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

Effective October 1, 2012

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.

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 *Effective 4/1/2012*	**No Prior Authorization Required (*Must meet eligibility criteria)** Aricept (5mg and 10mg) Aricept ODT 5mg,10mg generic donepezil tab donepezil ODT generic galantamine and galantamine ER NAMENDA	**Prior Authorization Required** COGNEX EXELON (cap, soln. and patch) RAZADYNE ARICEPT 23mg	***eligibility criteria for Preferred Agents –** 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) 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. Preferred agents will be approved if the client has a diagnosis of dementia.
ANTIEMETICS *Effective 1/1/2012*	**No Prior Authorization Required** ondansetron tablets ondansetron ODT tab ondansetron suspension (clients under 6 years only) ZOFRAN tablets	**Prior Authorization Required** ANZEMET EMEND KYTRIL SANCUSO ALOXI ZOFRAN suspension ZOFRAN ODT ZUPLENZ	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.) Ondansetron suspension will be approved for clients 6 and over with a feeding tube. 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.**

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ANTIDEPRESSANTS **Newer Generation Antidepressants** *Effective 1/1/2012*	**No Prior Authorization Required** Bupropion IR, SR, XL citalopram fluoxetine fluvoxamine mirtazipine nefazodone paroxetine sertraline venlafaxine IR, ER tabs venlafaxine XR capsules EFFEXOR IR, XR	**Prior Authorization Required** APLENZIN ER (bupropion ER) CYMBALTA (duloxetine) LEXAPRO (escitalopram) LUVOX CR (fluvoxamine CR) PRISTIQ (desvenlafaxine) PEXEVA (paroxetine) paroxetine CR PAXIL CR (paroxetine controlled release) PROZAC Weekly (fluoxetine) VIIBRYD	Non-preferred products will be approved for clients who have failed treatment with two 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) **Grandfathering:** 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.** Cymbalta: Clients will not need to fail on two Preferred Products if the diagnosis is Diabetic Peripheral Neuropathic Pain. 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. Cymbalta will be approved for individuals with chronic musculoskeletal pain related to osteoarthritis or chronic lower back pain, who have taken at least a 3 month trial of narcotic therapy. Lexapro: Clients will not need to fail on two 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.) Clients currently stabilized on Lexapro will be eligible for grandfathering for one year. **Verification may be provided from the prescriber or the pharmacy.**
ANTIHISTAMINES **Newer Generation Antihistamines** *Effective 7/1/2012*	**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.) Grandfathering: Clients already stabilized on a non-preferred newer generation antihistamine or a newer generation antihistamine combination will only be grandfathered through January 1, 2013.
Antihistamine/Decongestant Combinations *Effective 7/1/2012*	**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)	

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ANTIHYPERTENSIVES **Angiotensin Receptor Blockers (ARBs)** *Effective 7/1/2012*	**No Prior Authorization Required** AVAPRO (irbesartan) BENICAR (olmesartan) DIOVAN (valsartan) losartan	**Prior Authorization Required** ATACAND (candesartan) COZAAR (losartan) EDARBI (azilsartan) irbesartan MICARDIS (telmisartan) TEVETEN (eprosartan)	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.
ARB Combinations *Effective 7/1/2012*	**No Prior Authorization Required** AVALIDE (irbesartan/HCTZ) BENICAR-HCT (olmesartan/HCTZ) DIOVAN-HCT (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)	
Renin Inhibitors & Renin Inhibitor Combinations *Effective 7/1/2012*	**No Prior Authorization Required**	**Prior Authorization Required** AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	

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ANTIPLATELETS *Effective 1/1/2012*	AGGRENOX (ASA/dipyridamole) EFFIENT (prasugrel) PLAVIX (clopidogrel) Ticlopidine	BRILINTA (tigacrelor)	EFFIENT 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg. BRILINTA will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg or 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) *Effective 4/1/2012*	**No Prior Authorization Required** ABILIFY clozapine CLOZARIL GEODON olanzapine risperidone RISPERDAL quetiapine* SAPHRIS SEROQUEL IR* ZYPREXA	**Prior Authorization Required** FANAPT FAZACLO INVEGA LATUDA 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 including preferred products will require a prior authorization for clients under 5 years of age. Clients under 5 years of age who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. ▪ **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.** • 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.** • 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.

