

**Appendix P**  
**Colorado Medical Assistance Program**  
**Prior Authorization Procedures and Criteria**  
**For Physicians and Pharmacists**

Drugs requiring a prior authorization are listed in this document. The Prior Authorization criteria are based on FDA approved indications, CMS approved compendia, and peer-reviewed medical literature.

**Prior Authorization Request (PAR) Process**

- Pharmacy PA forms are available by visiting: <https://www.colorado.gov/hcpf/provider-forms>
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons cannot sign the PA form
- Physicians or assistants who are acting as the agents of the physicians can request a PA by phone
- Pharmacists from long-term-care pharmacies and infusion pharmacy must obtain a signature from someone who is authorized to prescribe drugs before they submit PA forms
- Pharmacists from long-term-care pharmacies and infusion pharmacies can request a PA by phone if specified in the criteria
- All PA's are coded online into the PA system
- Prior Authorizations can be called or faxed to the helpdesk at:
  - Phone: 1-800-365-4944
  - Fax: 1-888-772-9696
- As of July 1, 2007, ICD-9 codes can be submitted in the point-of-sale system to override certain prior authorizations. To verify an ICD-9 code contact the PAR Helpdesk at:
  - Phone: 1-800-365-4944

**Medical Supply Items and Medications**

- All supplies, including insulin needles, food supplements and diabetic supplies are not covered under the pharmacy benefit, but are covered as medical supply items through Durable Medical Equipment (DME)
- If a medical benefit requires a PA, the PA request can be submitted through the provider application available at: <http://www.coloradopar.com/carewebqi/carewebqi-portal-access>.
- Effective March 4, 2013 all PARs and revisions processed by the Colorado PAR Program must be submitted using CWQI. After April 1, 2013, PARs submitted via fax or mail will not be entered into CWQI and subsequently not reviewed for medical necessity.
- DME questions should be directed to Xerox at: 303-534-0279 or 800-237-0757. Only policy questions regarding Durable Medical Equipment should be directed to the state at 303-866-2687.
- Medications given in a hospital, doctor's office or dialysis unit are to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion.

Drug	Criteria	PAR Length
<p><b>ACETAMINOPHEN CONTAINING PRODUCTS</b></p>	<p>A prior authorization is required for dosages of acetaminophen containing products over 4000mg/day of acetaminophen.</p>	<p>N/A Not qualified for emergency 3 day supply PA</p>
<p><b>ACNE PRODUCTS</b>  Topical Tretinoin Products and Isotretinoin Products</p>	<p>Prior authorization is required for all topical tretinoin and isotretinoin products. Payment for topical tretinoin therapy and isotretinoin products will be authorized for the following diagnoses: Cystic acne, disorders of Keratinization, psoriasis, neoplasms, comedonal or acne vulgaris.</p> <ul style="list-style-type: none"> <li>➤ <i>Cystic acne, disorders of Keratinization, psoriasis, or neoplasms</i>, do <b>not</b> require previous trials and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for a one-year period.</li> <li>➤ The diagnosis of <i>comedonal</i> does <b>not</b> require previous trial and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for an initial three-month period. <u>IF</u> topical tretinoin therapy is effective after the initial approval period, a prior authorization will be granted for a one-year period.</li> <li>➤ A diagnosis of <i>acne vulgaris</i> <b>requires</b> previous trials and treatment failures on antibiotic and /or topical treatments. If criteria are met, a prior authorization will be granted for a one-year period.</li> </ul>	<p><b>See criteria</b> Not qualified for emergency 3 day supply PA</p>
<p><b>ADOXA TT AND CK KIT</b></p>	<p>A prior authorization will only be approved if a client has tried and failed on the generic oral doxycycline or topical clindamycin for a period of 3 or more months in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p>	<p><b>One year</b></p>
<p><b>ALBUMIN</b></p>	<p>Must have an FDA approved indication and given in the client’s home or in a long-term care facility for approval. The following are FDA approved indications:</p> <ul style="list-style-type: none"> <li>➤ Hypoproteinemia</li> <li>➤ Burns</li> <li>➤ Shock due to: <ul style="list-style-type: none"> <li>▪ Burns</li> <li>▪ Trauma</li> <li>▪ Surgery</li> <li>▪ Infection</li> </ul> </li> <li>➤ Erythrocyte resuspension</li> <li>➤ Acute nephrosis</li> <li>➤ Renal dialysis</li> <li>➤ Hyperbilirubinemia</li> <li>➤ Erythroblastosis fetalis</li> </ul>	<p><b>One year</b></p>
<p><b>ALLERGY EXTRACT PRODUCTS-Oral</b>  (Grastek, Oralair, Ragwitek)</p>	<p><i>Grastek (Timothy grass pollen allergen extract)</i></p> <p>Must be between 5 and 65 years old. Must not be pregnant or nursing. Must be prescribed by an allergist. Must have a documented diagnosis to <b>ONLY</b> timothy grass pollen allergen extract or the Pooideae family (meadow fescue, orchard, perennial rye, Kentucky blue, and red top grasses) confirmed by positive skin test or IgE antibodies.</p>	<p><b>One year</b></p>

