



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

Effective July 1, 2014

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

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

**BNR = Brand Name Required**

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

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			<p>Has a labile INR for reasons other than noncompliance (e.g, INR outside 2-3 <math>\geq</math> 60% of the time for a period of two months) <b>OR</b>            Has significant difficulty with complying with monitoring <b>OR</b>            Has an allergy or intolerance to warfarin</p> <p>XARELTO will be approved if:            The client is <b>NOT</b> on dialysis <b>AND</b>            The client has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) <b>OR</b>            Is in need of a prophylaxis of DVT following knee or hip replacement surgery <b>OR</b>            The client has a diagnosis of nonvalvular atrial fibrillation <b>AND</b>            The client does not have a mechanical prosthetic heart valve <b>AND</b>            The client does not have an active pathological bleed <b>AND</b>            Has a labile INR for reasons other than noncompliance (e.g, INR outside 2-ay <math>\geq</math> 60% of the time for a period of two months) <b>OR</b>            Has significant difficulty with complying with monitoring <b>OR</b>            Has an allergy or intolerance to warfarin</p> <p><b>Grandfathering:</b>            Beginning 10/1/2013, clients currently stabilized on a non-preferred agent can receive approval to continue on that agent for one year if medically necessary</p>
<b>ANTIEMETICS</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  ondansetron tablets ondansetron ODT tab ondansetron suspension (clients under 5 years only) ZOFRAN tablets	<b>Prior Authorization Required</b>  ANZEMET EMEND KYTRIL SANCUSO ALOXI ZOFRAN suspension ZOFRAN ODT ZUPLENZ DICLEGIS	<p>Non-preferred products will be approved for clients who have failed treatment with brand or generic ondansetron within the last year. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p>Ondansetron suspension will be approved for client's <math>\geq</math> 5 years old and with a feeding tube.</p> <p>Emend will be approved upon verification that the client is undergoing moderately emetogenic or highly emetogenic chemotherapy as part of a regimen with a corticosteroid and a 5HT3 antagonist. <b>Verification may be provided from the prescriber or the pharmacy.</b>            Emend will be approved for prophylaxis of postoperative nausea and vomiting (one 40mg capsule will be approved). <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p>Approval for DICLEGIS will be granted if the client has nausea and vomiting associated with pregnancy <b>AND</b>            The client has failed a trial of doxylamine 10-12.5mg <b>OR</b></p>

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			<p>The client has failed a trial of oral ondansetron 4mg every 8 hours for five days  <b>OR</b>            The client has an intolerance or contraindication to ondansetron</p>						
<p><b>ANTIDEPRESSANTS</b></p> <p><b>Newer Generation Antidepressants</b></p> <p><i>Effective 1/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>Bupropion IR, SR, XL            citalopram            fluoxetine            fluvoxamine            mirtazipine            nefazodone            paroxetine            sertraline            venlafaxine IR tabs            venlafaxine XR capsules</p>	<p><b>Prior Authorization Required</b></p> <p>APLENZIN ER (bupropion ER)            BRINTELLIX            CYMBALTA (duloxetine)            FETZIMA            KHEDEZLA (desvenlafaxine base)            LEXAPRO (escitalopram)            LUVOX CR (fluvoxamine CR)            PRISTIQ (desvenlafaxine succinate)            PEXEVA (paroxetine)            paroxetine CR            PAXIL CR (paroxetine controlled release)            PROZAC Weekly (fluoxetine)            VIIBRYD</p>	<p>Non-preferred products will be approved for clients who have failed treatment with three Preferred Products with exceptions for Cymbalta and Lexapro (see below). (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p> <p><b>Grandfathering:</b>            Clients currently stabilized on a Non-preferred newer generation antidepressant can receive approval to continue on that agent for one year if medically necessary. <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p>Cymbalta: Clients will not need to fail on three Preferred Products if the diagnosis is Diabetic Peripheral Neuropathic Pain.</p> <p>Cymbalta will also be approved for patients with chronic musculoskeletal pain (e.g. osteoarthritis or chronic lower back pain) who have failed a one month consecutive trial of three non-narcotic analgesic agents (e.g. acetaminophen, NSAID, tramadol) at maximally tolerated doses.</p> <p>Lexapro: Clients will not need to fail on three Preferred Products if they are under 18 years of age and have failed therapy with fluoxetine. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p>						
<p><b>ANTI-HERPETIC AGENTS</b></p> <p><i>Effective 1/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>Acyclovir tablet, capsule (generic)</p>	<p><b>Prior Authorization Required</b></p> <p>Acyclovir suspension            Valacyclovir            Famcyclovir            VALTRES            FAMVIR            ZOVIRAX            SITAVIG</p>	<p>Non-preferred products will be approved for clients who have failed an adequate trial with acyclovir (dose and duration) as deemed by approved compendium (see below) (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)</p> <table border="1" data-bbox="1213 1305 2064 1468"> <thead> <tr> <th data-bbox="1222 1312 1444 1334">Indication</th> <th data-bbox="1451 1312 1724 1334">Adult</th> <th data-bbox="1730 1312 2055 1334">Pediatric</th> </tr> </thead> <tbody> <tr> <td data-bbox="1222 1339 1444 1414"><b>Genital herpes simplex: Initial</b></td> <td data-bbox="1451 1339 1724 1468">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="1730 1339 2055 1446">12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.</td> </tr> </tbody> </table>	Indication	Adult	Pediatric	<b>Genital herpes simplex: Initial</b>	400 mg orally 3 times daily for 7 to 10 days or 200 mg orally 5 times daily (guideline dosing) for 10 days.	12 years or older, 1000 to 1200 mg/day orally in 3 to 5 divided doses for 7 to 10 days.
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			<b>Varicella with HIV infection</b>	20 mg/kg (MAX, 800 mg) ORALLY 5 times daily for 5 to 7 days	20 mg/kg (MAX, 800 mg) ORALLY 4 times daily for 7 to 10 days or until no new lesions appear for 48 hours.
<p><b>ANTI-HISTAMINES</b></p> <p><b>Newer Generation Antihistamines</b></p> <p><i>Effective 7/1/2014</i></p> <p><b>Antihistamine/Decongestant Combinations</b></p> <p><i>Effective 7/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>loratadine (generic OTC Claritin) cetirizine (generic OTC Zyrtec)</p> <p><b>No Prior Authorization Required</b></p>	<p><b>Prior Authorization Required</b></p> <p>ALLEGRA (fexofenadine) CLARINEX (desloratadine) CLARITIN (loratadine) fexofenadine (generic Allegra) levocetirizine XYZAL (levocetirizine) ZYRTEC (cetirizine) Brand</p> <p><b>Prior Authorization Required</b></p> <p>ALLEGRA-D (fexofen./PSE) CLARINEX-D (desloratadineD) CLARITIN-D (loratadine-D) loratadine-D SEMPREX-D (acrivastine-D) ZYRTEC-D (cetirizine-D)</p>	<p>Non-preferred antihistamines and antihistamine/decongestant combinations will be approved for clients who have failed treatment with two preferred products in the last 6 months and have at least one trial with intranasal corticosteroids (for children age 4 and older). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</p>		
<p><b>ANTI-HYPERTENSIVES</b></p> <p><b>Angiotensin Receptor Blockers (ARBs)</b></p> <p><i>Effective 7/1/2014</i></p> <p><b>ARB Combinations</b></p> <p><i>Effective 7/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>irbesartan</p> <p>BENICAR (olmesartan)</p> <p>DIOVAN<sup>BNR</sup> (valsartan)</p> <p>losartan</p> <p><b>No Prior Authorization Required</b></p> <p>BENICAR-HCT (olmesartan/HCTZ)</p> <p>DIOVAN-HCT<sup>BNR</sup> (valsartan/HCTZ)</p>	<p><b>Prior Authorization Required</b></p> <p>ATACAND (candesartan) AVAPRO (irbesartan) brand COZAAR (losartan) EDARBI (azilsartan) MICARDIS (telmisartan) TEVETEN (eprosartan) Valsartan</p> <p><b>Prior Authorization Required</b></p> <p>ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (amlodipine/olmesartan) EXFORGE (amlodipine/valsartan) EXFORGE HCT (amlodipine/valsartan/hctz)</p>	<p>Non-preferred ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products will be approved for clients who have failed treatment with three preferred products in the last 12 months (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.).</p> <p>Tekturna®, Tekturna HCT®, Valutrna®, and Amturnide® will not be approved in patients with diabetes. Receiving an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination in combination with a renin inhibitor is contraindicated.</p> <p><b>Grandfathering:</b> Clients currently stabilized on brand name Avapro or Avalide can receive approval to continue on that agent for one year if medically necessary. <b>Verification may be provided from the prescriber or the pharmacy.</b></p>		

