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:
        - 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

Contents

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

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General

Combination agents

General Prior Authorization Form

Group Criteria:

- 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).

Dispense as Written (DAW1)

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

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

A. Primary insurance requires a ND Medicaid non-preferred branded product
B. All of the following are met (1-3):
   1. The requested brand-name product must not have an authorized generic available
   2. The patient must have failed a 30-day trial of each pharmaceutically equivalent generic product from each available manufacturer, as evidenced by paid claims or pharmacy print outs
      a. A failure is defined as product was not effective at maximum tolerated dose or caused adverse reaction where the branded product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient
      b. The patient or prescriber preference is NOT criteria considered for approval
   3. A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request

Medications that cost over $3000/month

General Prior Authorization Form

Group Criteria:

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

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

Non-solid dosage preparations

General Prior Authorization Form

Group Criteria:

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

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

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

See Preferred Dosage Forms List

Cardiology

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, methyldopa)
    - 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.
  - Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine are not covered with morphine. Other opioid analgesics are covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine.
    - Morphine may diminish the antiplatelet effect and serum concentrations of P2Y12 Inhibitor antiplatelet agents (clopidogrel, prasugrel, ticagrelor, and ticlopidine).

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

Non-Preferred Agents Criteria:

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

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

Anticoagulants - Injectable

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

Antihemophilic Factor Products

Prior Authorization Form - Antihemophilic Factors

Group Criteria:

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

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the PREFFERED AGENTS (subject to clinical review).
- The patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

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

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

Hematopoietic, Colony Stimulating Factors

General Prior Authorization Form

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

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).

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

Platelet Aggregation 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 30-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

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

Thrombocytopenia

General Prior Authorization Form

Group Criteria:

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

Non-Preferred Agents Criteria:

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

Diagnosis Specific Criteria: Chronic immune thrombocytopenia (ITP):

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

- If on maximum dose: The patient's platelet count must have increased to a level sufficient to avoid clinically important bleeding after the recommended duration for the product*
  *Promacta, Nplate, Doptelet: 4 weeks
  *Tavalisse: 12 weeks

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

Diagnosis Specific Criteria: Chronic liver disease-associated thrombocytopenia

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

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

Diagnosis Specific Criteria: Chronic hepatitis C infection-associated thrombocytopenia

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

Diagnosis Specific Criteria: Aplastic Anemia

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

Hypertension

Vecamyl

General Prior Authorization Form

Group Criteria:

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

Heart Failure

Edecrin

General Prior Authorization Form

Product Specific Criteria:

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

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

Entresto

Diagnosis

- The patient must have an FDA-approved indication for use

Age

- The patient must be an FDA-approved indication for use

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

Lipid-Lowering Agents

Juxtapid

Prior Authorization Form - Juxtapid

Product Specific Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have LDL levels of >130 mg/dL after a 90-day trial of the following, as evidenced by paid claims or pharmacy printouts:
    A. 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
PRALUENT PEN (Alirocumab)	
REPATHA PUSHTRONEX (Evolocumab)	
REPATHA SURECLICK (Evolocumab)	
REPATHA SYRINGE (Evolocumab)	

Pulmonary Hypertension

General Prior Authorization Form

PDE-5 Inhibitors

Electronic Age Verification

- Sildenafil/Tadalafil: Prior authorization is not required for ages less than 12 years old
- Revatio Suspension: Prior authorization is not required for ages less than 9 years old

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age), with medical documentation (e.g. clinical notes) of their diagnosis attached to the request.

Product Specific Criteria:

- **Revatio Suspension:**
    - The provider must submit clinical documentation of the patient's inability to ingest a solid dosage form.

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

Soluble Guanylate Cyclase Stimulators

Electronic Diagnosis Verification

- The patient must have an FDA-approved diagnosis for use
-

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

Endothelin Receptor Antagonists

Electronic Diagnosis Verification

- The patient must have an FDA-approved diagnosis for use

Electronic Age Verification

- Tracleer Suspension: Prior authorization is not required for ages less than 9 years old

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

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

Prostacyclins

Electronic Diagnosis Verification

- The patient must have an FDA-approved diagnosis for use

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

Dermatology

Acne

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

Electronic Age Verification

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

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

CLINDAMYCIN-BENZOYL PEROXIDE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Clindamycin-benzyl peroxide 1.2%-5%	ACANYA (Clindamycin-benzoyl peroxide) 1.2%-2.5%
Clindamycin/benzoyl peroxide 1%-5% without pump	BENZACLIN (Clindamycin/benzoyl peroxide without pump) 1%-5%
ONEXTON (Clindamycin/benzoyl peroxide) 1.2%-3.75%	BENZACLIN (Clindamycin/benzoyl peroxide with pump) 1%-5%
	Clindamycin/benzoyl peroxide 1%-5% with pump
	Clindamycin-benzoyl peroxide 1.2%-2.5%
	DUAC (lindamycin/benzoyl peroxide) 1.2%-5%
	NEUAC (Clindamycin/benzoyl peroxide) 1.2%-5%
CLINDAMYCIN	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
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
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) *(brand preferred)*	CLINDAGEL (Clindamycin) GEL DAILY
	Clindamycin Gel Daily
	Clindamycin foam
	Clindamycin-tretinoin 1.2%-0.025%
	EVOCLIN (Clindamycin) FOAM
RETINOID	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ALTRENO (tretinoin) LOTION	ATRALIN (Tretinoin) 0.05% GEL
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.06%	ARAZLO (Tazarotene) 0.045% LOTION
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.08%	Clindamycin-tretinoin 1.2%-0.025%
RETIN-A (Tretinoin) GEL 0.01%, 0.025% (*Brand Preferred)*	FABIOR (Tazarotene) 0.1% FOAM
RETIN-A (Tretinoin) CREAM (*Brand Preferred)*	RETIN-A (Tretinoin) GEL 0.05%%
Tretinoin gel (Generic co-preferred)	RETIN-A MICRO (Tretinoin Microsphere) GEL WITHOUT PUMP

Tretinoin cream (Generic co-preferred)	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.04%
tretinoin microsphere without pump	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.10%
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) *(brand preferred)*	tretinoin microsphere with pump
ADAPALENE	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Adapalene gel	Adapalene 0.1% cream
DIFFERIN (adapalene) CREAM (*brand preferred*)	Adapalene 0.3% gel with pump
DIFFERIN (adapalene) GEL W/ PUMP *(brand preferred)*	Adapalene/Benzoyl Peroxide 0.1%-2.5%
DIFFERIN (adapalene) LOTION	
EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5% *(brand preferred)*	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ACZONE (Dapsone) GEL WITH PUMP 7.5%	AKLIEF (Trifarotene) CREAM 0.005%
ACZONE (Dapsone) GEL WITHOUT PUMP 5%	AZELEX (Azelaic Acid) CREAM
Azelaic Acid Gel	Dapsone gel without pump 5%
SSS 10-5 (Sulfacetamide) FOAM	
TETRACYCLINES	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Doxycycline hyclate capsule	AMZEEQ (Minocycline) Foam
Doxycycline hyclate tablet 20mg, 100mg	Demeclocycline
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
VIBRAMYCIN (Doxycycline calcium) 50 mg/5mL SYRUP	Doxycycline monohydrate tablet 75mg, 150 mg
	Doxycycline hyclate tablet DR
	MINOCIN (Minocycline) CAPSULE
	Minocycline tablet
	Minocycline Tablet ER
	MINOLIRA ER (Minocycline) TABLET
	MORGIDOX (Doxycycline hyclate) CAPSULE
	SEYSARA (Sarecycline)
	SOLODYN ER (Minocycline) TABLET
	Tetracycline
	VIBRAMYCIN (Doxycycline monohydrate) 25mg/5mL SUSPENSION
	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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ALDARA (Imiquimod) 0.5% CREAM	Fluorouracil 0.5% cream
CARAC (Fluorouracil) 0.5% CREAM	Fluorouracil 2% solution
Diclofenac 3% sodium gel	Fluorouracil 5% solution
Imiquimod 5% cream packet	Imiquimod 3.75% cream pump
Fluorouracil 5% cream	PICATO (ingenol mebutate)
	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*
    A. The patient must have a diagnosis of an FDA approved indication for use
        - Diagnosis must be confirmed by potassium hydroxide (KOH) preparation
    B. 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
    C. Adequate time must have passed since treatment cessation to accurately assess healthy toenail outgrow (at least 6 months)
    D. One of the following must be met (A or B):
        A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
        B. The active ingredient of the requested product is not available in a preferred formulation
- **Other diagnoses:** *Approval Duration = 12 months*
    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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Ciclopirox cream	CICLODAN (Ciclopirox) CREAM
Ciclopirox gel	CICLODAN (Ciclopirox) SOLUTION
Ciclopirox shampoo	EXELDERM CREAM (sulconazole)
Ciclopirox solution	EXELDERM SOLUTION (sulconazole)
Clotrimazole cream	EXTINA (Ketoconazole) FOAM
Clotrimazole solution	JUBLIA (efinaconazole) SOLUTION
Econazole cream	KERYDIN (tavaborole) SOLUTION
ERTACZO (sertraconazole) CREAM	Ketoconazole foam
Ketoconazole cream	LOPROX (Ciclopirox) CREAM
Ketoconazole shampoo	LOPROX (Ciclopirox) SHAMPOO

