



COLORADO

Department of Health Care
Policy & Financing

**Colorado Department of Health Care Policy and Financing
Preferred Drug List (PDL)
Effective July 1, 2016**

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 4/1/2016</i>	No PA Required (*Must meet eligibility criteria) Donepezil tab Donepezil ODT Galantamine Galantamine ER Memantine	PA Required ARICEPT (donepezil) ARICEPT 23mg (donepezil) ARICEPT ODT (donepezil) EXELON (rivastigmine) (cap, soln. and patch) MESTINON (pyridostigmine) (tab, syrup) NAMENDA IR (memantine) NAMENDA XR (memantine) NAMZARIC (memantine/donepezil) RAZADYNE (galantamine) (tab, oral soln) 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.

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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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) SAVAYSA (edoxaban)	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 • 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) PRADAXA® will be approved if: <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
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			<ul style="list-style-type: none"> ○ 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) <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
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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"> • 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"> ○ 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>
ANTI-EMETICS <i>Effective 1/1/2016</i>	No PA Required Ondansetron tablets Ondansetron ODT tab Ondansetron oral solution (members under 5 years only) DICLEGIS (doxylamine/pyridoxine)	PA Required AKYNZEO (netupitant/palansetron) ANZEMET (dolasetron) EMEND (aprepitant) KYTRIL (granisetron) SANCUSO (granisetron) VARUBI (rolapitant) ZOFTRAN (ondansetron) tabs ZOFTRAN (ondansetron) suspension ZOFTRAN ODT (ondansetron) ZUPLENZ (ondansetron)	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.) Ondansetron suspension will be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube. Diclegis will be approved if the member has nausea and vomiting associated with pregnancy . 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. 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.

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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ANTI-DEPRESSANTS Newer Generation Antidepressants <i>Effective 1/1/2016</i>	No PA Required Bupropion IR, SR, XL Citalopram Escitalopram Fluoxetine Mirtazapine Paroxetine Sertraline Venlafaxine IR tabs Venlafaxine XR capsules	PA Required APLENZIN ER (bupropion ER) 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)	<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> <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 two 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 demonstrated failure on a one month consecutive trial of two analgesic agents (e.g. acetaminophen, NSAID) at maximally tolerated doses.</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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		TRINTELLIX (vortioxetine) VIIBRYD (vilazodone) WELLBUTRIN IR, SR, XL													
ANTI-HERPETIC AGENTS <i>Effective 1/1/2016</i>	No PA Required Acyclovir tablet, capsule, suspension (generic)	PA Required FAMVIR (famciclovir) Famcyclovir SITAVIG (acyclovir) VALTREX (valacyclovir) Valacyclovir VALCYTE (valgancyclovir) Valgancyclovir (oral solution) ZOVIRAX (acyclovir)	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) <table border="1" data-bbox="1226 573 2018 1352"> <thead> <tr> <th data-bbox="1226 573 1444 605">Indication</th> <th data-bbox="1444 573 1698 605">Adult</th> <th data-bbox="1698 573 2018 605">Pediatric</th> </tr> </thead> <tbody> <tr> <td data-bbox="1226 605 1444 743">Genital herpes simplex: Initial</td> <td data-bbox="1444 605 1698 743">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="1698 605 2018 743">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="1226 743 1444 1076">Genital herpes simplex: episodic</td> <td data-bbox="1444 743 1698 1076">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="1698 743 2018 1076">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="1226 1076 1444 1352">Genital herpes simplex: Suppressive An adequate trial of acyclovir for Genital Herpes Simplex (Suppressive) will be one month.</td> <td data-bbox="1444 1076 1698 1352">400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.</td> <td data-bbox="1698 1076 2018 1352">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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			<table border="1"> <tr> <td data-bbox="1234 241 1444 472">Genital Herpes Simplex with HIV infection: Initial or Recurrent</td> <td data-bbox="1444 241 1698 472">400 mg ORALLY 3 times daily for 5 to 14 days</td> <td data-bbox="1698 241 2005 472">< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours. Adolescents: 400 mg ORALLY twice daily for 5 to 14 days.</td> </tr> <tr> <td data-bbox="1234 472 1444 643">Genital Herpes Simplex with HIV infection: Chronic suppression</td> <td data-bbox="1444 472 1698 643">400 mg orally twice daily</td> <td data-bbox="1698 472 2005 643"></td> </tr> <tr> <td data-bbox="1234 643 1444 699">Herpes labialis</td> <td data-bbox="1444 643 1698 699">400 mg orally 3 times daily for 5 to 10 days</td> <td data-bbox="1698 643 2005 699"></td> </tr> <tr> <td data-bbox="1234 699 1444 784">Herpes zoster, Shingles</td> <td data-bbox="1444 699 1698 784">800 mg orally every 4 hours 5 times a day for 7 to 10 days</td> <td data-bbox="1698 699 2005 784"></td> </tr> <tr> <td data-bbox="1234 784 1444 898">Herpes Zoster, Shingles with HIV infection</td> <td data-bbox="1444 784 1698 898">800 mg orally 5 times daily for 7 to 10 days</td> <td data-bbox="1698 784 2005 898"></td> </tr> <tr> <td data-bbox="1234 898 1444 1036">Varicella</td> <td data-bbox="1444 898 1698 1036">800 mg orally 4 times a day for 5 days</td> <td data-bbox="1698 898 2005 1036">2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days</td> </tr> <tr> <td data-bbox="1234 1036 1444 1190">Varicella with HIV infection</td> <td data-bbox="1444 1036 1698 1190">20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days</td> <td data-bbox="1698 1036 2005 1190">20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours.</td> </tr> </table>	Genital Herpes Simplex with HIV infection: Initial or Recurrent	400 mg ORALLY 3 times daily for 5 to 14 days	< 45 kg: 20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours. Adolescents: 400 mg ORALLY twice daily for 5 to 14 days.	Genital Herpes Simplex with HIV infection: Chronic suppression	400 mg orally twice daily		Herpes labialis	400 mg orally 3 times daily for 5 to 10 days		Herpes zoster, Shingles	800 mg orally every 4 hours 5 times a day for 7 to 10 days		Herpes Zoster, Shingles with HIV infection	800 mg orally 5 times daily for 7 to 10 days		Varicella	800 mg orally 4 times a day for 5 days	2 years or older: 20 mg/kg ORALLY 4 times a day for 5 days; over 40 kg, 800 mg ORALLY 4 times a day for 5 days	Varicella with HIV infection	20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days	20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours.
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ANTI-HISTAMINES Newer Generation Antihistamines <i>Effective 7/1/2016</i>	No PA Required Cetirizine (generic OTC Zyrtec) 5mg and 10mg tab, chew tab, syrup	PA Required ALAVERT (loratadine) ALLEGRA (fexofenadine) CLARINEX (desloratadine)	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. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months. 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.)
	Loratadine (generic OTC Claritin) 10mg tab and syrup	CLARITIN (loratadine) Desloratadine Fexofenadine Levocetirizine Loratadine ODT XYZAL (levocetirizine) ZYRTEC (cetirizine)	
Antihistamine/Decongestant Combinations <i>Effective 7/1/2016</i>	No PA Required	PA Required ALLEGRA-D (fexofenadine/PSE) Cetirizine-D 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 7/1/2016</i>	No PA Required BENICAR (olmesartan) Valsartan Irbesartan Losartan	PA Required ATACAND (candesartan) AVAPRO (irbesartan) Candesartan COZAAR (losartan) DIOVAN (valsartan)	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). Renin inhibitors and combinations will not approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination.

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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		EDARBI (azilsartan) Eprosartan MICARDIS (telmisartan) Telmisartan TEVETEN (eprosartan)	
ARB Combinations <i>Effective 7/1/2016</i>	No PA Required BENICAR HCT *BNR* (olmesartan/HCTZ) DIOVAN HCT *BNR* (valsartan/HCTZ) Losartan/HCTZ	PA Required Amlodipine/valsartan Amlodipine/valsartan/hctz ATACAND HCT (candesartan/HCTZ) Candesartan/HCTZ AVALIDE (irbesartan/HCTZ) AZOR (amlodipine/olmesartan) EDARBYCLOR (azilsartan/chlorthalidone) Eprosartan/HCTZ EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz) HYZAAR HCT (losartan/hctz)	

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		Irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) Telmisartan/HCTZ Telmisartan/amlodipine TEVETEN HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) Valsartan/HCTZ	
Renin Inhibitors & Renin Inhibitor Combinations <i>Effective 7/1/2016</i>	No PA Required	PA Required TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	
ANTI-PLATELETS <i>Effective 1/1/2016</i>	No PA Required AGGRENOX (ASA/dipyridamole) ASA/dipyridamole Clopidogrel BRILINTA (tigacrelor)	PA Required EFFIENT (prasugrel) PLAVIX (clopidogrel) TICLID (ticlopidine) Ticlopidine ZONTIVITY (vorapaxar)	EFFIENT® will be approved for patients that have a contraindication or intolerable side effects to Brilinta. <ul style="list-style-type: none"> • EFFIENT should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke. • Grandfathering: Members currently stable on Effient will be granted prior authorization approval. Patients taking BRILINTA must also 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.