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<b>Renin Inhibitors &amp; Renin Inhibitor Combinations</b>  <i>Effective 7/1/2014</i>	losartan/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	
	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> AMTURNIDE (aliskirin/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	
<b>ANTIPLATELETS</b>  <i>Effective 1/1/2014</i>	AGGRENOX (ASA/dipyridamole)  clopidogrel  EFFIENT (prasugrel)  Ticlopidine	BRILINTA (tigacrelor) PLAVIX (clopidogrel) ZONTIVITY (vorapaxar)	EFFIENT 10mg should only be considered for patients < 75 years of age and patients weighing ≥ 60 kg without a known diagnosis of TIA or ischemic stroke.  BRILINTA will be approved for patients who have a contraindication to Effient (e.g., body weight < 60kg, age ≥ 75 years OR who have had a hypersensitivity reaction to clopidogrel or prasugrel AND must be taking a maintenance dose of aspirin not exceeding 100 mg/day.  Ticlopidine should only be considered for patients who can be monitored for neutropenia and thrombocytopenia during the first four months of therapy.  ZONTIVITY will require manual review.
<b>ATYPICAL ANTIPSYCHOTICS (oral)</b>  <i>Effective 4/1/2014</i>	<b>No Prior Authorization Required**</b> ABILIFY ABILIFY ODT clozapine CLOZARIL	<b>Prior Authorization Required</b> FANAPT FAZACLO INVEGA SAPHRIS SEROQUEL XR	*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

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	GEODON LATUDA olanzapine risperidone risperidone ODT RISPERDAL RISPERDAL ODT quetiapine* SEROQUEL IR* ZYPREXA ziprasidone	ZYPREXA ZYDIS <b>* for injectable Atypical Antipsychotics please see Appendix P for criteria</b>	<p>products in the last 5 years. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). See Table 1.</p> <p><b>**Age Limits:</b> 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.</p> <p><b>New Atypical Antipsychotic prescriptions for clients under 5 years of age will be reviewed on an individual basis by a clinical health care professional at the Department. Prior authorization approval will be based upon medical necessity, evidence to support therapy, proposed monitoring and additional risk/benefit information supplied by the prescriber. Clients under 5 years will be reviewed annually for appropriateness of therapy and proper monitoring.</b></p> <p><b>Grandfathering:</b> Clients currently stabilized on a non-preferred atypical antipsychotic can receive approval to continue on that agent for two years even if the client does not meet the age, dosing or FDA approved indication requirements. <b>Verification may be provided from the prescriber or the pharmacy.</b></p> <p><b>Quantity Limits:</b> 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>Fazacllo 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>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<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 662 2032 1208"> <thead> <tr> <th data-bbox="1241 662 1442 699">Drug</th> <th data-bbox="1442 662 2032 699">Indication</th> </tr> </thead> <tbody> <tr> <td data-bbox="1241 699 1442 732">Fanapt®</td> <td data-bbox="1442 699 2032 732"> <ul style="list-style-type: none"> <li>Acute treatment of schizophrenia in adults</li> </ul> </td> </tr> <tr> <td data-bbox="1241 732 1442 857">Fazaclo®</td> <td data-bbox="1442 732 2032 857"> <ul style="list-style-type: none"> <li>Treatment-resistant schizophrenia</li> <li>Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder</li> </ul> </td> </tr> <tr> <td data-bbox="1241 857 1442 922">Invega®</td> <td data-bbox="1442 857 2032 922"> <ul style="list-style-type: none"> <li>Schizophrenia</li> <li>Schizoaffective disorder</li> </ul> </td> </tr> <tr> <td data-bbox="1241 922 1442 1208">Seroquel XR®</td> <td data-bbox="1442 922 2032 1208"> <ul style="list-style-type: none"> <li>Treatment of schizophrenia</li> <li>Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex</li> <li>Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex</li> <li>Adjunctive treatment of major depressive disorder (MDD)</li> </ul> </td> </tr> </tbody> </table> <p>Table 2: Quantity Limits</p> <table border="1" data-bbox="1209 1271 2064 1537"> <thead> <tr> <th data-bbox="1209 1271 1360 1360">Brand Name</th> <th data-bbox="1360 1271 1539 1360">Generic Name</th> <th data-bbox="1539 1271 2064 1360">Quantity Limits</th> </tr> </thead> <tbody> <tr> <td data-bbox="1209 1360 1360 1403">Abilify</td> <td data-bbox="1360 1360 1539 1403">aripiprazole</td> <td data-bbox="1539 1360 2064 1403">Maximum one tablet per day</td> </tr> <tr> <td data-bbox="1209 1403 1360 1445"></td> <td data-bbox="1360 1403 1539 1445">clozapine</td> <td data-bbox="1539 1403 2064 1445">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1209 1445 1360 1487">Fazaclo</td> <td data-bbox="1360 1445 1539 1487">clozapine</td> <td data-bbox="1539 1445 2064 1487">Maximum dosage of 900mg per day</td> </tr> <tr> <td data-bbox="1209 1487 1360 1537">Fanapt</td> <td data-bbox="1360 1487 1539 1537">iloperidone</td> <td data-bbox="1539 1487 2064 1537">Maximum two tablets per day</td> </tr> </tbody> </table>	Drug	Indication	Fanapt®	<ul style="list-style-type: none"> <li>Acute treatment of schizophrenia in adults</li> </ul>	Fazaclo®	<ul style="list-style-type: none"> <li>Treatment-resistant schizophrenia</li> <li>Reducing the risk of recurrent suicidal behavior in patients with schizophrenia or schizoaffective disorder</li> </ul>	Invega®	<ul style="list-style-type: none"> <li>Schizophrenia</li> <li>Schizoaffective disorder</li> </ul>	Seroquel XR®	<ul style="list-style-type: none"> <li>Treatment of schizophrenia</li> <li>Acute treatment of manic or mixed episodes associated with bipolar I disorder, as monotherapy or as an adjunct to lithium or divalproex</li> <li>Maintenance treatment of bipolar I disorder as an adjunct to lithium or divalproex</li> <li>Adjunctive treatment of major depressive disorder (MDD)</li> </ul>	Brand Name	Generic Name	Quantity Limits	Abilify	aripiprazole	Maximum one tablet per day		clozapine	Maximum dosage of 900mg per day	Fazaclo	clozapine	Maximum dosage of 900mg per day	Fanapt	iloperidone	Maximum two tablets per day
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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Table 3: FDA Approved Dosing by Age