Luliconazole cream	LOPROX (Ciclopirox) SUSPENSION
MENTAX (butenafine) CREAM	LUZU (Luliconazole) Cream
Miconazole	Miconazole/zinc oxide/white petrolatum ointment
Nystatin cream	Natfifine Cream
Nystatin ointment	Natfifine Gel
Nystatin powder	NAFTIN (Naftifine) CREAM
Nystatin – triamcinolone cream	NAFTIN (Naftifine) GEL
Nystatin – triamcinolone ointment	NIZORAL (Ketoconazole) SHAMPOO
	NYAMYC (Nystatin) POWDER
	NYSTOP (Nystatin) POWDER
	Oxiconazole cream
	OXISTAT (Oxiconazole) CREAM
	OXISTAT (Oxiconazole) LOTION
	PENLAC (Ciclopirox) SOLUTION
	Sulconazole cream
	Sulconazole 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

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

Eczema / Atopic Dermatitis

Prior Authorization Form - Eczema

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

Category PA Criteria:

- Patient must meet FDA label recommendations for indication and age

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

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

- **Dupixent**
  - Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy printouts:
    - Tacrolimus OR Pimecrolimus
  - One of the following must be met (A or B):
    A. Patient must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy printouts.
    B. Patient must meet both of the following (1 AND 2):
       1. Affected area is on face, groin, axilla, or under occlusion
       2. Patient must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy printouts.

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

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

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
DUPIXENT (dupilumab)***	Tacrolimus 0.03%
EUCRISA (crisaborole) OINTMENT***	Tacrolimus 0.1%
Pimecrolimus – Labeler 68682	ELIDEL (pimecrolimus) CREAM
PROTOPIC (tacrolimus) OINTMENT 0.03%	Pimecrolimus – Labeler 00591 and 68462
PROTOPIC (tacrolimus) OINTMENT 0.1%***	

Lice

General Prior Authorization Form

Category Criteria:

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

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

Steroids - Topical

General Prior Authorization Form

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

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
        - 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
- Humulin R U-500 is not allowed with any other insulin (basal or prandial)
    - Humulin R U-500 is indicated for monotherapy. It acts differently than regular insulin (U-100). It provides both basal and prandial coverage. Injections can be increased to 3 times per day for prandial coverage.

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: Alogliptin and Saxagliptan have a potentially higher risk for heart failure

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

DPP4-Inhibitors/SGLT2 Inhibitors Combination

General Prior Authorization Form

Group Criteria:

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

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
	GLYXAMBI (Empagliflozin/linagliptin)
	STEGLUJAN (Ertugliflozin/Sitagliptin)
	TRIJARDY XR (Empagliflozin/Linagliptan/Metformin)
	++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 90-day trial, as evidenced by paid claims or pharmacy printouts of each of the following:
    - Victoza
    - An SGLT-2 Inhibitor: Jardiance, Farxiga, or Invokana

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

Glucose Rescue Medications

Duration Coverage

- 1 dose is covered every 365 days without prior authorization

General Prior Authorization Form

Group Criteria (Initial):

- Glucose Rescue medications do NOT require prior authorization for the initial dose

Group Criteria (Renewal):

- The provider must attest that it is known that the previous dose was taken by the patient (and not diverted or given to another person)
- 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 a hypoglycemic episode
    C. The patient is currently taking insulins or sulfonylureas and meets one of the following criteria:
        - The diabetes treatment has been adjusted to prevent future instances of hypoglycemia
        - The provider has provided medical justification why the diabetes treatment has not been adjusted at this time to prevent future instances of hypoglycemia.

Non-Preferred Criteria

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BAQSIMI (Glucagon)	GVOKE (Glucagon)
Glucagon Kit	GLUCOGEN (Glucagon) HYPOKIT

Insulin/GLP-1 Agonist Combination

General Prior Authorization Form

Group Criteria:

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

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

Insulin

Insulin Prior Authorization Form

Group Criteria:

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

Product Specific Criteria:

- ***Humulin N/Humulin 70/30:** One of the following must be met (A or B):
  A. The patient must be pregnant or breastfeeding
  B. Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- ***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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMALOG JUNIOR KWIKPEN (insulin lispro)	AFREZZA (insulin regular, human)
**++HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	BASAGLAR KWIKPEN U-100 (insulin glargine)***
**++HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN	FIASP (insulin aspart) CARTRIDGE***
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	FIASP (insulin aspart) VIAL***
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	HUMALOG U-100 (insulin lispro) KWIKPEN
***++HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	HUMALOG (insulin lispro) VIAL
***++HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	HUMALOG (insulin lispro) CARTRIDGE
***++HUMULIN N (insulin NPH human isophane) VIAL	HUMALOG U-200 (insulin lispro) KWIKPEN
***++HUMULIN N (insulin NPH human isophane) KWIKPEN	Insulin aspart flexpan
HUMULIN R (insulin regular, human) VIAL	Insulin aspart vial
HUMULIN R (Insulin regular, human) U-500 KWIKPEN	Insulin aspart protamine/insulin aspart
HUMULIN R U-500 (insulin regular, human) VIAL	++NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
Insulin lispro vial	++NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
Insulin lispro syringe	++NOVOLIN N (insulin NPH human isophane) FLEXPEN
LANTUS (insulin glargine) SOLOSTAR	++NOVOLIN N (insulin NPH human isophane) VIAL
LANTUS (insulin glargine) VIAL	TOUJEO MAX SOLOSTAR (insulin glargine)***
LEVEMIR (insulin detemir) VIAL	TOUJEO SOLOSTAR (insulin glargine)***
LEVEMIR (insulin detemir) FLEXTOUCH	TRESIBA (insulin degludec) FLEXTOUCH U-100***
NOVOLIN R (insulin regular, human) VIAL	TRESIBA (insulin degludec) FLEXTOUCH U-200***
NOVOLOG (insulin aspart) CARTRIDGE – *Brand Preferred*	TRESIBA (insulin degludec) VIAL***
NOVOLOG (insulin aspart) FLEXPEN – *Brand Preferred*	
NOVOLOG (insulin aspart) VIAL – *Brand Preferred*	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN	
NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) 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.

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED 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

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

Growth Hormone

Prior Authorization Form - Growth Hormone

Group Criteria:

- Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone.
    - Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone.

- **For Initial or Renewal Requests:**
  - Patient must have a diagnosis of a **covered indication** (listed below):
    - Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
    - Turner's syndrome
    - SHOX syndrome
    - Noonan syndrome
    - Chronic renal insufficiency
    - Prader–Willi syndrome
    - Endogenous growth hormone deficiency
  - <u>For all covered indications:</u>
    - Patient must not have active malignancy
    - Prescriber must be an endocrinologist or nephrologist, or prescriber must have at least one annual consultation about the patient with the pediatric specialty.
    - Patient must not have epiphyseal closure and must still be growing, unless one of the below exceptions is present:
      - Exceptions:
        - Patient has a diagnosis of Prader-Willi syndrome
        - Patient has a diagnosis of endogenous growth hormone deficiency - and is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose.
  - <u>Diagnosis of chronic renal insufficiency (additional criteria):</u>
    - Patient must not have received a renal transplant.
    - Patient must consult with a dietitian to maintain a nutritious diet.
  - <u>Diagnosis of Prader–Willi syndrome (additional criteria):</u>
    - 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:**
  - <u>Diagnosis of endogenous growth hormone deficiency:</u>
    - 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**
  - <u>For all covered indications:</u>
    - Patient must have been compliant with growth hormone (last 6 fills must have been on time).
  - <u>Diagnosis of Prader–Willi syndrome (additional criteria):</u>
    - If patient is obese, BMI must have decreased. If patient is not obese, BMI must have maintained or decreased.

