



Colorado Department of Health Care Policy and Financing Preferred Drug List (PDL)

Effective October 1, 2015

PA Forms: available online at <https://www.colorado.gov/hcpf/provider-forms>

The PDL applies to Medicaid fee-for-service members. It does not apply to members enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

**Brand Name Required = BNR
 Prior Authorization = PA**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
ALZHEIMER’S AGENTS <i>Effective 4/1/2015</i>	No PA Required (*Must meet eligibility criteria) donepezil tab donepezil ODT galantamine galantamine ER NAMENDA IR	PA Required ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT (donepezil) EXELON (rivastigmine) (cap, soln. and patch) NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) RAZADYNE ER (galantamine)	*eligibility criteria for Preferred Agents – All preferred products will be approved without PA if the member has a diagnosis of dementia which can be verified by SMART PA. Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Members currently stabilized on a non-preferred product can receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of dementia.
ANTICOAGULANTS- ORAL <i>Effective 10/1/2015</i>	No PA Required (*Must meet eligibility criteria) warfarin *XARELTO (rivaroxaban) (2nd line)	PA Required COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran)	ELIQUIS® will be approved if: <ul style="list-style-type: none"> • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) OR • The member is need of prophylaxis for DVT following knee or hip replacement surgery OR • The member has a diagnosis of non-valvular atrial fibrillation AND

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		SAVAYSA (edoxaban)	<ul style="list-style-type: none"> • The member does not have a mechanical prosthetic heart valve AND • The member does not have an active pathological bleed AND • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: <ul style="list-style-type: none"> ○ The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) OR ○ The member has significant difficulty with complying with monitoring OR ○ The member is on dialysis ○ The member has an allergy or intolerance to warfarin AND • The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) <p>PRADAXA® will be approved if:</p> <ul style="list-style-type: none"> • The member is not on dialysis AND • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) OR • The member has a diagnosis of non-valvular atrial fibrillation AND • The member does not have a mechanical prosthetic heart valve AND • The member does not have an active pathological bleed AND • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: <ul style="list-style-type: none"> ○ The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) OR ○ The member has significant difficulty with complying with monitoring OR ○ The member has an allergy or intolerance to warfarin AND • The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)
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			<p>SAVAYSA® will be approved if all the following criteria have been met:</p> <ul style="list-style-type: none"> • Member is not on dialysis AND • Member does not have CrCl > 95 mL/min AND • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) OR • The member has a diagnosis of non-valvular atrial fibrillation AND • The member does not have a mechanical prosthetic heart valve AND • The member does not have an active pathological bleed AND • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria: <ul style="list-style-type: none"> ○ The member has a labile INR for reasons other than noncompliance (e.g, member has an INR outside of 2-3 > 60% of the time for a period of two months) OR ○ The member has significant difficulty with complying with monitoring OR ○ The member has an allergy or intolerance to warfarin <p>AND</p> <ul style="list-style-type: none"> • The member has failed a one month trial of Xarelto®. (Failure is defined as : lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) <p>*XARELTO® will be approved if all the following criteria have been met:</p> <ul style="list-style-type: none"> • The member is not on dialysis AND • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) OR • The member is in need of a prophylaxis of DVT following knee or hip replacement surgery OR • The member has a diagnosis of non-valvular atrial fibrillation AND • The member does not have a mechanical prosthetic heart valve AND • The member does not have an active pathological bleed AND • The member has failed warfarin or is not a candidate for warfarin as defined as meeting one of the following criteria:
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			<ul style="list-style-type: none"> ○ Labile INR for reasons other than noncompliance (e.g. member has an INR outside of 2-3 > 60% of the time for a period of two months) OR ○ The member has significant difficulty with complying with monitoring OR ○ The member has an allergy or intolerance to warfarin <p>Grandfathering: Beginning 10/1/2013, members currently stabilized on a non-preferred agent can receive approval to continue on that agent for one year if medically necessary</p>
<p>ANTI-EMETICS</p> <p><i>Effective 1/1/2015</i></p>	<p>No PA Required</p> <p>ondansetron tablets</p> <p>ondansetron ODT tab</p> <p>ondansetron oral solution (members under 5 years only)</p>	<p>PA Required</p> <p>AKYNZEO (netupitant/palansetron)</p> <p>ANZEMET (dolasetron)</p> <p>DICLEGIS (doxylamine/pyridoxine)</p> <p>EMEND (aprepitant)</p> <p>KYTRIL (granisetron)</p> <p>SANCUSO (granisetron)</p> <p>VARUBI (rolapitant)</p> <p>ZOFRAN (ondansetron) tabs</p> <p>ZOFRAN (ondansetron) suspension</p> <p>ZOFRAN ODT (ondansetron)</p> <p>ZUPLENZ (ondansetron)</p>	<p>Non-preferred products will be approved for members who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Ondansetron suspension will be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube.</p> <p>Emend will be approved upon verification that the member is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. Verification may be provided from the prescriber or the pharmacy.</p> <p>Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). Verification may be provided from the prescriber or the pharmacy.</p> <p>Approval for DICLEGIS will be granted if the member has nausea and vomiting associated with pregnancy AND</p> <p>The member has failed a trial of doxylamine 10-12.5mg OR</p> <p>The member has failed a trial of oral ondansetron 4mg every 8 hours for five days OR</p> <p>The member has an intolerance or contraindication to ondansetron</p>
<p>ANTI-DEPRESSANTS</p> <p>Newer Generation Antidepressants</p> <p><i>Effective 1/1/2015</i></p>	<p>No PA Required</p> <p>bupropion IR, SR, XL</p> <p>citalopram</p>	<p>PA Required</p> <p>APLENZIN ER (bupropion ER)</p> <p>BRINTELLIX (vortioxetine)</p>	<p>Non-preferred products will be approved for members who have failed treatment with three Preferred Products with exceptions for Cymbalta (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p>

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	escitalopram fluoxetine mirtazipine paroxetine sertraline venlafaxine IR tabs venlafaxine XR capsules	CYMBALTA (duloxetine) desvenlafaxine succinate Duloxetine EFFEXOR IR EFFEXOR XR FETZIMA (levomilnacipran) fluvoxamine (generic Luvox) KHEDEZLA (desvenlafaxine base) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) Nefazodone (generic Serzone) OLEPTRO ER (trazodone ER) PRISTIQ (desvenlafaxine succinate) PEXEVA (paroxetine) paroxetine CR PAXIL CR (paroxetine controlled release) PROZAC Weekly (fluoxetine) VIIBRYD (vilazodone) WELLBUTRIN IR, SR, XL	<p>Grandfathering: Members currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. Verification may be provided from the prescriber or the pharmacy.</p> <p>Cymbalta or duloxetine: Members will NOT need to fail on three Preferred Products if the diagnosis is Diabetic Peripheral Neuropathic Pain.</p> <p>Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses.</p>
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<p>ANTI-HERPETIC AGENTS</p> <p><i>Effective 1/1/2015</i></p>	<p>No PA Required</p> <p>acyclovir tablet, capsule, suspension (generic)</p>	<p>PA Required</p> <p>FAMVIR (famciclovir)</p> <p>famciclovir</p> <p>SITAVIG (acyclovir)</p> <p>VALTREX (valacyclovir)</p> <p>valacyclovir</p> <p>VALCYTE (valgancyclovir)</p> <p>ZOVIRAX (acyclovir)</p>	<p>Non-preferred products will be approved for members who have failed an adequate trial with acyclovir (dose and duration) as deemed by approved compendium (see below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p> <table border="1" data-bbox="1245 418 2026 1302"> <thead> <tr> <th data-bbox="1245 418 1461 448">Indication</th> <th data-bbox="1461 418 1715 448">Adult</th> <th data-bbox="1715 418 2026 448">Pediatric</th> </tr> </thead> <tbody> <tr> <td data-bbox="1245 448 1461 613">Genital herpes simplex: Initial</td> <td data-bbox="1461 448 1715 613">400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.</td> <td data-bbox="1715 448 2026 613">12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.</td> </tr> <tr> <td data-bbox="1245 613 1461 976">Genital herpes simplex: episodic</td> <td data-bbox="1461 613 1715 976">400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.</td> <td data-bbox="1715 613 2026 976">12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days</td> </tr> <tr> <td data-bbox="1245 976 1461 1302">Genital herpes simplex: Suppressive An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive) will be one month.</td> <td data-bbox="1461 976 1715 1302">400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.</td> <td data-bbox="1715 976 2026 1302">12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months</td> </tr> </tbody> </table>	Indication	Adult	Pediatric	Genital herpes simplex: Initial	400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.	12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.	Genital herpes simplex: episodic	400 mg orally 3 times daily for 5 days or 800 mg orally twice daily for 5 days or 800 mg orally 3 times daily for 2 days (guideline dosing); or 200 mg orally every 4 hours, 5 times daily for 5 days; initiate at earliest sign or symptom of recurrence.	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days	Genital herpes simplex: Suppressive An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive) will be one month.	400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.	12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months
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ANTI-HISTAMINES Newer Generation Antihistamines <i>Effective 7/1/2015</i>	No PA Required cetirizine (generic OTC Zyrtec) 5mg and 10mg tab, chew tab, syrup loratadine (generic OTC Claritin) 10mg tab and syrup	PA Required ALAVERT (loratadine) ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) fexofenadine levocetirizine loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine)	Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for members who have failed treatment with two preferred products in the last 6 months and have at least one trial with intranasal corticosteroids (for children age 4 and older). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
Antihistamine/Decongestant Combinations <i>Effective 7/1/2015</i>	No PA Required	PA Required ALLEGRA-D (fexofenadine./PSE) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	
ANTI-HYPERTENSIVES Angiotensin Receptor Blockers (ARBs) <i>Effective 7/1/2015</i>	No PA Required BENICAR (olmesartan) DIOVAN ^{*BNR*} (valsartan)	PA Required ATACAND (candesartan) AVAPRO (irbesartan) COZAAR (losartan)	Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for members who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.).

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	irbesartan losartan	EDARBI (azilsartan) MICARDIS (telmisartan) TEVETEN (eprosartan) Valsartan	Renin inhibitors and combinations will not approved in patients with diabetes. Receiving an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination in combination with a renin inhibitor is contraindicated. Grandfathering: Members currently stabilized on brand name Avapro or Avalide can receive approval to continue on that agent for one year if medically necessary. Verification may be provided from the prescriber or the pharmacy.
ARB Combinations <i>Effective 7/1/2015</i>	No PA Required BENICAR-HCT *BNR* (olmesartan/HCTZ) DIOVAN-HCT *BNR* (valsartan/HCTZ) losartan/HCTZ	PA Required ATACAND-HCT (candesartan/HCTZ) candesartan/HCTZ AVALIDE (irbesartan/HCTZ) AZOR(amlodipine/olmesartan) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (amlodipine/valsartan) amlodipine/valsartan EXFORGE HCT (amlodipine/valsartan/hctz) Amlodipine/valsartan/hctz HYZAAR HCT (losartan/hctz) irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ)	

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		telmisartan/HCTZ TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) VALTURNA (aliskiren/valsartan) valsartan/HCTZ	
Renin Inhibitors & Renin Inhibitor Combinations <i>Effective 7/1/2015</i>	No PA Required	PA Required AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	
ANTI-PLATELETS <i>Effective 1/1/2015</i>	No PA Required AGGRENOX (ASA/dipyridamole) ASA/dipyridamole clopidogrel EFFIENT (prasugrel) Ticlopidine	PA Required BRILINTA (tigacrelor) PLAVIX (clopidogrel) TICLID (ticlopidine) ZONTIVITY (vorapaxar)	EFFIENT 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke. BRILINTA will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg, age ≥ 75 years OR who have had a hypersensitivity reaction to clopidogrel or prasugrel AND must be taking a maintenance dose of aspirin not exceeding 100 mg/day. Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy.

