



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

Effective January 1, 2014

**Prior Authorization Forms:** available online at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132>

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

**BNR = Brand Name Required**

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>ALZHEIMER'S AGENTS</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required (*Must meet eligibility criteria)</b> Aricept (5mg and 10mg) Aricept ODT 5mg,10mg generic donepezil tab donepezil ODT generic galantamine and galantamine ER NAMENDA	<b>Prior Authorization Required</b> COGNEX EXELON (cap, soln. and patch) RAZADYNE ARICEPT 23mg NAMENDA XR	<p><b>*eligibility criteria for Preferred Agents</b> – All preferred agents will be approved without prior authorization if the client has a diagnosis of dementia which can be verified by SMART PA. Non-preferred products will be approved if the client 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)</p> <p>Clients 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.</p> <p>Preferred agents will be approved if the client has a diagnosis of dementia.</p>
<b>ORAL ANTICOAGULANTS</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  warfarin	<b>Prior Authorization Required</b>  COUMADIN ELIQUIS PRADAXA XARELTO	<p>ELIQUIS or PRADAXA will be approved if:            The client is <b>NOT</b> on dialysis <b>AND</b>            The client has a diagnosis of nonvalvular atrial fibrillation <b>AND</b>            The client does not have a mechanical prosthetic heart valve <b>AND</b>            The client does not have an active pathological bleed <b>AND</b>            Has a labile INR for reasons other than noncompliance (e.g, INR outside 2-3 <math>\geq</math> 60% of the time for a period of two months) <b>OR</b>            Has significant difficulty with complying with monitoring <b>OR</b>            Has an allergy or intolerance to warfarin</p> <p>XARELTO will be approved if:            The client is <b>NOT</b> on dialysis <b>AND</b>            The client has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) <b>OR</b>            Is in need of a prophylaxis of DVT following knee or hip replacement surgery <b>OR</b></p>

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			<p>The client has a diagnosis of nonvalvular atrial fibrillation <b>AND</b>            The client does not have a mechanical prosthetic heart valve <b>AND</b>            The client does not have an active pathological bleed <b>AND</b>            Has a labile INR for reasons other than noncompliance (e.g, INR outside 2-ay <math>\geq</math> 60% of the time for a period of two months) <b>OR</b>            Has significant difficulty with complying with monitoring <b>OR</b>            Has an allergy or intolerance to warfarin</p> <p><b>Grandfathering:</b>            Beginning 10/1/2013, clients currently stabilized on a non-preferred agent can receive approval to continue on that agent for one year if medically necessary</p>
<b>ANTIEMETICS</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  ondansetron tablets ondansetron ODT tab ondansetron suspension (clients under 5 years only) ZOFRAN tablets	<b>Prior Authorization Required</b>  ANZEMET EMEND KYTRIL SANCUSO ALOXI ZOFRAN suspension ZOFRAN ODT ZUPLENZ DICLEGIS	<p>Non-preferred products will be approved for clients who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Ondansetron suspension will be approved for client's <math>\geq</math> 5 years old and with a feeding tube.</p> <p>Emend will be approved upon verification that the client is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p>Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p>Approval for DICLEGIS will be granted if the client has nausea and vomiting associated with pregnancy <b>AND</b>            The client has failed a trial of doxylamine 10-12.5mg <b>OR</b>            The client has failed a trial of oral ondansetron 4mg every 8 hours for five days <b>OR</b>            The client has an intolerance or contraindication to ondansetron</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)									
<p><b>ANTIDEPRESSANTS</b></p> <p><b>Newer Generation Antidepressants</b></p> <p><i>Effective 1/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>Bupropion IR, SR, XL  citalopram  fluoxetine  fluvoxamine  mirtazipine  nefazodone  paroxetine  sertraline  venlafaxine IR tabs  venlafaxine XR capsules</p>	<p><b>Prior Authorization Required</b></p> <p>APLENZIN ER (bupropion ER)  BRINTELLIX  CYMBALTA (duloxetine)  FETZIMA  KHEDEZLA (desvenlafaxine base)  LEXAPRO (escitalopram)  LUVOX CR (fluvoxamine CR)  PRISTIQ (desvenlafaxine succinate)  PEXEVA (paroxetine)  paroxetine CR  PAXIL CR (paroxetine controlled release)  PROZAC Weekly (fluoxetine)  VIIBRYD</p>	<p>Non-preferred products will be approved for clients who have failed treatment with three Preferred Products with exceptions for Cymbalta and Lexapro (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p> <p><b>Grandfathering:</b>  Clients currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p>Cymbalta: Clients will not need to fail on three Preferred Products if the diagnosis is Diabetic Peripheral Neuropathic Pain.</p> <p>Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses.</p> <p>Lexapro: Clients will not need to fail on three Preferred Products if they are under 18 years of age and have failed therapy with fluoxetine. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p>									
<p><b>ANTI-HERPETIC AGENTS</b></p> <p><i>Effective 1/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>Acyclovir tablet, capsule (generic)</p>	<p><b>Prior Authorization Required</b></p> <p>Acyclovir suspension  Valacyclovir  Famcyclovir  VALTRES  FAMVIR  ZOVIRAX  SITAVIG</p>	<p>Non-preferred products will be approved for clients who have failed an adequate trial with acyclovir (dose and duration) as deemed by approved compendium (see below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p> <table border="1" data-bbox="1213 1057 2066 1477"> <thead> <tr> <th data-bbox="1213 1057 1451 1089">Indication</th> <th data-bbox="1451 1057 1724 1089">Adult</th> <th data-bbox="1724 1057 2066 1089">Pediatric</th> </tr> </thead> <tbody> <tr> <td data-bbox="1213 1089 1451 1227"><b>Gential herpes simplex: Initial</b></td> <td data-bbox="1451 1089 1724 1227">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="1724 1089 2066 1227">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="1213 1227 1451 1477"><b>Gential herpes simplex: episodic</b></td> <td data-bbox="1451 1227 1724 1477">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;</td> <td data-bbox="1724 1227 2066 1477">12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days</td> </tr> </tbody> </table>	Indication	Adult	Pediatric	<b>Gential herpes simplex: Initial</b>	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.	<b>Gential herpes simplex: episodic</b>	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;	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days
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<b>Gential herpes simplex: Initial</b>	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.										
<b>Gential herpes simplex: episodic</b>	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;	12 years or older, 1000 to 1200 mg/day orally in 3 divided doses for 3 to 5 days										

