0.05%
		Clobex (*Brand Required*) Shampoo	0.05%	Clobetasol emulsion foam	0.05%
		Clobex (*Brand Required*) Spray	0.05%	Clobetasol propionate foam	0.05%
		Clobetasol Propionate Gel	0.05%	Lexette (Halobetasol) foam	0.05%
				Desoximetasone spray	0.25%
				STEP2* Cordran (Flurandrenolide) Tape	4MCG/SQ CM
				STEP 2* Ultravate (Halobetasol) lotion	0.05%
Class 2 - High Potency	**Class 2 - High Potency**				
	Cream	Betamethasone, augmented	0.05%	Apexicon E	0.05%
		Desoximetasone	0.25%	Halog	0.10%
		Diflorasone Diacetate	0.05%	Fluocinonide-E	0.05%
		Fluocinonide	0.05%	STEP2* Amcinonide	0.10%
		Triamcinolone Acetonide	0.50%		
	Ointment	Betamethasone Dipropionate	0.05%	Diflorasone Diacetate	0.05%
		Betamethasone Valerate	0.10%		

Please use the Prior Authorization Form Lookup to find Prior Authorization (PA) Forms

		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%	Desoximetasone gel	0.05%
		Fluocinonide solution	0.05%	Bryhali (halobetasol)	0.01%
				STEP2* Amcinonide Lotion	0.10%
Class 3 - Medium Potency	**Class 3 - Medium Potency**				
	Cream	Betamethasone Valerate	0.10%	Betamethasone Dipropionate	0.05%
		Fluticasone Propionate	0.05%	Clocortolone Pivalate	0.10%
		Mometasone Furoate	0.10%	Fluocinolone Acetonide	0.025%
		Synalar	0.025%	Pandel	0.10%
		Triamcinolone Acetonide	0.10%	Prednicarbate	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 (Betamethasone)	0.05%
Class 4 - Low Potency	**Class 4 - 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%		

Clinic Administered Drugs

Brineura

Prior Authorization Form - Brineura

Initial Criteria: *Approval Duration = 6 months*

- Patient must be between 3 and 8 years of age.
- The patient must have diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency confirmed by the following:
    - A genetic test confirming CLN2 disease
    - An enzyme assay confirming deficiency of tripeptidyl peptidase 1 (TPP1)
- Brineura must be prescribed by or in consultation with a metabolic specialist, geneticist, or pediatric neurologist.
- Patient must not have ventriculoperitoneal shunts
- Baseline results of motor and language domains of the Hamburg CLN2 Clinical Rating Scale must be submitted and meet the following parameters
    - Results must show a combined score of less than 6 in the motor and language domains
    - Results must show a score of at least 1 in each of these domains

Renewal Criteria: *Approval Duration = 12 months*

- The patient must not have acute, unresolved localized infection on or around the device insertion site or suspected or confirmed CNS infection
- Patient maintains at a score of at least 1 in the motor domain on the Hamburg CLN2 Clinical Rating Scale
- The patient has responded to therapy compared to pretreatment baseline with stability/lack of decline* in motor function/milestones

**: Decline is defined as having an unreversed (sustained) 2-category decline or an unreversed score of 0 in the Motor domain of the CLN2 Clinical Rating Scale*

Spinraza

Prior Authorization Form - Spinraza

Criteria: *Approval Duration = 12 months*

- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2, or 3:
    - The patient must not have respiratory insufficiency (need for invasive or noninvasive ventilation for more than 6 hours per 24-hour period)

- The patient must not require gastric feeding tubes for the majority of feeds
- The patient must not have severe contractures or severe scoliosis
- The patient must not have wasting or cachexia

- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 3:
  - The 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)

Synagis

Prior Authorization Form - Synagis

Criteria: *Approval Duration = 5 months (allows for 5 monthly doses between October 19th through April 21st)*

- Patient must have one of the following diagnoses (A, B, or C) and the additional criteria outlined for diagnosis:

A. Prematurity:
- < 29 weeks, 0 days gestational age
- ≤12 months of age at start of RSV season

B. 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

C. Congenital Heart Disease
- ≤12 months of age at start of RSV season
  - Hemodynamically significant cyanotic or acyanotic congenital heart disease with medical therapy required

REVIEW OF GLUCAGON AGENTS

INDICATIONS:

- Hypoglycemia: Treatment of severe hypoglycemia in pediatric and adult patients*.
- *Products not packaged with a syringe and diluent necessary for rapid preparation and administration during an emergency outside of a health care facility are not indicated for the emergency treatment of hypoglycemia
- Note: The American Diabetes Association (ADA) recommends that glucagon be prescribed for all patients with diabetes at increased risk of level 2 hypoglycemia (less than 54 mg/dL); caregivers, school personnel, or family members of these patients should be trained on when and how to administer glucagon
- **Diagnostic aid:** As a diagnostic aid during radiologic examinations to temporarily inhibit movement of the GI tract in adults.

PRODUCTS:

Drug	**Route**
Glucagon (generic)	SQ, IM or IV
Glucagon Emergency	SQ, IM or IV
GlucaGen Hypokit	SQ, IM or IV
GlucaGen Diagnostic	IM or IV
Gvoke PFS	SQ
Baqsimi	Nasal

DOSING:

- **Hypoglycemia:**

	Adult Dosing	**Pediatric Cutoff**	**Pediatric Dose**
GlucaGen Hypokit	1 mg*	< 6 years or <25 kg	0.5 mg*
Glucagon Emergency Kit	1 mg*	< 20 kg	0.5 mg or 0.02-0.03 mg/kg*
Gvoke PFS	1 mg*	≥2 years, <45 kg	0.5 mg*
Baqsimi	3 mg* (1 actuation)	N/A	N/A
* may repeat in 15 minutes if needed			

- Injection as diagnostic aid:
  - Relaxation of the stomach, duodenal bulb, duodenum, and small bowel:
    - 0.2 to 0.5 mg IV or 1 mg IM
  - Relaxation of the colon:
    - 0.5 to 0.75 mg IV or 1 to 2 mg IM

TIME TO ONSET AND PEAK EFFECT:

Administration	Onset of Effect	Max Peak Effect
IV	<1 minute	5-20 minutes
IM	10 minutes	>90 minutes
SQ	10 minutes	>90 minutes
Nasal*	16 minutes	>90 minutes
**No statistically significant efficacy outcomes noted between Nasal formulation and injection formulations despite delayed onset.*		

COST:

Drug	Strength	Package Size	AWP Pkg Price	AWP Unit Price
Glucagon (generic)	1 mg sln	1	$204.60	$204.60
Glucagon Novaplus	1 mg sln	1 or 10	$162.00-$1,620.00	$162.00
Glucagon Emergency	1 mg sln	1	$336.96	$336.96
GlucaGen Hypokit	1 mg sln	1	$338.46	$338.46
GlucaGen Diagnostic	1 mg sln	1	$205.92	$205.92
Gvoke PFS/Hypopen	0.5 mg/0.1 mL SQ	1 or 2	$336.96-673.92	$1684.80-3369.60
Gvoke PFS/ Hypopen	1 mg.0.2 mL SQ	1 or 2	$336.96-673.92	$1684.80-3369.60
Baqsimi	3 mg/1 actuation	1-2	$336.96-673.92	$336.96

CURRENT UTILIZATION:

ND Medicaid Utilization (09/2018 – 08/2019)		
Label Name	**Rx Num**	**Total Reimb Amt**
Baqsimi	**1**	**$574.06**
Glucagon Emergency	**124**	**$30,615.69**
GlucaGen Hypokit	**11**	**$2,837.15**
GlucaGen Diagnostic	**0**	**0**
Gvoke PFS	**0**	**0**

REFERENCES:

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3. Glucagon Emergency Kit (glucagon) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; July 2018.
4. Glucagen and Glucagen Hypokit (glucagon) [product information]. Mississuaga, Ontario, Canada: Novo Nordisk Canada Inc; February 2014.
5. Glucagon injection [prescribing information]. Lake Zurich, IL: Fresenius Kabi; January 2016.
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NORTH DAKOTA MEDICAID
RETROSPECTIVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
4TH QUARTER 2019

Criteria Recommendations ***Approved*** ***Rejected***

1. Solriamfetol / Overutilization _____ _____

Alert Message: Sunosi (solriamfetol) may be overutilized. The recommended dose range for solriamfetol is 75 mg to 150 mg once daily. Based on efficacy and tolerability, the dosage of solriamfetol may be doubled at intervals of at least 3 days. The maximum recommended dose is 150 mg once daily. Dosages above 150 mg daily do not confer increased effectiveness sufficient to outweigh dose-related adverse reactions.

Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Solriamfetol		CKD 3, 4 & 5
		ESRD

Max Dose: 150 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

2. Solriamfetol / Overutilization – Moderate Renal Impairment _____ _____

Alert Message: The maximum recommended dosage of Sunosi (solriamfetol) in patients with moderate renal impairment (eGFR 30-59 mL/min/1.73 m2) is 75 mg once daily after at least 7 days of initial dosing at 37.5 once daily. Patients with moderate or severe renal impairment may be at a higher risk of increases in blood pressure and heart rate because of the prolonged half-life of solriamfetol. The maximum dosage of solriamfetol in patients with severe renal impairment (eGFR 15-29 mL/min/1.73 m2) is 37.5 mg once daily.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Solriamfetol		CKD 3

Max Dose: 75 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

3. Solriamfetol / Overutilization – Severe Renal Impairment _____ _____

Alert Message: The maximum recommended dosage of Sunosi (solriamfetol) in patients with severe renal impairment (eGFR 15-29 mL/min/1.73 m2) is 37.5 mg once daily. Patients with moderate or severe renal impairment may be at a higher risk of increases in blood pressure and heart rate because of the prolonged half-life of solriamfetol. The maximum dosage of solriamfetol in patients with moderate renal impairment (eGFR 30-59 mL/min/1.73 m2) is 75 mg once daily after at least 7 days of initial dosing at 37.5 once daily.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Solriamfetol		CKD 4 & 5

Max Dose: 37.5 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

4. Solriamfetol / ESRD _____ _____

Alert Message: The use of Sunosi (solriamfetol) is not recommended in patients with ESRD (eGFR < 15 mL/min/1.73 m2). Solriamfetol is primarily renally eliminated and exposure (AUC) and half-life of solriamfetol are significantly increased in patients with end-stage renal disease.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Solriamfetol		ESRD

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

5. Solriamfetol / MAOIs _____ _____

Alert Message: Sunosi (solriamfetol) is contraindicated in patients receiving concomitant treatment with monoamine oxidase (MAO) inhibitors, or within 14 days following discontinuation of monoamine oxidase inhibitor, because of the risk of hypertensive reaction.

Drugs/Diseases

Util A	Util B		Util C
Solriamfetol	Isocarboxazid	Rasagiline	
	Phenelzine	Linezolid	
	Tranylcypromine	Safinamide	

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

6. Solriamfetol / Dopaminergic Agents _____ _____

Alert Message: Use caution when concomitantly administering dopaminergic drugs with Sunosi (solriamfetol). Solriamfetol is a dopamine and norepinephrine reuptake inhibitor (DNRI), and use with dopaminergic drugs that increase levels of dopamine or that bind directly to dopamine receptors might result in pharmacodynamic interactions with solriamfetol. Interactions with dopaminergic drugs have not been evaluated with solriamfetol.

Drugs/Diseases

Util A	Util B		Util C
Solriamfetol	Amantadine	Ropinirole	
	Bromocriptine	Rotigotine	
	Bupropion	Pramipexole	
	Levodopa	Tolcapone	
	Entacapone		

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

Criteria Recommendations *Approved* *Rejected*

7. Solriamfetol / Serious Heart Problems _____ _____

Alert Message: The use of Sunosi (solriamfetol) should be avoided in patients with unstable cardiovascular disease, serious heart arrhythmias, or other serious heart problems. Solriamfetol may cause dose-dependent increases in blood pressure and heart rate. If increases in blood pressure or heart rate occur and cannot be managed with dose reduction of solriamfetol or other appropriate medical interventions, consider discontinuation of solriamfetol.

Drugs/Diseases

Util A	Util B	Util **C (Include)**
Solriamfetol		Arrhythmia
		Unstable Angina
		Myocardial Infarction
		Valve Disorders
		Heart Failure

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, March 2019, Jazz Pharmaceuticals, Inc.

8. Solriamfetol / Blood Pressure & Heart Rate Increases _____ _____

Alert Message: Exercise caution when prescribing Sunosi (solriamfetol) to patients at high risk for cardiovascular events (e.g., patients with known cardiovascular or cerebrovascular disease, preexisting hypertension, advanced age). Solriamfetol may cause dose-dependent increases in blood pressure and heart rate. If increases in blood pressure or heart rate occur and cannot be managed with dose reduction of solriamfetol or other appropriate medical interventions, consider discontinuation of solriamfetol.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Solriamfetol		Hypertension
		Tachycardia
		Diabetes
		Hyperlipidemia
		Obesity

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, March 2019, Jazz Pharmaceuticals, Inc.

9. Solriamfetol / Psychiatric Symptoms _____ _____

Alert Message: Psychiatric adverse reactions have been observed in clinical trials with Sunosi (solriamfetol), including anxiety, insomnia, and irritability. Caution should be exercised when treating patients with solriamfetol who have a history of psychosis or bipolar disorders. Patients treated with solriamfetol should be observed for the possible emergence or exacerbation of psychiatric symptoms. If psychiatric symptoms develop in association with the administration of solriamfetol, consider dose reduction or discontinuation of solriamfetol.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Solriamfetol		Bipolar Disorder
		Psychosis
		Anxiety
		Agitation
		Irritability
		Insomnia

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

10. Solriamfetol / Drugs the Increase BP or HR _____ _____

Alert Message: Caution should be exercised when prescribing Sunosi (solriamfetol) with other medications that increase blood pressure and/or heart rate. Solriamfetol can cause dose-dependent increases in blood pressure and heart rate, and concurrent use with other medications that increase blood pressure and/or heart rate may increase the risk of the adverse effects.

Drugs/Diseases

Util A	Util B	Util C
Solriamfetol	Amphetamine	Benzphetamine
	Dextroamphetamine	Diethylpropion
	Lisdexamfetamine	Phendimetrazine
	Methamphetamine	Phentermine
	Methylphenidate	Droxidopa
	Dexmethylphenidate	Venlafaxine
	Pseudoephedrine	Esketamine
	Phenylephrine	Triptans
	Indomethacin	Ibuprofen
	Naproxen	Piroxicam

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

11. Solriamfetol / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Sunosi (solriamfetol) in pediatric patients have not been established. Clinical studies of solriamfetol in pediatric patients have not been conducted.

Drugs/Diseases

Util A	Util B	Util C
Solriamfetol		

Age Range 0 – 17 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

12. Solriamfetol / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no available human data regarding the use of Sunosi (solriamfetol) during pregnancy to be informative of any drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Results from some animal reproductive studies using doses exceeding the maximum recommended human dose (MRHD) of solriamfetol showed fetal harm and maternal toxicity. Healthcare providers are encouraged to register pregnant patients in the Sunosi Pregnancy Registry.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Solriamfetol	Pregnancy	Miscarriage
		Delivery
		Abortion

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

13. Solriamfetol / Lactation _____ _____

Alert Message: There are no data available on the presence of Sunosi (solriamfetol) or its metabolites in human milk, the effects on the breastfed infant, or the effect of this drug on milk production. Solriamfetol is present in rat milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for solriamfetol and any potential adverse effects on the breastfed child from solriamfetol or from the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Solriamfetol	Lactation	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Sunosi Prescribing Information, June 2019, Jazz Pharmaceuticals, Inc.

14. Aclidinium/Formoterol / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Duaklir Pressair (aclidinium/formoterol) have not been established in the pediatric population.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol		

Age Range: 0 – 17 yoa

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

15. Aclidinium/Formoterol / Overuse _____ _____

Alert Message: Duaklir Pressair (aclidinium/formoterol) may be over-utilized. The manufacturer's maximum recommended dose is one oral inhalation (400 mcg/12 mcg) twice daily. Clinically significant cardiovascular effects and fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol		

Max Dose: 800 mcg/24 mcg daily

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

16. Aclidinium/Formoterol / Therapeutic Appropriateness _____ _____

Alert Message: Duaklir Pressair (aclidinium/formoterol) is indicated for maintenance treatment of patients with chronic obstructive pulmonary disease (COPD) and is not indicated for the relief of acute bronchospasm or for the treatment of asthma. The safety and efficacy of aclidinium/formoterol in patients with asthma has not been established.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Aclidinium/Formoterol	Asthma	COPD

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

17. Aclidinium/Formoterol / Cardiovascular, Convulsive Disorders, Thyrotoxicosis & Diabetes _____ _____

Alert Message: Duaklir Pressair (aclidinium/formoterol) should be used with caution in patients with cardiovascular or convulsive disorders, thyrotoxicosis, diabetes mellitus, or sensitivity to sympathomimetic drugs. The formoterol component is a sympathomimetic amine and can exacerbate these conditions.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol	Hypertension	
	Arrhythmias	
	Heart Failure	
	Diabetes	
	Seizures	
	Epilepsy	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

18. Aclidinium/Formoterol / Narrow Angle Glaucoma _____ _____

Alert Message: Duaklir Pressair (aclidinium/formoterol) should be used with caution in patients with narrow-angle glaucoma. Aclidinium is an anticholinergic agent and may worsen this condition. Prescribers and patients should be alert for signs and symptoms of acute narrow-angle glaucoma (e.g., eye pain or discomfort, blurred vision, or visual halos).