Drug	FDA Approved Indication	FDA Approved Age	Maximal FDA Approved Dose
Asenapine (Saphris®)	NOT APPROVED		
Aripiprazole (Abilify®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia	6-17 years 10-17 years 13-17 years	15mg/day 30mg/day 30mg/day
Clozapine (Fazaclo®, Clozaril®)	NOT APPROVED		
lloperidone (Fanapt®)			
Lurasidone (Latuda®)			
Olanzapine (Zyprexa®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years	10mg/day
Olanzapine (Zyprexa Zydys®)		13-17 years	10mg/day
Paliperidone (Invega ER®)	Schizophrenia	12-17 years	12mg/day
Risperidone (Risperdal®)	Autism/Psychomotor Agitation Bipolar Disorder/Mixed Mania Schizophrenia	5-16 years 10-17 years 13-17 years	3mg/day 6mg/day 6mg/day

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)			
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			Quetiapine Fumarate (Seroquel®)	Schizophrenia Bipolar Disorder/Mixed Mania	13-17 years 10-17 years	800 mg/day 800 mg/day
			Quetiapine Fumarate (Seroquel XR®)	NOT APPROVED		
			Ziprasidone (Geodon®)	NOT APPROVED		
<b>BISPHOSPHONATES (oral)</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  alendronate (generic) 5mg, 10mg, 35mg, and 70mg tablets	<b>Prior Authorization Required</b> ACTONEL ACTONEL w/Calcium BINOSTO BONIVA DIDRONEL FOSAMAX (brand) FOSAMAX plus D Etidronate SKELID	Non-preferred products will be approved for clients who have failed treatment with at least one strength of alendronate. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)  Prior authorization will be approved for etidronate in clients with heterotopic ossification without treatment failure.			
<b>DIABETES MANAGEMENT CLASSES (oral)</b>  <b>Biguanides</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  metformin generic 500mg, 850mg, and 1000mg tablets metformin generic extended-release 500mg tablets (generic Glucophage XR)	<b>Prior Authorization Required</b> FORTAMET GLUCOPHAGE (brand) GLUCOPHAGE XR (brand) GLUMETZA metformin ER 750mg RIOMET 500mg/5ml metformin extended-release 500 and 1000mg (generic Fortamet)	Non-preferred products will be approved for clients who have failed treatment with two Preferred Products. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)  Liquid metformin will be approved for clients who meet one of the following: <ul style="list-style-type: none"> <li>➤ under the age of 12</li> <li>➤ with a feeding tube</li> <li>➤ who have difficulty swallowing</li> </ul>			
<b>Fluroquinolones (oral)</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  Ciprofloxacin tablet CIPRO oral suspension (<5 years old) Levofloxacin tablet	<b>Prior Authorization Required</b> LEVAQUIN TABLET CIPRO TABLET AVELOX NOROXIN Ofloxacin	Non-preferred products will be approved for clients who have failed an adequate trial (7days) with at least one preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)  CIPRO suspension approved for clients < 5 years of age without prior authorization  For clients ≥ 5 years of age, CIPRO suspension will only be approved for those clients who cannot swallow a whole or crushed tablet  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.)			



Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>Long Acting</b>	LEVEMIR vial and pen	LANTUS all forms	Non-preferred products will be approved if the client has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
<b>Mixtures</b>	HUMALOG MIX 75/25 vial and pen HUMALOG MIX 50/50 vial and pen HUMULIN 70/30 vial and pen NOVOLOG MIX 70/30 vial and pen NOVOLIN 70/30 vial	None	Non-preferred products will be approved if the client has failed treatment with one of the preferred products in the last month (Failure is defined as: allergy or intolerable side effects)
<b>Meglitinides</b> <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> PRANDIN STARLIX	Non-preferred products will be approved for clients who have failed treatment with one Sulfonylurea (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)
<b>Newer Diabetic Agents</b> <i>Effective 10/1/2013</i>	<b>No prior authorization required</b>  *BYETTA (exenatide) *JANUVIA (sitagliptin) *TRADJENTA (linagliptin)	<b>Prior Authorization Required</b>  BYDUREON (exenatide) SYMLIN (pramlintide) VICTOZA (liraglutide) ONGLYZA (saxagliptin) NESINA (alogliptin) INVOKANA (canagliflozin) FARXIGA (dapagliflozin) TANZEUM (albiglutide)	<p>* Approval for selected preferred products require a 3 month trial of (or documented contraindication to) metformin therapy prior to initiation of therapy. <b>For all products</b>, dosing will be limited to FDA approved dosing. Prior Authorization will be required for doses in excess of FDA approved dosing.</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 <math>\geq</math> 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 &lt; 45ml/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 <math>\geq</math> 7%), allergy, intolerable side effects, or a significant drug-drug interaction. 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 &lt; 45ml/min).</p> <p>Non-preferred products will be approved for clients who have failed treatment with one preferred product in the last year. Prior authorization will be approved for Symlin products for clients with Diabetes Mellitus Type 1 without failed</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>Thiazolidinediones</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b> AVANDIA (rosiglitazone) ACTOS (pioglitazone)	<p>treatment. (Failure is defined as: lack of efficacy (e.g., hemoglobin A1C <math>\geq</math> 7%), allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p><b>*Note: Agents in this class may be associated with increased cardiovascular risks. Risk/benefit analysis should be considered before initiating therapy.</b></p> <p>Prior authorizations for rosiglitazone will be manually reviewed by the Department based upon reported risk mitigation, medical justification and contraindication to pioglitazone.</p> <p>Pioglitazone will be approved upon documentation that following criteria have been met:</p> <ul style="list-style-type: none"> <li>○ The client has been counseled that TZD's may cause or exacerbate heart failure and has been given examples of signs and symptoms of heart failure;</li> <li>○ The client does not currently have NYHA Class III-IV heart failure;</li> <li>○ The client does not have active bladder cancer or prior history of bladder cancer.</li> <li>○ The prescriber agrees to monitor for signs and symptoms of heart failure at all follow-up appointments;</li> <li>○ Liver tests are obtained prior to initiation of therapy.</li> </ul> <p>Clients currently stabilized on and compliant with pioglitazone therapy will be allowed to continue therapy. Prior authorization will be required for new starts or when no claims have been filled in the last 120 days.</p>
<b>ERYTHROPOIESIS STIMULATING AGENTS</b>  <i>Effective 10/1/2013</i>	<b>*Must meet eligibility criteria</b> PROCRIT ARANESP	<b>Prior Authorization Required</b> EPOGEN	<p><b>*Eligibility Criteria for all agents in the class</b></p> <p>Clients must meet all criteria in one of the following four areas:</p> <ul style="list-style-type: none"> <li>➤ A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin of 10g/dL or lower.</li> <li>➤ A diagnosis of chronic renal failure, and hemoglobin below 10g/dL</li> <li>➤ A diagnosis of hepatitis C, currently taking Ribavirin and failed response to a reduction of Ribavirin dose, and hemoglobin less than 10g/dL (or less than 11g/dL if symptomatic).</li> <li>➤ A diagnosis of HIV, currently taking Zidovudine, hemoglobin less than 10g/dL, and serum erythropoietin level of 500mUnits/mL or less.</li> </ul> <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><b>Non-preferred products:</b></p> <ul style="list-style-type: none"> <li>➤ Same as above; <b>and</b></li> <li>➤ Failed treatment with Procrit. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p><b>Note: The FDA has announced a risk evaluation mitigation strategy for the use of Erythropoiesis Stimulating Agents (ESAs) in patients with cancer, who are currently receiving chemotherapy, and who are experiencing chemotherapy induced anemia. Patients must receive a medication guide outlining the risks and benefits of treatment, and patient consent must be obtained before therapy. Prescribers are required to enroll and register in the ESA APPRISE Oncology program and complete training prior to prescribing ESAs to patients with cancer. For non-cancer indications, the distribution of a medication guide to the patient is the only requirement currently.</b></p>
<p><b>FIBROMYALGIA AGENTS</b>  <i>Effective 7/1/2014</i></p>	<p><b>No Prior Authorization Required</b>  LYRICA (pregabalin) SAVELLA (milnacipran)</p>	<p><b>Prior Authorization Required</b>  CYMBALTA (duloxetine) duloxetine</p>	<p>Cymbalta and duloxetine will be approved for fibromyalgia if ALL of the following criteria have been met:</p> <ul style="list-style-type: none"> <li>• Failure of an adequate trial (8 weeks) of at least two of the following: tramadol, a tricyclic antidepressant, and appropriately titrated dosed gabapentin (1200-2400 mg in divided doses); AND</li> <li>• Documented non-pharmacologic therapies to the Department (e.g, cognitive behavioral therapies, exercise).</li> </ul> <p>Lycia will have a maximum dosage limitation of 600 mg/day and a unit limit of three capsules per day.</p>
<p><b>GROWTH HORMONES</b>  <i>Effective 4/1/2014</i></p>	<p><b>No Prior Authorization Required</b>  NORDITROPIN OMNITROPE SAIZEN</p>	<p><b>Prior Authorization Required</b>  GENOTROPIN HUMATROPE NUTROPIN SEROSTIM TEV-TROPIN ZORBTIVE</p>	<p>Non-preferred Growth Hormones will be approved if <b>both</b> of the following criteria are met:</p> <ul style="list-style-type: none"> <li>▪ Client failed treatment with two preferred products within the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</li> <li>▪ Client has a qualifying diagnosis: <ul style="list-style-type: none"> <li>➢ Prader-Willi</li> <li>➢ Chronic renal insufficiency/failure</li> <li>➢ Turner's Syndrome</li> <li>➢ Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma</li> <li>➢ Wasting associated with AIDS or cachexia</li> <li>➢ Noonan Syndrome</li> </ul> </li> </ul>
<p><b>HEPATITIS C VIRUS TREATMENTS</b>  <i>Effective 10/1/2013</i> <i>Revised 6/1/2014</i></p>	<p><b>*Must meet eligibility criteria</b>  VICTRELIS (boceprevir)</p>	<p><b>Prior Authorization Required</b>  INCIVEK (Telaprevir) OLYSIO (Simeprevir) SOVALDI (Sofosbuvir)</p>	<p>Requests for <b>Victrelis®</b> will be prior authorized if the following criteria are met:</p> <ul style="list-style-type: none"> <li>○ A documented diagnosis of Hepatitis C Genotype 1 with no HIV co-infection AND concurrent therapy with ribavirin and pegylated interferon.</li> <li>○ The patient will be on a treatment regimen of ribavirin and pegylated interferon for four (4) weeks prior to initiation of Victrelis.</li> <li>○ The patient is eighteen (18) years or older.</li> </ul>

