



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

Effective April 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.)
ALZHEIMER'S AGENTS <i>Effective 4/1/2014</i>	No Prior Authorization Required (*Must meet eligibility criteria) generic donepezil tab donepezil ODT generic galantamine and galantamine ER NAMENDA IR	Prior Authorization Required ARICEPT ARICEPT ODT ARICEPT 23mg EXELON (cap, soln. and patch) RAZADYNE RAZADYNE ER NAMENDA XR	*eligibility criteria for Preferred Agents – All preferred products 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) 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.
ORAL ANTICOAGULANTS <i>Effective 10/1/2013</i>	No Prior Authorization Required warfarin	Prior Authorization Required COUMADIN ELIQUIS PRADAXA XARELTO	ELIQUIS or PRADAXA will be approved if: The client is NOT on dialysis AND The client has a diagnosis of nonvalvular atrial fibrillation AND The client does not have a mechanical prosthetic heart valve AND The client does not have an active pathological bleed AND Has a labile INR for reasons other than noncompliance (e.g, INR outside 2-3 \geq 60% of the time for a period of two months) OR Has significant difficulty with complying with monitoring OR Has an allergy or intolerance to warfarin XARELTO will be approved if: The client is NOT on dialysis AND The client has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) OR Is in need of a prophylaxis of DVT following knee or hip replacement surgery OR The client has a diagnosis of nonvalvular atrial fibrillation AND The client does not have a mechanical prosthetic heart valve AND

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			<p>The client does not have an active pathological bleed AND Has a labile INR for reasons other than noncompliance (e.g, INR outside 2-ay \geq 60% of the time for a period of two months) OR Has significant difficulty with complying with monitoring OR Has an allergy or intolerance to warfarin</p> <p>Grandfathering: 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>
ANTIEMETICS <i>Effective 1/1/2014</i>	No Prior Authorization Required ondansetron tablets ondansetron ODT tab ondansetron suspension (clients under 5 years only) ZOFRAN tablets	Prior Authorization Required 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 \geq 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. 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.</p> <p>Approval for DICLEGIS will be granted if the client has nausea and vomiting associated with pregnancy AND The client has failed a trial of doxylamine 10-12.5mg OR The client has failed a trial of oral ondansetron 4mg every 8 hours for five days OR The client has an intolerance or contraindication to ondansetron</p>
ANTIDEPRESSANTS Newer Generation Antidepressants <i>Effective 1/1/2014</i>	No Prior Authorization Required Bupropion IR, SR, XL citalopram fluoxetine	Prior Authorization Required APLENZIN ER (bupropion ER) BRINTELLIX CYMBALTA (duloxetine)	<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>Grandfathering:</p>

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	fluvoxamine mirtazipine nefazodone paroxetine sertraline venlafaxine IR tabs venlafaxine XR capsules	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>Clients 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: 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>
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ANTI-HERPETIC AGENTS <i>Effective 1/1/2014</i>	No Prior Authorization Required Acyclovir tablet, capsule (generic)	Prior Authorization Required Acyclovir suspension Valacyclovir Famcyclovir VALTREX FAMVIR ZOVIRAX SITAVIG	<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 906 2060 1523"> <thead> <tr> <th data-bbox="1213 906 1451 938">Indication</th> <th data-bbox="1451 906 1728 938">Adult</th> <th data-bbox="1728 906 2060 938">Pediatric</th> </tr> </thead> <tbody> <tr> <td data-bbox="1213 938 1451 1076">Genital herpes simplex: Initial</td> <td data-bbox="1451 938 1728 1076">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="1728 938 2060 1076">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 1076 1451 1409">Genital herpes simplex: episodic</td> <td data-bbox="1451 1076 1728 1409">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="1728 1076 2060 1409">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="1213 1409 1451 1523">Genital herpes simplex: Suppressive</td> <td data-bbox="1451 1409 1728 1523">400 mg orally twice daily for up to 12 months; alternative</td> <td data-bbox="1728 1409 2060 1523">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	400 mg orally twice daily for up to 12 months; alternative	12 years or older, 800 to 1200 mg/day orally in 2 divided doses for up to 12 months
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ANTI-HISTAMINES Newer Generation Antihistamines <i>Effective 7/1/2013</i>	No Prior Authorization Required loratadine (generic OTC Claritin) cetirizine (generic OTC Zyrtec)	Prior Authorization Required ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) fexofenadine (generic Allegra) levocetirizine XYZAL (levocetirizine) ZYRTEC (cetirizine) Brand	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.)																								