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			ZONTIVITY will be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly.
ATYPICAL ANTI-PSYCHOTICS (oral) <i>Effective 4/1/2015</i>	No PA Required** ABILIFY ^{*BNR*} (aripiprazole) tab aripiprazole oral solution ABILIFY ODT ^{*BNR*} (aripiprazole) clozapine CLOZARIL (clozapine) GEODON (Ziprasidone) LATUDA (lurasidone) olanzapine risperidone risperidone ODT RISPERDAL (risperidone) RISPERDAL ODT (risperidone) quetiapine* SEROQUEL IR* (quetiapine)	PA Required aripiprazole FANAPT (iloperidone) FAZACLO (clozapine) INVEGA (paliperidone) Rexulti (brexpiprazole) SAPHRIS (asenapine) SEROQUEL XR (quetiapine) ZYPREXA ZYDIS (olanzapine) * for injectable Atypical Antipsychotics please see Appendix P for criteria	<p><i>*IR quetiapine when given at sub therapeutic doses may be restricted for therapy. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day except for utilization (when appropriate) in members age 65 years or older.</i></p> <p>Non-preferred products will only be approved for their FDA approved indications and age limits and only if the member has failed on three preferred products in the last 5 years. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). See Table 1.</p> <p>**Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent. Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. See Table 3.</p> <p>New Atypical Antipsychotic prescriptions for members under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. PA approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Members under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.</p> <p>Grandfathering: Members currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the member does not meet the age, dosing or FDA approved indication requirements. Verification may be provided from the prescriber or the pharmacy.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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	ziprasidone ZYPREXA (olanzapine)		<p>Quantity Limits: All products including preferred products will have quantity limits. In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen. See Table 2.</p> <p>Fazaclo will be approved for the treatment of schizophrenia if the member is 18 years of age or older and has tried and failed treatment with three preferred products (one of which must be generic clozapine) in the last 5 years.</p> <p>Invega will be approved for the treatment of schizophrenia or schizoaffective disorder if the member is 18 years of age or older (12 years or older for schizophrenia) and has tried and failed treatment with / has had adherence issues with three preferred products in the last 5 years. A maximum of one tablet per day will be approved.</p> <p>Seroquel XR will be approved if the member is 18 years of age or older, has tried and failed treatment with three preferred products in the last five years and is being treated for one of the FDA approved indications. See Table 1.</p> <p>If a member has been stabilized on quetiapine for at least 30 days with a positive response but is unable to tolerate the side effects, Seroquel XR may be approved without failure of two additional agents.</p> <p>Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar 1 disorder if the member is 13 years of age or older and has tried and failed treatment with three preferred products (one of which must be an olanzapine tablet) in the last 5 years.</p> <p>For members that are stabilized on Zyprexa tablets with a documented need for occasional supplementation to treat acute symptoms, up to 5 tablets per month will be allowed without three product failures.</p> <p>Table 1: Approved Indications</p> <table border="1" data-bbox="1241 1304 2030 1406"> <thead> <tr> <th data-bbox="1249 1310 1440 1336">Drug</th> <th data-bbox="1440 1310 2022 1336">Indication</th> </tr> </thead> <tbody> <tr> <td data-bbox="1249 1336 1440 1369">Fanapt®</td> <td data-bbox="1440 1336 2022 1369"> <ul style="list-style-type: none"> Acute treatment of schizophrenia in adults </td> </tr> <tr> <td data-bbox="1249 1369 1440 1401">Fazaclo®</td> <td data-bbox="1440 1369 2022 1401"> <ul style="list-style-type: none"> Treatment-resistant schizophrenia </td> </tr> </tbody> </table>	Drug	Indication	Fanapt®	<ul style="list-style-type: none"> Acute treatment of schizophrenia in adults 	Fazaclo®	<ul style="list-style-type: none"> Treatment-resistant schizophrenia
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			Invega®	<ul style="list-style-type: none"> Schizophrenia Schizoaffective disorder 																										
			Saphris®	<ul style="list-style-type: none"> Acute and maintenance of schizophrenia Bipolar mania, monotherapy Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex 																										
			Seroquel XR®	<ul style="list-style-type: none"> Treatment of schizophrenia Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex Adjunctive treatment of major depressive disorder (MDD) 																										
			Table 2: Quantity Limits																											
<table border="1"> <thead> <tr> <th data-bbox="1249 880 1388 963">Brand Name</th> <th data-bbox="1388 880 1570 963">Generic Name</th> <th data-bbox="1570 880 2022 963">Quantity Limits</th> </tr> </thead> <tbody> <tr> <td data-bbox="1249 963 1388 1005">Abilify</td> <td data-bbox="1388 963 1570 1005">aripiprazole</td> <td data-bbox="1570 963 2022 1005">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1249 1005 1388 1047"></td> <td data-bbox="1388 1005 1570 1047">clozapine</td> <td data-bbox="1570 1005 2022 1047">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1249 1047 1388 1089">Fazaclo</td> <td data-bbox="1388 1047 1570 1089">clozapine</td> <td data-bbox="1570 1047 2022 1089">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1249 1089 1388 1131">Fanapt</td> <td data-bbox="1388 1089 1570 1131">iloperidone</td> <td data-bbox="1570 1089 2022 1131">Maximum two tablets per day</td> </tr> <tr> <td data-bbox="1249 1131 1388 1174">Invega</td> <td data-bbox="1388 1131 1570 1174">paliperidone</td> <td data-bbox="1570 1131 2022 1174">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1249 1174 1388 1216">Latuda</td> <td data-bbox="1388 1174 1570 1216">lurasidone</td> <td data-bbox="1570 1174 2022 1216">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1249 1216 1388 1323"></td> <td data-bbox="1388 1216 1570 1323">olanzapine</td> <td data-bbox="1570 1216 2022 1323">Maximum one tablet per day (see Zyprexa Zydis criteria for Zydis information)</td> </tr> <tr> <td data-bbox="1249 1323 1388 1359"></td> <td data-bbox="1388 1323 1570 1359">quetiapine</td> <td data-bbox="1570 1323 2022 1359">Maximum three tablets per day</td> </tr> </tbody> </table>				Brand Name	Generic Name	Quantity Limits	Abilify	aripiprazole	Maximum one tablet per day		clozapine	Maximum dosage of 900mg per day	Fazaclo	clozapine	Maximum dosage of 900mg per day	Fanapt	iloperidone	Maximum two tablets per day	Invega	paliperidone	Maximum one tablet per day	Latuda	lurasidone	Maximum one tablet per day		olanzapine	Maximum one tablet per day (see Zyprexa Zydis criteria for Zydis information)		quetiapine	Maximum three tablets per day
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)	
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				Bipolar Disorder/Mixed Mania Schizophrenia	10-17 years	6mg/day
			Quetiapine Fumarate (Seroquel®)	Schizophrenia	13-17 years	6mg/day
			Quetiapine Fumarate (Seroquel XR®)	Bipolar Disorder/Mixed Mania	13-17 years	800 mg/day 800 mg/day
			Ziprasidone (Geodon®)	NOT APPROVED		
BISPHOSPHONATES (oral) <i>Effective 10/1/2015</i>	No PA Required alendronate (generic) 5mg, 10mg, 35mg, 70mg tablets	PA Required ACTONEL (risedronate) ACTONEL w/Calcium (risedronate w/calcium) ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) FOSAMAX (alendronate) FOSAMAX (alendronate) oral solution FOSAMAX plus D (alendronate w/D) Etidronate SKELID (tiludronate)	Non-preferred products will be approved for members who have failed treatment with at least one strength of alendronate. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) PA will be approved for etidronate in members with heterotopic ossification without treatment failure. For members who have a low risk of fracture, prior authorization will be required for members exceeding 5 years of either a preferred or non-preferred bisphosphonate. Low risk will be defined as having an osteopenic bone mineral density (most recent T-score between -1 and -2.5) AND no history of vertebral fracture.			
DIABETES MANAGEMENT CLASSES Amylin <i>Effective 10/1/2015</i>	No PA Required	PA Required SYMLIN (pramlintide)	Symlin® will only be approved after a member has failed a three month trial of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%) OR the member cannot tolerate metformin, DPP4-inhibitor and GLP-1 analogue			