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

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>detection of approximately 10 to 15 IU/ml is required to be submitted before the start of therapy.</p> <ul style="list-style-type: none"> <li>○ For patients with HCV genotype 1a, evidence should be provided that the patient does not have NS3 Q80K polymorphism prior to starting therapy.</li> </ul> <p>Prior authorization for Olysio ® will be determined on a case by case basis. Providers must provide the Department with full documentation regarding the rationale for treatment with Olysio ®</p> <p><b>Sovaldi (Sofosbuvir)</b>            Will be approved on a case by case basis            Will be evaluated based on the following interim criteria:</p> <ol style="list-style-type: none"> <li>1. Must have chronic Hepatitis C (HCV) genotype 1, 2, or 4 AND</li> <li>2. Clients is 18 years of age and older AND</li> <li>3. Women of childbearing potential and their male partners must use two forms of effective (non-hormonal) contraception during treatment. Initial pregnancy test must be performed prior to beginning therapy.</li> <li>4. Sofosbuvir is prescribed by or in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist AND</li> <li>5. Meets one of the following categories based on liver biopsy or other accepted test:               <ul style="list-style-type: none"> <li>• Clients with serious extra-hepatic manifestations of HCV such as leukocytoclastic vasculitis, hepatocellular carcinoma meeting Milan criteria, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia despite mild liver disease.</li> <li>• Clients with compensated or decompensated cirrhosis defined by one of the following: Child-Turcotte Pugh class A or B (Score 5-9 ascites), hepatic encephalopathy, or variceal bleeding.</li> <li>• Transplant patients with fibrosing cholestatic HCV or recipient who have cirrhosis from recurrent HCV and have been approved for re-transplantation</li> <li>• Client is listed on the transplant list with a projected time to transplant of &lt; 1 year.</li> <li>• Client has a Metavir fibrosis score of 3-4</li> </ul> </li> <li>6. For clients with Genotype 1, must be Hepatitis C treatment naïve AND</li> <li>7. The client does not have severe renal impairment (eGFR&lt;30 ml/min/1.73m<sup>2</sup>) or end state renal disease requiring hemodialysis AND</li> </ol>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<ol style="list-style-type: none"> <li>8. Client must be 6 months free of substance abuse/opioid/alcohol dependence as documented by appropriate drug screens and counseled about the importance of refraining from drug and/or alcohol abuse. Routine substance/alcohol/opioid screens must be conducted monthly for clients that have a history (within the past 2 years) of drug or alcohol abuse AND</li> <li>9. Client must have a baseline HCV RNA level within 30 days of anticipated start date AND</li> <li>10. Client is not receiving concomitant treatment with a hepatitis protease inhibitor (e.g. telaprevir or boceprevir) AND</li> <li>11. All approvals will initially be for a 8 week time period, with further approvals dependent on the submission of the HCV RNA level at 4, at week 12, and week 24 to rational drug therapy (see discontinuation criteria) AND</li> <li>12. If the week 4 HCV RNA is detectable while on sofosbuvir therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has increased (i.e., &gt;1 log<sub>10</sub> IU/ml from nadir) all treatment will be discontinued unless documentation is provided to support continuation of therapy.</li> <li>13. Must be in accordance to approved regimens and duration (see Table 1) AND</li> <li>14. Must be adherent to treatment regimen (see discontinuation criteria) AND</li> <li>15. Must be Sofosbuvir naïve</li> </ol> <p><b>Note:</b> Once treated, the Department will only cover a once per lifetime treatment with Sofosbuvir.</p> <p><b>Discontinuation Criteria:</b></p> <ul style="list-style-type: none"> <li>• Patients receiving a Sofosbuvir based regimen should have HCV RNA levels assessed at weeks, 4, 6 (if applicable), and 12 (if applicable); if the HCV RNA is above the lower limit of quantification by a validated test at any of these time points, all treatment will be discontinued.</li> <li>• The department will prospectively evaluate medication adherence based on prescription fills. If a patient documents non-adherence to filling their Sofosbuvir prescription (e.g. within 7 days), all treatment will be discontinued.</li> </ul> <p><b>Quantity and Refill Limits:</b>            Quantity Limit: one 400mg tablet per day (28 tablets/28days)            Length of authorization: Based on HCV subtype</p>
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>Refills: Should be reauthorized in order to continue the appropriate treatment plan. The patient <b>MUST</b> receive refills within one week of completing the previous fill.</p> <p><b>Table 1. Recommended Regimens and Treatment Duration for Sofosbuvir</b></p> <table border="1"> <thead> <tr> <th data-bbox="1251 423 1619 553">HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-Co-infected)</th> <th data-bbox="1619 423 1835 553">Treatment</th> <th data-bbox="1835 423 2060 553">Duration</th> </tr> </thead> <tbody> <tr> <td data-bbox="1251 553 1619 748">Patients with genotype 1 or 4 HCV with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon eligible</td> <td data-bbox="1619 553 1835 748">Sofosbuvir + peginterferon alfa + ribavirin</td> <td data-bbox="1835 553 2060 748">12 weeks</td> </tr> <tr> <td data-bbox="1251 748 1619 911">Patients with genotype 1 with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon ineligible</td> <td data-bbox="1619 748 1835 911">Sofosbuvir + ribavirin</td> <td data-bbox="1835 748 2060 911">24 weeks</td> </tr> <tr> <td data-bbox="1251 911 1619 1040">Patients with genotype 2 HCV with or without compensated cirrhosis (including those with hepatocellular carcinoma)</td> <td data-bbox="1619 911 1835 1040">Sofosbuvir + ribavirin</td> <td data-bbox="1835 911 2060 1040">12 weeks</td> </tr> <tr> <td data-bbox="1251 1040 1619 1235">Post-transplant patients (genotypes 1,2, and 4) with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon eligible</td> <td data-bbox="1619 1040 1835 1235">Sofosbuvir + peginterferon alfa+ ribavirin</td> <td data-bbox="1835 1040 2060 1235">12 weeks</td> </tr> <tr> <td data-bbox="1251 1235 1619 1430">Post-transplant patients (genotypes 1,2, and 4) with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon ineligible</td> <td data-bbox="1619 1235 1835 1430">Sofosbuvir + ribavirin</td> <td data-bbox="1835 1235 2060 1430">24 weeks</td> </tr> </tbody> </table> <p><b>Interferon Alpha Ineligible defined:</b></p> <ul style="list-style-type: none"> <li>• Platelet count &lt;75,000mm3</li> </ul>	HCV Genotype and Comorbidities (Mono-infected and HCV/HIV-Co-infected)	Treatment	Duration	Patients with genotype 1 or 4 HCV with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon eligible	Sofosbuvir + peginterferon alfa + ribavirin	12 weeks	Patients with genotype 1 with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon ineligible	Sofosbuvir + ribavirin	24 weeks	Patients with genotype 2 HCV with or without compensated cirrhosis (including those with hepatocellular carcinoma)	Sofosbuvir + ribavirin	12 weeks	Post-transplant patients (genotypes 1,2, and 4) with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon eligible	Sofosbuvir + peginterferon alfa+ ribavirin	12 weeks	Post-transplant patients (genotypes 1,2, and 4) with or without compensated cirrhosis (including those with hepatocellular carcinoma) if interferon ineligible	Sofosbuvir + ribavirin	24 weeks