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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			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 4/1/2016</i>	No PA Required** ABILIFY ^{*BNR*} (aripiprazole) tab Aripiprazole oral solution ABILIFY ODT ^{*BNR*} (aripiprazole) Clozapine CLOZARIL (clozapine) GEODON (ziprasidone) LATUDA (lurasidone) Olanzapine Quetiapine* Risperidone Risperidone ODT RISPERDAL (risperidone) RISPERDAL M-tab (risperidone ODT)	PA Required Aripiprazole FANAPT (iloperidone) FAZACLO (clozapine ODT) INVEGA (paliperidone) Olanzapine ODT NUPLAZID (pimavanserin) REXULTI (brexpiprazole) RISPERDAL oral soln (risperidone) SAPHRIS (asenapine) SEROQUEL XR (quetiapine) SYMBYAX (olanzapine/fluoxetine) VERSACLOZ susp (clozapine) VRAYLAR (cariprazine) ZYPREXA ZYDIS (olanzapine ODT) * 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 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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	SEROQUEL IR* (quetiapine) 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>Fazacllo 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 Zydys 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="1234 1333 1990 1425"> <thead> <tr> <th data-bbox="1243 1339 1434 1365">Drug</th> <th data-bbox="1434 1339 1982 1365">Indication</th> </tr> </thead> <tbody> <tr> <td data-bbox="1243 1365 1434 1391">Fanapt®</td> <td data-bbox="1434 1365 1982 1391"> <ul style="list-style-type: none"> • Acute treatment of schizophrenia in adults </td> </tr> <tr> <td data-bbox="1243 1391 1434 1417">Fazacllo®</td> <td data-bbox="1434 1391 1982 1417"> <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 	Fazacllo®	<ul style="list-style-type: none"> • Treatment-resistant schizophrenia
Drug	Indication								
Fanapt®	<ul style="list-style-type: none"> • Acute treatment of schizophrenia in adults 								
Fazacllo®	<ul style="list-style-type: none"> • Treatment-resistant schizophrenia 								

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 2: Quantity Limits</p> <table border="1"> <thead> <tr> <th data-bbox="1234 878 1379 966">Brand Name</th> <th data-bbox="1379 878 1560 966">Generic Name</th> <th data-bbox="1560 878 2009 966">Quantity Limits</th> </tr> </thead> <tbody> <tr> <td data-bbox="1234 969 1379 1011">Abilify</td> <td data-bbox="1379 969 1560 1011">Aripiprazole</td> <td data-bbox="1560 969 2009 1011">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1234 1015 1379 1057"></td> <td data-bbox="1379 1015 1560 1057">Clozapine</td> <td data-bbox="1560 1015 2009 1057">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1234 1060 1379 1102">Fazaclo</td> <td data-bbox="1379 1060 1560 1102">Clozapine</td> <td data-bbox="1560 1060 2009 1102">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1234 1105 1379 1148">Fanapt</td> <td data-bbox="1379 1105 1560 1148">Iloperidone</td> <td data-bbox="1560 1105 2009 1148">Maximum two tablets per day</td> </tr> <tr> <td data-bbox="1234 1151 1379 1193">Invega</td> <td data-bbox="1379 1151 1560 1193">Paliperidone</td> <td data-bbox="1560 1151 2009 1193">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1234 1196 1379 1239">Latuda</td> <td data-bbox="1379 1196 1560 1239">Lurasidone</td> <td data-bbox="1560 1196 2009 1239">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1234 1242 1379 1320"></td> <td data-bbox="1379 1242 1560 1320">Olanzapine</td> <td data-bbox="1560 1242 2009 1320">Maximum one tablet per day (see Zyprexa Zydis criteria for Zydis information)</td> </tr> <tr> <td data-bbox="1234 1323 1379 1349"></td> <td data-bbox="1379 1323 1560 1349">Quetiapine</td> <td data-bbox="1560 1323 2009 1349">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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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) alendronate oral solution FOSAMAX plus D (alendronate w/D) Etidronate	<p>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.)</p> <p>PA will be approved for etidronate in members with heterotopic ossification without treatment failure.</p> <p>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.</p>																															

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DIABETES MANAGEMENT CLASSES Amylin <i>Effective 10/1/2015</i>	No PA Required (*Must meet eligibility criteria)	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 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>	No PA Required Metformin 500mg, 850mg, 1000mg tablets Metformin ER 500mg tablets (generic Glucophage XR)	PA Required FORTAMET (metformin) GLUCOPHAGE (brand) (metformin) GLUCOPHAGE XR (brand) (metformin XR) GLUMETZA ER (metformin) Metformin ER 750mg Metformin ER 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>	No PA Required (*Must meet eligibility criteria) *TRADJENTA (linagliptin)	PA Required Alogliptin 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

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
GLP-1 Agonist <i>Effective 10/1/2015</i>	No PA Required (*Must meet eligibility criteria) *BYETTA (exenatide)	PA Required BYDUREON (exenatide) TANZEUM (albiglutide) TRULICITY (dalaglutide) VICTOZA (liraglutide)	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.) *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 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. Grandfathering: Members currently stabilized on Victoza® can receive approval to continue on that agent for one year.
Hypoglycemic Combinations <i>Effective 10/1/2015</i>	No PA Required	PA Required Alogliptin/metformin Alogliptin/pioglitazone ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR (pioglitazone/metformin) Pioglitazone/metformin AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride)	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.)
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		Pioglitazone/glimepiride Glipizide/metformin GLUCOVANCE (glyburide/metformin) Glyburide/metformin GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE (saxagliptin/metformin) METAGLIP (glipizide/metformin) OSENI (alogliptin/pioglitazone) PRANDIMET (repaglinide/metformin) Repaglinide/metformin	
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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.)
		SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozen/metformin)	
Meglitinides <i>Effective 10/1/2015</i>	No PA Required	PA Required Nateglinide PRANDIN (repaglinide) 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	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>
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)	<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.

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		MIRCERA (methoxy peg-epoetin beta) PROCRIT (epoetin alfa)	<ul style="list-style-type: none"> • 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 Epogen. (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 indications, the distribution of a medication guide to the patient is the only requirement currently.</p>
FIBROMYALGIA AGENTS <i>Effective 7/1/2016</i>	No PA Required LYRICA (pregabalin) Duloxetine	PA Required CYMBALTA (duloxetine) SAVELLA (milnacipran)	<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>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> <p>Generic DULOXETINE will be approved if the member has diagnosis of fibromyalgia.</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.)
FLUOROQUINOLONE (oral) <i>Effective 1/1/2016</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	Non-preferred products will be approved for members who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) CIPRO suspension approved for members < 5 years of age without PA For members ≥ 5 years of age, CIPRO suspension will only be approved for those members who cannot swallow a whole or crushed tablet 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.)
GROWTH HORMONES <i>Effective 4/1/2016</i>	No PA Required GENOTROPIN NORDITROPIN	PA Required HUMATROPE NUTROPIN OMNITROPE SAIZEN SEROSTIM ZOMACTON ZORBTIVE	Non-preferred Growth Hormones will be approved if both of the following criteria are met: <ul style="list-style-type: none"> • Member failed treatment with Genotropin OR Norditropin 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 ○ 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 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.
HEPATITIS C VIRUS TREATMENTS <i>Effective 10/1/2015</i> <i>Refined 3/1/2016</i>	Must meet eligibility criteria*	PA Required DAKLINZA (daclatasvir)	Preferred agent criteria:

