

# Preferred Drug List (PDL)

**Including:**

**Prior Authorization Criteria**

**Therapeutic Duplication**

**Electronic Step Care and Concurrent Medications**

**First Fill**

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Please use the [NDC Drug 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 can be found at [www.hidesigns.com/ndmedicaid](http://www.hidesigns.com/ndmedicaid):
    - Preferred Diabetic Supply List (PDSL)
    - Coverage Rules on Medications
- Please use the [NDC Drug Lookup](#) tool to access PA form, view coverage status, quantity limits, copay, and prior authorization information for all medications.
- 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 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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



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

### *Therapeutic Duplication*

- One Strength of one medication is allowed at a time
  - Exceptions:
    - Carvedilol IR 25mg allowed with all other strengths
    - Warfarin strengths are allowed together
    - Prazosin strengths are allowed together
- Medication classes not payable together:
  - Entresto, ACE Inhibitors, ARBs, and Renin Inhibitors are not allowed with each other
  - Sildenafil, Tadalafil, Adempas, nitrates are not allowed with each other
  - Carvedilol and Labetalol are not allowed with other alpha blockers (Alfuzosin ER, doxazosin, dutasteride-tamsulosin, prazosin, terazosin, and tamsulosin)
    - Carvedilol and Labetalol are nonselective beta blockers with alpha 1 blocking activity
  - Tizanidine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyl dopa)
    - Tizanidine is also an alpha 2 agonist
  - Clopidogrel is not covered with esomeprazole or omeprazole. Other PPIs such as pantoprazole are covered with clopidogrel.
    - Clopidogrel is a substrate for 2C19 and esomeprazole and omeprazole are strong 2C19 inhibitors and can decrease effectiveness of Clopidogrel.

## 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).

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

## Blood Modifying Agents

### Anticoagulants - Oral:

#### *Underutilization*

- Eliquis, Pradaxa, Xarelto, and Savaysa must be used compliantly and will reject on point of sale for late fill

#### *Prior Authorization*

[General Prior Authorization Form](#)

### **Group Criteria:**

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)
  - The patient must have had a 30-day trial of enoxaparin, as evidenced by paid claims or pharmacy printouts.
  - The request must be for fondaparinux and the patient must have a diagnostic history of heparin-induced thrombocytopenia (HIT)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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 PREFERRED AGENTS (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	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NOVOSEVEN RT (Coagulation Factor VIIa recombinant)	
FACTOR VIII – HEMOPHILIA A	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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)	

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XYNTHA (factor VIII recombinant)	
XYNTHA SOLOFUSE (factor VIII recombinant)	
<b>FACTOR VIII:C – HEMOPHILIA A</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
MONOCLATE-P (Antihemophilic Factor VIII:C (human))	
<b>FACTOR VIII – HEMOPHILIA A/vWF</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
ALPHANATE (Antihemophilic Factor/Von Willebrand Factor Complex (Human))	
HUMATE-P (Factor VIII/von Willebrand Factor (human))	
WILATE (Factor VIII/von Willebrand Factor (human))	
<b>FACTOR VIII – VON WILLEBRAND FACTOR - RECOMBINANT</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
	VONVENDI (Recombinant human vWF)
<b>FACTOR IX – HEMOPHILIA B</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
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)	
<b>FACTOR IXa/IX</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
HEMLIBRA (Emicizumab-kxwh)	
<b>FACTOR X</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
COAGADEX (Coagulation Factor X (Human))	
<b>FACTOR X</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
CORIFACT (Factor XIII Concentrate (Human))	
<b>FACTOR XIII A – SUBUNIT, RECOMBINANT</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
TRETEN (Factor XIII A-Subunit, recombinant)	
<b>ANTI-INHIBITOR COAGULANT COMPLEX</b>	
<b>PREFERRED AGENTS (CLINICAL PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
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).

#### **Non-Preferred Agents Criteria:**

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

<b>PREFERRED AGENTS (NO PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
FULPHILA (Pegfilgrastim-JMDB)	GRANIX (TBO-Filgrastim)
LEUKINE (Sargramostim)	NEULASTA (Pegfilgrastim)
NEUPOGEN (Filgrastim)	NIVESTYM (Figrastim-AAFI)
UDENYCA (Pegfligrastrim-CBQV)	ZARXIO (Filgrastim-SNDZ)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## 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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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)
  - The patient must have a documented sulfa allergy
  - The patient must have failed a 30-day trial of all preferred agents, as evidenced by paid claims or pharmacy print outs.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
furosemide	ethacrynic acid
bumetanide	
toremide	

## Entresto

#### **Product Specific Criteria:**

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

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

## Lipid-Lowering Agents

### Juxtapid

### [Prior Authorization Form - Juxtapid](#)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

### **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. 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).

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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):
    - The patient must be less than 12 years of age
    - 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):
    - The patient must be less than 9 years of age.
    - The provider must submit clinical documentation of the patient's inability to ingest a solid dosage form.

PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALYQ (Tadalafil)	ADCIRCA (Tadalafil) TABLET
REVATIO (Sildenafil) SUSPENSION*** - <i>Brand Required</i>	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.

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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



## 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Ambrisentan	Bosentan
TRACLEER (bosentan) SUSPENSION***	LETAIRIS (ambrisentan)
TRACLEER (bosentan) TABLETS - <i>Brand Preferred</i>	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.

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

# Dermatology

## Acne

### *Therapeutic Duplication*

- One strength of one retinoid medication is allowed at a time
- One strength of one benzoyl peroxide containing medication is allowed at a time

### *Prior Authorization Criteria*

#### [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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)		NON-PREFERRED AGENTS (PA REQUIRED)	
Clindamycin-benzyl peroxide 1.2%-5%		ACANYA (Clindamycin-benzoyl peroxide) 1.2%-2.5%	
Clindamycin/benzoyl peroxide 1%-5% without pump		BENZAACLIN (Clindamycin/benzoyl peroxide without pump) 1%-5%	
ONEXTON (Clindamycin/benzoyl peroxide) 1.2%-3.75%		BENZAACLIN (Clindamycin/benzoyl peroxide with pump) 1%-5%	
		Clindamycin/benzoyl peroxide 1%-5% with pump	
		Clindamycin-benzoyl peroxide 1.2%-2.5%	
		DUAC (Clindamycin/benzoyl peroxide) 1.2%-5%	
		NEUAC (Clindamycin/benzoyl peroxide) 1.2%-5%	
RETINOID			
PREFERRED AGENTS (NO PA REQUIRED)		NON-PREFERRED AGENTS (PA REQUIRED)	
ALTRENO (tretinoin) LOTION		ATRALIN (Tretinoin) 0.05% GEL	
AVITA (tretinoin) CREAM ( <i>brand preferred</i> )		Clindamycin-tretinoin 1.2%-0.025%	
RETIN-A (tretinoin) CREAM ( <i>brand preferred</i> )		FABIOR (tazarotene) 0.1% FOAM	
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%	
Tretinoin gel 0.01%, 0.03%		RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.10%	
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) ( <i>brand preferred</i> )		tretinoin microsphere without pump	
		tretinoin microsphere with pump	
		Tretinoin cream	
		Tretinoin gel 0.05%	
ADAPALENE			
PREFERRED AGENTS (NO PA REQUIRED)		NON-PREFERRED AGENTS (PA REQUIRED)	
DIFFERIN (adapalene) CREAM ( <i>brand preferred</i> )		Adapalene 0.1% cream	
Adapalene gel		Adapalene 0.3% gel with pump	
DIFFERIN (adapalene) GEL W/ PUMP ( <i>brand preferred</i> )		Adapalene/Benzoyl Peroxide 0.1%-2.5%	
DIFFERIN (adapalene) LOTION		EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5%	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%			
OTHER			
PREFERRED AGENTS (NO PA REQUIRED)		NON-PREFERRED 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			
PREFERRED AGENTS (NO PA REQUIRED)		NON-PREFERRED AGENTS (PA REQUIRED)	
Doxycycline hyclate capsule		AMZEEQ (Minocycline) Foam	
Doxycycline hyclate tablet 20mg, 100mg		Demeclocycline	

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

Doxycycline monohydrate 25 mg/5mL suspension	DORYX (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate tablet 50 mg, 75mg, 100mg	DORYX MPC (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate capsule 50 mg, 100mg	Doxycycline monohydrate capsule 75mg, 150mg
Minocycline capsule	Doxycycline hyclate tablet 75mg, 150 mg
Minocycline tablet	Doxycycline monohydrate tablet 75mg, 150 mg
VIBRAMYCIN (Doxycycline) 25mg/5mL SUSPENSION	Doxycycline hyclate tablet DR
VIBRAMYCIN (Doxycycline calcium) 50 mg/5mL SYRUP	MINOCIN (Minocycline) CAPSULE
	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](#)

#### **Product Specific Criteria:**

- Diclofenac 3% sodium gel requires electronic diagnosis verification of FDA indication

#### **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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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	TOLAK (Fluorouracil) 4% CREAM
	ZYCLARA (imiquimod) 3.75% CREAM PUMP
	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 outgrowth (at least 6 months)
  - One of the following must be met (A or B):