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<ul style="list-style-type: none"> <li>Decompensated liver cirrhosis (CTP Class B or C or CTP score <math>\geq 7</math>).</li> <li>Documented history of depression or mood disorder, which are not stable on current drug regimen.</li> <li>Autoimmune hepatitis and another autoimmune disorder</li> <li>Inability to complete a prior treatment course due to a documented interferon-related adverse event.</li> </ul>
<b>INTRANASAL CORTICOSTEROIDS</b>  <i>Effective 4/1/2014</i>	<b>No Prior Authorization Required</b>  fluticasone (generic FLONASE)  NASONEX	<b>Prior Authorization Required</b> 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).  ★Rhinocort AQ will be approved for pregnant clients without failure of Preferred products. ★Brand name Flonase will require a letter of medical necessity
<b>LEUKOTRIENE MODIFIERS</b>  <i>Effective 4/1/2014</i>	<b>No Prior Authorization Required</b>  montelukast (generic SINGULAIR)	<b>Prior Authorization Required</b>  ACCOLATE (zafirlukast) ZYFLO (zileuton) SINGULAIR	Non-preferred Leukotrienes will be approved if <b>both</b> of the following criteria are met: <ul style="list-style-type: none"> <li>Client failed treatment with montelukast in the last 12 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</li> <li>Client has a diagnosis of Asthma</li> </ul>
<b>MULTIPLE SCLEROSIS AGENTS</b>  <i>Effective 4/1/2014</i>	<b>No Prior Authorization Required</b> AVONEX BETASERON REBIF COPAXONE 20MG INJECTION	<b>Prior Authorization Required</b> AMPYRA EXTAVIA GILENYA AUBAGIO TECFIDERA COPAXONE 40MG INJECTION	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). <b>Ampyra</b> – Up to a 90 day supply of Ampyra will be approved if all of the following criteria are met: <ul style="list-style-type: none"> <li>Client has a diagnosis of MS;</li> <li>Client is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment;</li> <li>Client is currently receiving a disease modifying agent (if indicated);</li> <li>Client has no history of seizure disorder;</li> <li>Client has no history of moderate to severe renal dysfunction (CrCl &gt; 50 ml/min);</li> <li>Prescriber is a neurologist;</li> <li>The prescribed dose does not exceed 10 mg twice daily.</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p>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"> <li>• Has failed six month trial with COPAXONE 20mg 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"> <li>• 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.</li> <li>• On clinical exam, signs and symptoms consistent with functional limitations, except sensory relapse, that last one month or longer.</li> </ul> </li> </ul> <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> <li>• Has a diagnosis of a relapsing form of MS AND</li> <li>• Is being prescribed by a neurologist AND</li> <li>• Has no active infections AND</li> <li>• 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</li> <li>• Had transaminase and bilirubin levels with ALT&lt;2 times the upper limit of normal within the 6 months prior to initiating therapy AND</li> <li>• Had a complete blood count with differential within the six months prior to initiating therapy AND</li> <li>• Has a documented baseline blood pressure AND</li> <li>• Has been evaluated for active or latent tuberculosis infections by documented test results (purified protein derivative test) or blood test.</li> </ul> <p>TECFIDERA will be approved if the client has met all the following criteria:</p> <ul style="list-style-type: none"> <li>• Has failed six month trial with COPAXONE 20mg 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"> <li>• 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.</li> <li>• On clinical exam, signs and symptoms consistent with functional limitations, except sensory relapse, that last one month or longer.</li> </ul> </li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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			<p>AND</p> <ul style="list-style-type: none"> <li>• Has a diagnosis of a relapsing form of MS AND</li> <li>• Is being prescribed by a neurologist AND</li> <li>• Has no active infections AND</li> <li>• Had a complete blood count with differential within the six months prior to initiating therapy.</li> </ul> <p>GILENYA will be approved if the client has met all the following criteria:</p> <ul style="list-style-type: none"> <li>• Has failed six month trial with COPAXONE 20mg 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"> <li>• 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.</li> <li>• On clinical exam, signs and symptoms consistent with functional limitations, except sensory relapse, that last one month or longer.</li> </ul> </li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• Has a diagnosis of a relapsing form of MS AND</li> <li>• Is being prescribed by a neurologist AND</li> <li>• 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</li> <li>• Does not have a history or presence of Mobitz Type II 2<sup>nd</sup> degree or 3<sup>rd</sup> degree AV block or sick sinus syndrome unless patient has a pacemaker</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• Has a baseline QTc interval &lt;500 ms prior to starting therapy AND</li> <li>• Is not receiving treatment with a Class Ia or Class III anti-arrhythmic medication AND</li> <li>• Has no active infections AND</li> <li>• Had an ophthalmologic evaluation (ocular coherence test) prior to starting therapy within 3-4 months after starting therapy AND</li> <li>• Had a baseline complete blood count with differential and liver function tests.</li> </ul>
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>OPHTHALMIC ALLERGY</b>  <i>Effective 4/1/2014</i>	<b>No Prior Authorization Required</b> cromolyn PATANOL PATADAY	<b>Prior Authorization Required</b> ALAMAST, ALAWAY ALOCRIL, 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)
<b>OPIOIDS Long Acting – Oral Opioids</b>  <i>Effective 7/1/2014</i>	<b>FIRST LINE (No Prior Authorization Required)</b>  methadone (generic Dolophine)  morphine ER (generic MS Contin)  fentanyl patches	<b>Prior Authorization Required</b>  AVINZA (morphine ER) BUTRANS (buprenorphine) DOLOPHINE (methadone) DURAGESIC (fentanyl patch) KADIAN (morphine ER) MS CONTIN (morphine ER) – Brand NUCYNTA ER (tapentadol ER) ORAMORPH SR (morphine ER) - Brand OXYCONTIN (oxycodone ER) OPANA ER (oxymorphone ER) EMBEDA(morphine/naltrex.) XARTEMIS XR (oxycodone/acetaminophen) 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.)  Butrans patches will be approved for clients who have failed treatment with ONE preferred agent in the last 6 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.)  Zohydro ER will be approved for clients who have failed treatment with two preferred products, AND at least one other long acting opiate in the past year.  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 MUST counsel women of childbearing age regarding the risks of becoming pregnant while receiving opioids, including the risk of neonatal abstinence syndrome. Providers should offer access to contraceptive services when necessary.
<b>OVERACTIVE BLADDER AGENTS</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required</b>  oxybutynin tablets (generic) oxybutynin ER tablets (generic)	<b>Prior Authorization Required</b>  DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) flavoxate	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.