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)	
				initiate at earliest sign or symptom of recurrence.
			<b>Genital herpes simplex: Suppressive</b>	400 mg orally twice daily for up to 12 months; alternative dosing, 200 mg orally 3 to 5 times daily.
			<b>Genital Herpes Simplex with HIV infection: Initial or Recurrent</b>	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.
			<b>Genital Herpes Simplex with HIV infection: Chronic suppression</b>	400 mg orally twice daily
			<b>Herpes labialis</b>	400 mg orally 3 times daily for 5 to 10 days
			<b>Herpes zoster, Shingles</b>	800 mg orally every 4 hours 5 times a day for 7 to 10 days
			<b>Herpes Zoster, Shingles with HIV infection</b>	800 mg orally 5 times daily for 7 to 10 days
			<b>Varicella</b>	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
			<b>Varicella with HIV infection</b>	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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<p><b>ANTIHIISTAMINES</b></p> <p><b>Newer Generation Antihistamines</b></p> <p><i>Effective 7/1/2013</i></p> <p><b>Antihistamine/Decongestant Combinations</b></p> <p><i>Effective 7/1/2013</i></p>	<p><b>No Prior Authorization Required</b></p> <p>loratadine (generic OTC Claritin) cetirizine (generic OTC Zyrtec)</p> <p><b>No Prior Authorization Required</b></p>	<p><b>Prior Authorization Required</b></p> <p>ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) fexofenadine (generic Allegra) levocetirizine XYZAL (levocetirizine) ZYRTEC (cetirizine) Brand</p> <p><b>Prior Authorization Required</b></p> <p>ALLEGRA-D (fexofen./PSE) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)</p>	<p>Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for clients who have failed treatment with two preferred products in the last 6 months and have at least one trial with intranasal corticosteroids (for children age 4 and older). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p>
<p><b>ANTIHYPERTENSIVES</b></p> <p><b>Angiotensin Receptor Blockers (ARBs)</b></p> <p><i>Effective 7/1/2013</i></p> <p><b>ARB Combinations</b></p> <p><i>Effective 7/1/2013</i></p>	<p><b>No Prior Authorization Required</b></p> <p>AVAPRO <sup>BNR</sup> (irbesartan) BENICAR (olmesartan) DIOVAN <sup>BNR</sup> (valsartan) losartan</p> <p><b>No Prior Authorization Required</b></p> <p>AVALIDE <sup>BNR</sup> (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT <sup>BNR</sup> (valsartan/HCTZ)</p>	<p><b>Prior Authorization Required</b></p> <p>ATACAND (candesartan) COZAAR (losartan) EDARBI (azilsartan) irbesartan MICARDIS (telmisartan) TEVETEN (eprosartan) valsartan</p> <p><b>Prior Authorization Required</b></p> <p>ATACAND-HCT (candesartan/HCTZ) AZOR(amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz) HYZAAR HCT BRAND irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ)</p>	<p>Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for clients 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.).</p> <p>Tekturna®, Tekturna HCT®, Valutrna® , and Amturnide® will not approved in patients with diabetes. Receiving an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination in combination with a renin inhibitor is contraindicated.</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.)
<b>Renin Inhibitors &amp; Renin Inhibitor Combinations</b>  <i>Effective 7/1/2013</i>	losartan/HCTZ	TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWINSTA (telmisartan/amlodipine) VALTURNA (aliskiren/valsartan) valsartan/HCTZ	
	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTRNA (aliskiren) TEKTRNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	
<b>ANTIPLATELETS</b>  <i>Effective 1/1/2014</i>	AGGRENOX (ASA/dipyridamole)  clopidogrel  EFFIENT (prasugrel)  Ticlopidine	BRILINTA (tigacrelor) PLAVIX (clopidogrel)	EFFIENT 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke.  BRILINTA will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg, age ≥ 75 years OR who have had a hypersensitivity reaction to clopidogrel or prasugrel AND must be taking a maintenance dose of aspirin not exceeding 100 mg/day.  Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy.
<b>ATYPICAL ANTIPSYCHOTICS (oral)</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required**</b> ABILIFY clozapine CLOZARIL GEODON LATUDA olanzapine risperidone RISPERDAL	<b>Prior Authorization Required</b> FANAPT FAZACLO INVEGA SEROQUEL XR ZYPREXA ZYDIS * for injectable Atypical Antipsychotics please see Appendix P for criteria	*IR quetiapine when given at subtherapeutic doses may be restricted for therapy exceeding 30 days. See Appendix P for more details.  Non-preferred products will only be approved for their FDA approved indications and age limits and only if the client 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).  **Age Limits: All products will require prior authorization for clients who are under the FDA approved minimum age for the product. Clients who are

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
	quetiapine* SAPHRIS SEROQUEL IR* ZYPREXA		<p>currently stabilized on an atypical antipsychotic will be eligible for grandfathering. See Table 3.</p> <p><b>New Atypical Antipsychotic prescriptions for clients under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. Prior authorization approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Clients under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.</b></p> <p>Grandfathering: Clients currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the client does not meet the age, dosing or FDA approved indication requirements. <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p>Quantity Limits: All products including preferred products will have quantity limits. In order to receive approval for off-label dosing, the client must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen. See Table 2.</p> <p>Fazaclo will be approved for the treatment of schizophrenia if the client 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 client 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 client 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 client 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>