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

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

Serostim

Prior Authorization Form - Growth Hormone

Product Specific Criteria (Initial):

- Patient must have a diagnosis of treatment of HIV with wasting cachexia
- Patient must not have an active malignancy
- Prescriber must be experienced in the diagnosis and management of HIV infection
- Patient must be on concomitant antiretroviral therapy
- Patient must have failed a 3-month trial with Megace, as evidenced by paid claims or pharmacy Printouts

Product Specific Criteria (Renewal):

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

Zorbtive

Prior Authorization Form - Growth Hormone

Product Specific Criteria:

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

Pituitary Suppressants

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

Gastrology

Constipation – Irritable Bowel Syndrome/Opioid Induced

Therapeutic Duplication

- One medication is allowed at a time

Idiopathic Constipation

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

- 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

Product Specific Criteria

- ***Motegrity: The patient must have had a 30 day trial with Trulance, as evidenced by paid claims or pharmacy printouts

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

Opioid-Induced Constipation:

Electronic Step Care and Concurrent Medications

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

Product Specific Criteria:

- ***Relistor Syringe and Vial:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

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

Diarrhea – Irritable Bowel Syndrome

Electronic Step Care and Concurrent Medications

- Xifaxan: Xifaxan does not require prior authorization for hepatic encephalopathy if used concurrently with lactulose
    - A total of 30 days of Lactulose must be paid within 65 days prior to Xifaxan'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 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.
- ***Xifaxan**: Must be used for an FDA-approved indication for use (meeting label recommendations for diagnosis, age, and duration of treatment)
- *** **Dicylclomine Oral Syrup:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

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

Digestive Enzymes

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

Nausea/Vomiting

Chemo Induced

Prior Authorization Form - Nausea/Vomiting

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

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

Product Specific Criteria:

- **Syndros**

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

Pregnancy

Prior Authorization Form - Nausea/Vomiting

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

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient's due date must be provided

Product specific criteria:

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

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

Proton Pump Inhibitor

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 alkalizing agents should be avoided

Electronic Step Care and Concurrent Medications

- Non-Preferred Step 1 Agents: Use least expensive proton pump inhibitors must be trialed first
  - A total of 28 days of 2 preferred agents at max dose 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).
- Non-Solid Dosage Forms: The patient must have feeding tube in place

Solid Dosage Forms

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	Rabeprazole	Esomeprazole strontium
omeprazole		NEXIUM (esomeprazole)
pantoprazole		Omeprazole-Sodium bicarbonate
		PREVACID (Lansoprazole)
		PRILOSEC (Omeprazole)
		PROTONIX (Pantoprazole)

Non-Solid Dosage Forms

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

Vancomycin - Oral

General Prior Authorization Form

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

- The patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- The patient must be 18 years of age or older

- The patient must have failed a 10-day trial with vancomycin, as evidenced by paid claims or pharmacy printouts
- Request must be for treatment of the first recurrence for a patient whose initial episode was treated with Dificid

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

Genetic and Rare Disease

Cystic Fibrosis Inhaled Antibiotics

General Prior Authorization Form

Product Specific Criteria:

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

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

Hereditary Angioedema

General Prior Authorization Form

Category Criteria:

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

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

Idiopathic Pulmonary Fibrosis / 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.

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

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:

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

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

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

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

HUMIRA (adalimumab)	

Dupixent

Prior Authorization Form - Dupixent

Asthma

Click to Jump to Criteria

Eczema

Click to Jump to Criteria

Chronic Rhinosinusitis

General Prior Authorization Form

Initial Criteria: *Approval Duration = 3 months*

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

Renewal Criteria: *Approval Duration = 9 months*

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

Eosinophilic Asthma

Prior Authorization Form – Eosinophilic Asthma

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

- The patient must meet label recommendations for indication and age.
- The patient must have had 2 or more asthma exacerbations in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) or long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts

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

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

Epinephrine

General Prior Authorization Form

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Epinephrine – Labeler 49502	Epinephrine – Labeler 00935
SYMJEPI (Epinephrine)	Epinephrine – Labeler 11516
	EPIPEN (Epinephrine)
	EPIPEN (Epinephrine) JUNIOR

Gout

General Prior Authorization Form

Category Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Allopurinol Tablet	COLCRYS (Colchicine) TABLETS
Colchicine Capsules	Febuxostat
Colchicine Tablets	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

Category 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 SQ administration with preferred products that can be given subcutaneously.
  - 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

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BIVIGAM (human immunoglobulin gamma)	ASCENIV (human immune globulin G slra)

FLEBOGAMMA DIF (human immunoglobulin gamma)	CUTAQUIG (human immune globulin G solution)
GAMUNEX-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)	PANZYGA (Immune Globulin- IFAS)
OCTAGAM (human immunoglobulin gamma)	XEMBIFY (human immune globulin-klhw)
PRIVIGEN (human immunoglobulin gamma)	

Steroids - Nasal

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific Criteria:

- ***Xhance (fluticasone):**
  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)

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

Ulcerative Colitis Agents

General Prior Authorization Form

Category PA Criteria:

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

Oral

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
APRISO (mesalamine) CAPSULE	AZULFIDINE (sulfasalazine)
ASACOL HD (mesalamine)	AZULFIDINE DR (sulfasalazine)
Balsalazide capsule	COLAZAL (balsalazide)
DELZICOL (mesalamine) CAPSULE	Mesalamine DR
DIPENTUM (olsalazine)	Mesalamine HD
LIALDA (mesalamine) TABLET	SULFAZINE (sulfasalazine)
PENTASA (mesalamine)	
Sulfasalazine DR tablet	
Sulfasalazine tablet	

Rectal

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

Mesalamine enema	CANASA (mesalamine) RECTAL SUPPOSITORY
Mesalamine rectal suppository	Mesalamine enema kit
	ROWASA (mesalamine) ENEMA KIT
	SF ROWASA (mesalamine) ENEMA
	UCERIS (budesonide) RECTAL FOAM

Infectious Disease

Antibiotics - Resistance Prevention

Prior Authorization Form – Antibiotics – Resistance Prevention

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 5 days*
  - Patient must have an FDA-approved indication for use (meets label recommendations for diagnosis & age)
    - Diagnosis must be proven to be caused by a susceptible microorganism by culture and susceptibility testing
  - Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol.
  - One of the following criteria must be met (A or B)
    - A. Prescriber must provide evidence-based medical justification for use, explaining why a preferred antibiotic is not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
    - B. The patient is continuing treatment upon discharge from an acute care facility
- **Renewal Criteria:** *Approval Duration = 5 days*
  - Prescriber must attest that the patient's condition is improving and that it is medically necessary to continue treatment course after re-evaluation of the patient's condition.
  - The total requested duration of use must not be greater than manufacturer labeling or treatment guideline recommendations (whichever is greater).

Community-Acquired Pneumonia

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

Methicillin-Resistant *Staphylococcus aureus* (MRSA):

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

Minocycline	
Trimethoprim-Sulfamethoxazole	

Helicobacter pylori

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED 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)

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

Antimalarial Agents

Electronic Step Care and Concurrent Medications

- A total of 30 days of same active ingredient must be paid within 99 days prior to current claim for hydroxychloroquine and chloroquine. Prior authorization required to initiate treatment.

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria:

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

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
daraprim	ARAKODA (tafenoquine)
hydroxychloroquine	atovaquone/proguanil

quinine	chloroquine
	COARTEM (artemether/lumefantrine)
	KRINTAFEL (tafenoquine)
	MALARONE (atovaquone/proguanil)
	mefloquine
	primaquine
	QUALAQUIN (Quinine)

Human Immunodeficiency Virus (HIV)

Serostim - Wasting Cachexia

Dronabinol/Syndros - Loss of 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

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

Non-Nucleoside Reverse Transcriptase Inhibitors

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

Nucleoside Reverse Transcriptase Inhibitors

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Abacavir	COMBIVIR (lamivudine/zidovudine)
Abacavir/lamivudine	EPIVIR (lamivudine)
Abacavir/lamivudine/zidovudine	EPZICOM (abacavir)
ATRIPLA (efavirenz/emtricitabine/tenofovir)	RETROVIR (zidovudine)
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	TRIZIVIR (abacavir/lamivudine)

CIMDUO (lamivudine/tenofovir)	VIDEX EC (didanosine)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	VIREAD (tenofovir)
DELSTRIGO (doravirine/lamivudine/tenofovir)	ZERIT (stavudine) CAPSULE
DESCOVY (emtricitabine/tenofovir)	ZIAGEN (abacavir)
Didanosine	
EMTRIVA (emtricitabine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
Lamivudine	
Lamivudine/zidovudine	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
SYMFI (efavirenz/lamivudine/tenofovir)	
SYMFI LO (efavirenz/lamivudine/tenofovir)	
Stavudine	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
Tenofovir	
TEMIXYS (Lamivudine/Tenofovir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRUVADA (emtricitabine/tenofovir)	
VIDEX (didanosine)	
Zidovudine	

Post-Attachment Inhibitor

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

Protease Inhibitor

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

Lipodystrophy – Growth Hormone-Releasing Hormone Analogue

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

Hepatitis C Treatments

Prior Authorization Form – 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.
- PA approval duration will be based on label recommendation.