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
	TOVIAZ (fesoterodine ER)	GELNIQUE (oxybutynin gel) OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) tolterodine VESICARE (solifenacin) Myrbetriq (mirabegron)	
<b>PANCREATIC ENZYMES</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  CREON ZENPEP	<b>Prior Authorization Required</b>  PANCREAZE PANCRELIPASE PERTZYE ULTRESA VIOKACE	Non-preferred products will be approved for clients who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.)  Grandfathering: Clients currently stabilized on a Non-preferred pancreatic enzyme can receive approval to continue on that agent for one year if medically necessary.
<b>PROTON PUMP INHIBITORS</b>  <i>Effective 1/1/2014</i>	<b>*Must meet eligibility criteria</b>  ACIPHEX (rabeprazole)  lansoprazole 15mg OTC (currently available as PREVACID 24HR)  NEXIUM (esomeprazole) capsules and <b>packets</b>  omeprazole generic capsules  PREVACID solutab <sup>BNR</sup> (lansoprazole) (for clients under 2)	<b>Prior Authorization Required</b>  ACIPHEX sprinkles (rabeprazole)  KAPIDEX (dexlansoprazole)  DEXILANT (dexlansoprazole)  lansoprazole capsules lansoprazole solutabs  pantoprazole  PREVACID (lansoprazole) capsules & suspension  PRILOSEC OTC (omeprazole)  PROTONIX (pantoprazole)  ZEGERID (omeprazole/Na bicarbonate)	*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.  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.  Non-preferred proton pump inhibitors will be approved if all of the following criteria are met: <ul style="list-style-type: none"> <li>➤ Client failed treatment with two Preferred Products within the last 24 months,</li> <li>➤ Client has a qualifying diagnosis, and</li> <li>➤ Client has been diagnosed by an appropriate diagnostic method.</li> </ul> <b>The Qualifying Diagnoses are:</b>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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H. Pylori Treatments		First-omeprazole  First-lansoprazole	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 <b>The Appropriate Diagnostic Methods are:</b> GI Specialist, Endoscopy, X-Ray, Biopsy, Blood test, or Breath test  <b>Quantity Limits:</b> 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. <b>Age Limits:</b> 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 $\geq 2$ 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.