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			due to allergy, intolerable side effects, or a significant drug-drug interaction. For all products , dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. PA will be approved for Symlin products for members with Diabetes Mellitus Type 1 without failed treatment
Biguanides <i>Effective 10/1/2015</i>	metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended-release 500mg tablets (generic Glucophage XR)	FORTAMET (metformin) GLUCOPHAGE (brand) (metformin) GLUCOPHAGE XR (brand) (metformin XR) GLUMETZA ER (metformin) metformin ER 750mg metformin extended-release 500 and 1000mg (generic Fortamet) RIOMET 500mg/5ml (metformin)	Non-preferred products will be approved for members who have failed treatment with two Preferred Products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Liquid metformin will be approved for members who meet one of the following: <ul style="list-style-type: none"> ➤ under the age of 12 ➤ with a feeding tube who have difficulty swallowing
DPP-4 Inhibitor <i>Effective 10/1/2015</i>	*TRADJENTA (linagliptin)	JANUVIA (sitagliptin) NESINA (alogliptin) ONGLYZA (saxagliptin)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. For all products , dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing. Non preferred DPP-4 inhibitors will be approved after a member has failed a three month trial of metformin and Tradjenta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C \geq 7%), OR the member cannot tolerate Tradjenta and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.)
GLP-1 Agonist <i>Effective 10/1/2015</i>	*BYETTA (exenatide)	BYDUREON (exenatide) TANZEUM (albiglutide)	*Approval for preferred products require a three month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		TRULICITY (dalaglutide) VICTOZA (liraglutide)	<p>For all products, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.</p> <p>Non preferred GLP-1 agonists will be approved after a member has failed a three month trial of metformin and Byetta®. Failure is defined as lack of efficacy (e.g., hemoglobin A1C \geq 7%) OR the member cannot tolerate Byetta® and metformin due to allergy, intolerable side effects, or a significant drug-drug interaction.</p> <p>Grandfathering: Members currently stabilized on Victoza® can receive approval to continue on that agent for one year.</p>
Hypoglycemic Combinations <i>Effective 10/1/2015</i>	No PA Required	PA Required ACTOPLUS MET (pioglitazone/metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (glipizide/metformin) GLUCOVANCE (brand) (glyburide/metformin) glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) JANUMET (sitagliptin/metformin) JENTADUETO (linagliptin/metformin)	Non-preferred products will be approved for members who have been stable on the two individual ingredients for 3 months and have an adherence issue.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		KAZANO (alogliptin/metformin) KOMBIGLYZE (saxagliptin/metformin) METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) PRANDIMET (repaglinide/metformin) repaglinide/metformin SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozen/metformin)	
Meglitinides <i>Effective 10/1/2015</i>	No PA Required	PA Required PRANDIN (repaglinide) STARLIX (nateglinide)	Non-preferred products will be approved for members who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
SGLT-2 Inhibitor <i>Effective 10/1/2015</i>	No PA Required	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	<p>The SGLT-2 inhibitors will only be approved after a member has failed a three month trial of two of metformin and a DPP4-inhibitor or a GLP-1 analogue. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C \geq 7%) OR the member cannot tolerate metformin, a DPP4-inhibitor, and a GLP-1 analogue due to allergy, intolerable side effects, or a significant drug-drug interaction.</p> <p>The SGLT-2 inhibitors will not be approved for members requiring dialysis or those who are pregnant, or have type 1 diabetes, end stage renal disease or severe renal impairment (defined as a creatinine clearance < 45ml/min).</p> <p>For all products, dosing will be limited to FDA approved dosing. PA will be required for doses in excess of FDA approved dosing.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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Thiazolidinediones <i>Effective 10/1/2015</i>	No PA Required pioglitazone	PA Required ACTOS (pioglitazone) AVANDIA (rosiglitazone)	<p>*Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy. Prior authorizations for rosiglitazone will be manually reviewed by the Department based upon reported risk mitigation, medical justification and contraindication to pioglitazone.</p>
ERYTHROPOIESIS STIMULATING AGENTS <i>Effective 10/1/2015</i>	*Must meet eligibility criteria EPOGEN (epoetin alfa)*	PA Required ARANESP (darbepoetin alfa) MIRCERA (methoxy peg-epoetin beta) PROCIT (epoetin alfa)	<p>*Eligibility Criteria for all agents in the class Members must meet all criteria in one of the following four areas:</p> <ul style="list-style-type: none"> ➤ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. ➤ A diagnosis of chronic renal failure, and hemoglobin below 10g/dL ➤ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). ➤ A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. <p>Hemoglobin results must be from the last 30 days. Medication must be administered in the member's home or long-term care facility.</p> <p>Non-preferred products:</p> <ul style="list-style-type: none"> ➤ Same as above; and ➤ Failed treatment with Epopen. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) <p>Note: The FDA has announced a risk evaluation mitigation strategy for the use of Erythropoiesis Stimulating Agents (ESAs) in patients with cancer, who are currently receiving chemotherapy, and who are experiencing chemotherapy induced anemia. Patients must receive a medication guide outlining the risks and benefits of treatment, and patient consent must be obtained before therapy. Prescribers are required to enroll and register in the ESA APPRISE Oncology program and complete training prior to prescribing ESAs to patients with cancer. For non-cancer</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
FIBROMYALGIA AGENTS <i>Effective 7/1/2015</i>	No PA Required LYRICA (pregabalin) duloxetine	PA Required CYMBALTA (duloxetine) SAVELLA (milnacipran)	<p>indications, the distribution of a medication guide to the patient is the only requirement currently.</p> <p>Non-preferred agents will be approved for fibromyalgia if member has failed an adequate trial (8 weeks) of both Lyrica and duloxetine OR the member has contraindication to Lyrica and duloxetine</p> <p>GENERIC DULOXETINE will be approved if the member has diagnosis for fibromyalgia.</p> <p>For members with no epilepsy diagnosis in the last two years (as confirmed by SMART PA), PA will be required for LYRICA prescriptions requiring more than 3 capsules per day or for prescriptions requiring doses greater than 600mg per day.</p>
FLUOROQUINOLONE (oral) <i>Effective 1/1/2015</i>	No PA Required Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	PA Required AVELOX (moxifloxacin) CIPRO TABLET (ciprofloxacin) FACTIVE (gemifloxacin) LEVAQUIN TABLET (levofloxacin) LEVAQUIN oral solution Levofloxacin oral solution NOROXIN (norfloxacin) Ofloxacin	<p>Non-preferred products will be approved for members who have failed an adequate trial (7days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>CIPRO suspension approved for members < 5 years of age without PA</p> <p>For members ≥ 5 years of age, CIPRO suspension will only be approved for those members who cannot swallow a whole or crushed tablet</p> <p>Levofloxacin solution will be approved for members who require administration via feeding tube OR who have failed an adequate trial (7 days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, presence of feeding tube, allergy, intolerable side effects, or significant drug-drug interaction.)</p>
GROWTH HORMONES <i>Effective 4/1/2015</i>	No PA Required GENOTROPIN	PA Required HUMATROPE NORDITROPIN NUTROPIN	<p>Non-preferred Growth Hormones will be approved if both of the following criteria are met:</p> <ul style="list-style-type: none"> ▪ Member failed treatment with Genotropin within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Member has a qualifying diagnosis: <ul style="list-style-type: none"> ➢ Prader-Willi ➢ Chronic renal insufficiency/failure

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	<ul style="list-style-type: none"> ➤ Turner’s Syndrome ➤ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma ➤ Wasting associated with AIDS or cachexia ➤ Noonan Syndrome <p>Grandfathering: If the member has a diagnosis for short bowel syndrome OR cachexia associated with AIDS, member will be grandfathered and receive approval for a non-preferred agent due to medical necessity based on FDA approved indications.</p>
HEPATITIS C VIRUS TREATMENTS <i>Effective 10/1/2015</i>	Must meet eligibility criteria* VIEKIRA PAK* (ombitasvir/paritaprevir/ritonavir/ dasabuvir)	PA Required DAKLINZA (daclastavir) HARVONI (sofosbuvir/ledipasvir) OLYSIO (Simeprevir) SOVALDI (Sofosbuvir) TECHNIVIE (ombitasvir/paritaprevir/ritonavir)	<p>Preferred agent criteria:</p> <p>Requests for Viekira Pak® (ombitasvir/paritaprevir/ritonavir/dasabuvir) will be granted prior authorization if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Physician attests to the member’s readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. Must have chronic Hepatitis C (HCV) genotype 1a or 1b AND 4. Member is not co-infected with Hepatitis B AND 5. Member is 18 years of age and older AND 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Viekira Pak is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 9. Meets one of the following categories based on liver biopsy or other accepted test: <ul style="list-style-type: none"> • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); or CTP B (7 or greater)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>and on transplant list with projected time to transplant < 1 year;</p> <ul style="list-style-type: none"> • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND <ol style="list-style-type: none"> 10. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 11. Post-transplant recipients will be evaluated on a case by case basis AND 12. Members may be HIV positive AND 13. Member does not have end stage renal disease requiring hemodialysis AND 14. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 15. Member must be 6 months free of: alcohol; and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Members must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment with Viekira Pak for members that have a history (within the past 2 years) of alcohol/drug abuse AND 16. Member is not taking moderate or strong CYP3A inducers, or strong CYP2C8 inducers or inhibitors AND 17. Member is not taking alfuzosin, amiodarone, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergoamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing agents, St. John's wort, lovastatin, simvastatin, pimozone, efavirenz, sildenafil dosed for treatment

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>of pulmonary arterial hypertension, triazolam, oral midazolam, voriconazole, fluticasone, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, salmeterol AND</p> <ol style="list-style-type: none"> 18. If member is taking amiodarone, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine, ketoconazole, amlodipine, furosemide, atazanavir/ritonavir, rosuvastatin, pravastatin, cyclosporine, tacrolimus, buprenorphine/naloxone, omeprazole, or alprazolam, provider attests that appropriate dose adjustments have made to ensure safe coadministration AND 19. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND 20. If the week 4 HCV RNA is detectable (>25 copies) while on Viekira Pak therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log₁₀ IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND 21. Must be in accordance to approved regimens and duration (see Table 1) AND 22. Must be adherent to treatment regimen (see discontinuation criteria) <u>AND</u> prescriber must confirm member enrollment in the proCeed Nurse Connector program (by phone: 1-844-2proCeed or Fax: 1-866-299-1687 or online at: https://www.viekira.com/proceed-program) to re-enforce adherence AND 23. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity. <p><u>Note:</u> Once treated, the Department will only cover a once per lifetime treatment with any DAA.</p> <p>Table 1. Recommended Regimens and Treatment Duration for Viekira Pak</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<table border="1" data-bbox="1287 235 2032 735"> <thead> <tr> <th data-bbox="1295 241 1619 358">HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-1 Co-infected)</th> <th data-bbox="1619 241 1885 358">Treatment</th> <th data-bbox="1885 241 2024 358">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1295 358 1619 451">Members with genotype 1a, without compensated cirrhosis</td> <td data-bbox="1619 358 1885 451">Viekira Pak + ribavirin</td> <td data-bbox="1885 358 2024 451">12 weeks</td> </tr> <tr> <td data-bbox="1295 451 1619 513">Members with genotype 1a, with compensated cirrhosis</td> <td data-bbox="1619 451 1885 513">Viekira Pak + ribavirin</td> <td data-bbox="1885 451 2024 513">24 weeks</td> </tr> <tr> <td data-bbox="1295 513 1619 605">Members with genotype 1b, without compensated cirrhosis</td> <td data-bbox="1619 513 1885 605">Viekira Pak</td> <td data-bbox="1885 513 2024 605">12 weeks</td> </tr> <tr> <td data-bbox="1295 605 1619 667">Members with genotype 1b, with compensated cirrhosis</td> <td data-bbox="1619 605 1885 667">Viekira Pak + ribavirin</td> <td data-bbox="1885 605 2024 667">12 weeks</td> </tr> <tr> <td data-bbox="1295 667 1619 735">Post-transplant members</td> <td data-bbox="1619 667 1885 735">Viekira Pak + ribavirin</td> <td data-bbox="1885 667 2024 735">24 weeks</td> </tr> </tbody> </table> <p data-bbox="1241 769 1535 797">Quantity and Refill Limits:</p> <ul data-bbox="1287 802 2024 1045" style="list-style-type: none"> • Quantity Limit: two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily and one dasabuvir 250 mg tablet twice daily (112 tablets/28days) • Length of authorization: Based on HCV subtype and comorbidities • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. <p data-bbox="1241 1079 1514 1107">Discontinuation Criteria:</p> <ul data-bbox="1287 1112 2024 1416" style="list-style-type: none"> • Members receiving a Viekira Pak-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • Members receiving a Viekira Pak-based regimen should have ALT levels at baseline, 4 weeks, and again as clinically necessary. Members may need to discontinue if ALT levels remain over 10 times ULN, and will need to discontinue if ALT elevation is accompanied with signs or symptoms of liver 	HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-1 Co-infected)	Treatment	Duration	Members with genotype 1a, without compensated cirrhosis	Viekira Pak + ribavirin	12 weeks	Members with genotype 1a, with compensated cirrhosis	Viekira Pak + ribavirin	24 weeks	Members with genotype 1b, without compensated cirrhosis	Viekira Pak	12 weeks	Members with genotype 1b, with compensated cirrhosis	Viekira Pak + ribavirin	12 weeks	Post-transplant members	Viekira Pak + ribavirin	24 weeks
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>inflammation, increased conjugated bilirubin, alkaline phosphatase, or INR.</p> <ul style="list-style-type: none"> The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Viekira Pak prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. <p>Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV.</p> <p>Non-Preferred Agents criteria are below:</p> <p>Requests for Daklinza® (daclatasvir) will be granted prior authorization if the following criteria are met:</p> <ol style="list-style-type: none"> Physician attests to the member's readiness for adherence AND Physician attests to provide SVR12 timely AND Member must have chronic Hepatitis C (HCV) genotype 3 AND Member is not co-infected with Hepatitis B or Human Immunodeficiency Virus (HIV) AND Member is 18 years of age and older AND Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND Daclatasvir is prescribed with sofosbuvir AND Daclatasvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND Member meets one of the following categories based on liver biopsy, symptoms or other accepted test: <ul style="list-style-type: none"> Member with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year;