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Brand Name	Generic Name	Quantity Limits
Abilify	**aripiprazole**	**Maximum one tablet per day**
	clozapine	**Maximum dosage of 900mg per day**
Clozaril	**clozapine**	**Maximum dosage of 900mg per day**
Fazaclo	**clozapine**	**Maximum dosage of 900mg per day**
Fanapt	**iloperidone**	**Maximum two tablets per day**
Geodon	**ziprasidone**	**Maximum two tablets per day**
Invega	**paliperidone**	**Maximum one tablet per day**
Latuda	**lurasidone**	**Maximum one tablet per day**
Risperdal	**risperidone**	**Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day**
	risperidone	**Maximum two tablets per day except 4mg tablets will be approved for up to 4 tablets per day**
Saphris	**asenapine**	**Maximum two tablets per day**
Seroquel	**quetiapine**	**Maximum three tablets per day**
Seroquel XR	**quetiapine XR**	**Maximum one tablet per day except 300mg and 400mg tablets will be approved for up to 2 tablets per day**
Zyprexa	**olanzapine**	**Maximum one tablet per day**

INDICATIONS

- Fanapt - Acute treatment of schizophrenia in adults
- Fazaclo
  - Treatment-Resistant Schizophrenia
  - Reducing the Risk of Recurrent Suicidal Behavior in Patients with Schizophrenia or Schizoaffective Disorder
- Invega
  - acute and maintenance treatment of schizophrenia
  - acute treatment of schizoaffective disorder as monotherapy
  - acute treatment of schizoaffective disorder as an adjunct to

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			mood stabilizers and/or antidepressants ▪ Latuda - Treatment of schizophrenia ▪ Seroquel XR ➢ Treatment of schizophrenia ➢ Acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex ➢ Acute treatment of depressive episodes associated with bipolar I disorder ➢ Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex ➢ Adjunctive treatment of major depressive disorder (MDD) ▪ Zyprexa Zydis ➢ Schizophrenia ➢ Bipolar I Disorder (Manic or Mixed Episodes) Fanapt 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 in the last 5 years. A maximum of two tablets per day will be approved. 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. 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. Latuda 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 in the last 5 years. A maximium of one tablet per day will be approved (two tabs of the 80mg may be approved if needed for max dose of 160mg). Latuda will be approved without failed treatment for the treatment of newly diagnosed schizophrenia in female clients that are pregnant. A maximum of one tablet per day will be approved.

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			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 following indications: ▪ Schizophrenia ▪ Acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex ▪ Acute treatment of depressive episodes associated with bipolar I disorder ▪ Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex ▪ Adjunctive treatment of major depressive disorder (MDD) If a client has been stabilized on Seroquel 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. *Please see quantity limit table for limitations.* 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. A maximum of one tablet per day will be approved. 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.
BISPHOSPHONATES (oral) *Effective 10/1/2012*	**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 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.
DIABETES MANAGEMENT CLASSES (oral) **Biguanides** *Effective 10/1/2012*	**No Prior Authorization Required** metformin generic 500mg, 850mg, and	**Prior Authorization Required** FORTAMET GLUCOPHAGE (brand) GLUCOPHAGE XR (brand)	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: ➢ under the age of 12

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	1000mg tablets metformin generic extended-release 500mg tablets (generic Glucophage XR)	GLUMETZA metformin ER 750mg RIOMET 500mg/5ml metformin extended-release 500 and 1000mg (generic Fortamet)	➢ with a feeding tube ➢ who have difficulty swallowing
Hypoglycemic Combinations *Effective 10/1/2012*	**No Prior Authorization Required**	**Prior Authorization Required** ACTOPLUS MET AVANDAMET AVANDARYL DUETACT glipizide/metformin GLUCOVANCE (brand) METAGLIP PRANDIMET glyburide/metformin JANUMET (sitagliptin/metformin) JENTADUETO (linagliptin/metformin) JUVISYNC (sitagliptin/simvastatin) KOMBIGLYZE (saxaglipin/metformin)	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.
Meglitinides *Effective 10/1/2012*	**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 *Effective 10/1/2012*	**no prior authorization required** *BYETTA (exenatide) *JANUVIA (sitagliptin) *TRADJENTA (linagliptin)	**Prior Authorization Required** SYMLIN (pramlintide) VICTOZA (liraglutide) ONGLYZA (saxagliptin)	* Approval for selected preferred products require a 3 month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. **For all products**, dosing will be limited to FDA approved dosing. Prior Authorization will be required for doses in excess of FDA approved dosing. 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.)