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			<p>Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar I disorder if the client 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. A maximum of one tablet per day will be approved.</p> <p>For clients 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="1243 537 2032 1084"> <thead> <tr> <th data-bbox="1243 537 1442 573">Drug</th> <th data-bbox="1442 537 2032 573">Indication</th> </tr> </thead> <tbody> <tr> <td data-bbox="1243 573 1442 609">Fanapt®</td> <td data-bbox="1442 573 2032 609"> <ul style="list-style-type: none"> <li>Acute treatment of schizophrenia in adults</li> </ul> </td> </tr> <tr> <td data-bbox="1243 609 1442 732">Fazaclo®</td> <td data-bbox="1442 609 2032 732"> <ul style="list-style-type: none"> <li>Treatment-resistant schizophrenia</li> <li>Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder</li> </ul> </td> </tr> <tr> <td data-bbox="1243 732 1442 800">Invega®</td> <td data-bbox="1442 732 2032 800"> <ul style="list-style-type: none"> <li>Schizophrenia</li> <li>Schizoaffective disorder</li> </ul> </td> </tr> <tr> <td data-bbox="1243 800 1442 1084">Seroquel XR®</td> <td data-bbox="1442 800 2032 1084"> <ul style="list-style-type: none"> <li>Treatment of schizophrenia</li> <li>Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex</li> <li>Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex</li> <li>Adjunctive treatment of major depressive disorder (MDD)</li> </ul> </td> </tr> </tbody> </table> <p>Table 2: Quantity Limits</p> <table border="1" data-bbox="1213 1146 2062 1458"> <thead> <tr> <th data-bbox="1213 1146 1358 1235">Brand Name</th> <th data-bbox="1358 1146 1539 1235">Generic Name</th> <th data-bbox="1539 1146 2062 1235">Quantity Limits</th> </tr> </thead> <tbody> <tr> <td data-bbox="1213 1235 1358 1279">Abilify</td> <td data-bbox="1358 1235 1539 1279">aripiprazole</td> <td data-bbox="1539 1235 2062 1279">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1213 1279 1358 1323"></td> <td data-bbox="1358 1279 1539 1323">clozapine</td> <td data-bbox="1539 1279 2062 1323">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1213 1323 1358 1367">Fazaclo</td> <td data-bbox="1358 1323 1539 1367">clozapine</td> <td data-bbox="1539 1323 2062 1367">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1213 1367 1358 1411">Fanapt</td> <td data-bbox="1358 1367 1539 1411">iloperidone</td> <td data-bbox="1539 1367 2062 1411">Maximum two tablets per day</td> </tr> <tr> <td data-bbox="1213 1411 1358 1458">Invega</td> <td data-bbox="1358 1411 1539 1458">paliperidone</td> <td data-bbox="1539 1411 2062 1458">Maximum one tablet per day</td> </tr> </tbody> </table>	Drug	Indication	Fanapt®	<ul style="list-style-type: none"> <li>Acute treatment of schizophrenia in adults</li> </ul>	Fazaclo®	<ul style="list-style-type: none"> <li>Treatment-resistant schizophrenia</li> <li>Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder</li> </ul>	Invega®	<ul style="list-style-type: none"> <li>Schizophrenia</li> <li>Schizoaffective disorder</li> </ul>	Seroquel XR®	<ul style="list-style-type: none"> <li>Treatment of schizophrenia</li> <li>Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex</li> <li>Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex</li> <li>Adjunctive treatment of major depressive disorder (MDD)</li> </ul>	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
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			<b>Latuda</b>	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																																	
				risperidone	Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day																																	
			<b>Saphris</b>	asenapine	Maximum two tablets per day																																	
			<b>Seroquel XR</b>	quetiapine XR	Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)																																	
				ziprasidone	Maximum two tablets per day																																	
Table 3: FDA Approved Dosing by Age																																						
<table border="1"> <thead> <tr> <th data-bbox="1213 711 1436 813">Drug</th> <th data-bbox="1436 711 1755 813">FDA Approved Indication</th> <th data-bbox="1755 711 1929 813">FDA Approved Age</th> <th data-bbox="1929 711 2068 813">Maximal FDA Approved Dose</th> </tr> </thead> <tbody> <tr> <td data-bbox="1213 813 1436 889">Asenapine (Saphris®)</td> <td colspan="3" data-bbox="1436 813 2068 889">NOT APPROVED</td> </tr> <tr> <td data-bbox="1213 889 1436 966">Aripiprazole (Abilify®)</td> <td data-bbox="1436 889 1755 966">Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia</td> <td data-bbox="1755 889 1929 966">6-17 years 10-17 years 13-17 years</td> <td data-bbox="1929 889 2068 966">15mg/day 30mg/day 30mg/day</td> </tr> <tr> <td data-bbox="1213 966 1436 1042">Clozapine (Fazaclo®, Clozaril®)</td> <td colspan="3" data-bbox="1436 966 2068 1042" rowspan="3">NOT APPROVED</td> </tr> <tr> <td data-bbox="1213 1042 1436 1118">Iloperidone (Fanapt®)</td> </tr> <tr> <td data-bbox="1213 1118 1436 1195">Lurasidone (Latuda®)</td> </tr> <tr> <td data-bbox="1213 1195 1436 1271">Olanzapine (Zyprexa®)</td> <td data-bbox="1436 1195 1755 1271" rowspan="2">Schizophrenia Bipolar Disorder/Mixed Mania</td> <td data-bbox="1755 1195 1929 1271">13-17 years</td> <td data-bbox="1929 1195 2068 1271">10mg/day</td> </tr> <tr> <td data-bbox="1213 1271 1436 1347">Olanzapine (Zyprexa Zydis®)</td> <td data-bbox="1755 1271 1929 1347">13-17 years</td> <td data-bbox="1929 1271 2068 1347">10mg/day</td> </tr> <tr> <td data-bbox="1213 1347 1436 1424">Paliperidone (Invega ER®)</td> <td data-bbox="1436 1347 1755 1424">Schizophrenia</td> <td data-bbox="1755 1347 1929 1424">12-17 years</td> <td data-bbox="1929 1347 2068 1424">12mg/day</td> </tr> <tr> <td data-bbox="1213 1424 1436 1466">Risperidone (Risperdal®)</td> <td data-bbox="1436 1424 1755 1466">Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania</td> <td data-bbox="1755 1424 1929 1466">5-16 years 10-17 years</td> <td data-bbox="1929 1424 2068 1466">3mg/day 6mg/day</td> </tr> </tbody> </table>						Drug	FDA Approved Indication	FDA Approved Age	Maximal FDA Approved Dose	Asenapine (Saphris®)	NOT APPROVED			Aripiprazole (Abilify®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia	6-17 years 10-17 years 13-17 years	15mg/day 30mg/day 30mg/day	Clozapine (Fazaclo®, Clozaril®)	NOT APPROVED			Iloperidone (Fanapt®)	Lurasidone (Latuda®)	Olanzapine (Zyprexa®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years	10mg/day	Olanzapine (Zyprexa Zydis®)	13-17 years	10mg/day	Paliperidone (Invega ER®)	Schizophrenia	12-17 years	12mg/day	Risperidone (Risperdal®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania	5-16 years 10-17 years	3mg/day 6mg/day
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)			
			Quetiapine Fumarate (Seroquel®)	Schizophrenia Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 13-17 years 10-17 years	6mg/day 800 mg/day 800 mg/day
			Quetiapine Fumarate (Seroquel XR®)	NOT APPROVED		
			Ziprasidone (Geodon®)	NOT APPROVED		
<b>BISPHOSPHONATES (oral)</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets	<b>Prior Authorization Required</b> ACTONEL ACTONEL w/Calcium BINOSTO BONIVA DIDRONEL FOSAMAX (brand) FOSAMAX plus D Etidronate SKELID	Non-preferred products will be approved for clients 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.)  Prior authorization will be approved for etidronate in clients with heterotopic ossification without treatment failure.			
<b>DIABETES MANAGEMENT CLASSES (oral)</b>  <b>Biguanides</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended-release 500mg tablets (generic Glucophage XR)	<b>Prior Authorization Required</b> FORTAMET GLUCOPHAGE (brand) GLUCOPHAGE XR (brand) GLUMETZA metformin ER 750mg RIOMET 500mg/5ml metformin extended-release 500 and 1000mg (generic Fortamet)	Non-preferred products will be approved for clients 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 clients who meet one of the following: <ul style="list-style-type: none"> <li>➤ under the age of 12</li> <li>➤ with a feeding tube</li> <li>➤ who have difficulty swallowing</li> </ul>			
<b>Fluroquinolones (oral)</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	<b>Prior Authorization Required</b> LEVAQUIN TABLET CIPRO TABLET AVELOX NOROXIN Ofloxacin	Non-preferred products will be approved for clients who have failed an adequate trial (7days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)  CIPRO suspension approved for clients < 5 years of age without prior authorization  For clients ≥ 5 years of age, CIPRO suspension will only be approved for those clients who cannot swallow a whole or crushed tablet			