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest ($\geq 0.58\text{kPa}$) or FibroScan ($\geq 9.6\text{kPa}$) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND <ol style="list-style-type: none"> 10. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m²), end stage renal disease, on hemodialysis AND 11. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment for clients that have a history (within the past 2 years) of alcohol/drug abuse AND 12. Member is not taking amiodarone, dabigatran, phenytoin, carbamazepine, rifampin, St. John's wort or other strong CYP3A inducers AND 13. If member is taking moderate CYP3A inducers, moderate to strong CYP3A inhibitors, digoxin, or HMG-CoA reductase inhibitors, provider attests that appropriate dose adjustments have made to ensure safe coadministration AND 14. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 15. All approvals will initially be for a 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND 16. If the week 4 HCV RNA is detectable (>25 copies) while on daclatasvir/sofosbuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>>1 log₁₀ IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND</p> <p>17. Must be in accordance to approved regimens and duration (see Table 1) AND</p> <p>18. Must be adherent to treatment regimen (see discontinuation criteria) AND</p> <p>19. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.</p> <p>Note: The Department will only cover a once per lifetime treatment with any DAA.</p> <p>Table 1. Recommended Regimens and Treatment Duration for Daklinza</p> <table border="1" data-bbox="1285 753 2001 1019"> <thead> <tr> <th>HCV Genotype</th> <th>Daily Treatment</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td>Genotype 3</td> <td>Daclatasvir 60mg + 400 mg sofosbuvir</td> <td>12 weeks</td> </tr> <tr> <td>Genotype 3 taking strong CYP3A inhibitors</td> <td>Daclatasvir 30mg + 400 mg sofosbuvir</td> <td>12 weeks</td> </tr> <tr> <td>Genotype 3 taking moderate CYP3A inducers</td> <td>Daclatasvir 90mg + 400 mg sofosbuvir</td> <td>12 weeks</td> </tr> </tbody> </table> <p>Quantity and Refill Limits:</p> <ul style="list-style-type: none"> Quantity Limit: one daclatasvir 60mg tablet and one sofosbuvir 400mg tablet per day (28 tablets each/28days) and adjusted as indicated in Table 1 above Length of authorization: Based on current medication regimen Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. <p>Discontinuation Criteria:</p> <ul style="list-style-type: none"> Members receiving a sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 	HCV Genotype	Daily Treatment	Duration	Genotype 3	Daclatasvir 60mg + 400 mg sofosbuvir	12 weeks	Genotype 3 taking strong CYP3A inhibitors	Daclatasvir 30mg + 400 mg sofosbuvir	12 weeks	Genotype 3 taking moderate CYP3A inducers	Daclatasvir 90mg + 400 mg sofosbuvir	12 weeks
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>(if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued.</p> <ul style="list-style-type: none"> The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their sofosbuvir prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. <p>Requests for Harvoni® (sofosbuvir/ledipasvir) will be considered if Viekira Pak® is contraindicated or cannot be used due to documented resistance to protease inhibitors for the treatment of Hepatitis C virus (e.g. Olysio, Victrelis, Incivek). Prior authorization may be granted if the following criteria are met:</p> <ol style="list-style-type: none"> Physician attests to the member’s readiness for adherence AND Physician attests to provide SVR12 and SVR24 timely AND Must have chronic Hepatitis C (HCV) genotype 1a or 1b AND Member is 18 years of age and older AND Member is not co-infected with Hepatitis B or Human Immunodeficiency Virus (HIV) AND Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND Harvoni is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND Meets one of the following categories based on liver biopsy or other accepted test: <ul style="list-style-type: none"> Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease;
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND <ol style="list-style-type: none"> 9. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 10. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m²), end stage renal disease, on hemodialysis AND 11. Member must be 6 months free of: alcohol; and Schedule I controlled substances (including marijuana), and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment for members that have a history (within the past 2 years) of alcohol/drug abuse AND 12. Member is not taking potent P-gp inducers AND 13. Member is not taking amiodarone, carbamazepine, phenytoin, phenobarbital, , rifampin, rifabutin, rifapentine, St. John's wort, tipranavir/ritonavir, elvitegravir, cobicistat, emtricitabine, simeprevir, rosuvastatin AND 14. If member is taking H₂ receptor antagonist, antacid, proton pump inhibitor, digoxin, efavirenz, HIV protease inhibitor, provider attests that appropriate dose adjustments have been made to ensure safe coadministration AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>15. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND</p> <p>16. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND</p> <p>17. If the week 4 HCV RNA is detectable (>25 copies) while on sofosbuvir/ledipasvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log₁₀ IU/ml from nadir), all treatment will be discontinued unless documentation is provided to support continuation of therapy AND</p> <p>18. Must be in accordance to approved regimens and duration (see Table 1) AND</p> <p>19. Must be adherent to treatment regimen (see discontinuation criteria) AND</p> <p>20. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.</p> <p>Note: Once treated, the Department will only cover a once per lifetime treatment with any DAA.</p> <p>Table 1. Recommended Regimens and Treatment Duration for Harvoni</p> <table border="1" data-bbox="1285 1027 2034 1424"> <thead> <tr> <th data-bbox="1293 1034 1627 1195">HCV Genotype and Comorbidities</th> <th data-bbox="1627 1034 1824 1195">Treatment</th> <th data-bbox="1824 1034 2026 1195">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1293 1195 1627 1317">Treatment naïve with or without compensated cirrhosis</td> <td data-bbox="1627 1195 1824 1317">Harvoni</td> <td data-bbox="1824 1195 2026 1317">12 weeks</td> </tr> <tr> <td data-bbox="1293 1317 1627 1417">Treatment-experienced without compensated cirrhosis</td> <td data-bbox="1627 1317 1824 1417">Harvoni</td> <td data-bbox="1824 1317 2026 1417">12 weeks</td> </tr> </tbody> </table>	HCV Genotype and Comorbidities	Treatment	Duration	Treatment naïve with or without compensated cirrhosis	Harvoni	12 weeks	Treatment-experienced without compensated cirrhosis	Harvoni	12 weeks
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			<table border="1" data-bbox="1285 235 2037 332"> <tr> <td data-bbox="1285 235 1627 332">Treatment-experienced with compensated cirrhosis</td> <td data-bbox="1627 235 1827 332">Harvoni</td> <td data-bbox="1827 235 2037 332">24 weeks</td> </tr> </table> <p data-bbox="1243 365 1554 397">Quantity and Refill Limits:</p> <ul data-bbox="1291 397 2016 609" style="list-style-type: none"> • Quantity Limit: one ledipasvir 90 mg/sofosbuvir 400 mg tablet per day (28 tablets/28days) • Length of authorization: Based on comorbidities and treatment status • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. <p data-bbox="1243 641 1533 673">Discontinuation Criteria:</p> <ul data-bbox="1291 673 2016 1104" style="list-style-type: none"> • Members receiving a Sofosbuvir-based regimen should have HCV RNA levels assessed at weeks 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Harvoni prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. <p data-bbox="1243 1136 2016 1193">Requests for Olysio® (simeprevir) will be granted prior authorization if the following criteria are met:</p> <ol data-bbox="1291 1193 2016 1404" style="list-style-type: none"> 1. Physician attests to the member’s readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. A documented diagnosis of Hepatitis C Genotype 1 with concurrent therapy with ribavirin and pegylated interferon unless in combination with a polymerase inhibitor. 4. Member is not co-infected with HIV or Hepatitis B AND 5. Member is 18 years of age and older AND 	Treatment-experienced with compensated cirrhosis	Harvoni	24 weeks
Treatment-experienced with compensated cirrhosis	Harvoni	24 weeks				

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<ol style="list-style-type: none"> 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. The patient's previous treatment history and weight are presented at the time of initial request. Meets one of the following categories based on liver biopsy or other accepted test: <ul style="list-style-type: none"> • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); or CTP B (7 or greater) and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND 9. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly for clients that have a history (within the past 2 years) of alcohol/drug abuse.
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>10. The patient is not receiving moderate to strong inhibitors (e.g., erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g., carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John’s wort) of CYP3A4.</p> <p>11. The patient has not previously tried and failed therapy with a hepatitis C protease inhibitor (Incivek® or Victrelis®).</p> <p>12. Olysio® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist.</p> <p>13. If the week 4 HCV RNA is detectable (>25 copies) while on Viekira Pak therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log₁₀ IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND</p> <p>14. For patients with HCV genotype 1a, evidence must be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy.</p> <p>15. Must be in accordance to approved regimens and duration (see Table 1) AND</p> <p>16. Must be adherent to treatment regimen (see discontinuation criteria) AND</p> <p>17. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.</p> <p>Table 1. Recommended Regimens and Treatment Duration for Olysio</p> <table border="1" data-bbox="1287 1149 2022 1382"> <thead> <tr> <th data-bbox="1287 1149 1614 1256">HCV Genotype and Comorbidities</th> <th data-bbox="1614 1149 1875 1256">Treatment</th> <th data-bbox="1875 1149 2022 1256">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1287 1256 1614 1382">Treatment naïve or treatment experienced without compensated cirrhosis</td> <td data-bbox="1614 1256 1875 1382">Simeprevir + sofosbuvir</td> <td data-bbox="1875 1256 2022 1382">12 weeks</td> </tr> </tbody> </table>	HCV Genotype and Comorbidities	Treatment	Duration	Treatment naïve or treatment experienced without compensated cirrhosis	Simeprevir + sofosbuvir	12 weeks
HCV Genotype and Comorbidities	Treatment	Duration							
Treatment naïve or treatment experienced without compensated cirrhosis	Simeprevir + sofosbuvir	12 weeks							

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<table border="1" data-bbox="1289 235 2022 326"> <tr> <td data-bbox="1289 235 1614 326">Treatment naïve or treatment experienced with compensated cirrhosis</td> <td data-bbox="1614 235 1875 326">Simeprevir + sofosbuvir</td> <td data-bbox="1875 235 2022 326">24 weeks</td> </tr> </table> <p data-bbox="1241 362 1554 386">Quantity and Refill Limits:</p> <ul data-bbox="1289 394 2011 638" style="list-style-type: none"> • Quantity Limit: one simeprevir 150 mg tablet once daily and one sofosbuvir 400 mg tablet once daily (28 tablets each /28days) • Length of authorization: Based on comorbidities and treatment status • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. <p data-bbox="1241 670 1530 695">Discontinuation Criteria:</p> <ul data-bbox="1289 703 2016 1130" style="list-style-type: none"> • Members receiving an Olysio-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Olysio prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. <p data-bbox="1241 1166 2022 1312">Requests for Sovaldi® (sofosbuvir) will be considered for genotype 1 if Viekira Pak® is contraindicated or cannot be used due to documented resistance to protease inhibitors for the treatment of Hepatitis C virus (e.g. Olysio, Victrelis, Incivek). Prior authorization may be granted if the following criteria are met:</p> <ol data-bbox="1289 1320 2016 1430" style="list-style-type: none"> 1. Physician attests to the member’s readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. Member must have chronic Hepatitis C (HCV) genotype 1, 2, 3 or 4 AND 	Treatment naïve or treatment experienced with compensated cirrhosis	Simeprevir + sofosbuvir	24 weeks
Treatment naïve or treatment experienced with compensated cirrhosis	Simeprevir + sofosbuvir	24 weeks				