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>VIEKIRA PAK* (ombitasvir/paritaprevir/ ritonavir/dasabuvir)</p>	<p>EPCLUSA (sofosbuvir/velpatasvir) HARVONI (sofosbuvir/ledipasvir) OLYSIO (simeprevir) SOVALDI (sofosbuvir) TECHNIVIE (ombitasvir/paritaprevir/ritonavir) ZEPATIER (elbasvir/grazoprevir)</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. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity AND 6. Member is 18 years of age and older AND 7. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) AND 9. Prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 10. Meets one of the following categories: (NOTE: baseline levels within 90 days of anticipated start date for relevant labs such as: HCV RNA; CBC; CMP; INR) <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 fibrosing cholestatic HCV; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A(5-6) AND; <ul style="list-style-type: none"> ○ Member has cirrhosis (METAVIR F4) based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (≥ 9.6kPa); OR ▪ Imaging indicating definitive evidence of cirrhosis, or portal hypertension, or splenomegaly or history of varices or ascites; OR ▪ FibroMeter (>0.8kPa) not more than 6 months old; OR
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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"> ▪ FibroTest (> 0.74kPa) not more than 6 months old <p>OR</p> <ul style="list-style-type: none"> ○ Member has a fibrosis score equivalent to METAVIR F3 based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (\geq 9.6kPa); OR ▪ Imaging indicating definitive fibrosis stage 3; OR ▪ Concordance among one of the following FibroTest (>0.58kPa) not more than 6 months old or FibroMeter (> 0.58kPa) not more than 6 months old PLUS one of the following APRI (> 1) or FIB4 (> 2.2); AND <ol style="list-style-type: none"> 11. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 12. Liver post-transplant recipients approved despite any liver disease AND 13. Members may be HIV positive AND 14. Member must have genotyping results within 1 year of anticipated therapy start date AND 15. Member must have baseline alcohol/drug screen within 30 days of anticipated start date AND 16. 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 17. Member is not taking agents highly dependent on CYP3A for clearance; strong inducers of CYP3A and strong inducers and inhibitors of CYP2C8; amiodarone; or ethyl estradiol containing agents AND 18. Member is not taking agents that are contraindicated with ribavirin if ribavirin will be coadministered for treatment AND 19. For drugs that decrease the effectiveness of Viekira, provider to supply plan as to how to manage these drug-drug interactions 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>20. 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>21. 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>22. Must be in accordance with approved regimens and duration (see Table 1) AND</p> <p>23. Must be adherent to treatment regimen (see discontinuation criteria) AND prescriber must confirm member enrollment in the proCeed Nurse Connector program (by phone: 1-855-984-3547 or Fax: 1-866-299-1687 or online at: https://www.viekira.com/proceed-program) to re-enforce adherence.</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 Viekira Pak</p> <table border="1" data-bbox="1234 1008 1969 1370"> <thead> <tr> <th data-bbox="1243 1015 1612 1040">Patient Population</th> <th data-bbox="1612 1015 1839 1040">Treatment</th> <th data-bbox="1839 1015 1961 1040">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1243 1040 1612 1097">Members with genotype 1a, without compensated cirrhosis</td> <td data-bbox="1612 1040 1839 1097">Viekira Pak + ribavirin</td> <td data-bbox="1839 1040 1961 1097">12 weeks</td> </tr> <tr> <td data-bbox="1243 1097 1612 1154">Members with genotype 1a, treatment naive, with cirrhosis</td> <td data-bbox="1612 1097 1839 1154">Viekira Pak + ribavirin</td> <td data-bbox="1839 1097 1961 1154">12 weeks</td> </tr> <tr> <td data-bbox="1243 1154 1612 1247">Members with genotype 1a, treatment experienced, with cirrhosis</td> <td data-bbox="1612 1154 1839 1247">Viekira Pak + ribavirin</td> <td data-bbox="1839 1154 1961 1247">24 weeks</td> </tr> <tr> <td data-bbox="1243 1247 1612 1304">Members with genotype 1b, with or without compensated cirrhosis</td> <td data-bbox="1612 1247 1839 1304">Viekira Pak</td> <td data-bbox="1839 1247 1961 1304">12 weeks</td> </tr> <tr> <td data-bbox="1243 1304 1612 1360">Post-transplant members</td> <td data-bbox="1612 1304 1839 1360">Viekira Pak + ribavirin</td> <td data-bbox="1839 1304 1961 1360">24 weeks</td> </tr> </tbody> </table>	Patient Population	Treatment	Duration	Members with genotype 1a, without compensated cirrhosis	Viekira Pak + ribavirin	12 weeks	Members with genotype 1a, treatment naive, with cirrhosis	Viekira Pak + ribavirin	12 weeks	Members with genotype 1a, treatment experienced, with cirrhosis	Viekira Pak + ribavirin	24 weeks	Members with genotype 1b, with or without compensated cirrhosis	Viekira Pak	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.)
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			<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 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>Discontinuation Criteria:</p> <ul 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 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 Viekira Pak 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>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) genotypes 1 and 3 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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			<ol style="list-style-type: none"> 4. Member is not co-infected with Hepatitis B or Human Immunodeficiency Virus (HIV) AND 5. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity AND 6. Member is 18 years of age and older AND 7. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) AND 9. Daklinza is prescribed with sofosbuvir AND 10. Prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 11. Meets one of the following categories: (NOTE: baseline levels within 90 days of anticipated start date for relevant labs such as: HCV RNA; CBC; CMP; INR) <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 fibrosing cholestatic HCV; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A or CTP > 6 and on liver transplant with projected time to transplant < 1 year AND; <ul style="list-style-type: none"> ○ Member has cirrhosis (METAVIR F4) based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan ($\geq 9.6\text{kPa}$); OR ▪ Imaging indicating definitive evidence of cirrhosis, or portal hypertension, or splenomegaly or history of varices or ascites; OR ▪ FibroMeter ($>0.8\text{kPa}$) not more than 6 months old; OR ▪ FibroTest ($> 0.74\text{kPa}$) not more than 6 months old <p>OR</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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			<ul style="list-style-type: none"> ○ Member has a fibrosis score equivalent to METAVIR F3 based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (≥ 9.6kPa); OR ▪ Imaging indicating definitive fibrosis stage 3; OR ▪ Concordance among one of the following FibroTest (>0.58kPa) not more than 6 months old or FibroMeter (> 0.58kPa) not more than 6 months old PLUS one of the following APRI (> 1) or FIB4 (> 2.2); AND 12. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 13. Liver post-transplant recipients approved despite any liver disease AND 14. Member does not have severe renal impairment (eGFR<30), end stage renal disease, or on hemodialysis AND 15. Member must have genotyping results within 1 year of anticipated therapy start date AND 16. Member must have baseline alcohol/drug screen within 30 days of anticipated start date AND 17. 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 18. Member is not taking strong inducers of CYP3A or amiodarone AND 19. For drugs that decrease the effectiveness of Daklinza, provider to supply plan as to how to manage these drug-drug interactions AND 20. 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 21. If the week 4 HCV RNA is detectable (>25 copies) while on Daklinza therapy, HCV RNA will be reassessed in 2 weeks. If the
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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>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>22. Must be in accordance with approved regimens and duration (see Table 1) AND</p> <p>23. Must be adherent to treatment regimen (see discontinuation criteria).</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="1255 678 1976 1089"> <thead> <tr> <th>Patient Population</th> <th>Daily Treatment</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td>GT 1: with or without cirrhosis and CTP A</td> <td>Daklinza 60mg + 400 mg sofosbuvir</td> <td>12 weeks</td> </tr> <tr> <td>GT 3: without cirrhosis</td> <td>Daklinza 60mg + 400 mg sofosbuvir</td> <td>12 weeks</td> </tr> <tr> <td>GT 3: with cirrhosis</td> <td>Daklinza 60mg + 400 mg sofosbuvir + ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>GT 1 or 3: Post transplant</td> <td>Daklinza 60mg + 400 mg sofosbuvir + ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>Taking moderate CYP3A inducers</td> <td>Daklinza 30mg + 400 mg sofosbuvir</td> <td>12 weeks</td> </tr> <tr> <td>Taking moderate CYP3A inducers</td> <td>Daklinza 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 with 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>	Patient Population	Daily Treatment	Duration	GT 1: with or without cirrhosis and CTP A	Daklinza 60mg + 400 mg sofosbuvir	12 weeks	GT 3: without cirrhosis	Daklinza 60mg + 400 mg sofosbuvir	12 weeks	GT 3: with cirrhosis	Daklinza 60mg + 400 mg sofosbuvir + ribavirin	12 weeks	GT 1 or 3: Post transplant	Daklinza 60mg + 400 mg sofosbuvir + ribavirin	12 weeks	Taking moderate CYP3A inducers	Daklinza 30mg + 400 mg sofosbuvir	12 weeks	Taking moderate CYP3A inducers	Daklinza 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.)
			<ul style="list-style-type: none"> • Members receiving a daclatasvir 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 Epclusa® (sofosbuvir/velpatasvir) will be reviewed on a case-by-case basis until final criteria can be developed for genotypes 1-6. It 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) or significant drug-drug interactions exist between member's drug regimen and Viekira.</p> <p>Requests for Harvoni® (sofosbuvir/ledipasvir) for genotype 1 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), significant drug-drug interactions exist between member's drug regimen and Viekira, or increased risk of adverse events associated with the change in CTP class status. Other genotypes (4, 5, 6) will not require a contraindication to Viekira®. Prior authorization may be granted 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) genotypes 1, 4, 5, or 6 AND 4. Member is not co-infected with Hepatitis B AND 5. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity AND 6. Member is 18 years of age and older 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>7. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND</p> <p>8. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) AND</p> <p>9. Prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND</p> <p>10. Meets one of the following categories: (NOTE: baseline levels within 90 days of anticipated start date for relevant labs such as: HCV RNA; CBC; CMP; INR)</p> <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 fibrosing cholestatic HCV; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A or decompensated cirrhosis CTP > 6 with no contraindication to liver transplant AND: <ul style="list-style-type: none"> ○ Member has cirrhosis (METAVIR F4) based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan ($\geq 9.6\text{kPa}$); OR ▪ Imaging indicating definitive evidence of cirrhosis, or portal hypertension, or splenomegaly or history of varices or ascites; OR ▪ FibroMeter ($>0.8\text{kPa}$) not more than 6 months old; OR ▪ FibroTest ($> 0.74\text{kPa}$) not more than 6 months old <p>OR</p> <ul style="list-style-type: none"> ○ Member has a fibrosis score equivalent to METAVIR F3 based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan ($\geq 9.6\text{kPa}$); OR ▪ Imaging indicating definitive fibrosis stage 3; OR ▪ Concordance among one of the following FibroTest ($>0.58\text{kPa}$) not more than 6 months old or FibroMeter ($>$
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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>0.58kPa) not more than 6 months old PLUS one of the following APRI (> 1) or FIB4 (> 2.2); AND</p> <ol style="list-style-type: none"> 11. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND 12. Liver post-transplant recipients approved despite any liver disease AND 13. Members may be HIV positive AND 14. Member does not have severe renal impairment (eGFR<30), end stage renal disease, on hemodialysis AND 15. Member must have genotyping results within 1 year of anticipated therapy start date AND 16. Member must have baseline alcohol/drug screen within 30 days of anticipated start date AND 17. 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 18. Member is not taking potent P-gp inducers or amiodarone AND 19. Member is not taking agents that are contraindicated with ribavirin if ribavirin will be coadministered for treatment AND 20. For drugs that decrease the effectiveness of Harvoni, provider to supply plan as to how to manage these drug-drug interactions AND 21. 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 22. 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 23. Must be in accordance with approved regimens and duration (see Table 1) 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>24. Must be adherent to treatment regimen (see discontinuation criteria).</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 Harvoni</p> <table border="1" data-bbox="1241 483 1959 919"> <thead> <tr> <th data-bbox="1249 490 1682 548">Patient Population</th> <th data-bbox="1682 490 1839 548">Treatment</th> <th data-bbox="1839 490 1950 548">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1249 548 1682 613">GT1: Treatment naïve with or without compensated cirrhosis</td> <td data-bbox="1682 548 1839 613">Harvoni</td> <td data-bbox="1839 548 1950 613">12 weeks</td> </tr> <tr> <td data-bbox="1249 613 1682 678">GT:1 Treatment experienced without compensated cirrhosis</td> <td data-bbox="1682 613 1839 678">Harvoni</td> <td data-bbox="1839 613 1950 678">12 weeks</td> </tr> <tr> <td data-bbox="1249 678 1682 751">GT1: Treatment experienced with compensated cirrhosis</td> <td data-bbox="1682 678 1839 751">Harvoni + ribavirin</td> <td data-bbox="1839 678 1950 751">12 weeks</td> </tr> <tr> <td data-bbox="1249 751 1682 824">GT1: Treatment-naïve or -experienced with decompensated cirrhosis</td> <td data-bbox="1682 751 1839 824">Harvoni + ribavirin</td> <td data-bbox="1839 751 1950 824">12 weeks</td> </tr> <tr> <td data-bbox="1249 824 1682 912">GT4, 5, 6: Treatment-naïve or -experienced with or without compensated cirrhosis</td> <td data-bbox="1682 824 1839 912">Harvoni</td> <td data-bbox="1839 824 1950 912">12 weeks</td> </tr> </tbody> </table> <p>Quantity and Refill Limits:</p> <ul 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>Discontinuation Criteria:</p> <ul style="list-style-type: none"> Members receiving a sofosbuvir/ledipasvir-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. 	Patient Population	Treatment	Duration	GT1: Treatment naïve with or without compensated cirrhosis	Harvoni	12 weeks	GT:1 Treatment experienced without compensated cirrhosis	Harvoni	12 weeks	GT1: Treatment experienced with compensated cirrhosis	Harvoni + ribavirin	12 weeks	GT1: Treatment-naïve or -experienced with decompensated cirrhosis	Harvoni + ribavirin	12 weeks	GT4, 5, 6: Treatment-naïve or -experienced with or without compensated cirrhosis	Harvoni	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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			<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 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>Requests for Olysio® (simeprevir) will be considered if Viekira Pak® is contraindicated or cannot be used as significant drug-drug interactions exist between member's drug regimen and Viekira Pak®. Prior authorization may be granted 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. A documented diagnosis of Hepatitis C Genotype 1 with concurrent therapy with ribavirin and pegylated interferon unless in combination with a polymerase inhibitor AND 4. For members with HCV genotype 1a, evidence must be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy AND 5. Member is not co-infected with HIV or Hepatitis B AND 6. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity AND 7. Member is 18 years of age and older AND 8. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 9. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) AND 10. Prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 11. Meets one of the following categories: (NOTE: baseline levels within 90 days of anticipated start date for relevant labs such as: HCV RNA; CBC; CMP; INR) <ul style="list-style-type: none"> • Members with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma
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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>meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease;</p> <ul style="list-style-type: none"> • Members with fibrosing cholestatic HCV; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A(5-6) ; or CTP > 6 and on liver transplant list with projected time to transplant < 1 year AND; <ul style="list-style-type: none"> ○ Member has cirrhosis (METAVIR F4) based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (≥ 9.6kPa); OR ▪ Imaging indicating definitive evidence of cirrhosis, or portal hypertension, or splenomegaly or history of varices or ascites; OR ▪ FibroMeter (>0.8kPa) not more than 6 months old; OR ▪ FibroTest (> 0.74kPa) not more than 6 months old <p>OR</p> <ul style="list-style-type: none"> ○ Member has a fibrosis score equivalent to METAVIR F3 based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (≥ 9.6kPa); OR ▪ Imaging indicating definitive fibrosis stage 3; OR ▪ Concordance among one of the following FibroTest (>0.58kPa) not more than 6 months old or FibroMeter (> 0.58kPa) not more than 6 months old PLUS one of the following APRI (> 1) or FIB4 (> 2.2); AND <p>12. Members may be treatment naïve or treatment experienced excepts with a hepatitis C protease inhibitor (Incivek® or Victrelis®) AND</p> <p>13. Liver post-transplant recipients approved despite any liver disease AND</p> <p>14. Member does not have severe renal impairment (eGFR<30), end stage renal disease, on hemodialysis AND</p> <p>15. Member must have genotyping results within 1 year of anticipated therapy start date AND</p> <p>16. Member must have baseline alcohol/drug screen within 30 days of anticipated start date AND</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>17. 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</p> <p>18. Member is not taking moderate or strong inducers or inhibitors of CYP3A4 AND</p> <p>19. Member is not taking agents that are contraindicated with ribavirin if ribavirin will be coadministered for treatment AND</p> <p>20. For drugs that decrease the effectiveness of Olysio, provider to supply plan as to how to manage these drug-drug interactions AND</p> <p>21. Approvals in conjunction with sofosbuvir 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>22. If the week 4 HCV RNA is detectable (>25 copies) while on 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>23. Must be in accordance with approved regimens and duration (see Table 1) AND</p> <p>24. Must be adherent to treatment regimen (see discontinuation criteria).</p> <p>Table 1. Recommended Regimens and Treatment Duration for Olysio</p> <table border="1" data-bbox="1276 1247 1982 1388"> <thead> <tr> <th data-bbox="1285 1253 1684 1295">Patient Population</th> <th data-bbox="1684 1253 1852 1295">Treatment</th> <th data-bbox="1852 1253 1974 1295">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1285 1302 1684 1382">Treatment naïve or treatment experienced without compensated cirrhosis</td> <td data-bbox="1684 1302 1852 1382">Olysio + sofosbuvir</td> <td data-bbox="1852 1302 1974 1382">12 weeks</td> </tr> </tbody> </table>	Patient Population	Treatment	Duration	Treatment naïve or treatment experienced without compensated cirrhosis	Olysio + sofosbuvir	12 weeks
Patient Population	Treatment	Duration							
Treatment naïve or treatment experienced without compensated cirrhosis	Olysio + 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="1276 235 1982 324"> <tr> <td data-bbox="1276 235 1686 324">Treatment naïve or treatment experienced with compensated cirrhosis</td> <td data-bbox="1686 235 1852 324">Olysio + sofosbuvir</td> <td data-bbox="1852 235 1982 324">24 weeks</td> </tr> </table> <p data-bbox="1234 358 1545 386">Quantity and Refill Limits:</p> <ul data-bbox="1234 391 2003 621" 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="1234 656 1524 683">Discontinuation Criteria:</p> <ul data-bbox="1234 688 2003 1081" 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="1234 1115 2003 1297">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) or significant drug-drug interactions exist between member’s drug regimen and Viekira. Prior authorization may be granted if the following criteria are met:</p> <ol data-bbox="1234 1302 2003 1422" 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	Olysio + sofosbuvir	24 weeks
Treatment naïve or treatment experienced with compensated cirrhosis	Olysio + 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.)
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			<ol style="list-style-type: none"> 4. Member is not co-infected with Hepatitis B AND 5. Must have received or in progress of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity AND 6. Member is 18 years of age and older AND 7. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) AND 9. Prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND 10. Meets one of the following categories: (NOTE: baseline levels within 90 days of anticipated start date for relevant labs such as: HCV RNA; CBC; CMP; INR) <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 fibrosing cholestatic HCV • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A or CTP > 6 and on liver transplant with projected time to transplant < 1 year AND; <ul style="list-style-type: none"> ○ Member has cirrhosis (METAVIR F4) based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (≥ 9.6kPa); OR ▪ Imaging indicating definitive evidence of cirrhosis, or portal hypertension, or splenomegaly or history of varices or ascites; OR ▪ FibroMeter (>0.8kPa) not more than 6 months old; OR ▪ FibroTest (> 0.74kPa) not more than 6 months old <p>OR</p> <ul style="list-style-type: none"> ○ Member has a fibrosis score equivalent to METAVIR F3 based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ FibroScan (≥ 9.6kPa); OR
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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"> ▪ Imaging indicating definitive fibrosis stage 3; OR ▪ Concordance among one of the following FibroTest (>0.58kPa) not more than 6 months old or FibroMeter (> 0.58kPa) not more than 6 months old PLUS one of the following APRI (> 1) or FIB4 (> 2.2); 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. Liver post-transplant recipients approved despite any liver disease AND 12. Members may be HIV positive AND 13. Member does not have severe renal impairment (eGFR<30), end stage renal disease, on hemodialysis AND 14. Member must have genotyping results within 1 year of anticipated therapy start date AND 15. Member must have baseline alcohol/drug screen within 30 days of anticipated start date AND 16. 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 17. Member is not taking potent P-gp inducers or amiodarone AND 18. Member is not taking agents that are contraindicated with ribavirin if ribavirin will be coadministered for treatment AND 19. For drugs that decrease the effectiveness of Sovaldi, provider to supply plan as to how to manage these drug-drug interactions AND 20. 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 21. If 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
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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>IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy AND</p> <p>22. Must be in accordance with approved regimens and duration (see Table 1) AND</p> <p>23. Must be adherent to treatment regimen (see discontinuation criteria).</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 Sofosbuvir</p> <table border="1" data-bbox="1276 646 1984 1063"> <thead> <tr> <th>Patient Population</th> <th>Treatment</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td>Genotype 1: interferon eligible</td> <td>Sovaldi + peginterferon alfa + ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>Genotype 1: interferon ineligible</td> <td>Sovaldi + ribavirin</td> <td>24 weeks</td> </tr> <tr> <td>Genotype 2</td> <td>Sovaldi + ribavirin</td> <td>16 weeks</td> </tr> <tr> <td>Genotype 3</td> <td>Sovaldi + ribavirin</td> <td>24 weeks</td> </tr> <tr> <td>Genotype 4: interferon eligible</td> <td>Sovaldi + peginterferon alfa + ribavirin</td> <td>12 weeks</td> </tr> <tr> <td>Genotype 4: interferon ineligible</td> <td>Sovaldi + ribavirin</td> <td>24 weeks</td> </tr> </tbody> </table> <p>Quantity and Refill Limits:</p> <ul 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>Interferon Alpha Ineligible defined:</p> <ul style="list-style-type: none"> Platelet count <75,000mm³ Decompensated liver cirrhosis (CTP Class B/C or CTP score ≥ 7) 	Patient Population	Treatment	Duration	Genotype 1: interferon eligible	Sovaldi + peginterferon alfa + ribavirin	12 weeks	Genotype 1: interferon ineligible	Sovaldi + ribavirin	24 weeks	Genotype 2	Sovaldi + ribavirin	16 weeks	Genotype 3	Sovaldi + ribavirin	24 weeks	Genotype 4: interferon eligible	Sovaldi + peginterferon alfa + ribavirin	12 weeks	Genotype 4: interferon ineligible	Sovaldi + ribavirin	24 weeks
Patient Population	Treatment	Duration																						
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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"> • Documented history of depression or mood disorder, which are not stable on current drug regimen • Autoimmune hepatitis and another autoimmune disorder • 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 Sovaldi 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. Must have received or in process of receiving full courses of both Hepatitis A and Hepatitis B vaccinations, or have immunity AND 6. Member is 18 years of age and older AND 7. Member is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). Initial pregnancy test must be performed not more than 30 days prior to beginning therapy AND 8. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment (for ribavirin containing regimens only) 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>9. Prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND</p> <p>10. Meets one of the following categories: (NOTE: baseline levels within 90 days of anticipated start date for relevant labs such as: HCV RNA; CBC; CMP; INR)</p> <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 fibrosing cholestatic HCV; • Members with compensated cirrhosis defined by Child-Turcotte-Pugh (CTP) class A (5-6); AND <ul style="list-style-type: none"> ○ Member have a fibrosis score equivalent to METAVIR F3 based on: <ul style="list-style-type: none"> ▪ Biopsy not more than 5 years old; OR ▪ Fibroscan ($\geq 9.6\text{kPA}$); OR ▪ Imaging indicating definitive fibrosis state 3; OR ▪ Concordance among one of the following FibroTest ($>0.58\text{kPA}$) not more than 6 months old or FibroMeter ($>0.58\text{kPA}$) not more than 6 months old PLUS one of the following APRI (> 1) or FIB4 (> 2.2); AND <p>11. Members may be treatment naïve or treatment experienced, except with a direct-acting antiviral (DAA) AND</p> <p>12. Liver post-transplant recipients approved despite any liver disease AND</p> <p>13. Member must have genotyping results within 1 year of anticipated start date AND</p> <p>14. Member must have baseline alcohol/drug screen within 30 days of anticipated start date AND</p> <p>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</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>monthly during treatment for members that have a history (within the past 2 years) of alcohol/drug abuse AND</p> <ol style="list-style-type: none"> 16. Member is not taking agents that are highly dependent on CYP3A for clearance; moderate and strong inducers of CYP3A; amiodarone; or ethyl estradiol containing agents AND 17. Member is not taking agents that are contraindicated with ribavirin if ribavirin will be coadministered for treatment AND 18. For drugs that decrease the effectiveness of Technivie, provider to supply plan as to how to manage these drug-drug interactions 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 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 with approved regimens and duration (see Table 1) AND 22. Must be adherent to treatment regimen (see discontinuation criteria) AND prescriber must confirm member enrollment in the proCeed Nurse Connector program (by phone: 1-844-277-6233 or Fax: 1-866-299-1687 or online at: https://www.viekira.com/proceed-program) to re-enforce adherence. <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 Technivie</p> <table border="1" data-bbox="1276 1274 1959 1383"> <thead> <tr> <th data-bbox="1285 1281 1602 1320">Patient Population</th> <th data-bbox="1602 1281 1814 1320">Treatment</th> <th data-bbox="1814 1281 1950 1320">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1285 1320 1602 1377">Members with genotype 4 without cirrhosis</td> <td data-bbox="1602 1320 1814 1377">Technivie + ribavirin</td> <td data-bbox="1814 1320 1950 1377">12 weeks</td> </tr> </tbody> </table> <p>Quantity and Refill Limits:</p>	Patient Population	Treatment	Duration	Members with genotype 4 without cirrhosis	Technivie + ribavirin	12 weeks
Patient Population	Treatment	Duration							
Members with genotype 4 without cirrhosis	Technivie + ribavirin	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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			<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 screens during treatment to continue receiving treatment for HCV. <p>Requests for Zepatier® (elbasvir/grazoprevir) will be reviewed on a case-by-case basis until final criteria can be developed for genotypes 1 and 4. It 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) or significant drug-drug interactions exist between member's drug regimen and Viekira.</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.)
INSULIN <i>Effective 4/1/2016</i> Rapid Acting	No PA Required NOVOLOG vial/ pen	PA Required AFREZZA APIDRA all forms HUMALOG vial/ pen/ kwikpen	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/pen	NOVOLIN R all forms HUMULIN R kwikpen	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/ pen/ kwikpen	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/ pen *LANTUS (2 nd line)	BASAGLAR (glargine) all forms TOUJEO all forms TRESIBA (degludec) all forms	Non-preferred products will be approved if the member has failed treatment with Levemir and Lantus (Failure is defined as: allergy or intolerable side effects) Lantus will be approved if the member has failed treatment with Levemir in the last month (Failure is defined as: allergy or intolerable side effects)
Mixtures	HUMULIN 70/30 vial/ pen/ kwikpen HUMALOG MIX 50/50 vial/ pen HUMALOG MIX 75/25 vial/ pen NOVOLOG MIX 70/30 vial/ pen	NOVOLIN 70/30 vial	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 4/1/2016</i>	No PA Required Fluticasone (generic FLONASE) NASONEX (mometasone)	PA Required BECONASE AQ (beclomethasone dipropionate) Budesonide CHILD NASACORT (triamcinolone) DYMISTA (azelastine/ fluticasone propionate) FLONASE (fluticasone) Flunisolide 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 4/1/2016</i>	No PA Required Montelukast (tab, chewable)	PA Required ACCOLATE (zafirlukast) SINGULAIR (montelukast) (tab, chewable tab)	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