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol	Narrow-Angle Glaucoma	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

19. Aclidinium/Formoterol / Urinary Retention _____ _____

Alert Message: Duaklir Pressair (aclidinium/formoterol) should be used with caution in patients with urinary retention or bladder neck obstruction. Aclidinium is an anticholinergic agent which may worsen urinary retention. Prescribers and patients should be alert for signs and symptoms of urinary retention (e.g., difficulty passing urine, painful urination), especially in patients with prostatic hyperplasia or bladder neck obstruction. Instruct patients to consult a physician immediately should any of these signs or symptoms develop.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol	Urinary Retention	
	Prostatic Hyperplasia	
	Bladder-Neck Obstruction	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

20. Aclidinium/Formoterol / Paradoxical Bronchospasm _____ _____

Alert Message: Inhaled medicines, including Duaklir Pressair (aclidinium/formoterol), may cause paradoxical bronchospasm, which may be life-threatening. If paradoxical bronchospasm occurs following dosing with aclidinium/formoterol, it should be treated immediately with an inhaled, short-acting bronchodilator. Aclidinium/formoterol should be discontinued immediately, and alternative therapies should be instituted.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol	Bronchospasm	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

21. Aclidinium/Formoterol / Anticholinergic Drugs _____ _____

Alert Message: The concurrent use of Duaklir Pressair (aclidinium/formoterol) with anticholinergic medications should be avoided. The aclidinium component of the combination medication is an anticholinergic drug, and use with another anticholinergic agent may result in additive anticholinergic adverse effects.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol	Anticholinergics	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

22. Aclidinium/Formoterol / Adrenergic Drugs _____ _____

Alert Message: Caution should be exercised when Duaklir Pressair (aclidinium/formoterol) is prescribed concurrently with other adrenergic sympathomimetic agents, administered by any route, because the sympathetic effects of the formoterol component of the combination product may be potentiated.

Drugs/Diseases

Util A	Util B			
Aclidinium/Formoterol	Ephedrine	Metaproterenol	Lisdexamfetamine	Oxymetazoline
	Epinephrine	Terbutaline	Diethylpropion	Tetrahydrozoline
	Pseudoephedrine	Methamphetamine	Benzphetamine	
	Phenylephrine	Methylphenidate	Phentermine	
	Albuterol	Amphetamine	Phendimetrazine	
	Pirbuterol	Dextroamphetamine	Naphazoline	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

23. Aclidinium/Formoterol / Xanthine Derivatives & Steroids _____ _____

Alert Message: Caution should be exercised when Duaklir Pressair (aclidinium/formoterol) is prescribed concurrently with xanthine derivatives or steroids because concomitant administration may potentiate the hypokalemic effect of the formoterol component of the combination agent.

Drugs/Diseases

Util A	Util B	
Aclidinium/Formoterol	Theophylline	Hydrocortisone
	Aminophylline	Methylprednisolone
	Dyphylline	Prednisone
	Betamethasone	Prednisolone
	Budesonide	Dexamethasone
	Cortisone	

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

24. Aclidinium/Formoterol / Non-Potassium Sparing Diuretics _____ _____

Alert Message: Caution should be exercised when Duaklir Pressair (aclidinium/formoterol), a beta2-agonist containing combo agent, is prescribed concurrently with non-potassium sparing diuretics because concomitant administration may potentiate the ECG changes or hypokalemia that may result from the administration of the diuretic.

Drugs/Diseases

Util A	Util B		Util C
Glycopyrrolate/Formoterol	Furosemide	Indapamide	
	Bumetanide	Methyclothiazide	
	Torsemide	Metolazone	
	Chlorothiazide		
	Chlorthalidone		
	HCTZ		

References:
Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

25. Aclidinium/Formoterol / MAOIs, TCA & Other QT Prolong Meds _____ _____

Alert Message: Duaklir Pressair (aclidinium/formoterol), as with other drugs containing beta2-agonists, should be administered with caution to patients being treated with monoamine oxidase inhibitors, tricyclic antidepressants, or other drugs known to prolong the QTc interval, because the action of adrenergic agonists on the cardiovascular system may be potentiated by these agents. Drugs that are known to prolong the QTc interval have an increased risk of ventricular arrhythmias.

Drugs/Diseases

Util A	Util B				Util C
Aclidinium/Formoterol	Albuterol	Disopyramide	Imipramine	Pazopanib	
	Alfuzosin	Dofetilide	Indapamide	Pentamidine	
	Amantadine	Dolasetron	Isradipine	Pimozide	
	Tolterodine	Amiodarone	Doxepin	Itraconazole	
	Posaconazole	Trazodone	Amitriptyline	Dronedarone	
	Ketoconazole	Procainamide	TMP/SMZ	Amphetamine	
	Droperidol	Lapatinib	Propafenone	Trimipramine	
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline	
	Vandetanib	Asenapine	Epinephrine	Levofloxacin	
	Quetiapine	Vardenafil	Atazanavir	Erythromycin	
	Lithium	Quinidine	Venlafaxine	Atomoxetine	
	Escitalopram	Metaproterenol	Ranolazine	Tizanidine	
	Ziprasidone	Azithromycin	Felbamate	Tamoxifen	
	Risperidone	Zolmitriptan	Chloral Hydrate	Flecainide	
	Moexipril/HCTZ	Ritonavir	Ezogabine	Chloroquine	
	Fluconazole	Moxifloxacin	Salmeterol	Rasagiline	
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir	
	Phenelzine	Ciprofloxacin	Foscarnet	Nilotinib	
	Sertraline	Tranylcypromine	Citalopram	Fosphenytoin	
	Solifenacin	Linezolid	Clarithromycin	Galantamine	
	Nortriptyline	Sotalol	Thioridazine	Terbutaline	
	Clomipramine	Tacrolimus	Octreotide	Sunitinib	
	Clozapine	Granisetron	Ofloxacin	Artemether/Lumefantrine	
	Dasatinib	Haloperidol	Ondansetron		
	Desipramine	Isocarboxazid	Paliperidone		
	Diphenhydramine	Iloperidone	Paroxetine		

References:

Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

26. Aclidinium/Formoterol / Nonselective Beta Blockers _____ _____

Alert Message: Beta-adrenergic receptor antagonists (beta-blockers) and Duaklir Pressair (aclidinium/formoterol) may antagonize the effect of each other when administered concurrently. Beta-blockers not only block the therapeutic effects of beta2-agonists, such as formoterol, but may produce severe bronchospasm in COPD patients. Therefore, patients with COPD should not normally be treated with beta-blockers. If therapy is warranted, cardioselective beta-blockers could be considered, although they should be administered with caution.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Glycopyrrolate/Formoterol	Carvedilol	Acebutolol
	Nadolol	Atenolol
	Labetalol	Betaxolol
	Penbutolol	Bisoprolol
	Pindolol	Metoprolol
	Propranolol	Nebivolol
	Sotalol	
	Timolol	

References:

Duaklir Pressair Prescribing Information, March 2019, AstraZeneca.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

27. Aclidinium/Formoterol / Non-adherence _____ _____

Alert Message: Based on refill history, your patient may be under-utilizing Duaklir Pressair (aclidinium/formoterol). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Aclidinium/Formoterol		

References:

van Boven JF, Chavannes NH, van der Molen T, et al. Clinical and Economic Impact of Non-adherence in COPD: A Systematic Review. Respir Med. 2015 Jan;108(1):103-113.
Restrepo RD, Alvarez MT, Wittnebel LD, et al., Medication Adherence Issues in Patients Treated for COPD. International Journal of COPD. 2008;3(3):371-384.
Simoni-Wastila L, Wei Y, Qian J, et al., Association of Chronic Obstructive Pulmonary Disease Maintenance Medication Adherence With All-Cause Hospitalization and Spending in a Medicare Population. Am Jrnl Geriatr Pharmacother. 2012 Jun;10(3):201-210.
Lareau SC, Yawn BP. Improving Adherence with Inhaler Therapy in COPD. International Journal COPD. 2010 Nov 24;5:401-406.