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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*
  - A. 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
  - B. 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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:**
  - A. 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:**
  - A. Patient must have failed a 30-day trial of a preferred agent, as evidenced by paid claims or pharmacy print outs
- **For Ointments:**
  - A. Patient must have failed 30-day trials of the preferred ointment formulations, as evidenced by paid claims or pharmacy print outs

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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*

- **Eucria:**
  - 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*

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

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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%***	

## Lice

### [General Prior Authorization Form](#)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

### 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*).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)
VANALICE (Piperonyl butoxide/Pyrethrins)	SKLICE (ivermectin)
	Spinosad

## Steroids - Topical

### [General Prior Authorization Form](#)

#### Non-Preferred Agents Criteria:

- **Non-preferred Step 1 agents (not labeled as “STEP 2”):**
  - B. 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”:**
  - A. 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

#### References:

1. American Diabetes Association Diabetes Care 2020 Jan; 43(Supplement 1): S98-S110. <https://doi.org/10.2337/dc20-S009>

#### Therapeutic Duplication

- One Strength of one medication is allowed at a time
- Medication classes not payable together:
  - DPP4-Inhibitors and GLP-1 Agonists
    - GLP-1 and DPP4-Inhibitors should not be used concurrently due to similar mechanisms of action
  - DPP4-Inhibitors and Insulins
    - GLP-1 should be considered in most patients prior to insulin
    - When initiating injectable therapy, sulfonylureas and DPP-4 inhibitors are typically discontinued
  - Sulfonylureas and Insulins
    - When initiating injectable therapy, sulfonylureas and DPP-4 inhibitors are typically discontinued
  - Thiazolidinediones with Insulins or Sulfonylureas

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- Thiazolidinediones increases the adverse effects of hypoglycemia, fluid retention, and heart failure when used concomitantly with sulfonylureas and insulin.
- **COVERED options in combination WITH INSULIN** therapy: GLP-1 Agonists, SGLT-2 inhibitors, and metformin.
  - GLP-1 Agonist and SGLT-2 inhibitors are recommended first line treatments for every pathway indicated in the guidelines (ASCVD, HF, CKD, Hypoglycemia risk, and to minimize weight gain)
  - Metformin is recommended throughout treatment escalation

### *Electronic Step Care and Concurrent Medications*

- Metformin requires initiation titration
  - A total of 7 days supply of metformin 500mg or 1000mg must be paid within 100 days prior to the metformin 1000mg date of service.
    - Slow titration is needed to decrease GI side effects. Recommended to increase dose weekly starting at 500mg twice daily, 1000mg and 500mg daily, and then 1000mg twice daily.

### *Underutilization*

- Toujeo, Tresiba, and Metformin 1000mg must be used compliantly and will reject on point of sale for late fill

## DPP4-Inhibitors

### *Electronic Step Care and Concurrent Medications*

- DPP4-Inhibitors require concurrent metformin
  - A total of 84 day supply of metformin must be paid within 100 days prior to the DPP4-Inhibitors date of service.
    - Metformin is recommended to be continued with escalation of therapy with DPP4-Inhibitors. If metformin is not tolerated, SGLT2 inhibitor and GLP-1 Agonists are recommended as part of the glucose-lowering regimen independent of A1C and are first line alternatives.

### *Prior Authorization Criteria*

#### 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

++Clinically Non-Preferred: Saxagliptan has a potentially higher risk for heart failure

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
JANUMET (sitagliptin/metformin)	alogliptan/pioglitazone
JANUMET XR (sitagliptin/metformin)	alogliptin

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

++Clinically Non-Preferred: Saxagliptan has a potentially higher risk for heart failure

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

## GLP-1 Agonists

### [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 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).
- The patient must have had a 30-day trial, as evidenced by paid claims or pharmacy printouts of:
  - Two of the following GLP-1 Agonists: Victoza or Bydureon
  - Two of the following SGLT-2 Inhibitors: Jardiance, Farxiga, or Invokana

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

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

## Insulin

### [Insulin Prior Authorization Form](#)

#### Group Criteria:

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



- **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)

++ Clinically Non-preferred: Lantus and Levemir have been demonstrated to reduce the risk of symptomatic and nocturnal hypoglycemia compared with NPH insulin.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	AFREZZA (insulin regular, human)
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	BASAGLAR KWIKPEN U-100 (insulin glargine)***

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

HUMULIN R (insulin regular, human) VIAL	FIASP (insulin aspart) FLEXTOUCH***
HUMULIN R U-500 (insulin regular, human) VIAL	FIASP (insulin aspart) VIAL ***
LANTUS (insulin glargine) SOLOSTAR	HUMALOG (insulin lispro) VIAL
LANTUS (insulin glargine) VIAL	HUMALOG (insulin lispro) CARTRIDGE
LEVEMIR (insulin detemir) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)
LEVEMIR (insulin detemir) FLEXTOUCH	HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN
NOVOLIN R (insulin regular, human) VIAL	HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN
NOVOLOG (insulin aspart) CARTRIDGE	HUMALOG U-100 (insulin lispro) KWIKPEN
NOVOLOG (insulin aspart) FLEXPEN	HUMALOG U-200 (insulin lispro) KWIKPEN
NOVOLOG (insulin aspart) VIAL	++HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	++HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL	++HUMULIN N (insulin NPH human isophane) VIAL
	++HUMULIN N (insulin NPH human isophane) KWIKPEN
	HUMULIN R (Insulin regular, human) U-500 KWIKPEN
	++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)

++ Clinically Non-preferred: Pioglitazone has a potential benefit over rosiglitazone for ASCVD.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Pioglitazone	++Rosiglitazone

## SGLT2 Inhibitors

### [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 each preferred agent, as evidenced by paid claims or pharmacy printouts.
- 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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FARXIGA (dapagliflozin)	STEGLATRO (ertugliflozin)
INVOKANA (canagliflozin)	STEGLATROMET (ertugliflozin/metformin)
INVOKAMET (canagliflozin)	
INVOKAMET XR (canagliflozin/metformin)	
JARDIANCE (empagliflozin)	
SYNJARDY (empagliflozin/metformin)	
SYNJARDY XR (empagliflozin/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).

++Clinically Non-preferred: Glyburide is not recommended due to hypoglycemia

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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:

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GENOTROPIN (somatropin)	HUMATROPE (somatropin)
GENOTROPIN MINIQUICK (somatropin)	NUTROPIN AQ (somatropin)
NORDITROPIN FLEXPPO (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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

#### *Therapeutic Duplication*

- One medication is allowed at a time

### Idiopathic Constipation

[General Prior Authorization Form](#)

#### **Non-Preferred Agents 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).
- The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
  - Amitiza and Linzess

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

### Opioid-Induced Constipation:

#### *Electronic Step Care and Concurrent Medications*

- Medications indicated for opioid-induced constipation should be discontinued when opioids are stopped.

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- A total of 30 days of opioid analgesics must be paid within 40 days prior to requested Movantik, Symproic, or Relistor's date of service

### *Prior Authorization Criteria*

#### [General Prior Authorization Form](#)

#### **Non-Preferred Agents 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).
- 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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:**

- 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).
- 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.

PREFERRED 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 PREFERRED 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

# 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**

A. 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	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
VARUBI (Rolapitant) TABLET	AKYNZEO (Netupitant/Palonosetron)
	Aprepitant Capsule
	EMEND (Aprepitant) CAPSULE
	EMEND (Aprepitant) SUSPENSION
5-HT3 RECEPTOR ANTAGONISTS	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Granisetron tablet	AKYNZEO (Netupitant/Palonosetron)
Ondansetron ODT	SANCUSO (Granisetron) PATCH
Ondansetron solution	ZOFRAN (Ondansetron) TABLET
Ondansetron tablet	ZUPLLENZ (Ondansetron) FILM
CANNABINOIDS	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DICLEGIS (doxylamine/vitamin B6) – <i>Brand Required</i>	BONJESTA (doxylamine/vitamin B6)
meclizine	Doxylamine/Vitamin B6
metoclopramide	
ondansetron	

## Proton Pump Inhibitor

### References

1. Katz PO, Gerson LB, Vela MF. Guidelines for the diagnosis and management of gastroesophageal reflux disease. Am J Gastroenterol 2013;108:308-28.
2. Fackler WK, Ours TM, Vaezi MF, Richter JE. Long-term effect of H2RA therapy on nocturnal gastric breakthrough. Gastroenterology. 2002;122:625-632.

### Therapeutic Duplication

- One strength of one medication is allowed at a time
- Proton Pump Inhibitors is not allowed with:
  - H2 Blockers
  - Esomeprazole or omeprazole are not covered with Clopidogrel. Other PPIs such as pantoprazole are covered with clopidogrel.
    - Clopidogrel is a substrate for 2C19 and esomeprazole and omeprazole are strong 2C19 inhibitors and can decrease effectiveness of Clopidogrel.
  - Dextroamphetamine/Amphetamine ER
    - Proton Pump Inhibitors increase blood levels and potentiate the action of amphetamine. Co-administration of Adderall XR and gastrointestinal or urinary alkalinizing agents should be avoided

## Solid Dosage Forms

### Electronic Step Care and Concurrent Medications

- Use least expensive proton pump inhibitors must be trialed first
  - A total of 25 days of pantoprazole, omeprazole, deslansoprazole, lansoprazole, esomeprazole, or rabeprazole must be paid within 90 days prior to step 1 agents date of service.