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Levofloxacin solution will be approved for clients who have failed an adequate trial (7days) of ciprofloxacin suspension. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
<b>Hypoglycemic Combinations</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> ACTOPLUS MET AVANDAMET AVANDARYL DUETACT glip/met GLUCOVANCE (brand) METAGLIP PRANDIMET glyburide/metformin JANUMET (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) JUVISYNC (sitagliptin/simvastatin) KOMBIGLYZE (saxagliptin/metformin) KAZANO (alogliptin/metformin) OSENI (alogliptin/pioglitazone)	Non-preferred products will be approved for clients who have been stable on the two individual ingredients for 3 months and have an adherence issue.
<b>Meglitinides</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> PRANDIN STARLIX	Non-preferred products will be approved for clients who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
<b>Newer Diabetic Agents</b>  <i>Effective 10/1/2013</i>	<b>No prior authorization required</b>  *BYETTA (exenatide) *JANUVIA (sitagliptin) *TRADJENTA (linagliptin)	<b>Prior Authorization Required</b>  BYDUREON (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide) ONGLYZA (saxagliptin) NESINA (alogliptin) INVOKANA (canaglifozin)	* Approval for selected preferred products require a 3 month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. <b>For all products</b> , dosing will be limited to FDA approved dosing. Prior Authorization will be required for doses in excess of FDA approved dosing.  Invokana will only be approved after a client has failed a three month trial of two of the following: metformin, a sulfonylurea, or any of the preferred products. Failure is defined as: lack of efficacy (e.g., hemoglobin A1C $\geq$ 7%), allergy, intolerable side effects, or a significant drug-drug interaction.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>Invokana will not be approved for patients 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 &lt; 45ml/min).</p> <p>Non-preferred products will be approved for clients who have failed treatment with one preferred product in the last year. Prior authorization will be approved for Symlin products for clients with Diabetes Mellitus Type 1 without failed treatment. (Failure is defined as: lack of efficacy (e.g., hemoglobin A1C ≥ 7%), allergy, intolerable side effects, or significant drug-drug interaction.)</p>
<b>Thiazolidinediones</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> AVANDIA (rosiglitazone) ACTOS (pioglitazone)	<p><b>*Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy.</b></p> <p>Prior authorizations for rosiglitazone will be manually reviewed by the Department based upon reported risk mitigation, medical justification and contraindication to pioglitazone.</p> <p>Pioglitazone will be approved upon documentation that following criteria have been met:</p> <ul style="list-style-type: none"> <li>○ The client has been counseled that TZD's may cause or exacerbate heart failure and has been given examples of signs and symptoms of heart failure;</li> <li>○ The client does not currently have NYHA Class III-IV heart failure;</li> <li>○ The client does not have active bladder cancer or prior history of bladder cancer.</li> <li>○ The prescriber agrees to monitor for signs and symptoms of heart failure at all follow-up appointments;</li> <li>○ Liver tests are obtained prior to initiation of therapy.</li> </ul> <p>Clients currently stabilized on and compliant with pioglitazone therapy will be allowed to continue therapy. Prior authorization will be required for new starts or when no claims have been filled in the last 120 days.</p>
<b>ERYTHROPOIESIS STIMULATING AGENTS</b>  <i>Effective 10/1/2013</i>	<b>*Must meet eligibility criteria</b> PROCRT ARANESP	<b>Prior Authorization Required</b> EPOGEN	<p><b>*Eligibility Criteria for all agents in the class</b></p> <p>Clients must meet all criteria in one of the following four areas:</p> <ul style="list-style-type: none"> <li>➤ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower.</li> <li>➤ A diagnosis of chronic renal failure, and hemoglobin below 10g/dL</li> <li>➤ 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).</li> <li>➤ A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less.</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			Hemoglobin results must be from the last 30 days. Medication must be administered in the client's home or long-term care facility. (CONTINUED) <b>Non-preferred products:</b> <ul style="list-style-type: none"> <li>➤ Same as above; <b>and</b></li> <li>➤ Failed treatment with Procrit. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</li> </ul> <b>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.</b>
<b>FIBROMYALGIA AGENTS</b>  <i>Effective 7/1/2013</i>	<b>No Prior Authorization Required</b>  LYRICA (pregabalin) SAVELLA (milnacipran)	<b>Prior Authorization Required</b>  CYMBALTA (duloxetine)	Cymbalta will be approved for fibromyalgia if ALL of the following criteria have been met: <ul style="list-style-type: none"> <li>• Failure of an adequate trial (8 weeks) of at least two of the following: tramadol, a tricyclic antidepressant, and appropriately titrated dosed gabapentin (1200-2400 mg in divided doses); AND</li> <li>• Documented non-pharmacologic therapies to the Department (e.g, cognitive behavioral therapies, exercise).</li> </ul> Lycia will have a maximum dosage limitation of 600 mg/day and a unit limit of three capsules per day.
<b>GROWTH HORMONES</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required</b>  NORDITROPIN OMNITROPE SAIZEN	<b>Prior Authorization Required</b>  GENOTROPIN HUMATROPE NUTROPIN SEROSTIM TEV-TROPIN ZORBTIVE	Non-preferred Growth Hormones will be approved if <b>both</b> of the following criteria are met: <ul style="list-style-type: none"> <li>▪ Client failed treatment with two preferred products within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</li> <li>▪ Client has a qualifying diagnosis:               <ul style="list-style-type: none"> <li>➤ Prader-Willi</li> <li>➤ Chronic renal insufficiency/failure</li> <li>➤ Turner's Syndrome</li> <li>➤ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma</li> <li>➤ Wasting associated with AIDS or cachexia</li> <li>➤ Noonan Syndrome</li> </ul> </li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>INTRANASAL CORTICOSTEROIDS</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required</b>  fluticasone (generic FLONASE)  triamcinolone acetonide (generic NASACORT AQ)  NASONEX	<b>Prior Authorization Required</b> BECONASE AQ FLONASE NASAREL NASACORT AQ OMNARIS RHINOCORT AQ VERAMYST ZETONNA	Non-preferred Intranasal Corticosteroids will be approved if the client 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).  ★Rhincort AQ will be approved for pregnant clients without failure of Preferred products. ★Brand name Flonase will require a letter of medical necessity
<b>LEUKOTRIENE MODIFIERS</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required</b>  montelukast (generic SINGULAIR)	<b>Prior Authorization Required</b>  ACCOLATE (zafirlukast) ZYFLO (zileuton) SINGULAIR	Non-preferred Leukotrienes will be approved if <b>both</b> of the following criteria are met: <ul style="list-style-type: none"> <li>▪ Client 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)</li> <li>▪ Client has a diagnosis of Asthma</li> </ul>
<b>MULTIPLE SCLEROSIS AGENTS</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required</b> AVONEX BETASERON REBIF COPAXONE	<b>Prior Authorization Required</b>  AMPYRA EXTAVIA GILENYA AUBAGIO TECFIDERA	<b>Ampyra</b> – Two 30 day supplies of Ampyra will be approved if all of the following criteria are met: <ul style="list-style-type: none"> <li>• Client has a diagnosis of MS;</li> <li>• Client is ambulatory and has established a baseline Timed 25-foot Walk (T25FW) assessment;</li> <li>• Client is currently receiving a disease modifying agent (if indicated);</li> <li>• Client has no history of seizure disorder;</li> <li>• Client has no history of moderate to severe renal dysfunction (CrCl &gt; 50 ml/min);</li> <li>• Prescriber is a neurologist or is consulting a neurologist;</li> <li>• The prescribed dose does not exceed 10 mg twice daily.</li> </ul> Extended coverage of Ampyra (up to one year) will be approved if documentation shows improvement in ambulation (measured by T25FW assessment).  GILENYA will be approved if the client has failed treatment with one interferon and Copaxone. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Lack of efficacy is defined by client meeting one of the three following criteria: a clinical relapse within the past 12 month period; progression of disease as verified by MRI; or continued worsening of physical disability.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>AUBAGIO will be approved if the client has failed treatment with one interferon and Copaxone. Female patients must have a negative pregnancy test and must be using reliable contraception. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Lack of efficacy is defined by client meeting two of the three following criteria: 2 clinical relapses within the past 12 month period; progression of disease as verified by MRI during active treatment period; or continued worsening of physical disability.</p> <p>TECFIDERA will be approved if the client has failed treatment with one interferon and Copaxone. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Lack of efficacy is defined by client meeting one of the three following criteria: a clinical relapse within the past 12 month period; progression of disease as verified by MRI; or continued worsening of physical disability.</p> <p>Non-preferred Interferon products will be approved if the client 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).</p>
<b>OPHTHALMIC ALLERGY</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required</b> cromolyn PATANOL PATADAY ZADITOR	<b>Prior Authorization Required</b> ALAMAST, ALAWAY ALOCRIL, ALOMIDE BEPREVE, ELESTAT EMADINE, OPTIVAR	Non-preferred Ophthalmic Allergy medications will be approved if the client 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)
<b>OPIOIDS</b> <b>Long Acting – Oral Opioids</b>  <i>Effective 7/1/2013</i>	<b>FIRST LINE (No Prior Authorization Required)</b>  methadone (generic Dolophine)  morphine ER (generic MS Contin)  fentanyl patches	<b>Prior Authorization Required</b>  AVINZA (morphine ER) BUTRANS (buprenorphine) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) KADIAN (morphine ER) MS CONTIN (morphine ER) – Brand NUCYNTA ER (tapentadol ER) ORAMORPH SR (morphine ER) - Brand	Non-preferred, long-acting oral opioids will be approved for clients 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.)  Oxycotin®, Opana ER®, Nucynta ER®, and Zohydro ER® will only be approved for twice daily dosing.  No more than one long-acting oral opioid will be approved at one time.  Medicaid is not mandating that a patient switch from a non-preferred drug to methadone. Methadone requires special training due to its complex