	<p>Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.                  Must be willing to administer epinephrine in case of severe allergic reaction.                  Must take first dose in physician’s office.                  Must be started 12 weeks prior to the season if giving only seasonally.                  May be taken daily for up to 3 consecutive years.</p> <p>Must NOT have:</p> <ul style="list-style-type: none"> <li>• Severe, unstable or uncontrolled asthma</li> <li>• Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat</li> <li>• Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before</li> <li>• Been diagnosed with eosinophilic esophagitis</li> <li>• Allergic to any of the inactive ingredients contained in Grastek which include gelatin, mannitol, and sodium hydroxide</li> <li>• A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension.</li> <li>• Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics.</li> <li>• Be taken with other immunotherapy (oral or injectable)</li> </ul> <p><b><i>Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass mixed pollens allergen extract)</i></b></p> <p>Must be between 10 and 65 years old.                  Must not be pregnant or nursing.                  Must be prescribed by an allergist.                  Must have a documented diagnosis to ONLY Sweet Vernal, Orchard, Perennial Rye, Timothy, or Kentucky Blue Grass allergen extract confirmed by positive skin test or IgE antibodies.                  Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.                  Must be willing to administer epinephrine in case of severe allergic reaction.                  Must take first dose in physician’s office.</p> <p>Must NOT have:</p> <ul style="list-style-type: none"> <li>• Severe, unstable or uncontrolled asthma</li> <li>• Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat</li> <li>• Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before</li> <li>• Been diagnosed with eosinophilic esophagitis</li> <li>• Allergic to any of the inactive ingredients contained in Oralair which include mannitol, microcrystalline cellulose, croscarmellose sodium, colloidal anhydrous silica, magnesium stearate, and lactose monohydrate.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension.</li> <li>• Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics.</li> <li>• Be taken with other immunotherapy (oral or injectable)</li> </ul> <p><b>Ragwitek (short ragweed pollen allergen extract)</b></p> <p>Must be between 18 and 65 years old.          Must be started 12 weeks prior to the season and only prescribed seasonally.          Must not be pregnant or nursing.          Must be prescribed by an allergist.          Must have a documented diagnosis to ONLY short ragweed pollen allergen extract or the Ambrosia family (giant, false, and western ragweed) confirmed by positive skin test or IgE antibodies.          Must have tried and failed allergy shots for reasons other than needle phobia.          Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.          Must be willing to administer epinephrine in case of a severe allergic reaction.          Must take first dose in physician’s office.</p> <p>Must NOT have:</p> <ul style="list-style-type: none"> <li>• Severe, unstable or uncontrolled asthma</li> <li>• Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat</li> <li>• Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before</li> <li>• Been diagnosed with eosinophilic esophagitis</li> <li>• Allergic to any of the inactive ingredients contained in Ragwitek which include gelatin, mannitol, and sodium hydroxide</li> <li>• A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension.</li> <li>• Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics.</li> <li>• Be taken with other immunotherapy (oral or injectable)</li> </ul>	
<p><b>ALPHA –1 PROTEINASE INHIBITORS</b></p> <p><b>Aralast, Prolastin and Zemaira</b></p>	<p>FDA approved indication if given in the client’s home or in a long-term care facility:</p> <ul style="list-style-type: none"> <li>➤ Aralast: Chronic augmentation therapy in clients having congenital deficiency of Alpha –1 Proteinase Inhibitor with clinically evident emphysema</li> <li>➤ Prolastin: Emphysema associated with Alpha-1 Antitrypsin Deficiency</li> </ul>	<p>Lifetime</p>

	<ul style="list-style-type: none"> <li>➤ Zemaira: Chronic augmentation and maintenance therapy in clients with Alpha- 1 Proteinase Inhibitor deficiency with clinically evident emphysema</li> </ul>	
<b>ANOREXIANTS (Diet Pills)</b>	<p>Belviq (lorcaserin)</p> <p>Qsymia (phentermine/topiramate ER)</p> <p>Xenical (Orlistat)</p>	Weight loss drugs are not a covered benefit.
<b>ANTI-ANEMIA DRUGS</b> (Oral and injectable drugs)	<p>FDA approved indication: Iron Deficiency Anemia</p> <p><u>Injectable Drugs</u> [i.e.: Infed (iron dextran), Venofer, Ferrlecit]</p> <ul style="list-style-type: none"> <li>➤ Diagnosis of iron deficiency anemia when oral preparations are ineffective or cannot be used.</li> </ul> <p>Must be administered in a client’s home or in a long-term care facility</p>	Lifetime
<b>ATYPICAL ANTIPSYCHOTICS (Injectable)</b>  Abilify, Invega Sustenna, Geodon and Risperdal Consta, Zyprexa Relprevv	<p>A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client’s home.</p> <p>Oral atypical antipsychotic criteria can be found on the Preferred Drug List.</p>	One year
<b>BACTROBAN</b> (mupirocin)  Nasal Cream and Ointment (Generic Bactroban Ointment does not require a prior authorization)	<p><b>Bactroban Cream</b> (mupirocin calcium cream) must be prescribed for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm<sup>2</sup> in total area), impetigo, infected eczema or folliculitis caused by susceptible strains of Staphylococcus aureus and Streptococcus pyogenes.</p> <p><b>Bactroban Nasal Ointment</b> (mupirocin calcium) must be prescribed for the eradication of nasal colonization with methicillin-resistant Staphylococcus aureus in adult patients and health care workers as part of a comprehensive infection control program to reduce the risk of infection among patients at high risk of methicillin-resistant S. aureus infection during institutional outbreaks of infections with this pathogen.</p>	<p>Cream: One year</p> <p>Nasal Ointment: Lifetime</p>
<b>BARBITURATES</b> Medicare-Medicaid enrollees	<p>Barbiturates will require prior authorization for all Medicaid clients. Beginning on January 1, 2013, the Colorado Medicaid Program will no longer be allowed to cover barbiturates for Medicare-Medicaid enrollees (dual-eligible clients) if they are to be used in the treatment of epilepsy, cancer, or a chronic mental health disorder. Prior authorization will be approved for dual-eligible clients for use in sedation, treatment of insomnia, tension headache, muscle contraction headache and treatment of raised intracranial pressure. All other uses will require manual review. For Medicaid primary clients, barbiturates will be approved for use in epilepsy, cancer, chronic mental health disorder, sedation, treatment of insomnia, tension headache, muscle contraction headache and treatment of raised intracranial pressure. All other uses will require manual review.</p>	One year
<b>BENLYSTA</b> (belimumab)	<p>A prior authorization may be approved only when documentation has been received indicating that the drug is being administered in the client’s home or long-term care facility. The client must also meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Diagnosis of autoantibody positive SLE with organ involvement; AND</li> <li>• Incomplete response to standard therapy from at least two of the following therapeutic classes: antimalarials, immunosuppressants and glucocorticoids; AND</li> <li>• Maintenance of standard therapy while on BENLYSTA.</li> </ul>	One year