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Antihistamine/Decongestant Combinations <i>Effective 7/1/2013</i>	No Prior Authorization Required	Prior Authorization Required ALLEGRA-D (fexofen./PSE) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)	
ANTIHYPERTENSIVES Angiotensin Receptor Blockers (ARBs) <i>Effective 7/1/2013</i> ARB Combinations <i>Effective 7/1/2013</i>	No Prior Authorization Required AVAPRO ^{BNR} (irbesartan) BENICAR (olmesartan) DIOVAN ^{BNR} (valsartan) losartan	Prior Authorization Required ATACAND (candesartan) COZAAR (losartan) EDARBI (azilsartan) irbesartan MICARDIS (telmisartan) TEVETEN (eprosartan) valsartan	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.). 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.
No Prior Authorization Required AVALIDE ^{BNR} (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT ^{BNR} (valsartan/HCTZ) losartan/HCTZ	Prior Authorization Required ATACAND-HCT (candesartan/HCTZ) AZOR(amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz) HYZAAR HCT BRAND irbesartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) TEVETEN-HCT (eprosartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/hctz) TWYNSTA (telmisartan/amlodipine) VALTURNA (aliskiren/valsartan) valsartan/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.)
Renin Inhibitors & Renin Inhibitor Combinations <i>Effective 7/1/2013</i>	No Prior Authorization Required	Prior Authorization Required AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	
ANTIPLATELETS <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.
ATYPICAL ANTIPSYCHOTICS (oral) <i>Effective 4/1/2014</i>	No Prior Authorization Required** ABILIFY ABILIFY ODT clozapine CLOZARIL GEODON LATUDA olanzapine risperidone risperidone ODT RISPERDAL RISPERDAL ODT quetiapine* SEROQUEL IR* ZYPREXA ziprasidone	Prior Authorization Required FANAPT FAZACLO INVEGA SAPHRIS SEROQUEL XR ZYPREXA ZYDIS * for injectable Atypical Antipsychotics please see Appendix P for criteria	<i>*IR quetiapine when given at subtherapeutic doses may be restricted for therapy exceeding 30 days. See Appendix P for more details.</i> 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). See Table 1. **Age Limits: All products including preferred products will require a prior authorization for clients younger than the FDA approved age for the agent. Clients 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. 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.

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>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. Verification may be provided from the prescriber or the pharmacy.</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> <p>Zyprexa Zydis will be approved for the treatment of schizophrenia or bipolar 1 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.</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="1241 1453 2032 1523"> <thead> <tr> <th data-bbox="1241 1453 1442 1490">Drug</th> <th data-bbox="1442 1453 2032 1490">Indication</th> </tr> </thead> <tbody> <tr> <td data-bbox="1241 1490 1442 1523">Fanapt®</td> <td data-bbox="1442 1490 2032 1523"> <ul style="list-style-type: none"> Acute treatment of schizophrenia in adults </td> </tr> </tbody> </table>	Drug	Indication	Fanapt®	<ul style="list-style-type: none"> Acute treatment of schizophrenia in adults
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BISPHOSPHONATES (oral) <i>Effective 10/1/2013</i>	No Prior Authorization Required alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets	Prior Authorization Required ACTONEL ACTONEL w/Calcium BINOSTO BONIVA DIDRONEL FOSAMAX (brand) FOSAMAX plus D	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.																																													