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Thiazolidinediones *Effective 10/1/2012*	**No Prior Authorization Required**	**Prior Authorization Required** AVANDIA (rosiglitazone) ACTOS (pioglitazone)	***Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy.** Prior authorizations for rosiglitazone will be manually reviewed by the Department based upon reported risk mitigation, medical justification and contraindication to pioglitazone. Pioglitazone will be approved upon documentation that following criteria have been met: o 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; o The client does not currently have NYHA Class III-IV heart failure; o The client does not have active bladder cancer or prior history of bladder cancer. o The prescriber agrees to monitor for signs and symptoms of heart failure at all follow-up appointments; o Liver tests are obtained prior to initiation of therapy. 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.
ERYTHROPOIESIS STIMULATING AGENTS *Effective 10/1/2012*	***Must meet eligibility criteria** PROCRIT	**Prior Authorization Required** ARANESP EPOGEN	***Eligibility Criteria for all agents in the class** Clients must meet all criteria in one of the following four areas: ➢ 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. Hemoglobin results must be from the last 30 days. Medication must be administered in the client's home or long-term care facility. (CONTINUED) **Non-preferred products:** ➢ Same as above; **and** ➢ Failed treatment with Procrit. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) **Note: The FDA has announced a risk evaluation mitigation strategy for**

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			the use of Erythropoeisis 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.
FIBROMYALGIA AGENTS *Effective 7/1/2012*	**No Prior Authorization Required** LYRICA (pregabalin) SAVELLA (milnacipran)	**Prior Authorization Required** CYMBALTA (duloxetine)	Cymbalta will be approved for fibromyalgia if ALL of the following criteria have been met: • 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). Lycia will have a maximum dosage limitation of 600 mg/day and a unit limit of three capsules per day.
GROWTH HORMONES *Effective 4/1/2012*	**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: ▪ 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: ➢ 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 *Effective 4/1/2012*	**No Prior Authorization Required** fluticasone (generic FLONASE) NASACORT AQ	**Prior Authorization Required** BECONASE AQ FLONASE NASAREL NASONEX OMNARIS RHINOCORT AQ VERAMYST	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). ★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products. ★Brand name Flonase will require a letter of medical necessity

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LEUKOTRIENE MODIFIERS *Effective 4/1/2012*	**No Prior Authorization Required** SINGULAIR (montelukast)	**Prior Authorization Required** ACCOLATE (zafirlukast) ZYFLO (zileuton)	Non-preferred Leukotrienes will be approved if **both** of the following criteria are met: ▪ Client failed treatment with Singulair 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 *Effective 4/1/2012*	**No Prior Authorization Required** AVONEX BETASERON REBIF COPAXONE	**Prior Authorization Required** AMPYRA EXTAVIA GILENYA	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). **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). **Ampyra** – A 30 day supply of Ampyra will be approved if all of the following criteria are met: • Client has a diagnosis of MS; • Client is ambulatory and has established a baseline 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 or is consulting a neurologist; • The prescribed dose does not exceed 10 mg twice daily. Extended coverage of Ampyra (up to one year) will be approved if documentation shows improvement in ambulation (measured by T25FW assessment).
OPHTHALMIC ALLERGY *Effective 4/1/2012*	**No Prior Authorization Required** cromolyn PATANOL PATADAY ZADITOR	**Prior Authorization Required** 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)
OPIOIDS **Long Acting – Oral Opioids** *Effective 7/1/2012*	**FIRST LINE (No Prior Authorization Required)** methadone (generic Dolophine) morphine ER (generic MS	**Prior Authorization Required** AVINZA (morphine ER) BUTRANS (buprenorphine) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) KADIAN (morphine ER) MS CONTIN (morphine ER) –	*Fentanyl patches are considered first line only for clients unable take oral long acting opiates or for clients that have an allergy to morphine. *Fentanyl patches are considered second line and will require failure with one oral first line agent in the last six months. Non-preferred, long-acting oral opioids will be approved for clients who have failed treatment with two 1st or 2nd line preferred agents in the last six months.