<p><b>BENZODIAZEPINES</b> Medicare-Medicaid enrollees</p>	<p>Benzodiazepines will no longer be a Medicaid benefit for Medicare-Medicaid enrollees (dual-eligible clients). The claims are no longer excluded from Medicare part D coverage, and thus must be billed to Medicare part D. The Colorado Medicaid Program will no longer be allowed to cover these medications beginning on January 1, 2013.  Coverage will remain in effect for Medicaid primary clients.</p>	<p>One year</p>
<p><b>BISPHOSPHONATES</b> (Injectable)  Didronel, Boniva, Aredia, Miacalcin, Zemplar, Hectorol, Zometa, Pamidronate, and Ganite</p>	<p>A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client’s home.</p>	<p>One year Not qualified for emergency 3 day supply PA</p>
<p><b>BLOOD PRODUCTS</b></p>	<p>FDA approved indications if given in the client’s home or in a long-term care facility:</p> <ul style="list-style-type: none"> <li>➤ Plasma protein fraction; shock due to burns, trauma, surgery; hypoproteinemia; adult respiratory distress syndrome; cardiopulmonary bypass; liver failure; renal dialysis; or hemophilia.</li> </ul>	<p>Lifetime</p>
<p><b>BOTOX / MYOBLOC INJECTION</b></p>	<p>FDA approved indication if given in the client’s home or in a long-term care facility.</p> <ul style="list-style-type: none"> <li>➤ <i>Cervical or Facial Dystonia</i></li> </ul> <p><b>Not approved for Cosmetic Purposes</b></p>	<p>One year</p>
<p><b>BRAND NAME MEDICATIONS</b></p>	<p>Only brand name drugs that have a generically equivalent drug (as determined by the FDA) require a prior authorization. Exceptions to the rule include:</p> <ul style="list-style-type: none"> <li>➤ The brand name drug has been exempted (see the list below)</li> <li>➤ When the reimbursement for a brand-name drug is less expensive than the cost of the generic equivalent</li> <li>➤ <b>The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient’s stabilized drug regimen</b></li> <li>➤ <b>The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient’s physician</b></li> </ul> <p>The following list of drug classes is exempt from the generic mandate rule (no PA is required). Medications used for the treatment of:</p> <ul style="list-style-type: none"> <li>➤ Biologically based mental illness defined in 10-16-104 (5.5) C.R.S.</li> <li>➤ Cancer</li> <li>➤ Epilepsy</li> <li>➤ HIV/AIDS</li> </ul>	<p>One year</p>
<p><b>BUTALBITAL-CONTAINING PRODUCTS</b> Quantity limits</p>	<p>Effective August 1, 2014, products containing butalbital are limited to 180 units in 30 days. For clients receiving more than 180 tablets in 30 days, these claims will be escalated to the Department for individual review. Please note that if more than one agent is used, the combined total utilization may not exceed 180 units in 30 days.</p>	<p>Case by case</p>
<p><b>CIALIS (tadalafil)</b></p>	<p>Cialis will be approved for clients with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month).  Documentation of BPH diagnosis will require BOTH of the following:</p>	<p>One year</p>

	<p>1. AUA Prostate Symptom Score <math>\geq</math> 8 AND</p> <p>2. Results of a digital rectal exam.</p> <p>Cialis will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population.</p> <p>Doses exceeding 5mg per day of Cialis will not be approved.</p>																	
<b>CITALOPRAM (high dose)</b>	<p>Prior authorization will be required for doses exceeding 40mg/day. Please see the FDA guidance at: <a href="http://fda.gov/Drugs/DrugSafety/ucm269086.htm">http://fda.gov/Drugs/DrugSafety/ucm269086.htm</a> for important safety information.</p>	One year																
<b>COLCRYS (colchicine)</b>	<p><u>Quantity Limits:</u></p> <ul style="list-style-type: none"> <li>Chronic hyperuricemia/gout prophylaxis: 60 tablets per 30 days</li> <li>Familial Mediterranean Fever: 120 tablets per 30 days</li> </ul>	One year																
<b>COUGH AND COLD (Rx)</b>	<p>Client &lt;21 years: covered benefit. A prior authorization is not needed.</p> <p>Client <math>\geq</math> 21 years must have diagnosis of a chronic condition such as COPD or asthma.</p>	One year																
<p><b>COX-2 INHIBITORS</b></p> <p><b>Celebrex (celecoxib)</b></p>	<p>PA is required for clients who are 64 years of age and younger. Clients over the age of 65 do not require a PA.</p> <p>A PA will be approved if the COX-2 is prescribed for a FDA approved indication.</p> <table border="1"> <thead> <tr> <th>FDA Approved Indication</th> <th>Dose and Length of PA</th> </tr> </thead> <tbody> <tr> <td>Acute Pain</td> <td>Up to 600mg day 1; 200mg BID for no more than 30 days</td> </tr> <tr> <td>Dysmenorrhea</td> <td>Up to 600mg day 1; 200mg BID. One year approval</td> </tr> <tr> <td>Ankylosing spondylitis</td> <td>200mg daily; after 6 weeks of 200mg daily dosing if client's condition has been unresponsive, 400mg daily may be approved. Lifetime approval</td> </tr> <tr> <td>Familial Adenomatous Polyposis</td> <td>400mg BID. Lifetime approval</td> </tr> <tr> <td>Osteoarthritis</td> <td>200mg daily; 100mg BID. Lifetime approval</td> </tr> <tr> <td>Rheumatoid Arthritis</td> <td>100-200mg BID. Lifetime approval</td> </tr> <tr> <td>Juvenile Rheumatoid Arthritis</td> <td>Up to 100mg BID. 6 month approval</td> </tr> </tbody> </table>	FDA Approved Indication	Dose and Length of PA	Acute Pain	Up to 600mg day 1; 200mg BID for no more than 30 days	Dysmenorrhea	Up to 600mg day 1; 200mg BID. One year approval	Ankylosing spondylitis	200mg daily; after 6 weeks of 200mg daily dosing if client's condition has been unresponsive, 400mg daily may be approved. Lifetime approval	Familial Adenomatous Polyposis	400mg BID. Lifetime approval	Osteoarthritis	200mg daily; 100mg BID. Lifetime approval	Rheumatoid Arthritis	100-200mg BID. Lifetime approval	Juvenile Rheumatoid Arthritis	Up to 100mg BID. 6 month approval	See chart
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<b>DESI DRUGS</b>	<p>DESI drugs (Drugs designated by the Food and Drug Administration as Less Than Effective Drug Efficacy Study Implementation medications) are not a covered benefit.</p>	None																
<b>DIFICID (fidoxomicin)</b>	<p>Dificid will be approved if all the following criteria are met:</p> <ul style="list-style-type: none"> <li>The indicated diagnosis (including any applicable labs and/or tests) and medication usage must be supported by documentation from the patient's medical records AND</li> </ul>	10 days																