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
DIABETES MANAGEMENT CLASSES (oral) Biguanides <i>Effective 10/1/2013</i>	No Prior Authorization Required metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended-release 500mg tablets (generic Glucophage XR)	Etidronate SKELID Prior Authorization Required 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"> ➤ under the age of 12 ➤ with a feeding tube ➤ who have difficulty swallowing
Fluroquinolones (oral) <i>Effective 1/1/2014</i>	No Prior Authorization Required Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	Prior Authorization Required 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 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.)
Hypoglycemic Combinations <i>Effective 10/1/2013</i>	No Prior Authorization Required	Prior Authorization Required ACTOPLUS MET AVANDAMET AVANDARYL DUETACT glip/met GLUCOVANCE (brand) METAGLIP PRANDIMET glyburide/metformin JANUMET (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) JUVISYNC (sitagliptin/simvastatin)	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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Meglitinides <i>Effective 10/1/2013</i>	No Prior Authorization Required	Prior Authorization Required 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.)
Newer Diabetic Agents <i>Effective 10/1/2013</i>	No prior authorization required *BYETTA (exenatide) *JANUVIA (sitagliptin) *TRADJENTA (linagliptin)	Prior Authorization Required BYDUREON (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide) ONGLYZA (saxagliptin) NESINA (alogliptin) INVOKANA (canagliflozin) FARXIGA (dapagliflozin)	<p>* Approval for selected preferred products require a 3 month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy.</p> <p>For all products, dosing will be limited to FDA approved dosing. Prior Authorization will be required for doses in excess of FDA approved dosing.</p> <p>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.</p> <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 $< 45\text{ml/min}$).</p> <p>Farxiga 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.</p> <p>Farxiga 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 $< 45\text{ml/min}$).</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 $\geq 7\%$), allergy, intolerable side effects, or significant drug-drug interaction.)</p>
Thiazolidinediones <i>Effective 10/1/2013</i>	No Prior Authorization Required	Prior Authorization Required AVANDIA (rosiglitazone) ACTOS (pioglitazone)	<p>*Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy.</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"> ○ 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;

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"> ○ The client does not currently have NYHA Class III-IV heart failure; ○ The client does not have active bladder cancer or prior history of bladder cancer. ○ The prescriber agrees to monitor for signs and symptoms of heart failure at all follow-up appointments; ○ Liver tests are obtained prior to initiation of therapy. <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>
ERYTHROPOIESIS STIMULATING AGENTS <i>Effective 10/1/2013</i>	*Must meet eligibility criteria PROCRT ARANESP	Prior Authorization Required EPOGEN	*Eligibility Criteria for all agents in the class Clients must meet all criteria in one of the following four areas: <ul style="list-style-type: none"> ➤ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower. ➤ A diagnosis of chronic renal failure, and hemoglobin below 10g/dL ➤ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic). ➤ A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less. <p>Hemoglobin results must be from the last 30 days. Medication must be administered in the client's home or long-term care facility. (CONTINUED)</p> <p>Non-preferred products:</p> <ul style="list-style-type: none"> ➤ Same as above; and ➤ Failed treatment with Procrit. (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 7/1/2013</i>	No Prior Authorization Required	Prior Authorization Required CYMBALTA (duloxetine)	Cymbalta will be approved for fibromyalgia if ALL of the following criteria have been met:

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	LYRICA (pregabalin) SAVELLA (milnacipran)		<ul style="list-style-type: none"> 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 Documented non-pharmacologic therapies to the Department (e.g, cognitive behavioral therapies, exercise). <p>Lycia will have a maximum dosage limitation of 600 mg/day and a unit limit of three capsules per day.</p>
GROWTH HORMONES <i>Effective 4/1/2014</i>	No Prior Authorization Required NORDITROPIN OMNITROPE SAIZEN	Prior Authorization Required GENOTROPIN HUMATROPE NUTROPIN SEROSTIM TEV-TROPIN ZORBTIVE	Non-preferred Growth Hormones will be approved if both of the following criteria are met: <ul style="list-style-type: none"> 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) Client 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
INTRANASAL CORTICOSTEROIDS <i>Effective 4/1/2014</i>	No Prior Authorization Required fluticasone (generic FLONASE) NASONEX	Prior Authorization Required BECONASE AQ FLONASE NASAREL NASACORT AQ OMNARIS QNASL RHINOCORT AQ Triamcinolone acetonide 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). <ul style="list-style-type: none"> ★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products. ★Brand name Flonase will require a letter of medical necessity
LEUKOTRIENE MODIFIERS <i>Effective 4/1/2014</i>	No Prior Authorization Required montelukast (generic SINGULAIR)	Prior Authorization Required ACCOLATE (zafirlukast) ZYFLO (zileuton) SINGULAIR	Non-preferred Leukotrienes will be approved if both of the following criteria are met: <ul style="list-style-type: none"> 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) Client has a diagnosis of Asthma
MULTIPLE SCLEROSIS AGENTS <i>Effective 4/1/2014</i>	No Prior Authorization Required AVONEX BETASERON	Prior Authorization Required AMPYRA EXTAVIA	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).