28. Budesonide ER Tablets / Hepatic Impairment _____ _____

Alert Message: Uceris (budesonide extended-release tablets) is primarily metabolized in the liver. Patients with moderate to severe hepatic impairment (Child-Pugh Class B and C, respectively) could be at increased risk of hypercorticism and adrenal axis suppression due to increased systemic exposure of oral budesonide. Monitor the patient for increased signs and/or symptoms of hypercorticism. Discontinuing the use of budesonide extended-release tablets should be considered in these patients.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Budesonide ER Tabs		Hepatic Impairment

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Uceris Prescribing Information, Nov. 2016, Valeant Pharmaceuticals.

29. Budesonide ER Tablets / Strong CYP3A4 Inhibitors _____ _____

Alert Message: The concurrent use of Uceris (budesonide extended-release tablets) with strong CYP3A4 inhibitors should be avoided. Budesonide is a CYP3A4 substrate, and coadministration with strong CYP3A4 inhibitors can significantly increase the systemic exposure to budesonide.

Drugs/Diseases

Util A	Util B		Util C
Budesonide ER Tabs	Itraconazole	Indinavir	
	Ketoconazole	Nelfinavir	
	Atazanavir	Telithromycin	
	Clarithromycin	Nefazodone	
	Saquinavir	Cobicistat	
	Ritonavir		

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Uceris Prescribing Information, Nov. 2016, Valeant Pharmaceuticals.

30. Stiripentol / Overutilization _____ _____

Alert Message: Diacomit (stiripentol) may be over-utilized. The recommended maximum total dosage of stiripentol is 3,000 mg/day.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol		

Max Dose: 3000 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

31. Stiripentol / Therapeutic Appropriateness _____ _____

Alert Message: A recent review of the patient drug history does not reveal a current prescription for clobazam. Diacomit (stiripentol) is indicated for the treatment of seizures associated with Dravet syndrome (DS) in patients 2 years of age and older taking clobazam. There are no clinical data to support the use of stiripentol as monotherapy in Dravet syndrome.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Stiripentol		Clobazam

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

32. Stiripentol / Neutropenia & Thrombocytopenia _____ _____

Alert Message: Diacomit (stiripentol) can cause a significant decline in neutrophil count and platelet count. Hematologic testing should be obtained prior to starting treatment with stiripentol, and then every 6 months.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol	Neutropenia	
	Thrombocytopenia	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

33. Stiripentol / Clobazam _____ _____

Alert Message: Co-administration of Diacomit (stiripentol), which inhibits CYP3A4 and CYP2C19, with clobazam results in increased plasma concentrations of clobazam (a substrate of CYP3A4) and norclobazam, the active metabolite of clobazam (a substrate of CYP2C19). This may increase the risk of clobazam-related adverse reactions. Consider a reduction in dosage of clobazam if adverse reactions are experienced when co-administered with stiripentol.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol	Clobazam	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

34. Stiripentol / CYP1A2, 3A4 & 2C19 Inducers _____ _____

Alert Message: Induction-based interactions leading to decreases in Diacomit (stiripentol) concentrations are possible when co-administered with a potent CYP1A2, CYP3A4, or CYP2C19 inducer, such as rifampin, phenytoin, phenobarbital, and carbamazepine, as these enzymes all metabolize stiripentol. Concomitant use of strong inducers with stiripentol should be avoided, or dosage adjustments should be made.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol	Rifampin	
	Phenytoin	
	Phenobarbital	
	Carbamazepine	
	Omeprazole	
	Lansoprazole	

References:

Diacomit Prescribing Information, August 2018, Biocodex.
FDA Drug Development and Drug Interaction: Tables of Substrates, Inhibitors, and Inducers. Available at: https://www.fda.gov/drugs/drug-interactions-labeling/drug-development-and-drug-interactions-table-substrates-inhibitors-and-inducers

35. Stiripentol / Substrates of CYP2C8, 2C19, P-gp & BCRP _____ _____

Alert Message: Because of potential inhibition of enzyme/transporter activity by Diacomit (stiripentol), consider a reduction in dosage of substrates of CYP2C8, CYP2C19 (e.g., diazepam, clopidogrel), P-gp (e.g., digoxin), and BCRP (e.g., methotrexate, prazosin, glyburide), if adverse reactions are experienced when administered concomitantly with stiripentol.

Drugs/Diseases

Util A	Util B			Util C
Stiripentol	Diazepam	Rabeprazole	Digoxin	
	Clopidogrel	Voriconazole	Fexofenadine	
	Dantrolene	Loperamide	Quinidine	
	Methotrexate	Glyburide	Sulfasalazine	
	Prazosin	Repaglinide	Rosuvastatin	

References:

Diacomit Prescribing Information, August 2018, Biocodex.
FDA Drug Development and Drug Interaction: Tables of Substrates, Inhibitors, and Inducers. Available at: https://www.fda.gov/drugs/drug-interactions-labeling/drug-development-and-drug-interactions-table-substrates-inhibitors-and-inducers

36. Stiripentol / Substrates of CYP1A2, 2B6 & 3A4 _____ _____

Alert Message: In vitro data show that Diacomit (stiripentol) is both an inhibitor and inducer of CYP1A2, CYP2B6, and CYP3A4. Because of potential drug-drug interactions, consider dose adjustment of CYP1A2 substrates (e.g., theophylline, caffeine), CYP2B6 substrates (e.g., sertraline, thiotepa), and CYP3A4 substrates (e.g., midazolam, triazolam, quinidine), as clinically appropriate, when administered concomitantly with stiripentol.

Drugs/Diseases

Util A	Util B		Util C
Stiripentol	Dexamethasone	Pirfenidone	Crizotinib
	Midazolam	Eszopiclone	Dasatinib
	Alprazolam	Ethosuximide	Erlotinib
	Triazolam	Galantamine	Ibrutinib
	Alosetron	Hydrocodone	Lapatinib
	Bupropion	Loratadine	Nilotinib
	Etoposide	Lurasidone	Pazopanib
	Irinotecan	Maraviroc	Sunitinib
	Cyclophosphamide	Oxycodone	Vandetanib
	Selegiline	Prasugrel	Clozapine
	Imatinib	Quazepam	Tasimelteon
	Methadone	Simvastatin	Ramelteon
	Ketamine	Lovastatin	Fosamprenavir
	Velpatasvir	Tadalafil	Atazanavir
	Apixaban	Tiagabine	Tipranavir
	Bortezomib	Axitinib	Delavirdine
	Bosutinib	Vilazodone	Theophylline
	Buprenorphine	Axitinib	Tizanidine
	Clomipramine	Cabozantinib	Theophylline
	Disulfiram	Ceritinib	Efavirenz
	Avanafil	Darifenacin	Everolimus
	Naloxegol	Nisoldipine	Sirolimus
	Vardenafil	Duloxetine	Tacrolimus
	Buspirone	Dronedarone	Budesonide
	Dasatinib	Eletriptan	Eplerenone
	Felodipine	Indinavir	Lurasidone
	Maraviroc	Quetiapine	Sildenafil
	Ticagrelor	Tolvaptan	Aprepitant
	Atorvastatin	Colchicine	Eliglustat
	Pimozide	Rilpivirine	Rivaroxaban

References:

Diacomit Prescribing Information, August 2018, Biocodex.
FDA Drug Development and Drug Interaction: Tables of Substrates, Inhibitors, and Inducers. Available at: https://www.fda.gov/drugs/drug-interactions-labeling/drug-development-and-drug-interactions-table-substrates-inhibitors-and-inducers

37. Stiripentol / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Diacomit (stiripentol) in pediatric patients below the age of 2 years have not been established.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol		

Age Range: 0 – 1 yoa

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

38. Stiripentol / Moderate & Severe Renal Impairment _____ _____

Alert Message: There is no formal study of the pharmacokinetics and metabolism of Diacomit (stiripentol) in patients with renal impairment. However, since stiripentol metabolites are eliminated mainly through the kidney, administration to patients with moderate or severe renal impairment is not recommended.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Stiripentol		CKD 4, 5 & ESRD

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

39. Stiripentol / Hepatic Impairment _____ _____

Alert Message: There has been no formal study of the pharmacokinetics of Diacomit (stiripentol) in patients with liver impairment. However, since stiripentol is mainly metabolized by the liver, administration to patients with moderate or severe liver impairment is not recommended.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Stiripentol		Hepatic Impairment

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

40. Stiripentol / Nonadherence _____ _____

Alert Message: Based on the refill history, your patient may be underutilizing Diacomit (stiripentol). Non-adherence to the prescribed dosing regimen may result in sub-therapeutic effects, which may lead to decreased patient outcomes and additional healthcare costs.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005; 353:487- 497.
Faught E, Duh MS, Weiner JR, et al. Nonadherence to Antiepileptic Drugs and Increased Mortality, Findings from the RANSOM Study. Neurology 2008;71(20): 1572-1578.
Hodges JC, Treadwell J, Malphrus AD, et al., Identification and Prevention of Antiepileptic Drug Noncompliance: The Collaborative Use of State-Supplied Pharmaceutical Data. ISRN Pediatr. 2014 Feb 19:1-8.
Viswanathan M, Golin CE, Jones DC, et al., Interventions to Improve Adherence to Self-administered Medications for Chronic Disease in the United States: A Systemic Review. Ann Intern Med. 2012:157:785-792.