	<ul style="list-style-type: none"> <li>• Prescriber must be a gastroenterologist or an infectious disease specialist AND</li> <li>• Diagnosed with Clostridium difficile-associated diarrhea AND</li> <li>• ≥ 18years of age AND</li> <li>• Failed at least a 10 day treatment course with oral metronidazole AND oral vancomycin OR</li> <li>• Allergy and/or intolerance to both metronidazole and vancomycin</li> </ul> <p>Quantity limits: Dificid: Max 20 tabs/30 days</p>	
<b>ELESTRIN GEL (estradiol)</b>	A prior authorization will only be approved if a client has tried and failed on generic oral estradiol therapy and diagnosed with moderate-to-severe vasomotor symptoms (hot flashes) associated with menopause. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
<b>EPANED (enalapril)</b>	Epaned will be approved for clients under the age of 5 years who cannot swallow a whole or crushed tablet.	One year
<b>ERECTILE DYSFUNCTION DRUGS</b>  Caverject Cialis Edex Levitra Muse Viagra	<p>These drugs are not a covered benefit.</p> <hr/> <p>Yohimbine: PAs can no longer be approved for erectile dysfunction. Any PAs for use as a mydriatic agent or a vasodilator (not related to erectile dysfunction) may be approved.</p>	<p>Not available Not qualified for emergency 3 day supply PA ----- Lifetime</p>
<b>FENTANYL PREPARATIONS</b>  Short acting Actiq, Fentora, Onsolis  Long acting Duragesic Transdermal System	<p>Actiq, Fentora and Onsolis: Approval will be granted if the client is diagnosed with terminal illness and has already received and is tolerant to opioid drugs for the cancer pain. The PA may be granted for up to 4 lozenges, tablets or soluble films per day.</p> <p>Duragesic Transdermal System: A PA is required for doses of more than 1 Patch/2 Days.</p> <p>For all Fentanyl preparations: If the patient is in hospice and palliative care, the PA will be automatically granted regardless of the number of doses prescribed.</p>	One year
<b>FLECTOR 1.3% PATCH (diclofenac)</b>	A prior authorization will only be approved if a client has tried and failed on Voltaren Gel. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
<b>FLUORIDE PREPARATIONS</b>	<p>A prior authorization will not be needed for clients less than 21 years of age.</p> <p>Prior authorization requests for clients 21 years of age and older will be individually reviewed by the state.</p>	N/A
<b>FILGRASTIM/ PEGFILGRASTIM / SARGRAMOSTIM</b>  Neupogen, Neulasta and Leukine	<p>Prior authorization is required for therapy with filgrastim, pegfilgrastim or sargramostim.</p> <p><b>Prior authorizations for PEGFILGRASTIM will be approved for the following indication if the criterion is met:</b></p>	One year

	<p><u>Indication:</u> To decrease the incidence of infection due to neutropenia in clients receiving myelosuppressive anti-cancer therapy.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. CBC and platelet count obtained before chemotherapy is administered.</li> </ul> <p><b>Prior authorizations will be approved for FILGRASTIM AND SARGRAMOSTIM for the following indications if the applicable criteria are met:</b></p> <p><u>Indication:</u> To decrease the incidence of infection due to severe neutropenia caused by myelosuppressive anti-cancer therapy.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Either the post nadir ANC is less than 10,000 cells/mm<sup>3</sup> or the risk of neutropenia for the client is calculated to be greater than 20%</li> <li>➤ Criterion 2. Routine CBC and platelet counts twice weekly</li> </ul> <p><u>Indication:</u> Use in patients undergoing bone marrow transplant and for use after bone marrow transplant.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Routine CBC and platelet counts at least three times weekly for filgrastim and two times weekly for sargramostim.</li> </ul> <p><u>Indication:</u> For patients undergoing peripheral blood progenitor cell collection and therapy.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Monitoring of neutrophil counts after four days of treatment.</li> </ul> <p><u>Indication:</u> For filgrastim only, for chronic administration to reduce the incidence and duration of clients with congenital neutropenia, cyclic neutropenia or idiopathic neutropenia.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. CBC and platelet count obtained before treatment with filgrastim begins.</li> <li>➤ Criterion 2. Routine CBC and platelet counts twice weekly during initial four weeks of therapy and during the two weeks following any dose adjustment.</li> </ul> <p><u>Indication:</u> To decrease the incidence of infection due to severe neutropenia in HIV/AIDS clients.</p> <ul style="list-style-type: none"> <li>➤ Criterion 1. Evidence of neutropenia Infection exists or ANC is below 750 cells/mm<sup>3</sup></li> <li>➤ Criterion 2. ANC is maintained at Approximately 1,000 cells/mm<sup>3</sup> by filgrastim adjustment</li> <li>➤ Criterion 3. Routine CBC and platelet counts as needed.</li> </ul>	
<p><b>FUZEON (enfuvirtide)</b></p>	<p>If administered in the physician’s office or delivered to physician’s office, physician must bill as a medical claim on the 1500 claim form (<b>no PA required</b>).</p> <p>If administered in the client’s home or in a long-term care facility, a prior authorization is required and must meet the criteria below for approval</p> <p>Based on clinical trial data, ENF should be used as part of an <i>optimized</i> background regimen for treatment-experienced clients:</p> <ul style="list-style-type: none"> <li>➤ For treatment-experienced clients with evidence of HIV-1 replication, treatment should include at least one antiretroviral</li> </ul>	<p>Six months</p>

	<p>agent with demonstrated HIV-1 susceptibility on the basis of genotypic/phenotypic <i>resistance</i> assays, and <i>two</i> “active” antiretroviral agents.</p> <ul style="list-style-type: none"> <li>○ Clients must have limited treatment options among currently commercially available agents.</li> <li>➤ Clients must be 18 years of age or older with advanced HIV-1 infection, and not responding to approved antiretroviral therapy.</li> <li>➤ Clients must have a CD4 lymphocyte count less than 100 cells/mm<sup>3</sup> and a viral load greater than 10,000 copies/ml (measurement within the last 90 days).</li> </ul> <p>Past adherence must be demonstrated based on:</p> <ul style="list-style-type: none"> <li>➤ Attendance at scheduled appointments, and/or</li> <li>➤ Prior antiretroviral regimen adherence, and/or</li> <li>➤ Utilization data from pharmacy showing client’s use of medications as prescribed</li> <li>➤ Ability to reconstitute and self-administer ENF therapy.</li> </ul> <p>At 24 weeks, clients must experience at least <math>\geq 1 \log_{10}</math> decrease in HIV RNA or have HIV RNA below quantifiable limits to continue treatment with ENF.</p> <p>Clients are not eligible if antiretroviral treatment-naive and/or infected with HIV-2.</p> <p>Pre-approval is necessary</p> <p>Practitioner must either be Board Certified in Infectious Disease, or be an HIV experienced practitioner. Verification must be produced with the prior approval documents.</p> <p><b>These guidelines may be modified on the basis of other payer formularies and/or the emergence of new data.</b></p>	
<p><b>GATTEX (teduglutide)</b></p>	<p>Prior authorization will be approved if all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Client is 18 years of age or older;</li> <li>• Client has documented short bowel syndrome;</li> <li>• Client is dependent on parenteral nutrition for twelve consecutive months;</li> <li>• The prescribing physician is a gastroenterologist; and</li> <li>• Medical necessity documentation has been received and approved by Colorado Medicaid clinical staff (please fax to 303-866-3590 attn: Clinical Pharmacy Staff)</li> <li>• The initial prior authorization will be limited to a two month supply.</li> </ul>	<p>Two months initially; may be approved by State for up to one year</p>
<p><b>H2 BLOCKERS</b></p> <p><b>Ranitidine capsules and liquid</b></p>	<p><b>Generic H2 Blockers</b> do not require a PA except for ranitidine capsules and liquid.</p> <p><u>Ranitidine capsules</u>: Require the prescribing provider to certify that capsules are “medically necessary” and that the client cannot use the tablets.</p> <p><u>Ranitidine liquid</u>: A prior authorization will be granted for clients with a feeding tube or who have difficulty swallowing. A prior authorization is not required for children under 12 years of age.</p>	<p>One year</p>
<p><b>Hetlioz (tasimelteon)</b></p>	<p><b>HETLIOZ®</b> will be approved for clients who meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Have a documented diagnosis of non-24-hour sleep wake disorder (non-24 or N24) by a sleep specialist AND</li> </ul>	<p>One year</p>