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	REBIF COPAXONE 20MG INJECTION	GILENYA AUBAGIO TECFIDERA COPAXONE 40MG INJECTION	<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"> • Client has a diagnosis of MS; • Client is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment; • Client is currently receiving a disease modifying agent (if indicated); • Client has no history of seizure disorder; • Client has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min); • Prescriber is a neurologist; • The prescribed dose does not exceed 10 mg twice daily. <p>Extended coverage of Ampyra (up to one year) will be approved if documentation shows a 20% improvement in ambulation (measured by T25FW assessment) after three months of therapy.</p> <p>AUBAGIO will be approved if the client has met all the following criteria:</p> <ul style="list-style-type: none"> • Has failed six month trial with COPAXONE or a preferred interferon products. 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 new spinal lesions, cerebellar or brain stem lesions, or T2 or T1 lesions, or change in brain atrophy. • On clinical exam, signs and symptoms consistent with functional limitations, except sensory relapse, that last one month or longer. <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Has no active infections AND • If a female patient of child bearing age, has a negative pregnancy test at baseline and is using a form of highly effective contraceptive AND • Had transaminase and bilirubin levels with ALT < 2 times the upper limit of normal within the 6 months prior to initiating therapy AND • Had a complete blood count with differential within the six months prior to initiating therapy AND • Has a documented baseline blood pressure AND • Has been evaluated for active or latent tuberculosis infections by documented test results (purified protein derivative test) or blood test.

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>TECFIDERA will be approved if the client has met all the following criteria:</p> <ul style="list-style-type: none"> • Has failed six month trial with COPAXONE or a preferred interferon products. 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 new spinal lesions, cerebellar or brain stem lesions, or T2 or T1 lesions, or change in brain atrophy. • On clinical exam, signs and symptoms consistent with functional limitations, except sensory relapse, that last one month or longer. <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • 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 client has met all the following criteria:</p> <ul style="list-style-type: none"> • Has failed six month trial with COPAXONE or a preferred interferon products. 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 new spinal lesions, cerebellar or brain stem lesions, or T2 or T1 lesions, or change in brain atrophy. • On clinical exam, signs and symptoms consistent with functional limitations, except sensory relapse, that last one month or longer. <p>AND</p> <ul style="list-style-type: none"> • Has a diagnosis of a relapsing form of MS AND • Is being prescribed by a neurologist AND • Does not have a recent history of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or New York Heart Association Class III-IV heart failure within six months of initiating therapy 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
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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.)
			AND <ul style="list-style-type: none"> • Has a baseline QTc interval <500 ms prior to starting therapy AND • Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND • Has no active infections AND • Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy within 3-4 months after starting therapy AND • Had a baseline complete blood count with differential and liver function tests.
OPHTHALMIC ALLERGY <i>Effective 4/1/2014</i>	No Prior Authorization Required cromolyn PATANOL PATADAY	Prior Authorization Required ALAMAST, ALAWAY ALOCRI, ALOMIDE BEPREVE, ELESTAT EMADINE, LASACRAFT, OPTICROM, OPTIVAR, ZADITOR	Non-preferred Ophthalmic Allergy medications will be approved if the client 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 7/1/2013</i>	FIRST LINE (No Prior Authorization Required) methadone (generic Dolophine) morphine ER (generic MS Contin) fentanyl patches	Prior Authorization Required 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 OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER) EMBEDA(morphine/naltrex.) ZOHYDRO ER (hydrocodone ER)	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.) Oxycontin®, 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 pharmacokinetic profile. However, if a patient has tried and failed methadone in the past, it can be considered a trial of one preferred drug. 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. 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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
OVERACTIVE BLADDER AGENTS <i>Effective 10/1/2013</i>	No Prior Authorization Required oxybutynin tablets (generic) oxybutynin ER tablets (generic) TOVIAZ (fesoterodine ER)	Prior Authorization Required 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.
PANCREATIC ENZYMES <i>Effective 1/1/2014</i>	No Prior Authorization Required CREON ZENPEP	Prior Authorization Required 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.
HEPATITIS C VIRUS TREATMENTS <i>Effective 10/1/2013</i>	*Must meet eligibility criteria VICTRELIS	Prior Authorization Required INCIVEK OLYSIO SOVALDI	Requests for Victrelis® will be prior authorized if the following criteria are met: <ul style="list-style-type: none"> ○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. ○ The patient will be on a treatment regimen of ribavirin and pegylated interferon for four (4) weeks prior to initiation of Victrelis. ○ The patient is eighteen (18) years or older. ○ The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin). ○ The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse. ○ The patient's previous treatment history and weight are presented at the time of initial request