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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		ZAFIRLUKAST ZYFLO (zileuton) ZYFLO CR (zileuton)	
MULTIPLE SCLEROSIS AGENTS <i>Effective 4/1/2016</i>	No PA Required (unless indicated) AVONEX (interferon beta 1a) BETASERON (interferon beta 1b) *GILENYA (fingolimid) (2 nd line) REBIF (interferon beta 1a) COPAXONE 20MG INJECTION (glatiramer)	PA Required AUBAGIO (teriflunomide) AMPYRA (dalfampridine) COPAXONE 40MG INJECTION (glatiramer) EXTAVIA (interferon beta 1b) GLATOPA (glatiramer) PLEGRIDY (peg-interferon beta 1a) TECFIDERA (dimethyl fumarate) ZINBRYTA (daclizumab)	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. For treatment of EARLY disease, Gilenya will be approved for members that meet the following criteria: <ul style="list-style-type: none"> • Documented, diagnosis of multiple sclerosis made by neurologist in the last 3 years AND • Documentation provided by prescribing neurologist, or is prescribed in conjunction with a neurologist, for marked functional decline as demonstrated by two of the following: <ul style="list-style-type: none"> ○ MRI, EDSS scale OR medical chart notes that specify increased burden of disease AND • Provider attests to shared decision making with respect to risks versus benefits of medical treatment 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 AND • 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 AND • 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