<p><b>Homozygous Familial Hypercholesterolemia (HoFH)</b></p>	<ul style="list-style-type: none"> <li>• Client is completely blind</li> </ul> <p><b>Juxtapid (lomitapide)</b>                  Prior authorization will be approved if all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Client is 18 years of age or older;</li> <li>• Client has documented diagnosis of homozygous familial hypercholesterolemia (HoFH);</li> <li>• Client has failed therapy with high dose statin therapy (e.g. atorvastatin 40mg or higher, Crestor 20mg or higher)</li> <li>• The prescribing physician is enrolled in the Juxtapid REMS program.</li> </ul> <p><b>Kynamro (mipomersen)</b> will be approved for clients meeting all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) as determined by either a or b                         <ul style="list-style-type: none"> <li>a. Laboratory tests confirming diagnosis of HoFH:                                   LDLR DNA Sequence Analysis OR                                   LDLR Deletion/Duplication Analysis for large gene rearrangement testing---only if the Sequence Analysis is negative OR                                   APOB and dPCSK9 testing if both of the above tests are negative but a strong clinical picture exists.</li> <li>b. Documentation is received confirming a clinical or laboratory diagnosis of HoFH</li> </ul> </li> <li>• Has a history of therapeutic failure, contraindication, or intolerance to high dose statin therapy or cholesterol absorption inhibitor (ezetimibe or bile acid resin) AND</li> <li>• Is being prescribed by a physician specializing in metabolic lipid disorders AND</li> <li>• The prescriber is enrolled in the REMS program AND</li> <li>• Is not being used as monotherapy AND</li> <li>• Has baseline liver function (AST,ALT, ALK., and total bilirubin) AND</li> </ul> <p>Does not have moderate or severe hepatic impairment or active liver disease.</p>	
<p><b>HORIZANT (gabapentil enacarbil)</b></p>	<p>A prior authorization may be approved for clients meeting all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Diagnosis of Restless Leg Syndrome;</li> <li>• Therapy failure on at least a one month trial of Mirapex (pramipexole) and Requip (ropirinole);</li> <li>• Incomplete therapeutic response to generic gabapentin.</li> </ul> <p>A maximum of one tablet per day will be approved.</p>	<p>One year</p>
<p><b>HORMONE THERAPY</b></p>	<p><b>Depo Provera (medroxyprogesterone)/Lunelle (estradiol cipationate/medroxyprogesterone)</b>                  FDA approved indication if given in a long-term care facility or in the clients home:</p>	<p>One year</p>

	<ul style="list-style-type: none"> <li>• Females: Contraception, uterine bleeding, amenorrhea, endometrial cancer</li> <li>• Males: Sexual aggression / Pedophilia – Only Depo-Provera will be approved</li> <li>• Not approved for administration in the physician’s office – these must be billed through medical.</li> </ul> <p><b>Implanon (etonogestrel)</b> See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.</p> <p><b>Nexplanon (etonogestrel)</b></p> <ul style="list-style-type: none"> <li>• See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.</li> </ul>	
<p><b>IVIG</b></p>	<p>Clients must have one of the following conditions:</p> <ul style="list-style-type: none"> <li>➤ <u>Immunodeficiency disorders:</u> <ol style="list-style-type: none"> <li>2. Common Variable Immunodeficiency (CVID)</li> <li>3. Severe Combined Immunodeficiency (SCID)</li> <li>4. X-Linked Agammaglobulinemia</li> <li>5. X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency</li> <li>6. Wiskott-Aldrich Syndrome</li> <li>7. Pediatric Human Immunodeficiency Virus (HIV):                             <ul style="list-style-type: none"> <li>▪ Clients are less than 13 years of age and CD-4 Count is &gt; 200/mm<sup>3</sup></li> </ul> </li> </ol> </li> <li>➤ <u>Neurological disorders:</u> <ol style="list-style-type: none"> <li>1. Guillain-Barre’ Syndrome</li> <li>2. Relapsing-Remitting Multiple Sclerosis</li> <li>3. Chronic Inflammatory Demyelinating Polyneuropathy</li> <li>4. Myasthenia Gravis</li> <li>5. Polymyositis and Dermatomyositis</li> </ol> </li> <li>➤ <u>Chronic Lymphocytic Leukemia (CLL)</u></li> <li>➤ <u>Autoimmune Neutropenia (AN):</u> <ol style="list-style-type: none"> <li>1. Absolute neutrophil count is less than 800 mm</li> </ol> <p>And</p> <ol style="list-style-type: none"> <li>2. Has recurrent bacterial infections</li> </ol> </li> <li>➤ <u>Autoimmune Hemolytic Anemia (AHA)</u></li> <li>➤ <u>Liver or Intestinal Transplant</u></li> <li>➤ <u>Idiopathic Thrombocytopenic Purpura (ITP):</u> <ol style="list-style-type: none"> <li>1. Preoperatively for clients undergoing elective splenectomy with platelet count &lt; 20,000</li> <li>2. Clients with active bleeding &amp; platelet count &lt;30,000.</li> <li>3. Pregnant women with platelet counts &lt;10,000 in the third trimester.</li> <li>4. Pregnant women with platelet count 10,000 to 30,000 who are bleeding.</li> </ol> </li> </ul>	<p>One year</p> <p>One year</p> <p>CLL: One year AN: 6 months</p> <p>AHA: 5 weeks ITP: 5 days</p>
<p><b>KALYDECO (ivacaftor)</b></p>	<p>Kalydeco will only be approved if all of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Client has been diagnosed with cystic fibrosis AND</li> <li>2. Client is an adult or pediatric patient 6 years of age or older AND</li> </ol>	<p>One year</p>