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"> ○ The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). ○ The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek®, Victrelis®, or Olysio®). ○ The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). ○ Victrelis® is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. ○ 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. <p>Requests for Incivek® will be prior authorized if the following criteria are met:</p> <ul style="list-style-type: none"> ○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. ○ The patient is eighteen (18) years or older. ○ The patient's previous treatment history and weight are presented at the time of initial request. ○ The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse. ○ The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). ○ The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin) or drug dependent on CYP3A4 clearance (e.g., alfuzosin, cisparide, dihydroergotamine, ergonovine, ergotamine, lovastatin, sildenafil, tadalafil, simvastatin, triazolam). ○ The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek®, Victrelis®, or Olysio®). ○ The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). ○ Incivek® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. ○ 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. ○ Prior authorization for Incivek® will be determined on a case by case basis. Providers must provide 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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			<p>Department with full documentation regarding the rationale for treatment with Incivek®</p> <p>Requests for Olysio® will be prior authorized if the following criteria are met:</p> <ul style="list-style-type: none"> ○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. ○ The patient is eighteen (18) years or older. ○ The patient's previous treatment history and weight are presented at the time of initial request. ○ The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse. ○ The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). ○ 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. ○ The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek® or Victrelis®). ○ The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). ○ 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. ○ Olysio ® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. ○ 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. ○ For patients with HCV genotype 1a, evidence should be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy.
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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>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>
PROTON PUMP INHIBITORS <i>Effective 1/1/2014</i>	<p>*Must meet eligibility criteria</p> <p>ACIPHEX (rabeprazole)</p> <p>lansoprazole 15mg OTC (currently available as PREVACID 24HR)</p> <p>NEXIUM (esomeprazole) capsules and packets</p> <p>omeprazole generic capsules</p> <p>PREVACID solutab ^{BNR} (lansoprazole) (for clients under 2)</p>	<p>Prior Authorization Required</p> <p>ACIPHEX sprinkles (rebeprazole)</p> <p>KAPIDEX (dexlansoprazole)</p> <p>DEXILANT (dexlansoprazole)</p> <p>lansoprazole capsules</p> <p>lansoprazole solutabs</p> <p>pantoprazole</p> <p>PREVACID (lansoprazole) capsules & suspension</p> <p>PRILOSEC OTC (omeprazole)</p> <p>PROTONIX (pantoprazole)</p> <p>ZEGERID (omeprazole/Na bicarbonate)</p> <p>First-Omeprazole</p> <p>First- Lansoprazole</p>	<p>*Prior authorization will be required for therapy beyond 60 days of treatment per year for all agents. For clients treated for GERD, once 60 days of therapy per year has been exceeded, clients must fail an adequate trial of a histamine 2 receptor antagonist before PPI therapy can be reconsidered. An adequate trial is defined as 8 weeks of histamine 2 receptor antagonist.</p> <p>Long-term therapy will be approved for clients with Barrett’s Esophagus, Erosive Esophagitis, GI Bleed, Hypersecretory Conditions (Zollinger Ellison), Recurrent Aspiration Syndrome, chronic NSAID therapy, Spinal Cord Injury clients with an acid reflux diagnosis, or children (< 18 years of age) with Cystic Fibrosis, on mechanical ventilation or who have a feeding tube. In addition, clients 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"> ➤ Client failed treatment with two Preferred Products within the last 24 months, ➤ Client has a qualifying diagnosis, and ➤ Client 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:</p>