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"> • Has no active infections AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy and within 3-4 months follow-up after starting therapy AND • Had baseline complete blood count with differential and liver function tests. <p>For the treatment of <u>EARLY</u> disease, Tecfidera and Aubagio may be approved for members that meet the following criteria:</p> <ul style="list-style-type: none"> • Member has failed Gilenya. Failure will be defined as intolerable side effects, drug-drug interaction, contraindication to, or lack of efficacy AND • Documented, diagnosis of multiple sclerosis made by neurologist in the last 3 years AND • Documentation provided by prescribing neurologist, or is prescribed in conjunction with a neurologist, for marked functional decline as demonstrated by <i>two</i> of the following: AND <ul style="list-style-type: none"> ○ MRI, EDSS scale OR medical chart notes that specify increased burden of disease • Provider attests to shared decision making with respect to risks versus benefits of medical treatment AND • Appropriate safety criteria for Tecfidera and Aubagio are met below: <table border="1" data-bbox="1234 1049 2003 1399"> <thead> <tr> <th colspan="2" data-bbox="1234 1049 2003 1097">Safety Criteria</th> </tr> <tr> <th data-bbox="1234 1097 1610 1146">Tecfidera</th> <th data-bbox="1610 1097 2003 1146">Aubagio</th> </tr> </thead> <tbody> <tr> <td data-bbox="1234 1146 1610 1399"> <ul style="list-style-type: none"> • Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy </td> <td data-bbox="1610 1146 2003 1399"> <ul style="list-style-type: none"> • 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 </td> </tr> </tbody> </table>	Safety Criteria		Tecfidera	Aubagio	<ul style="list-style-type: none"> • Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy 	<ul style="list-style-type: none"> • 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
Safety Criteria									
Tecfidera	Aubagio								
<ul style="list-style-type: none"> • Has no active infections AND • Had a complete blood count with differential within the six months prior to initiating therapy 	<ul style="list-style-type: none"> • 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 								

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="1234 235 2005 602"> <tr> <td data-bbox="1234 235 1612 602"></td> <td data-bbox="1612 235 2005 602"> 6 months prior to initiating therapy AND <ul style="list-style-type: none"> • 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 infection by documented test results (purified protein derivative test) or blood test. </td> </tr> </table> <p data-bbox="1234 638 2005 662">AUBAGIO will be approved if member 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 drug-drug interaction, or lack of efficacy] <p data-bbox="1234 792 1276 816">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, drug-drug interaction, or lack of efficacy. Lack of efficacy will be defined as 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 AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist or is prescribed in conjunction with 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 		6 months prior to initiating therapy AND <ul style="list-style-type: none"> • 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 infection by documented test results (purified protein derivative test) or blood test.
	6 months prior to initiating therapy AND <ul style="list-style-type: none"> • 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 infection by documented test results (purified protein derivative test) or blood test. 				