### Prior Authorization Criteria

#### [General Prior Authorization Form](#)

**Group Criteria:** Approval Duration = 6 months

#### Non-Preferred Agents Criteria: Step 2 Agents:

- 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)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



## 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FIRVANQ (vancomycin) SOLUTION	DIFICID (fidaxomicin) TABLET
Vancomycin capsule	VANCOGIN (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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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 / Interstitial Lung Disease

### [Prior Authorization Form - Idiopathic Pulmonary Fibrosis](#)

#### **Category Criteria:**

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The prescriber must be, or in consult with, a pulmonologist or rheumatologist.
- The patient must have forced vital capacity (FVC) ≥ 40% of predicted within prior 60 days
- The patient must have carbon monoxide diffusing capacity (DLCO, corrected for hemoglobin) of 30% to 79% of predicted.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ESBRIET (Pirfenidone)	
OFEV (Nintedanib)	

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

# Phenylketonuria

## Kuvan:

### *Underutilization*

- Kuvan must be used compliantly and will reject on point of sale for late fill

### *Prior Authorization Criteria*

#### [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
  - A. For females of child bearing potential: PHE levels must be above 360 micromoles/liter
  - B. 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:
  - A. PHE level must be between 60 and 360 micromoles per liter
- For a dose increase from previous trial:
  - A. PHE levels must be attached that were taken after 1 month of previous trial
  - B. The patient's PHE level must be greater than 360 micromoles per liter
  - C. 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:**
  - A. PHE level must be between 60 and 360 micromoles per liter
- **For a dose increase to 40 mg:**
  - A. PHE levels must be attached that were taken after 24 weeks of 20 mg
  - B. 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	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	SIMPONI (golimumab)
HUMIRA (adalimumab)	TALTZ (ixekizumab)
BEHCET'S SYNDROME	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	OTEZLA (apremilast)
CHRONIC INFANTILE NEUROLOGICAL, CUTANEOUS AND ARTICULAR SYNDROME	
PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KINERET (anakinra)	
CROHN'S DISEASE	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	CIMZIA (certolizumab)
	STELARA (ustekinumab)***
CYTOKINE RELEASE SYNDROME	
PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACTEMRA (tocilizumab)	
GIANT CELL ARTERITIS	
PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACTEMRA (tocilizumab)	
HIDRADENITIS SUPPURATIVA	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	
NON-RADIOGRAPHIC AXIAL SPONDYLARTHRTIS	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	CIMZIA (certolizumab)
PLAQUE PSORIASIS	

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
COSENTYX (secukinumab)	CIMZIA (certolizumab)
ENBREL (etanercept)	OTEZLA (apremilast)
HUMIRA (adalimumab)	SILIQ (brodalumab)***
	SKYRIZI (risankizumab-rzaa)***
	STELARA (ustekinumab)***
	TALTZ (ixekizumab)***
	TREMFYA (guselkumab)***
<b>PSORIATIC ARTHRITIS</b>	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)
<b>RHEUMATOID ARTHRITIS</b>	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)
<b>SCHNITZLER SYNDROME</b>	
PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KINERET (anakinra)	
<b>ULCERATIVE COLITIS</b>	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	SIMPONI (golimumab)
	STELARA (ustekinumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
<b>UVEITIS</b>	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	

## Dupixent

[Prior Authorization Form - Dupixent](#)

## Asthma

[Click to Jump to Criteria](#)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## 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

**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 (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DUPIXENT (Dupilumab)	
FASENRA (Benralizumab)	
NUCALA (Mepolizumab)	

## Epinephrine

[General Prior Authorization Form](#)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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. testos
- **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:**

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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Allopurinol Tablet	COLCRYS (Colchicine) TABLETS
Colchicine Capsules	Febuxostat
Colchicine Tablets	GLOPERBA (Colchicine) ORAL SOLUTION
Probenecid-Colchicine Tablets	MITIGARE (Colchicine) CAPSULE
Probenecid Tablets	ULORIC (Febuxostat) TABLET
	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:**
  - 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

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

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## 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):**

- A. Clinical justification must be provided explaining why the patient is unable to use another product with the same active ingredient (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

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# 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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 Appetite](#)

## Antiretrovirals

#### 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.

### *Integrase Strand Transfer Inhibitors*

PREFERRED 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*

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ATRIPLA (Efavirenz/Emtricitabine/Tenofovir)	SUSTIVA (Efavirenz)
COMPLERA (Emtricitabine/Rilpivirine/tenofovir)	VIRAMUNE (Nevirapine)

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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*

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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 (darunavir/cobicistat/emtricitabine/tenofovir)	
Tenofovir	
TEMIXYS (Lamivudine/Tenofovir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRUVADA (emtricitabine/tenofovir)	
VIDEX (didanosine)	
Zidovudine	

*Post-Attachment Inhibitor*

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

*Protease Inhibitor*

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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	

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SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
VIRACEPT (nelfinavir)	

## Lipodystrophy – Growth Hormone-Releasing Hormone Analogue

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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:**

- **\*\*\*Eplclusa:**
  - Must be used with ribavirin for patients with decompensated cirrhosis (Child-Pugh B C).
- **\*\*\*Mavyret/Vosevi:**

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- 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.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
EPCLUSA (sofosbuvir/velpatasvir) <i>Brand Preferred</i> ***	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

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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Methicillin-Resistant *Staphylococcus aureus* (MRSA):

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

## *Helicobacter pylori*

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
OMECLAMOX-PAK (Omeprazole/Clarithromycin/Amoxicillin)	TALICIA (Omeprazole/Amoxicillin/Rifabutin)
PYLERA (Bismuth Subcitrate Potassium/Metronidazole/Tetracycline)	
PREVPAC (Lansoprazole/Amoxicillin/Clarithromycin)	

## Antifungals - Aspergillus and Candidiasis Infections

### [General Prior Authorization Form](#)

**Non-Preferred Agents Criteria:** Approval Duration = Per label recommendations

- The request must be for use as prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- The patient must meet one of the following (A or B):
  - A. The patient must have documented history of failure to all preferred agents as evidenced by paid claims or pharmacy printouts
  - B. Prescriber must provide evidence-based medical justification for use, explaining why preferred antifungals are not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Injectable/Implantable

PREFERRED 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

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

## Topical

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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) – <i>brand required</i>	tadalafil
tamsulosin	
terazosin	

## Nephrology/Urology

### Hematopoietic, Erythropoiesis Stimulating Agents

#### [General Prior Authorization Form](#)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

### **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.

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

## Hyperkalemia (Chronic)

### [Prior Authorization Form - Hyperkalemia](#)

#### **Group Criteria:**

- **Initial criteria:** *Approval Duration = 3 months*
  - . The patient must be 18 years of age or older.
  - A. Medication must be prescribed by, or in consultation with, a nephrologist
  - B. 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
  - C. The patient must not have gastrointestinal motility disorders (e.g. severe constipation, bowel obstruction or impaction, abnormal postoperative bowel motility disorders)
  - D. 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
  - E. 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

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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*
  - A. The prescriber must attest that all other potential causes for bladder pain/discomfort have been ruled out.
  - B. The patient must have a diagnosis of pain or discomfort due to interstitial cystitis.
  - C. The patient must be 16 years of age or older.

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- D. 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).
- E. 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*
    - A. The patient must have experienced a significant reduction in bladder pain/discomfort since initiating therapy (supported by clinical documentation).

PREFERRED AGENTS (PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

### Therapeutic Duplication

- One strength of one of the following medications is allowed at a time: dutasteride, Jalyn, or finasteride
- Alpha 1 blockers (Alfuzosin ER, Doxazosin, Dutasteride-Tamsulosin, Prazosin, Terazosin, Tamsulosin) are not allowed with carvedilol or labetalol
  - Carvedilol and Labetalol are nonselective beta blockers with alpha 1 blocking activity
- Anticholinergic medications (tolterodine, oxybutynin, trospium, solifenacin) are not covered with Acetylcholinesterase Inhibitors. [Click here](#) for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other and the therapeutic effect of both products is diminished

### Prior Authorization Criteria

[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:

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



- **\*\*\* 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

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

## Neurology

### Anticonvulsants

#### *Therapeutic Duplication*

- One Vimpat strength is allowed at a time
- One Potiga strength is allowed at a time
- Lyrica and Gabapentin are not allowed together
- Lyrica and Gabapentin oral solutions are not allowed with benzodiazepines, muscle relaxant, or narcotic tablets or capsules
  - If a patient can swallow, they should be transitioned to a tablet or capsule formulation

#### *Electronic Step Care and Concurrent Medications*

- Diacomit is FDA approved to be used in combination with clobazam.
  - A total of 28 days of clobazam must be paid within 45 days prior to Diacomit (stiripentol)

#### *Prior Authorization Criteria*

##### **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.

PREFERRED 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)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