	<p>3. Documentation has been provided to indicate one of the following gene mutation: in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P,S549N, or S549R.* AND</p> <p>4. Documentation has been provided that baseline ALT and AST have been accessed and are within 2x normal limits (AST and ALT should be examined every 3 months for the first year and annually after that).</p> <p>5.</p> <p>* If the member’s genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.</p> <p>Kalydeco will only be approved at doses no more than 150 mg twice daily. Prior Authorizations need to be obtained yearly.</p> <p>Kalydeco will not be approved for clients who are concurrently receiving rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John’s Wort.</p>	
<p><b>LHRH/GnRH</b> Luteinizing Hormone Releasing Hormone/Gonadotropin Releasing Hormone</p>	<p>Must be given in the client’s home or in a long-term care facility. Prior authorization will be granted for FDA Approved Indications Only:</p> <ul style="list-style-type: none"> <li>➤ <b>Eligard:</b> Palliative-treatment of Advanced Prostate Cancer</li> <li>➤ <b>Lupron (leuprolide):</b> Prostate Cancer, Endometriosis, Uterine Leiomyomata (fibroids), Precocious Puberty</li> <li>➤ <b>Trelstar:</b> Palliative treatment of Advanced Prostate Cancer</li> <li>➤ <b>Viadur:</b> Palliative treatment of Advanced Prostate Cancer</li> <li>➤ <b>Vantas:</b> Palliative treatment of Advanced Prostate Cancer</li> <li>➤ <b>Zoladex:</b> Breast Cancer, Endometriosis, Endometrial Thinning, Prostate Cancer</li> </ul>	<p>One year</p>
<p><b>LIPIDS/AMINO ACIDS/PLASMA PROTEINS</b></p>	<p>Approval will be given if administered in the client’s home or in a long-term care facility. If given in the hospital or physician’s office, the claim must be billed as a medical expense.</p>	<p>Lifetime</p>
<p><b>MAKENA</b> Hydroxyprogesterone caproate injection</p>	<p>Makena will be approved for clients that meet the following criteria</p> <ul style="list-style-type: none"> <li>• The drug is being administered in the home or in long-term care setting;</li> <li>• Client has a Singleton pregnancy and a history of singleton spontaneous preterm birth;</li> <li>• Therapy is being initiated between 16 weeks gestation and 20 weeks, 6 days gestation.</li> <li>• Continue through 36 weeks 6 days gestation or delivery; whichever occurs first.</li> <li>• Dose is administered by a healthcare professional.</li> </ul>	
<p><b>MOXATAG (amoxicillin)</b></p>	<p>A prior authorization will only be approved if a client is allergic to inactive ingredients in immediate release amoxicillin.</p>	<p>One year</p>
<p><b>NEWLY APPROVED PRODUCTS</b></p>	<p>Newly marketed drugs may be subject to prior authorization for a minimum of nine months following FDA marketing approval. Initial approval criteria will include non-preferred criteria (for drugs within a reviewed PDL class); or FDA approved indications, dose, age and place in therapy. For drugs in PDL classes, the next class annual review will include the new agent. For non-PDL drugs,</p>	<p>One year</p>



	<ul style="list-style-type: none"> <li>➤ client has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions),</li> <li>➤ client has been diagnosed with rosacea with inflammatory lesions, and</li> <li>➤ client is 18 years of age or older</li> </ul>	
<p><b>ORAL OPIOIDS- SHORT ACTING</b></p>	<p><b>Short acting opioids</b> will be limited to a total of 120 tablets per 30 days per client. Exceptions will be made for clients with a diagnosis of a terminal illness (hospice or palliative care) or sickle cell anemia. For clients who are receiving more than 120 tablets currently and who do not have a qualifying exemption diagnosis, a 6 month prior authorization can be granted via the prior authorization process for providers to taper clients. Please note that if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days.</p> <p>Information regarding tapering, morphine equivalents, other therapies and other resources can be found on the Department website at:  <a href="https://www.colorado.gov/hcpf/provider-forms">https://www.colorado.gov/hcpf/provider-forms</a>.</p> <p><b>Acute Pain: Beginning 8/25/2014: If a client has an acute pain situation, and is prescribed more than 4 tablets per day, the pharmacy may enter diagnosis code 338.1 on the claim to receive an immediate override. Please note that the override will be available for acute pain indications only.</b> Prior authorization will still be required for more than 120 tablets per 30 days. The Department will monitor the utilization of the diagnosis code to assure it is being used to override daily limits for cases of acute pain indications only. The pharmacy or prescriber may also still call 1-800-365-4944 and request a prior authorization for acute pain. Examples of acute pain situations are post-operative surgery (including dental), fractures, shingles, and a car accident. This is not an all-inclusive list.</p>	<p>Chronic pain: 6 months to allow for the tapering of a client down to the limit of 120 units per 30 days</p> <p>Acute pain: one time override per claim</p>
<p><b>OTC PRODUCTS</b></p>	<p>Medical Necessity</p> <ul style="list-style-type: none"> <li>➤ Aspirin, Insulin and Plan B are covered without a PA</li> <li>➤ Prilosec OTC: <i>See Proton Pump Inhibitor's section</i></li> <li>➤ Guaifenesin 600mg LA is covered for clients having an abnormal amount of sputum</li> <li>➤ Quinine Sulfate <i>is no longer covered</i> for leg cramps</li> <li>➤ Herbal products are not a benefit except for cranberry tablets, which are covered for urinary tract infections</li> <li>➤ Diabetic needles and supplies are not a prescription benefit and should be billed as supply</li> <li>➤ Broncho saline is not covered- refer to Sodium Chloride section</li> <li>➤ Cough and Cold Products must have a diagnosis of a chronic respiratory condition for which these medications may be prescribed or otherwise be medically necessary</li> <li>➤ Antihistamine (w/ decongestant) must have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis or otherwise be medically necessary</li> <li>➤ Nicomide is approved for acne</li> </ul> <p><i>Nursing Facilities: Please provide OTC floor stock list.</i></p> <p>*Clients with Erythema Bullosum (EB) can receive any OTC medication with a prior authorization.*</p>	<p>One year Qualifies for emergency 3 day supply PA</p>