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
EPCLUSA (sofosbuvir/velpatasvir) *Brand Preferred****	HARVONI (ledipasvir/sofosbuvir) 90mg/400mg tablet
HARVONI (ledipasvir/sofosbuvir) 45 mg/200mg tablet	Ledipasvir/sofosbuvir
MAVYRET (glecaprevir/pibrentasvir)***	Sofosbuvir/velpatasvir
SOVALDI (sofosbuvir) 200mg tablet	SOVALDI (sofosbuvir) 400mg tablet
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)***
	ZEPATIER (elbasvir/grazoprevir)

Traveler's Diarrhea

Electronic Step Care and Concurrent Medications

- Xifaxan: Xifaxan does not require prior authorization for hepatic encephalopathy if used concurrently with lactulose
  - A total of 30 days of Lactulose must be paid within 65 days prior to Xifaxan's date of service.

Prior Authorization Criteria

Category Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a trial of appropriate duration with azithromycin and a fluoroquinolone

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Azithromycin	XIFAXAN (Rifaximin) 550mg
Ciprofloxacin	
Levofloxacin	

Men's Health

Androgens

General Prior Authorization Form

Group Criteria:

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

Injectable/Implantable

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

Oral

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

Topical

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

Benign Prostatic Hyperplasia

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

alfuzosin ER	AVODART (Dutasteride)
CARDURA XL (doxazosin)	CARDURA (Doxazosin)
doxazosin	FLOMAX (Tamsulosin)
dutasteride	MINIPRESS (Prazosin)
finasteride	PROSCAR (Finasteride)
prazosin	RAPAFLO (silodosin)
silodosin	sildenafil
tamsulosin	tadalafil
terazosin	

Nephrology/Urology

Hematopoietic, Erythropoiesis Stimulating Agents

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

Hyperkalemia (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

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

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.

Solid dosage form

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Calcium acetate	AURYXIA (ferric citrate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET *– brand preferred*	Lanthanum chew tab
Sevelamer Carbonate Tablet	RENAGEL (Sevelamer HCl) TABLET
	RENVELA (sevelamer carbonate) TABLET
	Sevelamer HCl 400mg Tablet
	Sevelamer HCl 800mg Tablet
	VELPHORO (Sucroferric oxyhydroxide)

Non-solid dosage form

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
PHOSLYRA (calcium acetate) ORAL solution	FOSRENOL (lanthanum) POWDER PACK
Sevelamer Powder Pack - Labeler 00955	RENVELA (sevelamer) POWDER PACK
	Sevelamer Powder Pack - Labeler 65862, 43598

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:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ENABLEX (darifenacin ER) – *Brand Preferred*	Darifenacin ER
Flavoxate	DETROL (tolterodine)
GELNIQUE (oxybutynin)	DETROL LA (tolterodine)
JALYN (Dutasteride/Tamsulosin)	DITROPAN XL (oxybutynin)
Oxybutynin ER	FLOMAX (Tamsulosin)
Oxybutynin syrup	MYRBETRIQ (mirabegron)
Oxybutynin tablet	Tolterodine
OXYTROL (oxybutynin) PATCH	Tolterodine ER
Solifenacin	Trospium ER***
Tamsulosin	VESICARE (solifenacin)
TOVIAZ (fesoterodine)	
Trospium	

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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
APTIOM (Eslicarbazepine)	CARBATROL (Carbamazepine)
BANZEL (Rufinamide) ORAL SUSPENSION	DEPAKENE (Valproic acid) CAPSULE
BANZEL (Rufinamide) TABLET	DEPAKENE (Valproic acid) ORAL SOLUTION
BRIVIACT (Brivaracetam)	DEPAKOTE (Divalproex sodium) TABLET
Carbamazepine chewable tablet	DEPAKOTE ER (Divalproex sodium)
Carbamazepine ER capsule	DEPAKOTE SPRINKLE (Divalproex sodium)
Carbamazepine oral suspension	DILANTIN (Phenytoin) CHEWABLE TABLET
Carbamazepine tablet	DILANTIN (Phenytoin) ORAL SUSPENSION

Carbamazepine XR tablet	DILANTIN ER (Phenytoin)
CELONTIN (Methsuximide)	EPITOL (Carbamazepine)
DIACOMIT (Stiripentol)	FELBATOL (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
Felbamate Tablet	LAMICTAL (Lamotrigine) DOSE PACK
FELBATOL (Felbamate) ORAL SUSPENSION - *Brand Preferred*	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) - *Brand Preferred*	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) - *Brand Preferred*	
SABRIL (Vigabatrin) POWDER PACK - *Brand Preferred*	
SPRITAM (Levetiracetam)	
TEGRETOL (Carbamazepine)	
Topiramate ER	
Topiramate sprinkle capsule	
Topiramate tablet	
TROKENDI XR (Topiramate)	
Valproic acid capsule	
Valproic acid oral solution	
VIMPAT (lacosamide)	
VIMPAT (lacosamide) ORAL SOLUTION	
XCOPRI (Cenobamate)	
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

Electronic Age Verification

- Patients must be greater than 30 years old

Prior Authorization Criteria

General Prior Authorization Form

Category PA Criteria:

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

Non-Preferred Product Criteria:

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

Product Specific Criteria:

- Donepezil 23mg:
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

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

Emflaza

Prior Authorization Form - Emflaza

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 2 years of age or older
- The patient must have diagnosis of Duchenne muscular dystrophy (DMD) confirmed by the documented presence of abnormal dystrophin or a confirmed mutation of the dystrophin gene

- Onset of weakness must have occurred before 2 years of age
- The medication must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- The patient must have serum creatinine kinase activity of at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- The patient must have failed a 6-month trial of prednisone due to inadequate treatment response, intolerance, or contraindication, as evidenced by paid claims or pharmacy printouts
- The provider must submit baseline motor milestone score results from at least ONE the following assessments:
    i. 6-minute walk test (6MWT)
    ii. North Star Ambulatory Assessment (NSAA)
    iii. Motor Function Measure (MFM)
    iv. Hammersmith Functional Motor Scale (HFMS)
- The patient must have ONE of the following significant intolerable adverse effects supported by documentation:
    i. Cushingoid appearance
    ii. Central (truncal) obesity
    iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
    iv. Diabetes and/or hypertension that is difficult to manage
    v. Severe behavioral adverse effect

Renewal Criteria: *Approval Duration = 12 months*

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

Headache/Migraine

Prophylaxis of Migraine – CGRP Inhibitors

Prior Authorization Form –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:

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

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

Cluster Headache – Emgality

Prior Authorization Form –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 medication is allowed at a time

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria:

- Within the past 2 years, the patient must have had 30-day trials of two triptans (5HT-1 agonists), as evidenced by paid claims or pharmacy printouts.

Non-Preferred Agents:

- Within the past 2 years, the patient must have had a 30-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Non-Triptan Agents

PREFERRED AGENTS (CLINCAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NURTEC ODT (Rimegepant)	CAFERGOT (ergotamine/caffeine) TABLET
	CAMBIA (Diclofenac Potassium) POWDER PACK
	D.H.E.45 (dihydroergotamine) INJECTION
	Dihydroergotamine Injection
	Dihydroergotamine Nasal Spray
	ERGOMAR (ergotamine) SL TABLET
	MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
	MIGRANAL (dihydroergotamine) SPRAY
	REYVOW (Lasmiditan)
	UBRELVY (Ubrogepant)

Triptans (5HT-1 agonists)

Approval Duration = 6 months

Preferred Non-Oral Dosage Form Agents:

- Patients must not able to take oral medications (as evidenced by swallow study documentation):

Non-Preferred Step 1 Agents Criteria:

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.

Non-preferred step 2 agents:

- 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).