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H. Pylori Treatments			Aciphex, Protonix, and Zegerid will not be approved for clients less than 18 years of age. Prevacid Solutab will be approved for clients less than 2 years old and ≥ 2 years with a feeding tube.
	NONE	PREVPAC HELIDAC PYLERA OMECLAMOX-PAK	H. Pylori treatments should be used as individual products unless one of the individual products is not commercially available then a prior authorization for the combination product will be given.
PULMONARY ARTERIAL HYPERTENSION THERAPIES Phosphodiesterase Inhibitors <i>Effective 1/1/2014</i>	*Must meet eligibility criteria Sildenafil (generic Revatio) ADCIRCA (tadalafil)	Prior Authorization Required REVATIO	*Eligibility Criteria for all agents in the class Approval will be granted for a diagnosis of pulmonary hypertension.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
Endothelin Antagonists <i>Effective 1/1/2014</i>	No Prior Authorization Required Letairis (ambrisentan)	Prior Authorization Required 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) Grandfathering: 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.
Prostanoids <i>Effective 1/1/2014</i>	No Prior Authorization Required epoprostenol (generic) Veletri (epoprostenol)	Prior Authorization Required Flolan (brand) Remodulin (treprostinil) Tyvaso (treprostinil) Ventavis (iloprost) Orenitram (treprostinil)	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) Grandfathering: 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.
Guanylate Cyclase (sGC) Stimulator <i>Effective 1/1/2014</i>	No Prior Authorization Required	Prior Authorization 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).

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 Anticholinergics & Anticholinergic Combinations <i>Effective 7/1/2013</i>	No Prior Authorization Required <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)	Prior Authorization Required <u>Solutions</u> ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium) <u>Short-Acting Inhalers</u> <u>Long-Acting Inhalers</u> TUDORZA Pressair (aclidinium)	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name 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.
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (short acting) <i>Effective 7/1/2013</i>	No Prior Authorization Required <u>Solutions</u> albuterol (generic) solution <u>Inhalers</u> PROAIR (albuterol) HFA inhaler	Prior Authorization Required <u>Solutions</u> ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. <u>Inhalers</u> ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler MAXAIR (pirbuterol) autohaler PROVENTIL (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	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).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS Inhaled Beta2 Agonists (long acting) <i>Effective 7/1/2013</i>	No Prior Authorization Required	Prior Authorization Required <u>Solutions</u> BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution <u>Inhalers</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.
RESPIRATORY INHALANTS Inhaled Corticosteroids <i>Effective 7/1/2013</i>	No Prior Auth Required <u>Solutions</u> budesonide nebulizer <u>Inhalers</u> ASMANEX twist (mometasone) FLOVENT (fluticasone) HFA FLOVENT diskus 50, 100 & 250 mcg QVAR (beclomethasone)	Prior Authorization Required <u>Inhalers</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.
RESPIRATORY INHALANTS Inhaled Corticosteroid Combinations <i>Effective 7/1/2013</i>	No Prior Authorization Required ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) SYMBICORT (budesonide/formoterol) DULERA (mometasone/formoterol)	Prior Authorization Required BREO Ellipta	Non-preferred inhaled corticosteroid combination inhalants will be approved for clients meeting both of the following criteria: <ul style="list-style-type: none"> ➤ Client has a qualifying diagnosis of asthma or COPD; and ➤ Client cannot take preferred drug due to 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.)