41. Stiripentol / Pregnancy / Pregnancy Negating _____ _____

Alert Message: There are no adequate data on the developmental risks associated with the use of Diacomit (stiripentol) in pregnant women. Administration of stiripentol to pregnant animals produced evidence of developmental toxicity at maternal doses lower than the recommended clinical dose. Physicians are advised to recommend that pregnant patients taking stiripentol enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Stiripentol	Pregnancy	Miscarriage
		Delivery
		Abortion

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

42. Stiripentol / Lactation _____ _____

Alert Message: There are no data on the presence of Diacomit (stiripentol) in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for stiripentol and any potential adverse effects on the breastfed infant from stiripentol or the underlying maternal condition.

Drugs/Diseases

Util A	Util B	Util C
Stiripentol	Lactation	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

43. Stiripentol Solution / Phenylketonuria _____ _____

Alert Message: Phenylalanine can be harmful to patients with phenylketonuria (PKU). Diacomit (stiripentol) powder for suspension contains phenylalanine, a component of aspartame. Each 250 mg packet contains 1.40 mg phenylalanine; each 500 mg packet contains 2.80 mg phenylalanine. Before prescribing stiripentol powder for suspension to a patient with PKU, consider the combined daily amount of phenylalanine from all sources, including stiripentol powder for suspension. Stiripentol capsules do not contain phenylalanine.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Stiripentol Solution		Phenylketonuria

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Diacomit Prescribing Information, August 2018, Biocodex.

44. Efavirenz/Lamivudine/Tenofovir / All Other Antiretrovirals _____ _____

Alert Message: Symfi (efavirenz/lamivudine/tenofovir disoproxil) is a complete regimen for the treatment of HIV-1 infection; therefore, it should not be administered with other antiretroviral medications for the treatment of HIV-1 infection.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Cellular Chemokine Receptor (CCR5) Antagonist	
	Fusion Inhibitors	
	Integrase Inhibitors	
	NNRTIs	
	NRTIs	
	Nucleotide Analog Reverse Transcriptase Inhibitors	
	Protease Inhibitors	
	Antiretroviral Combos	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

45. Efavirenz/Lamivudine/Tenofovir / Overutilization _____ _____

Alert Message: Symfi (efavirenz/lamivudine/tenofovir disoproxil) may be over-utilized. The recommended maximum daily dose in adults and pediatric patients weighing at least 40 kg, and can swallow a solid tablet, is one tablet once daily on an empty stomach, preferably at bedtime.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir		

Max Dose: 1 tablet/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

46. Efavirenz/Lamivudine/Tenofovir / Elbasvir/Grazoprevir _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with Zepatier (elbasvir/grazoprevir) is contraindicated due to the potential for loss elbasvir/grazoprevir virologic response. The efavirenz component of the combination antiretroviral product is a CYP3A4 inducer, and both components of the antiviral combination product are CYP3A4 substrates.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Elbasvir/Grazoprevir	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

47. Efavirenz/Lamivudine/Tenofovir / Renal Impairment _____ _____

Alert Message: Because Symfi (efavirenz/lamivudine/tenofovir disoproxil) is a fixed-dose combination tablet and cannot be dose adjusted, the agent is not recommended for use in patients with impaired renal function (CrCl < 50 mL/min) or patients with ESRD requiring hemodialysis. Renal impairment, including cases of acute renal failure and Fanconi syndrome, has been reported with the use of the tenofovir component of this combination tablet.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Efavirenz/Lamivudine/Tenofovir		CKD 3, 4, & 5 ESRD Dialysis

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

48. Efavirenz/Lamivudine/Tenofovir / Hepatic Impairment _____ _____

Alert Message: Symfi (efavirenz/lamivudine/tenofovir disoproxil) use is not recommended in patients with moderate to severe hepatic impairment (Child-Pugh B or C). Efavirenz/lamivudine/tenofovir disoproxil should be used with caution in patients with mild hepatic impairment. Postmarketing cases of hepatitis, including fulminant hepatitis progressing to liver failure requiring transplantation or resulting in death, have been reported in patients treated with efavirenz, a component of the combination product.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Efavirenz/Lamivudine/Tenofovir		Hepatic Impairment

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

49. Efavirenz/Lamivudine/Tenofovir / Seizure Disorders _____ _____

Alert Message: Symfi (efavirenz/lamivudine/tenofovir disoproxil) should be used with caution in patients with a history of seizures. The use of the efavirenz, a component in the combination antiretroviral product, has been associated with the occurrence of convulsions, generally in the presence of a known medical history of seizures.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Efavirenz/Lamivudine/Tenofovir		Seizures Convulsions

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

50. Efavirenz/Lamivudine/Tenofovir / Drugs Causing QT Prolongation _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with drugs that prolong the QTc interval may increase the risk for QTc prolongation. QTc prolongation has been observed with the use of efavirenz, a component in the combination antiretroviral. It is recommended to consider alternatives to products containing efavirenz when coadministered with a drug with a known risk of torsade de pointes or when administered to patients at higher risk of torsade de pointes.

Drugs/Diseases

Util A	Util B			Util C
Efavirenz/Lamivudine/Tenofovir	Albuterol	Disopyramide	Imipramine	Pazopanib
	Alfuzosin	Dofetilide	Indapamide	Pentamidine
	Amantadine	Dolasetron	Isradipine	Pimozide
	Tolterodine	Amiodarone	Doxepin	Itraconazole
	Posaconazole	Trazodone	Amitriptyline	Dronedarone
	Ketoconazole	Procainamide	TMP/SMZ	Amphetamine
	Droperidol	Lapatinib	Propafenone	Trimipramine
	Arsenic Trioxide	Ephedrine	Levalbuterol	Protriptyline
	Vandetanib	Asenapine	Epinephrine	Levofloxacin
	Quetiapine	Vardenafil	Atazanavir	Erythromycin
	Lithium	Quinidine	Venlafaxine	Atomoxetine
	Escitalopram	Metaproterenol	Ranolazine	Tizanidine
	Ziprasidone	Azithromycin	Felbamate	Tamoxifen
	Risperidone	Zolmitriptan	Chloral Hydrate	Flecainide
	Moexipril/HCTZ	Ritonavir	Ezogabine	Chloroquine
	Fluconazole	Moxifloxacin	Salmeterol	Rasagiline
	Chlorpromazine	Fluoxetine	Nicardipine	Saquinavir
	Phenelzine	Ciprofloxacin	Foscarnet	Nilotinib
	Sertraline	Tranylcypromine	Citalopram	Fosphenytoin
	Solifenacin	Linezolid	Clarithromycin	Galantamine
	Nortriptyline	Sotalol	Thioridazine	Terbutaline
	Clomipramine	Tacrolimus	Octreotide	Sunitinib
	Clozapine	Granisetron	Ofloxacin	Artemether/Lumefantrine
	Dasatinib	Haloperidol	Ondansetron	
	Desipramine	Isocarboxazid	Paliperidone	
	Diphenhydramine	Iloperidone	Paroxetine	

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

51. Efavirenz/Lamivudine/Tenofovir / Risk Factors for Torsade de Pointes _____ _____

Alert Message: QTc prolongation has been observed with the use of efavirenz, a component in the combination antiretroviral Symfi (efavirenz/lamivudine/tenofovir disoproxil). It is recommended to consider alternative therapy in patients at higher risk of torsade de pointes.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Long QT Syndrome	
	Bradycardia	
	Hypokalemia	
	Hypomagnesemia	
	Arrhythmias	

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.
Jatin D. (2017, Jan. 31) Torsade de Pointes. eMedicine, Medscape.com.