<b>Otezla (apremilast)</b>	<p>Otezla® will be approved for clients who meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Client is ≥ 18 years of age AND</li> <li>• Is not receiving rifampin, phenobarbital, carbamazepine, or phenytoin AND</li> <li>• Client does not have severe renal impairment (Crcl &lt; 30 ml/min) AND</li> <li>• Has failed a 12 week trial of two of the following: leflunamide, methotrexate, sulfasalazine, and cyclosporine AND a 12 week trial of either ENBREL or HUMIRA. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions</li> </ul>	One year
<b>OXSORALEN (methoxsalen)</b>	Approval will be granted with diagnosis of: Myosis; Fungoides; Psoriasis or Vitiligo	One year
<b>PHYSICIAN ADMINISTERED DRUGS</b>	Medications given in a hospital, doctor’s office or dialysis unit are only to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion following prior authorization approval. Prior authorizations will be approved based upon documentation of the location for administration.	
<b>PROCYSBI (cysteamine)</b>	Approval will be granted if the client is 6 years of age or older <b>AND</b> Has a diagnosis of neuropathic cystinosis <b>AND</b> documentation is provided to the Department that treatment with cysteamine IR (Cystagon®) was ineffective, not tolerated, or is contraindicated.	One year
<b>PROMETHAZINE</b>	<b>A Prior authorization is required for all routes of administration for clients under the age of two. Children under the age of two should not use Promethazine. Promethazine is contraindicated in such patients because of the potential for fatal respiratory depression.</b>	One year Not qualified for emergency 3 day supply PA
<b>PROPECIA (finasteride)</b>	<i>Not covered for hair loss</i>	One year Not qualified for emergency 3 day supply PA
<b>RAVICTI (glycerol phenylbutyrate)</b>	<p>Ravicti will only be approved for clients meeting the following criteria:</p> <ul style="list-style-type: none"> <li>• Client must be 2 years of age or older</li> <li>• Client must have a documented diagnosis of urea cycle disorder (UCD)</li> <li>• Client must be on a dietary protein restriction (verified by supporting documentation)</li> <li>• Client must have tried and failed Buphenyl as evidenced by uncontrolled hyperammonia over the past 365 days</li> <li>• Medication must be prescribed by a physician experienced in the management of UCD (e.g., geneticist)</li> </ul>	One year
<b>REBATE DISPUTE DRUGS</b>	Medical necessity.	One year Not qualified for emergency 3 day supply PA
<b>REQUIP XL (pramipexole)</b>	A prior authorization will only be approved if a client has tried and failed on generic immediate release ropinirole for a period of 3 or more months in the last 6 months and the client has a diagnosis of Parkinson’s disease. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year

	<p><b>Grandfathering:</b>                  Clients who have been previously stabilized on Requip XL can receive approval to continue on the medication for one year if medically necessary.</p>	
<b>REVIA (naltrexone)</b>	Please see opioid agonist/antagonist.	N/A
<b>SANDOSTATIN (octreotide)</b>	Approved for: acromegaly; carcinoid tumors; and vasoactive intestinal peptide tumors.	Lifetime
<b>SILENOR (doxepin)</b>	<p>A prior authorization will be approved if a client meets one of the following criteria:</p> <ul style="list-style-type: none"> <li>• Contraindication to preferred oral sedative hypnotics (Lunesta, zaleplon and zolpidem)</li> <li>• Medical necessity for doxepin dose &lt; 10 mg</li> <li>• Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criteria is met)</li> </ul>	One year
<b>SIMVASTATIN 80mg</b>	Simvastatin 80mg dose products will only be covered for clients who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in clients who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication entitled, "FDA Drug Safety Communication: New restrictions, contraindications, and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.	One year
<b>SMOKING CESSATION (Rx &amp; OTC)</b>	<p>Clients should be referred to the QuitLine or another behavior modification program. The name of that program should be included on the prior authorization form.</p> <p>Medical Assistance Program will pay for only <b>one product</b> at a time but a client may receive multiple strengths of a product or multiple products during the two 90-day paid benefit periods.</p>	<p>Two 90-day paid benefits per year</p> <p>Not qualified for emergency 3 day supply PA</p>
<b>SODIUM CHLORIDE</b> For inhalation use	<p>Broncho Saline is <b>not</b> covered as a drug benefit.</p> <p><b>Sodium Chloride 0.9%:</b> Only the 3cc unit dose is covered, if the client is sight-impaired and used in the client's home.</p> <p><b>Sodium Chloride 3% and 7% vial:</b> Nebulizer treatment for clients with cystic fibrosis and other pulmonary diseases for mucolytic therapy done in the home.</p> <p>All other requests for sodium chloride (inhalation use) must be billed through medical.</p>	<p>Lifetime</p> <p>Qualifies for emergency 3 day supply PA</p>
<b>SOLARAZE 3% GEL (diclofenac sodium)</b>	A prior authorization will only be approved if the client has a diagnosis of Actinic Keratoses (AK).	
<b>SUBOXONE and SUBUTEX</b>	Please refer to Opioid Agonist/Antagonist	
<b>SYNAGIS (Palivizumab)</b>	<p><b>Pharmacy Prior Authorization requests for Synagis must be submitted by fax or phone using the Synagis Prior Authorization Form found at <a href="http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550">http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696550</a>. Medical PAs must be submitted through coloradopar.com.</b></p> <p><b>**Updated criteria coming in Fall 2014.**</b></p>	Maximum of 5 doses per season

<p><b>TARGETED IMMUNE MODULATORS FOR RA (iv infused products)</b></p>	<p>Orencia (abatacept) – will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following:</p> <ul style="list-style-type: none"> <li>➤ Clients with moderate to severe rheumatoid arthritis who have failed therapy with both Enbrel and Humira</li> <li>➤ Clients with moderate to severe juvenile idiopathic arthritis</li> </ul> <p>Remicade (infliximab) will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following:</p> <ul style="list-style-type: none"> <li>➤ clients with ulcerative colitis</li> <li>➤ clients with rheumatoid arthritis who have tried and failed therapy with both Enbrel and Humira</li> <li>➤ clients with psoriatic arthritis</li> <li>➤ clients with ankylosing spondylitis</li> <li>➤ clients with juvenile idiopathic arthritis</li> <li>➤ clients with plaque psoriasis</li> <li>➤ clients with Crohn’s Disease</li> </ul> <p>Rituxan (rituximab) - will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following:</p> <ul style="list-style-type: none"> <li>➤ Clients with moderate to severe rheumatoid arthritis who have tried and failed both Enbrel and Humira</li> <li>➤ Clients with Chronic Lymphocytic Leukemia</li> <li>➤ Clients with Non-Hodgkins Lymphoma</li> </ul>	<p>One year</p>
<p><b>THROMBOLYTIC ENZYMES</b></p>	<p>Approved for <b>IV Catheter Clearance or Occluded AV Cannula</b> if given in client’s home or long term care facility.</p>	<p>One year</p>
<p><b>TPN PRODUCTS</b></p>	<p>Approval will be given if administered in the client’s home or in a long-term care facility. If given in the hospital or physician’s office, the claim must be billed as a medical expense.</p>	<p>Lifetime</p>
<p><b>TRAMADOL</b></p>	<p>Tramadol is not approved for more than 400mg/day.</p> <p><b>Rybix ODT</b> Rybix will be approved for clients who are unable to swallow oral tablets or for clients who are unable to absorb oral medications.interactions)</p> <p><b>Ryzolt</b> A prior authorization will only be approved if a client has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p><b>Ultram ER (tramadol ER)</b> A prior authorization will only be approved if a client has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug</p>	<p>One year</p> <p>Qualified for emergency 3 day supply PA</p> <p>Not qualified for emergency 3 day supply PA</p> <p>Not qualified for emergency 3 day supply PA</p>