CELONTIN (Methsuximide)	EPITOL (Carbamazepine)
DIACOMIT (Stiripentol)	Felbamate Tablet
Divalproex ER	Felbamate Oral Suspension
Divalproex sprinkle	KEPPRA (Levetiracetam)
Divalproex tablet	KEPPRA (Levetiracetam) ORAL SOLUTION
EPIDIOLEX (cannabidiol)	KEPPRA XR (Levetiracetam)
Ethosuximide capsule	LAMICTAL (Lamotrigine)
Ethosuximide oral solution	LAMICTAL (Lamotrigine) CHEWABLE TABLET
FELBATOL (Felbamate) ( <i>Brand Preferred</i> )	LAMICTAL (Lamotrigine) DOSE PACK
FELBATOL (Felbamate) ORAL SUSPENSION ( <i>Brand Preferred</i> )	LYRICA (Pregabalin)
FYCOMPA (Perampanel)	LYRICA (Pregabalin) ORAL SOLUTION
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) ( <i>Brand Preferred</i> )	QUDEXY XR (Topiramate)
LAMICTAL ER (Lamotrigine) DOSE PACK	TEGRETOL XR (Carbamazepine)
LAMICTAL ODT (Lamotrigine)	TEGRETROL (Carbamazepine oral suspension)
LAMICTAL ODT (Lamotrigine) DOSE PACK	Tiagabine
LAMICTAL XR (Lamotrigine)	TOPAMAX (Topiramate)
Lamotrigine chewable tablet	TOPAMAX (Topiramate) SPRINKLE CAPSULE
Lamotrigine dose pack	TRILEPTAL (Oxcarbazepine)
Lamotrigine ER	TRILEPTAL (Oxcarbazepine) ORAL SUSPENSION
Lamotrigine ODT	Vigabatrin
Lamotrigine tablet	Vigabatrin powder pack
Levetiracetam ER	VIGADRONE (Vigabatrin)
Levetiracetam oral solution	ZARONTIN (Ethosuximide)
Levetiracetam tablet	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	
Pregabalin	
Pregabalin oral solution	
Primidone	
SABRIL (Vigabatrin) ( <i>Brand Preferred</i> )	
SABRIL (Vigabatrin) POWDER PACK ( <i>Brand Preferred</i> )	
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	

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

# Dementia

## Therapeutic Duplication

- One memantine medication is allowed at a time
- Anticholinergic medications are not covered with Acetylcholinesterase Inhibitors (Aricept, Exelon, Razadyne, Pyridostigmine). [Click here](#) for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other and the therapeutic effect of both products is diminished

## Prior Authorization Criteria

### [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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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:
  - 6-minute walk test (6MWT)
  - North Star Ambulatory Assessment (NSAA)
  - Motor Function Measure (MFM)
  - Hammersmith Functional Motor Scale (HFMS)
- The patient must have ONE of the following significant intolerable adverse effects supported by documentation:
  - Cushingoid appearance
  - Central (truncal) obesity
  - Undesirable weight gain (>10% of body weight gain increase over 6-month period)
  - Diabetes and/or hypertension that is difficult to manage
  - Severe behavioral adverse effect

**Renewal Criteria:** *Approval Duration = 12 months*

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

## Headache/Migraine

### Prophylaxis of Migraine – CGRP Inhibitors

[Prior Authorization Form –Migraine/Cluster Headache Prophylaxis](#)

**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:**

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

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

## Cluster Headache – Emgality

### [Prior Authorization Form –Migraine/Cluster Headache Prophylaxis](#)

**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

### *Therapeutic Duplication*

- One strength of one triptan is allowed at a time

### *Prior Authorization Criteria*

#### [General Prior Authorization Form](#)

#### **Non-Preferred Agents Criteria:**

- **Non-preferred step 1 agents:**
  - **Patients able to take oral medications:**
    - A. 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.
    - B. 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):**
    - A. The patient must have had a 30-day trial of rizatriptan within the past 24 months, as evidenced by paid claims or pharmacy printouts.
- **Non-preferred step 2 agents:**
  - A. The patient must meet criteria for Step 1 agents
  - B. 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

#### **Product Specific Criteria:**

- **\*\*\*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:**

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (PA REQUIRED)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
RELPAK (eletriptan) – <i>Brand Preferred</i>	ONZETRA XSAIL (sumatriptan) NASAL SPRAY	Almotriptan Tablet***
Rizatriptan	ZOMIG (zolmitriptan) NASAL SPRAY	ALSUMA (sumatriptan) PEN INJCTR***
Rizatriptan ODT	zolmitriptan ODT	AMERGE (naratriptan) TABLET
Sumatriptan tablet		CAFERGOT (ergotamine/caffeine) TABLET
		D.H.E.45 (dihydroergotamine) INJECTION
		Dihydroergotamine Injection
		Dihydroergotamine Nasal Spray
		Eletriptan Tablet
		ERGOMAR (ergotamine) SL 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)
		MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
		MIGRANAL (dihydroergotamine) SPRAY
		Naratriptan Tablet
		Sumatriptan Cartridge***
		Sumatriptan Pen Injctr***
		Sumatriptan Spray***
		Sumatriptan Syringe***
		Sumatriptan Vial
		Sumatriptan/Naproxen Tablet***
		TOSYMRA (Sumatriptan) NASAL SPRAY***
		TREXIMET (Sumatriptan/Naproxen) TABLET
		UBRELVY (Ubrogepant)
		ZEMBRANCE SYMTOUCH (Sumatriptan)***
		Zolmitriptan Tablet***
		ZOMIG (zolmitriptan) TABLET***
		ZOMIG ODT (zolmitriptan)

## 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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- The patient must have had a 3-month trial of at least 1 preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
COPAXONE (glatiramer) 20 MG/ML – <i>Brand Preferred</i>	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):
  - The patient must have had a 3-month trial of Copaxone, as evidenced by paid claims or pharmacy printouts.
  - 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AUBAGIO (teriflunomide)	MAVENCLAD (Cladribine)
GILENYA (fingolimod)	MAYZENT (Siponimod)
	TECFIDERA (dimethyl fumarate)
	VUMERITY (Diroximel Fumarate)

## Narcolepsy

### *Therapeutic Duplication*

- Sunosi and Wakix are not allowed together
- Provigil and Nuvigil are not allowed together
- Xyrem is not allowed with sleeping medication or benzodiazepines

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Electronic Step Care and Concurrent Medications

- Wakix requires titration to 17.8 mg dose with 4.45 mg tablets.

## Underutilization

- Wakix and Sunosi must be used compliantly and will reject on point of sale for late fill

## Prior Authorization Criteria

### [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:**
  - A. 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
  - B. 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  $\geq 10$
- **Obstructive Sleep Apnea:**
  - A. The requested agent must be Sunosi
  - B. The patient must have failed 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts
  - C. 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  $\geq 10$

#### **Renewal Criteria:**

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
Modafinil	Armodafinil
NUVIGIL (Armodafinil) – <i>Brand Preferred</i>	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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



- The prescriber must provide the following information:
  - A. Baseline Center for Neurological Studies lability (CNS-LS) score
  - B. 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:
  - A. Amyotrophic Lateral Sclerosis (ALS)
  - B. Multiple Sclerosis (MS)
  - C. Alzheimer’s Disease
  - D. Stroke
- **Additional initial criteria for a diagnosis of PBA due to Alzheimer’s disease or stroke:**
  - A. Neurologic condition must have been stable for at least 3 months
  - B. 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:**
  - A. Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
  - B. Current CNS-LS score must be reduced by at least 30% from baseline

## Parkinson’s disease

### *Electronic Step Care and Concurrent Medications*

- Xadago and Nourianz is FDA approved for adjunctive treatment to levodopa/carbidopa.
  - A total of 28 days of levodopa/carbidopa treatment must be paid within 40 days prior to Xadago or Nourianz’s date of service

### *Prior Authorization Criteria*

#### [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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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
Benzotropine	DUOPA (Levodopa/Carbidopa)
Bromocriptine	EMSAM (Selegiline) PATCH
Carbidopa-levodopa-entacapone	GOCOVRI (Amantadine ER)
Carbidopa-Levodopa Capsules	INBRIJA (Levodopa)
Carbidopa-Levodopa ER	NOURIANZ (Istradefylline)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

### *Electronic Step Care and Concurrent Medications*

- Start Ingrezza with Initiation Pack before continuing therapy with 80mg capsules
  - The 30-count 40 mg bottle is not packaged for titration to 80 mg. If therapy is expected to be continued at 40 mg at time of drug initiation, please call for override.

### *Prior Authorization*

#### [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

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALOMIDE (Iodoxamide)	ALOCRIAL (nedocromil)
Azelastine	ELESTAT (epinastine)
BEPREVE (bepotastine)	Epinastine

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

Cromolyn	
LASTACAFT (alcaftadine)	
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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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:

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.