<b>PULMONARY ARTERIAL HYPERTENSION THERAPIES</b> <b>Phosphodiesterase Inhibitors</b>	<b>*Must meet eligibility criteria</b> Sildenafil (generic Revatio)	<b>Prior Authorization Required</b>  REVATIO	<b>*Eligibility Criteria for all agents in the class</b> Approval will be granted for a diagnosis of pulmonary hypertension.
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<i>Effective 1/1/2014</i>	ADCIRCA (tadalafil)		
<b>Endothelin Antagonists</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  Letairis (ambrisentan)	<b>Prior Authorization Required</b>  Tracleer (bosentan) OPSUMIT (Macitentan)	Non-preferred products will be approved for clients who have failed treatment with Letairis or for clients requiring a dose preparation not available with a preferred product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) <b>Grandfathering:</b> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.
<b>Prostanoids</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>  epoprostenol (generic) Veletri (epoprostenol)	<b>Prior Authorization Required</b>  Flolan (brand) Remodulin (treprostinil) Tyvaso (treprostinil) Ventavis (iloprost) 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) <b>Grandfathering:</b> Clients who have been previously stabilized on a Non-preferred product can receive approval to continue on the medication for one year if medically necessary.
<b>Guanylate Cyclase (sGC) Stimulator</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  Adempas (riociguat)	Adempas will be approved for patients who meet the following criteria: <ul style="list-style-type: none"> <li>○ Patient is not a pregnant female and is able to receive monthly pregnancy tests while taking Adempas and one month after stopping therapy. AND</li> <li>○ Women of childbearing potential and their male partners must use one of the following contraceptive methods during treatment and one month after stopping treatment (e.g, IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method). AND</li> <li>○ Patient is not receiving dialysis or has severe renal failure (e.g, Crcl &lt; 15 ml/min). AND</li> <li>○ Patient does not have severe liver impairment (e.g, Child Pugh C). AND</li> <li>○ Prescriber must be enrolled with the Adempas REMS Program. AND</li> <li>○ Female patients, regardless of reproductive potential, must be enrolled in the Adempas REMS program prior to starting therapy. AND</li> <li>○ Patient has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR</li> <li>○ Patient has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension.</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			(Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions).
<b>RESPIRATORY INHALANTS Inhaled Anticholinergics &amp; Anticholinergic Combinations</b>  <i>Effective 7/1/2014</i>	<b>No Prior Authorization Required</b>  <u>Solutions</u> albuterol/ipratropium (generic Duoneb) ipratropium (generic Atrovent) <u>Short-Acting Inhalers</u> ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ipratropium) <u>Long-Acting Inhalers</u> SPIRIVA Handihaler (tiotropium)	<b>Prior Authorization Required</b>  <u>Solutions</u> ATROVENT (ipratropium) solution DUONEB (albuterol/ipratropium)  <u>Short-Acting Inhalers</u>  <u>Long-Acting Inhalers</u> TUDORZA Pressair (aclidinium) INCRUSE ELLIPTA ANORO ELLIPTA	Non-preferred anticholinergic inhalants and anticholinergic combination inhalants will require a brand-name prior authorization stating medical necessity.  Tudorza Pressair will be approved for clients who have failed treatment with Spiriva Handihaler (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction), or who have a contraindication to Spiriva Handihaler.
<b>RESPIRATORY INHALANTS Inhaled Beta2 Agonists (short acting)</b>  <i>Effective 7/1/2014</i>	<b>No Prior Authorization Required</b>  <u>Solutions</u> albuterol (generic) solution  <u>Inhalers</u> PROAIR (albuterol) HFA inhaler	<b>Prior Authorization Required</b>  <u>Solutions</u> ACCUNEB (albuterol) solution AIRET (albuterol) solution ALUPENT (metaproterenol) PROVENTIL (albuterol) soln. VENTOLIN (albuterol) solution XOPENEX (levalbuterol) soln. <u>Inhalers</u> 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	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>RESPIRATORY INHALANTS Inhaled Beta2 Agonists (long acting)</b>  <i>Effective 7/1/2014</i>	<b>No Prior Authorization Required</b>	<b>Prior Authorization Required</b>  <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.
<b>RESPIRATORY INHALANTS Inhaled Corticosteroids</b>  <i>Effective 7/1/2014</i>	<b>No Prior Auth Required</b>  <u>Solutions</u> budesonide nebulizer  <u>Inhalers</u> ASMANEX twist (mometasone) FLOVENT (fluticasone) HFA FLOVENT diskus QVAR (beclomethasone)	<b>Prior Authorization Required</b>  <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.
<b>RESPIRATORY INHALANTS Inhaled Corticosteroid Combinations</b>  <i>Effective 7/1/2014</i>	<b>No Prior Authorization Required</b>  ADVAIR Diskus (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol)	<b>Prior Authorization Required</b>  BREO Ellipta (vilanterol/fluticasone furoate) SYMBICORT (budesonide/formoterol)	Non-preferred inhaled corticosteroid combination inhalants will be approved for clients meeting the following criteria: <ul style="list-style-type: none"> <li>➤ Client has a qualifying diagnosis of asthma or COPD; and</li> <li>➤ Clients with a diagnosis of asthma will have to fail two preferred agents due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.</li> <li>➤ Clients with a diagnosis of COPD will only have to fail one preferred agent due to lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.</li> </ul>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<p><b>SEDATIVE- HYPNOTICS (non-benzodiazepine)</b></p> <p><i>Effective 4/1/2014</i></p>	<p><b>No Prior Authorization Required* (unless duplication criteria apply)</b></p> <p>LUNESTA (eszopiclone) zaleplon zolpidem</p>	<p><b>Prior Authorization Required</b></p> <p>AMBIEN CR (zolpidem) AMBIEN (zolpidem) - Brand EDLUAR (zolpidem) INTERMEZZO (zolpidem) ROZEREM (ramelteon) SONATA (zaleplon) - Brand ZOLPIMIST (zolpidem)</p>	<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 <math>\geq 65</math> 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><b><u>Children:</u></b> Prior authorizations will be approved for clients 18 years of age and older.</p> <p><b><u>*Duplications:</u></b> Only one agent in this drug class will be approved at a time. Approval will not be granted for clients currently taking a long-acting benzodiazepine such as clonazepam or temazepam.</p>
<p><b>SKELETAL MUSCLE RELAXANTS</b></p> <p><i>Effective 7/1/2014</i></p>	<p><b>No Prior Authorization Required For Clients under 75 years of age*</b></p> <p>baclofen (generic Lioresal)</p> <p>cyclobenzaprine (generic Flexeril)</p> <p>tizanidine (generic Zanaflex)</p>	<p><b>Prior Authorization Required</b></p> <p>AMRIX ER chlorzoxazone carisoprodol DANTRIUM dantrolene FEXMID FLEXERIL metaxolone methocarbamol NORFLEX orphenadrine PARAFLEX PARAFON FORTE REMULAR ROBAXIN SKELAXIN ZANAFLEX SOMA VANADOM RELA</p>	<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.)
<b>STATINS &amp; STATIN COMBINATIONS</b>  <i>Effective 4/1/2014</i>	<b>No Prior Authorization Required</b>  CRESTOR (rosuvastatin)  atorvastatin  pravastatin  simvastatin*	<b>Prior Authorization Required</b> ALTOPREV (lovastatin ER) LESCOL (fluvastatin) LESCOL XL (fluvastatin ER) LIPITOR (atorvastatin) LIVALO (pitavastatin) lovastatin (generic Mevacor) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR* (simvastatin) <b>Statin Combinations</b> ADVICOR (niacin ER / lovastatin) CADUET (amlodipine /atorvastatin) LIPTRUZET (ezetimibe/atorvastatin) SIMCOR (niacin/simvastatin) VYTORIN* (ezetimibe/simvas.)	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)  <b>Children:</b> Altoprev, Advicor, Livalo and Vytorin will be approved for clients 18 years of age and older. Caduet, fluvastatin and lovastatin will be approved for clients 10 years of age and older.  *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.
<b>STIMULANTS and other ADHD agents</b>  <i>Effective 10/1/2013</i>	<b>No Prior Authorization Required (as long as age, daily dose and diagnosis limitations are met)</b>  mixed-amphetamine salts (generic Adderall) ADDERALL XR (brand name mixed amphetamine salts ER) CONCERTA (brand name methylphenidate ER) dexmethylphenidate (generic)	<b>Prior Authorization Required</b> ADDERALL (brand name mixed amphetamine salts) mixed-amphetamine salts ER (generic for Adderall XR) DAYTRANA (methylphenidate transdermal) DESOXYN (methamphetamine) DEXEDRINE (dextroamphetamine) FOCALIN (brand name dexmethylphenidate) INTUNIV (guanfacine ER) KAPVAY (clonidine ER) METADATE CD (methylphenidate ER)	For beneficiaries with ADD/ADHD or narcolepsy warranting treatment with a stimulant or non-stimulant (either preferred or non-preferred), a diagnosis of ADD/ADHD or narcolepsy must be documented in the beneficiaries medical record at the time of diagnosis and annually.  For patients with ADD/ADHD, prior to receiving pharmacotherapy, the beneficiary must have additional documentation through a validated ADHD/ADD instrument.  For beneficiaries with ADD/ADHD who are currently receiving a stimulant or non-stimulant but does not have an official diagnosis of ADD/ADHD, the beneficiary will have six months to obtain a diagnosis otherwise the medication will be discontinued.  Non-preferred agents will be approved for clients who have documented failure with two Preferred products in the last 12 months (age six years or older) or