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"> • 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, drug-drug interaction, or lack of efficacy OR • In members with a contraindication to GILENYA, has failed COPAXONE or a preferred interferon product. Failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy. 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 AND • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist or is prescribed in conjunction with 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, drug-drug interaction, or lack of efficacy. 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 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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			<ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist or is prescribed in conjunction with 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 AND • 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 AND • 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>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 or is prescribed in conjunction with 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 improvement in ambulation (measured by T25FW assessment) or improvement in ADLs after three months of therapy.</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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			Grandfathering: Members currently stabilized on GILENYA, TECFIDERA, and AUBAGIO may receive approval to continue on that agent.
OPHTHALMIC ALLERGY <i>Effective 4/1/2016</i>	No PA Required Cromolyn Olopatadine 0.1% PATADAY (olopatadine) PAZEO (olopatadine) ZADITOR (ketotifen)	PA Required ALAMAST (pemirolast) ALAWAY (ketotifen) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) Azelastine BEPREVE (bepotastine) ELESTAT (epinastine) EMADINE (emedastine) LASACRAFT (alcaftadine) Ketotifen OPTICROM (sodium cromoglicate) PATANOL (olopatadine)	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 <i>Effective 7/1/2016</i>	No PA Required FIRST LINE Fentanyl patches Methadone (generic Dolophine) Morphine ER (generic MS Contin)	PA Required BELBUCA (buprenorphine) buccal film *BUTRANS (buprenorphine) patch CONZIP (TRAMADOL ER)	Non-preferred, long-acting oral opioids will be approved for members who have failed treatment with two preferred agents in the last six months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Fentanyl patches (Duragesic) will require a PA for doses of more than 1 patch/2 days. *Butrans patches will be approved for members who have failed treatment with ONE preferred agent in the last 6 months. (Failure is

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	Tramadol ER	DOLOPHINE (methadone) DURAGESIC (fentanyl patch) EMBEDA (morphine/naltrexone) EXALGO (hydromorphone ER) Hydromorphone ER HYSINGLA (hydrocodone ER) KADIAN (morphine ER) MS CONTIN (morphine ER) MORPHABOND (morphine ER) NUCYNTA ER (tapentadol ER) OPANA ER (oxymorphone ER) OXYCONTIN (oxycodone ER) XARTEMIS XR (oxycodone/acetaminophen) ZOHYDRO ER (hydrocodone ER)	<p>defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>ZOHYDRO ER and HYSINGLA® ER and OXYCONTIN (new starts) 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. For all prior authorization requests for opiate agents, provider must attest to counseling provided to women of childbearing age.</p> <p>The total daily limit of milligrams of morphine equivalents is 300mg effective 2/17/2016. This includes opioid-containing products where conversion calculations are applied. Prescriptions that cause the member's drug regimen to exceed the maximum daily limit of 300 milligrams of morphine equivalents (MME) will be denied. This does not currently include methadone prescriptions.</p> <p>Prior authorizations will be granted to allow for 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.)
			<ul style="list-style-type: none"> • A one year PA will be granted for diagnosis of sickle cell anemia or admission to or diagnosis of hospice or end of life care. • A one year PA will be granted for pain associated with cancer. <p>Medicaid provides guidance on the treatment of pain, including tapering, on our website Pain Management Resources and Opioid Use at www.Colorado.gov/hcpf then search Pain Management.</p> <p>Only one long-acting oral opioid agent (including different strengths) and one short-acting opioid agent (including different strengths) will be considered for a prior authorization.</p>
OVERACTIVE BLADDER AGENTS <i>Effective 10/1/15</i>	No PA Required Oxybutynin tablets (generic) Oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	PA Required DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxybutynin gel) MYRBETRIQ (mirabegron) Oxybutynin syrup OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER)	<p>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.).</p> <p>Members with hepatic failure can receive approval to receive trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.</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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		Tolterodine VESICARE (solifenacin)															
PANCREATIC ENZYMES <i>Effective 1/1/2016</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 1/1/2016</i>	*Must meet eligibility criteria NEXIUM (esomeprazole) capsules and packets ^{BNR} Omeprazole generic capsules Pantoprazole tablets PREVACID solutab ^{BNR} (lansoprazole) (for members under 2)	PA Required ACIPHEX tab, sprinkles (rabeprazole) DEXILANT (dexlansoprazole) KAPIDEX (dexlansoprazole) Esomeprazole (generic Nexium) Esomeprazole strontium Lansoprazole capsules Lansoprazole 15mg OTC (currently available as PREVACID 24HR) NEXIUM 24 hour PREVACID (lansoprazole) capsules & suspension PRILOSEC OTC (omeprazole)	*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 (H2A) before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist at optimal doses listed in the table below. <table border="1" data-bbox="1276 906 1980 1170"> <thead> <tr> <th data-bbox="1285 912 1535 935">Drug</th> <th data-bbox="1535 912 1971 935">Optimal Dose</th> </tr> </thead> <tbody> <tr> <td data-bbox="1285 935 1535 958">Erbrotidine</td> <td data-bbox="1535 935 1971 958">800 mg once daily</td> </tr> <tr> <td data-bbox="1285 958 1535 980">Famotidine</td> <td data-bbox="1535 958 1971 980">20 mg twice daily</td> </tr> <tr> <td data-bbox="1285 980 1535 1003">Nizatidine</td> <td data-bbox="1535 980 1971 1003">150 mg twice daily</td> </tr> <tr> <td data-bbox="1285 1003 1535 1026">Ranitidine</td> <td data-bbox="1535 1003 1971 1026">150 mg twice daily</td> </tr> <tr> <td data-bbox="1285 1026 1535 1049">Ranitidine</td> <td data-bbox="1535 1026 1971 1049">** For children less than 30 kg, maximum dose is 10mg/kg per day divided in 2 doses</td> </tr> <tr> <td data-bbox="1285 1049 1535 1071">Roxatidine</td> <td data-bbox="1535 1049 1971 1071">150 mg once daily or 75mg twice daily</td> </tr> </tbody> </table> <p data-bbox="1234 1203 1997 1414">Long-term therapy, without a H2A trial, will be approved for members with Barrett’s Esophagus, Erosive Esophagitis, GI Bleed, post-bariatric surgery; 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.</p>	Drug	Optimal Dose	Erbrotidine	800 mg once daily	Famotidine	20 mg twice daily	Nizatidine	150 mg twice daily	Ranitidine	150 mg twice daily	Ranitidine	** For children less than 30 kg, maximum dose is 10mg/kg per day divided in 2 doses	Roxatidine	150 mg once daily or 75mg twice daily
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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.)
		PROTONIX (pantoprazole) tablets and suspension Rabeprazole (generic Aciphex) ZEGERID (omeprazole/Na bicarbonate)	<p>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 three 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>
H. Pylori Treatments	NONE	HELIDAC (tetracycline/tripotassium dicitrateobismuthate/metronidazole) OMECLAMOX-PAK (amoxicillin/omeprazole/ clarithromycin)	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.

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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		PREPAC (amoxicillin/lansoprazole/ clarithromycin) Amoxicillin/lansoprazole/ clarithromycin PYLERA (bismuth subcitrate/ metronidazole/tetracycline)	
PULMONARY ARTERIAL HYPERTENSION THERAPIES Phosphodiesterase Inhibitors <i>Effective 1/1/2016</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.
Endothelin Antagonists <i>Effective 1/1/2016</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.
Prostanoids <i>Effective 1/1/2016</i>	No PA Required Epoprostenol (generic) VENTAVIS (iloprost)	PA Required FLOLAN (brand) (epoprostenol) ORENITRAM (treprostiril) REMODULIN (treprostiril) TYVASO (treprostiril) VELETRI (epoprostenol) UPTRAVI (selexipag)	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) Grandfathering: Members who have been previously stabilized on a non-preferred product can receive approval to continue on the medication.