SEDATIVE- HYPNOTICS (non-benzodiazepine) <i>Effective 4/1/2014</i>	No Prior Authorization Required* (unless duplication criteria apply) LUNESTA (eszopiclone) zaleplon zolpidem	Prior Authorization Required AMBIEN CR (zolpidem) AMBIEN (zolpidem) - Brand EDLUAR (zolpidem) INTERMEZZO (zolpidem) ROZEREM (ramelteon) SONATA (zaleplon) - Brand ZOLPIMIST (zolpidem)	<p>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)</p> <p>Sedative hypnotics will require prior authorization for client's ≥ 65 years of age exceeding 90 days of therapy.</p> <p>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</p> <p>Children: Prior authorizations will be approved for clients 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 clients currently taking a long-acting benzodiazepine such as clonazepam or temazepam.</p>
SKELETAL MUSCLE RELAXANTS <i>Effective 7/1/2013</i>	No Prior Authorization Required For Clients under 75 years of age* baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril) tizanidine (generic Zanaflex)	Prior Authorization Required AMRIX ER chlorzoxazone carisoprodol DANTRIUM dantrolene FEXMID FLEXERIL metaxolone methocarbamol NORFLEX orphenadrine PARAFLEX PARAFON FORTE REMULAR ROBAXIN SKELAXIN ZANAFLEX SOMA VANADOM RELA	<p>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.</p> <p>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.)</p> <p>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.</p> <p>Tapering: Due to potential withdrawal symptoms, tapering is recommended when discontinuing high doses of carisoprodol. A one month approval will be granted for clients tapering off of carisoprodol. *A PA will only be granted for any carisoprodol product for short-term use or tapering.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
STATINS & STATIN COMBINATIONS <i>Effective 4/1/2014</i>	No Prior Authorization Required CRESTOR (rosuvastatin) atorvastatin pravastatin simvastatin*	Prior Authorization Required ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin) Statin Combinations 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>Children: 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>
STIMULANTS and ADHD <i>Effective 10/1/2013</i>	No Prior Authorization Required (as long as age, daily dose and diagnosis limitations are met) mixed-amphetamine salts (generic Adderall) ADDERALL XR (brand name mixed amphetamine salts ER) CONCERTA (brand name methylphenidate ER) dexmethylphenidate (generic)	Prior Authorization Required 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)	<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 clients who have documented failure with two Preferred products in the last 12 months (age six years or older) or</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.)
	FOCALIN XR (dexamethylphenidate ER) methylphenidate (generic RITALIN) methylphenidate SR (generic for Ritalin SR) methylphenidate ER (generic for Concerta) STRATTERA (atomoxetine) VYVANSE (lisdexamfetamine)	METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) NUVIGIL (armodafinil) PROVIGIL (modafinil) QUILLIVANT XR (methylphenidate) RITALIN (brand name methylphenidate)	<p>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"> ▪ 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. ▪ 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. ▪ 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 clients with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism. <p>And</p> <p>Non-preferred agents will only be approved for FDA approved age limitations.</p> <ul style="list-style-type: none"> ▪ Provigil will be approved for clients 16 years of age and older. ▪ Nuvigil will be approved for clients 17 years of age and older. ▪ Adderall IR, Dexedrine and Dextrostat will be approved for clients 3 years of age and older. ▪ All other medications in this class will be approved for clients 6 years of age and older. <p>Daytrana , Methylin solution and Quillivant XR: 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>