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
		OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER) EMBEDA(morphine/naltrex.) ZOHYDRO ER (hydrocodone ER)	<p>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 should counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of neonatal abstinence syndrome.</p> <p>Phasing out grandfathering will begin two months following implementation of the opiate education program. The Department will notify all providers once this goes in effect.</p>
<b>OVERACTIVE BLADDER AGENTS</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  oxybutynin tablets (generic) oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	<b>Prior Authorization Required</b>  DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) tolterodine VESICARE (solifenacin) Myrbetriq (mirabegron)	Non-preferred products will be approved for clients who have failed treatment with two preferred products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.). Clients with hepatic failure can receive approval to receive trospium or trospium extended-release (Sanctura XR) products without a trial on a Preferred product.
<b>PANCREATIC ENZYMES</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  CREON ZENPEP	<b>Prior Authorization Required</b>  PANCREAZE PANCRELIPASE PERTZYE ULTRESA VIOKACE	Non-preferred products will be approved for clients 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: Clients currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.
<b>HEPATITIS C VIRUS TREATMENTS</b>	<b>*Must meet eligibility criteria</b>	<b>Prior Authorization Required</b>	Requests for Victrelis® will be prior authorized if the following criteria are met:

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<i>Effective 10/1/2013</i>	VICTRELIS	INCIVEK OLYSIO SOVALDI	<ul style="list-style-type: none"> <li>○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon.</li> <li>○ The patient will be on a treatment regimen of ribavirin and pegylated interferon for four (4) weeks prior to initiation of Victrelis.</li> <li>○ The patient is eighteen (18) years or older.</li> <li>○ The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin).</li> <li>○ The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse.</li> <li>○ The patient's previous treatment history and weight are presented at the time of initial request</li> <li>○ The patient's Child-Pugh score is &lt;6 (compensated cirrhotic liver disease).</li> <li>○ The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek®, Victrelis®, or Olysio®).</li> <li>○ The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication).</li> <li>○ Victrelis® is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist.</li> <li>○ A sensitive RT-PCR assay HCV-RNA test with a lower limit of quantification of ≤25 IU/ml and a limit of detection of approximately 10 to 15 IU/ml is required to be submitted before the start of therapy.</li> </ul> <p>Requests for Incivek® will be prior authorized if the following criteria are met:</p> <ul style="list-style-type: none"> <li>○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon.</li> <li>○ The patient is eighteen (18) years or older.</li> <li>○ The patient's previous treatment history and weight are presented at the time of initial request.</li> <li>○ The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse.</li> <li>○ The patient's Child-Pugh score is &lt;6 (compensated cirrhotic liver disease).</li> <li>○ The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin) or drug dependent on CYP3A4 clearance (e.g., alfuzosin, cisparide,</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>dihydroergotamine, ergonovine, ergotamine, lovastatin, sildenafil, tadalafil, simvastatin, triazolam).</p> <ul style="list-style-type: none"> <li>○ The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek®, Victrelis®, or Olysio®).</li> <li>○ The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication).</li> <li>○ Incivek® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist.</li> <li>○ A sensitive RT-PCR assay HCV-RNA test with a lower limit of quantification of <math>\leq 25</math> IU/ml and a limit of detection of approximately 10 to 15 IU/ml is required to be submitted before the start of therapy.</li> <li>○ Prior authorization for Incivek® will be determined on a case by case basis. Providers must provide the Department with full documentation regarding the rationale for treatment with Incivek®</li> </ul> <p>Requests for Olysio® will be prior authorized if the following criteria are met:</p> <ul style="list-style-type: none"> <li>○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon.</li> <li>○ The patient is eighteen (18) years or older.</li> <li>○ The patient's previous treatment history and weight are presented at the time of initial request.</li> <li>○ The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse.</li> <li>○ The patient's Child-Pugh score is &lt;6 (compensated cirrhotic liver disease).</li> <li>○ The patient is not receiving moderate to strong inhibitors (e.g. erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (e.g. carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St Johns Wort) of CYP3A4.</li> <li>○ The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor ( e.g. Incivek® or Victrelis®).</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> <li>○ The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication).</li> <li>○ Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment and for at least 6 months after treatment has concluded. Routine monthly pregnancy tests must be performed during this time.</li> <li>○ Olysio ® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist.</li> <li>○ A sensitive RT-PCR assay HCV-RNA test with a lower limit of quantification of <math>\leq 25</math> IU/ml and a limit of detection of approximately 10 to 15 IU/ml is required to be submitted before the start of therapy.</li> <li>○ For patients with HCV genotype 1a, evidence should be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy.</li> </ul> <p>Prior authorization for Olysio ® will be determined on a case by case basis. Providers must provide the Department with full documentation regarding the rationale for treatment with Olysio ®</p> <p>Prior authorization for Sovaldi® will be determined on a case by case basis. Providers must provide the Department with full documentation regarding the rationale for urgent treatment with Sovaldi®</p>



Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>PULMONARY ARTERIAL HYPERTENSION THERAPIES</b> <b>Phosphodiesterase Inhibitors</b>  <i>Effective 1/1/2014</i>	<b>*Must meet eligibility criteria</b> Sildenafil (generic Revatio) ADCIRCA (tadalafil)	<b>Prior Authorization Required</b>  REVATIO	<b>*Eligibility Criteria for all agents in the class</b> Approval will be granted for a diagnosis of pulmonary hypertension.
<b>Endothelin Antagonists</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  Letairis (ambrisentan)	<b>Prior Authorization Required</b>  Tracleer (bosentan) OPSUMIT (Macitentan)	Non-preferred products will be approved for clients who have failed treatment with Letairis or for clients 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) <b>Grandfathering:</b> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.
<b>Prostanoids</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  epoprostenol (generic) Veletri (epoprostenol)	<b>Prior Authorization Required</b>  Flolan (brand) Remodulin (treprostinil) Tyvaso (treprostinil) Ventavis (iloprost)	Non-preferred products will be approved for clients 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) <b>Grandfathering:</b> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.
<b>Guanylate Cyclase (sGC) Stimulator</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  Adempas (riociguat)	Adempas will be approved for patients who meet the following criteria: <ul style="list-style-type: none"> <li>○ Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND</li> <li>○ 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</li> <li>○ Patient is not receiving dialysis or has severe renal failure (e.g, Crcl &lt; 15 ml/min). AND</li> <li>○ Patient does not have severe liver impairment (e.g, Child Pugh C). AND</li> <li>○ Prescriber must be enrolled with the Adempas REMS Program. AND</li> </ul>

			<ul style="list-style-type: none"> <li>○ Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND</li> <li>○ Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR</li> <li>○ 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).</li> </ul>
<b>Therapeutic Drug Class</b>	<b>Preferred Agents</b>	<b>Non-preferred Agents</b>	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>RESPIRATORY INHALANTS Inhaled Anticholinergics &amp; Anticholinergic Combinations</b>  <i>Effective 7/1/2013</i>	<b>No Prior Authorization Required</b>  <u>Solutions</u> albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) <u>Short-Acting Inhalers</u> ATROVENT HFA (ipratropium) COMBIVENT MDI (albuterol/ipratropium) COMBIVENT RESPIMAT (albuterol/ipratropium) <u>Long-Acting Inhalers</u> SPIRIVA Handihaler (tiotropium)	<b>Prior Authorization Required</b>  <u>Solutions</u> ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium) <u>Short-Acting Inhalers</u>  <u>Long-Acting Inhalers</u> TUDORZA Pressair (aclidinium)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name prior authorization stating medical necessity. COMBIVENT RESPIMAT will be covered if the MDI is unavailable or contraindicated.  Tudorza Pressair will be approved for clients 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.
<b>RESPIRATORY INHALANTS Inhaled Beta2 Agonists (short acting)</b>  <i>Effective 7/1/2013</i>	<b>No Prior Authorization Required</b>  <u>Solutions</u> albuterol (generic) solution  <u>Inhalers</u> PROAIR (albuterol) HFA inhaler	<b>Prior Authorization Required</b>  <u>Solutions</u> ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. <u>Inhalers</u>	Non-preferred, short acting beta2 agonists will be approved for clients who have failed treatment with one preferred agent. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).

		ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler MAXAIR (pirbuterol) autohaler PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	
<b>Therapeutic Drug Class</b>	<b>Preferred Agents</b>	<b>Non-preferred Agents</b>	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>RESPIRATORY INHALANTS Inhaled Beta2 Agonists (long acting)</b>  <i>Effective 7/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  <u><b>Solutions</b></u> BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution <u><b>Inhalers</b></u> FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler ARCAPTA (indacaterol) neohaler	Long acting beta-2 agonists will be approved for clients with moderate to severe asthma who are currently using an inhaled corticosteroid and require add-on therapy, or for clients with moderate to very severe COPD.
<b>RESPIRATORY INHALANTS Inhaled Corticosteroids</b>  <i>Effective 7/1/2013</i>	<b>No Prior Auth Required</b>  <u><b>Solutions</b></u> budesonide nebules <u><b>Inhalers</b></u> ASMANEX twist (mometasone) FLOVENT (fluticasone) HFA FLOVENT diskus <b>50,</b> <b>100</b> & 250 mcg QVAR (beclomethasone)	<b>Prior Authorization Required</b>  <u><b>Inhalers</b></u> AEROBID (flunisolide) inhaler ALVESCO (ciclesonide) AZMACORT (triamcinolone) inhaler PULMICORT (budesonide) flexhaler	Non-preferred inhaled corticosteroids will be approved in clients with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.)  Pulmicort Flexhaler will only be approved without failure on preferred products for female clients with asthma who have a new diagnosis of pregnancy.  Budesonide nebulizer solution will only be approved for a maximal dose of 2mg/day.