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 1/1/2016</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 7/1/2016</i>	No PA Required <u>Solutions</u> Albuterol/ipratropium solution Ipratropium (generic Atrovent) solution <u>Short-Acting Inhalers</u> ATROVENT HFA (ipratropium)	PA Required <u>Solutions</u> ATROVENT (ipratropium) solution <u>Short-Acting Inhalers</u> <u>Long-Acting Inhalers</u> ANORO ELLIPTA (umeclidinium/vilanterol)	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. SPIRIVA RESPIMAT ® will be approved for members with a diagnosis of asthma requiring the use of this drug for maintenance 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.)
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	COMBIVENT RESPIMAT (albuterol/ipratropium) <u>Long-Acting Inhalers</u> SPIRIVA Handihaler (tiotropium)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol fumarate) INCRUSE ELLIPTA (umeclidinium) SEEBRI Neohaler (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) STIOLTO Respimat (tiotropium/olodaterol) TUDORZA Pressair (aclidinium) UTIBRON Neohaler (glycopyrrolate/indacaterol)	<p>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.</p> <p>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®.</p>
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (short acting) <i>Effective 7/1/2016</i>	<p>No PA Required</p> <p><u>Solutions</u> Albuterol (generic) solution</p> <p><u>Inhalers</u> PROAIR (albuterol) HFA</p>	<p>PA Required</p> <p><u>Solutions</u> Metaproterenol Levalbuterol solution PROVENTIL (albuterol) solution XOPENEX (levalbuterol) solution</p> <p><u>Inhalers</u> Metaproterenol inhaler Pirbuterol PROAIR Resplick PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler</p>	<p>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).</p> <p>Proair HFA, Proventil HFA, Ventolin HFA: Quantity limits: 2 inhalers / 30 days</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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		XOPENEX (levalbuterol) Inhaler	
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (long acting) <i>Effective 7/1/2016</i>	No PA Required* (if dx restrictions met) SEREVENT DISKUS* (salmeterol) inhaler	PA Required <u>Solutions</u> BROVANA (Arformoterol) solution PERFOROMIST (formoterol) solution <u>Inhalers</u> ARCAPTA (indacaterol) neohaler FORADIL (formoterol) STRIVERDI RESPIMAT (olodaterol)	SEREVENT ® will be approved for members with moderate to very severe COPD. Non-preferred agents will be approved for members with moderate to severe COPD, AND members must have failed a trial of SEREVENT (Failure is defined as: lack of efficacy, allergy, contraindication to, intolerable side effects, or significant drug-drug interaction). **For treatment of members with diagnosis of asthma needing add-on therapy, please refer to preferred agents in combination Long-Acting Beta Agonist/Inhaled Corticosteroid. SEREVENT will not be approved for treatment of asthma in members needing add-on therapy due to safety risks associated with monotherapy.
RESPIRATORY INHALANTS Inhaled Corticosteroids <i>Effective 7/1/2016</i>	No PA Required <u>Solutions</u> Budesonide nebules 0.25mg and 0.5mg PULMICORT (budesonide) nebules 1mg <u>Inhalers</u> ASMANEX twisthaler (mometasone) FLOVENT (fluticasone) diskus FLOVENT (fluticasone) HFA QVAR (beclomethasone)	PA Required <u>Solutions</u> PULMICORT (budesonide) nebules 0.25mg and 0.5mg <u>Inhalers</u> AEROSPAN HFA (flunisolide) inhaler ALVESCO (ciclesonide) inhaler ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) 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, contraindication to, intolerable side effects, or significant drug-drug interactions.) Pulmicort Flexhaler will only be approved 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 7/1/2016</i>	No PA Required ADVAIR Diskus (fluticasone/salmeterol) DULERA (mometasone/ formoterol)	PA Required ADVAIR HFA (fluticasone/salmeterol) BREO Ellipta (vilanterol/fluticasone furoate) SYMBICORT (budesonide/formoterol) inhaler	Non-preferred inhaled corticosteroid combinations will be approved for members meeting both of the following criteria: <ul style="list-style-type: none"> • Member has a qualifying diagnosis of asthma or COPD; AND • Member (with a diagnosis of asthma) has failed 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 4/1/2016</i>	No PA Required* (unless duplication criteria apply) Eszopiclone Zaleplon Zolpidem	PA Required AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) EDLUAR (zolpidem) (sublingual) INTERMEZZO (zolpidem) (sublingual) 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 John’s Wort) of CYP3A4 AND • Member does not have a diagnosis of 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 7/1/2016</i></p>	<p>No PA Required (if under 65 years of age)*</p> <p>Baclofen (generic Lioresal)</p> <p>Cyclobenzaprine (generic Flexeril) 5mg and 10mg tablet</p> <p>Tizanidine (generic Zanaflex) 2mg and 4mg tablet</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>LORZONE (chlorzoxazone)</p> <p>METAXALL (metaxolone)</p> <p>Metaxolone</p> <p>Methocarbamol</p> <p>Orphenadrine</p> <p>PARAFON FORTE (chlorzoxazone)</p> <p>ROBAXIN (methocarbamol)</p>	<p>All agents in this class will require a PA for members 65 years of age and older. 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-day supply.</p> <p>Non-preferred skeletal muscle relaxants will be approved for members who have failed two preferred agents in the last 6-months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to, 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 three preferred products.</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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		SKELAXIN (metaxalone) SOMA (carisoprodal) Tizanidine 2, 4, 6mg caps ZANAFLEX (tizanadine)	
STATINS <i>Effective 4/1/2016</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) Pitavastatin PRAVACHOL (pravastatin) Rosuvastatin ZOCOR* (simvastatin)	<p>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)</p> <p>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.</p> <p>*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.</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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STATIN COMBINATIONS <i>Effective 4/1/2016</i>		ADVICOR (niacin ER / lovastatin) CAUDET (amlodipine /atorvastatin) JUVISYNC (sitagliptin/ simvastatin) LIPTRUZET (ezetimibe/ atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvastatin.)	
STIMULANTS and other ADHD agents <i>Effective 10/1/2015</i>	No PA Required (if age, daily dose, dx restrictions met) ADDERALL IR (mixed-amphetamine salts) ADDERALL XR ^{*BNR*} (mixed amphetamine salts ER) FOCALIN IR ^{*BNR*} (brand name dexamethylphenidate) FOCALIN XR ^{*BNR*} (dexamethylphenidate ER) INTUNIV ^{*BNR*} (guanfacine ER) Methylphenidate IR (generic Ritalin IR) Methylphenidate LA (generic Ritalin LA)	PA Required ADZENYS XR ODT (amphetamine) APTENSIO XR (methylphenidate XR) CONCERTA (methylphenidate ER) D-amphetamine spansule DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) DEXTROSTAT (dextroamphetamine) Dexamethylphenidate (generic Focalin IR) Dexamethylphenidate (generic Focalin XR)	<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: Non-preferred agents will only be approved for FDA and official compendium indications.</p> <ul style="list-style-type: none"> • Provigil will only be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder,