<p><b>VACCINES</b> Flu, Hepatitis B and Pneumonia</p>	<p>H1N1 vaccine is a covered benefit.  All other vaccines must be bill on Colorado 1500 form as a medical expense unless administered in long-term care facility. Any vaccine can be approved by prior authorization if a client is living in a long-term care facility. (Not a covered benefit for regular patients – only long-term care facilities).</p>	<p>One year Not qualified for emergency 3 day supply PA</p>
<p><b>VERIPRED (prednisolone)</b></p>	<p>A prior authorization will only be approved if a client has tried and failed on a generic prednisolone product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p>	<p>One year</p>
<p><b>VERSED (Midazolam)</b></p>	<p>Approved if given in the client’s home or in a long-term care facility and given for:  <ul style="list-style-type: none"> <li>➤ Preoperative sedation or anesthesia</li> <li>➤ Terminally ill clients with Cancer</li> <li>➤ Client with Erythema Bullosum (EB) –approval for one year</li> </ul> </p>	<p>One month</p>
<p><b>VERSED</b> Midazolam injection used as nasal spray</p>	<p>Midazolam injection used as a nasal inhalation will be approved for clients who meet the following criteria:  <ol style="list-style-type: none"> <li>1. Client is ≥ 6 months of age AND</li> <li>2. Has a diagnosis of seizure disorder AND</li> <li>3. Is prescribed by or in conjunction with a Neurologist AND</li> <li>4. Treatment dose does not exceed 10mg</li> </ol> <p><u>Dosing Limits:</u> 10 vials/month Only MIDAZOLAM 5mg/ml (for doses ≤ 5mg) and 10mg/2ml vials (for doses &gt; 5 mg) will be covered.</p> </p>	<p>One year</p>
<p><b>VIMOVO (naproxen/esomeprazole magnesium)</b></p>	<p>Approved if client has failed treatment with two Preferred Proton Pump Inhibitors within the last 24 months, and has one of the following diagnoses:  <ul style="list-style-type: none"> <li>➤ Ankylosing spondylitis in patients at increased risk of developing NSAID induced ulcers;</li> <li>➤ Osteoarthritis in patients at increased risk of developing NSAID induced ulcers;</li> <li>➤ Rheumatoid arthritis in patients at increased risk of developing NSAID induced ulcers.</li> </ul> </p>	<p>One year</p>
<p><b>VITAMINS (Rx)</b></p>	<p><b>Prescription Vitamins (except for prenatales) will be authorized for:</b>  <ul style="list-style-type: none"> <li>➤ ESRD, CRF, renal insufficiency, diabetic neuropathy or renal transplant</li> <li>➤ Clients under the age of 21 with a diagnosis disease that prohibits the nutrition absorption process as a secondary effect of the disease.</li> <li>➤ Clients with Erythema Bullosum (EB)</li> </ul> <p><b>(continued on next page)</b> Hydroxocobalamin Injections <b>In addition to the above general vitamin criteria, approval can also be given for methylmalonic academia (MMA).</b></p> <p>Cyanocobalamin Injections <b>In addition to the above general vitamin criteria, approval can also be given for vitamin B12 deficiency.</b></p> <p>Folic Acid Vitamins (exceptions exist for Folic Acid 1mg, see below)</p> </p>	<p>One year  Qualifies for emergency 3 day supply PA</p>

	<p><b>In addition to the above general vitamin criteria, approval can also be given for folic acid vitamins if one of the following criteria is met:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Currently taking Methotrexate or Alimta</b></li> <li>➤ <b>A diagnosis of folic acid deficiency (megaloblastic and macrocytic anemia are the most common). Some drugs or other conditions may cause deficiency -- Approval will be granted for these indications IF the client has current folic acid deficiency and documented by the provider.</b></li> <li>➤ <b>For Female Clients: Approval will be granted for the prevention of a neural tube defect pregnancy and for the prevention of miscarriages.</b></li> <li>➤ <b>Homocysteinemia</b></li> <li>➤ <b>Sickle cell disease</b></li> </ul> <p>Cyanocobalamin/Folic Acid/Pyridoxine</p> <p><b>In addition to the above general vitamin criteria, approval can also be given for clients:</b></p> <ul style="list-style-type: none"> <li>➤ with Homocysteinemia or Homocystinuria</li> <li>➤ on dialysis</li> <li>➤ with or at risk for cardiovascular disease</li> </ul> <p>Deplin <b>approved for depressed clients who are currently taking antidepressants and are partial or non-responders</b></p> <p><b>Metanx</b> approved for clients with non-healing diabetic wounds</p> <p><b>Prenatal Vitamins are a regular benefit for all female clients. Prenatal vitamins are not covered for male clients.</b></p> <p><b>Folic Acid 1mg does not require a prior authorization for female clients.</b></p> <p><b>Prescription Vitamin D and Vitamin K products do not require a prior authorization.</b></p>	
<b>VIVITROL</b>	Please refer to Opioid Agonist/Antagonist	
<b>VUSION OINTMENT (miconazole/zinc oxide/white petrolatum)</b>	A prior authorization will only be approved if a client has failed on an OTC antifungal <b>and</b> a generic prescription antifungal. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
<b>XOLAIR (omalizumab)</b>	<p>A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility. Medications administered in a physician’s office must be billed as a medical expense.</p> <p>Because this medication has a Black Box warning requiring the administration under the supervision of a physician, a PA will not be approved if administered in a client’s home.</p>	One year Qualifies for emergency 3 day supply PA
<b>ZUBSOLV</b>	Please refer to Opioid Agonist/Antagonist	