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
	FOCALIN XR (dexmethylphenidate 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><b>In addition:</b>            Non-preferred agents will only be approved for FDA and official compendium indications.</p> <ul style="list-style-type: none"> <li>▪ Intuniv will be approved for clients with a diagnosis of ADHD and ADD. Beneficiaries with ADD/ADHD must fail a 4 week trial of generic guanfacine before the use of Intuniv® will be approved. Only one tablet per day will be approved.</li> <li>▪ Beginning 11/1/2013, Provigil will only be approved for Narcolepsy, Obstructive Sleep Apnea/Hypopnea Syndrome, Shift Work Sleep Disorder, Traumatic Brain Injury, Multiple Sclerosis related fatigue or ADHD. Beneficiaries must fail a 4 week trial of a Preferred Stimulant before the use of Provigil® will be approved. Only one tablet per day will be approved.</li> <li>▪ Nuvigil will be approved for obstructive sleep apnea/hypopnea syndrome, narcolepsy and shift work sleep disorder. Beneficiaries with ADD/ADHD must fail a 4 week trial of a Preferred Stimulant before the use of Nuvigil® will be approved. Only one tablet per day will be approved.</li> <li>▪ All other Non-preferred products will be approved for clients with a diagnosis of ADD, ADHD, Narcolepsy, Multiple Sclerosis related fatigue, traumatic brain injury or severe autism.</li> </ul> <p><b>And</b></p> <p>Non-preferred agents will only be approved for FDA approved age limitations.</p> <ul style="list-style-type: none"> <li>▪ Provigil will be approved for clients 16 years of age and older.</li> <li>▪ Nuvigil will be approved for clients 17 years of age and older.</li> <li>▪ Adderall IR, Dexedrine and Dextrostat will be approved for clients 3 years of age and older.</li> <li>▪ All other medications in this class will be approved for clients 6 years of age and older.</li> </ul> <p><b>Daytrana, Methylin solution and Quillivant XR:</b> Clients with documented difficulty swallowing that are unable to utilize alternative dosing with FOCALIN XR, VYVANSE or ADDERALL XR can receive approval without failure on preferred products. Provider must document contraindications.</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
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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"><b>Preferred</b></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"><b>Non preferred</b></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	<b>Preferred</b>		AMPHETAMINE SALTS	40 mg/day	CONCERTA ER ®	54 mg/day or 72 mg/day ≥ age 13	METHYLPHENIDATE ER	60 mg/day	VYVANSE ®	70 mg/day	FOCALIN XR ®	40 mg/day	ADDERALL XR®	40 mg/day	METHYLPHENIDATE	60 mg/day	METHYLIN	60 mg/day	METHYLPHENIDATE	60 mg/day	METHYLPHENIDATE SR	60 mg/day	<b>Non preferred</b>		METADATE CD ®	60 mg/day	KAPVAY ER ®	0.1 mg/day	D-AMPHETAMINE ER	40 mg/day	DAYTRANA ®	30 mg/day	PROVIGIL ®	400 mg/day	RITALIN LA ®	60 mg/day	INTUNIV ER®	4 mg/day	ADDERALL ®	40 mg/day	NUVIGIL ®	250 mg/day	METHYLIN ER ®	60 mg/day	METHYLIN SUSPENSION®	60 mg/day	FOCALIN ®	20 mg/day
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Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred Products will be approved for one year unless otherwise stated.)
<p><b>TARGETED IMMUNE MODULATORS FOR RHEUMATOID ARTHRITIS</b></p> <p><i>Effective 1/1/2014</i></p>	<p><b>No Prior Authorization Required</b></p> <p>ENBREL (etanercept) HUMIRA (adalimumab)</p>	<p><b>Prior Authorization Required</b></p> <p>CIMZIA (certolizumab) KINERET (anakinra) ORENCIA (abatacept) Subcutaneous SIMPONI (golimumab) XELJANZ (tofacitinib) STELARA (ustekinumab) ACTEMRA (tocilizumab)</p> <p><b>*for information on IV infused Targeted Immune Modulators for Rheumatoid Arthritis please see Appendix P</b></p>	<p><b>Cimzia</b> (all dosage forms)</p> <ul style="list-style-type: none"> <li>will be approved for treatment of Crohn’s disease in clients who have had treatment failure with Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</li> <li>will be approved for treatment of RA in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</li> <li>will be approved for treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</li> </ul> <p><b>Kineret</b> will be approved for treatment of RA in clients who have had treatment failure with Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p><b>Kineret</b> will be approved without prior authorization for clients with documented neonatal-onset multisystem inflammatory disease (NOMID).</p> <p><b>Orencia</b> will be approved for the treatment of RA in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p><b>Simponi</b> will be approved (in combination with methotrexate) for treatment of RA in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p><b>Simponi</b> will be approved with or without methotrexate for the treatment of Ankylosing Spondylitis or Psoriatic Arthritis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction).</p> <p><b>Stelara</b> will be approved with or without methotrexate for the treatment of Psoriatic Arthritis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
			<p><b>Stelara</b> will be approved for moderate to severe plaque psoriasis in clients who have tried and failed Enbrel and Humira (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p><b>Xeljanz</b> will be approved for the treatment of RA in clients who have had treatment failure with methotrexate with at least two separate preferred TNF inhibitors (Humira and Enbrel). (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p> <p><b>Xeljanz</b> will be not be approved for combination therapy with a biologic disease modifying agent.</p> <p>Quantity Limits: 2 tablets per day or 60 tablets for a 30 day supply</p> <p><b>Grandfathering:</b> Clients currently stabilized on a Non-preferred product can receive approval to continue on that agent for one year if medically necessary.</p>
<p><b>TESTOSTERONE PRODUCTS</b></p> <p><i>Effective 7/1/2014</i></p>	<p><b>No prior authorization required (must meet criteria)</b></p> <p>Androgel 1.62% (testosterone topical)</p> <p>Androderm (testosterone patch)</p> <p>Depo Testosterone <sup>BNR</sup> (testosterone injection)</p>	<p><b>Prior Authorization Required</b></p> <p>Androgel 1% Testosterone Cypionate Testim gel Axiron Fortesta gel Testosterone Enanthate</p>	<p>Preferred androgenic drugs will be approved for clients meeting the following:</p> <p><i>Hypogonadotropic or Primary Hypogonadism</i></p> <ul style="list-style-type: none"> <li>• Male patient <math>\geq 18</math> years of age</li> <li>• Has a documented diagnosis of hypogonadotropic or primary hypogonadism (Patients with other diagnoses will require a manual review by a state pharmacist) AND</li> <li>• Has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND</li> <li>• Does not have a diagnosis of breast or prostate cancer AND</li> <li>• Does not have a palpable prostate nodule or prostate-specific antigen (PSA) <math>&gt;4\text{ng/ml}</math> AND</li> <li>• Has normal liver function tests prior to initiation of therapy</li> </ul> <p><i>Gender Transition</i></p> <ul style="list-style-type: none"> <li>• Biologically born female patient <math>\geq 18</math> years of age* AND</li> <li>• Is undergoing female to male transition AND</li> <li>• Has a negative pregnancy test AND</li> <li>• Has normal liver function test prior to initiation of therapy</li> </ul> <p>*For clients <math>&lt;18</math> years of age, a manual review will be required.</p> <p>Non preferred androgenic products will be approved for patients meeting the above criteria with documented failure with an 8 week trial of a preferred androgenic product. (Failure is defined as: lack of efficacy of a three month trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p>

Therapeutic Drug Class	Preferred Agents	Non-preferred Agents	<b>Prior Authorization Criteria</b> (All Non-preferred Products will be approved for one year unless otherwise stated.)
<b>TOPICAL IMMUNOMODULATORS</b>  <i>Effective 7/1/2014</i>	<b>No Prior Authorization Required (must meet criteria)</b> ELIDEL (pimecrolimus)*	<b>Prior Authorization Required</b> PROTOPIC (tacrolimus)	<p>*Elidel 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>Protopic will only be approved for a client who had an adequate trial (e.g. one month or longer) of a topical steroid and Elidel and failed treatment. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). This will be a one-time prior authorization.</p> <p>Prior authorization is required for children &lt; 2 years of age.</p> <p>Prior authorization will be required for clients warranting ≥ 6 weeks of therapy with either Elidel or Protopic.</p>
<b>TRIPTANS</b>  <i>Effective 1/1/2014</i>	<b>No Prior Authorization Required (monthly quantity limits may apply)</b>  IMITREX tablets  IMITREX nasal spray and injection <sup>BNR</sup>  sumatriptan tablets  MAXALT MLT tablets (rizatriptan)  naratriptan tablets	<b>Prior Authorization Required</b>  AXERT (almotriptan)  AMERGE (naratriptan)  FROVA (frovatriptan)  RELPAX (eletriptan)  SUMAVEL DOSEPRO  TREXIMET (sumatriptan and naproxen)  ZOMIG (zolmitriptan)  Maxalt tablets (rizatriptan)  sumatriptan nasal spray and injection	<p>Non-preferred products will be approved for clients who have failed treatment with two Preferred Products within the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p><b>Quantity Limits:</b>            Amerge, Frova, Imitrex, Treximet and Zomig: Max 9 tabs / 30 days.            Axert and Relpax: Max 6 tabs / 30 days.            Maxalt: Max 12 tabs / 30 days.            Zomig nasal spray and Imitrex Nasal Spray: Max 6 inhalers / 30 days.            Imitrex injection: Max 4 injectors / 30 days</p>