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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

# 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.

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

# 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

### Therapeutic Duplication

- One strength of one medication is allowed at a time (topical and oral formulations are not allowed together)

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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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
	RELAFEN DS (Nabumetone)
	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)

## 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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Diclofenac 1.5% Topical Solution	Diclofenac Patch
FLECTOR (diclofenac) PATCH ( <i>Brand Preferred</i> )	PENNSAID (Diclofenac) 2% PUMP

## Opium Analgesics – Long Acting

### Therapeutic Duplication

- One extended release product/strength is allowed at a time
- One immediate release product is allowed (single ingredient or combination)
- Nucynta and Nucynta ER are not allowed with other narcotic medications
- Opioid-acetaminophen combination products are not allowed with acetaminophen
- Tramadol immediate release with tramadol extended release
- Methadone is not allowed
- 3A4 Substrates (Fentanyl, methadone, and oxycodone) are not allowed with strong 3A4 inhibitors. [Click here](#) for a full listing of medications included.
- Methadone: Not allowed with narcotics, benzodiazepines, or opioid use disorder medications
- Opioids are not allowed with:
  - Quetiapine: Due to guidance in The SUPPORT for Patients and Communities Act (H.R. 6) on CNS depression risk between antipsychotics and opioids.
  - Benzodiazepines: Includes long acting narcotics over 90 MME/day or immediate release opioids over 15 MME/dose due to guidance in The SUPPORT for Patients and Communities Act (H.R. 6) on CNS depression risk between benzodiazepines and opioids
  - Carisoprodol: The “Holy Trinity” consists of an opioid, a benzodiazepine, and carisoprodol and is a highly abused dangerous combination that can lead to additive CNS depression, overdose, and death. It is not covered.
  - Opioid use disorder medications

### Underutilization

- Long acting opioid analgesics must be used compliantly and will reject on point of sale for late fill

### Prior Authorization Criteria

#### [Prior Authorization Form – Opioid Analgesics](#)

##### **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 patient must have established opioid tolerability by using short acting opioids daily for at least 7 days prior to request for long acting opioid, as evidenced by paid claims or pharmacy printouts
- 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

##### **Category Criteria (renewal):**

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

## Partial Agonist/Antagonist Opioids

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BELBUCA (Buprenorphine)	buprenorphine patches

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

#### **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).

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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  $\geq 17$
  - **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

#### **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).

Full Agonist Opioids Without Abuse Deterrent Formulations	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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)
Morphine ER tablets	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr
	Hydromorphone ER tablets
	KADIAN (morphine)
	Morphine ER capsules
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Opioid Analgesic – Short Acting

### First Fill

- Short acting opioid analgesics must be filled with a 7 day supply if no previous fill within past 34 days
  - If patient is filling prescription less than every 34 days due to decreased utilization, please get a new prescription for a lower quantity that reflects actual utilization within a 34 day window.

### Prior Authorization Criteria

#### [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
    - 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  $\geq 150$  mg MED per day
    - Oxycodone 20 mg tablet:** long-acting opioid must provide  $\geq 200$  mg MED per day
    - Oxycodone 30 mg tablet:** long-acting opioid must provide  $\geq 300$  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).

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Acetaminophen/Codeine Solution	ABSTRAL (Fentanyl) SUBLINGUAL TABLET
Acetaminophen/Codeine Tablets	ACTIQ (Fentanyl) LOZENGE

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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
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

### *Therapeutic Duplication*

- One strength of one medication is allowed at a time
- Carisoprodol is not allowed with narcotics, benzodiazepines, or opioid use disorder medications
  - The “Holy Trinity” consists of an opioid, a benzodiazepine, and carisoprodol and is a highly abused dangerous combination that can lead to additive CNS depression, overdose, and death. It is not covered.
- Tizanidine is not allowed with:
  - Antipsychotics: visual hallucinations being reported in 3% of patients receiving tizanidine, psychosis has also been reported.
  - Other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyl dopa) as tizanidine is also an alpha 2 agonist

### *Prior Authorization Criteria*

#### General Prior Authorization Form

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

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

#### *Therapeutic Duplication*

- **For all stimulants:**
  - First fill limited to 14 days supply with a 90 day lookback
  - The following are not payable:
    - Multiple strengths of a single medication
    - Amphetamine Agent + Methylphenidate Agent
    - Multiple Long Acting Agents
    - Multiple Short Acting Agents
- **Amphetamines:** One product will be allowed at a time. The following are not payable regimens:
  - Long Acting Agent + Short Acting Agent
  - Dextroamphetamine/Amphetamine ER with Proton Pump Inhibitors
    - Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- Proton Pump Inhibitors increase blood levels and potentiate the action of amphetamine. Co-administration of Adderall XR and gastrointestinal or urinary alkalizing agents should be avoided
- Concurrent use of Mydayis with benzodiazepines or sedatives
  - Insomnia has been reported in 25-56% of patients receiving Mydayis. Patients reporting insomnia should use a shorter acting product that does not reach steady state.
- **Methylphenidates:** Long Acting Agent + Short Acting Agent is a payable regimen with the following exceptions:
  - Concurrent use of dexmethylphenidate and methylphenidate
  - Non-Solid dosage forms are not allowed with other agents and should be transitioned to a solid form of medication when a patient can swallow
- **For all non-stimulants:**
  - One strength of one medication is allowed at a time except for Guanfacine 4mg IR and ER which may be combined Guanfacine IR and ER, respectively, to form dosages up to 7mg per day
  - Clonidine, guanfacine are not allowed with each other or other alpha 2 agonists (clonidine/chlorthalidone, methyldopa, or tizanidine)
    - Methyldopa and tizanidine are also alpha 2 agonists

### First Fill

- Long Acting ADHD medications (stimulants and guanfacine ER) must be filled with a 14 day supply (or less) if no previous fill within past 34 days

### Prior Authorization Criteria

#### 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Atomoxetine	Clonidine ER***
Clonidine	INTUNIV (guanfacine ER)
Guanfacine	STRATTERA (atomoxetine)
Guanfacine ER	

## Stimulants

Stimulants - Methylphenidates	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ADHANSIA XR (methylphenidate)	Dexmethylphenidate ER
APTENSIO XR (methylphenidate)	FOCALIN (dexmethylphenidate)
CONCERTA (methylphenidate) – <i>Brand Preferred</i>	METADATE ER (methylphenidate)
COTEMPLA XR - ODT (methylphenidate)	METHYLIN (methylphenidate) chew tablets
DAYTRANA (methylphenidate)	Methylphenidate ER 72 mg
Dexmethylphenidate	Methylphenidate ER tablet
FOCALIN XR (dexmethylphenidate) – <i>Brand Preferred</i>	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)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

Stimulants - Methylphenidates	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
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 – <i>Brand Preferred</i>	

Stimulants - Amphetamines	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Amphetamine ER solution	ADZENYS ER (Amphetamine) SOLUTION
ADZENYS XR - ODT (Amphetamine)	ADDERALL (Dextroamphetamine/amphetamine)
DESOXYN (Methamphetamine) – <i>Brand Preferred</i>	ADDERALL XR (Dextroamphetamine/amphetamine)
Dextroamphetamine	Amphetamine
Dextroamphetamine ER	DEXEDRINE (Dextroamphetamine)
Dextroamphetamine/amphetamine	Dextroamphetamine 5 mg/5 ml
Dextroamphetamine/amphetamine ER	Methamphetamine
DYANAVEL XR (Amphetamine)	ZENZEDI (Dextroamphetamine)
EVEKEO (Amphetamine) – <i>Brand Preferred</i>	
EVEKEO ODT (Amphetamine)	
MYDAYIS (Dextroamphetamine/dextroamphetamine)	
PROCENTRA (Dextroamphetamine) – <i>Brand Preferred</i>	
VYVANSE (Lisdexamfetamine)	
VYVANSE (Lisdexamfetamine) CHEW TABLET	

## Atypical Antipsychotics

### Therapeutic Duplication

- Long acting injections are not allowed with oral tablets of the same active ingredient or prodrug
    - In some cases (e.g. missed/delayed dose or during initiation), time-limited concomitant therapy with oral formulation may be indicated.
  - First generation antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Thioridazine, Trifluoperazine, Haloperidol
    - One strength allowed at a time
    - No other antipsychotic medication is allowed concurrently
  - Second generation antipsychotics:
    - Aripiprazole: one strength of one medication is allowed at a time
    - Risperidone: not allowed with paliperidone concurrently
    - Fanapt, Latuda, Paliperidone, Rexulti, Saphris, Vraylar, Ziprasidone: one strength is allowed at a time and no other antipsychotic medication is allowed concurrently
    - Quetiapine:
      - Immediate release: 200mg, 300mg, and 400mg are not allowed together
      - Extended release: 200mg, 300mg, and 400mg are not allowed together or with immediate release. 150mg is not allowed with 50mg.
      - Opioids are not allowed with quetiapine due to risk of CNS depression.
- Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

○ Olanzapine:

- Olanzapine 2.5mg is not allowed with olanzapine 5mg or 7.5mg
- Olanzapine 5mg not allowed with 10mg or 15mg
- All other olanzapine tablet strengths are allowed together
- ODT and tablets are not allowed concurrently
- Symbyax is not allowed with any other product containing olanzapine.

Additional information:

- Quantity limit is 1 tablet per day due to the 30 hour half-life of the medication
  - Pharmacokinetic studies show that olanzapine tablets and olanzapine ODT are bioequivalent
- Tizanidine is not allowed with antipsychotics due to visual hallucinations being reported in 3% of patients receiving tizanidine, psychosis has also been reported.

## Oral

### *Electronic Step Care and Concurrent Medication*

- Start Vraylar with Initiation pack or 1.5 mg tablets prior to continuing therapy with doses of 3 mg or more
  - Vraylar requires titration from 1.5 mg dose at initiation.