Solid Oral Dosage Forms		
PREFERRED AGENTS (NO PA REQUIRED)	**PREFERRED STEP 1 AGENTS (PA REQUIRED)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
RELPAX (eletriptan) TABLET – *Brand Preferred*	Naratriptan Tablet	Almotriptan Tablet
Rizatriptan tablet	Zolmitriptan Tablet	AMERGE (naratriptan) TABLET
Sumatriptan tablet		Eletriptan Tablet
		FROVA (frovatriptan) TABLET
		Frovatriptan Tablet
		IMITREX (sumatriptan) TABLET
		MAXALT (rizatriptan) TABLET
		Sumatriptan/Naproxen Tablet
		TREXIMET (Sumatriptan/Naproxen) TABLET
		ZOMIG (zolmitriptan) TABLET
Non-Solid Oral Dosage Form		
PREFERRED AGENTS (NO PA REQUIRED)	**PREFERRED STEP 1 AGENTS (PA REQUIRED)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
Rizatriptan ODT	Zolmitriptan ODT	MAXALT MLT (rizatriptan)
		ZOMIG ODT (zolmitriptan)
Non-Oral Dosage Forms		
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**PREFERRED STEP 1 AGENTS (PA REQUIRED)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
ONZETRA XSAIL (sumatriptan) NASAL SPRAY	ZOMIG (zolmitriptan) NASAL SPRAY	ALSUMA (sumatriptan) PEN INJCTR
		IMITREX (sumatriptan) CARTRIDGE
		IMITREX (sumatriptan) PEN INJCTR
		IMITREX (sumatriptan) SPRAY
		IMITREX (sumatriptan) VIAL
		Sumatriptan Cartridge
		Sumatriptan Pen Injctr
		Sumatriptan Spray
		Sumatriptan Syringe
		Sumatriptan Vial
		TOSYMRA (Sumatriptan) NASAL SPRAY
		ZEMBRANCE SYMTOUCH (Sumatriptan

Multiple Sclerosis

General Prior Authorization Form

Interferons

Non-Preferred Agents Criteria:

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

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

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

Injectable Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of each of the following, as evidenced by paid claims or pharmacy printouts.
    - Copaxone 20mg/mL, Aubagio, Gilenya, and Tecfidera
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

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

Oral Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- One of the following must be met (A OR B):
    - 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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED 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

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 ≥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 ≥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 ≥10

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

Nuedexta

Prior Authorization Form - Nuedexta

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

- The patient must be 18 years of age or older
- The patient must not have a diagnosis of any of the following: prolonged QT interval, heart failure, or complete atrioventricular (AV) block

- The prescriber must provide the following information:
    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. Amytrophic 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

- The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
- Documentation of intermittent hypomobility or "off" episodes (number and frequency) must be provided
- The patient must have had inadequate response to medications in two of the following classes to reduce number and frequency of OFF episodes, as evidenced by paid claims or pharmacy printouts
  - A monoamine oxidase-B (MAO-B) inhibitor (e.g. rasagiline and selegiline)
  - A dopamine agonist (e.g. pramipexole IR, ropinirole IR)
  - A catechol-O-methyltransferase (COMT) inhibitor (e.g. entacapone)

- **Xadago and Nourianz:**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The patient must be currently experiencing intermittent hypomobility or "off" episodes
  - The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - The patient must be exhibiting deterioration in quality of response to during levodopa/carbidopa therapy for intermittent hypomobility, or "off" episodes
  - The patient must have had inadequate response to rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts
- **Nuplazid**:
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The patient must be experiencing recurrent or continuous hallucinations and/or delusions for the past 30 days
  - The patient must have experienced an inadequate response to a 30-day trial of quetiapine or clozapine, as evidenced by paid claims or pharmacy printouts
  - The patient must not have experienced a reduction in symptoms of psychosis, despite documented medication dosage reduction and discontinuation trials (with a goal of levodopa monotherapy)
- **Tolcapone**
  - The patient must have failed a 30-day trial of entacapone, as evidenced by paid claims or pharmacy printouts
- **Rasagiline and Emsam**
  - The patient must have failed a 30-day trial of selegiline, as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria (Renewal):

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
Amantadine IR	APOKYN (Apomorphine)
AZILECT (Rasagiline)	Carbidopa-Levodopa ODT
Benztropine	DUOPA (Levodopa/Carbidopa)
Bromocriptine	EMSAM (Selegiline) PATCH
Carbidopa-levodopa-entacapone	GOCOVRI (Amantadine ER)
Carbidopa-Levodopa Capsules	INBRIJA (Levodopa)
Carbidopa-Levodopa ER	NOURIANZ (Istradefylline)

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

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

Ophthalmic

Antihistamines

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ALOCRIL (nedocromil)	Epinastine
ALOMIDE (lodoxamide)	
Azelastine	

BEPREVE (bepotastine)	
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.

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

Anti-infectives/Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS
Neomycin/polymyxin b/dexamethasone ointment	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT
Neomycin/polymyxin b/hydrocortisone ointment	Neomycin/bacitracin/polymyxin b/hydrocortisone ointment
PRED-G (gentamicin/prednisol ac) DROPS	Neomycin/polymyxin b/hydrocortisone drops
PRED-G (gentamicin/prednisol ac) OINTMENT	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT
Sulfacetamide/prednisolone drops	TOBRADEX ST (tobramycin/dexamethasone) DROPS
TOBRADEX (tobramycin/dexamethasone) DROPS	Tobramycin/dexamethasone
TOBRADEX (tobramycin/dexamethasone) OINTMENT	
ZYLET (tobramycin/lotepred etab) DROPS	

Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

Dry Eye Syndrome

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific Criteria:

- **Cequa, Restasis Multidose**
  - The patient must have had a 30-day trials of Xiidra, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

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

Glaucoma

Alpha Adrenergics

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

Beta Blockers

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

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

Prostaglandins

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Latanoprost	Bimatoprost 0.03%
LUMIGAN (Bimatoprost) 0.01%	Travoprost
ROCKLATAN (Netarsudil/Latanoprost)	VYZULTA (latanoprostene)
TRAVATAN Z (Travoprost) - *Brand Preferred*	XALATAN (Latanoprost)
ZIOPTAN (Tafluprost)	XELPROS (Latanoprost)

Other

Non-Preferred Agents Criteria:

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

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

Otic

Anti-infectives/Anti-inflammatories – Fluoroquinolones

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CIPRO HC (ciprofloxacin/hydrocortisone)	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:

- **Mefenamic 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)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Celecoxib 50mg, 100mg, 200mg	ARTHROTEC (Diclofenac/Misoprostol)
Diclofenac potassium	Celecoxib 400mg
Diclofenac sodium 50mg, 75mg	CELEBREX (Celecoxib)
Etodolac	CONSENSI (Amlodipine/Celecoxib)
Fenoprofen 600mg	DAYPRO (Oxaprozin)
Flurbiprofen	Diclofenac sodium ER 100mg
Ibuprofen	Diclofenac sodium 25mg
Indomethacin	Diclofenac/Misoprostol

Indomethacin ER	DUEXIS (Famotidine/Ibuprofen)
Ketoprofen 50mg, 75mg	Etodolac ER
Ketorolac	FELDENE (Piroxicam)
Meloxicam	Fenoprofen 400mg
Nabumetone	INDOCIN (Indomethacin)
Naproxen 220mg, 250mg, 500mg	Ketoprofen 25mg
Piroxicam	Ketoprofen ER 200mg
Sulindac	Meclofenamate
Tolmetin 200mg, 400mg	Mefenamic acid
VIMOVO (Naproxen/Esomeprazole) – *Brand preferred*	MOBIC (Meloxicam)
	NALFON (Fenoprofen)
	NAPRELAN (Naproxen)
	Naproxen ER 375 mg
	Naproxen 275mg, 550mg
	Naproxen/Esomeprazole
	Oxaprozin
	RELAFEN DS (Nabumetone)
	TIVORBEX (indomethacin, submicronized)
	Tolmetin 600mg
	VIVLODEX (meloxicam, submicronized)
	ZIPSOR (diclofenac)
	ZORVOLEX (diclofenac, submicronized)

Non-Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Product Specific Criteria:

- **Indomethacin oral solution**:
    A. The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation
    B. 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	INDOCIN (Indomethacin) SOLUTION
Naproxen	QMIIZ ODT (meloxicam)

Nasal

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of 2 oral and 1 topical preferred agents, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use another dosage form (subject to clinical review).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
	Ketorolac Nasal Spray
	SPRIX (Ketorolac) NASAL SPRAY

Topical:

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

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

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

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

Opioid 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
- Morphine is not covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine. Other opioid analgesics are covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine.
  - Morphine may diminish the antiplatelet effect and serum concentrations of P2Y12 Inhibitor antiplatelet agents (clopidogrel, prasugrel, ticagrelor, and ticlopidine).

Underutilization

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

Morphine Milligram Equivalents (MME)

Prior Authorization Form – Opioid Analgesics

- A cumulative maximum of 90 MME will be allowed without authorization
- Patient must meet Prior Authorization Criteria

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 patient must have access to Narcan and be counseled on overdose risk
- 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

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

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

Prior Authorization Form – Opioid Analgesics

Additional Group Criteria:

- The patient must have 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).