<p><b>RESPIRATORY INHALANTS Inhaled Corticosteroid Combinations</b></p> <p><i>Effective 7/1/2013</i></p>	<p><b>No Prior Authorization Required</b></p> <p>ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) SYMBICORT (budesonide/formoterol) DULERA (mometasone/formoterol)</p>	<p><b>Prior Authorization Required</b></p> <p>BREO Ellipta</p>	<p>Non-preferred inhaled corticosteroid combination inhalants will be approved for clients meeting both of the following criteria:</p> <ul style="list-style-type: none"> <li>➤ Client has a qualifying diagnosis of asthma or COPD; and</li> <li>➤ Client cannot take preferred drug due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.</li> </ul>
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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.)
<b>SEDATIVE- HYPNOTICS (non-benzodiazepine)</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required* (unless duplication criteria apply)</b>  LUNESTA (eszopiclone) zaleplon zolpidem	<b>Prior Authorization Required</b>  AMBIEN CR (zolpidem) AMBIEN (zolpidem) - Brand EDLUAR (zolpidem) INTERMEZZO (zolpidem) ROZEREM (ramelteon) SONATA (zaleplon) - Brand ZOLPIMIST (zolpidem)	Non-preferred sedative hypnotics will be approved for clients 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)  Rozerem will be approved for clients with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent  <b>Children:</b> Prior authorizations will be approved for clients 18 years of age and older.  <b>*Duplications:</b> Only one agent in this drug class will be approved at a time. Approval will not be granted for clients currently taking a long-acting benzodiazepine such as clonazepam or temazepam.
<b>SKELETAL MUSCLE RELAXANTS</b>  <i>Effective 7/1/2013</i>	<b>No Prior Authorization Required For Clients under 75 years of age*</b>  baclofen (generic Lioresal)  cyclobenzaprine (generic Flexeril)  tizanidine (generic Zanaflex)	<b>Prior Authorization Required</b>  AMRIX ER chlorzoxazone carisoprodol DANTRIUM dantrolene FEXMID FLEXERIL metaxolone methocarbamol NORFLEX orphenadrine PARAFLEX PARAFON FORTE REMULAR ROBAXIN SKELAXIN ZANAFLEX SOMA VANADOM RELA	All agents in this class will require a prior authorization for clients over 65 years of age. Approval will only be given if the client has had at least a 7 day trial with an opiate or has a diagnosis of spasticity. The maximum allowable approval will be for a 7 days' supply.  Non-preferred skeletal muscle relaxants will be approved for clients who have documented lack of efficacy with two preferred agents in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions.)  Authorization for any carisoprodol product will be given for a maximum 3 week one time authorization for clients with acute, painful musculoskeletal conditions who have failed treatment with two preferred products.  Tapering: Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for clients tapering off of carisoprodol. *A PA will only be granted for any carisoprodol product for short-term use or tapering.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>STATINS &amp; STATIN COMBINATIONS</b>  <i>Effective 4/1/2013</i>	<b>No Prior Authorization Required</b>  CRESTOR (rosuvastatin)  atorvastatin  pravastatin  simvastatin*	<b>Prior Authorization Required</b> ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin) <b>Statin Combinations</b> ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) LIPTRUZET (ezetimibe/ atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvas.)	<p>Non-preferred Statin/Statin combinations will be approved if the client 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><b>Children:</b> Altoprev, Advicor, Livalo and Vytorin will be approved for clients 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for clients 10 years of age and older.</p> <p>*Simvastatin 80mg dose products will only be covered for clients who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in clients who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication 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>