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ol style="list-style-type: none"> 4. Member is not co-infected with Hepatitis B AND 5. Member is 18 years of age and older AND 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Sofosbuvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 9. Member meets one of the following categories based on liver biopsy, symptoms or other accepted test: <ul style="list-style-type: none"> • Member with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A; or CTP B and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND 10. Member does not have severe renal impairment (eGFR<30 ml/min/1.73m²), end stage renal disease, on hemodialysis AND 11. Member must be 6 months free of: alcohol and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Member must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>screens must be conducted monthly during treatment for clients that have a history (within the past 2 years) of alcohol/drug abuse AND</p> <ol style="list-style-type: none"> 12. Member is not taking potent P-gp inducers AND 13. Member is not taking amiodarone, carbamazepine, phenytoin, phenobarbital, cyclosporine, rifampin, rifabutin, rifapentine, St. John's wort, tipranavir/ritonavir AND 14. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 15. All approvals will initially be for a 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND 16. If the week 4 HCV RNA is detectable (>25 copies) while on sofosbuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e. >1 log₁₀ IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND 17. Must be in accordance to approved regimens and duration (see Table 1) AND 18. Must be adherent to treatment regimen (see discontinuation criteria) AND 19. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity. <p><u>Note:</u> Once treated, the Department will only cover a once per lifetime treatment with any DAA.</p> <p>Table 1. Recommended Regimens and Treatment Duration for Sofosbuvir</p> <table border="1" data-bbox="1285 1271 2028 1341"> <thead> <tr> <th data-bbox="1293 1278 1608 1334">HCV Genotype</th> <th data-bbox="1608 1278 1871 1334">Treatment</th> <th data-bbox="1871 1278 2020 1334">Duration</th> </tr> </thead> </table>	HCV Genotype	Treatment	Duration
HCV Genotype	Treatment	Duration				

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<table border="1" data-bbox="1285 235 2028 954"> <tbody> <tr> <td data-bbox="1293 235 1610 391">Genotype 1: interferon eligible</td> <td data-bbox="1610 235 1871 391">Sofosbuvir + peginterferon alfa + ribavirin</td> <td data-bbox="1871 235 2020 391">12 weeks</td> </tr> <tr> <td data-bbox="1293 391 1610 472">Genotype 1: interferon ineligible</td> <td data-bbox="1610 391 1871 472">Sofosbuvir + ribavirin</td> <td data-bbox="1871 391 2020 472">24 weeks</td> </tr> <tr> <td data-bbox="1293 472 1610 553">Genotype 2</td> <td data-bbox="1610 472 1871 553">Sofosbuvir + ribavirin</td> <td data-bbox="1871 472 2020 553">12 weeks</td> </tr> <tr> <td data-bbox="1293 553 1610 634">Genotype 3</td> <td data-bbox="1610 553 1871 634">Sofosbuvir + ribavirin</td> <td data-bbox="1871 553 2020 634">24 weeks</td> </tr> <tr> <td data-bbox="1293 634 1610 797">Genotype 4: interferon eligible</td> <td data-bbox="1610 634 1871 797">Sofosbuvir + peginterferon alfa + ribavirin</td> <td data-bbox="1871 634 2020 797">12 weeks</td> </tr> <tr> <td data-bbox="1293 797 1610 954">Genotype 4: interferon ineligible</td> <td data-bbox="1610 797 1871 954">Sofosbuvir + ribavirin</td> <td data-bbox="1871 797 2020 954">24 weeks</td> </tr> </tbody> </table> <p data-bbox="1243 987 1535 1016">Quantity and Refill Limits:</p> <ul data-bbox="1293 1019 2003 1175" style="list-style-type: none"> • Quantity Limit: one 400mg tablet per day (28 tablets/28days) • Length of authorization: Based on HCV genotype • Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. <p data-bbox="1243 1208 1625 1237">Interferon Alpha Ineligible defined:</p> <ul data-bbox="1293 1240 2016 1425" style="list-style-type: none"> • Platelet count <75,000mm³ • Decompensated liver cirrhosis (CTP Class B or C or CTP score ≥ 7) • Documented history of depression or mood disorder, which are not stable on current drug regimen • Autoimmune hepatitis and another autoimmune disorder 	Genotype 1: interferon eligible	Sofosbuvir + peginterferon alfa + ribavirin	12 weeks	Genotype 1: interferon ineligible	Sofosbuvir + ribavirin	24 weeks	Genotype 2	Sofosbuvir + ribavirin	12 weeks	Genotype 3	Sofosbuvir + ribavirin	24 weeks	Genotype 4: interferon eligible	Sofosbuvir + peginterferon alfa + ribavirin	12 weeks	Genotype 4: interferon ineligible	Sofosbuvir + ribavirin	24 weeks
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<ul style="list-style-type: none"> • Inability to complete a prior treatment course due to a documented interferon-related adverse event. <p>Discontinuation Criteria:</p> <ul style="list-style-type: none"> • Members receiving a sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. • The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their sofosbuvir prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. • Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol screens during treatment to continue receiving treatment for HCV. <p>Requests for Technivie® (ombitasvir/paritaprevir/ritonavir) will be granted prior authorization if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Physician attests to the member’s readiness for adherence AND 2. Physician attests to provide SVR12 and SVR24 timely AND 3. Must have chronic Hepatitis C (HCV) genotype 4 without cirrhosis AND 4. Member is not co-infected with Hepatitis B or Human Immunodeficiency Virus (HIV) AND 5. Member is 18 years of age and older AND 6. The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication) AND 7. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed no more than 30 days prior to beginning therapy AND 8. Technivie is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 9. Meets one of the following categories based on liver biopsy or other accepted test:
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<ul style="list-style-type: none"> • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); or CTP B (7 or greater) and on transplant list with projected time to transplant < 1 year; • Transplant members with fibrosing cholestatic HCV or members who have cirrhosis from recurrent HCV and have been approved for re-transplantation; • Member has a fibrosis score equivalent to METAVIR 3-4 based on biopsy not more than 10 years old. If biopsy is not available, concordant scores among APRI (> 1) and FIB-4 (> 2.2) plus either FibroSure/FibroTest (≥ 0.58kPa) or FibroScan (≥ 9.6kPa) that demonstrate scores equivalent to fibrosis 3-4 must be provided; Unless further evidence of cirrhosis is provided such as varices, pulmonary hypertension, splenomegaly AND <ol style="list-style-type: none"> 10. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 11. Member does not have end stage renal disease requiring hemodialysis AND 12. Member must have baseline levels within 90 days of anticipated start date for: HCV RNA; CBC; CMP; INR; and FibroTest or FibroScan (if applicable) AND 13. Member must be 6 months free of: alcohol; and Schedule I controlled substances (including marijuana); and cocaine, opiate, benzodiazepine, and barbiturate misuse/abuse as documented by appropriate alcohol/drug screens. Members must also be counseled about the importance of refraining from alcohol use and drug misuse/abuse. Random alcohol/drug screens must be conducted monthly during treatment with Technivie for members that have a history (within the past 2 years) of alcohol/drug abuse AND 14. Member is not taking moderate or strong CYP3A inducers, or strong CYP2C8 inducers or inhibitors AND
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>15. Member is not taking alfuzosin, carbamazepine, phenytoin, phenobarbital, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing agents, voriconazole, salmeterol, St. John’s wort, lovastatin, simvastatin, rifampin, pimozide, efavirenz, atazanavir, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, sildenafil dosed for treatment of pulmonary arterial hypertension, triazolam, oral midazolam AND</p> <p>16. If member is taking amiodarone, disopyramide, flecainide, lidocaine (systemic), mexiletine, propafenone, quinidine, digoxin, ketoconazole, quetiapine amlodipine, furosemide, pravastatin, cyclosporine, tacrolimus, buprenorphine/naloxone, omeprazole, or alprazolam, provider attests that appropriate dose adjustments have been made to ensure safe co-administration AND</p> <p>17. All approvals will initially be for an 8 week time period, with further approvals dependent on the submission of the HCV RNA level at week 4, week 12, and week 24 to justify continuing drug therapy (see discontinuation criteria) AND</p> <p>18. If the week 4 HCV RNA is detectable (>25 copies) while on Technivie therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log₁₀ IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND</p> <p>19. Must be in accordance to approved regimens and duration (see Table 1) AND</p> <p>20. Must be adherent to treatment regimen (see discontinuation criteria) AND prescriber must confirm member enrollment in the proCeed Nurse Connector program (by phone: 1-844-2proCeed or Fax: 1-866-299-1687 or online at: https://www.viekira.com/proceed-program) to re-enforce adherence AND</p> <p>21. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity.</p> <p><u>Note:</u> Once treated, the Department will only cover a once per lifetime treatment with any DAA.</p>
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>Table 1. Recommended Regimens and Treatment Duration for Technivie</p> <table border="1" data-bbox="1287 326 2026 505"> <thead> <tr> <th data-bbox="1287 326 1610 440">HCV Genotype and Comorbidities</th> <th data-bbox="1610 326 1824 440">Treatment</th> <th data-bbox="1824 326 2026 440">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1287 440 1610 505">Members with genotype 4 without cirrhosis</td> <td data-bbox="1610 440 1824 505">Technivie + ribavirin</td> <td data-bbox="1824 440 2026 505">12 weeks</td> </tr> </tbody> </table> <p>Quantity and Refill Limits:</p> <ul style="list-style-type: none"> Quantity Limit: two ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg tablets once daily Length of authorization: 12 weeks Refills: Should be reauthorized in order to continue the appropriate treatment plan. The member MUST receive refills within one week of completing the previous fill. <p>Discontinuation Criteria:</p> <ul style="list-style-type: none"> Members receiving a Technivie-based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable). If the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued. Members receiving a Technivie-based regimen should have ALT levels at baseline, 4 weeks, and again as clinically necessary. Members may need to discontinue if ALT levels remain over 10 times ULN, and will need to discontinue if ALT elevation is accompanied with signs or symptoms of liver inflammation, increased conjugated bilirubin, alkaline phosphatase, or INR. The department will prospectively evaluate medication adherence based on prescription fills. If a member is non-adherent in filling their Technivie prescription (e.g. not filled within 7 days of the end of the previous fill), all treatment will be discontinued. Members with a history of drug or alcohol abuse/misuse within the last 2 years must provide random monthly drug and alcohol 	HCV Genotype and Comorbidities	Treatment	Duration	Members with genotype 4 without cirrhosis	Technivie + ribavirin	12 weeks
HCV Genotype and Comorbidities	Treatment	Duration							
Members with genotype 4 without cirrhosis	Technivie + ribavirin	12 weeks							