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

Full Agonist Opioids Without Abuse Deterrent Formulations

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

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

- Patients have reached the max dose of Oxycontin and are switching to Morphine ER Tablets for an Opioid Rotation strategy

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	
PREFFERED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Fentanyl 12 mcg/hr	DURAGESIC (Fentanyl) Patch
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr	EXALGO (hydromorphone)
Morphine ER tablets	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr
	Hydrocodone ER Tablets
	Hydromorphone ER tablets
	KADIAN (morphine)
	Morphine ER capsules
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets
	ZOHYDRO ER (hydrocodone)

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:**
  A. The patient's age must be within label recommendations
  B. The patient must have a diagnosis of cancer pain
  C. 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):**
  A. The patient must have required around-the-clock pain relief for the past 90 days, as evidenced by paid claims or pharmacy printouts
  B. The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports
  C. 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.)
  D. 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**

A. The above Initial Criteria must be met
B. The patient must currently be on a long-acting opioid analgesic that provides a daily Morphine Equivalent Dose (MED) which meets requirements below (based on requested strength), as evidenced by paid claims or pharmacy printouts (Please use an Opioid Dose Calculator to find the MED for specific products):
    - **Oxycodone 15 mg tablet:** long-acting opioid must provide ≥150 mg MED per day
    - **Oxycodone 20 mg tablet:** long-acting opioid must provide ≥200 mg MED per day
    - **Oxycodone 30 mg tablet:** long-acting opioid must provide ≥300 mg MED per day

- **Meperidine, butalbital-codeine products:**
    A. The above Initial Criteria must be met
    B. 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):**
    A. Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Acetaminophen/Codeine Solution	ABSTRAL (Fentanyl) SUBLINGUAL TABLET
Acetaminophen/Codeine Tablets	ACTIQ (Fentanyl) LOZENGE
Benzhydrocodone/Acetaminophen	Butalbital-Codeine
Codeine Tablets	CONZIP (Tramadol)
Hydrocodone/Acetaminophen 7.5-325/15ml Solution	DEMEROL (Meperidine)
hydrocodone-acetaminophen 5-325 MG	DILAUDID (Hydromorphone)
hydrocodone-acetaminophen 7.5-325 MG	ENDOCET (Oxycodone/Acetaminophen)
hydrocodone-acetaminophen 10-325 MG	FENTORA (Fentanyl) EFFERVESCENT TABLET
Hydrocodone/Ibuprofen	Fentanyl Citrate Buccal Tablet
Hydromorphone Liquid	Fentanyl Lozenge
Hydromorphone Tablet	Hydrocodone/Acetaminophen 5-163mg/7.5mL Solution
Morphine Tablets	hydrocodone-acetaminophen 2.5-325 MG
Morphine Solution	hydrocodone-acetaminophen 10MG-300MG
NUCYNTA (Tapentadol) TABLETS	hydrocodone-acetaminophen 5 MG-300MG
Oxycodone 5mg, 10mg Tablets	hydrocodone-acetaminophen 7.5-300 MG
Oxycodone Solution	LAZANDA (Fentanyl) SPRAY
oxycodone-acetaminophen 5-325 MG	LORCET (Hydrocodone/Acetaminophen)
oxycodone-acetaminophen 10 -325 MG	LORTAB (Hydrocodone/Acetaminophen) SOLUTION
Oxymorphone Tablets	Meperidine
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)

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

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, methyldopa) as tizanidine is also an alpha 2 agonist

Prior Authorization Criteria

General Prior Authorization Form

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

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

Product Specific Criteria

- **Metaxalone:** *Approval Duration = 3 months*
  - **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)

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

Psychiatry

ADHD Agents

Therapeutic Duplication

- **For all stimulants:**
  - The following are not payable:
    - Multiple strengths of a single medication
    - Amphetamine Agent + Methylphenidate Agent
    - Multiple Long Acting Agents
    - Multiple Short Acting Agents
    - Non-Solid dosage + Solid dosage forms

- These long acting products are not allowed with short acting products is not allowed with the following products:
  - Aptensio XR (Methylphenidate)
  - Adhansia XR (Methylphenidate)
  - Cotempla XR-ODT (Methylphenidate)
  - Daytrana (Methylphenidate)
  - Adderall XR (Mixed Salts of a Single-Entity Amphetamine Product)
  - Adzenys XR ODT (Amphetamine Suspension, Extended Release)
  - Adzenys ER (Amphetamine Suspension, Extended Release)
  - Dyanavel XR (amphetamine suspension, Extended Release)
  - Mydayis (Mixed Salts of a Single-Entity Amphetamine Product)
  - Vyvanse (Lisexamfetamine)
  - Vyvanse Chewable (Lisexamfetamine)

- Amphetamines: One product will be allowed at a time. The following are not payable regimens:
  - Dextroamphetamine/Amphetamine ER with Proton Pump Inhibitors
    - 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: The following are not payable regimens
  - Concurrent use of dexmethylphenidate and methylphenidate

- **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 65 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

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

Stimulants

Stimulants - Methylphenidates	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ADHANSIA XR (methylphenidate)	Dexmethylphenidate ER
APTENSIO XR (methylphenidate)	FOCALIN (dexmethylphenidate)
CONCERTA (methylphenidate) – *Brand Preferred*	METADATE ER (methylphenidate)
COTEMPLA XR - ODT (methylphenidate)	METHYLIN (methylphenidate) chew tablets
DAYTRANA (methylphenidate)	Methylphenidate ER 72 mg
Dexmethylphenidate	Methylphenidate ER tablet
FOCALIN XR (dexmethylphenidate) – *Brand Preferred*	Methylphenidate LA capsules - 50-50 – 20mg, 30mg, 40mg, 60mg
Methylphenidate solution	METHYLIN (methylphenidate) solution
Methylphenidate CD 30-70	RELEXXII (methylphenidate)
Methylphenidate chew tablet	RITALIN (methylphenidate)
Methylphenidate ER capsules 50-50	RITALIN LA (methylphenidate LA capsules - 50-50) 10mg
Methylphenidate LA capsules - 50-50 – 10mg	
Methylphenidate tablet	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
RITALIN LA (methylphenidate LA capsules - 50-50) 20mg, 30mg, 40mg – *Brand Preferred*	

Stimulants - Amphetamines	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
ADDERALL XR (Dextroamphetamine/amphetamine) – *Brand Preferred*	ADZENYS ER (Amphetamine) SOLUTION
ADZENYS XR - ODT (Amphetamine)	ADDERALL (Dextroamphetamine/amphetamine)
Amphetamine ER solution	Amphetamine
DESOXYN (Methamphetamine) – *Brand Preferred*	DEXEDRINE (Dextroamphetamine)
Dextroamphetamine	Dextroamphetamine 5 mg/5 ml
Dextroamphetamine ER	Methamphetamine
Dextroamphetamine/amphetamine	ZENZEDI (Dextroamphetamine)
DYANAVEL XR (Amphetamine)	Dextroamphetamine/amphetamine ER

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

Stimulants - Amphetamines	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
EVEKEO (Amphetamine) – *Brand Preferred*	
EVEKEO ODT (Amphetamine)	
MYDAYIS (Dextroamphetamine/dextroamphetamine)	
PROCENTRA (Dextroamphetamine) – *Brand Preferred*	
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: Chloropromazine, Fluphenazine, Perphenazine, Thioridazine, Trifluoperazine, Haloperidol
    - One strength allowed at a time
    - No other antipsychotic medication is allowed concurrently
- Second generation antipsychotics:
    - Aripiprazole: one strength is allowed at a time
    - Risperidone: not allowed with paliperidone concurrently
    - Caplyta, Fanapt, Latuda, Paliperidone, Rexulti, Saphris, Secuado, 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 IR due to risk of CNS depression.
    - 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

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

First Fill

- Caplyta, Fanapt, Latuda, Paliperidone ER, Rexulti, Saphris, Sacuado, and Vraylar must be filled with a 10 day supply if no previous fill within past 65 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).

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Aripiprazole solution	ABILIFY (aripiprazole)
Aripiprazole	ABILIFY DISCMELT (aripiprazole)
Aripiprazole ODT	CLOZARIL (clozapine)
CAPLYTA (Lumateperone)	FAZACLO (clozapine) RAPDIS
Clozapine	GEODON (ziprasidone)
Clozapine ODT	INVEGA ER (paliperidone)
FANAPT (Iloperidone)	Olanzapine/Fluoxetine***
LATUDA (Lurasidone)	RISPERDAL (risperidone)
Olanzapine	RISPERDAL (risperidone) ORAL SOLUTION
Olanzapine ODT	RISPERDAL M-TAB (risperidone)
Paliperidone ER	SEROQUEL (quetiapine)
Quetiapine	SEROQUEL XR (quetiapine)
Quetiapine ER	SYMBYAX (olanzapine/fluoxetine) ***
REXULTI (Brexpiprazole)	ZYPREXA (olanzapine)
Risperidone	ZYPREXA ZYDIS (olanzapine)
Risperidone ODT	
Risperidone oral solution	
SAPHRIS (Asenapine)	
SECUADO (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.