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	Contin) **SECOND LINE (see PA Criteria)** ***Fentanyl patches**	Brand NUCYNTAER (tapentadol ER) ORAMORPH SR (morphine ER) - Brand OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER) EMBEDA(morphine/naltrex.)	(Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.) Oxycontin®, Opana ER®, and Nucynta ER® will only be approved for twice daily dosing. Grandfathering: Clients stabilized on a non-preferred long-acting opiate will only be grandfathered through January 1, 2013. Non-preferred long-acting opiates will approved for clients who have failed treatment with two preferred products in the last six months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
OVERACTIVE BLADDER AGENTS *Effective 10/1/2012*	**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 (oxbutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) tolterodine VESICARE (solifenacin)	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.
PROTEASE INHIBITORS FOR HEPATITIS C *Effective 10/1/2012*	***Must meet eligibility criteria** VICTRELIS	**Prior Authorization Required** INCIVEK	Requests for Victrelis® will be prior authorized if the following criteria are met: o A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. o The patient has been on a treatment regimen of ribavirin and pegylated interferon for three (3) weeks. o The patient is eighteen (18) years or older. o The patient is not receiving strong CYP3A4 inducer (e.g., rifampin, rifabutin, phenytoin). o The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse. o The patient's previous treatment history and weight are

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			presented at the time of initial request o The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). o The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek® or Victrelis®). o The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). o Victrelis® is prescribed by or in conjuction with an infectious disease specialist, gastroenterologist, or hepatologist. o 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. Further testing must be scheduled for the end of weeks eight (8), twelve (12) and twenty-four (24). Initial test results and the scheduled testing dates for the indicated weeks must be submitted before prior authorization will be issued. o The dispensing pharmacy agrees to dispense an initial six-week supply. The prescriber should ensure that viral levels are done at treatment weeks eight (8), twelve (12) and twenty-four (24).(Initial approval of Victrelis® will be for six (6) weeks, providing four (4) weeks for initial treatment and 2 weeks for administrative review.) o Viral levels are submitted at the end of treatment weeks eight (8), twelve (12) and twenty-four (24) of the treatment course. (Further prior approvals will not be issued without submission of viral levels performed with the sensitive RT-PCR assay HCV-RNA test with a lower limit of quantification of ≤25 IU/ml and a limit of detection of approximately 10-15 IU/ml.) o Continuation of therapy will be approved in accordance with the manufacturer's guidelines according to viral levels at the established treatment timelines. Requests for Incivek® will be prior authorized if the following criteria are met: o A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon. o The patient is eighteen (18) years or older. o The patient's previous treatment history and weight are

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			presented at the time of initial request. o The patient has been screened and counseled about the importance of refraining from drug and/or alcohol abuse. o The patient's Child-Pugh score is <6 (compensated cirrhotic liver disease). o 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, lovastastin, sildenafil, tadalafil, simvastatin, triazolam). o The patient has not previously tried/failed therapy with a hepatitis C protease inhibitor (e.g. Incivek® or Victrelis®). o The patient is not a pregnant female or a male with a pregnant female partner (ribavirin contraindication). o Incivek® is prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist. o 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. Further testing must be scheduled for the end of weeks four (4), twelve (12) and twenty-four (24). Initial test results and the scheduled testing dates for the indicated weeks must be submitted before prior authorization will be issued. o The dispensing pharmacy agrees to dispense an initial six-week supply. The prescriber should ensure that viral levels are done at weeks four (4), twelve (12) and twenty-four (24) of therapy. (Initial approval of Incivek® will be for six (6) weeks, providing 4 weeks for initial treatment and 2 weeks for administrative review) o Viral levels are to be submitted at the end of weeks four (4), twelve (12) and twenty-four (24) of the treatment course. (Further prior approvals will not be issued without submission of viral levels performed with the sensitive RT-PCR assay HCV-RNA test with a lower limit of quantification of ≤25 IU/ml and a limit of detection of approximately 10-15 IU/ml.) 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®