### *Underutilization*

- Paliperidone ER, Fanapt, Latuda, Rexulti, Saphris and Vraylar must be used compliantly and will reject on point of sale for late fill

### *First Fill*

- Paliperidone ER, Fanapt, Latuda, Rexulti, Saphris and Vraylar must be filled with a 10 day supply if no previous fill within past 34 days

### *Prior Authorization Criteria*

#### **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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



Risperidone ODT	ZYPREXA ZYDIS (olanzapine)
Risperidone oral solution	
SAPHRIS (asenapine)	
VRAYLAR (cariprazine)	
Ziprasidone	

## Long Acting Injectable

### *Electronic Step Care and Concurrent Medication*

- Oral formulations must be used prior to injectable formulations to establish tolerability and achieve steady state.
  - Please call for exception if there is a history of tolerability to active ingredient and no requirement for oral overlap for missed dose / initiation of long-acting injectable antipsychotic.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

### *Therapeutic Duplication*

- One strength of one medication is allowed at a time
  - Benzodiazepines indicated only for insomnia are not covered with other non-barbiturate insomnia medications or other benzodiazepines
- Sedative/hypnotics are not covered with:
  - Xyrem
  - Mydayis
    - Insomnia has been reported in 25-56% of patients receiving Mydayis. Patients reporting insomnia should use a shorter acting product that does not reach steady state.
  - Long Acting Benzodiazepines due to CNS depression
    - Belsomra is not covered with short or long acting benzodiazepines
- Ramelteon is a 1A2 Substrate and is not covered with Fluvoxamine, a strong 1A2 inhibitor
- Mirtazapine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
  - Mirtazapine is also an alpha 2 agonist
- Benzodiazepines are not covered with Opioids: Includes long acting narcotics over 90 MME/day or immediate release opioids over 15 MME/dose due to guidance in The SUPPORT for Patients and Communities Act (H.R. 6) on CNS depression risk between benzodiazepines and opioids

### *Electronic Step Care and Concurrent Medications*

- Zolpidem: Initiation with trial of 5 mg must be used for 7 days prior to 10 mg tablets
  - Zolpidem is recommended to be used at lowest dose possible.

### *Prior Authorization Criteria*

#### [Prior Authorization Form - Sedative/Hypnotics](#)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

**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, flurazepam, 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 benzodiazepines)**

- **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

<b>NON - DEA SCHEDULED (NON-ADDICTIVE) MEDICATION:</b>	
<b>PREFERRED AGENTS (NO PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
Mirtazapine	Doxepin
ROZEREM (ramelteon)	Ramelteon
SILENOR (doxepin)	
Trazodone	
<b>DEA SCHEDULED MEDICATIONS</b>	
<b>PREFERRED AGENTS (NO PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

### References:

2. [Albuterol Overuse: A Marker of Psychological Distress?](#) Joe K. Gerald, Tara F. Carr, Christine Y. Wei, Janet T. Holbrook, Lynn B. Gerald. J Allergy Clin Immunol Pract. 2015 Nov-Dec; 3(6): 957–962. Published online 2015 Sep 1. doi: 10.1016/j.jaip.2015.06.021. PMID: PMC4641773
3. Global Initiative for Asthma. Global strategy for asthma management and prevention. 2019 GINA Main Report. Available from: [www.ginasthma.org](http://www.ginasthma.org). (Accessed February 5, 2020)
4. National Asthma Education and Prevention Program, Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda (MD): National Health, Lung, and Blood Institute (US); 2007 Aug. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK7232>
5. [High-Dose Albuterol by Metered-Dose Inhaler Plus a Spacer Device Versus Nebulization in Preschool Children With Recurrent Wheezing: A Double-Blind, Randomized Equivalence Trial](#) Dominique Ploin, François R. Chapuis, Didier Stamm, Jacques Robert, Louis David, Pierre G. Chatelain, Guy Dutau and Daniel Floret Pediatrics August 2000, 106 (2) 311-317; DOI: <https://doi.org/10.1542/peds.106.2.311>

### Therapeutic Duplication

- One medication from each class is allowed at time (nebulizers and inhalers are not payable together)
  - One inhaled steroid
  - Long acting anticholinergic
  - Leukotriene pathway inhibitor
  - One long acting beta agonist
  - One short acting beta agonist
    - Inhalers and Nebulizers work equally well whether used at home, in school, or otherwise outside of the home. If patient receives multiple forms of rescue medication, the risk of unidentified uncontrolled asthma and rescue inhaler dependence is increased.
    - Exceptions:
      - Maximally treated patients with end-stage COPD will be allowed an ongoing override
      - Acutely ill children will be allowed a one-time override
- Anticholinergic medications are not covered with Acetylcholinesterase Inhibitors (Aricept, Exelon, Razadyne, Pyridostigmine). [Click here](#) for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other and the therapeutic effect of both products is diminished

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Concurrent Medication and Step Care

- Daliresp
  - A total of 25 days of an inhaled short or long acting anticholinergic must be paid within 45 days prior to daliresp's date of service.
    - According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, Daliresp is a recommended add-on therapy to patients experiencing exacerbations while on antimuscarinic therapy.

## Albuterol/Levalbuterol Rescue Inhalers

### Concurrent Medication and Step Care

- Ventolin HFA and ProAir Respiclick
  - A total of 30 days of steroid inhaler must be paid within 40 days prior to Ventolin HFA or ProAir Respiclick's date of service. The quantity limit for ProAir HFA is set to 2 canisters per 6 months (2 puffs per day). If more is needed, patient must switch to Ventolin HFA and be on a steroid inhaler to control asthma.
    - According to the GINA guidelines:
      - A low dose ICS should be taken whenever SABA taken for step 1 control of asthma.
      - Dispensing  $\geq 3$  canisters per year is associated with higher risk of emergency department presentations
      - Dispensing  $\geq 12$  canisters per year is associated with higher risk of death
  - Exception:
    - If primary insurance will only pay for Ventolin HFA or ProAir Respiclick and patient is well-controlled without steroid inhaler (i.e. uses less than 2 canisters per 6 months).

### Prior Authorization

[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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Albuterol HFA – Labeler 66993***	Albuterol HFA – Labeler 00933 and 00254
PROAIR (albuterol) HFA – <i>Brand Preferred</i>	ProAir Digihaler
PROAIR RESPICLICK (albuterol)***	PROVENTIL (albuterol) HFA
XOPENEX (levalbuterol) HFA - <i>Brand Preferred</i>	VENTOLIN (albuterol) HFA***

## 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Albuterol/ipratropium	DUAKLIR PRESSAIR (Aclidinium/Formoterol)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)
COMBIVENT RESPIMAT (albuterol/ipratropium)	

## 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
SPIRIVA HANDIHALER (tiotropium)	INCRUSE ELLIPTA (umeclidinium)
SPIRIVA RESPIMAT 2.5 MG (tiotropium)	LONHALA MAGNAIR (glycopyrrolate)***
TUDORZA PRESSAIR (aclidinium)	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).

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

### Product Specific Criteria:

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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PERFOROMIST (formoterol)	BROVANA (arformoterol)***
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 Handihaler, Spiriva Respimat, or Incruse Ellipta
      - II. Brovana, 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, Bevespi Aerosphere, or Trelegy Ellipta
  - **For asthma diagnosis:**
    - The patient must have been reviewed for step down therapy for all renewal requests.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)	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:
  - Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics
  - Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steroid

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

## Substance Use

## Nicotine / Tobacco Dependence Treatment

### *Concurrent Medication and Step Care*

- A total of 14 days of Nicotine patch, Chantix, or Zyban must be paid within 40 days prior to Nicotrol Nasal Spray, Nicotine Lozenge, or Nicotine Gum's date of service.

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- Better outcomes are associated with concurrent use of short acting and long acting tobacco cessation products.
- A total of 14 days of Nicotine patch must be paid within 40 days prior to Zyban's date of service.
  - Better outcomes are associated with concurrent use of short acting and long acting tobacco cessation products. Nicotine products can help bridge treatment until Zyban becomes effective.

#### *Duration Coverage*

- A total of 12 consecutive weeks will be covered for all other products, every 6 months (Chantix may be extended to 24 consecutive weeks if abstinent)

#### *Therapeutic Duplication*

- Nicotine Gum, Lozenge, Inhaler, and Spray will not be paid concurrently
- Zyban will not be paid with other forms of bupropion

#### *Underutilization*

- Nicotine Patch, Chantix, and Bupropion must be used compliantly and will reject on point of sale for late fill

#### *Prior Authorization Criteria*

#### [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.

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 Polacrilex 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):**

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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

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

## Opioid Partial Agonist

### *Therapeutic Duplication*

- One strength of one medication is allowed at a time
- Opioid Partial Agonists are not allowed with:
  - Methadone
  - Carisoprodol
  - Opioid Analgesics

### *Underutilization*

- Buprenorphine and buprenorphine/naloxone must be used compliantly and will reject on point of sale for late fill

### *Prior Authorization Criteria*

#### [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).
- A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request
- [DAW \(Dispense As Written\) Criteria](#) must be met in addition to Opioid Partial Agonist 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).
  - A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request
  - [DAW \(Dispense As Written\) Criteria](#) must be met in addition to Opioid Partial Agonist Group PA Criteria.