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	

INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
ZYPREXA RELPREVV (olanzapine)	

Sedatives/Hypnotics

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

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

- **Zolpidem 10mg** (prior authorization required for females only):
  - The patient must have failed a 25-day trial of zolpidem 5 mg within the last 30 days, as evidenced by paid claims or pharmacy print outs
- **Zolpidem ER:**
  - The patient's insomnia must be characterized by difficulty with sleep maintenance
  - The patient must have failed a 25-day trial of eszopiclone within the last 30 days, as evidenced by paid claims or pharmacy printouts
- **Belsomra:**
  - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
    - Silenor (doxepin)
    - Eszopiclone
    - Zolpidem ER

- **Temazepam, zolpidem SL:**
  - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
  - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
    - Zolpidem ER
    - Eszopiclone
    - Silenor (doxepin)
    - Belsomra
- **Edluar (Zolpidem):**
  - The patient's insomnia must be characterized by difficulty with sleep onset
  - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
    - Zolpidem IR
    - Zaleplon
    - Eszopiclone
- **Triazolam, fluazepam, estazolam, Seconal sodium, Zolpimist:**
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

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

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

NON - DEA SCHEDULED (NON-ADDICTIVE) MEDICATION:	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Mirtazapine	Doxepin
ROZEREM (ramelteon)	Ramelteon
SILENOR (doxepin) – *Brand Preferred*	
Trazodone	
DEA SCHEDULED MEDICATIONS	
PREFFERED AGENTS (NO PA REQUIRED)	**NON-PREFFERED AGENTS (PA REQUIRED)**
Eszopiclone	AMBIEN (Zolpidem)
Zaleplon	AMBIEN CR (Zolpidem)
Zolpidem	BELSOMRA (Suvorexant)
Zolpidem ER	EDLUAR (Zolpidem)
	Estazolam
	Flurazepam
	LUNESTA (Eszopiclone)
	SECONAL SODIUM (Secobarbital)
	Temazepam
	Triazolam
	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. PMCID: PMC4641773
3. Global Initiative for Asthma. Global strategy for asthma management and prevention. 2019 GINA Main Report. Available from: 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 Healrth, 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

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
  - 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 ≥ 3 canisters per year is associated with higher risk of emergency department presentations
  - Dispensing ≥ 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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Albuterol HFA – Labeler 66993***	Albuterol HFA – Labeler 00933, 00254, 45802
PROAIR (albuterol) HFA – *Brand Preferred*	ProAir Digihaler
PROAIR RESPICLICK (albuterol)	PROVENTIL (albuterol) HFA
XOPENEX (levalbuterol) HFA - *Brand Preferred*	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.

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

Corticosteroids – Inhaled

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific Criteria:

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

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

	QVAR REDIHALER (beclomethasone)

Long Acting Anticholinergics

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

Product Specific Criteria:

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

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

Spiriva Respimat 1.25 mcg

General Prior Authorization Form

Criteria for coverage:

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

Long Acting Beta Agonists

General Prior Authorization Form

Group Criteria:

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

Product Specific Criteria:

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

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

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED 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, NIcotrol Inhaler, or Nicotine Gum's date of service.
  - 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 Polarcrilex Gum	
NICOTROL (Nicotine Polacrilex) INHALER	
NICOTROL (Nicotine Polacrilex) SPRAY	

Opioid Dependence Treatment

Lucemyra

General Prior Authorization Form

Group Criteria:

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

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

Naloxone Rescue Medications

General Prior Authorization Form

Group Criteria (Initial):

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

Group Criteria (Renewal):

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

Opioid Antagonist

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

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
CLIMARA PRO (estradiol-levonorgestrel) PATCH	ACTIVELLA (Estradiol/Norethindrone) TABLET
COMBIPATCH (Estradiol- Norethindrone)	ALORA (Estradiol) PATCH TWICE WEEKLY

ELESTRIN (estradiol) GEL	AMABELZ (Estradiol/Norethindrone) TABLET
Estradiol Tablet	BIJUVA (Estradiol/Progesterone)
ESTRING (estradiol)	CLIMARA (Estradiol) PATCH WEEKLY
EVAMIST (estradiol) SPRAY	DELESTROGEN (Estradiol Valerate) INJECTION
MENOSTAR (estradiol) PATCH	DEPO-ESTRADIOL (Estradiol Cypionate) INJECTION
Norethindrone-Ethinyl Estradiol tablet	DIVIGEL (estradiol) GEL
PREMARIN (estrogens, conjugated) INJECTION	DOTTI (Estradiol) PATCH TWICE WEEKLY
PREMARIN (estrogens, conjugated) TABLET	ESTRACE (Estradiol) TABLET
PREMARIN (estrogens, conjugated) VAGINAL CREAM	Estradiol Valerate Injection
PREMPHASE (estrogen, conj.,m-progest) TABLET	Estradiol- Norethindrone Tablet
PREMPRO (estrogen, conj.,m-progest) TABLET	Estradiol Patch Twice Weekly
VAGIFEM (estradiol) VAGINAL TABLET	Estradiol Patch Weekly
	Estradiol Vaginal Cream
	Estradiol Vaginal Tablet
	FEMRING (estradiol)
	FYAVOLV (Norethindrone-Ethinyl Estradiol) TABLET
	JINTELI (Norethindrone-Ethinyl Estradiol) TABLET
	LOPREEZA (Estradiol/Norgestimate) TABLET
	MENEST (estrogens, esterified) TABLET
	MIMVEY (Estradiol/Norgestimate) TABLET
	MINIVELLE (Estradiol) PATCH TWICE WEEKLY
	PREFEST (Estradiol/Norgestimate) TABLET
	VIVELLE-DOT (Estradiol) PATCH TWICE WEEKLY
	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):
    - A. **Pregnancy must have resulted from an act of rape or incest, and one of the following (I or II)**
        - I. The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
        - II. The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.
    - B. **Both of the following must be met (I and II)**
        - I. The woman must suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a provider, place the woman in danger of death unless an abortion is performed
        - II. The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Orilissa

Prior Authorization Form - Orilissa

Initial Criteria: *Approval Duration = 6 months*

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

Renewal Criteria: *Approval Duration = 18 months*

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

Osteoporosis

Prior Authorization Form - Osteoporosis

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

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    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 ≥3% as assessed with the FRAX
    D. 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX

Product Specific Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Alendronate	Alendronate oral solution
Calcitonin, Salmon Nasal Spray	BINOSTO (Alendronate) EFFERVESCENT TAB
Ibandronate	FORTEO (Teriparatide)
PROLIA (Denosumab)	MIACALCIN (Calcitonin, Salmon)***
Risedronate	TYMLOS (Abaloparatide)

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

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

PREFFERED AGENTS (CLINICAL PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
MAKENA (hydroxyprogesterone caproate) – *Brand Preferred*	hydroxyprogesterone caproate

Vaginal Anti-Infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

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

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
AVC (sulfanilamide)	Clindamycin cream
CLEOCIN (Clindamycin) SUPPOSITORY	CLEOCIN (Clindamycin) CREAM
CLINDESSE (Clindamycin) CREAM	METROGEL-VAGINAL (Metronidazole)
GYNAZOLE 1 (butoconazole) CREAM	MICONAZOLE 3 (miconazole) suppository
Metronidazole gel	terconazole suppository
NUVESSA (Metronidazole) GEL	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.