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
PROTON PUMP INHIBITORS *Effective 1/1/2012*	***Must meet eligibility criteria** ACIPHEX (rabeprazole) lansoprazole 15mg OTC (currently available as PREVACID 24HR) NEXIUM (esomeprazole) **packets** omeprazole generic capsules PREVACID solutab **brand** (lansoprazole) (for clients under 6) PRILOSEC OTC (omeprazole)	**Prior Authorization Required** KAPIDEX (dexlansoprazole) DEXILANT (dexlansoprazole) lansoprazole capsules lansoprazole solutabs NEXIUM (esomeprazole) capsules pantoprazole PREVACID (lansoprazole) capsules & suspension PROTONIX (pantoprazole) ZEGERID (omeprazole/Na bicarbonate) PREVPAC HELIDAC	*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. The policy listed above will become effective September 15, 2012. 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 or Spinal Cord Injury clients with an acid reflux diagnosis. 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. Non-preferred proton pump inhibitors will be approved if all of the following criteria are met: ➢ 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. **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 **The Appropriate Diagnostic Methods are:** GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test **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. **Age Limits:** Aciphex, Protonix, and Zegerid will not be approved for clients less than 18 years of age. Prevacid Solutab will be approved for clients 6 and older with a feeding tube. Pantoprazole will be approved for clients that have clinically significant drug-drug interactions with other PPI agents.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
PULMONARY ARTERIAL HYPERTENSION THERAPIES **Phosphodiesterase Inhibitors** *Effective 1/1/2012*	***Must meet eligibility criteria** REVATIO (sildenafil) ADCIRCA (tadalafil)	**Prior Authorization Required**	***Eligibility Criteria for all agents in the class** Approval will be granted for a diagnosis of pulmonary hypertension.
Endothelin Antagonists *Effective 1/1/2012*	**No Prior Authorization Required** Letairis (ambrisentan)	**Prior Authorization Required** Tracleer (bosentan)	Non-preferred products will be approved for clients who have failed treatment with Letairis. (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 *Effective 1/1/2012*	**No Prior Authorization Required** epoprostenol (generic) Veletri (epoprostenol)	**Prior Authorization Required** 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) **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.
RESPIRATORY INHALANTS **Inhaled Anticholinergics & Anticholinergic Combinations** *Effective 7/1/2012*	**No Prior Authorization Required** **<u>Solutions</u>** albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) **<u>Inhalers</u>** ATROVENT HFA (ipratropium) COMBIVENT MDI (albuterol/ipratropium) SPIRIVA Handihaler (tiotropium)	**Prior Authorization Required** **<u>Solutions</u>** ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium) **<u>Inhalers</u>** COMBIVENT RESPIMAT (albuterol/ipratropium)	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.