52. Efavirenz/Lamivudine/Tenofovir / Bupropion _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with a bupropion-containing agent may result in decreased plasma concentrations and pharmacologic effects of bupropion. Adjustments to the bupropion dosage may be necessary and should be guided by clinical response. The bupropion dose should not exceed the maximum recommended dose.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Bupropion	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

53. Efavirenz/Lamivudine/Tenofovir / Sertraline _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with sertraline may result in decreased plasma concentrations and pharmacologic effects of sertraline. Adjustments to the sertraline dosage may be necessary and should be guided by clinical response. The sertraline dose should not exceed the maximum recommended dose.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Sertraline	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

54. Efavirenz/Lamivudine/Tenofovir / Ketoconazole & Itraconazole _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with ketoconazole or itraconazole (CYP3A4 substrates) can result in decreased plasma concentrations of the antifungal agent due to induction of CYP3A4-mediated metabolism by efavirenz. In addition, both antifungal agents as well as efavirenz are associated with QT prolongation and concomitant use may result in additive effects on the QT interval. Consider alternative antifungal treatment because no dose recommendation for the antifungal can be made.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Ketoconazole Itraconazole	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

55. Efavirenz/Lamivudine/Tenofovir / Posaconazole _____ _____

Alert Message: The concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with posaconazole should be avoided unless the benefit outweighs the risk. The efavirenz component of the combination antiretroviral product is a UDP-glucuronidase inducer and coadministration with posaconazole, a UDP-G substrate, can result in a significant decrease in the posaconazole plasma concentrations. In addition, both posaconazole and efavirenz are associated with QT prolongation and concomitant use may result in additive effects on the QT interval.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Posaconazole	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

56. Efavirenz Containing Agents / Certain Statins _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with atorvastatin, pravastatin or simvastatin can result in decreased statin plasma concentrations due to induction, by efavirenz, of the statin CYP3A4-mediated metabolism. Statin dosage adjustment may be necessary, but do not exceed the maximum recommended statin dose.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Atorvastatin Simvastatin Pravastatin	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

57. Efavirenz/Lamivudine/Tenofovir / Velpatasvir-Sofosbuvir _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with Epclusa (velpatasvir/sofosbuvir) is not recommended because it may result in loss of therapeutic effect of velpatasvir-sofosbuvir. The efavirenz component of the antiretroviral agent is a CYP3A4 inducer, and the velpatasvir component of the antiviral is a CYP3A4 substrate.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Velpatasvir-Sofosbuvir	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

58. Efavirenz/Lamivudine/Tenofovir / Immunosuppressants 3A4 Substrate _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with an immunosuppressant drug that is a CYP3A4 substrate may result in decreased immunosuppressant exposure. Dosage adjustment of the immunosuppressant may be required. Close monitoring of the immunosuppressant concentrations for at least 2 weeks is recommended when starting or stopping treatment with an efavirenz-containing drug.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Cyclosporine	
	Tacrolimus	
	Sirolimus	
	Everolimus	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

59. Efavirenz/Lamivudine/Tenofovir / CCBs that are CYP3A4 Substrates _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with a calcium channel blocker (CCB) that is a CYP3A4 substrate can result in a decrease in the CCB plasma concentrations. The efavirenz component of the antiretroviral combination product is a CYP3A4 inducer. Dosage adjustment of the CCB may be necessary and should be guided by clinical response to the CCB.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Diltiazem	
	Verapamil	
	Felodipine	
	Nicardipine	
	Nifedipine	
	Nimodipine	
	Nisoldipine	
	Amlodipine	
	Isradipine	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

60. Efavirenz/Lamivudine/Tenofovir / Rifampin _____ _____

Alert Message: Caution is recommended when using Symfi (efavirenz/lamivudine/tenofovir disoproxil) with rifampin. Both rifampin and the efavirenz component of the antiretroviral are inducers and substrates of CYP3A4 metabolism. Coadministration use of these agents may result in decreased plasma concentrations of both drugs. Monitor the patient for loss of efficacy of efavirenz and rifampin.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Rifampin	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

61. Efavirenz/Lamivudine/Tenofovir / Atovaquone _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with atovaquone is not recommended. Coadministration of these agents may cause a decrease in atovaquone plasma concentrations and result in the reduced efficacy of atovaquone.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Atovaquone	

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

62. Efavirenz/Lamivudine/Tenofovir / Atovaquone-Proguanil _____ _____

Alert Message: Concurrent use of Symfi (efavirenz/lamivudine/tenofovir disoproxil) with atovaquone/proguanil is not recommended. Coadministration of these agents may cause a decrease in both the atovaquone and proguanil plasma concentrations and result in the reduced efficacy of the antimalarial product.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir	Atovaquone-Proguanil	

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Symfi Prescribing Information, March 2018, Mylan Specialty LP.

63. Efavirenz/Lamivudine/Tenofovir / Nonadherence _____ _____

Alert Message: Based on the refill history, your patient may be underutilizing Symfi (efavirenz/lamivudine/tenofovir disoproxil). Nonadherence to antiretroviral therapy may result in insufficient plasma levels and partial suppression of viral load leading to the development of resistance, HIV progression, and increased mortality.

Drugs/Diseases

Util A	Util B	Util C
Efavirenz/Lamivudine/Tenofovir		

References:

Symfi Prescribing Information, March 2018, Mylan Specialty LP.
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med 2005;353:487-97.
Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. Department of Health and Human Services. Oct. 25, 2018.
Available at: http://www.aidsinfo.nih.gov/guidelines/ht,l/1/adult-and-adolescent-arv/0
Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Sept. 12, 2019. Available at:
http://aidsinfo.nih.gov/contentfiles/lvguidelines/pe diatricguidelines.pdf

64. Entecavir / Overutilization – Nucleoside Inhibitor Naive _____ _____

Alert Message: Entecavir may be over-utilized. The recommended daily dose of entecavir for chronic hepatitis B virus infection in nucleoside inhibitor-treatment-naïve adults and adolescents 16 years of age and older is 0.5 mg once daily.

Drugs/Diseases

Util A	Util B	Util C **(Negate)**
Entecavir		Lamivudine

Max Dose: 0.5 mg/day
Age Range: 16 – 999 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.
Baraclude Prescribing Information, Dec. 2018. Bristol-Myers Squibb.

65. Entecavir / Overutilization _____ _____

Alert Message: Entecavir may be over-utilized. The recommended daily dose of entecavir in adults and adolescents (at least 16 years of age) with a history of hepatitis B viremia while receiving lamivudine or known lamivudine or telbivudine resistance substitutions rtM204I/V with or without rtL180M, rtL80I/V, or rtV173L is 1 mg once daily.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Entecavir		Lamivudine

Max Dose: 1.0 mg/day
Age Range: 16 – 999 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

66. Entecavir / Overutilization – Decompensated Liver Disease _____ _____

Alert Message: Entecavir may be over-utilized. The recommended daily dose of entecavir for chronic hepatitis B virus infection in adults with decompensated liver disease is 1.0 mg once daily.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Entecavir		Jaundice
		Ascites
		Variceal Hemorrhage
		Hepatic Failure

Max Dose: 1.0 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

67. Entecavir / Overutilization – Renal Impairment _____ _____

Alert Message: Entecavir may be over-utilized. In adult subjects with renal impairment, the apparent oral clearance of entecavir decreased as creatinine clearance decreased. Dosage adjustment of entecavir is recommended for patients with creatinine clearance less than 50 mL/min, including patients on hemodialysis or continuous ambulatory peritoneal dialysis (CAPD). Please refer to the official prescribing information for the recommended entecavir dosage adjustment.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Entecavir		CKD Stage 4
		CDK Stage 5
		ESRD
		Hemodialysis

Max Dose: 0.5 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

68. Entecavir / Nonadherence _____ _____

Alert Message: Based on the refill history, your patient may be under-utilizing entecavir. Nonadherence to antiviral therapy may result in insufficient plasma levels and partial suppression of viral load leading to the loss of antiviral efficacy.

Drugs/Diseases

Util A	Util B	Util C
Entecavir		

References:
Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005; 353(5):487–497.
Lieveld FI, van Vlerken LG, Siersena PD, van Erpecum KJ. Patient Adherence to Antiviral Treatment for Chronic Hepatitis B and C: A Systemic Review. Ann Hepatol. 2013 May-June;12(3):380-391.
Ford N, Scourse R, Lemoine M, et al., Adherence to Nucleoside Analogue Therapies for Chronic Hepatitis B Infection: A Systemic Review and Meta-Analysis. Hepatol Commun. 2018 Sep 25;2(10):11670-1167.

69. Entecavir / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of entecavir have not been established in pediatric patients less than 2 years of age.