ORAL AGENTS	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Buprenorphine-naloxone tablets	BUNAVAIL FILM (buprenorphine/naloxone)
Buprenorphine tablets***	buprenorphine/naloxone film

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms



	SUBOXONE FILM (buprenorphine/naloxone)
	ZUBSOLV (buprenorphine/naloxone)
<b>NON-ORAL AGENTS</b>	
<b>PREFERRED AGENTS (NO PA REQUIRED)</b>	<b>NON-PREFERRED AGENTS (PA REQUIRED)</b>
SUBLOCADE (buprenorphine)	
PROBUPHINE (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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CLIMARA PRO (estradiol-levonorgestrel) PATCH	ALORA (Estradiol) PATCH TWICE WEEKLY
COMBIPATCH (Estradiol- Norethindrone)	BIJUVA (Estradiol/Progesterone)
ELESTRIN (estradiol) GEL	CLIMARA (Estradiol) PATCH WEEKLY
Estradiol Tablet	DELESTROGEN (Estradiol Valerate) INJECTION
ESTRING (estradiol)	DEPO-ESTRADIOL (Estradiol Cypionate) INJECTION
EVAMIST (estradiol) SPRAY	DIVIGEL (estradiol) GEL
MENOSTAR (estradiol) PATCH	Estradiol Valerate Injection
Norethindrone-Ethinyl Estradiol tablet	Estradiol- Norethindrone Tablet
PREMARIN (estrogens, conjugated) INJECTION	Estradiol Patch Twice Weekly
PREMARIN (estrogens, conjugated) TABLET	Estradiol Patch Weekly
PREMARIN (estrogens, conjugated) VAGINAL CREAM	Estradiol Vaginal Cream
PREMPHASE (estrogen, conj.,m-progest) TABLET	Estradiol Vaginal Tablet
PREMPRO (estrogen, conj.,m-progest) TABLET	FEMRING (estradiol)
VAGIFEM (estradiol) VAGINAL TABLET	MENEST (estrogens, esterified) TABLET
	MINIVELLE (Estradiol) PATCH TWICE WEEKLY
	PREFEST (estradiol-norgestimate) TABLET
	VIVELLE-DOT (Estradiol) PATCH
	YUVAFEM (estradiol) VAGINAL TABLET

### 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):
  - Pregnancy must have resulted from an act of rape or incest, and one of the following (I or II)**
    - 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.

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

- 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  $\leq -2.5$  OR new fracture after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
  - A. Alendronate or Risedronate
  - B. Denosumab
- Patient must be at high risk of fracture, confirmed by at least one of the following:
  - A. The patient with a history of hip or vertebral fracture
  - B. The patient with a T-score of  $-2.5$  or lower at the femoral neck or spine
  - C. 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  $\geq 3\%$  as assessed with the FRAX
  - D. 10-year risk of a major osteoporosis-related fracture of  $\geq 20\%$  as assessed with the FRAX

#### **Product Specific Criteria:**

- **\*\*\*Forteo and Miacalcin:**
  - A. The patient must have a current BMD T-score  $\leq -2.5$  OR new fracture after a 6-month trial of Tymlos (Abaloparatide), as evidenced by paid claims or pharmacy printouts
- **\*\*\*Binosto and alendronate oral solution:**

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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.
- Clinical justification must be provided explaining why medication is medically necessary

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED 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.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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	VANDAZOLE (Metronidazole) GEL
terconazole cream	

## 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.

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

\*: 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

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

## Antihistamines

### Therapeutic Duplication

- One strength of one medication is allowed at a time

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

## Bactroban

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

## Belladonna Alkaloids/Phenobarbital

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

## Bowel Prep Agents

Required trial duration: 1 complete dose

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
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Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

Paroxetine tablets	Paroxetine Mesylate 7.5mg capsules
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## Butalbital-Acetaminophen-Caffeine

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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)

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

## Gabapentin

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

## Jadenu (Deferasirox)

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

## Kits

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FDA approved products prescribed separately	CAMPHOTREX 4%-10% ROLL-ON G (menthol/camphor)
	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX CINLONE-I CPI (triamcinolone/lidocaine/prilocaine)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	DERMACINRX LEXITRAL PHARMAP (diclofenac/capsicum oleoresin)
	DERMACINRX PHN PAK (lidocaine/emollient cmb no.102)
	DERMACINRX SILAPAK (triamcinolone/dimeth/silicone)
	DERMACINRX SURGICAL PHARMAP (mupirocin/chlorhexidine/dimeth)
	DERMACINRX THERAZOLE PAK (clotrimazole/betameth dip/zinc)
	DERMACINRX ZRM PAK (lidocaine/dimethicone)
	ESOMEPRAZOLE KIT (esomeprazole mag/glycerin)
	TRIXYLITRAL (diclofenac/lidocaine/tape)
	ELLZIA PAK (triamcinolone/dimethicone)
	INFAMMACIN (diclofenac/capsicum)
	LOPROX (ciclopirox/skin cleanser No. 40)
	MIGRANOW KIT(sumatriptan/menthol/camphor)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

	MORGIDOX (Doxycycline/skin cleanser No. 19)
	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SILAZONE-II KIT (triamcinolone acetone/silicones)
	TICANASE KIT (fluticasone/sodium chloride/sodium bicarbonate)
	XRYLIX 1.5% KIT (diclofenac/kinesiology tape)
	GABACAINE KIT (gabapentin/lidocaine)
	LIDOPURE PATCH 5% COMBO PAC (lidocaine/kinesiology tape)
	NUVAKAAN KIT (lidocaine/prilocaine/silicone)
	ZILACAINE PATCH 5% COMBO PA (lidocaine/silicone, adhesive)
	PRILO PATCH KIT (lidocaine/prilocaine)

## Metformin

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

## Methotrexate

**Required trial duration:** 6 weeks

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

## Mupirocin

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

## Nascobal (Cyanocobalamin) Nasal Spray

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

## Nitroglycerin Spray

**Required trial duration:** 1 dose while on preventative medication

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

## Nocurna (desmopressin)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Desmopressin	Nocurna (desmopressin)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Onmel (itraconazole)

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

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

## Potassium

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

## Procysbi (cysteamine)

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

## Ribavirin

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

## Siklos (Hydroxyurea)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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 Intenol
Prednisone Solution	Prednisolone sodium phosphate ODT
Prednisone Tablets	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
	RAYOS (prednisone)
	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

## Tacrolimus

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Tacrolimus	ASTAGRAF XL (Tacrolimus)
	ENVARUSUS ER (Tacrolimus)

Please use the [NDC Drug Lookup](#) to find Prior Authorization (PA) Forms

## Tirosint (levothyroxine)

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

## Tussicaps

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED 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	<b>Class 1 - Very High Potency</b>			
	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 ( <i>Brand Required</i> ) Shampoo	0.05%	Clobetasol emulsion foam 0.05%
		Clobex ( <i>Brand Required</i> ) 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	<b>Class 2 - High Potency</b>			
	Cream	Betamethasone, augmented	0.05%	Apexicon E 0.05%
		Desoximetasone	0.25%	Fluocinonide-E 0.05%
		Diflorasone Diacetate	0.05%	STEP2* Amcinonide 0.10%
		Fluocinonide	0.05%	
		Halog- <i>brand required</i>	0.10%	
		Triamcinolone Acetonide	0.50%	
	Ointment	Betamethasone Dipropionate	0.05%	Diflorasone Diacetate 0.05%
		Betamethasone Valerate	0.10%	
Desoximetasone		0.25%		

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		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	<b>Class 3 - Medium Potency</b>					
	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	<b>Class 4 - Low Potency</b>					
	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%			

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Oil, Lotion, Shampoo, Solution	Hydrocortisone	2.50%		
	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*

### Duchenne Muscular Dystrophy (DMD)

#### Exondys / Vyondys

**Category Criteria (Initial):** *Approval Duration: 8 weeks*

- The patient must be a male between ages of 4 and 19 years old
- The prescriber must be, or in consult with, a neurologist specializing in treatment of DMD (submit documentation of formal consultation with specialist)
- The patient must have an FDA-approved diagnosis confirmed by genetic test as recommended by manufacturer
- The prescriber must submit medical records confirming the patient has

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- A baseline 6-Minute Walk Time (6MWT)  $\geq$  300 meters while walking independently (e.g. without side-by-side assist, cane, walker, wheelchair, etc.)
- Stable respiratory function – FVC predicted  $>$  50%, not requiring ventilatory assistance
- Stable cardiac function – LVEF  $>$  40 % by ECHO
- Inadequate treatment response with standard corticosteroid therapy for a minimum of 6 months with adherence, as evidenced by paid claims or pharmacy printouts
- The patient must be currently taking corticosteroids, as evidenced by paid claims or pharmacy printouts, and will continue taking with requested agent
- Weight and calculated dose must be provided consistent with approved FDA dose of 30 mg/kg infused once weekly
- The patient must not be taking any other RNA antisense agent or any other gene therapy

**Category Criteria (Renewal):** *Approval Duration: 6 months*

- The prescriber must be, or in consult with, a neurologist specializing in treatment of DMD (submit documentation of formal consultation with specialist)
- The prescriber must submit medical records confirming the patient has maintained
  - A 6MWT  $\geq$  300 meters while walking independently (e.g. without side-by-side assist, cane, walker, wheelchair, etc.)
  - Stable respiratory function – FVC predicted  $>$  50%, not requiring ventilatory assistance
  - Stable cardiac function – LVEF  $>$  40 % by ECHO

## Gamifant

**Category Criteria (Initial):** *Approval Duration: 3 months or up to the hematopoietic stem cell transplantation (HSCT) date*