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** **(short acting)** *Effective 7/1/2012*	**No Prior Authorization Required** **Solutions** albuterol (generic) solution **Inhalers** PROAIR (albuterol) HFA inhaler VENTOLIN (albuterol) HFA inhaler	**Prior Authorization Required** **Solutions** ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. **Inhalers** ALUPENT (metaproterenol) Inhaler XOPENEX (levalbuterol) Inhaler MAXAIR (pirbuterol) autohaler PROVENTIL (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).
RESPIRATORY INHALANTS **Inhaled Beta2 Agonists** **(long acting)** *Effective 7/1/2012*	**No Prior Authorization Required**	**Prior Authorization Required** **Solutions** BROVANA (Arformoterol) soln. solution PERFOROMIST (formoterol) solution **Inhalers** FORADIL (formoterol) inhaler SEREVENT (salmeterol) inhaler	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. Arcapta Neohaler® will only be approved for once daily use in clients with COPD who have failed an adequate trial of two other long-acting beta-2 agonists. An adequate trial is defined as at least one week.
RESPIRATORY INHALANTS **Inhaled Corticosteroids** *Effective 7/1/2012*	**No Prior Auth Required** **Solutions** budesonide nebules **Inhalers** ASMANEX twist (mometasone) FLOVENT (fluticasone) HFA FLOVENT diskus **50**, **100** & 250 mcg QVAR (beclomethasone)	**Prior Authorization Required** **Inhalers** 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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
RESPIRATORY INHALANTS **Inhaled Corticosteroid Combinations** *Effective 7/1/2012*	**No Prior Authorization Required** ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) SYMBICORT (budesonide/formoterol) DULERA (mometasone/formoterol)	**Prior Authorization Required**	Non-preferred inhaled corticosteroid combination inhalants will be approved for clients meeting both of the following criteria: ➢ 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.
SEDATIVE- HYPNOTICS (non-benzodiazepine) *Effective 4/1/2012*	**No Prior Authorization Required* (unless duplication criteria apply)** LUNESTA (eszopiclone) zaleplon zolpidem	**Prior Authorization Required** AMBIEN CR (zolpidem) AMBIEN (zolpidem) - Brand EDLUAR (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 **Children:** Prior authorizations will be approved for clients 18 years of age and older. ***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.
SKELETAL MUSCLE RELAXANTS *Effective 7/1/2012*	**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 (cyclobenzaprine ER) chlorzoxazone (generic Parafon Forte) DANTRIUM (dantrolene) – Brand dantrolene (generic Dantrium)	All agents in this class will require a prior authorization for clients over 75 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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) – Brand LIORESAL (baclofen) – Brand methocarbamol (generic Robaxin) NORFLEX (orphenadrine) orphenadrine (generic Norflex) PARAFLEX (chlorzoxazone) PARAFON FORTE (chlorzoxazone) REMULAR (chlorzoxazone) ROBAXIN (methocarbamol) – Brand SKELAXIN (metaxalone) ZANAFLEX (tizanidine) – Brand SOMA (carisoprodol), VANADOM (carisoprodol), RELA (carisoprodol)	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.)
STATINS & STATIN COMBINATIONS *Effective 4/1/2012*	**No Prior Authorization Required** CRESTOR (rosuvastatin) LIPITOR (atorvastatin) pravastatin (generic Pravachol) simvastatin* (generic Zocor)	**Prior Authorization Required** ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin) **Statin Combinations** ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvas.)	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) **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. 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.
STIMULANTS and ADHD *Effective 10/1/2012*	**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)	**Prior Authorization Required** ADDERALL (brand name mixed amphetamine salts) mixed-amphetamine salts ER (generic for Adderall XR) DAYTRANA (methylphenidate transdermal)	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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	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)	DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) FOCALIN (brand name dexmethyphenidate) INTUNIV (guanfacine ER) KAPVAY (clonidine ER) METADATE CD (methylphenidate ER) METADATE ER (methylphenidate ER) METHYLIN SUSPENSION (methylphenidate) NUVIGIL (armodafinil) PROVIGIL (modafinil) RITALIN (brand name methylphenidate)	Non-preferred agents will be approved for clients who have documented failure with two Preferre 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 fo Daytrana, Intuniv, Methylin solution, Nuvigil and Provigil. Please see the criteria below. **In addition:** Non-preferred agents will only be approved for FDA and official compendium indications. ▪ 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. ▪ Provigil will be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, 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 o 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. **And** Non-preferred agents will only be approved for FDA approved age limitations. ▪ 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. **Daytrana and Methylin solution**: 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. Prior authorization will be required for patients who exceed the following maximum daily doses.

Drug	Maximum Daily Dose
Preferred	
AMPHETAMINE SALTS	40 mg/day
CONCERTA ER ®	54 mg/day or 72 mg/day ≥ age 13

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			METHYLPHENIDATE ER — 60 mg/day VYVANSE ® — 70 mg/day FOCALIN XR ® — 30 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
TARGETED IMMUNE MODULATORS FOR RHEUMATOID ARTHRITIS *Effective 1/1/2012*	**No Prior Authorization Required** ENBREL (etanercept) HUMIRA (adalimumab)	**Prior Authorization Required** CIMZIA (certolizumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous SIMPONI (golimumab) ***for information on IV infused Targeted Immune**	**Cimzia** (all dosage forms) • 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, 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.) **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.) **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).

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
		Modulators for Rheumatoid Arthritis please see Appendix 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). **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, allergy, intolerable side effects or significant drug-drug interaction). **Grandfathering:** Clients currently stabilized on a Non-preferred product can receive approval to continue on that agent for one year if medically necessary.
TOPICAL IMMUNOMODULATORS *Effective 7/1/2012*	**No Prior Authorization Required (unless therapy exceeds 6 weeks)*** ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)	**Prior Authorization Required**	Prior authorization is required for children < 2 years of age. *Prior authorization will be required for clients warranting ≥ 6 weeks of therapy with either Elide or Protopic.
TRIPTANS *Effective 1/1/2012*	**No Prior Authorization Required (monthly quantity limits may apply)** IMITREX (brand) tablets, nasal spray and injection sumatriptan tablets MAXALT MLT tablets (rizatriptan)	**Prior Authorization Required** AXERT (almotriptan) AMERGE (naratriptan) FROVA (frovatriptan) RELPAX (eletriptan) TREXIMET (sumatriptan and naproxen) ZOMIG (zolmitriptan) Maxalt tablets (rizatriptan) sumatriptan nasal spray and injection	Non-preferred products will be approved for clients who have failed treatment with one Preferred Product within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **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