Drugs/Diseases

Util A	Util B	Util C
Entecavir		

Age Range: 0 – 1 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

70. Entecavir / Drugs That Reduce Renal Function or Compete for ATS _____ _____

Alert Message: Since entecavir is primarily eliminated by the kidneys, coadministration of entecavir with drugs that reduce renal function or compete for active tubular secretion may increase serum concentrations of either entecavir or the coadministered drug. The effects of coadministration of entecavir with other drugs that are renally eliminated or are known to affect renal function have not been evaluated, and patients should be monitored closely for adverse events when entecavir is coadministered with such drugs.

Drugs/Diseases

Util A	Util B		Util C
Entecavir	Acyclovir	Morphine	
	Amiloride	NSAIDs	
	ACE Inhibitors	Pamidronate	
	Cimetidine	Procainamide	
	Cisplatin	Prochlorperazine	
	Cyclosporine	Ranitidine	
	Quinidine	Tacrolimus	
	Digoxin	Triamterene	
	Dofetilide	Trimethoprim	
	Memantine	Trospium	
	Foscarnet	Valacyclovir	
	Midodrine	Valganciclovir	
	Ketoconazole	Vancomycin	
	Megestrol	Zoledronic Acid	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

71. Entecavir / Black Box Warning _____ _____

Alert Message: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogue inhibitors, including entecavir, alone or in combination with antiretrovirals. Particular caution should be exercised when administering nucleoside analogue inhibitors to any patient with known risk factors for liver disease. Treatment with entecavir should be suspended in any patient who develops clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Entecavir		Lactic Acidosis
		Hepatomegaly

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

72. Entecavir / HIV / Antiretroviral Therapy _____ _____

Alert Message: Entecavir has not been evaluated in HIV/HBV co-infected patients who were not simultaneously receiving effective HIV treatment. Limited clinical experience suggests there is a potential for the development of resistance to HIV nucleoside reverse transcriptase inhibitors if entecavir is used to treat chronic hepatitis B virus infection in patients with HIV infection that is not being treated. Therefore, therapy with entecavir is not recommended for HIV/HBV co-infected patients who are not also receiving HAART.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Entecavir	HIV	HAART

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

73. Tofacitinib / RA & PsA / Risk Factors for Thrombosis (Black Box) _____ _____

Alert Message: Avoid the use of tofacitinib (Xeljanz/Xeljanz XR) in patients that may be at increased risk of thrombosis. Thrombosis, including pulmonary embolism, deep venous thrombosis, and arterial thrombosis, was observed at an increased incidence in patients with rheumatoid arthritis 50 years of age and older with at least one CV risk factor treated with Xeljanz (tofacitinib) 10 mg twice daily compared to tofacitinib 5 mg twice daily or TNF blockers in a large, ongoing postmarketing study. Many of these events were serious, and some resulted in death.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Tofacitinib	Rheumatoid Arthritis	Hyperlipidemia
	Psoriatic Arthritis	Smoking
		Diabetes
		Hypertension
		Abdominal Obesity

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Wolters Kluwer Health.
Xeljanz/Xeljanz XR Prescribing Information, July 2019, Pfizer, Inc.
Xeljanz, Xeljanz XR (tofacitinib): Drug Safety Communication - Due to an Increased Risk of Blood Clots and Death with Higher Dose. [07/26/2019].

74. Halobetasol/Tazarotene / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Duobrii (halobetasol/tazarotene lotion) is contraindicated in pregnancy. Based on data from animal reproduction studies, retinoid pharmacology, and the potential for systemic absorption, halobetasol/tazarotene lotion may cause fetal harm when administered to a pregnant female. Tazarotene elicits teratogenic and developmental effects associated with retinoids after topical or systemic administration in rats and rabbits.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Halobetasol/Tazarotene	Pregnancy	Miscarriage
		Delivery
		Abortion

Age Range: 11 – 50 yoa
Gender: Female

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Duobrii Prescribing Information, April 2019, Bausch Health Companies Inc.

75. Halobetasol/Tazarotene / Therapeutic Appropriateness _____ _____

Alert Message: The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Duobrii (halobetasol/tazarotene lotion) and any potential adverse effects on the breastfed child from halobetasol/tazarotene lotion. There are no data on the presence of tazarotene, halobetasol propionate or its metabolites in human milk, the effects on the breastfed infant, or the effects on milk production after treatment with halobetasol/tazarotene lotion.

Drugs/Diseases

Util A	Util B	Util C
Halobetasol/Tazarotene	Lactation	

Age Range: 11 – 50 yoa
Gender: Female

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Duobrii Prescribing Information, April 2019, Bausch Health Companies Inc.

76. Halobetasol/Tazarotene / Contraceptives _____ _____

Alert Message: Females of reproductive potential should be warned of the potential risk to a fetus if they were to become pregnant while on Duobrii (halobetasol/tazarotene lotion) therapy. The patient should be advised to use effective birth control measures during treatment with halobetasol/tazarotene lotion. A negative pregnancy test should be obtained within 2 weeks prior to halobetasol/tazarotene lotion therapy. Treatment should be initiated during a menstrual period.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Halobetasol/Tazarotene		Contraceptives

Age Range: 11 – 50 yoa
Gender: Female

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Duobrii Prescribing Information, April 2019, Bausch Health Companies Inc.

77. Halobetasol/Tazarotene / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Duobrii (halobetasol/tazarotene lotion) in pediatric patients under the age of 18 years have not been evaluated. Because of higher skin surface area to body mass ratios, pediatric patients are at a greater risk than adults of HPA axis suppression and Cushing's syndrome when they are treated with topical corticosteroids. They are therefore also at greater risk of adrenal insufficiency during or after withdrawal of treatment. Adverse reactions, including striae, have been reported with the use of topical corticosteroids in infants and children.

Drugs/Diseases

Util A	Util B	Util C
Halobetasol/Tazarotene		

Age Range: 0 - 17

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Duobrii Prescribing Information, April 2019, Bausch Health Companies Inc.

78. Buprenorphine Transdermal / CYP3A4 Inhibitors _____ _____

Alert Message: Concurrent use of Butrans (buprenorphine transdermal), a CYP3A4 substrate, with a CYP3A4 inhibitor can increase buprenorphine plasma concentrations resulting in prolonged opioid effects.

Drugs/Diseases

Util A	Util B	Util C
Buprenorphine transdermal	Clarithromycin	
	Nefazodone	
	Cobicistat	
	Saquinavir	
	Ritonavir	
	Nelfinavir	
	Indinavir	
	Voriconazole	
	Ketoconazole	
	Itraconazole	
	Posaconazole	

Reference:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.
Butrans Prescribing Information, Sept. 2018, Endo Pharmaceuticals, Inc.

79. Apalutamide / Ischemic Heart Disease _____ _____

Alert Message: Ischemic cardiovascular events, including events leading to death, occurred in patients receiving Erleada (apalutamide). Monitor for signs and symptoms of ischemic heart disease. Optimize management of cardiovascular risk factors, such as hypertension, diabetes, or dyslipidemia. Consider discontinuation of apalutamide for Grade 3 and 4 events.

Drugs/Diseases

Util A	Util B	Util C
Apalutamide	Syncope	
	Dyspnea	
	Tachycardia	
	Bradycardia	
	Palpitations	
	Angina	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Erleada Prescribing Information, Sept. 2019, Janssen Products.

80. Delafloxacin / Overutilization _____ _____

Alert Message: Baxdela (delafloxacin) may be over-utilized. The recommended maximum dosage of delafloxacin is 450 mg orally every 12 hours. The recommended duration of treatment is 5 to 14 days for acute bacterial skin and skin structure infections (ABSSSI) and 5 to 10 days for community-acquired bacterial pneumonia (CABP).

Drugs/Diseases

Util A	Util B	Util C
Delafloxacin		

Max Dose: 900 mg/day

References:
Baxdela Prescribing Information, Oct. 2019, Melinta Therapeutics, Inc.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

81. Delafloxacin / Therapeutic Appropriateness _____ _____

Alert Message: The use of Baxdela (delafloxacin) in patients with end-stage renal disease (ESRD) is not recommended. There is insufficient information to provide dosing recommendations in this patient population.

Drugs/Diseases

Util A	Util B	Util C
Delafloxacin	End-Stage Renal Disease	

References:
Baxdela Prescribing Information, Oct. 2019, Melinta Therapeutics, Inc.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

82. Delafloxacin / Therapeutic Appropriateness _____ _____

Alert Message: Fluoroquinolones have been associated with disabling and potentially irreversible serious adverse reactions that have occurred together, including; tendinitis and tendon rupture, peripheral neuropathy, and CNS effects. Discontinue Baxdela (delafloxacin) immediately and avoid the use of fluoroquinolones in patients who experience any of these adverse reactions.