**: A failure is defined as product was not effective at maximum tolerated dose or patient has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient*

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

Amoxicillin ER

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

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

Antihistamines

Therapeutic Duplication

- One strength of one medication is allowed at a time

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

Bactroban

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

Belladonna Alkaloids/Phenobarbital

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

Bowel Prep Agents

Required trial duration: 1 complete dose

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE
GOLYTELY 236-22.74G	GAVILYTE-C
MOVIPREP	GAVILYTE-N
OSMOPREP	NULYTELY
PEG-3350 AND ELECTROLYTES 236-22.74G	PEG 3350-ELECTROLYTE 240-22.72G
	PEG 3350-ELECTROLYTE 420 G
	PLENVU
	PREPOPIK
	SUPREP
	TRILYTE

Brisdelle (Paroxetine)

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

Butalbital-Acetaminophen-Caffeine

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

Daxbia (Cephalexin)

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

Fenofibrate

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
Fenofibrate capsules	Fenofibrate tablets 40mg, 120mg
Fenofibrate tablets 48mg, 54mg, 145mg, 160mg	FENOGLIDE (Fenofibrate)
	LIPOFEN (Fenofibrate)
	TRICOR (Fenofibrate)
	TRIGLIDE (Fenofibrate)

Gabapentin

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

Jadenu (Deferasirox)

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

Kits

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
FDA approved products prescribed separately	CAMPHOTREX 4%-10% ROLL-ON G (menthol/camphor)
	CLINDACIN ETZ (clindamycin phos/skin clnsr 19)
	CLINDACIN PAC (clindamycin phos/skin clnsr 19)
	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX LEXITRAL PHARMAP (diclofenac/capsicum oleoresin)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAPAK (triamcinolone/dimeth/silicone)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	DERMACINRX SURGICAL PHARMAP (mupirocin/chlorhexidine/dimeth)
	DERMACINRX THERAZOLE PAK (clotrimazole/betameth dip/zinc)
	DERMACINRX ZRM PAK (lidocaine/dimethicone)
	ELLZIA PAK (triamcinolone/dimethicone)
	ESOMEP-EZS KIT (esomeprazole mag/glycerin)
	GABACAINE KIT (gabapentin/lidocaine)
	INFAMMACIN (diclofenac/capsicum)
	LIDOPURE PATCH 5% COMBO PAC (lidocaine/kinesiology tape)
	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)
	NUVAKAAN KIT (lidocaine/prilocaine/silicone)
	PRILO PATCH KIT (lidocaine/prilocaine)
	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SILAZONE-II KIT (triamcinolone aceton/silicones)
	SOLARAVIX (Diclofenac/silicone, adhesive)
	SUMADAN KIT (sulfacetamide/sulfur/cleansr23)
	SUMAXIN CP KIT (sulfacetamide/sulfur/cleansr23)
	TICANASE KIT (fluticasone/sodium chloride/sodium bicarbonate)
	TRIXYLITRAL (diclofenac/lidocaine/tape)
	XRYLIX 1.5% KIT (diclofenac/kinesiology tape)
	ZILACAINE PATCH 5% COMBO PA (lidocaine/silicone, adhesive)

Metformin

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

Methotrexate

Required trial duration: 6 weeks

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

Mupirocin

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

Nascobal (Cyanocobalamin) Nasal Spray

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

Nitroglycerin Spray

Required trial duration: 1 dose while on preventative medication

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

Nocdurna (desmopressin)

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

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

Onmel (itraconazole)

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

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

Potassium

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

Procysbi (cysteamine)

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

Ribavirin

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

Siklos (Hydroxyurea)

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

Statins (HMG-CoA inhibitors)

PREFFERED AGENTS (NO PA REQUIRED)	NON-PREFFERED AGENTS (PA REQUIRED)
atorvastatin	EZALLOR SPRINKLE (rosuvastatin)
fluvastatin	fluvastatin ER
LIVALO (pitavastatin)	ZYPITAMAG (pitavastatin)
lovastatin	
pravastatin	
simvastatin	

Steroids - Oral

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

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

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

Prednisone Tablets	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
	RAYOS (prednisone)
	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

Tacrolimus

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

Tirosint (levothyroxine)

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

Tussicaps

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

Topical Corticosteroids Preferred Medication List

Potency	Dosage Form	Preferred		Non-Preferred	
Class 1 - Very High Potency	**Class 1 - Very High Potency**				
	Cream	Clobetasol Propionate	0.05%	Clobetasol Emollient	0.05%
				Halobetasol Propionate	0.05%
				STEP2* Fluocinonide	0.10%
	Ointment	Betamethasone, augmented	0.05%	Halobetasol Propionate	0.05%
		Clobetasol Propionate	0.05%		
	Foam, Gel, Lotion, Shampoo, Solution, Spray, Tape	Clobetasol Propionate Solution	0.05%	Betamethasone, augmented lotion	0.05%
		Clobetasol Propionate Lotion	0.05%	Betamethasone, augmented gel	0.05%
		Clobex (*Brand Required*) Shampoo	0.05%	Clobetasol emulsion foam	0.05%
		Clobex (*Brand Required*) Spray	0.05%	Clobetasol propionate foam	0.05%
		Clobetasol Propionate Gel	0.05%	Lexette (Halobetasol) foam	0.05%
				Desoximetasone spray	0.25%
				STEP2* Cordran (Flurandrenolide) Tape	4MCG/SQ CM
				STEP 2* Ultravate (Halobetasol) lotion	0.05%
Class 2 - High	**Class 2 - High Potency**				
	Cream	Betamethasone, augmented	0.05%	Apexicon E	0.05%

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		Desoximetasone	0.25%	Fluocinonide-E	0.05%
		Diflorasone Diacetate	0.05%	STEP2* Amcinonide	0.10%
		Fluocinonide	0.05%		
		Halog-*brand required*	0.10%		
		Triamcinolone Acetonide	0.50%		
	Ointment	Betamethasone Dipropionate	0.05%	Diflorasone Diacetate	0.05%
		Betamethasone Valerate	0.10%		
		Desoximetasone	0.25%		
		Fluocinonide	0.05%		
		Fluticasone Propionate	0.01%		
		Halog	0.10%		
		Mometasone Furoate	0.10%		
		Triamcinolone Acetonide	0.50%		
	Gel, Lotion Solution	Fluocinonide gel	0.05%	Desoximetasone gel	0.05%
		Fluocinonide solution	0.05%	Bryhali (halobetasol)	0.01%
				STEP2* Amcinonide Lotion	0.10%
Class 3 - Medium Potency	**Class 3 - Medium Potency**				
	Cream	Betamethasone Valerate	0.10%	Betamethasone Dipropionate	0.05%
		Fluticasone Propionate	0.05%	Clocortolone Pivalate	0.10%
		Mometasone Furoate	0.10%	Fluocinolone Acetonide	0.025%
		Synalar	0.025%	Pandel	0.10%
		Triamcinolone Acetonide	0.10%	Prednicarbate	0.10%
				STEP2* Desoximetasone	0.05%
				STEP2* Flurandrenolide	0.05%
				STEP2* Hydrocortisone Butyrate	0.10%
				STEP2* Hydrocortisone Butyrate Emollient	0.10%
				STEP2* Hydrocortisone Valerate	0.20%
	Ointment	Fluocinolone Acetonide	0.025%	Desoximetasone	0.05%
		Desonide	0.05%	Hydrocortisone Valerate	0.20%
		Hydrocortisone Butyrate	0.10%	Triamcinolone	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%

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

Class 4 - Low Potency	**Class 4 - Low Potency**				
	Cream	Alclometasone Dipropionate	0.05%		
		Desonide	0.05%		
		Fluocinolone Acetonide	0.01%		
		Hydrocortisone	2.50%		
		Hydrocortisone	1.00%		
		Triamcinolone Acetonide	0.025%		
	Ointment	Alclometasone Dipropionate	0.05%		
		Hydrocortisone	1.00%		
		Hydrocortisone	2.50%		
	Oil, Lotion, Shampoo, Solution	Capex Shampoo	0.01%	Betamethasone Valerate Lotion	0.10%
		Desonide Lotion	0.05%		
		Fluocinolone Acetonide Oil	0.01%		
		Fluocinolone Acetonide Solution	0.01%		
		Hydrocortisone Lotion	2.50%		
		Texacort Solution	2.50%		
		Triamcinolone Acetonide Lotion	0.025%		

Clinic Administered Drugs

Brineura

Prior Authorization Form - Brineura

Initial Criteria: *Approval Duration = 6 months*

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

Renewal Criteria: *Approval Duration = 12 months*

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

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

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
  - A baseline 6-Minute Walk Time (6MWT) ≥ 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 ≥ 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 ≥ 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 ≥ 265 mg/dL (2 mmol/L)
      - Hypofibrinogenemia defined as fibrinogen ≤ 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 ≥ 500 mg/L
    - Soluble CD25 (i.e., soluble IL-2 receptor) ≥ 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.

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 SMNI gene)
        - Homozygous mutation of SMN1 gene (biallelic mutations of the exon 7)
        - Compound heterozygote mutation of SMN1 gene (deletion of SNM1 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 o the SMN2 gene
- Baseline Documentation has been submitted confirming anti-adeno-associated virus 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 21st)*

- 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

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
  - 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

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)	
Cuvposa (Glycopyrrolate)	
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	
Trospium	
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	Corlanor
Darunavir	Fentanyl
Dasabuvir	Midazolam
Idelaisib	Methadone
Indinavir	Oxycodone
Itraconazole	
Ketoconazole	
Lopinavir	

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Mifepristone	
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.

Antidepressants

- 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.
- Desvenlafaxine ER: 30 days of 50 mg must be paid within 40 days of 25 mg date of service
  - 25 mg is intended only for gradual titration before discontinuation. It is not a therapeutic dose.

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 65 days