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INSULIN <i>Effective 4/1/2015</i> Rapid Acting	No Prior Authorization Required NOVOLOG vial and pen	Prior Authorization Required AFREZZA APIDRA all forms HUMALOG vial and pen	screens during treatment to continue receiving treatment for HCV. Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects) AFREZZA (human insulin) will be approved for members with the following criteria: <ul style="list-style-type: none"> • Member is 18 years or older AND • Member has intolerable side effects or severe allergic reactions to Novolog AND • Member must not have chronic lung disease such as asthma and COPD AND • If member is a type 1 diabetic, must use in conjunction with long-acting insulin AND • Member must not be a smoker
Short Acting	HUMULIN R vial and pen	NOVOLIN R all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Intermediate Acting	HUMULIN N vial and pen	NOVOLIN N all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Long Acting	LEVEMIR vial and pen	LANTUS all forms TOUJEO all forms	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
Mixtures	HUMULIN 70/30 vial and pen NOVOLIN 70/30 vial HUMALOG MIX 50/50 vial and pen HUMALOG MIX 75/25 vial and pen NOVOLOG MIX 70/30 vial and pen	None	Non-preferred products will be approved if the member has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
INTRANASAL CORTICOSTEROIDS <i>Effective 4/1/2015</i>	No Prior Authorization Required fluticasone (generic FLONASE) NASONEX	Prior Authorization Required BECONASE AQ (beclomethasone dipropionate) FLONASE (fluticasone) NASAREL (flunisolide) NASACORT AQ (triamcinolone) OMNARIS (ciclesonide) QNASL (beclomethasone dipropionate) RHINOCORT AQ (budesonide) Triamcinolone acetonide VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	Non-preferred Intranasal Corticosteroids will be approved if the member has failed treatment with 2 preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). <ul style="list-style-type: none"> • Rhinocort AQ will be approved for pregnant members without failure of preferred products. • Brand name Flonase will require a letter of medical necessity
LEUKOTRIENE MODIFIERS <i>Effective 4/1/2015</i>	No Prior Authorization Required Montelukast (generic SINGULAIR)	Prior Authorization Required ACCOLATE (zafirlukast) SINGULAIR (montelukast) ZYFLO (zileuton)	Non-preferred Leukotrienes will be approved if both of the following criteria are met: <ul style="list-style-type: none"> ▪ Member failed treatment with montelukast in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) ▪ Member has a diagnosis of Asthma
MULTIPLE SCLEROSIS AGENTS <i>Effective 4/1/2015</i>	No Prior Authorization Required AVONEX (interferon beta 1a) BETASERON (interferon beta 1b)	Prior Authorization Required AUBAGIO (teriflunomide) AMPYRA (dalfampridine) COPAXONE 40MG INJECTION (glatiramer)	Non-preferred Interferon products will be approved if the member has failed treatment with three preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Copaxone® 40mg will be approved for members who have a severe intolerable injection site reactions (e.g. pain requiring local anesthetic, oozing, lipoatrophy, swelling, or ulceration) to Copaxone 20mg.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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	<p>*GILENYA (fingolimid) (2nd line)</p> <p>REBIF (interferon beta 1a)</p> <p>COPAXONE 20MG INJECTION (glatiramer)</p>	<p>EXTAVIA (interferon beta 1b)</p> <p>GLATOPIA (glatiramer)</p> <p>PLEGRIDY (peg-interferon beta 1a)</p> <p>TECFIDERA (dimethyl fumarate)</p>	<p>Ampyra – Up to a 90 day supply of Ampyra will be approved if all of the following criteria are met:</p> <ul style="list-style-type: none"> • Member has a diagnosis of MS; • Member is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment; • Member has no history of seizure disorder; • Member has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min); • Prescriber is a neurologist; • The prescribed dose does not exceed 10 mg twice daily. <p>Extended coverage of Ampyra (up to one year) will be approved if documentation shows a 20% improvement in ambulation (measured by T25FW assessment) after three months of therapy.</p> <p>AUBAGIO will be approved if the member has met all the following criteria:</p> <ul style="list-style-type: none"> • In members without a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product AND GILENYA. [Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial)] <p>OR</p> <ul style="list-style-type: none"> • In members with a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: <ul style="list-style-type: none"> • On MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy. • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer. <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> • Is being prescribed by a neurologist AND • Has no active infections AND • If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND • Had transaminase and bilirubin levels with ALT<2 times the upper limit of normal within the 6 months prior to initiating therapy AND • Had a complete blood count with differential within the six months prior to initiating therapy AND • Has a documented baseline blood pressure AND • Has been evaluated for active or latent tuberculosis infections by documented test results (purified protein derivative test) or blood test. <p>TECFIDERA will be approved if the member has met all the following criteria:</p> <ul style="list-style-type: none"> • In members without a contraindication to GILENYA, member has failed COPAXONE or a preferred interferon product and GILENYA. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial) OR • In members with a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: <ul style="list-style-type: none"> • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer. <p>AND</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy. <p>*GILENYA will be approved if the member has met all the following criteria:</p> <ul style="list-style-type: none"> • Has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects (3 month trial), drug-drug interaction, or lack of efficacy (6 month trial). Lack of efficacy will be defined as one of the following: <ul style="list-style-type: none"> • One of the following on MRI: presence of any new spinal lesions, cerebellar or brain stem lesions, or change in brain atrophy • On clinical exam, signs and symptoms consistent with functional limitations that last one month or longer. <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or New York Heart Association Class III-IV heart failure within six months of initiating therapy <p>AND</p> <ul style="list-style-type: none"> • Does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome unless patient has a pacemaker <p>AND</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> • Has a baseline QTc interval <500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Has no active infections AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy within 3-4 months after starting therapy AND • Had a baseline complete blood count with differential and liver function tests. <p>Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, and AUBAGIO can receive approval to continue on that agent.</p>
OPHTHALMIC ALLERGY <i>Effective 4/1/2015</i>	No Prior Authorization Required Cromolyn PATANOL (olopatadine) PATADAY (olopatadine)	Prior Authorization Required ALAMAST (pemirolast) ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) BEPREVE (bepotastine) ELESTAT (epinastine) EMADINE (emedastine) LASACRAFT (alcaftadine) OPTICROM (sodium cromoglicate) OPTIVAR (azelastine) ZADITOR (ketotifen)	Non-preferred Ophthalmic Allergy medications will be approved if the member has failed treatment with two preferred products in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)
OPIOIDS Long Acting – Oral Opioids	FIRST LINE (No PA Required)	PA Required *BUTRANS (buprenorphine)	Non-preferred, long-acting oral opioids will be approved for members who have failed treatment with two preferred agents in the last six

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<i>Effective 7/1/2015</i>	fentanyl patches methadone (generic Dolophine) morphine ER (generic MS Contin) tramadol ER	CONZIP (TRAMADOL ER) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) EMBEDA (morphine/naltrexone) HYSINGLA (hydrocodone ER) KADIAN (morphine ER) MS CONTIN (morphine ER) NUCYNTA ER (tapentadol ER) OPANA ER (oxymorphone ER) ORAMORPH SR (morphine ER) OXYCONTIN (oxycodone ER) TARGINIQ ER (oxycodone ER) XARTEMIS XR (oxycodone/acetaminophen) ZOXYDRO ER (hydrocodone ER)	<p>months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Fentanyl patches (Duragesic) will require a PA for doses of more than 1 patch/2 days.</p> <p>*Butrans patches will be approved for members who have failed treatment with ONE preferred agent in the last 6 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Zohydro ER and Hysingla® ER will be approved for members who have failed treatment with two preferred products, AND at least one other long acting opiate in the past year.</p> <p>Oxycontin®, Opana ER®, Nucynta ER®, and Zohydro ER® will only be approved for twice daily dosing.</p> <p>Hysingla ER® will only be approved for once daily dosing.</p> <p>No more than one long-acting oral opioid will be approved at one time.</p> <p>Medicaid is not mandating that a patient switch from a non-preferred drug to methadone. Methadone requires special training due to its complex pharmacokinetic profile. However, if a patient has tried and failed methadone in the past, it can be considered a trial of one preferred drug.</p> <p>Use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome. Providers MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of neonatal abstinence syndrome. Providers should offer access to contraceptive services when necessary.</p>
OVERACTIVE BLADDER AGENTS <i>Effective 10/1/15</i>	No Prior Authorization Required oxybutynin tablets (generic)	Prior Authorization Required DETROL (tolterodine) DETROL LA (tolterodine ER)	Non-preferred products will be approved for members who have failed treatment with two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxbutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine VESICARE (solifenacin) MYRBETRIQ (mirabegron)	Members with hepatic failure can receive approval to receive trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.
PANCREATIC ENZYMES <i>Effective 1/1/2015</i>	No PA Required CREON (pancrelipase) ZENPEP (pancrelipase)	PA Required PANCREAZE (pancrelipase) PANCRELIPASE (pancrelipase) PERTZYE (pancrelipase) ULTRESA (pancrelipase) VIOKACE (pancreatin)	Non-preferred products will be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) Grandfathering: Members currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.
PROTON PUMP INHIBITORS <i>Effective 1/1/2015</i>	*Must meet eligibility criteria lansoprazole 15mg OTC (currently available as PREVACID 24HR)	PA Required ACIPHEX tab, sprinkles (rabeprazole) DEXILANT (dexlansoprazole)	*PA will be required for therapy beyond 60 days of treatment per year for all agents. For members treated for GERD, once 60 days of therapy per year has been exceeded, members must fail an adequate trial of a histamine 2 receptor antagonist before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	<p>NEXIUM (esomeprazole) capsules and packets ^{BNR}</p> <p>omeprazole generic capsules</p> <p>pantoprazole tablets</p> <p>PREVACID solutab ^{BNR} (lansoprazole) (for members under 2)</p>	<p>KAPIDEX (dexlansoprazole)</p> <p>Esomeprazole (generic Nexium)</p> <p>Esomeprazole strontium</p> <p>lansoprazole capsules</p> <p>NEXIUM 24 hour</p> <p>PREVACID (lansoprazole) capsules & suspension</p> <p>PRILOSEC OTC (omeprazole)</p> <p>PROTONIX (pantoprazole) tablets and suspension</p> <p>rabeprazole (generic Aciphex)</p> <p>ZEGERID (omeprazole/Na bicarbonate)</p>	<p>Long-term therapy will be approved for members with Barrett’s Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID or prednisone therapy, Spinal Cord Injury members with an acid reflux diagnosis, or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube. In addition, members with continuing, symptomatic GERD or recurrent peptic ulcer disease who have documented failure on step-down therapy to an H2-receptor antagonist will be approved for up to one year of daily PPI therapy.</p> <p>Non-preferred proton pump inhibitors will be approved if all of the following criteria are met:</p> <ul style="list-style-type: none"> ➤ Member failed treatment with two Preferred Products within the last 24 months, ➤ Member has a qualifying diagnosis, and ➤ Member has been diagnosed by an appropriate diagnostic method. <p>The Qualifying Diagnoses are: Barrett’s Esophagus, Duodenal Ulcer, Erosive Esophagitis, Gastric Ulcer, GERD, GI Bleed, H. pylori, Hypersecretory Conditions (Zollinger-Ellison), NSAID-Induced Ulcer, Pediatric Esophagitis, Recurrent Aspiration Syndrome or Ulcerative GERD</p> <p>The Appropriate Diagnostic Methods are: GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test</p> <p>Quantity Limits: Non-preferred agents will be limited to once daily dosing except for the following diagnoses: Barrett’s Esophagus, GI Bleed, H. pylori, Hypersecretory Conditions, or Spinal Cord Injury patients with any acid reflux diagnosis.</p> <p>Age Limits: Aciphex, Protonix, and Zegerid will not be approved for members less than 18 years of age. Prevacid Solutab will be approved for members less than 2 years old and ≥ 2 years with a feeding tube.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
H. Pylori Treatments	NONE	HELIDAC (tetracycline/tripotassium dicitrateobismuthate/metronidazole) OMECLAMOX-PAK (amoxicillin/omeprazole/clarithromycin) PREVPAC (amoxicillin/lansoprazole/clarithromycin) amoxicillin/lansoprazole/clarithromycin PYLERA (bismuth subcitrate/metronidazole/tetracycline)	H. Pylori treatments should be used as individual products unless one of the individual products is not commercially available then a PA for the combination product will be given.
PULMONARY ARTERIAL HYPERTENSION THERAPIES Phosphodiesterase Inhibitors <i>Effective 1/1/2015</i>	*Must meet eligibility criteria Sildenafil (generic Revatio)	PA Required ADCIRCA (tadalafil) REVATIO (sildenafil)	*Eligibility Criteria for all agents in the class Approval will be granted for a diagnosis of pulmonary hypertension. Grandfathering: Members currently stabilized on Adcirca can receive approval to continue on that agent for one year if medically necessary.
Endothelin Antagonists <i>Effective 1/1/2015</i>	No PA Required LETAIRIS (ambrisentan)	PA Required OPSUMIT (macitentan) TRACLEER (bosentan)	Non-preferred products will be approved for members who have failed treatment with Letairis or for members requiring a dose preparation not available with a preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) Grandfathering: Members who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Prostanoids <i>Effective 1/1/2015</i>	No PA Required epoprostenol (generic)	PA Required FLOLAN (brand) (epoprostenol) ORENITRAM (treprostiniil) REMODULIN (treprostiniil) TYVASO (treprostiniil) VELETRI (epoprostenol) VENTAVIS (iloprost)	Non-preferred products will be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Guanylate Cyclase (sGC) Stimulator <i>Effective 1/1/2015</i>	No PA Required	PA Required ADEMPAS (riociguat)	Adempas will be approved for patients who meet the following criteria: <ul style="list-style-type: none"> ○ Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND ○ Women of childbearing potential and their male partners must use one of the following contraceptive methods during treatment and one month after stopping treatment (e.g, IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method). AND ○ Patient is not receiving dialysis or has severe renal failure (e.g, Crcl < 15 ml/min). AND ○ Patient does not have severe liver impairment (e.g, Child Pugh C). AND ○ Prescriber must be enrolled with the Adempas REMS Program. AND ○ Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND ○ Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR ○ Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
RESPIRATORY INHALANTS Inhaled Anticholinergics & Anticholinergic Combinations <i>Effective 7/1/2015</i>	No PA Required <u>Solutions</u> albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) <u>Short-Acting Inhalers</u> ATROVENT HFA (ipratropium)	PA Required <u>Solutions</u> ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium) <u>Short-Acting Inhalers</u> <u>Long-Acting Inhalers</u> TUDORZA Pressair (aclidinium)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name PA stating medical necessity. ATROVENT® solution and DUONEB ® will require a brand-name prior authorization stating medical necessity. Non-preferred anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have failed treatment with Spiriva Handihaler® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction or who have a contraindication to Spiriva Handihaler.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	COMBIVENT RESPIMAT (albuterol/ipratropium) <u>Long-Acting Inhalers</u> SPIRIVA Handihaler (tiotropium)	INCRUSE ELLIPTA (umeclidinium) ANORO ELLIPTA (umeclidinium/vilanterol) SPIRIVA RESPIMAT (tiotropium) STIOLTO Respimat (tiotropium/olodaterol)	Non-preferred combination anticholinergic agents will be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema AND has failed treatment with Combivent Respimat® (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction), OR who have a contraindication to Combivent Respimat®.
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (short acting) <i>Effective 7/1/2015</i>	<p align="center">No PA Required</p> <u>Solutions</u> albuterol (generic) solution <u>Inhalers</u> PROAIR (albuterol) HFA inhaler	<p align="center">PA Required</p> <u>Solutions</u> ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. <u>Inhalers</u> ALUPENT (metaproterenol) Inhaler MAXAIR (pirbuterol) autohaler PROAIR Respiclick PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler XOPENEX (levalbuterol) Inhaler	Non-preferred, short acting beta2 agonists will be approved for members who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Proair HFA, Proventil HFA, Ventolin HFA: Quantity limits: 2 inhalers / 30 days (will go into effect late 2015)