<b>Therapeutic Drug Class</b>	<b>Preferred Agents</b>	<b>Non-preferred Agents</b>	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>STIMULANTS and ADHD</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b> <b>(as long as age, daily dose and diagnosis limitations are met)</b>  mixed-amphetamine salts (generic Adderall) ADDERALL XR (brand name mixed amphetamine salts ER) CONCERTA (brand name methylphenidate ER) dexmethylphenidate (generic) FOCALIN XR (dexmethylphenidate ER) methylphenidate (generic RITALIN) methylphenidate SR (generic for Ritalin SR) methylphenidate ER (generic for Concerta) STRATTERA (atomoxetine) VYVANSE (lisdexamfetamine)	<b>Prior Authorization Required</b> ADDERALL (brand name mixed amphetamine salts) mixed-amphetamine salts ER (generic for Adderall XR) DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) FOCALIN (brand name dexmethylphenidate) INTUNIV (guanfacine ER) KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) NUVIGIL (armodafinil) PROVIGIL (modafinil) QUILLIVANT XR (methylphenidate) RITALIN (brand name methylphenidate)	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.  For patients with ADD/ADHD, prior to receiving pharmacotherapy, the beneficiary must have additional documentation through a validated ADHD/ADD instrument.  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.  Non-preferred agents will be approved for clients 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.  <b>In addition:</b> Non-preferred agents will only be approved for FDA and official compendium indications. <ul style="list-style-type: none"> <li>▪ Intuniv will be approved for clients with a diagnosis of ADHD and ADD. Beneficiaries with ADD/ADHD must fail a 4 week trial of generic guanfacine before the use of Intuniv® will be approved. Only one tablet per day will be approved.</li> <li>▪ Beginning 11/1/2013, Provigil will only be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Traumatic Brain Injury, Multiple Sclerosis related fatigue or ADHD. Beneficiaries must fail a 4 week trial of a Preferred Stimulant before the use of Provigil® will be approved. Only one tablet per day will be approved.</li> <li>▪ 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.</li> <li>▪ All other Non-preferred products will be approved for clients with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism.</li> </ul> <b>And</b>  Non-preferred agents will only be approved for FDA approved age limitations. <ul style="list-style-type: none"> <li>▪ Provigil will be approved for clients 16 years of age and older.</li> <li>▪ Nuvigil will be approved for clients 17 years of age and older.</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<p align="center"><b>Prior Authorization Criteria</b></p> <p align="center">(All Non-preferred Products will be approved for one year unless otherwise stated.)</p>																																																		
			<ul style="list-style-type: none"> <li>▪ Adderall IR, Dexedrine and Dextrostat will be approved for clients 3 years of age and older.</li> <li>▪ All other medications in this class will be approved for clients 6 years of age and older.</li> </ul> <p><b>Daytrana , Methylin solution and Quillivant XR:</b> Clients 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> <p>Prior authorization will be required for patients who exceed the following maximum daily doses.</p> <table border="1" data-bbox="1073 557 2053 1373"> <thead> <tr> <th data-bbox="1073 557 1509 589">Drug</th> <th data-bbox="1509 557 2053 589">Maximum Daily Dose</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="1073 589 2053 621"><b>Preferred</b></td> </tr> <tr> <td data-bbox="1073 621 1509 654">AMPHETAMINE SALTS</td> <td data-bbox="1509 621 2053 654">40 mg/day</td> </tr> <tr> <td data-bbox="1073 654 1509 686">CONCERTA ER ®</td> <td data-bbox="1509 654 2053 686">54 mg/day or 72 mg/day ≥ age 13</td> </tr> <tr> <td data-bbox="1073 686 1509 719">METHYLPHENIDATE ER</td> <td data-bbox="1509 686 2053 719">60 mg/day</td> </tr> <tr> <td data-bbox="1073 719 1509 751">VYVANSE ®</td> <td data-bbox="1509 719 2053 751">70 mg/day</td> </tr> <tr> <td data-bbox="1073 751 1509 784">FOCALIN XR ®</td> <td data-bbox="1509 751 2053 784">40 mg/day</td> </tr> <tr> <td data-bbox="1073 784 1509 816">ADDERALL XR®</td> <td data-bbox="1509 784 2053 816">40 mg/day</td> </tr> <tr> <td data-bbox="1073 816 1509 849">METHYLPHENIDATE</td> <td data-bbox="1509 816 2053 849">60 mg/day</td> </tr> <tr> <td data-bbox="1073 849 1509 881">METHYLIN</td> <td data-bbox="1509 849 2053 881">60 mg/day</td> </tr> <tr> <td data-bbox="1073 881 1509 914">METHYLPHENIDATE</td> <td data-bbox="1509 881 2053 914">60 mg/day</td> </tr> <tr> <td data-bbox="1073 914 1509 946">METHYLPHENIDATE SR</td> <td data-bbox="1509 914 2053 946">60 mg/day</td> </tr> <tr> <td colspan="2" data-bbox="1073 946 2053 979"><b>Non preferred</b></td> </tr> <tr> <td data-bbox="1073 979 1509 1011">METADATE CD ®</td> <td data-bbox="1509 979 2053 1011">60 mg/day</td> </tr> <tr> <td data-bbox="1073 1011 1509 1044">KAPVAY ER ®</td> <td data-bbox="1509 1011 2053 1044">0.1 mg/day</td> </tr> <tr> <td data-bbox="1073 1044 1509 1076">D-AMPHETAMINE ER</td> <td data-bbox="1509 1044 2053 1076">40 mg/day</td> </tr> <tr> <td data-bbox="1073 1076 1509 1109">DAYTRANA ®</td> <td data-bbox="1509 1076 2053 1109">30 mg/day</td> </tr> <tr> <td data-bbox="1073 1109 1509 1141">PROVIGIL ®</td> <td data-bbox="1509 1109 2053 1141">400 mg/day</td> </tr> <tr> <td data-bbox="1073 1141 1509 1174">RITALIN LA ®</td> <td data-bbox="1509 1141 2053 1174">60 mg/day</td> </tr> <tr> <td data-bbox="1073 1174 1509 1206">INTUNIV ER®</td> <td data-bbox="1509 1174 2053 1206">4 mg/day</td> </tr> <tr> <td data-bbox="1073 1206 1509 1239">ADDERALL ®</td> <td data-bbox="1509 1206 2053 1239">40 mg/day</td> </tr> <tr> <td data-bbox="1073 1239 1509 1271">NUVIGIL ®</td> <td data-bbox="1509 1239 2053 1271">250 mg/day</td> </tr> <tr> <td data-bbox="1073 1271 1509 1304">METHYLIN ER ®</td> <td data-bbox="1509 1271 2053 1304">60 mg/day</td> </tr> <tr> <td data-bbox="1073 1304 1509 1336">METHYLIN SUSPENSION®</td> <td data-bbox="1509 1304 2053 1336">60 mg/day</td> </tr> <tr> <td data-bbox="1073 1336 1509 1369">FOCALIN ®</td> <td data-bbox="1509 1336 2053 1369">20 mg/day</td> </tr> </tbody> </table>	Drug	Maximum Daily Dose	<b>Preferred</b>		AMPHETAMINE SALTS	40 mg/day	CONCERTA ER ®	54 mg/day or 72 mg/day ≥ age 13	METHYLPHENIDATE ER	60 mg/day	VYVANSE ®	70 mg/day	FOCALIN XR ®	40 mg/day	ADDERALL XR®	40 mg/day	METHYLPHENIDATE	60 mg/day	METHYLIN	60 mg/day	METHYLPHENIDATE	60 mg/day	METHYLPHENIDATE SR	60 mg/day	<b>Non preferred</b>		METADATE CD ®	60 mg/day	KAPVAY ER ®	0.1 mg/day	D-AMPHETAMINE ER	40 mg/day	DAYTRANA ®	30 mg/day	PROVIGIL ®	400 mg/day	RITALIN LA ®	60 mg/day	INTUNIV ER®	4 mg/day	ADDERALL ®	40 mg/day	NUVIGIL ®	250 mg/day	METHYLIN ER ®	60 mg/day	METHYLIN SUSPENSION®	60 mg/day	FOCALIN ®	20 mg/day
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<p><b>TARGETED IMMUNE MODULATORS FOR RHEUMATOID ARTHRITIS</b></p> <p><i>Effective 1/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>ENBREL (etanercept) HUMIRA (adalimumab)</p>	<p><b>Prior Authorization Required</b></p> <p>CIMZIA (certolizumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous SIMPONI (golimumab) XELJANZ (tofacitinib) STELARA (ustekinumab) ACTEMRA (tocilizumab)</p> <p><b>*for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P</b></p>	<p><b>Cimzia</b> (all dosage forms)</p> <ul style="list-style-type: none"> <li>will be approved for treatment of Crohn’s disease in clients 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.)</li> <li>will be approved for treatment of RA in clients 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.)</li> <li>will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients 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.)</li> </ul> <p><b>Kineret</b> will be approved for treatment of RA in clients 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><b>Kineret</b> will be approved without prior authorization for clients with documented neonatal-onset multisystem inflammatory disease (NOMID).</p> <p><b>Orencia</b> will be approved for the treatment of RA in clients 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><b>Simponi</b> will be approved (in combination with methotrexate) for treatment of RA in clients 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><b>Simponi</b> will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients 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><b>Stelara</b> will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in clients 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><b>Stelara</b> will be approved for moderate to severe plaque psoriasis in clients 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>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p><b>Xeljanz</b> will be approved for the treatment of RA in clients who have had treatment failure with methotrexate with at least two separate preferred TNF inhibitors (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><b>Xeljanz</b> will be not be approved for combination therapy with a biologic disease modifying agent.</p> <p>Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply</p> <p><b>Grandfathering:</b> Clients currently stabilized on a Non-preferred product can receive approval to continue on that agent for one year if medically necessary.</p>
<b>TOPICAL IMMUNOMODULATORS</b>  <i>Effective 7/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)	<p>Elidel or Protopic will only be approved after a client has had an adequate trial (e.g., one month or longer) of a topical steroid and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time prior authorization.</p> <p>Additional criteria must be met for children &lt; 2 years of age.</p> <p>An additional prior authorization will be required for clients warranting <math>\geq</math> 6 weeks of therapy with either Elidel or Protopic.</p>
<b>TRIPTANS</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required (monthly quantity limits may apply)</b>  IMITREX tablets  IMITREX nasal spray and injection <sup>BNR</sup>  sumatriptan tablets  MAXALT MLT tablets (rizatriptan)  naratriptan tablets	<b>Prior Authorization Required</b>  AXERT (almotriptan)  AMERGE (naratriptan)  FROVA (frovatriptan)  RELPAX (eletriptan)  SUMAVEL DOSEPRO	<p>Non-preferred products will be approved for clients 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><b>Quantity Limits:</b>            Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days.            Axert and Relpax: Max 6 tabs / 30 days.            Maxalt: Max 12 tabs / 30 days.            Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days.            Imitrex injection: Max 4 injectors / 30 days</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
		TREXIMET (sumatriptan and naproxen)  ZOMIG (zolmitriptan)  Maxalt tablets (rizatriptan)  sumatriptan nasal spray and injection	