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>Prior authorization will be required for patients who exceed the following maximum daily doses.</p> <table border="1" data-bbox="1152 331 2074 1149"> <thead> <tr> <th data-bbox="1152 331 1587 367">Drug</th> <th data-bbox="1587 331 2074 367">Maximum Daily Dose</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="1152 367 2074 402">Preferred</td> </tr> <tr> <td data-bbox="1152 402 1587 431">AMPHETAMINE SALTS</td> <td data-bbox="1587 402 2074 431">40 mg/day</td> </tr> <tr> <td data-bbox="1152 431 1587 461">CONCERTA ER ®</td> <td data-bbox="1587 431 2074 461">54 mg/day or 72 mg/day ≥ age 13</td> </tr> <tr> <td data-bbox="1152 461 1587 490">METHYLPHENIDATE ER</td> <td data-bbox="1587 461 2074 490">60 mg/day</td> </tr> <tr> <td data-bbox="1152 490 1587 519">VYVANSE ®</td> <td data-bbox="1587 490 2074 519">70 mg/day</td> </tr> <tr> <td data-bbox="1152 519 1587 548">FOCALIN XR ®</td> <td data-bbox="1587 519 2074 548">40 mg/day</td> </tr> <tr> <td data-bbox="1152 548 1587 578">ADDERALL XR®</td> <td data-bbox="1587 548 2074 578">40 mg/day</td> </tr> <tr> <td data-bbox="1152 578 1587 607">METHYLPHENIDATE</td> <td data-bbox="1587 578 2074 607">60 mg/day</td> </tr> <tr> <td data-bbox="1152 607 1587 636">METHYLIN</td> <td data-bbox="1587 607 2074 636">60 mg/day</td> </tr> <tr> <td data-bbox="1152 636 1587 665">METHYLPHENIDATE</td> <td data-bbox="1587 636 2074 665">60 mg/day</td> </tr> <tr> <td data-bbox="1152 665 1587 695">METHYLPHENIDATE SR</td> <td data-bbox="1587 665 2074 695">60 mg/day</td> </tr> <tr> <td colspan="2" data-bbox="1152 695 2074 730">Non preferred</td> </tr> <tr> <td data-bbox="1152 730 1587 760">METADATE CD ®</td> <td data-bbox="1587 730 2074 760">60 mg/day</td> </tr> <tr> <td data-bbox="1152 760 1587 789">KAPVAY ER ®</td> <td data-bbox="1587 760 2074 789">0.1 mg/day</td> </tr> <tr> <td data-bbox="1152 789 1587 818">D-AMPHETAMINE ER</td> <td data-bbox="1587 789 2074 818">40 mg/day</td> </tr> <tr> <td data-bbox="1152 818 1587 847">DAYTRANA ®</td> <td data-bbox="1587 818 2074 847">30 mg/day</td> </tr> <tr> <td data-bbox="1152 847 1587 876">PROVIGIL ®</td> <td data-bbox="1587 847 2074 876">400 mg/day</td> </tr> <tr> <td data-bbox="1152 876 1587 906">RITALIN LA ®</td> <td data-bbox="1587 876 2074 906">60 mg/day</td> </tr> <tr> <td data-bbox="1152 906 1587 935">INTUNIV ER®</td> <td data-bbox="1587 906 2074 935">4 mg/day</td> </tr> <tr> <td data-bbox="1152 935 1587 964">ADDERALL ®</td> <td data-bbox="1587 935 2074 964">40 mg/day</td> </tr> <tr> <td data-bbox="1152 964 1587 993">NUVIGIL ®</td> <td data-bbox="1587 964 2074 993">250 mg/day</td> </tr> <tr> <td data-bbox="1152 993 1587 1023">METHYLIN ER ®</td> <td data-bbox="1587 993 2074 1023">60 mg/day</td> </tr> <tr> <td data-bbox="1152 1023 1587 1052">METHYLIN SUSPENSION®</td> <td data-bbox="1587 1023 2074 1052">60 mg/day</td> </tr> <tr> <td data-bbox="1152 1052 1587 1081">FOCALIN ®</td> <td data-bbox="1587 1052 2074 1081">20 mg/day</td> </tr> </tbody> </table>	Drug	Maximum Daily Dose	Preferred		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	Non preferred		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>TARGETED IMMUNE MODULATORS FOR RHEUMATOID ARTHRITIS</p> <p><i>Effective 1/1/2014</i></p>	<p>No Prior Authorization Required</p> <p>ENBREL (etanercept) HUMIRA (adalimumab)</p>	<p>Prior Authorization Required</p> <p>CIMZIA (certolizumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous SIMPONI (golimumab) XELJANZ (tofacitinib) STELARA (ustekinumab) ACTEMRA (tocilizumab)</p> <p>*for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P</p>	<p>Cimzia (all dosage forms)</p> <ul style="list-style-type: none"> 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.) 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.) 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.) <p>Kineret 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>Kineret will be approved without prior authorization for clients with documented neonatal-onset multisystem inflammatory disease (NOMID).</p> <p>Orencia 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>Simponi 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>Simponi 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>Stelara 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>

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>Stelara 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> <p>Xeljanz 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>Xeljanz will not be approved for combination therapy with a biologic disease modifying agent.</p> <p>Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply</p> <p>Grandfathering: Clients currently stabilized on a Non-preferred product can receive approval to continue on that agent for one year if medically necessary.</p>
TOPICAL IMMUNOMODULATORS <i>Effective 7/1/2013</i>	No Prior Authorization Required	Prior Authorization Required 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 < 2 years of age.</p> <p>An additional prior authorization will be required for clients warranting ≥ 6 weeks of therapy with either Elidel or Protopic.</p>
TRIPTANS <i>Effective 1/1/2014</i>	No Prior Authorization Required (monthly quantity limits may apply) IMITREX tablets IMITREX nasal spray and injection ^{BNR} sumatriptan tablets MAXALT MLT tablets (rizatriptan) naratriptan tablets	Prior Authorization Required AXERT (almotriptan) AMERGE (naratriptan) FROVA (frovatriptan) RELPAX (eletriptan) SUMAVEL DOSEPRO TREXIMET (sumatriptan and naproxen) ZOMIG (zolmitriptan)	<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>Quantity Limits: 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	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		Maxalt tablets (rizatriptan) sumatriptan nasal spray and injection	