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (long acting) <i>Effective 7/1/2015</i>	No PA Required	PA Required <u>Solutions</u> BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution <u>Inhalers</u> ARCAPTA (indacaterol) neohaler FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler STRIVERDI RESPIMAT (olodaterol)	Long acting beta-2 agonists will be approved for members with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for members with moderate to very severe COPD.
RESPIRATORY INHALANTS Inhaled Corticosteroids <i>Effective 7/1/2015</i>	No PA Required <u>Solutions</u> budesonide nebulas 0.25mg and 0.5mg PULMICORT (budesonide) nebulas 1mg <u>Inhalers</u> ASMANEX twist (mometasone) FLOVENT (fluticasone) diskus FLOVENT (fluticasone) HFA QVAR (beclomethasone)	PA Required <u>Solutions</u> PULMICORT (budesonide) nebulas 0.25mg and 0.5mg <u>Inhalers</u> AEROBID (flunisolide) inhaler AEROSPAN HFA ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler AZMACORT (triamcinolone) inhaler PULMICORT (budesonide) flexhaler	Non-preferred inhaled corticosteroids will be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.) Pulmicort Flexhaler will only be approved without failure on preferred products for female members with asthma who have a new diagnosis of pregnancy. Budesonide nebulizer solution will only be approved for a maximal dose of 2mg/day.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS Inhaled Corticosteroid Combinations <i>Effective 7/1/2015</i>	No PA Required ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA 13gram canister (mometasone/formoterol)	PA Required BREO Ellipta (vilanterol/fluticasone furoate) DULERA 8.8 gram canister (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	Non-preferred inhaled corticosteroid combination inhalants will be approved for members meeting the following criteria: <ul style="list-style-type: none"> ➤ Member has a qualifying diagnosis of asthma or COPD; and ➤ Members with a diagnosis of asthma will have to fail two preferred agents due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. ➤ Members with a diagnosis of COPD will only have to fail one preferred agent due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.
SEDATIVE- HYPNOTICS (non-benzodiazepine) <i>Effective 4/1/2015</i>	No PA Required* (unless duplication criteria apply) eszopiclone zaleplon zolpidem	PA Required AMBIEN (zolpidem) BELSOMRA (suvorexant) AMBIEN CR (zolpidem) EDLUAR (zolpidem) INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SONATA (zaleplon) ZOLPIMIST (zolpidem)	Non-preferred sedative hypnotics will be approved for members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) BELSOMRA (suvorexant) will be approved for members that meet the following criteria: <ul style="list-style-type: none"> • Members who have failed treatment with two preferred agents in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND • Member is not receiving strong inhibitors (e.g. erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g. carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St Johns Wort) of CYP3A4 AND • Member does not have a diagnosis for narcolepsy Sedative hypnotics will require PA for member's ≥ 65 years of age exceeding 90 days of therapy. Rozerem will be approved for members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>Children: PAs will be approved for members 18 years of age and older.</p> <p>*Duplications: Only one agent in this drug class will be approved at a time. Approval will not be granted for members currently taking a long-acting benzodiazepine such as clonazepam or temazepam.</p>
<p>SKELETAL MUSCLE RELAXANTS</p> <p><i>Effective 7/1/2015</i></p>	<p>No PA Required For Members under 65 years of age*</p> <p>baclofen (generic Lioresal)</p> <p>cyclobenzaprine (generic Flexeril) 5mg and 10mg tabs</p> <p>tizanidine (generic Zanaflex) 2mg and 4mg tab</p>	<p>PA Required</p> <p>AMRIX ER (cyclobenzaprine ER)</p> <p>carisoprodol</p> <p>chlorzoxazone</p> <p>cyclobenzaprine 7.5mg tabs</p> <p>DANTRIUM (dantrolene)</p> <p>dantrolene</p> <p>FEXMID (cyclobenzaprine)</p> <p>FLEXERIL (cyclobenzaprine)</p> <p>metaxolone</p> <p>methocarbamol</p> <p>NORFLEX (orphenadrine)</p> <p>orphenadrine</p> <p>PARAFLEX (chlorzoxazone)</p> <p>PARAFON FORTE (chlorzoxazone)</p> <p>REMULAR (chlozoxone)</p> <p>ROBAXIN (methocarbamol)</p>	<p>All agents in this class will require a PA for members over 65 years of age. Approval will only be given if the member has had at least a 7 day trial with an opiate or has a diagnosis of spasticity. The maximum allowable approval will be for a 7 days' supply.</p> <p>Non-preferred skeletal muscle relaxants will be approved for members who have documented lack of efficacy with two preferred agents in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.)</p> <p>Authorization for any carisoprodol product will be given for a maximum 3 week one time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with two preferred products.</p> <p>Tapering: Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for members tapering off of carisoprodol. *A PA will only be granted for any carisoprodol product for short-term use or tapering.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		SKELAXIN (metaxalone) SOMA (carisoprodal) tizanidine 2, 4, 6mg caps ZANAFLEX (tizanadine) VANADOM (carisoprodal)	
STATINS <i>Effective 4/1/2015</i>	No PA Required atorvastatin CRESTOR (rosuvastatin) pravastatin simvastatin*	PA Required ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin)	Non-preferred Statin/Statin combinations will be approved if the member has failed treatment with two preferred products in the last 24 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Children: Altoprev, Advicor, Livalo and Vytorin will be approved for members 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for members 10 years of age and older. *Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication titled, "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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
STATIN COMBINATIONS <i>Effective 4/1/2015</i>		ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) LIPTRUZET (ezetimibe/ atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvastatin.)	
STIMULANTS and other ADHD agents <i>Effective 10/1/2015</i>	<p align="center">No PA Required (as long as age, daily dose and diagnosis limitations are met)</p> ADDERALL IR (mixed-amphetamine salts) ADDERALL XR ^{*BNR*} (mixed amphetamine salts ER) FOCALIN IR ^{*BNR*} (brand name dexmethylphenidate) FOCALIN XR ^{*BNR*} (dexmethylphenidate ER) INTUNIV ^{*BNR*} (guanfacine ER) Methylphenidate IR (generic Ritalin IR)	<p align="center">PA Required</p> APTENSIO XR (methylphenidate XR) CONCERTA (methylphenidate ER) DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexmethylphenidate (generic Focalin IR) dexmethylphenidate (generic Focalin XR) EVEKEO (amphetamine)	<p>For beneficiaries with ADD/ADHD or narcolepsy warranting treatment with a stimulant or non-stimulant (either preferred or non-preferred), a diagnosis of ADD/ADHD or narcolepsy must be documented in the beneficiaries medical record at the time of diagnosis and annually.</p> <p>For patients with ADD/ADHD, prior to receiving pharmacotherapy, the beneficiary must have additional documentation through a validated ADHD/ADD instrument.</p> <p>For beneficiaries with ADD/ADHD who are currently receiving a stimulant or non-stimulant but does not have an official diagnosis of ADD/ADHD, the beneficiary will have six months to obtain a diagnosis otherwise the medication will be discontinued.</p> <p>Non-preferred agents will be approved for members who have documented failure with two preferred products in the last 12 months (age six years or older) or documented failure with one preferred products in the last 12 months if ages 3 – 5 years (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). However, certain exceptions exist for Daytrana, Intuniv, Methylin solution, Quillivant XR, Nuvigil and Provigil. Please see the criteria below.</p> <p>In addition:</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	Methylphenidate LA (generic Ritalin LA) methylphenidate ER (generic Concerta) mixed-amphetamine salts (generic Adderall IR) RITALIN IR (methylphenidate) RITALIN LA (methylphenidate LA) STRATTERA (atomoxetine) ^{*BNR*} VYVANSE (lisdexamfetamine)	KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) Methylphenidate (generic RITALIN) mixed-amphetamine salts ER (generic for Adderall XR) modafanil (generic PROVIGIL) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid) PROVIGIL (modafinil) QUILLIVANT XR (methylphenidate) ZENZEDI (dextroamphetamine)	Non-preferred agents will only be approved for FDA and official compendium indications. <ul style="list-style-type: none"> ▪ Provigil will only be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Traumatic Brain Injury, Multiple Sclerosis related fatigue or ADHD. Only a maximum of 400mg per day will be approved. ▪ Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. Beneficiaries with ADD/ADHD must fail a 4 week trial of a preferred stimulant before the use of Nuvigil® will be approved. Only one tablet per day will be approved. ▪ All other Non-preferred products will be approved for members with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism. ▪ Daytrana, Methylin solution and Quillivant XR: Members with documented difficulty swallowing that are unable to utilize alternative dosing with FOCALIN XR, VYVANSE or ADDERALL XR can receive approval without failure on preferred products. Provider must document contraindications. <p>And</p> Non-preferred agents will only be approved for FDA approved age limitations. <ul style="list-style-type: none"> ▪ Provigil will be approved for members 16 years of age and older. ▪ Nuvigil will be approved for members 17 years of age and older. ▪ Adderall IR, Dexedrine and Dextrostat will be approved for members 3 years of age and older. ▪ All other medications in this class will be approved for members 6 years of age and older. <p>Below are the FDA recommended maximum daily doses:</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<table border="1"> <thead> <tr> <th data-bbox="1257 241 1646 269">Drug</th> <th data-bbox="1646 241 2037 269">Maximum Daily Dose</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="1257 269 2037 297">Preferred</td> </tr> <tr> <td data-bbox="1257 297 1646 324">ADDERALL ®</td> <td data-bbox="1646 297 2037 324">40 mg/day</td> </tr> <tr> <td data-bbox="1257 324 1646 352">ADDERALL XR®</td> <td data-bbox="1646 324 2037 352">40mg/day</td> </tr> <tr> <td data-bbox="1257 352 1646 380">AMPHETAMINE SALTS</td> <td data-bbox="1646 352 2037 380">40 mg/day</td> </tr> <tr> <td data-bbox="1257 380 1646 407">DESOXYN ®</td> <td data-bbox="1646 380 2037 407">25mg/day</td> </tr> <tr> <td data-bbox="1257 407 1646 435">DEXEDRINE ®</td> <td data-bbox="1646 407 2037 435">40mg/day</td> </tr> <tr> <td data-bbox="1257 435 1646 462">DEXTROSTAT ®</td> <td data-bbox="1646 435 2037 462">40mg/day</td> </tr> <tr> <td data-bbox="1257 462 1646 490">FOCALIN ®</td> <td data-bbox="1646 462 2037 490">20 mg/day</td> </tr> <tr> <td data-bbox="1257 490 1646 518">FOCALIN XR ®</td> <td data-bbox="1646 490 2037 518">40 mg/day</td> </tr> <tr> <td data-bbox="1257 518 1646 545">METHYLPHNIDATE ER</td> <td data-bbox="1646 518 2037 545">60 mg/day</td> </tr> <tr> <td data-bbox="1257 545 1646 573">INTUNIV ER®</td> <td data-bbox="1646 545 2037 573">4 mg/day</td> </tr> <tr> <td data-bbox="1257 573 1646 600">RITALIN® IR</td> <td data-bbox="1646 573 2037 600">60 mg/day</td> </tr> <tr> <td data-bbox="1257 600 1646 628">RITALIN LA ®</td> <td data-bbox="1646 600 2037 628">60 mg/day</td> </tr> <tr> <td data-bbox="1257 628 1646 656">STRATTERA®</td> <td data-bbox="1646 628 2037 656">100 mg/day</td> </tr> <tr> <td data-bbox="1257 656 1646 683">VYVANSE ®</td> <td data-bbox="1646 656 2037 683">70 mg/day</td> </tr> <tr> <td colspan="2" data-bbox="1257 683 2037 711">Non preferred</td> </tr> <tr> <td data-bbox="1257 711 1646 738">D-AMPHETAMINE ER</td> <td data-bbox="1646 711 2037 738">40 mg/day</td> </tr> <tr> <td data-bbox="1257 738 1646 766">DAYTRANA ®</td> <td data-bbox="1646 738 2037 766">30 mg/day</td> </tr> <tr> <td data-bbox="1257 766 1646 794">CONCERTA ER ®</td> <td data-bbox="1646 766 2037 794">54 mg/day or 72 mg/day > age 13</td> </tr> <tr> <td data-bbox="1257 794 1646 821">KAPVAY ER®</td> <td data-bbox="1646 794 2037 821">0.1 mg/day</td> </tr> <tr> <td data-bbox="1257 821 1646 849">METHYLIN ER ®</td> <td data-bbox="1646 821 2037 849">60 mg/day</td> </tr> <tr> <td data-bbox="1257 849 1646 876">METHYLIN</td> <td data-bbox="1646 849 2037 876">60 mg/day</td> </tr> <tr> <td data-bbox="1257 876 1646 904">METHYLIN SUSPENSION®</td> <td data-bbox="1646 876 2037 904">60 mg/day</td> </tr> <tr> <td data-bbox="1257 904 1646 932">METADATE CD ®</td> <td data-bbox="1646 904 2037 932">60mg/day</td> </tr> <tr> <td data-bbox="1257 932 1646 959">METADATE ER ®</td> <td data-bbox="1646 932 2037 959">60mg/day</td> </tr> <tr> <td data-bbox="1257 959 1646 987">METHYLPHENIDATE</td> <td data-bbox="1646 959 2037 987">60 mg/day</td> </tr> <tr> <td data-bbox="1257 987 1646 1015">PROVIGIL ®</td> <td data-bbox="1646 987 2037 1015">400 mg/day</td> </tr> <tr> <td data-bbox="1257 1015 1646 1042">NUVIGIL ®</td> <td data-bbox="1646 1015 2037 1042">250 mg/day</td> </tr> <tr> <td data-bbox="1257 1042 1646 1070">QUILLIVANT XR®</td> <td data-bbox="1646 1042 2037 1070">60 g/day</td> </tr> </tbody> </table>	Drug	Maximum Daily Dose	Preferred		ADDERALL ®	40 mg/day	ADDERALL XR®	40mg/day	AMPHETAMINE SALTS	40 mg/day	DESOXYN ®	25mg/day	DEXEDRINE ®	40mg/day	DEXTROSTAT ®	40mg/day	FOCALIN ®	20 mg/day	FOCALIN XR ®	40 mg/day	METHYLPHNIDATE ER	60 mg/day	INTUNIV ER®	4 mg/day	RITALIN® IR	60 mg/day	RITALIN LA ®	60 mg/day	STRATTERA®	100 mg/day	VYVANSE ®	70 mg/day	Non preferred		D-AMPHETAMINE ER	40 mg/day	DAYTRANA ®	30 mg/day	CONCERTA ER ®	54 mg/day or 72 mg/day > age 13	KAPVAY ER®	0.1 mg/day	METHYLIN ER ®	60 mg/day	METHYLIN	60 mg/day	METHYLIN SUSPENSION®	60 mg/day	METADATE CD ®	60mg/day	METADATE ER ®	60mg/day	METHYLPHENIDATE	60 mg/day	PROVIGIL ®	400 mg/day	NUVIGIL ®	250 mg/day	QUILLIVANT XR®	60 g/day
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TARGETED IMMUNE MODULATORS <i>Effective 1/1/2015</i>	No PA Required ENBREL (etanercept) HUMIRA (adalimumab)	PA Required ACTEMRA (tocilizumab) CIMZIA (certolizumab)	Actemra (SQ) will be approved for treatment of RA in members who have had treatment failure with at least one conventional DMARD (e.g, methotrexate, leflmonide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects or significant drug-drug interaction.) Cimzia (all dosage forms)																																																												