- The prescriber must be, or in consultation with, a hematologist, oncologist, immunologist, or transplant specialist
- The patient must have diagnosis of primary hemophagocytic lymphohistiocytosis (HLH)
- The patient has refractory, recurrent or progressive disease or intolerance with conventional HLH therapy (i.e., etoposide + dexamethasone, cyclosporine A, or Anti-thymocyte globulin)
- The patient must be a candidate for stem cell transplant
- The patient must have one of the following:
  - Confirmation of a gene mutation known to cause primary HLH (e.g. PRF1, UNC13D, STX11 RAB27A, or STXBP2)
  - Confirmation of 5 of the following clinical characteristics:
    - Fever  $\geq$  101.3F for over 7 days
    - Splenomegaly
    - Two of the following cytopenias in the peripheral blood:
      - ❖ Hemoglobin  $<$  9 g/dL (or  $<$  10 g/dL in infants less than 4 weeks of age)
      - ❖ Platelet count  $<$  100,000/microL
      - ❖ ANC  $<$ 1000/microL
    - One of the following:
      - ❖ Hypertriglyceridemia defined as fasting triglycerides  $\geq$  265 mg/dL (2 mmol/L)
      - ❖ Hypofibrinogenemia defined as fibrinogen  $\leq$  1.5 g/L
    - Hemophagocytosis in bone marrow or spleen or lymph nodes with no evidence of malignancy
    - Low or absent natural killer cell activity
    - Ferritin  $\geq$  500 mg/L
    - Soluble CD25 (i.e., soluble IL-2 receptor)  $\geq$  2,400 U/mL
- The requested medication must be administered with dexamethasone as part of the induction or maintenance phase of stem cell transplant, which is to be discontinued at the initiation of conditioning for stem cell transplant

**Category Criteria (Renewal):** *Approval Duration: 3 months or up to the HSCT date*

- At least 3 HLH abnormalities must be improved by at least 50% from baseline.

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## Spinal Muscular Atrophy (SMA)

### Spinraza

[Prior Authorization Form - Spinraza](#)

**Criteria:** *Approval Duration = 12 months*

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

### Zolgensma

**Criteria:** *Approval Duration = 1 month*

- Patient is less than 2 years of age AND less than 13.5 kg at time of infusion
- Patient has reached full gestational age
- Prescriber must be or in consultation with a pediatric neuromuscular specialist or neurologist specializing in spinal muscular atrophy (SMA)
- Patient must have diagnosis of SMA Type I with onset of symptoms prior to 6 months of age
- Genetic testing confirms one of the following:
  - Mutation or deletion of genes in chromosome 5q resulting in one of the following:
    - Homozygous gene deletion of SMN1 gene (absence of SMN1 gene)
    - Homozygous mutation of SMN1 gene (biallelic mutations of the exon 7)
    - Compound heterozygote mutation of SMN1 gene (deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
  - ≤ 2 copies of the SMN2 gene
  - Absence of the c.859G>C modification in exon 7 of the SMN2 gene
- Baseline Documentation has been submitted confirming anti-adenovirus serotype 9 (anti-AAV9) antibody titer is ≤ 1:50 measured by Enzyme-linked Immunosorbent Assay (ELISA) binding immunoassay
- Patient must not have advanced SMA type 1 evidenced by one of the following
  - Respiratory insufficiency (need for invasive or noninvasive ventilation for more than 6 hours per 24-hour period)
  - Gastric feeding tubes for the majority of feeds
  - Severe contractures or severe scoliosis
  - Wasting or cachexia
  - Established baseline motor ability score < 40 documented by submission of one of the following:
    - Hammersmith Infant Neurological Exam (HINE)
    - Children's Hospital of Philadelphia Test of Neuromuscular Disorders (CHOP INTEND)
- Patient will not be receiving SMN modifying therapy (e.g. Spinraza) after administration of Zolgensma

### Synagis

[Prior Authorization Form - Synagis](#)

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

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

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# Therapeutic Duplication Edits

Therapeutic Duplication Edits for medications on the PDL are embedded within those categories. This is a listing of therapeutic duplication edits on medications that are not managed by the PDL.

## Antidepressant Medications

- One strength of one medication per therapeutic class is allowed at a time
  - Exceptions: Sertraline 100mg and sertraline 25mg are allowed together
  - Therapeutic classes:
    - SSRIs
    - SNRIs
    - Tricyclic Antidepressants
    - Bupropion
    - Mirtazapine
    - Selegiline
- Mirtazapine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
  - Mirtazapine is also an alpha 2 agonist
- Fetzima, Viibryd, or Brintellix are not allowed with other antidepressant medications
  - Exceptions: trazodone and mirtazapine
- Fluvoxamine, a strong 1A2 inhibitor, is not covered with Ramelteon, a 1A2 Substrate.

## Benzodiazepines

- One short acting medication is allowed at a time: alprazolam, lorazepam, oxazepam
- One long acting medication is allowed at a time: chlordiazepoxide, clonazepam, diazepam, alprazolam ER
- Benzodiazepines are not covered with
  - Opioids: Includes long acting narcotics over 90 MME/day or immediate release opioids over 15 MME/dose due to guidance in The SUPPORT for Patients and Communities Act (H.R. 6) on CNS depression risk between benzodiazepines and opioids
  - Xyrem
  - Mydayis
    - Insomnia has been reported in 25-56% of patients receiving Mydayis. Patients reporting insomnia should use a shorter acting product that does not reach steady state.
- Benzodiazepines indicated only for insomnia are not allowed with other non-barbiturate insomnia medications or other benzodiazepines
- Long Acting Benzodiazepines are not covered with sleeping medication due to CNS depression
  - Belsomra is not covered with short or long acting benzodiazepines
- 3A4 Substrates (alprazolam, clonazepam, midazolam,) are not allowed with strong 3A4 inhibitors. [Click here](#) for a full listing of medications included.

## Long Acting Contraception

- One strength of one medication is allowed at a time

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# Therapeutic Duplication Class Expanded Lists

These classes are managed within the PDL. For full explanation of medications included within edit, an expanded list is provided here. Links with detailed explanation of how these edits work are included within the applicable sections within the PDL.

## Anticholinergics and Acetylcholinesterase Inhibitors

Anticholinergics	Acetylcholinesterase Inhibitors
Anoro Ellipta (Umeclidinium Bromide/Vilanterol)	Aricept (donepezil)
Atrovent HFA (Ipratropium Bromide)	Exelon (Rivastigmine)
Benztropine	Razadyne (Galantamine)
Bevespi Aerosphere (glycopyrrolate/formoterol)	Pyridostigmine
Combivent Respimat (Ipratropium/Albuterol)	
Detrol (tolterodine)	
Dicyclomine	
Enablex (Darifenacin)	
Glycopyrrolate	
Incruse Ellipta (Umeclidinium Bromide)	
Lonhala Magnair (glycopyrrolate)	
Oxybutynin	
Propantheline	
Seebri Neohaler (glycopyrrolate)	
Spiriva (Tiotropium Bromide)	
Spiriva Respimat (Tiotropium Bromide)	
Stiolto Respimat (Tiotropium/Olodaterol)	
Toviaz (Fesoterodine)	
Trelegy Ellipta (Fluticasone/Umeclidinium/Vilanterol)	
Trihexyphenidyl	
Tropium	
Tudorza Pressair (Aclidinium Bromide)	
Utibron Neohaler (indacaterol/glycopyrrolate)	
Vesicare (Solifenacin)	
Yupelri (Revefenacin)	

## CYP450 3A4 Interactions

Strong 3A4 Inhibitors	3A4 Substrates
Atazanavir	Alprazolam
Clarithromycin	Clonazepam
Cobicistat	Fentanyl
Darunavir	Midazolam
Dasabuvir	Methadone
Idelaisib	Oxycodone
Indinavir	
Itraconazole	
Ketoconazole	
Lopinavir	
Mifepristone	

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Nefazodone	
Nelfinavir	
Ombitasvir	
Paritaprevir	
Posaconazole	
Ritonavir	
Saquinavir	
Telithromycin	
Voriconazole	

## Electronic Step Care and Concurrent Medications

Electronic Step Care and Concurrent Medications for medications on the PDL are embedded within those categories. This is a listing of Electronic Step Care and Concurrent Medications on medications that are not managed by the PDL.

### Trintellix

- Initiation with 10 mg must be used for 10 days prior to continuing therapy with 20 mg
  - Trintellix recommended starting dose is 10 mg once daily.

### Test strips, Lancets, Meters

- A total of a 25 day supply of Insulin and/or Sulfonylurea therapy must be paid within 150 days prior to diabetic test strip's date of service.
  - The ADA guidelines point out the lack of clinical utility and cost-effectiveness of routine Self-Monitoring of Blood Glucose (SMBG) in non-insulin treated patients. Both the Society of General Internal Medicine and the Endocrine Society recommend against routine SMBG for type 2 diabetes patients not on insulin or agents that cause hypoglycemia.
- Gestational Diabetes is a covered indication for diabetic testing supplies. Patients with gestational diabetes must have prenatal vitamins or folic acid preparations in their prescription claim history for testing supplies to pay.

## First Fill

First Fill for medications on the PDL are embedded within those categories. This is a listing of First Fill on medications that are not managed by the PDL.

### Antidepressants

- Viibryd and Trintellix must be filled with a 10 day supply if no previous fill within past 34 days