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 ER (generic Concerta) Mixed-amphetamine salts (generic Adderall IR) RITALIN IR (methylphenidate) RITALIN LA (methylphenidate ER (LA)) STRATTERA (atomoxetine) *BNR* VYVANSE (lisdexamfetamine)	DYANAVEL XR solution (amphetamine) EVEKEO (amphetamine) Guanfacine ER KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) Methylphenidate ER (generic Metadate CD, ER) METHYLIN SUSPENSION (methylphenidate) Mixed-amphetamine salts ER (generic for Adderall XR) Modafanil (generic PROVIGIL) NUVIGIL (armodafinil) PROCENTRA (dextroamphetamine liquid) PROVIGIL (modafinil) QUILLICHEW (methylphenidate) QUILLIVANT XR suspension (methylphenidate) ZENZEDI (dextroamphetamine)	<p>Traumatic Brain Injury, Multiple Sclerosis related fatigue or ADHD. Only a maximum of 400mg per day will be approved.</p> <ul style="list-style-type: none"> 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, Quillichew 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 Non-preferred agents will only be approved for FDA approved age limitations.</p> <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="1234 241 1619 267">Drug</th> <th data-bbox="1619 241 2005 267">Maximum Daily Dose</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="1234 267 2005 293">Preferred</td> </tr> <tr><td data-bbox="1234 293 1619 326">ADDERALL ®</td><td data-bbox="1619 293 2005 326">40 mg/day</td></tr> <tr><td data-bbox="1234 326 1619 358">ADDERALL XR®</td><td data-bbox="1619 326 2005 358">40mg/day</td></tr> <tr><td data-bbox="1234 358 1619 391">AMPHETAMINE SALTS mixed</td><td data-bbox="1619 358 2005 391">40 mg/day</td></tr> <tr><td data-bbox="1234 391 1619 423">DESOXYN ®</td><td data-bbox="1619 391 2005 423">25mg/day</td></tr> <tr><td data-bbox="1234 423 1619 456">FOCALIN ®</td><td data-bbox="1619 423 2005 456">20 mg/day</td></tr> <tr><td data-bbox="1234 456 1619 488">FOCALIN XR ®</td><td data-bbox="1619 456 2005 488">40 mg/day</td></tr> <tr><td data-bbox="1234 488 1619 521">INTUNIV ER®</td><td data-bbox="1619 488 2005 521">4 mg/day</td></tr> <tr><td data-bbox="1234 521 1619 553">METHYLPHNIDATE IR</td><td data-bbox="1619 521 2005 553">60 mg/day</td></tr> <tr><td data-bbox="1234 553 1619 586">METHYLPHNIDATE LA (ER)</td><td data-bbox="1619 553 2005 586">60 mg/day</td></tr> <tr><td data-bbox="1234 586 1619 618">METHYLPHNIDATE ER</td><td data-bbox="1619 586 2005 618">54 mg/day or 72 mg/day > age 12</td></tr> <tr><td data-bbox="1234 618 1619 651">RITALIN® IR</td><td data-bbox="1619 618 2005 651">60 mg/day</td></tr> <tr><td data-bbox="1234 651 1619 683">RITALIN LA ®</td><td data-bbox="1619 651 2005 683">60 mg/day</td></tr> <tr><td data-bbox="1234 683 1619 716">STRATTERA®</td><td data-bbox="1619 683 2005 716">100 mg/day</td></tr> <tr><td data-bbox="1234 716 1619 748">VYVANSE ®</td><td data-bbox="1619 716 2005 748">70 mg/day</td></tr> <tr> <td colspan="2" data-bbox="1234 748 2005 774">Non preferred</td> </tr> <tr><td data-bbox="1234 774 1619 807">ADZENYS XR ODT ®</td><td data-bbox="1619 774 2005 807">18.8mg or 12.5mg > age 12</td></tr> <tr><td data-bbox="1234 807 1619 839">AMPHETAMINE SALTS ER mixed</td><td data-bbox="1619 807 2005 839">40mg/day</td></tr> <tr><td data-bbox="1234 839 1619 872">APTENSIO XR ®</td><td data-bbox="1619 839 2005 872">60 mg/day</td></tr> <tr><td data-bbox="1234 872 1619 904">CONCERTA ER ®</td><td data-bbox="1619 872 2005 904">54 mg/day or 72 mg/day > age 12</td></tr> <tr><td data-bbox="1234 904 1619 937">D-AMPHETAMINE ER spansule</td><td data-bbox="1619 904 2005 937">40 mg/day</td></tr> <tr><td data-bbox="1234 937 1619 969">DESOXYN ®</td><td data-bbox="1619 937 2005 969">25mg/day</td></tr> <tr><td data-bbox="1234 969 1619 1002">DAYTRANA ®</td><td data-bbox="1619 969 2005 1002">30 mg/day</td></tr> <tr><td data-bbox="1234 1002 1619 1034">DEXEDRINE ®</td><td data-bbox="1619 1002 2005 1034">40mg/day</td></tr> <tr><td data-bbox="1234 1034 1619 1066">DEXMETHYLPHENIDATE IR</td><td data-bbox="1619 1034 2005 1066">20 mg/day</td></tr> <tr><td data-bbox="1234 1066 1619 1099">DEXMETHYLPHENIDATE ER</td><td data-bbox="1619 1066 2005 1099">40 mg/day</td></tr> <tr><td data-bbox="1234 1099 1619 1131">DEXTROSTAT ®</td><td data-bbox="1619 1099 2005 1131">40mg/day</td></tr> <tr><td data-bbox="1234 1131 1619 1164">DYANAVEL XR ODT ®</td><td data-bbox="1619 1131 2005 1164">20 mg/day</td></tr> <tr><td data-bbox="1234 1164 1619 1196">EVEKEO ®</td><td data-bbox="1619 1164 2005 1196">20 mg/day</td></tr> <tr><td data-bbox="1234 1196 1619 1229">GUANFACINE ER</td><td data-bbox="1619 1196 2005 1229">4mg/day or 7mg/day >12</td></tr> <tr><td data-bbox="1234 1229 1619 1261">KAPVAY ER®</td><td data-bbox="1619 1229 2005 1261">0.1 mg/day</td></tr> <tr><td data-bbox="1234 1261 1619 1294">METADATE CD ®</td><td data-bbox="1619 1261 2005 1294">60 mg/day</td></tr> <tr><td data-bbox="1234 1294 1619 1326">METADATE ER ®</td><td data-bbox="1619 1294 2005 1326">60 mg/day</td></tr> <tr><td data-bbox="1234 1326 1619 1359">METHYLIN ER ®</td><td data-bbox="1619 1326 2005 1359">60 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CONCERTA ER ®	54 mg/day or 72 mg/day > age 12																																																																										
D-AMPHETAMINE ER spansule	40 mg/day																																																																										
DESOXYN ®	25mg/day																																																																										
DAYTRANA ®	30 mg/day																																																																										
DEXEDRINE ®	40mg/day																																																																										
DEXMETHYLPHENIDATE IR	20 mg/day																																																																										
DEXMETHYLPHENIDATE ER	40 mg/day																																																																										
DEXTROSTAT ®	40mg/day																																																																										
DYANAVEL XR ODT ®	20 mg/day																																																																										
EVEKEO ®	20 mg/day																																																																										
GUANFACINE ER	4mg/day or 7mg/day >12																																																																										
KAPVAY ER®	0.1 mg/day																																																																										
METADATE CD ®	60 mg/day																																																																										
METADATE ER ®	60 mg/day																																																																										
METHYLIN ER ®	60 mg/day																																																																										
METHYLIN SUSPENSION®	60 mg/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.)
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			<table border="1"> <tr><td>METHYLPHENIDATE ER</td><td>60 mg/day</td></tr> <tr><td>Modafanil</td><td>400mg/day</td></tr> <tr><td>NUVIGIL ®</td><td>250 mg/day</td></tr> <tr><td>PROCENTRA ®</td><td>40 mg/day</td></tr> <tr><td>PROVIGIL ®</td><td>400 mg/day</td></tr> <tr><td>QUILLICHEW ®</td><td>60 mg/day</td></tr> <tr><td>QUILLIVANT XR®</td><td>60 mg/day</td></tr> <tr><td>ZENZEDI ®</td><td>40 mg/day</td></tr> </table>	METHYLPHENIDATE ER	60 mg/day	Modafanil	400mg/day	NUVIGIL ®	250 mg/day	PROCENTRA ®	40 mg/day	PROVIGIL ®	400 mg/day	QUILLICHEW ®	60 mg/day	QUILLIVANT XR®	60 mg/day	ZENZEDI ®	40 mg/day
METHYLPHENIDATE ER	60 mg/day																		
Modafanil	400mg/day																		
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QUILLIVANT XR®	60 mg/day																		
ZENZEDI ®	40 mg/day																		
<p>TARGETED IMMUNE MODULATORS</p> <p><i>Effective 1/1/2016</i></p>	<p>No PA Required</p> <p>ENBREL (etanercept)</p> <p>HUMIRA (adalimumab)</p>	<p>PA Required</p> <p>ACTEMRA (tocilizumab)</p> <p>CIMZIA (certolizumab)</p> <p>COSENTYX (secukinumab)</p> <p>KINERET (anakinra)</p> <p>ORENCIA (abatacept) Subcutaneous</p> <p>OTEZLA (apremilast)</p> <p>SIMPONI (golimumab)</p> <p>STELARA (ustekinumab)</p> <p>TALTZ (ixekizumab)</p> <p>XELJANZ (tofacitinib)</p> <p>XELJANZ XR (tofacitinib)</p> <p>*for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P</p>	<p>The Department would like to remind providers that many products have patient support programs that assist patients in drug administration, education, and emotional support for our member’s diseases.</p> <p>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, leflunomide, 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.)</p> <p>Cimzia (all dosage forms) 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.)</p> <p>Cimzia (all dosage forms) 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.)</p> <p>Cimzia (all dosage forms) 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> <p>Cosentyx will be approved for moderate to severe plaque psoriasis in members who have tried and failed methotrexate, 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>																

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>Cosentyx will be approved for adults with 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>Cosentyx will be approved for adults with active ankyloses spondylitis 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>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>Otezla will be approved for treatment of plaque psoriasis in members who have had treatment failure at least one conventional DMARD (e.g, methotrexate, leflunomide, and sulfasalazine), 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 (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>
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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>Simponi will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis 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>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>Taltz will be approved for members with diagnosis of moderate to severe plaque psoriasis who have tried and failed methotrexate, Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction)</p> <p>Taltz approval will be given for an initial 12 weeks and further authorization will be provided based on clinical response</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 be not be approved for combination therapy with a biologic disease modifying agent.</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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			Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply
<p>TESTOSTERONE PRODUCTS</p> <p><i>Effective 7/1/2016</i></p>	<p>Must meet criteria</p> <p>ANDROGEL 1.62% (testosterone topical)</p> <p>ANDRODERM (testosterone patch)</p> <p>DEPO TESTOSTERONE (testosterone cypionate) IM</p> <p>Testosterone Cypionate IM</p>	<p>PA Required</p> <p>ANDROGEL 1% ^{BNR} (testosterone)</p> <p>ANDROID (methyltestosterone)</p> <p>ANDROXY (fluoxymesterone)</p> <p>AXIRON solution (testosterone)</p> <p>DELATESTRYL (testosterone enanthate) IM injection</p> <p>FORTESTA gel (testosterone)</p> <p>Methyltestosterone</p> <p>NATESTO nasal gel (testosterone)</p> <p>STRIANT buccal (testosterone)</p> <p>TESTIM gel (testosterone)</p> <p>Testosterone gel</p> <p>TESTRED (methyltestosterone)</p> <p>Testosterone enanthate IM injection</p> <p>VOGELXO gel</p>	<p><i>Hypogonadotropic or Primary Hypogonadism</i> Preferred androgenic drugs will be approved for members meeting the following:</p> <ol style="list-style-type: none"> 1. Male patient > 18 years of age AND 2. Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND 3. Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND 4. Does not have a diagnosis of breast or prostate cancer AND 5. Does not have a palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL AND 6. Has normal liver function tests prior to initiation of therapy <p><i>Gender Transition</i> Preferred androgenic drugs will be approved for members meeting the following:</p> <ol style="list-style-type: none"> 1. Biologically born female patient > 18 years of age* AND 2. Is undergoing female to male transition AND 3. Has a negative pregnancy test prior to initiation AND 4. Has normal liver function tests prior to initiation of therapy <p>*For members < 18 years of age, a manual review will be required.</p> <p>Non-preferred androgenic drugs will be approved for patients meeting the above criteria with documented failure with an 8 week trial of a preferred androgenic drug (Failure is defined as lack of efficacy, allergy, intolerable side effects, contraindication to, 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

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 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 AND • Has normal liver function tests prior to initiation of therapy
TOPICAL IMMUNOMODULATORS <i>Effective 7/1/2016</i>	Must meet criteria ELIDEL (pimecrolimus)*	PA Required PROTOPIC (tacrolimus) Tacrolimus (generic Protopic)	<p>Manual review will be required for members needing ≥ 6 weeks of therapy.</p> <p>*ELIDEL® will only be approved for a member who had an adequate trial (e.g. one month or longer) of a topical steroid and failed treatment. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.)</p> <p>Tacrolimus 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 a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.)</p> <p>For members under 18 years of age, must be prescribed by or in conjunction with a dermatologist.</p>
TRIPTANS <i>Effective 1/1/2016</i>	No PA Required (monthly quantity limits may apply) IMITREX ^{BNR} (sumatriptan) nasal spray and injection Naratriptan tablets RELPAX ^{BNR} (eletriptan)	PA Required AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX (sumatriptan) tablets MAXALT MLT tablets (rizatriptan)	<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.</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.)
	Rizatriptan MLT tablets Sumatriptan tablets	Maxalt tablets (rizatriptan) Rizatriptan tablets ONZETRA nasal powder (sumatriptan) SUMAVEL DOSEPRO (sumatriptan) TREXIMET (sumatriptan/ naproxen) Sumatriptan nasal spray and injection ZECURITY patch (sumatriptan) ZEMBRACE SYMTOUCH injection (sumatriptan) ZOMIG (zolmitriptan)	Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days. Zecuity patch: Max 4 patches /30 days