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		COSENTYX (secukinumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous OTEZLA (apremilast) SIMPONI (golimumab) STELARA (ustekinumab) XELJANZ (tofacitinib) *for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P	<ul style="list-style-type: none"> will be approved for treatment of Crohn’s disease in members who have had treatment failure with Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.) will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.) <p>Kineret will be approved for treatment of RA in members who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Kineret will be approved without PA for members with documented neonatal-onset multisystem inflammatory disease (NOMID).</p> <p>Orencia will be approved for the treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Orencia will be approved for the treatment juvenile idiopathic arthritis who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Simponi will be approved (in combination with methotrexate) for treatment of RA in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Simponi will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in members who have</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction).</p> <p>Simponi will be approved for treatment of ulcerative colitis in members who have tried and failed Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Stelara will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Stelara will be approved for moderate to severe plaque psoriasis in members who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Xeljanz will be approved for the treatment of RA in members who have had treatment failure with methotrexate, Humira, and Enbrel (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Xeljanz will not be approved for combination therapy with a biologic disease modifying agent.</p> <p>Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply</p>
TESTOSTERONE PRODUCTS <i>Effective 7/1/2015</i>	No PA required (must meet criteria) ANDROGEL 1.62% (testosterone topical) ANDRODERM (testosterone patch) DEPO TESTOSTERONE (testosterone cypionate injection)	PA Required ANDROGEL 1% AXIRON FORTESTA gel NATESTO STRIANT	Preferred androgenic drugs will be approved for members meeting the following: <i>Hypogonadotropic or Primary Hypogonadism</i> <ul style="list-style-type: none"> • Male patient ≥18 years of age • Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND • Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND • Does not have a diagnosis of breast or prostate cancer AND

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	Testosterone Cypionate	TESTIM gel Testosterone Enanthate VOGELXO	<ul style="list-style-type: none"> Does not have a palpable prostate nodule or prostate-specific antigen (PSA) >4ng/ml AND Has normal liver function tests prior to initiation of therapy <p><i>Gender Transition</i></p> <ul style="list-style-type: none"> Biologically born female patient ≥ 18 years of age* AND Is undergoing female to male transition AND Has a negative pregnancy test prior to initiation AND Has normal liver function test prior to initiation of therapy <p>*For members <18 years of age, a manual review will be required.</p> <p>Non preferred androgenic products will be approved for patients meeting the above criteria with documented failure with an 8 week trial of a preferred androgenic product. (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Grandfathering: Members may be grandfathered on preferred agents without requirement of updated low serum testosterone laboratory testing that meet the following criteria:</p> <ul style="list-style-type: none"> Male patient ≥ 18 years of age AND Has at least one past documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND Has documented diagnosis of hypogonadotropic or primary hypogonadism AND Does not have a diagnosis of breast or prostate cancer AND Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL
TOPICAL IMMUNOMODULATORS <i>Effective 7/1/2015</i>	No PA Required (must meet criteria) ELIDEL (pimecrolimus)*	PA Required PROTOPIC (tacrolimus) Tacrolimus (generic Protopic)	<p>*Elidel will only be approved after a member has had an adequate trial (e.g., one month or longer) of a topical steroid and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time PA.</p> <p>Protopic will only be approved for a member who had an adequate trial (e.g. one month or longer) of a topical steroid and Elidel and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time PA.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>PA is required for children < 2 years of age.</p> <p>PA will be required for members warranting \geq 6 weeks of therapy with either Elidel or Protopic.</p>
TRIPTANS <i>Effective 1/1/2015</i>	<p>No PA Required (monthly quantity limits may apply)</p> <p>IMITREX ^{BNR} (sumatriptan) nasal spray and injection</p> <p>naratriptan tablets</p> <p>RELPAX ^{BNR} (eletriptan)</p> <p>rizatriptan MLT tablets</p> <p>sumatriptan tablets</p>	<p>PA Required</p> <p>AMERGE (naratriptan)</p> <p>AXERT (almotriptan)</p> <p>FROVA (frovatriptan)</p> <p>IMITREX (sumatriptan) tablets</p> <p>MAXALT MLT tablets (rizatriptan)</p> <p>Maxalt tablets (rizatriptan)</p> <p>SUMAVEL DOSEPRO (sumatriptan)</p> <p>TREXIMET (sumatriptan and naproxen)</p> <p>sumatriptan nasal spray and injection</p> <p>ZEQUITY patch (sumatriptan)</p> <p>ZOMIG (zolmitriptan)</p>	<p>Non-preferred products will be approved for members who have failed treatment with two Preferred Products within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p>Quantity Limits: Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days. Axert and Relpax: Max 6 tabs / 30 days. Imitrex injection: Max 4 injectors / 30 days Maxalt: Max 12 tabs / 30 days. Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days. Zequity patch: Max 4 patches /30 days</p>