Drugs/Diseases

Util A	Util B	Util C
Delafloxacin		

References:
Baxdela Prescribing Information, Oct. 2019, Melinta Therapeutics, Inc.
Clinical Pharmacology, 2019 Elsevier/Gold Standard.

83. Mepolizumab Prefilled / Overutilization _____ _____

Alert Message: The recommended dose of Nucala (mepolizumab) in children aged 6 to 11 years of age with severe asthma with an eosinophilic phenotype is 40 mg once every 4 weeks by subcutaneous injection in the upper arm, thigh, or abdomen. The mepolizumab prefilled autoinjector and prefilled syringe are only for use in adults and adolescents aged 12 years and older.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Mepolizumab prefilled syringe		Asthma
Mepolizumab prefilled autoinjector		

Age Range: 6 – 11 yoa

References:
Nucala Prescribing Information, Sept. 2019, GlaxoSmithKline.

84. Rizatriptan / Therapeutic Appropriateness _____ _____

Alert Message: Safety and effectiveness of rizatriptan in pediatric patients under 6 years of age have not been established.

Drugs/Diseases

Util A	Util B	Util C
Rizatriptan		

Age Range: 0 - 5 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

85. Triptans / Cardiac & Cerebrovascular Contraindications _____ _____

Alert Message: Triptans are contraindicated in patients with ischemic heart disease, or previous myocardial infarction, stroke or coronary vasospasm (including Prinzmetal's angina) due to their vasoconstrictive effect. There have been reports of serious cardiovascular events, including death, associated with triptan use. Consider using a safer alternative in this patient.

Drugs/Diseases

Util A	Util B	Util C **(Include)**
Almotriptan		Myocardial Infraction
Eletriptan		Ischemic Heart Disease
Frovatriptan		Angina
Naratriptan		Arrhythmias
Rizatriptan		Transient Ischemic Attack
Sumatriptan		
Zolmitriptan		

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Facts & Comparisons, 2019 Updates, Wolters Kluwer Health.

86. Lorlatinib / Overutilization _____ _____

Alert Message: Lorbrena (lorlatinib) may be over-utilized. The recommended dosage of lorlatinib is 100 mg orally once daily.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib		

Max Dose: 100 mg/day

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

87. Lorlatinib / Strong CYP3A Inducers _____ _____

Alert Message: Lorbrena (lorlatinib), a CYP3A4 substrate, is contraindicated in patients taking strong CYP3A inducers. Concurrent use of these agents may result in serious hepatotoxicity, as well as decreased lorlatinib plasma concentrations. Discontinue strong CYP3A inducers for 3 plasma half-lives of the strong CYP3A4 inducer prior to initiating lorlatinib.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib	Carbamazepine	Apalutamide
	Phenytoin	Enzalutamide
	Phenobarbital	Lumacaftor/Ivacaftor
	Primidone	
	Rifampin	
	Mitotane	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

88. Lorlatinib / Moderate CYP3A Inducers _____ _____

Alert Message: The concurrent use of Lorbrena (lorlatinib) with moderate CYP3A inducers should be avoided. If concomitant use of moderate CYP3A inducers cannot be avoided, monitor AST, ALT, and bilirubin 48 hours after initiating lorlatinib and at least 3 times during the first week after initiating lorlatinib.

Drugs/Diseases

Util A	Util B		Util C
Lorlatinib	Bosentan	Butalbital	
	Efavirenz		
	Etravirine		
	Modafinil		

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

89. Lorlatinib / Therapeutic Appropriateness _____ _____

Alert Message: Advise female patients of reproductive potential to use effective non-hormonal contraception during treatment with Lorbrena (lorlatinib) and for at least 6 months after the final dose. Also advise females of reproductive potential to use a non-hormonal method of contraception, because lorlatinib can render hormonal contraceptives ineffective.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib		

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

90. Lorlatinib / Pregnancy / Pregnancy Negating _____ _____

Alert Message: Based on findings from animal studies and its mechanism of action, Lorbrena (lorlatinib) can cause embryo-fetal harm when administered to a pregnant woman. There are no available data on lorlatinib use in pregnant women. Advise a pregnant woman of the potential risk to a fetus.

Drugs/Diseases

Util A	Util B	Util C **(Negating)**
Lorlatinib	Pregnancy	Miscarriage
		Delivery
		Abortion

Gender: Female
Age Range: 11 – 55 yoa

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

91. Lorlatinib / Therapeutic Appropriateness _____ _____

Alert Message: Based on genotoxicity findings, advise males with female partners of reproductive potential to use effective non-hormonal contraception during treatment with Lorbrena (lorlatinib) and for at least 3 months after the final dose.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib		

Gender: Male

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

92. Lorlatinib / Therapeutic Appropriateness _____ _____

Alert Message: The safety and effectiveness of Lorbrena (lorlatinib) in pediatric patients have not been established.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib		

Age Range: 0 - 17 yoa

References:
Clinical Pharmacology, 2018 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

93. Lorlatinib / Interstitial Lung Disease _____ _____

Alert Message: Lorbrena (lorlatinib) can cause interstitial lung disease (ILD)/pneumonitis. Promptly investigate for ILD/pneumonitis in any patient who presents with worsening of respiratory symptoms indicative of ILD/pneumonitis (e.g., dyspnea, cough, and fever). Immediately withhold lorlatinib in patients with suspected ILD/pneumonitis. Permanently discontinue lorlatinib for treatment-related ILD/pneumonitis of any severity.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib	Dyspnea	
	Cough	
	Fever	
	Interstitial Pneumonia	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

94. Lorlatinib / Atrioventricular Block _____ _____

Alert Message: PR interval prolongation and atrioventricular (AV) block can occur in patients receiving Lorbrena (lorlatinib). Monitor ECG prior to initiating lorlatinib and periodically thereafter. Withhold and resume at a reduced dose or at the same dose in patients who undergo pacemaker placement. Permanently discontinue lorlatinib for recurrence in patients without a pacemaker.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib	Atrioventricular Block	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

95. Lorlatinib / Strong CYP3A Inhibitors _____ _____

Alert Message: The concurrent use of Lorbrena (lorlatinib) with strong CYP3A inhibitors should be avoided. Concomitant use of these drugs may result in increased lorlatinib plasma concentrations. If concomitant use with a strong CYP3A inhibitor cannot be avoided, reduce the starting dose of lorlatinib according to the official prescribing information. If concomitant use of a strong CYP3A inhibitor is discontinued, increase the lorlatinib dose (after 3 plasma half-lives of the strong CYP3A inhibitor) to the dose that was used before starting the strong inhibitor.

Drugs/Diseases

Util A	Util B		Util C
Lorlatinib	Nefazodone	Cobicistat	
	Clarithromycin	Saquinavir	
	Ketoconazole	Ritonavir	
	Itraconazole	Indinavir	
	Voriconazole	Saquinavir	
	Itraconazole		

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

96. Lorlatinib / CYP3A Substrates _____ _____

Alert Message: Lorbrena (lorlatinib) is a CYP3A4 inducer, and concurrent use with a drug that is a CYP3A4 substrate can result in a decrease in the concentration of the CYP3A substrate. Avoid concomitant use of lorlatinib with CYP3A substrates, where minimal concentration changes may lead to serious therapeutic failures. If concomitant use is unavoidable, increase the CYP3A substrate dosage in accordance with approved product labeling.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib	Estrogens	
	Oxycodone	
	Tramadol	
	Hydrocodone	
	Amlodipine	
	Amiodarone	
	Avanafil	
	Codeine	
	Dihydrocodeine	
	Diltiazem	
	Doravirine	
	Elbasvir/Grazoprevir	
	Elvitegravir	

References:
Clinical Pharmacology, 2019 Elsevier/Gold Standard
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.

97. Lorlatinib / Hyperlipidemia _____ _____

Alert Message: Increases in serum cholesterol and triglycerides can occur in patients receiving Lorbrena (lorlatinib). Initiate or increase the dose of lipid-lowering agents in patients with hyperlipidemia. Monitor serum cholesterol and triglycerides before initiating lorlatinib, 1 and 2 months after initiating lorlatinib, and periodically thereafter. Withhold and resume at the same dose for the first occurrence; resume at the same or a reduced dose of lorlatinib for recurrence based on severity.

Drugs/Diseases

Util A	Util B	Util C
Lorlatinib	Hyperlipidemia	
	Hypertriglyceridemia	

References:

Clinical Pharmacology, 2019 Elsevier/Gold Standard.
Lorbrena Prescribing Information, Nov. 2018, Pfizer, Inc.